NORWEGIAN MINISTRY OF HEALTH AND CARE SERVICES

NORWEGIAN MINISTRY OF FOREIGN AFFAIRS

Meld.St. 11 (2011-2012) (white paper)
Global health in foreign and development policy

Norwegian actors' engagement in global health

Content

Meld.St. 11 (2011-2012) (white paper) Global health in foreign and development policy describes challenges and gives clear priorities for a coherent Norwegian global health policy up to 2020 with particular focus on three priority areas: Mobilising for women's and children's rights and health, reducing the burden of disease with the emphasis on prevention, and promoting human security through health.

Through this publication, a large group of actors, including those outside the public sector, have reported on who they are and what they do within global health and the prioritised areas.

The editorial staff would like to thank them for all the contributions to this publication.

Foreword

Follow-up of Meld St. 11 (2011-2012) Report to the Storting (White Paper) Global health in foreign and development policy

In 2012 the Government presented a white paper to the Parliament on global health in foreign and development policy. The White Paper places the priorities for a coherent Norwegian global health policy in three main areas: mobilizing for women's and children's rights and health; reducing the burden of disease with the emphasis on prevention; and promoting human security through health. The engagement goes far beyond aid, and we see a general turn towards partnership, technical cooperation, capacity building and better governance.

The work towards global health holds a high priority for our Government. The Government's political platform takes special responsibility for Millennium Development Goals 4 and 5 on reducing child mortality and improving maternal health. The Prime Minister has flagged this as one of his priority areas.

We wish to further develop a coherent Norwegian global health policy. This policy must be identified in accordance with the full range of challenges and opportunities. Strengthening coordination to achieve this goal is something we will continuously work towards.

The Government's policy for global health shall be evidence based. This assumes systematic use of research and evidence which provides a basis for making good choices, stimulating innovation and formulating objectives which provide answers to existing global health challenges. Use of political networks across traditional fora and alliances has proven to be effective instruments for improving integration of health objectives in foreign and development policy. We are now seeing the results of these efforts. Child mortality has been reduced from 12 million in 1990 to 6.9 million in 2011, while maternal mortality has been reduced from 540,000 in 1990 to 278,000 in 2010. However, 19,000 children unfortunately still die every day from diseases which can be prevented and treated with simple methods. More can and must be done. At the same time we see a double burden arising. The global burden of disease is changing, with an increase of unhealthy life-style and other non-communicable diseases. Access to universal health coverage is important to ensure better health for all. Norway works actively to strengthen national health systems in low-income countries, with a focus on national ownership.

A greater part of the World's poorest is to be found in middle-income countries, which will mean that the reduction in poverty must be directed towards poor and marginal groups to a greater extent. Investment in health is, as education, an important tool in combating poverty.

The present development goals are set with 2015 as a deadline. The health goals will not be reached by then. The design of new development goals will in the near future be an important but complex process.

The new goals must be simple and measurable, necessitating the need for clarity and good data. We are of the opinion that the main emphasis shall be poverty reduction, equity and sustainable development. In 2013, the UN issued an invitation to the most inclusive and democratic consultation process in the UN's history, to contribute to the development agenda post-2015. All actors, both public and private, have been able to submit their contributions. There is a need for wide consultations and inputs from academic and research institutions, civil society, voluntary organizations and the private sector.

We wish to further develop a coherent Norwegian global health policy. This policy must be identified in accordance with the full range of challenges and opportunities. Strengthening coordination to achieve this goal is something we will continue to work towards.

This report is part of the follow-up of the White Paper on Global Health. We wish to work further to strengthen Norway's engagement for better health in a global world. We have therefore invited organizations, academic institutes, professional associations and the private sector, in addition to relevant Ministries and professional governmental agencies, to contribute with their activities and results to a report which reflects various Norwegian actors' engagement. The purpose of the report is to illustrate the wide range in activities with some concrete examples, show the results that have been achieved, as well as the challenges and possibilities the work offers.

The work towards global health holds a high priority for our Government. The Government's political platform takes special responsibility for Millennium Development Goals 4 and 5 on reducing child mortality and improving maternity health. The Prime Minister has flagged this as one of his priority areas.

Through 49 different contributions, we get a flare of what both public and non-governmental organisations are working on related to global health. The health stories and results are unique but nevertheless have many common features: Mobilization, prevention, competence-building, research and education, human rights, advocacy and collaboration across sectors.

The Report will be launched in connection with the World Health Day. We hope that the Report will contribute to better insight and inspire more debate and engagement for global health, to network-building and new forms of cooperation.

Espen Barth Eide
Minister of Foreign Affairs

Heikki Eidsvoll Holmås
Minister of International Development

Jonas Gahr Støre
Minister of Health and Care Services

Ministry of Foreign Affairs

The White Paper on "Global Health in Foreign and Development Policy" is the basis for all efforts made by the Ministry of Foreign Affairs on global health. During recent years we have seen positive results within the UN's health-related Millennium Development Goals, particularly in the reduction of child and maternal mortality.

The main part of the Norwegian aid is channelled through multilateral organizations such as WHO, UNAIDS, UNFPA, UNICEF and global health funds / mechanisms such as The Global Vaccine Alliance (GAVI), and The Global Fund to Fight AIDS, Tuberculosis and Malaria.

In its work with global health, which includes mobilizing for increased focus and support, Norway has close contact with international cooperation partners and other countries. Through the seven-country initiative, Norway cooperates with Thailand, Brazil, France, Indonesia, Senegal and South Africa on foreign policy and global health, where the focus in 2012 has been on universal health coverage.

Mobilizing for Women's and Children's Rights and Health
Mobilizing for women's and children's rights and health is one of the Government's main priorities. These efforts are made both bilaterally and globally, and are seen in the context of strengthening health services, recruitment of health personnel to the primary health service and sustainable health services. The Ministry of Foreign Affairs emphasizes national ownership, and in 2012 has had a close bilateral cooperation with India, Malawi, Nigeria, Pakistan and Tanzania regarding maternal and child health, with the objective of contributing to making these countries better able to reach their own health development objectives, ensuring better connections between Norway's global health initiative and the programmes, as well as better focus on results. Cooperation with other donors and international organizations including WHO and the World Bank, are central to contributing to consolidating and improving the efficiency of the many international financing initiatives for health. The point of departure for the cooperation is national priorities, initiatives and plans.

Globally, efforts for women's and children's health are anchored in the UN Secretary General's global strategy "Every Woman Every Child", and is leading for Norwegian priorities together with initiatives implemented to support this campaign. The strategy, to which Norway contributed with preparation, focuses on the most exposed groups such as pregnant women, neonates, young people and the disabled, in the 49 poorest countries in the world.

Together with Nigeria's President, Goodluck Jonathan, Prime Minister Stoltenberg led the Commission, the objective of which is to contribute to saving six million women and children over the next five years through focus on increased accessibility, price reductions and more efficient use of thirteen pharmaceuticals and family planning products.

As a part of the follow-up of the strategy, the UN Commission on Life-Saving Commodities for Women and Children in developing countries was launched in March 2012. Together with Nigeria's President, Goodluck Jonathan, Prime Minister Stoltenberg led the Commission, the objective of which is to contribute to saving six million women and children over the next five years through focus on increased accessibility, price reductions and more efficient use of thirteen pharmaceuticals and family planning products. Implementation of the Commission's recommendations is well underway and takes place on global and national levels. The Commission for Accountability and Information has already been in existence, launched in 2011, led by Canada and Tanzania, where the then Foreign Minister, Mr Støre, participated as a member of the Commission. Another important global health initiative within this framework is the "Family Planning Summit", held in London in July 2012, where global leaders committed themselves to increase accessibility to family planning methods for 120 million women by

2020. The partnership consists of developing countries, as well as Norway, the Bill and Melinda Gates Foundation, and Great Britain. In total, an amount of USD 4.6 billion was promised to reach the objective, and as a part of this, the Minister of Development, Mr Holmås, launched an increase of NOK 150 million annually over the next eight years for family planning. These funds will be connected to the implementation of the UN Commission on Life-Saving Commodities for Women and Children, where three of the products are family planning products.

Reducing the Burden of Disease with the Emphasis on Prevention
Vaccination in children's health is a central part of Norwegian efforts to achieve Millennium Development Goal 4 regarding reduced child mortality. In 2012, through GAVI, Norway contributed to preventing deaths among children, with the goal being to prevent a total of 3.9 million deaths during the period 2011–2015. AIDS, tuberculosis and malaria are included as an important part of the global health efforts, where The Global Fund to Fight AIDS, Tuberculosis and Malaria is the most important channel of support given to this area. Through the Global Fund, Norway contributes to saving ten million lives, as well as preventing 140-180 million new infections during the period 2012–2016. Other important channels used in 2012 for this work have been UNAIDS and UNITAID.

Strengthening of health systems is an important part of preventive work, and in 2012, the Ministry of Foreign Affairs also contributed considerable support through WHO for following up the Code for International Recruitment of Health Personnel and strengthening efforts towards health personnel, particularly in countries suffering from crises. GAVI is another important channel used by the Ministry of Foreign Affairs in the work to strengthen health systems, with focus on preparation for delivery of vaccines and other health services.

In 2012, Norway was a driving force for a clear and efficient division of work between the Global Fund, UNAIDS, UNITAID and WHO.

Promoting Human Security Through Health
In 2012, Norway participated actively in the ongoing reform process of WHO, with the objective that WHO should be able to maintain and strengthen its role as the leading normative organization within global health. The reform was started in 2011. In particular, Norway has strongly advocated for WHO adopting a new financing model that ensures better compliance between priorities and financial contributions.

The Ministry of Foreign Affairs has been a driving force for strengthening WHO's work with sexual violence, especially in relation to women and children. In 2012, the work began with anchoring the follow-up of the UN Commission on Life-Saving Commodities for Women and Children in WHO's governing bodies. Hereunder, the work with finding global solutions for how financing can be increased, coordination and monitoring of research and development of pharmaceuticals for diseases that occur in developing countries has been given priority in 2012.

In 2012, Norway participated actively as member representatives of WHO, The Global Fund, GAVI, UNAIDS and UNITAID.

Gry Larsen
State Secretary

Arvinn Eikeland Gadgil
State Secretary

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Ministry of Health and Care Services (HOD)

Health in All Policies

Prevention of Disease and Ill-Health

The so-called double burden of disease and the global epidemic of noncommunicable diseases (NCDs) must be fought with new acknowledgement and new measures. The World Health Organization's (WHO's) voluntary global framework for action against NCDs was negotiated under Norwegian leadership in November 2012, including nine targets and 25 indicators.

In the new national public health policy, a fundamental principle is to integrate the health aspect in all policy areas – to ensure health in all policies. We urge other WHO member countries to do the same.

The Ministry of Health and Care Services believes that low- and middle-income countries should receive assistance in establishing institutions for public health promotion at national level. Norway has recently assisted Palestine with establishing such an institution. The Norwegian Institute of Public Health also has collaboration with other countries to strengthen national public health work.

Norway is concerned about the threat from the tobacco industry to national tobacco control efforts. In 2011, the Norwegian Minister of Health and Care Services initiated a meeting with health ministers from Australia, England, Uruguay and New Zealand to share experiences. The ministers have met several times, the most recent being in connection with the World Health Assembly in 2012.

To be able to combat the global epidemic of noncommunicable diseases, the health aspect must be integrated in all policy areas.

Norway urges other countries to ratify and increase efforts to implement the WHO Framework Convention on Tobacco Control. We also wish to put problems arising from alcohol consumption higher on the international agenda. For this purpose Norway participates in the coordinating group for the implementation of WHO's global alcohol strategy. Norway has provided economic support to WHO's work towards strengthening preventive work in the area of alcohol and tobacco use.

Norway follows up the WHO guidelines for reducing marketing of unhealthy food and drinks towards children and young people through collaboration with the food industry to establish a system for reinforced industry self-regulation. Parallel to this, we will arrange a public hearing on a regulation regarding how such marketing could be regulated, in order to have an overview of what will be a possible alternative to self-regulation, if such approach does not succeed.

In continuing the Research Council of Norway's programme Global Health and Vaccination Research (GLOBVAC) 2012-2020, the expanded thematic areas will include health system and health policy research, implementation research and innovation in technology and methodology development. The Ministry of Health and Care Services will grant NOK 9.8 million to GLOBVAC in 2013.

Promoting Human Security through Health

Norway is a driving force for strengthening focus on underlying factors regarding health, such as clean drinking water, sanitation, hygiene, nutrition and food security. Norway chairs the Bureau for the Protocol on Water and Health until November 2013, participates actively in working groups under the protocol, and will host the third Meeting of the Parties under the Protocol in November 2013. The Government promotes integration of the principle of right to water in national legislation.

We view integration of food security and adaptation to climate change as an important part of the global work on health promotion. WHO and the UN Food and Agricultural Organization (FAO) will arrange a summit meeting on international challenges in nutrition in November 2013. At this meeting the entire spectrum of nutrition, food security and noncommunicable diseases will be addressed. Norwegian contributions must be seen in the context of food security promotion through agricultural development aid.

Norway participates in the Environment and Health process established by the WHO Europe Region, and follows up obligations laid down in the 2010 Parma Declaration on environment and health. The follow-up of the Declaration takes place in collaboration with the environmental authorities, and Norway is also a driving force in the work towards the next Ministerial Conference on the Environment and Health in 2016.

The Ministry of Health and Care Services has prioritized efforts regarding female genital mutilation by prevention and awareness raising activities, both in Norway and internationally. At national level, the Ministry has adopted a plan of action regarding female genital mutilation for the period 2013-2016.

Access to Pharmaceuticals
To ensure access to pharmaceutical products, the Government will continue to support research on development of pharmaceuticals for developing countries, with an emphasis on strengthening production capacity in these countries.

The Norwegian Directorate of Health represents Norway in the development of the second phase of the European and Developing Countries Clinical Trials Partnership (EDCTP), which is financed by GLOBVAC. The partnership contributes to development of pharmaceuticals, vaccines and diagnostics of HIV/AIDS, tuberculosis and malaria. Norway will contribute to innovative financing mechanisms in order to strengthen access by developing countries to effective pharmaceuticals within the framework of the existing patent system.

The Ministry of Health and Care Services has contributed to the follow-up of WHO's report on financing and coordination mechanisms for research and development of better pharmaceuticals and medical equipment addressing the needs of developing countries. The Ministry of Health and Care Services will collaborate with the Ministry of Foreign Affairs regarding follow-up of the report's recommendations in WHO.

The Ministry of Health and Care Services has also contributed to the Ministry of Trade and Industry's Report to the Storting on intellectual property rights, including the use of intellectual property rights, and as regards access to publicly-financed research data.

The Initiative for Foreign Policy and Global Health
The Initiative on Foreign Policy and Global Health (FPGH) has proved to be an important, unorthodox, and efficient network for setting the agenda and promoting dialogue across regions and positions in interaction between foreign policy and health. The initiative is primarily followed up through multilateral processes and arenas in Geneva, but also by regular reporting and debate in the UN General Assembly.

Norway's Minister of Health and Care Services participates annually in the minister breakfast hosted by the FPGH Initiative in the seven-country group, where Brazil, France, Indonesia, Norway, Senegal, South -Africa and Thailand are members. On this occasion a Ministerial Declaration is presented. Experts representing the Ministries of Foreign Affairs and the Ministries of Health of the seven countries are appointed to further develop the network and give direction to the work.

At the last expert meeting in Paris in June 2012, a resolution on "universal health coverage" was prepared for the 67th UN General Assembly autumn 2012. The UN resolution, adopted 18 September 0212, recommended *inter alia* to consider including 'equal distribution of health' in the discussions on development objectives for global health cooperation post 2015.

Nina Tangnæs Grønvold
State Secretary

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Ministry of Children, Equality and Social Inclusion

The ministry has an overall responsibility to actively work towards ensuring that the equality and non-discriminatory perspectives are addressed in all of the Government's policy areas. This includes the Norwegian foreign and development policy.

The ministry promotes equality and non-discrimination through the UN, the Council of Europe, the European Union and the Nordic Council of Ministers.

Mobilizing for Gender Equality and Children's Rights and Health
The ministry has coordinates Norway's follow-up of the UN Convention on the Rights of the Child, the UN Convention on the Elimination of All Forms of Discrimination against Women, and the UN Convention on the Elimination of All Forms of Racial Discrimination. Further, the ministry will also have be given responsibility to coordinate Norway's follow up of the UN Convention on the Rights of Persons with Disabilities (CRPD) when Norway ratifies the convention in 2013.

Regarding meetings at UN level the ministry also contributes to Norway's participation at the UN Commission for Social Development, which considers cases for youth, the elderly and persons with disabilities, the UN Commission on the Status of Women (CSW), which addresses the situation for girls and young women, and the UN Commission on Population and Development (UCPD), which considers themes which to a large degree concern children, youth and young people, especially girls and women.

The global equality agenda is under increasing pressure. It has been shown in several contexts that it is a challenge to ensure continued support for political and legal obligations for strengthening women's rights and promoting equality

Further, the ministry contributes to Norway's participation at the annual meetings in the 3rd Committee under the UN General Assembly concerning disability, children and youth, women, equality and racism. BLD also follows other UN related processes where equality and non-discriminatory perspectives, and children and youth perspectives are relevant, such as the revision of the Cairo platform 2014, and the development of a post-2015 agenda and the development of a set of sustainable development goals.

Improving Health by Emphasis on Prevention against Violence
There is a clear connection between violence and health. The Government gives priority to preventing and combating domestic violence. This work includes efforts directed towards children, youth and adults. At the international level in the ministry follows meetings at the Council of Europe, the UN and the EU handling issues concerning domestic violence and violence against women and girls.

Violence against women is a global problem. The health-related consequences of violence in close relations can be extensive, serious, and potentially life-threatening. A series of studies documents long-term negative health effects of violence in close relations. Several studies show clear connections between being exposed to violence and disability, as well as physical and mental health problems. Sexual assault, physical abuse and neglect have a greater impact on the psychological well-being of an individual than other health burdens. The number of assaults experienced is linked to increasing number of health problems. These findings correspond well with research reports from other countries, and with findings in international reports at the UN and Council of Europe with regards to causes of and prevalence of violence.

The ministry will this year (2013) launch a strategy addressing violence and sexual assault against children and youth in order to clarify the responsibility which rests on adults. The aim is to show the Government's policy, perspectives, and measures for preventing, protecting and helping children and youth under 18 years of age, who are exposed to violence and sexual assault in and outside the home.

Equality and Non-Discrimination
The ministry works towards integrating the equality and non-discriminatory perspectives in the efforts to prevent and combat violence. This approach requires that some of the interventions are directed towards persons who are especially vulnerable or exposed to violence, while others are formulated in more general terms. Violence against women is both a cause of the lack of equality between the genders and a hindrance to real equality between the genders. Equality, however, is not only about equality between the genders. In addition to a gender, individuals have a social background, an ethnic background, a life philosophy, functional ability, sexual orientation and age. Men are also exposed to violence in close relations, both in heterosexual and homosexual relations.

The ministry is responsible for coordinating the Government's work against forced marriages and genital mutilation. There are prioritized efforts in these areas through the Plan of Action against forced marriages, genital mutilation and serious limitations of the freedom of young people (2013-2016) that was launched in February 2013. The new Plan of Action includes 22 new and continuing measures, which develop the Government's efforts in these fields. Prevention, good public assistance by building competence and coordination, as well as research and development of methodology are the main areas in the plan, and several of the interventions include the health sector. BLD also participates in a working group in the EU which is to develop proposals for "best practice" and support to member countries' efforts to fight genital mutilation.

Challenges
The global equality agenda is under increasing pressure. On several occasions it has been a challenge to ensure continued support for political and legal obligations to strengthen women's rights and promote equality. For the first time, it was not possible to reach agreement on a final document at the CSW in 2012. The reason for not reaching an agreement was that the Commission became an objective of a broad campaign, led by an alliance of conservative states, voluntary organizations and religious communities that wanted to weaken the international women and equality agenda and norms and frameworks that previously had been agreed. In 2013, in the last minute and only after long and hard negotiations did the CSW manage to come to an agreement on the final document for this year. A positive sign is that the document includes a section about women and girls with disabilities. Gender equality is still under attack. Norway`s main priority in the future is be to build a wide alliance as a counterforce to this and, further, to mobilise for support to ensure that the international work in promoting gender equality and non-discrimination is not weakened.

Ahmad Ghanizadeh
State Secretary

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Ministry of Agriculture and Food

The Government's strategy on "Food Security in a Climatic Perspective" is the basis for the work with food security during the period 2012-2015.

For the Ministry of Agriculture and Food (LMD), the following areas are of significance to global health:

- Connection between animal health and public health
- Food security, health and climate
- Genetic resources
- International agricultural development, assistance and health considerations in trade

One World–One Health

One world–one health has become a concept for the significance of animal health for public health. Seventy-five per cent of new infectious diseases in humans come from animals. Infection can be transmitted directly, through food, water or insects. Examples of such diseases are swine influenza, bird influenza and illnesses which can be transmitted by a vector such as a mosquito or tick. Micro-organisms which transmit infection between animals and humans are called zoonoses.

These new threats are best countered through a strong international cooperation and a harmonized legal framework. In order to contribute to increased understanding of the connection between public health, animal health, and the health of wild animals, LMD participates actively in international alliances and organizations such as the EU, OIE and FAO, as well as the Nordic Council of Ministers. It is necessary to increase the understanding of the importance of preventive work, especially in relation to new, threatening diseases.

Food Security, Health and Climate

The connection between food security, nutrition and health is presented in the UN's definition of food security: *"Food security exists when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life."*

Seventy-five per cent of new infectious diseases in humans come from animals. Infection can be transmitted directly, through food, water or insects. Examples of such diseases are swine influenza, bird influenza and illnesses which can be transmitted by a vector such as a mosquito or tick.

The activity in this area includes a broad range of interventions, including long-term agricultural development and research. LMD contributes to international processes in the area, both in a UN context, and through European cooperation. LMD, together with the Ministry of Health and Care Services, is involved in planning the WHO/FAO International Conference on Nutrition (ICN+21) in the Autumn of 2014. This is a follow-up conference to the International Conference on Nutrition in Rome in 1992.

LMD also participates in the management and financing of the European research programme JPI-FACCE which focuses on agriculture, food security and climate change.

Genetic Resources
According to FAO, the genetic variation in agriculture has probably been reduced by 75 per cent over the past 50 years. Changes from small-scale agriculture to larger units and less variation in forms of production are some of the reasons for the loss of both the genetic resources and the relating knowledge.

Access to genetic diversity is the basis for breeding and processing, and central to climate adaptation and food security. Full availability of genetic resources is also important to the development of new health-promoting food plants (and new pharmaceuticals). LMD contributes with technical inputs to the work of the International Treaty on Plan Genetic resources for Food and Agriculture (ITPGRFA) and supports the Svalbard Global Seed Vault.

International Agricultural Development, Aid and Health Considerations in Trade
LMD contributes with professional expertise to international agricultural development as well as animal health and food safety to FAO; the UN organization for food and agriculture.

LMD coordinates the work in hygiene in the World Trade Organization (WTO) in the Committee for Hygiene and Veterinary Conditions, as well as Standards and Trade Development Facility (STDF) where WTO, WHO, FAO, OIE and the World Bank are partners. STDF is a global partnership which supports developing countries in building capacity to implement international hygiene and veterinary standards. This contributes both to safer food products and improves animal health domestically, as well as lays the basis for access to international markets with high demand for hygiene and animal health.

www.regjeringen.no/nb/dep/lmd

Norwegian Directorate of Health

The vision of the Norwegian Directorate of Health is "good health – good lives". In our global work, we aim to realize this vision beyond our borders, in particular by influencing public health and health services.

Global collaboration is an important means to influencing national health policies. European Union (EU) directives have direct impact on Norwegian legislation. The World Health Organization (WHO) and other United Nations agencies negotiate and adopt conventions, resolutions and declarations that are both politically and morally binding. Migration of health personnel, patent rights, danger of infections, and marketing of unhealthy products are among important health issues that go beyond national borders. They are global issues that need to be dealt with internationally.

The following objectives apply to our global work. The Directorate shall:

- be a leading professional body for Norway's global health work
- be a resource bank for competence and a connecting link between technical issues, management and policy
- contribute to that Norwegian research and centres of excellence participate in skills development and research in global health
- contribute to that Norway's inputs to global health issues are coherent, comprehensive and evidence based
- contribute to that Norway's bilateral and multilateral support yields good results
- contribute to technical capacity building and research as a means to increase global knowledge, evidence base and national policy formulation
- contribute to consistency by following issues up in all other relevant fora

UN and the Millennium Development Goals
Norway is strongly engaged in global health and is a driving force in the work to realize Millennium Development Goal (MDG) 4 – reducing child mortality, MDG 5 – improving maternal health, and MDG 6 – fighting HIV/AIDS, malaria and TB. The Directorate is represented in the national steering group for this work. Bilateral agreements have been drawn up with Malawi, India, Pakistan, Tanzania and Nigeria to strengthen national efforts in improving health services for mothers and children. This includes our involvement in implementation of these programmes, particularly in India and Pakistan.

World Health Organization (WHO)
The Directorate of Health has the national coordination responsibility for Norway's collaboration with WHO. This includes assistance to the Ministry of Health and Care Services on technical and evidence based matters related to our work with WHO. In addition, the Director-General of Health is the Minister of Health and Care Services' deputy chief of delegation to WHO's governing bodies. The Director-General is also Norway's representative to WHO's Executive Board during the period 2010-2013.

The Department of Global Health is responsible for coordinating preparations for the World Health Assembly, WHO's Executive Board meetings, Regional Committee meetings in Europe, as well as the Nordic WHO coordination. The Directorate coordinates and formulates drafts for instructions and reports which are approved politically by the Ministry of Foreign Affairs and by the Ministry of Health and Care Services. The divisions in the Directorate are responsible for submitting technical inputs to the Norwegian instructions for meetings in WHO. The follow-up of various WHO programmes and resolutions is assigned to the relevant divisions. The Department of Global Health supports this work. A Norwegian WHO strategy has been developed in connection with Norway's board membership in WHO during the period 2010-2013.

European Union and European Economic Area
The Directorate continues its participation in the Special Committee for Health, the Contact Committee for EU/EEA matters, and the EU/EEA Reference Group. These have been established to advance Norwegian interests in the health area. The Directorate is in close contact with the Counsellor for Health and Food Safety at the Permanent Norwegian mission to the EU. It is important to maintain the established contact network in EU institutions. Norwegian national experts, seconded to EU institutions and agencies, are used as door-openers and contact points.

The Directorate also has tasks regarding the implementation of legislative acts included in the EEA agreement. This is to ensure their effective and accurate implementation. Several EU health initiatives are open to Norwegian participation on a voluntary basis, beyond assigned tasks. Our technical divisions assess their participation on a case by case basis.

The Council of Europe
It is a goal for our Government to participate in the collaborations within the Council of Europe in line with Norwegian interests. The Directorate has been tasked with coordinating Norway's work in the Council of Europe in the area of health. The Bioethics committee works on the basis of the Biomedicine Convention and follows up recommendations in the use of force in mental health care, and in matters related to transplantation. The Pompidou group works in the narcotics area. Other committees in the partial agreements cover pharmaceuticals, transplantation, blood safety, cosmetics and food additives.

Organisation for Economic Cooperation and Development
The OECD Health Committee meets twice a year to discuss new or ongoing projects aimed at obtaining comparable data and knowledge which can be used as a basis for formulation of health policy. The Directorate provides contributions to the matters discussed by the committee, and participates on an ad hoc basis. OECD publishes comparable data regarding health services annually. In addition, a series of projects are initiated, where Norway participates with technical expertise on specific topics. A large ongoing project is Health Care Quality Indicator for development of quality indicators. This is organized in several sub-groups, with the overall responsibility placed in the Directorate.

It is clear to us in the Directorate of Health that health conditions in Norway are influenced by global trends. It is therefore important to understand and influence them.

The Nordic Countries
Several departments of the Directorate have a long tradition for close Nordic cooperation within their technical fields. This includes following up decisions under the auspices of the Nordic Council of Ministers. There exists a Nordic agreement on mutual approval of health personnel in the Nordic countries where the aim is to reduce cross-border hindrances and to improve exchange of information in the field. Regarding preparedness, the Svalbard group is a useful forum and network for exchange of information, and cooperation based on the Nordic health preparedness agreement.

North-West Russia
The Directorate assists the Ministry of Health and Care Services in the further development of health cooperation in Norway's surrounding and neighbouring areas, including participation in expert groups in accordance with the Directorate's national areas of responsibility. This encompasses the advisory programme committee for grants to projects under the Barents Health and Social Programme and advice within the framework of the EU's northern dimension (EUND) – Partnership for Health and Quality of Life.

Cooperation on Research
The Directorate represents Norway in the General Assembly for the European and Developing Countries Clinical Trials Partnership. Further, it is an observer on the Board of the Research Council's programme for global health and vaccination, and the Norwegian Forum for Global Health Research.

International Statistics
The Directorate of Health shall keep an overview of, and contribute to the reporting of, health and social data in international databases and organizations. It shall also ensure that statistics and analyses from the same databases and organizations are available. This responsibility also includes participation in international development of statistics in the area of health politics. This work is undertaken mainly under the direction of the OECD, the EU and WHO. The Department for Statistics is responsible for the statistics area internationally.

Bjørn Guldvog
Director

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Norad

Progress with the UN's Millennium Development Goals is encouraging even though considerable challenges remain. Results are achieved when there is political will and multidisciplinary actors all pull together over time and an increasing number of leaders in the high burden countries give priority to access to health services for women and children and fighting infectious diseases.

Norad facilitates the follow up of the White Paper on Global Health in cooperation with the Ministry of Foreign Affairs and a large network of international and national organizations and centres of excellence. Norway's aid profile related to global health has seen a significant change from traditional service-provision bilateral aid to global initiatives with international alliances and new partners. Norway has contributed through innovation, mobilization of resources, political leadership, and by promoting active participation by committed partners.

Norad plays an important role providing technical advice, managing funds, quality assuring, being a driving force for social debate, evaluating, and communicating on global health. A solid knowledge base and analyses are prerequisites for making good choices related to innovative thinking, risk reduction, formulating objectives and selecting criteria that give results in the future. Anti-corruption and legal quality assurance is central to Norad's work.

Norad has contributed to advocating for attention and mobilizing resources for women's and children's health through development and follow-up of the UN Secretary General's global initiative on "Every Woman Every Child" (EWEC), which has the objective of saving 16 million lives in 49 low-income countries by 2015. To date, over 250 commitments have been made towards the initiative, representing a total value of over USD 50 billion.

In support of the work of the Commission for Information and Accountability, Norad, through the University of Oslo, has contributed to development of health information systems for better results and follow-up of resources in more than 16 countries, in addition to the establishment of birth and death registers in cooperation with Statistics Norway. Norad's contribution to the Commission for Life-Saving Commodities for Women and Children (with Prime Minister Stoltenberg and President Jonathan as co-Chairs) has been significant, both administratively and in the work to achieve a price reduction on contraceptive implants and getting 13 selected commodities out to women and children in the poorest countries. This is expected to save up to six million lives by 2015.

A solid knowledge basis and analyses are prerequisites for making good choices related to innovative thinking, risk reduction, formulating objectives and selecting criteria that give results in the future.

Since 2010, Norad has coordinated the Innovation Working Group under the auspices of the UN Secretary General. This is part of the EWEC's initiative with the goal of developing new solutions for improving the health of women and children. The Working Group has supported new and promising projects in countries to scale up the use of mobile-health solutions, promote public-private cooperation, develop sustainable business models for entrepreneurs, and improve health services using quality-assurance checklists. Support from Norad and other partners for this work will give 1.5 million women access to important health messages and services through use of mobile health solutions, and increased quality of frontline services from providing at least 100 000 health workers with access to mobile health solutions.

Norad has provided technical advice to Norwegian embassies in India, Pakistan, Tanzania, Nigeria and Malawi related to Norway's bilateral partnership initiatives intended to improve maternal and child health. During the period 2005 to 2010, Tanzania's and Malawi's maternal mortality reduced from approximately 600 to 460 per 100,000 live births, while in Nigeria it was reduced from

approximately 800 to 630 during the same period. Pilot projects for results-based financing in India and Tanzania show strong increases in number of births at clinics. Multilateral organizations, global funds, various partnerships and research programmes such as GLOBVAC (the Programme for Global Health and Vaccination Research), AHPSR, TDR and HRP receive significant financial support from Norway. Norad contributes to this work with technical follow up and assessments, financial management, as well as representation on boards and in technical committees.

Norad is also responsible for the administration and allocation of funds to international and national health civil society organisations. A quarter of Norad support in this area last year went to the International Planned Parenthood Federation (IPPF), a key partner working on safe abortion and family planning, maternal and child health, STI (sexually transmitted infection) treatment, and HIV treatment, prevention and care, particularly among young people. IPPF's 152 member organizations work nationally in 172 countries to influence legislation concerning sexual and reproductive health and rights. In 2011, 89 million sexual and reproductive health services were delivered by IPPF's 65,000 health facilities.

Together with Sida, Norad contributed to documentation of rights violations against homosexuals, lesbians, bisexuals and transgender persons (LGBTs) in five countries. This work is included as part of Norwegian-Swedish regional cooperation in Africa in which Norway contributes NOK 35 million. Other specific targets for 2012 and 2013 include sex education for at least 8,000 youth, increased access to condoms in four countries (over 200 million condoms), prevention of mother-to-child HIV transmission among 40 000 children, strengthened prevention of HIV through improved access to information in 20 countries, increased participation by women in national and regional processes, long-term strategies for financing of HIV work developed in four countries, and strengthened capacity and leadership in two regional economic communities (East African Community and Southern African Development Community).

It is calculated that 200 million women and girls have unmet needs for family planning. The Family Planning 2020 Initiative was established in 2012 to ensure that an additional 120 million women get access to contraceptive methods, which is estimated to reduce mortality among girls and women by approximately 200,000 by 2020. Together with other partners and in addition to global coordination and monitoring, Norad is providing contraceptive implants for 27 million women.

Norad's work related to HIV and other infectious diseases includes engagement of youth and youth leadership, strengthening focus on rights, contributing to fulfilment of Norway's HIV strategy, and supporting research on HIV and AIDS. Norway plays an important role in supporting and addressing important, controversial themes. For example, support is provided so children and youth in 20 African countries have access to sexual education. Norad also provides technical advice and quality assures Norway's investments and engagement in the Global Fund (GFATM; Global Fund to Fight AIDS, Tuberculosis and Malaria). To date, the Fund has contributed to 3.3 million people receiving access to HIV treatment (ARVs (antiretroviral drugs)), 8.6 million receiving treatment for tuberculosis (DOTS (directly observed treatment, short-course)), and distribution of 230 million mosquito nets.

Norad works with a number of actors on issues related to health care workers. Norad's work includes following up cooperation between Norwegian and Malawi institutions on nursing education, organizing last year's consultation on "Health Workers at the Frontline" in Nairobi, and currently participating in preparations for the Third Global Forum for Health Personnel. Norad has contributed to the development of the Global Health Workers Alliance's (GHWA's) new strategy for 2013-2016. Norad sits also on the GHWA Board. In 2012, Norad launched its new capacity building programme for higher education and research in the south called; NORHED, where health is one of the six subcomponents.

Villa Kulild
Director General

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The Research Council of Norway

The main objective of the Research Council of Norway's programme for Global Health and Vaccination Research (GLOBVAC) is to support high-quality research which contributes to lasting improvements in health conditions and reduced inequalities in health for poor people in low and lower middle-income countries.

GLOBVAC is a continuation and expansion of a programme established in 2006. It contributes to the efforts of the Norwegian Government to improve women's and children's health with reference to the UN Millennium Development Goals 4, 5 and 6.

During the period 2013–2020, the programme will have an expected annual budget ceiling of approximately NOK 122 million. That is subsequent to a significant increase of grants. Some of the grants will be earmarked for projects which can contribute to following up the recommendations by the UN Commission for Life-Saving Commodities.

The programme prioritizes vaccine and vaccination research, health system and health policy research, innovation in technology and methodology development and implementation research.

The programme has a sub objective of building and strengthening research capacity on global health at Norwegian research institutions and in Norwegian companies performing research activities, as well as contributing to building research capacity in low and middle-income countries. Approximately 78 projects have received support during the period 2006- 2012.

In 2013, the Research Council of Norway plans two larger announcements of research funds for innovative projects in business, research projects and "Young Scientist Grants", respectively.

In the following the Research Council of Norway provides a brief description of GLOBVAC's work, relevant to the three priority areas of the Report to the Storting 11 (2011-2012) (White Paper) Global Health in Foreign and Development Policy: *"mobilising for women's and children's health and rights, reducing the burden of disease with the emphasis on prevention, and promoting human security through health".*

The programme identifies the need to actively stimulate the social science environments to direct their research to a greater degree towards the rights perspectives of women's and children's health.

Mobilising for Women's and Children's Health and Rights

A large proportion of previous and present projects in the programme's portfolio is directed towards women's and children's health. The research covers a wide spectrum of issues. Examples include developing a patent on rotavirus vaccine to prevent child mortality as a result of diarrhoea; the efficiency in child vaccination programmes; prevention of transmission of HIV infection from mother to child; effects of health system interventions such as birth and maternity care; use of technology to obtain health data and to provide information about measures at the primary health service level. In addition, support is given to research projects on domestic and gender-based violence and mental health of children.

The programme is to a large extent directed towards preventive measures against infectious diseases such as tuberculosis, HIV, contagious meningitis, as well as less widespread diseases such as hepatitis B, E-coli and shigella. All these are highly important as regards women's and children's health.

There are strong Norwegian research institutions in maternal and child health in low and middle-income countries, such as the Centre for Intervention Science in Maternal and Child Health at University of Bergen, where Professor Halvor Sommerfelt was awarded the Centre for Research Excellence (SFF) for a period of five years from 2013.

However, there have been few projects integrating focus on women's and children's health and rights. The programme identifies the need to actively stimulate the social science communities to direct their research more towards rights perspectives of women's and children's health. We will do this through objective information activity towards the whole spectrum of potential research environments.

Reducing the Burden of DiseaseWith the Emphasis on Prevention
GLOBVAC has had a strong focus on vaccine and vaccination research, including a contribution of USD 4 million to a large consortium led by the Program for Appropriate Technology in Health (PATH), in cooperation with amongst others the Bill and Melinda Gates Foundation. This is for the development of a rotavirus vaccine under Indian patent.

The main emphasis of vaccine and vaccination research has been on tuberculosis and HIV. In addition, support has been provided to prevention projects directed towards local mobilization against HIV and AIDS among men who have sex with men (MSM) in Tanzania.

GLOBVAC has strengthened its focus on health system research through the latest large grant of funds in 2012 a focus which will be maintained in the future. Non-communicable diseases are not covered by GLOBVAC's programme plan 2012-2020. The Research Council of Norway, however, has initiated a discussion on this with Norad and plan to raise this for the programme board before the next large announcement of funds taking place in the autumn of 2013.

Challenges and Possibilities
A general challenge for the programme is to increase the number of applicants to raise the number of high quality proposals. Nevertheless, the Research Council of Norway is of the opinion that over time there will be potential to meet this with the recent additional grants to global health.

Mari Kristine Nes
Director General

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FK Norway (Fredskorpset)

New health workers, improved clinical skills, increased insight into good organization of health services, greater awareness regarding the professional code of ethics, higher motivation for the job as a health worker. Those are some of the results to date in FK Norway's health exchange programme.

The overarching objective for FK Norway's health exchange programme is to contribute to solving the global health personnel crisis and to reach the health related Millennium Development Goals by strengthening education and delivery of health services in Norway's partner countries.

FK Norway and our partners invest in the knowledge and skills of the individual professional, who in his or her turn shares new knowledge with colleagues and institutions during the exchange period, and after returning home to his or her permanent employer. FK Norway's model of mutual exchange gives health personnel a unique possibility to gain personal experience in another environment. This is something which for health personnel from the south in particular is documented as having a greater effect than only having personnel from the north present in the southern environment. In 2012, FK Norway's health projects had 72 participants. That constitutes 11 per cent of the total number of exchanges.

Reducing the Personnel Crisis

It is estimated that sub-Saharan Africa has 24 per cent of the world's burden of disease, but only 3 per cent of all health personnel. Calculations show the need for educating 4.2 million more health workers. In several of the countries in which FK Norway partners have their projects, they cooperate with the country's only specialist within his or her professional area, whether it is gynaecology, neurosurgery, oncology, physiotherapy or orthopaedics.

A review of the FK Norway health exchange programme from 2011 shows that in addition to improved clinical skills, participants from partner countries in particular report changed attitudes to their profession and to how they receive patients.

Contributions to reducing the health personnel crisis is not only about educating more people, but also about strengthening professional environments so that it is attractive to stay in the profession. Increased quality of a worker's clinical skills, and better routines and organization of health services are objectives in the partnerships that receive support from FK Norway.

Participants in the FK Norway health programme stay abroad between six and eighteen months. FK finances both exchanges between Norway and countries in the south, and between countries in Africa and Asia respectively. Partners may be hospitals, voluntary organizations, ministries and educational institutions. The reciprocity and duration of the exchanges make the FK Norway model unique. There are several models of institutional cooperation between European countries and partners' s in developing countries, but most of those practise either only sending personnel from the north to the south, or offers a combination with short stays for health personnel from the south in the north.

Present efforts under the direction of FK Norway covers aspects such as rehabilitation, maternal and child health, prevention of non-communicable diseases, as well as health issues provoked by climate changes. In addition, there are a few stand-alone projects such as specialist training of neurosurgeons, infectious disease medicine, cancer care and laboratories. FK Norway's southern health partners are mainly in Eastern and Southern Africa, as well as in South and South-East Asia.

Long-Term Effects

Rehabilitation efforts includes the strengthening of physiotherapy training in Sudan and Malawi, establishment of rehabilitation services in Zambia and further development of orthopaedic services in

Malawi, Tanzania and Cambodia. These are important services with long-term effects, where people receive support to preserve health and working capability. In the long term, several of our Norwegian partners will withdraw and well-established institutional cooperation between regional partners in Africa and Asia will continue.

Climate Change
Maternal health interventions focus on training of midwives and nurses in the use of simple medical equipment and devices at hospitals in Malawi and Tanzania. In India, FK Norway's partner has worked within care and services for neonates, and both doctors and nurses have participated in the exchange program. Several of the FK projects in Asia deal with climate changes with direct and indirect consequences for health. Food security is being addressed through development of sustainable agricultural methods and cultivation of new types of rice which can tolerate changed climatic conditions. Another focus area is the reduction of pollution in Asian cities, with potentially large environmental and health gains. In addition, preventive efforts are being implemented such as ensuring access to primary health care services, campaigns against alcohol and tobacco abuse, building of sanitation installations, and the introduction of modern cooking apparatus which do not emit smoke, something which has a positive effect on the health of women and children in particular.

Changing Attitudes to the Profession
A review of the FK Norway health exchange programme from 2011 shows that in addition to improved clinical skills, participants from partner countries in particular report changed attitudes to their profession and to how they receive patients. This type of results can be challenging to measure, but are nonetheless important, and fundamental as a contribution to good professional environments with motivated and competent health workers.

Norwegian hospital departments also report that Norwegian staff has gained experience with diagnoses and conditions they seldom see in Norway. The experience may improve sensitivity towards patients with another cultural background, and increase staff's engagement for international cooperation. The educational institutions have gained experience in supporting training and education in the partner countries.

Since 2008, Norway has participated in the European Esther Alliance. The alliance has hospital cooperation/ twinnings between north and south as its niche. The Alliance exchanges experiences gained from capacity-building in health institutions, first and foremost through strengthening the skills of clinical personnel, which are not otherwise covered by programs offered by academic institutions.

Health is one of FK Norway's priority areas, and we will continue to support partnerships with long-term strategies in order to achieve lasting changes. Many low- and middle-income countries is experiencing high economic growth, rapid urbanization together with rapidly changing living conditions for large groups of the population. Non-communicable and life-style diseases, including mental problems, are rapidly invading these countries, on top of the challenges which are still not resolved with infectious diseases and high maternal and child mortality.

Life-style diseases such as high blood pressure, type 2 diabetes mellitus, some forms of cancer, and muscle and skeletal complaints can be prevented. In line with the need for preventive health work, in the future FK Norway also wishes to focus on these areas.

Among FK Norway's latest partnerships, there is increasing focus on mental health, strengthening of health systems and environmental health in urban districts. This is a development in line with upcoming new challenges and Norwegian priorities within global health.

Nita Kapoor
Director General

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Norwegian Institute of Public Health (NIPH)

During the past six years, NIPH has been increasingly engaged in global health through projects with bilateral and multilateral partners including low- and middle-income countries. NIPH has prioritized the mutual exchange of knowledge, building networks, disease prevention efforts, and the development of health surveillance systems.

NIPH receives assignments from the Ministry of Foreign Affairs (UD), Norad and the Ministry of Health and Care Services (HOD) connected to Norwegian priorities within global health challenges. NIPH serves as an adviser to the Norwegian authorities within the Institute's professional areas and works toward positioning global public health questions on the international agenda.

High-quality health data and an understanding of the causes of diseases and risk factors are important for preparedness, prevention, and priority-setting in research, public health policy and strategies. NIPH works with these challenges in the international arena where mutual exchange of knowledge and experience with infectious diseases, diagnostics and vaccines, forensic medicine, lifestyle-related disease research, maternal and child health, and mental health problems are prioritized fields. Additional activities include mapping the effects of environmental toxins and pollution on health.

NIPH collaborates with Norad, the World Health Organization (WHO), research institutions, and associate institutions in addition to participating in over 100 international groups, councils and committees worldwide.

Improving the Health of the Population
One goal of NIPH's international strategy is to cooperate with other countries and institutions and to share knowledge, experience and research that can contribute to better health both in Norway and outside its territorial boundaries. The Institute's organizational structure includes an international director and a division for international public health that initiates project cooperation and coordination. In addition, this division communicates research results on relevant areas and offers professional consultations on international and global issues.

One example is the intergovernmental negotiations in WHO that led to agreement on a preparedness response framework for pandemic influenza after several years of negotiations. NIPH was a part of the Norwegian delegation for these negotiations. Our participation in international processes and negotiations increases our insight into, and understanding of, global processes. Active participation assures that our national perspective is safeguarded.

The Norwegian Institute of Public Health performs an important social mission and has unique expertise. We contribute to outstanding knowledge for better health nationally and internationally, and we shall adapt our work to changes in disease burden.

Other areas of high priority include the further development of research and development (R&D) cooperation with sister organizations and with WHO on monitoring related to the health related Millennium Development Goals and health system development. An example of the latter is cooperation with WHO on an internationally harmonized framework for the development, administration and use of reproductive health registries.

Strengthened Cooperation on Public Health
NIPH participates in several international expert groups within environmental medicine, mental health, forensic toxicology, alcohol and drug abuse, as well as epidemiology, and has cooperation agreements in the High North and in Russia. NIPH has ties with health authorities and associate institutes in Armenia, Brazil, Burkina Faso, Cuba, Ethiopia, India, Malawi and Russia. Cooperation ranges from development of diagnostic methodology, to measurement of effects from environmental influences and air pollution, to research on infectious diseases, suicide, intoxication and traffic injuries, to causes of specific diseases, to development of health monitoring systems.

The Institute also sponsors exchange programmes for researchers from cooperating institutions to work at NIPH.

As a member of the International Association of National Public Health Institutes (IANPHI), NIPH works together with sister members and organizations to reach a common goal – a healthier population and a better understanding of what affects people's health in a globalized world. NIPH is also collaborating with WHO and Palestinian health authorities to establish a Palestinian Public Health Institute.

NIPH is the national contact point for International Health Regulations under WHO. This responsibility includes issuing warnings regarding serious international public health events in order to prevent and counteract the international outbreak of infectious diseases, as well as ensure internationally coordinated follow-up.

Cross-border cooperation contributes to mutual competence for NIPH and our partners, and contributes to an increased understanding of how common vulnerability requires common responsibility. This understanding represents the basis for providing sound advice to Norwegian administrative entities (Ministry of Health and Care Services and Ministry of Foreign Affairs) regarding questions connected to health challenges in a changing world.

Camilla Stoltenberg
Director General

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Norwegian Centre for Minority Health Research (NAKMI)

NAKMI is an interdisciplinary knowledge centre which works to promote research-based knowledge and competence in somatic as well as mental health and care for migrants and their descendants both nationally and internationally.

NAKMI is Norway's leading organization in capacity-building and research-based knowledge communication on migration and health, with emphasis on the largest immigrant groups and the most widespread health challenges among them. The main target groups are health policy makers and managers, health professionals, researchers and students. The objective for NAKMI's activity is to contribute to equity in health services.

NAKMI was established by the Ministry of Health and Care Services in 2003 and is managed by Oslo University Hospital. NAKMI reports to the Directorate of Health.

Migration and Health
NAKMI's most important contribution to global health is promoting and increasing knowledge about the relationship between migration and health. In addition, NAKMI raises attention to health issues of vulnerable groups such as undocumented migrants and on harmful traditional practices such as female genital mutilation.

NAKMI's core tasks are:
- Research and development
- Dissemination and advisory services
- Teaching and counselling

NAKMI's research is interdisciplinary and defined by assignments from the Directorate of Health. The five most important themes within the field of minority health are: living conditions and their significance to health, the health status of minority populations, the rights to health services, access to health services and the quality of health services. The objectives of NAKMI's research are to influence practice, to improve the quality of health services provided, to improve access to health services for migrant minorities, to increase migrant populations' knowledge of the Norwegian health service, and to strengthen the relationship between patients and health professionals. The main target groups for our research are health personnel and minority populations. These groups are understood to be active subjects and the involvement and ownership of these groups to our research projects is essential to us. As such, we aim to use both the target groups' own perspectives and scientific perspectives in our research. Methodologically, emphasis is laid on approaches which underpins theoretical positions through the use of a combination of quantitative and qualitative methods, combined with practice-oriented and participatory research.

The five most important themes within the field of minority health are: living conditions and their significance to health, the health status of minority populations, the rights to health services, access to health services and the quality of health services.

Responding to an Increased Ethnic Diversity
In 2011, NAKMI worked on a total of 30 research, development and communication projects. It is particularly in connection with research and development projects that NAKMI collaborates internationally on issues relating to migration and health and equity in health services.

NAKMI's international collaboration is mainly in the following form: NAKMI participates in the project 'Developing Standards for Migrant-Friendly Services' which is led and financed by the World Health Organization (WHO). In addition, NAKMI participates in and is represented on the board of Adapting European Health Systems to Diversity, the so-called ADAPT network. This is a project under

the European Cooperation in Science and Technology (COST) platform, which has the goal of promoting and implementing necessary health-politics actions in order to respond to an increased ethnic diversity in Europe.

Through the research project T-SHaRE (Transcultural Skills for Health and Care), NAKMI collaborates with eight other European research institutions, as well as the Adult Education Association in Oslo.

The aim of the project is to improve European health service systems and increase the availability of health services to migrant patients. This is done through the use of focus groups, interviews and mapping where users and key persons in immigrant environments, as well as cultural communicators and health professionals are involved. Based on this, we aim to develop educational measures designed for health professionals in the field of migration and health. These shall be adapted to the health professionals' qualifications and educational needs. NAKMI also has a standing collaboration agreement with the International Centre for Health, Migration and Development (ICHMD) in Geneva, which is also represented on NAKMI's professional advisory board. In addition, NAKMI has recently been invited to participate in a new EU project, 'Culturally Competent in Medical Education', under the Lifelong Learning Programme, together with 10 other European research institutions. The objective is to enhance the competence of health professionals in Europe concerning migration and health through the training of teachers.

In the global health context, NAKMI also contributes by ensuring competence-building among an increasing number of researchers from low- and middle-income countries in Asia and Africa, by providing guidance and other support in Master and PhD studies.

With regards to the global health challenges which female genital mutilation poses, NAKMI contributes in many ways. One development project investigates how the health services best can provide first line highly accessible services to genitally-mutilated women. Another project investigates how users from affected countries have experienced the health services' preventive work to combat female genital mutilation. NAKMI has also participated in a project regarding women's reproductive health. This project is concerned with the development of working methods in the provision of family planning services for minority women at the Women's Clinic, Oslo University Hospital.

In addition to the aforementioned, NAKMI has participated with medical professionals in a project in Somalia's capital city Mogadishu, which established a centre for rehabilitation of women who were strongly traumatized due to grave sexual violence. The centre worked according to a model which was developed on the basis of a solution-focused approach and adapted to local conditions in collaboration with a local women's group where the members themselves had extensive experience with traumas.

International dissemination:

- NAKMI manages the Norwegian part of mighealth.net which is a European web resource for researchers and practitioners within the field of minority health.
- NAKMI publishes its research findings in international publications. In 2001 we published ten scientific articles. The results for 2012 are not yet available.
- NAKMI participates annually in several international conferences on migration and health with presentations and posters.

Bernadette Kumar
Director

www.nakmi.no

Norwegian Knowledge Centre for the Health Services

Norwegian Knowledge Centre for the Health Services (NOKC) was established to contribute to increased use of research-based knowledge in the Norwegian health service. Since its establishment, a small and important proportion of the activities have been on global health issues.

A prerequisite for evidence-informed decisions is that systematic review(s) of all relevant research on the issue is available. One of the core activities of the Knowledge Centre is developing such systematic reviews, including in the field of global health.

Whether the aim is to promote women's and children's health, prevent disease, or advance human security through health, a functioning health system is a key factor. The NOKC Global Health Unit supports strengthening of health systems through:

- summarizing relevant research findings (systematic reviews)
- supporting use of research in decision making processes (evidence-informed policymaking)

The Cochrane Collaboration
The Cochrane Collaboration is an international network of researchers who prepare systematic reviews of research on effects of interventions in health service provision. The NOKC Global Health Unit is responsible for the activities of the Cochrane Collaboration that deal specifically with health systems strengthening in low- and middle-income countries.

Recommendations from the World Health Organization (WHO)
WHO provides recommendations for national health authorities, both in terms of clinical practice guidelines and recommendations on how organization of health services, especially for low and middle-income countries. Over several years, the Knowledge Centre has been a key collaborating partner in this work, both with regards to establishing internal routines for producing WHO recommendations and actual development of guidelines. The most important contribution during the last year has been developing recommendations for optimal utilization of health personnel – including "task shifting" – in order to improve the availability of maternal and newborn health services.

Communication for Vaccination
"Communicate to Vaccinate" (COMMVAC) is a research project which is led by the Knowledge Centre. The objective is to systematize existing knowledge about strategies to improve communication between parents and health workers. The overall intention is to contribute to increased immunization coverage.

Whether the aim is to promote women's and children's health, prevent disease, or advance human security through health, a functioning health system is a necessity.

Genital Mutilation
Researchers at NOKC have carried out several systematic reviews regarding female genital mutilation/cutting (FGM/C). Currently, a larger project is being conducted assessing and summarizing health consequences of FGM/C on girls at the request of WHO and Norad. This is of key importance to understand factors contributing to continuation of this practice, and for developing programmes able to fight genital mutilation effectively.

Skilled Birth Attendance
One of the research projects at the Knowledge Centre, "Skilled Attendants at Every Birth", aims at contributing to increased understanding of factors that determine whether a skilled birth attendant is present at birth. One output is a systematic review of factors promoting and/preventing the presence of skilled birth attendants.

Evidence-Informed Policymaking for Health
Summarizing research findings in systematic reviews is the cornerstone of the work at the Knowledge Centre. But the realization that this work is of limited value if not used has led to increased attention towards developing methods for improved availability of summaries of research findings. One example is the SUPPORT database with short versions of systematic reviews specifically aimed at supporting health bureaucrats and others who contribute to political decision-making processes. Another example is the database PDQ-evidence ("Pretty Darn Quick"), which provides quick, simple and free access to a large number of systematic reviews about public health interventions and strategies for health systems strengthening.

A prerequisite for evidence-informed decisions is that a systematic review of all the relevant research on the current problem is available.

In the project "Supporting the Use of Research Evidence for Policy in African Health Systems" (SURE), a number of different strategies are being developed, tested and assessed, such as "rapid response units" which shall assist the ministries of health on short notice. Uganda is one country where this is currently being tested. WHO through the "Evidence-Informed Policy Network" initiative is one of the partners in this project.

Challenges
One central question is: To what extent can research findings be relied upon, and how can pros and cons of an intervention be weighed against each other? The Knowledge Centre led the work that resulted in the GRADE system for grading of reliability of research findings – a system which is now routinely used by WHO, and several other agencies involved in development of guidelines.

Magne Nylenna
Chief Executive

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Haukeland University Hospital (HUS)

The international engagement of Haukeland University Hospital (Haukeland universitetssykehus (HUS)) has grown from small projects run by individuals to many large projects carried out under the auspices of HUS's Department for International Cooperation (AIS).

In May 2010, the Board of Directors of HUH adopted a new strategy for international cooperation that emphasized the usefulness of HUH's international work from a win-win perspective, and from having equal and long-term partnerships with institutions in the South. HUH currently has long-term collaboration with five partner hospitals in Africa, and with two more "advanced" university hospitals in India and South Africa. The new strategy allows for internal funding of international engagements (NOK 10 million for 2013) in addition to external project funding (NOK 32 million in 2012 for some 20 projects). An important goal of cooperation is strengthened competence of health sector professionals in the South and the North.

HUH owns two apartment complexes (16 apartments in total) for expatriate personnel residing on-campus at Christian Medical College, CMC in Vellore, India, and at Mnazi Mmoja Hospital in Zanzibar.

Project in Ethiopia
Neurosurgery: This project, funded by FK Norway (formerly Norwegian Peace Corps), is a collaboration between HUH, Black Lion University Hospital (BLH), and University of Bergen (UiB). Its objective is availability of sustainable neurosurgical services in Ethiopia through training of medical specialists (3 trained to date, and 7 in training) and nurses. Exchange of staff between HUH and BLH started in 2009, with 27 doctors and nurses having participated in exchange so far.
Anaesthesia: This project, which started in 2011, involves cooperation between HUH, UiB and BLH. A team of doctors from HUH instructs at the anaesthesia course offered at BLH, where 6 doctors are accepted into the program. Financing comes from internal HUH funds and the NOMA scholarship programme of UiB. A private donor from Bergen has contributed NOK 2 million to BLH for anaesthesia equipment.
Gastroenterology: This project, which started in 2010, involves cooperation between HUH, UiB and BLH. Doctors and nurses from HUH together with Ethiopian specialists hold courses in gastroenterology at BLH, with the aim being improved patient care at BLH. Access to, and maintenance of, equipment are major challenges. The project is supported with internal HUH funding.

Project in Norway
Norway's specialty competence on tropical infectious diseases is centred at HUH, and funded by Norway's Ministry of Health and Care Services. The Centre has expertise in the diagnosis, treatment and prevention of tropical infectious diseases.

The goals of cooperation are improved treatment of newborne babies at MMH on the one hand, and increased competence of HUS staff to clinically diagnose newborne babies on the other. ….. Newborne infant mortality at MMH has fallen from 40 per cent in 2011 to 10 per cent in 2013 (from 800 to 200 deaths per year).

Project in Malawi
Since 2007 and together with Oslo University Hospital and the University Hospital of Northern Norway, HUH collaborates with Bwaila Hospital and Kamuzu Central Hospital (KCH) in Lilongwe in the areas of mother-child health and surgery/orthopaedics. The project was funded by the Norwegian Embassy in Lilongwe until 2011, and has since then received funds from FK. The two hospitals have large shortages of qualified staff, medicines and medical equipment. A private donor from Bergen has contributed NOK 10 million for purchase of equipment to be used at Bwaila/KCH.

Mother-Child Health: The aim of this project is improvement of care for newborn babies at KCH. Teams of Norwegian midwives and gynaecologists continuously travel to KCH to work and instruct local staff through on-the-job training. In addition, this project supports the formal education of midwives and doctors with specialization.

Surgery/Orthopaedics: The objective of this project is improved quality and increased capacity of surgical services at KCH through education of specialists and training of nurses. Teams of Norwegian

surgeons, orthopaedic specialists and nurses continuously travel to KCH to work and instruct local staff through on-the-job training. The project supports formal specialist training of doctors, with 9 Malawian specialists currently undergoing training at KCH. In 2006, 25 per cent of all orthopaedic patients (approximately 1,500 per year) required amputation. Now KCH use modern methods (nails and plates), thus allowing most young patients to avoid being crippled for life by amputation.

FK Exchange Project: Since 2008, the collaboration between HUH and Bwaila/KCH on mother-child health has also included a FK exchange program for midwives, technicians, medical laboratory technologists and radiographers who provide essential support services related to their hospitals' overall mother-child health and surgery/orthopaedics services.

Project in Nepal
In 2012, HUH and Kanti Children's Hospital, Kathmandu received a seed grant from FK to fund exchange of blood bank personnel. A private donor from Bergen has contributed NOK 2 million for purchase of blood bank equipment for the hospital.

Project in Tanzania
Oncology: HUH has collaborated since 2004 with the Ocean Road Cancer Institute (ORCI) in Dar es Salaam. Through a FK-funded exchange programme, 3 doctors and 5 nurses from ORCI have had internships at HUH, while 7 nurses from HUH have interned at ORCI. The project has introduced safe use of cytotoxic chemotherapy, thus eliminating a major working environment problem for nurses.

Projects and co-operations with Zanzibar
Blood Bank: HUH has cooperated with Zanzibar National Blood Transfusion Services (ZNBTS) since 2010, with the overall objective being sufficient availability of blood and blood products at local hospitals. Through a FK-funded exchange programme, 7 bioengineers/nurses have served internships at HUH and ZNBTS respectively.
Paediatrics: Through a FK-funded exchange program, 2 paediatricians and 5 neonatal nurses from HUH have had internships at Mnazi Mmoja Hospital (MMH), while 2 paediatricians and 4 neonatal nurses MMH have interned at HUH. The goals of cooperation are improved treatment of newborn babies at MMH on the one hand, and increased competence of HUH staff to clinically diagnose newborn babies on the other. The Norwegian Embassy in Dar has granted NOK 5 million towards a new children's clinic at MMH, and a NOK 3 million donation has been received from a private individual in Bergen for procurement of equipment. The new clinic will open late in 2014. Newborn infant mortality at MMH has fallen from 40 per cent in 2011 to 10 per cent in 2013 (from 800 to 200 deaths per year).

Internal Medicine: Through a FK-funded exchange program, 2 doctors and 1 nurse from HUH have had internships at MMH since 2011, while 2 doctors and 2 nurses from MMH have interned at HUS. The goals of cooperation are improved treatment of patients in the medical ward of MMH, better hygiene at the wards and increased competence of HUH staff in clinical diagnosis of tropical diseases and other illnesses rarely seen in Norway.

Medical Technology: To help overcome a great shortage of medical equipment at MMH, HUH has shipped two containers of equipment to MMH since 2011. HUH's Medical Technology Department has been responsible for quality assurance of equipment being sent. The Department is also heavily involved in the establishment of a new 1-year diploma course for medical technicians at College of Health Science, Zanzibar, which started up in Sept, 2012.

Drug Rehabilitation: Authorities in Zanzibar have requested assistance from HUH to help set up a medical detoxification programme for drug addicts. FK has approved a 2013 seed grant to establish the new project of cooperation between MMH and HUH.

Other Cooperation: Since MMH-HUH collaboration began in 2011, a number of departments at HUH have established contact with MMH and organized internships at MMH to enable HUH-professionals to upgrade their skills or receive specialist training in such fields as ophthalmology (eye), physiotherapy, mental health, substance abuse, emergency medicine, and specialized nursing.

Jon Wigum Dahl
Director

www.helse-bergen.no/omoss/avdelinger/internasjonalt-samarbeid/Sider/enhet.aspx

Oslo University Hospital

Oslo University Hospital uses its medical skills in committed long-term cooperation with hospitals in low-income countries.

The focus is countries without major disasters or armed conflict, and where there is a functioning infrastructure. Selection of projects is based on the assumption that the reason for the extensive lack of health services in low-income countries is shortage of qualified health personnel. The aim is local education/training and to stimulate to retain trained staff in the country. A condition is creating and strengthening a meaningful working environment. Support to treatment institutions adjusted for the capacity of the individual country is of key importance.

India
Since October 2011, Oslo University Hospital has collaborated with the University Hospital of Kolkata, India. Transfer of competence within the field of neonatal medicine and reduction of infant mortality has been the overarching objective.

Considerable reduction in child mortality through increased knowledge of nutrition and breastfeeding has already been achieved. Nurses and doctors have increased knowledge and awareness of hygiene, respiratory-promoting measures and alleviation of motoric activity in premature babies. Earlier, neonates were wrapped in cotton and laid on the back. Now health personnel have learned to make small nests of sheets, so that the children lie in the fetal position. This promotes a feeling of security. Previously, babies did not have diapers and came in contact with urine and faeces from other infants, whereas now diapers are used. Good nursing is decisive for the children to avoid infections, gain weight and grow. Oslo University Hospital, upon request by India, has contributed with resource personnel to a project on a breast-milk bank. We are currently planning how the breast-milk bank can be established at the hospital in Kolkata.

Malawi
Since 2007, Oslo University Hospital, Health Bergen and the University Hospital of Northern Norway have collaborated with Kamazu Central Hospital in Lilongwe and Malawian authorities in a joint project towards Millennium Development Goals 4 and 5.

This has enabled teams consisting of a gynaecologist and a midwife travel to Malawi to work and teach for service periods of six months at Malawi's second largest maternity ward. Through this work they have accomplished the training of a total of 100 midwives and other health workers. The training focuses on practical and technical procedures or surgery. The candidates have no medical training.

The project has also contributed to building of a new maternity ward in Lilongwe. Previously, all babies were delivered in a room with 17 beds, with an average of 40 deliveries during a 24-hour period, with extremely primitive sanitary conditions and no possibility for family to be present. In the new ward, each woman giving birth has her own compartment where family can be present throughout the delivery. There are no similar family programmes for non-paying patients in Sub-Saharan Africa. This type of collaboration provides important learning for Norwegian health workers and contributes to increased skills when working with the hospital's many multicultural patients.

The treatment services we contribute to building up must be equal to modern medicine in the western world.

In cooperation with the University Hospital of Blantyre, establishment of the country's first neurosurgical division and education of neurosurgeons is being planned.

Ethiopia
In 2013, Oslo University Hospital receives funding from Active Against Cancer for collaboration with the Faculty of Medicine in Addis Ababa on training of oncologists. This will be carried out by Norwegian specialists teaching during their sabbaticals as Chief Surgeons.

Palestine
During their sabbaticals from Oslo University Hospital, Chief Surgeons have been teaching surgical techniques at August Victoria Hospital in Jerusalem. Due to this collaboration the hospital has become a referral hospital for cancer treatment. In addition there is collaboration with hospitals in Gaza and with Makassed Hospital in Jerusalem.

Russia/Archangel
Since 1994, the University Hospital of Northern Norway, in collaboration with Oslo University Hospital from 1996, has been significant contributors to building up a complete cardiac surgical department at No. 1 City Hospital in Archangel, Russia. The department performs cardiac surgery for Archangel County which has 1.3 million inhabitants. Currently they have a frequency of approximately 70 surgeries per 100,000 populations, three times the average of Russia. They have a complete register of cardiac and cardiovascular surgeries performed with good results.

Since 2007, the same university hospitals have also collaborated on gastro surgery and gastro medicine in Archangel, mainly concentrated on treatment of diseases of the pancreas, liver and bile duct. This has resulted in significant improvement in the treatment offered to these patients.

Transmission of Skills
Two doctors from Juba in South Sudan are working with a qualifying programme for specialists within orthopaedics, financed by FK Norway. They are stationed at the University Hospital in Medunsa, South Africa.

The work of Oslo University Hospital aims at transferring skills to low-income countries. In order for this to be done in a responsible manner, highly qualified professionals are required. The treatment and services introduced need to be at the level of modern medicine offered in high income countries. In order to match treatment level with available resources, extensive experience and knowledge is required. Our University Hospital has access to this. It is important that Norwegian medical assistance knows to value this competence.

Oslo University Hospital is also represented on the Board of the Norwegian Health Network for Development, serves as the Secretariat for the Network.

Kristin Schjølberg Hanche-Olsen
Head of Section

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Statistics Norway

Over some time, Statistics Norway has played an active role internationally, also in the work for global health. We cooperate with international UN-based organizations and with statistical offices in various countries and provide assistance in developing systems for data collection, establishing registers and quality assurance processes, as well as in dissemination of data for knowledge building.

The challenge is to establish sustainable systems where both those reporting data and data users acknowledge the usefulness of registration. Experience shows that incentive driven systems are necessary in order for solutions not to disintegrate.

Statistics Norway also prepares annual accounts which amongst others connect financial development and health in the individual countries. National health accounts is developed in accordance with international guidelines and provides comparable figures for countries independent of how the health services are organized in different countries. In the revised guidelines for preparation of health accounts, there is increased focus on women's and children's health, and on prevention.

The challenge is to establish sustainable systems where both those reporting data and data users acknowledge the usefulness of registration.

Maternal Mortality
In cooperation with Norad and the World Health Organization (WHO), we have focused on systems for quality assurance and comparing data on maternal mortality between countries.

Births and Causes of Deaths Registration
In collaboration with Norad and WHO, we have started work on how vaccination cards can be combined with the birth certificate, with registration of both in a national births register. This has received increased regional attention especially in Africa. Norway and other Scandinavian countries can provide valuable contributions to this work in the near future. The causes of death registration are also a prioritized area by Norad and WHO, but we believe that the establishment of such registers takes a longer time, since the incentives for participating are weaker. This work is probably more developed in other regions for the time being.

Registration of Causes of Death in Palestine
Statistics Norway assists the Norwegian Institute of Public Health on a subproject for reviewing routines for coding of causes of death and facilitating electronic submission solutions, and through this increase the quality of the local Causes of Death Register in Palestine.

Linking of Health Information Systems and Health Statistics
For several years, the Department of Informatics at the University of Oslo, has worked with development of health information systems with collection of data from hospitals and clinics. Discussion is on-going with IFI, Norad and WHO on linking this information with WHO's own service availability and readiness assessments (SARA). The purpose of this work is to obtain an overview of the linkages between health services and maternal and child mortality.

Child and Maternal Health
Statistics Norway's engagement within child and maternal health also includes contributions to the Global Alliance for Vaccines and Immunisation (GAVI) as documented by Roll-Hansen et. al. (2009) in "Towards Universal Childhood Immunization. An Evaluation of Measurement Methods", Report 2009/45, Statistics Norway.

WHO and the World Bank
Statistics Norway is currently planning collaboration with WHO and Norad on testing a global model disability survey to improve the international basis for statistics on persons with disabilities. This is an introduction to a follow-up of the Convention on Rights for Persons with Disabilities. Statistics Norway will possibly perform a development and cognitive test connected to this survey in Norway and in Malawi in addition to performing a pilot survey in Malawi.

Bjørn Kjetil Getz Wold
Head of Division

www.ssb.no

Sørlandet Hospital

Sørlandet Hospital (SSHF) has for a long time cooperated with hospitals in low-income countries.

The cooperation with Haydom Lutheran Hospital in Tanzania has been especially close and long-term. This cooperation has mainly been financed by FK Norway.

The hospital's strategy document emphasizes that international work shall be a part of SSHF's priorities in the future. This is expected to provide increased competence regarding international conditions, and diseases which are not common in Norway. Such knowledge is especially important in a time where international migration marks everyday life. The focus on international work aims to represent a positive contribution to the organizations SSHF chooses to cooperate with. The cooperation with other organizations shall always be based on equality, including in development cooperation.

The cooperation between SSHF and institutions outside Norway has three main purposes: research collaboration, knowledge development, and development cooperation.

Exchange of Personnel
SSHF and Haydom Lutheran Hospital have cooperated for over ten years. This cooperation has had several different purposes. Exchange of personnel and increasing skills at both hospitals has been fundamental. Research cooperation, provision of equipment, and direct funding through collections from the staff at SSHF has also been important.

The hospital's strategy document emphasizes that international work shall be a part of SSHF's priorities in the future. This is expected to provide increased competence regarding international conditions, and diseases which are not common in Norway.

In this cooperation, emphasis has been placed on development of neonatal and child medicine. A long-term project for developing laboratory skills at Haydom has also been central. SSHF has also contributed to developing financial management and medical-technical skills at Haydom. The Millennium Development Goals 4 and 5 have formed a significant guide for the cooperation and development at Haydom.

At the Clinic for Mental Health at SSHF, it is a goal for all departments to be engaged internationally. At present, there is a formal cooperation with Haydom, the Hospital at Rezekne in Latvia, the University of the North in Archangelsk, and the psychiatric hospital at Archangelsk. The cooperation with Haydom is being extended to other organizations in Tanzania, especially in connection with the child development programme ICD. Personnel from the clinic were also on assignment in Bhutan, Nepal and Vietnam during the last year.

The Medical Ward has a formal cooperation with Archangelsk. This is especially directed towards tuberculosis, and renders positive effects for both parties.

At least one of our cooperation projects within research is directly connected to women's health. The international work in SSHF is now being organized as a separate unit and this will receive advice from an international committee with participants from the hospital's various clinics.

In recent years, the hospital's international coordinator has been the Chair of the Board of Norwegian Health Network for Development.

Anders Wahlstedt
International Coordinator

www.sshf.no

Norwegian Health Network for Development

The Norwegian Health Network for Development (NHU) was established in 2009 following an initiative from Norad, the Directorate of Health, and FK Norway (Fredskorpset).

NHU contributes to better, more efficient and result-oriented development cooperation through coordination and exchange of experiences between health enterprises, other health institutions and relevant organizations, and Norwegian governmental health and aid administration. The objective is to create an arena where the various actors can learn from one another, establish new contacts and harmonize activities within a country or sector. Membership of the Network is at institutional level. There is no limit to how many persons an institution can send to the Network meetings.

The Network is led by a board, which is elected at the Network conferences every other year. The purpose, which is to bring together actors who are working with international projects in prioritized cooperation countries, is achieved first and foremost by arranging semi-annual conferences for the Network's members. It is also an important task for us to set up an overview of projects in which the members of the Network participate and to have a website with information regarding members, projects and current issues.

The Network's board also contributes as a body entitled to comment on relevant matters.

Until 2013, FK Norway carries out the secretarial function of the Network, but from then on Oslo University Hospital (OUS) takes on this task by establishing a project centre, which is financed by the initiators of the Network. This centre is operated from the International Section of OUS.

NHU contributes to better, more efficient and result-oriented development cooperation through coordination and exchange of experiences between health enterprises, other health institutions and relevant organizations, and Norwegian governmental health and aid administration.

The members of the Network consider the Network as relevant and the conferences as a useful meeting place. The participants constitute a broad professional spectrum and represent organizations with a considerable portfolio of aid and other international projects.

Anders Wahlstedt
Chair of the Board

Chr. Michelsen Institute (CMI)

CMI is an independent research institute with competence in issues pertaining to combating poverty, promoting human rights and sustainable social development.

More specifically CMI provides knowledge on following areas:

- access to high-quality health services for poor and vulnerable groups
- the right to health and priority challenges within global health
- the connection between health and financial development
- anti-corruption in the health sector

The Institute has a particular focus on maternal and child health and is a partner of the Center for Intervention Studies in Maternal and Child Health (CISMAC), a centre of excellence, based at the University of Bergen.

Health Systems and Health Services
CMI researches what can be done to strengthen access to health personnel, especially in rural areas and in areas that are difficult to access. We have completed studies focusing on health personnel distribution, and have researched on effective strategies that keep health personnel (newly qualified doctors and nurses) posted in remote areas. In addition, we have looked at what role the recruitment and employment systems play for local authorities' opportunities to attract job seekers.

The quality of health services is also an important research topic for the Institute. Our research findings show that equipment and competence are not enough if the health workers lack motivation to use their competence to do what is best for the patients. We have focused on measurements of quality in diagnosing and treating children with symptoms of important causes of death such as pneumonia, diarrhoea and malaria.

We are now developing several new projects which explore the effects of measures to ensure a more efficient utilization of available health personnel resources. Financial incentive for health workers is a new, controversial mechanism which is taken into use in more and more countries. The Institute is engaged in projects to increase the knowledge of the effects of such measures, and of alternative methods.

Research shows that equipment and skills are not enough if the health workers lack motivation to use their competencies to do what is best for the patients

Good utilization of health services also requires that there is sufficient demand for the services. The Institute has worked with the role of demand aspects to ensure high vaccine coverage. In particular, we have worked with increasing our understanding of barriers to health services during pregnancy and childbirth.

The Right to Health
CMI's research on the right to health also focuses on the significance of a rights-based approach for the design of health policies, distribution of scarce health resources and inclusion of vulnerable groups such as women, children, sexual, ethnic and religious minorities, the poor and village inhabitants.

One of our larger projects has analysed how legal actions in the health arena affect health policy and the distribution of resources among patient groups. Such legal actions are very widespread in Latin America, and also play an important role in some countries in Africa and Asia. Other projects analyze to what degree various population groups are involved in and listened to in connection with health reforms: rights mobilization for the right to food, the right to water, and the right to a clean environment. We also study the social and political consequences of rights mobilization on sexual and reproductive rights, and on how the right to health can be strengthened through climatic measures.

CMI has also researched people's opinion of fair distribution of health. Which groups should be given priority? To what extent should one deviate from the principle of cost efficiency in order to comply with fair distribution of health?

Health and Financial Development
CMI is engaged in understanding the connection between health and other development objectives, and has projects dealing with the connection between health, fertility and financial development. The empirical focus has been on Nepal. Now, we start a new project in Tanzania. In Nepal, we seek to find a causal connection between poverty and population growth. How does the number of children and the sex of the children affect the families' financial decisions, and thereby the financial development of the families? How does the sexual composition of the children in the family affect the distribution of food and thereby the nutritional situation? Our findings indicate that girls are more malnourished if they have older brothers. We explore whether the education and the health of a girl child are improved if the mother's position in the household is strengthened. In Tanzania, we compare the effects of various fertility reducing measures on the fertility of young girls. Traditional family planning programmes, where young girls receive information on reproductive health, are compared with a programme on education in economic activity, where the idea is that creating economic opportunities can be just as important for decisions regarding fertility.

Anti-Corruption in the Health Sector
The U4 Anti-Corruption Resource Centre is a knowledge centre at CMI that offers applied research, advice and guidance on how to deal with corruption challenges. The Centre is financed by eight aid donors and offers services regarding a number of different themes, including health.

CMI has also completed a research project which focuses on informal payments in the health sector and how this affects the quality of health services.

Possibilities and Challenges
There is a great need for increased knowledge on how known health interventions can be implemented more effectively in low- and middle-income countries. To a great extent, this is about understanding the context, creating possibilities for and simulating desired behaviour regarding both demand and supply of services. CMI's foundation in the social sciences provides a good starting point for important contributions to this knowledge base. CMI emphasizes a combination of solid academic quality and operational relevance, and works to bridge the gap between research and practice. Close cooperation with and contributions to strengthen the research capacity of our partners in the South are also important objectives.

In order for CMI to succeed, these challenges must be given high priority in the research policy, including predictable framework for long-term competence building in the institute sector.

Ottar Mæstad
Director

www.cmi.no.

Fafo

The Institute for Applied International Studies (Fafo AIS) is an independent research institute specialized in policy-relevant and empirically-founded research in areas marked by conflict, post-conflict and political transition.

Fafo's research within health and nutrition deals in particular with estimation of child mortality, maternal and child health including nutrition, breastfeeding, prevention of mother-to-child transmission of HIV, and food security. A key aspect of Fafo's work in this area is to develop indicators and measurement methods for correctly assessing changes in health and nutritional status.

Estimation of Child Mortality
Fafo's researchers participate in an international technical expert group in the UN's "Inter-Agency Group for Child Mortality Estimation" (IGME). Fafo's researchers have developed a programme which makes estimates of child mortality based on data which is collected through extensive, national surveys such as "Demographic and Health Surveys", "Multiple Indicator Cluster Surveys", PAPCHILD and "World Fertility Surveys". It is these estimates that are used in IGME's annual report on child mortality and reporting on Millennium Development Goal 4 which is to reduce child mortality.

Nutrition in Norwegian Development Policy
This study was conducted in 2012 commissioned by Save the Children Norway, and resulted in the report "Nutrition – Everybody's Business and Nobody's Business. Nutrition Within Norwegian Development Policy". The report gives an overview of the ongoing global processes in this area, as well as a description of how nutrition is handled in Norwegian development policy. The report also gives recommendations for how Norway can improve its work with nutrition within development policies and aid.

Economic Development, Health and Population Dynamics
The project "The Roles of Children in Household Risk Management in West Africa" is carried out in collaboration with L'Ecole Nationale d'Economie Appliquée (ENEA) and Institut de Population, Développement et Santé de la Reproduction in Senegal and Cabinet Stigmate/Université du Bénin during the period 2010-2013. The main objective of the project is to investigate the roles of children in household risk management in various types of crises. The project includes modules on fertility, reproductive health, the use of health services, food security and migration. The project is financed by the Norwegian Research Council's research programme ECONPOP which in its turn is partially financed through Norad and through PopPov (Population and Poverty Research Network), which is an internationally leading research network financed and administered by the Population Reference Bureau (PRB) and the William and Flora Hewlett Foundation. In January 2013, Fafo was host to the 7th annual conference in PopPov's research network on reproductive health and economic development. The foremost professional health research institutions and professional environments in the world today participate in the network, including the World Bank, Center for Global Development, IRD and ESRC, Universities such as Harvard, Michigan, Cornell, Duke, Boulder, Penn and Berkeley were all represented at this closed conference.

In addition to mapping the effects of the disaster on the health system in the areas, the studies provided the possibility of evaluating the effects of national health reforms which were carried out in China during the same period of time.

Health and Nutrition in Surveys of Living Conditions
Fafo has completed a number of surveys of living conditions, particularly in the Middle East, but also in countries such as China, Iraq, Uganda and Haiti. In refugee and conflict situations, the health-related research is focused on perceived needs. Fafo entered into collaboration with WHO's Mental Health Division to test an instrument for measurement of experienced health needs in crisis situations in the Palestinian areas in 2010. This resulted in an article in collaboration with a number of other research institutes.

Health in Conflict
Fafo has been active in research on health and conflict, especially with regard to mortality in war situations, particularly in Uganda, Iraq and DR Congo. Fafo has also prepared an overview report on the relationship between health and conflict.

Living Conditions in Earthquake Areas in Sichuan
After the extensive earthquake that hit China in 2008, Fafo has carried out three surveys in the hardest hit areas of the Sichuan province. These surveys have mapped the need for aid and the development situation at three points in time: Two months after, one year later, and finally three years after the disaster. Questions on health and access to health services were an important part of these surveys. In addition to mapping the effects of the disaster on the health system in the areas, the studies provided the possibility of evaluating the effects of national health reforms which were carried out in China during the same period of time. Fafo has published three reports based on the surveys in the earthquake areas. The qualitative study resulted in a Master thesis and a book on access to health services in villages in China.

Indicators for Sustainable Development in China
The project "Indicators for Sustainable Development" deals with developing a set of indicators that are suitable to evaluate to what extent China's development is sustainable. The project is being carried out in collaboration with China's Department of Science and Technology. Several health-related aspects are included, as they are regarded as being decisive for the further development of the country: the health condition of the population, the administration of the health system, and the ability to offer health services where there is a need.

Use of Disability Benefit and Treatment of HIV and AIDS
The project "Poverty Reduction Strategies From a Public Health Perspective. Social Grants, AIDS and the Roll-Out of HAART in South Africa" was carried out in collaboration with the University of Cape Town during the time period 2007-2009. It was financed by the Research Council. The project combined quantitative and qualitative methods for studying the connection between disability grants and the use of anti-retroviral treatment.

HIV and AIDS, WHO Guidelines and Breastfeeding
The project "Early and Rapid Cessation of Breastfeeding to Prevent Postnatal Transmission" was carried out in 2005 as a collaboration between Fafo, the University of KwaZulu Natal, the University of Oslo and the University of Bergen. A researcher from Fafo has been a co-supervisor for three PhD candidates and three Master degree students who have conducted research on breastfeeding, mother-to-child transmission of HIV and global guidelines. This has resulted in 11 publications.

The Child Health and Nutritional Situation in Madhya Pradesh
The purpose of the research project was to assess the health and nutritional situation during the first year of life of children in Madhya Pradesh, India. The project used qualitative and quantitative methods to describe critical influencing factors regarding birth, post-natal care, illness, vaccines, breastfeeding and complementary feeding. The study provided a series of results which are useful in the work with improving the health and nutritional situation for children in Madhya Pradesh. The project was carried out in collaboration with the Indian institution ANSWER during the period 2009-2011, with financing from the Norway-India Partnership Initiative (NIPI). The research project has resulted in three reports.

Eritrea
This research project was a full-scale demography and health survey in line with USAID's DHS surveys. Fafo contributed with extensive technical assistance with regard to the design of the survey, field work, data processing and analysis. The project was financed by UNICEF. The results are unfortunately not released by the Eritrean authorities.

Jon Pedersen
Managing Director

www.fafo.no

Norwegian Forum for Global Health Research (The Forum)

The Forum was initiated in 2005 as an interdisciplinary network of individuals and Norwegian institutions working with, or having an interest in, global health and health research.

In Norway, research units involved in global health research are of differing sizes, they are widespread, they work under varying conditions in public and private institutions, and quality and volume of the scientific results vary accordingly. At the beginning of year 2000, many of these units had a weak anchoring in their own institutions. Strong leaders in the field recognized the need for a common platform for collaboration, for consolidating global health as a field of academic studies within their own organizations as well as in the broader Norwegian context. The establishment of an organization would provide a forum for exchanging ideas and views on research and methodology, but also an arena for collaboration on issues related to academic training and curriculum development.

The Forum's statutes were approved by the first General Assembly on 16 November 2006. The purpose of the Forum is *to promote research and education of high quality with the aim of improving health and health services for marginalized population groups in low and middle-income countries.*

Our aim is to promote high quality research and training to improve health and health care for marginalized population groups in low- and middle-income countries.

The main objectives are:

- To improve and strengthen the involvement of Norwegian research institutions in global health research and education
- To contribute to increased international collaboration in global health research and training with special emphasis on strengthening the capacity of institutional partners in low- and middle-income countries
- To improve funding for relevant and high-quality global health research by the Norwegian Government and other sources
- To contribute to national and international processes and initiatives within global health and health research

The Forum's constituency consists of universities, university colleges, public and private research institutes without an educational mandate, in addition to individual members. Governmental bodies such as the Research Council of Norway (RCN), the Norwegian Directorate for Health, and Norad (the Norwegian Agency for Development Cooperation) have been supportively involved in the Forum work and development from the start, and the Forum has received continuous financial support from the GLOBVAC programme (RCN).

The individual members and institutions constitute the General Assembly which is the Forum's highest authority.

Important Meeting Arena
The Board is responsible for all the activities of the Forum and is the key meeting arena for leaders of global health research units in Norway per date. Each of the four large universities is represented by one member, and two members represent the collective institute sector. In addition, two independent candidates are elected among the members of the Forum. The RCN, the Directorate for Health and NORAD are represented as observers.

Recently, the Norwegian Medical Students Association was invited to participate in the Board with observer status. This observer arrangement has been of great importance for the Forum's work, discussions and agenda. Similarly, according to the observers, they greatly value the possibility of being able to interact regularly with the collective global health research community. The Board and its observers meet monthly in a one-hour telephone meeting, and for a meeting in person twice a year. Attendance is very good.

Secretarial support has been in place since 2006. The continuity of this function is fundamental for the sustainability of the Forum, as all other activities are carried out on a voluntary basis and are dependent on the goodwill of their own institutions. The Secretariat is staffed with a position in 20 per cent and has a permanent base at the Centre for International Health (CIH) at the University of Bergen. CIH contributes with infrastructure for the operation of the Secretariat.

The Forum has received funds from the Research Council of Norway, the GLOBVAC programme, since it was established in 2006. Since then the Forum has grown into a relatively robust and stable organization, functioning well after the intentions.

Inger B. Sheel
Chair of the Board

www.globalhealth.no

Peace Research Institute Oslo (PRIO)

According to recent studies on health and conflict, armed conflict can be a significant contributing factor to high maternal mortality.

A review of the status of the UN's Millennium Development Goals (2012) concluded that the objective of reduction of maternal mortality is far from being reached. This applies in particular to Sub-Saharan Africa, a region that is especially exposed due to a high conflict level. While the majority of both military and civilian victims killed in direct combat situations are men, several studies have also found considerably heightened mortality rates among women in conflict areas. High mortality rates are often maintained for several years after conflicts end, which indicates that conflicts have significant indirect health consequences. An important factor can be that conflicts negatively affect maternal health.

PRIO's research is aimed at increasing knowledge of how conflicts affect maternal health. We seek to contribute to the development of Norwegian humanitarian policy by showing possible measures to improve maternal health in conflict and post-conflict situations.

Research on Maternal Health in Armed Conflict

A number of different types of estimates exist for direct mortality in conflict, based either on aggregate figures from news bulletins and reports, or individual data regarding the cause of death from surveys including from the World Health Organization. However, it is more difficult to estimate the total human costs of war. Recent studies of the significance of conflict for life expectancy, assessing all the countries in the world and also taking a number of other factors into consideration, clearly show that countries at war experience significantly higher mortality rates amongst both genders. This excess mortality goes far beyond direct conflict mortality. Findings from some studies further indicate that women under some conditions may have mortality rate equivalent to that of men, which is dramatic given that far fewer women than men are direct victims of war. Even though the literature on conflict and health has indicated some possible causal effects, little systematic research has been undertaken on the specific causes of indirect conflict mortality. The high mortality rate for women in conflict areas would suggest that conflicts may have a significant negative effect on maternal health.

PRIO's research is aimed at increasing knowledge of how conflicts affect maternal health. We seek to contribute to the development of Norwegian humanitarian policy by showing possible measures to improve maternal health in conflict and post-conflict situations.

The objective of PRIO's maternal health project is to better understand the connection between conflict and high mortality among women in conflict areas. The approach includes the use of various research methods ranging from statistical studies of conflict data and aggregate health indicators as well as individual data, to focus group interviews with women in conflict areas and with employees in organizations which provide health services. The project represents a significant new development in that we combine data from large health surveys such as *"Demographic Health Surveys"* (DHS) with conflict data from the PRIO-related *"Armed Conflict Location and Event Database"* (ACLED), which contains detailed geographical and periodical information on some conflict events. This implies we can study local effects of armed conflict on certain maternal health indicators. We can further analyse how conflicts affect maternal health outside the actual conflict zones. By addressing factors affecting maternal health in conflict and post-conflict situations, we hope to contribute to increasing the knowledge about where various measures are most effective.

An article covering the first phase of the project will soon be published as part of a special edition on gender and conflict in the journal International Interactions. Henrik Urdal and Chi Primus Che address the effects of conflict on maternal health across countries between 1970 and 2005. Two objectives that deal with maternal health are studied: maternal mortality measured relative to the number of births, as well as total fertility. This builds on two main assumptions regarding conflict and maternal health. Firstly, it is assumed that the accessibility of maternal health services can be strongly reduced in conflict areas as a result of destruction of the health infrastructure, health workers forced to flee, and reduced mobility of women, which jointly implies that risk for birth-related deaths increases. Secondly, it is expected that a long-lasting conflict leads to increased fertility, both through the reduced access to family planning services and because long-lasting social and economic uncertainty increases the need for the security that lies in having many children, especially in areas where child mortality is high. One further aspect which can affect both these conditions is that armed conflict, especially if it is long-lasting, can lead to reduced education for girls.

The results of the first analysis give some support to the expectation that conflicts affect maternal health. Not least, the study finds that conflicts in poor countries seem to be associated with higher fertility levels. It is further documented that statistically, a medium-sized armed conflict increases the maternal mortality rate by 10 per cent. A surprising finding is that neighbouring countries to countries in conflict seem to have lower levels of maternal mortality, adjusted for several other factors. This can possibly be explained by the relative success of humanitarian actors in offering health services to refugees, which often has positive spill-over effects far beyond the refugee camps.

It is further documented that statistically, a medium-sized armed conflict increases the maternal mortality rate by 10 per cent.

The research project is led by Henrik Urdal, Senior Researcher at PRIO, and includes two doctoral research fellows, Christin Ormhaug (Norwegian University of Life Sciences and PRIO), and Chi Primus Che (Faculty of Medicine, University of Oslo and PRIO, financed through a larger EU cooperation project). Currently work is being done to obtain financing for a larger project with participation by researchers from the UK and Belgium.

Henrik Urdal
Senior Researcher

www.prio.no

Faculty of Medicine, NTNU

For the past two years the Faculty of Medicine (DMF) at NTNU has directed greater focus on global health, within both research and education. The activity is concentrated on a few countries: Nepal, Sierra Leone, Malawi and South Africa.

"Health for a better world" is the Faculty of Medicine's new vision. It is in line with NTNU's vision "knowledge for a better world" and reflects a wish to emphasize the social responsibility of the University. Global health is a joint effort of DMF and St. Olavs Hospital, and a part of the integration between the University and the hospital. In the joint effort it is emphasized that research, education and clinical practise shall contribute to solving the extensive global health challenges that exist.

NTNU is working with new interdisciplinary efforts for the whole of the University where DMF will be involved in health, welfare and technology. There will be a subtheme related to global health. This will also be a topic in the interdisciplinary area "sustainable city development". Together with the College and health authorities in the region, the Faculty arranges a global health day every autumn with contributions by national and international speakers. This activity is used for network building across the professional areas, but also across the institutions. An adviser has now been employed to coordinate the focus on global health together with St. Olavs Hospital. In 2012, NTNU was host to the annual research conference on global health, where the theme was *Innovation for Global Health*. That was a very important meeting place for researchers in the region, nationally and internationally.

Through guidance and a surgical training programme, the health workers will be able to carry out the most common surgical interventions, as well as Caesarean operations in a safe manner at the district hospitals.

Nepal
DMF established cooperation with Kathmandu University (KU), School of Medical Sciences/Dhulikhel Hospital in 2007. NTNU and Kathmandu University have had a cooperation agreement on teaching and research since 2002. During the period 2008-2012, over 10 scientific employees at DMF and St. Olavs Hospital visited KU School of Medical Sciences/Dhulikhel Hospital to teach students, establish research cooperation and run courses for the hospital employees. The cooperation includes a broad spectrum of disciplines, among them basic science subjects (molecular biology), trauma medicine, child and maternal health, psychiatry, immunology, as well as various teaching methods.

DMF has several ongoing PhD projects at KU/Dhulikhel Hospital. These contribute to strengthening the research capacity at the institution in Nepal. To date, they have no researcher education, but the future plan is that they shall carry out research themselves. The equipment for a molecular medicine laboratory was donated by St. Olavs Hospital and established at KU/Dhulikhel Hospital. Health care personnel that run and perform analyses at the laboratory have been trained by DMF. Establishment of this program was an important milestone, since KU had expressed a strong wish for this from the start of the cooperation in 2007.

Another aspect of the cooperation is exchange of students. The intention of the exchange is that medical students shall gain valuable practice they would not have gained in Norway, and a deeper understanding for local conditions and culture in the exchange country. At the same time it is emphasized that during their practice period they shall contribute actively and positively to the daily running of the clinic of which they are a part.

Sierra Leone
We have a close cooperation with a voluntary organization called CapeCare, which started at St. Olavs Hospital. The organization runs a project having the objective of increasing the medical competence of the district hospitals in Sierra Leone. This came at the request of the former Minister of Health in Sierra Leone, Zainab Bangura. Through guidance and a surgical training programme, the health

workers will be able to carry out the most common surgical interventions, as well as Caesarean operations in a safe manner at the district hospitals. Thirty health workers who are to be enrolled in the health service in Sierra Leone shall be educated in this programme up to 2016.

Several employees at St. Olavs Hospital and NTNU have already been on assignments in connection with the project. DMF and the health enterprise contribute with PhD fellowships as follow-up research in this project. This is a contribution to the knowledge basis concerning the health personnel challenges in poor countries.

Representatives from DMF visited Masanga Hospital in Sierra Leone in January, which is the starting point for the surgical training program. The Faculty is working further with developing a broader cooperation with the public authorities and medical education in the country. The greatest challenge they face is that specialization of doctors must be done abroad. This means that few or no doctors return to their homeland.

Malawi
An employee at the College of Medicine (COM) in Blantyre, Malawi, is doing his Master of Science in Exercise Physiology and Sport Sciences at DMF. This forms the basis for teaching and researcher competence at their new Institute of Physiotherapy at COM. NTNU has had cooperation with the University of Malawi for a number of years. A formal agreement was established between DMF and the College of Medicine in the autumn of last year. DMF has a good dialogue and we coordinate our cooperation with the University of Tromsø (UiT). It is important that our assistance is focused on the needs of the Institute in Malawi and that we do not duplicate any similar effort conducted by other Norwegian institutions.

South Africa
A large part of the population in South Africa lives under the poverty line. At the same time, a minority of the population experiences great riches, and this contributes to enormous equity contrasts. With its engagement in the country, DMF will focus on that part of the health services that are offered to the poor majority. It was first in 2011 that we signed a formal cooperation agreement with the University of KwaZulu Natal (UKZN), Nelson Mandela School of Medicine. The primary activity in the cooperation is a training programme for midwives. The programme is to educate district midwives in ultrasound and diagnosis in pregnancy. Education of midwives is carried out in cooperation with the World Health Organization collaborating centre in fetal medicine at St. Olavs Hospital.

There is a broad cooperation with both the business community and the technology centre at the university to develop a robust and mobile ultrasound with functionality that can be used in small health clinics in districts in South Africa. Each year, medical students travel from DMF to King Edward VIII Hospital in Durban and the mother-and-child hospital in Empangeni, a little north of Durban. Here they receive important clinical training within gynaecology, obstetrics and paediatrics. Several of the students have also written research papers related to the challenges with mother/child care in South Africa.

Stig A. Slørdahl
Dean

www.ntnu.no/dmf/forskning/global-helse

Health Information Systems Programme (HISP)

HISP is a global network established to strengthen health information systems in developing countries, managed and coordinated by the Department of Informatics at the University of Oslo.

This network has developed software for health information systems – DHIS2 – and implemented this together with ministries of health in more than 30 developing countries. Based on open source code and the Internet through the mobile network, DHIS2 has been established as an international standard. With a potential coverage of more than 1.3 billion people with its services, DHIS2 is according to an external evaluation for Norad evaluated as one of the largest and most successful health information systems software.

HISP was initiated in South Africa in 1994 as a part of the restructuring of the health system after apartheid. Information systems were established to support decentralization and local authority management of the health services, as well as to produce data so that the work for equality in the access to health services between races and ethnic groups could be measured. In order to support the use of information at both the local and national level, HISP started to develop an open source code software called District Health Information System. From being effectuated as a national standard in South Africa, the solution is now web-based and in use in more than 30 countries in Africa and Asia. Norad has supported this work since its inception, and through a professional centre agreement with the University of Oslo since 2009.

Knowledge for Launching Measures

Clinics, health districts, hospitals, and regional and central authorities in all countries need good and objective information in order to be able to lead, manage and deliver health services. There is a need for knowledge about the coverage of vaccines, pregnancy examinations, and use of mosquito nets, HIV treatment and other commodities and interventions. Keeping the overview of maternal mortality, child mortality and other important health indicators requires that information is routinely gathered and made available for health personnel and leaders at all levels. This is a prerequisite for being able to know the extent of coverage and occurrences and for implementing measures when and where they are most needed. HISP was, and is, based on the idea of decentralization of the health service, transfer of power to local users and a coordinated health service across programmes and services. This was a unique approach to health information systems based on principles of information for the users and the health districts as a hub for integrated information.

With a potential coverage of more than 1.3 billion people with its services, DHIS2 is evaluated as one of the largest and most successful global health information systems according to an external evaluation for Norad.

One problem is that the quality of data and systems is poor in most developing countries. To solve coordination problems, HISP has developed practical and technical methods to integrate information systems. The rapid development of the mobile network together with new fibre cables along the coast of Africa has made it possible to implement DHIS2 as a countrywide web-based system. This has made integration of data simpler and has facilitated the local registration of data in a national database with simultaneous access to data from other districts. This means that any district can compare itself with neighbouring districts and clinics. In 2012, DHIS2 in Kenya was the first countrywide web-based system within health in Africa.

Health via Mobile

In recent years, HISP has also developed solutions for mobile telephones which give even the most remote districts access to information systems. Use of the open source code means that the software is free and the users do not have to invest in expensive licences. Further, this approach makes it possible for developers from Vietnam, Tanzania and other countries to participate in software development and

thereby develop local competence and capacity. As a starting point, DHIS2 is based on aggregate data. An important part of the primary health care service simultaneously involves intervention towards individuals where there is a need to register personal data to support follow-up. For example, this concerns tuberculosis, HIV and AIDS, diabetes, care for pregnant women and vaccination. DHIS2 provides health workers with the possibility of registering data of individuals and also to notify pregnant women regarding health checks by SMS.

Setting Standards for Health Information
DHIS2 has been implemented in Africa, Asia and Latin America, in countries such as Nigeria, Tanzania, Kenya, Uganda, Burkina Faso, Senegal, Rwanda, Ghana, Liberia, Sierra Leone and Bangladesh. The authorities in several of the Indian federal states have decided that the system shall be the standard for health information.

At present, HISP cooperates with West African Health Organization (WAHO) on the establishment of standardized data reporting from the 15 countries in the ECOWAS region, and to use DHIS2 as a common regional information system. This will facilitate early warning and fast counteraction in the event of epidemics along and across the country borders in the region, such as in connection with the on-going stream of refugees from Mali to Burkina Faso and Niger. Such a regional information system will also support preventive work against cross-border epidemics since it will facilitate coordination of vaccination programmes in border areas. Recently, HISP has also established a formal cooperation with PEPFAR, the US President's Emergency Plan for AIDS Relief. PEPFAR now wishes to use DHIS2 for their HIV and AIDS reporting and as an integrated part of the country's own reporting. Implementation of DHIS2 is supported by several donors, such as Noradin Tanzania and DANIDA and USAID in Kenya.

Building Local Capacity
HISP is based on a global research network which includes public health, informatics and social science. The focus in the network is on intervention, action research and learning across countries and regions in close cooperation with the user organizations. The objective is to create scalable and sustainable solutions. HISP therefore also focuses on building local capacity and on use of information within the university sector, ministries of health, organizations, and private companies. The starting point for this is a PhD programme in Oslo with 28 active and 20 graduated PhD candidates, and Master programmes in Mozambique, South Africa, Malawi, Tanzania, Ethiopia and Sri Lanka. After graduation, candidates from these studies have been important in the management of the health information systems in their home countries.

There are enormous differences in the access to infrastructure and human resources between urban and rural areas and between the formal and informal sector in developing countries. Our challenges lie in supporting the health workers with technology, solutions and quality information where they are working.

The rapid development of the mobile network and the Internet means that supporting health workers with information systems at village level is now technically possible. But the challenges concerning competence, fragmentation and data quality must also be met.

Professor Morten Dæhlen
Dean

www.hisp.uio.no

Section for International Health, University of Oslo

For over 20 years, the Section for International Health has contributed professionally to reproductive health and maternal/neonate health. Capacity-building and obtaining knowledge has been especially important.

The focus on research has been broad:

- Childlessness and infertility in Africa
- Circumcision of Somali refugees and in countries where this is practised
- Maternal mortality
- Health services for women who are about to give birth
- Illnesses in pregnant mothers and mothers
- Mortality among neonates
- Stillborn babies
- Quality of health services in delivery rooms and hospitals

Broad Focus

The research has also included breastfeeding and nutrition among babies with HIV-positive mothers. This is something that entails a large stigma in some places and is therefore important to address in the relevant local communities. Other themes are the sexual health of teenagers and the risk they run of unwanted pregnancies, HIV infection and other sexually transmitted diseases.

The Section for International Health has also had projects which deal with illegal abortions, health services for abortions and the role of men concerning maternal health.

Much of the research has been published in international periodicals. Nearly all the research is done in cooperation with researchers from the relevant countries.

International Periodicals
Most of these projects have resulted in Master degrees and doctorates for people from the south. Thematically, these professional areas are taught in a couple of permanent courses. One in reproductive health taught in the autumn and one upper secondary course in reproductive and sexual health and rights taught in the spring.

Much of the research has been published in international periodicals. Nearly all the research is done in cooperation with researchers from the relevant countries: Ethiopia, Mozambique, Malawi, Botswana, Tanzania, Burkina Faso, Zimbabwe and Gambia.

Professor Johanne Sundby has been the only permanent employee who has worked within the area. Three of the Norwegians who have worked at the Section (Joar Svanemyr, Priya Lerberg and Elise Johansen) found jobs in the World Health Organization's Programme for Research for Reproductive Health where Professor Sundby has a seat on the Board.

The research has also included breastfeeding and nutrition among babies with HIV-positive mothers. This is something that entails a large stigma in some places and is therefore important to address in the relevant local communities.

Travel Back to Home Countries
Of the Africans who have been connected to the Section, four are employed in teaching health workers in their own country, many work for organizations or in the health service in their own country, others are in the UN system. A few have also got top management positions in their home country. None have so far chosen to remain in Norway.

Johanne Sundby
Professor

www.uio.no

Norwegian Centre for Integrated Care and Telemedicine

The Norwegian Centre for Integrated Care and Telemedicine (NST) at the University Hospital of North Norway is a national centre of competence and an international research and development centre within telemedicine and e-health.

Solid interdisciplinary competence is reflected in a personnel budget of approximately 100 man-years. The main objective is to design future health services. NST receives their assignments from the Norwegian health authorities. We shall contribute with:

- Advisory services connected to organization and implementation of e-health and telemedicine practice in the health sector
- Research on future services within interaction, telemedicine and e-health
- Development of telemedicine technology from idea to product and service

NST's core competence is knowledge, services and technology to support interaction and cooperation with and between patients and health personnel. Through research and service development, NST contributes to competence development and knowledge-sharing between health workers and between the health service and users.

This is E-Health

Telemedicine and e-health are technologies which contribute to improving and decentralizing the health service provision. The definition of telemedicine and e-health is: *"Examination, monitoring, treatment and administration of patients and personnel via systems which give immediate access to expertise and patient information independent of where patients or relevant information is geographically located"* (Norwegian Centre for Integrated Care and Telemedicine, NST 2011). Similar concepts such as m-health, p-health, and ICT for and in the health sector are partly overlapping. While m-health is especially relevant in countries with a high concentration of mobile phones and less widespread availability of personal computers and land-based communications networks, the various concepts are describing similar services in different locations.

Telemedicine and e-health are technologies which contribute to improving and decentralizing the health service provision.

WHO Collaborating Centre for Telemedicine and E-Health

NST was appointed a collaborating centre for telemedicine and e-health for the World Health Organization (WHO) in 2002, at the time the only centre in this field. Today there are about five WHO collaborating centres in ICT and health. WHO works closely with the International Telecommunication Union (ITU).

As a collaboration centre, the NST is an adviser within telemedicine and e-health for WHO's organization and for the individual member states. One of NST's roles as a collaborating centre is to give advice and facilitate telemedicine and e-health for different programmes in WHO. This includes:

- Demonstrate e-health solutions in practice
- Create e-health awareness in the health system
- Contribute to e-health in health reforms and policy development

Strengths and Weaknesses of Introducing E-Health

NST has contributed to the establishment, implementation and analysis of WHO's Global Observatory for eHealth (GOe). The aim of the GOe is to give member states strategic information regarding e-health through a standardized questionnaire. In 2013, GOe will focus on maternal and child health, and how ICT can support this area of work.

On behalf of WHO, NST has conducted feasibility studies and assisted with developing e-health strategies for member states. These studies typically focus on strengths, weaknesses and opportunities for the introduction of e-health services. A selection of countries NST has worked with are: Albania, Afghanistan, Bangladesh, Botswana, Cambodia, Croatia, the Czech Republic, Georgia, Kirgizstan, Malawi, Moldova, Nepal, Palestine, Rumania, Russia, Sri Lanka and South Africa.

In 2012-13, NST is engaged by the Ministry of Health in Moldova and WHO in developing a national e-health strategy in cooperation with the World Bank. This work is based on WHO/ITU's toolkit "National eHealth Strategy Toolkit". NST has offered to develop a net-based course for the toolkit.

Maternal and Child Health
NST supports and contributes to WHO's programmes for the member states. This is a generic approach in relation to development and strengthening of health systems, overview of the state of health as well as activities which are connected specifically to maternal and child health. The NST has been involved in the development of e-learning and ICT support for maternity care in Lilongwe, Malawi and has supervised students on m-health services to pregnant women in Nigeria.

Prevention
NST has various projects and services within life-style, prevention and self-management. Several of these have been developed for a mobile platform. Most of the services are tailored for individual needs such as support for smoking cessation, chronic illnesses, COPD (Chronic Obstructive Pulmonary Disease), rehabilitation and sexually transmitted diseases (STDs).

Health Atlas
Contracted by WHO, NST is developing a virtual atlas of inequalities in health. This is a presentation tool which uses health and demographic data from various sources such as Eurostat. The NST has developed a system for monitoring influenza, a distributed system for disseminating epidemiological data across health sectors and visualization of the prevalence of infection with regard to counties and municipalities (https://www.erdusyk.no/).

Northwest Russia
NST has cooperated with Northwest Russia since the 1990s through traditional telemedicine services, distance learning and various systems for health information. The cooperation has been useful for both parties. The first experiences with still photo systems were obtained by NST with Russian partners. In 2012, a cooperation was established with the health authorities in Nenet's autonomous area with special focus on pregnancy and follow-up of babies.

Tove Sørensen (author) and
Bjørn Engum
Head of NST

www.telemed.no/who

Noragric

The Department of International Environment and Development Studies, Noragric, at the Norwegian University of Life Sciences (UMB), carries out research, teaching, and international cooperation within environmental and development studies with an interdisciplinary perspective. Global health is part of the portfolio.

Noragric houses researchers and PhD candidates who focus on global health issues, and offers separate courses on health, environment and development for Bachelor students. In addition to evidence based knowledge on health issues, emphasis is placed on developing students' abilities to analyse health in the context of other development opportunities and challenges. Students are also expected to be able to discuss the perspectives and interests represented by various actors in debates on global health issues. Research areas include aspects of maternal and child health, water and sanitation, and food security.

Bachelor Studies

Associate Professor Cassandra Bergstrøm leads the University's interdisciplinary group for health and development and was responsible for developing Noragric's Bachelor course in health, environment and development. The course provides an introduction to the interdisciplinary field of health and development and includes three main areas: health and sustainable development, environment and health, and global health. The course enables participants to use central concepts and frameworks used by leading development agencies and to analyse and understand their different values and underlying interests of different positions. Students work on issues such as poverty and development, HIV/AIDS, biosecurity, genetically modified organisms and access to clean water and sanitation. Students are expected to demonstrate knowledge on relevant concepts, integrate knowledge and understanding of various development issues, and be able to explain and justify choice of approach to a given problem.

Research areas include aspects of child and maternal health, water and sanitation, and food security.

Food Security and Water and Sanitation

Associate Professor Ingrid Nyborg works, amongst others, on water and sanitation, food security, particularly in rural areas in Pakistan and Afghanistan. Publications emphasize the integration of technical and sociocultural aspects of improvement of water and sanitation systems. This work is carried out in cooperation with researchers at COMSATS University in Abottabad, Pakistan. These researchers are also involved in Noragric's course on health environment and development. In addition the research addresses food security in Pakistan, particularly in the Swat Valley, after floods added to an already severe security situation. Throughout, the research addresses gender and examines how food insecurity affects women and men differently.

Researcher Synne Movik works on water governance and the right to water, themes also central to the work of Professors Lyla Metha and Bill Derman.

Malnourishment in Children
PhD Candidate Devota Mwaseba is writing her dissertation on interventions that aim to prevent or reduce malnourishment by increasing milk in the diet of children under the age of five in two districts in Tanzania. Despite attempts to introduce various interventions over many years, malnourishment and undernourishment are still key challenges in the country. Mwaseba studies a project attempting to introduce goats and cows that produce larger quantities of milk, including the level of malnourishment by measuring the children as well as the sociocultural aspects of how households regard milk as a source of nutrition, for children, and how the project affects the participating households.

Maternal and Child Health Services in Countries in Conflict
PhD Candidate Christin M. Ormhaug's thesis is on maternal and child health during conflict, with data from countries in sub-Saharan Africa. Studies compare the access to maternal and child health services across borders and in the countries affected by conflict. In conflict areas, maternal and child services have lower utilization than in non-conflict areas; whereas within conflict areas, utilization of services is higher in areas where there are military clashes than others. An explanation might be fighting is more common in areas with more infrastructure and higher access to humanitarian assistance. These results are supported by qualitative studies on utilization of maternal health services in South Sudan during and after the civil war.

Poul Wisborg
Head of Department

www.umb.no/noragric

Centre for International Health, University of Bergen

The Centre for International Health (CIH) at the University of Bergen (UiB) was established in 1998 with the mandate within "global perspective and development-related research", which was and is a strategic priority area at UiB.

CIH's mandate was global health research of high quality in close cooperation with institutions in low-income countries (LICs). Building of institutional capacity locally was to be an area given particular priority. Organizationally, the Centre is placed at the Faculty of Medicine and Dentistry but has the role of an inter-faculty and inter-disciplinary centre at UiB. At present, the Centre for International Health holds a leading position in international and global health in Scandinavia. In the last external Research Council evaluation, two research groups at the Centre were presented for evaluation, "the HIV/TB Research Group" and "the Child Health and Nutrition Group", and both were evaluated as "Excellent". In addition, the Centre as a whole was evaluated as "The leading research centre within international/global health in the Scandinavian countries and one of the leading centres in Europe". In 2012, CIH achieved the award of "Centre for Excellence" with financing by the Research Council of Norway. Today the "Centre for Intervention Science in Maternal and Child Health" (CISMAC) is established as a part of the Centre for International Health.

Building of Local Capacity

The globally-skewed distribution of resources is reflected in unfair gaps between south and north concerning health condition and life expectancy. An extreme globally-skewed distribution regarding access to higher education and academic capacity is at present a decisive curb on development for LICs within all sectors of society. For example, the research competence and resources for research are decisive for building of local knowledge bases and leadership in order to ensure effective health measures. In global health research, local competence is decisive for relevance, quality and political influence of generated knowledge, and the Centre can refer to extensive contributions to the strengthening of capacity at the partner institutions. CIH has organized researcher education at Doctoral level and Master level. Since 2005, 70 candidates have been awarded their doctorates, and almost 90 per cent of these are from partner institutions in LICs. The candidates are recruited from partner institutions and carry out their research work in their home countries. This is probably the most important explanation of why almost all of them return and obtain central positions in their own institutions. In addition to the organized education at CIH, the Centre has established cooperation with partner institutions regarding the running of new Master courses locally: "Master of Science in Epidemiology" (Zambia, Malawi); "Master in Health Policy and Management" (Tanzania); and "Sandwich Programme on Clinical Medicine" (Tanzania, Ethiopia).

In global health research, local competence is decisive for relevance, quality and political influence of generated knowledge.

Research

CIH has established academic partnerships with institutions in several LICs (Cambodia, Burkina Faso, Ethiopia, India, Kenya, Malawi, Nepal, Sudan, Uganda, Tanzania, and Zambia). Among local challenges is finding local solutions but also regarding research on existing scientific challenges which can provide new knowledge of great impact on future public health programmes with relevance far beyond the local level. Prevention is a main focus, on methods or approaches, and this includes studies of determinants of illness/infection experiments and evaluation of preventive interventions or programmes. An illustrative example on research contributions is the proving of the positive preventive effect of zinc on acute diarrhoea in children.

This is now included in WHO's recommendations. The establishment of the "Centre for Intervention Science in Maternal and Child Health" from now on will mean that CIH as a whole will have its resources increased significantly for research on maternal and child health, and this also means strengthened established partnerships in LICs including local capacity-building. For partnership institutions in Africa south of the Sahara, HIV and AIDS pose an enormous and unique challenge. Here CIH has been a partner in extensive research over a long period of time and with good examples of direct political influence. This includes one of the most important research questions within today's HIV research: How to increase the intake to HIV testing and counselling in an ethical, fair and cost-effective manner which maximizes the potential of prevention and treatment of such services? CIH and its partners are at the research front of this theme. Attempts with home-based measures are a breakthrough, an approach with extensive preventive potential, better and more socially fair access to treatment.

CIH has a large thematic spectrum within research. In addition to the activity within the two largest research groups (Children and Nutrition, and HIV/AIDS/TB), there are active groups for Climate and Health, Oral Health, Oral Cancer, Occupational Health, Reproductive Health, and Vaccines and Immunology. Climate and Health is about to gain a footing across research groups.

Challenges
There is reason to emphasize the challenges in connection with priority-setting within global health research and measures from now on. There is little doubt that institutional capacity-building must be given far greater priority by the international society in order to ensure effective local solutions. In addition, we experience a strong global trend towards strongly increasing "treatment focus" – with very good conditions for the pharmaceutical industry. This is especially clear if one looks at how the international society prioritizes measures for the most serious HIV epidemics. For CIH, research on local competence building within public health solutions will also be the main priority in the future.

Knut Fylkesnes
Director

www.uib.no/cih

Centre for Development and the Environment

The Centre for Development and the Environment (SUM) contributes to research, information and teaching on global health.

Our research on global health covers the links between health and social, economic, political and environmental factors. We draw on perspectives from social science, especially social anthropology. The research includes global health governance, global health initiatives, and health systems, with the thematic focus on reproductive health and rights, maternal and child health and vaccines. Our research covers different country contexts and often looks at the connection between global agendas and local realities. The health challenges in the 21st century require interdisciplinary approaches. SUM contributes to such approaches through cooperation with international research environments within social medicine and public health and through UiO's research programme LEVE.

LEVE – living conditions in developing countries – is an interdisciplinary research arena of coordinated collaboration between researchers from the Faculty of Social Sciences, Faculty of Law, the Faculty of Medicine, and SUM, where SUM is the host institution. Global health is one of the main research areas. SUM is also a central actor in the Lancet - UiO –Commission on Global Governance for Health.

We publish articles in scientific journals and books, as well as communicate results at seminars, conferences, workshops, in popular science texts and in teaching. SUM brings a critical, social science perspective to debates on global health, which at times can be a challenge in a field dominated by medical and technical approaches.

International Cooperation
We collaborate with various institutions in Norway and internationally in connection with our research projects. SUM's projects on global health stretch from a global level to different country contexts such as India, Malawi, Burkina Faso and Nicaragua. We also collaborate with various actors in civil society on themes in which we are interested. In connection with reproductive health (especially maternal/child health) we have a close collaboration with the Institute of Health and Society (Section for International Health) at UiO, the London School of Hygiene and Tropical Medicine, and the Department of Anthropology at the University of Cambridge.

Teaching in Global Health
In addition to research, SUM teaches global health at Master and PhD level. The Master courses also recruit students to write about health-related themes in their Master's theses.

Global health is one of the four sections in SUM's Master course "Development and Environment: Theory and Policy Challenges". In addition, the Master course "Political Economy of Global Health" examines global health using a political-economy approach.

Health systems are decisive for achieving satisfactory vaccination for the population.

In cooperation with LEVE, SUM's Research School has completed an international doctorate course with the theme "Political Determinants of Health – Changing Perspectives on Health Inequality". The course obtained relevant lecturers from various international institutions and attracted doctoral candidates from several different countries.

An Interdisciplinary Approach to Different Vaccination Coverage
With SUM researcher Sidsel Roalkvam as leader, the project SUM Medic dealt with identifying factors that promote and prevent vaccination coverage. This was carried out by assessing social, political and economic aspects of the context surrounding the vaccination system. The team of researchers performed empirical research in Malawi and India and on the global governance systems. The project assessed the political process from global agendas and agreements, through national policy design, and implementation at local level. In cooperation with the Amsterdam School of Social Science Research,

the London School of Hygiene and Tropical Medicine, the World Bank, the University of Witwatersrand, the University of California SF, Delhi School of Economics and the University of New South Wales, the project has resulted in the book "Saving the World's Children: The Politics of Immunization", to be published by Oxford University Press in 2013.

Assessment of Norwegian-Indian Partnership Interventions in Maternal and Child Health
The project aimed at exploring whether the incentive arrangement implemented by the Indian health authorities can reduce maternal and child mortality. Financial incentives shall ensure that women who are going to give birth come to the hospital to give birth, but the arrangement is not without its problems in a country where the health service has great resource problems. The project was carried out in cooperation with SUM, the Institute for Health and Society, and the Public Health Foundation India (PHFI). The final report "Assessing and Supporting NIHI interventions" was submitted to the Norwegian Embassy in Delhi in November 2011.

Strengthening of the Health Systems through Vaccination Programmes
Health systems are decisive for achieving satisfactory vaccination for the population. Through a critical ethnographical perspective, an analysis is carried out of various actors' opinions of what it means to strengthen a health system, and research is being done on how a global vaccination initiative, particularly the GAVI Alliance, attempts to integrate a focus on "health system strengthening" within its technical and disease-focused approaches. In addition, the project explores attempts to integrate health system strengthening within vaccination programmes in India's National Rural Health Mission. The project is financed by the GLOBVAC programme (Global Health and Vaccination Research) in the Research Council of Norway, and carried out in collaboration between SUM researchers Sidsel Roalkvam and Katerini T. Storeng, and Arima Mishra at the Institute of Public Health, Bangalore, India.

Health Reform and Maternal Health
Post-doctorate researcher Katerini Storeng at SUM has received a grant in the shape of a four-year fellowship for young researchers from the GLOBVAC programme (Global Health and Vaccination Research) of the Research Council of Norway. The project "Advocacy and Policy Change for Health Equity in Low-Income Countries" starts at the end of 2013, and will support Ms. Storeng's participation in two international research projects focusing on under researched aspects of health reform and improvement in service provision for maternal health. In addition, Ms Storeng will carry out an independent ethnographic project focusing on social movements and their attempts to direct focus on social and political aspects in global health policy processes. Ms Storeng will cooperate with leading institutions and groups within global health research and policy, including the London School of Hygiene and Tropical Medicine (England) University of Aberdeen (Scotland), and the Guttmacher Institute (US).

Maternal Health in Nicaragua
SUM/LEVE research fellow Birgit Kvernflaten's PhD project: "Progress or Neglect: Maternal Health at the Margins" deals with the health system and maternal health in Nicaragua. The project explores Nicaragua's challenges regarding reducing maternal mortality among the poor and marginalized groups. The project also explores how global and national strategies for reducing maternal mortality develop at the local level, and how Nicaragua's health system deals with needs of women during pregnancy and birth.

Rights and Maternal Health
Another PhD candidate at SUM, Lotte Danielsen, carrying out her degree at Cambridge within a larger research project. The project: "Rights to Motherhood: A Comparative Ethnographic Study of Civil Society as Agents for Change" studies rights and maternal health in a larger comparative perspective.

Kristi Anne Stølen
Professor and Centre Director

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The Atlas Alliance

According to the UN, there are more than a billion persons with disabilities in the world. In *"World Report on Disability 2011"*, it is clearly stated that poverty leads to disabilities because of malnutrition and lack of treatment of diseases.

Many with disabilities in low-income countries experience exclusion from health services. Only 10 per cent have access to rehabilitation services (WHO).

To increase awareness and empower patients and persons with disabilities, the Atlas Alliance supports disabled people's organizations (DPOs) and patient organizations. The local organizations work on rights of patients and persons with disabilities to health services through community based rehabilitation (CBR) programmes.

Adapting Wheelchairs for Users
The Atlas Alliance supports programmes for treatment of children with spina bifida and hydrocephalus, treatment of curable eye diseases, and prevention of diabetes. Through the Norwegian Association of Heart and Lung Patients (LHL international), the Atlas Alliance supports organizations for people with tuberculosis and HIV.

Adaptation of wheelchairs and other technical aids for persons with disabilities is also central in the work of the Alliance. For example, 319 people received wheelchairs in 2011.

Programmes always involve local health authorities and user organizations. This contributes to accountability of authorities and increased sustainability.

Programmes always involve local health authorities and user organizations. This contributes to accountability of authorities and increased sustainability.

Women's and Girls' Right to Health
The UN High Commissioner for Human Rights has published the report *"Thematic Study on the Issue of Violence Against Women and Girls and Disability"*. The report states that persons with disabilities are especially vulnerable to sexual assault. Women and girls with disabilities run an even higher risk of assault. The reason behind this is prejudice against persons with disabilities, lack of knowledge and education, as well as isolation and institutionalization.

An example from Zanzibar illustrates how the Atlas Alliance works with this topic. Support is given to the local parent organization of people with developmental disabilities, ZAPDD. They have close cooperation with the health authorities and they also promote early health checks. Working to reduce sexual abuse of women and girls with developmental disabilities at Zanzibar, ZAPDD cooperates with Zanzibar Female Lawyers' Association (ZAFELA). They work on awareness raising and changing attitudes in the districts, and give legal advice to families who experience sexual abuse. That work, together with radio and TV programmes regarding child abuse, female genital mutilation and sexual abuse, has led to several reported cases. In some cases the perpetrator has been charged and sentenced. This project has people with developmental disabilities as the main target group.

ZAPDD is now trying to establish contact with the police stations and courts to carry out training of the employees. In addition, ZAPDD has a scheme for 25 young persons with developmental disabilities in five districts. The youth receive information about sexual relations, and learn about HIV and AIDS. They also receive information on how they can share this knowledge with others. Together with support persons they visit their local communities to share the information. This also contributes to prevent spreading of HIV and AIDS.

Building Bridges Between Local and National Centres

Another example is from Palestine, where the Norwegian Association of the Disabled (NAD) supports two resource centres at district level on the West Bank. They receive technical and financial support to address the gap between the community-based services in the villages and four rehabilitation centres at national level. The two resource centres at district level focus on assessing the needs of disabled children to ensure that the correct information and training is given to the local employees at the rehabilitation centres and to the parents of the children. The resource centres set up individual goals and plans for each child. This approach ensures that the need of each child is met at a local level, close to and in the child's home. This has a positive effect on children's health and inclusion in society. The centres will also evaluate the need for referral to the national rehabilitation centres with professional health workers.

Prevention of Diabetes

Diabetes is one of the largest health and development challenges in this century. No country, rich or poor, is immune to the epidemic. Even though diabetes is possible to prevent, the illness leads to disabilities and millions of deaths annually. In parts of the world where infectious diseases dominate, diabetes is an additional challenge.

Since 2008 the Atlas Alliance, through the cooperation between the Norwegian Diabetes Association and Diabetes Association Zambia, has carried out education of health personnel, influence of health policy, and information and awareness in connection with local health clinics. It is a great challenge that most people who suffer from diabetes are not diagnosed in Zambia. On a world basis, approximately 50 per cent of everyone having diabetes (187 million) is still not diagnosed, of which 78 per cent live in Africa. Information on how diabetes can be prevented, as well as information regarding the diagnoses, is important components of our work in Zambia. Cooperation with nongovernmental organizations, more research and better health structures are required to curb the diabetes epidemic.

Rikke Bækkevold
General Manager

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CARE

CARE's work with global health is particularly focused on sexual and reproductive health and rights (SRHR), gender-based violence and human security.

CARE's main focus is on women's rights and empowerment. Efforts take place on different levels: local, national, regional, and global. Strengthening local civil society organisations and efforts for engaging men, including traditional and religious leaders, are important strategies. SRHR efforts depend on country context and organization of the various programmes, but by and large it is about strengthening women's rights and economic, social and political participation, strengthening of local communities and their ability to hold their authorities accountable, and capacity-building of local health systems. Dialogue at village and household level has proved to be a very good entry point to working with such a sensitive theme as SRHR. We see that the work with women's economic and political rights increases their influence on decisions at household level. It is being increasingly reported from our programmes that men accompany their wives to the health stations and that the use of contraceptives has increased.

The work with SRHR and gender-based violence encounters many challenges at different levels. It takes time to change socio-cultural traditions and in many places there is a lack of political will by the authorities to prioritise the work. We also see a mobilisation of conservative forces in some countries as well as at various global fora. At the same time there are many possibilities for mobilising change agents in all societies. Important change agents include women's organizations, traditional leaders, and youth.

In CARE's programme focus area, the use of modern contraceptive means increased from 17 per cent in 2009 to 37 per cent in 2011.

Rwanda: Work with Sociocultural Barriers
CARE Norway's SRHR programme in Rwanda identified seven sociocultural barriers to the use of family planning methods. Through savings and loan groups 3,603 (of which 88 per cent were women) reported that they had started using contraceptives during 2010-2011. The programme will monitor if the effect is long-term. Since religion plays an important part in the use of contraceptives, CARE works closely with religious leaders. During 2010-2011, 60 religious leaders (Christians and Muslims) prepared a plan of action to influence their congregations to use family planning services. CARE has also contributed to rehabilitation of health stations and improved distribution of contraceptive commodities.

Tanzania: Influencing and Accountability of Authorities
CARE's AIM project (Advocacy for Improved Maternal Health) has led to several meetings and consultations with health authorities, legal authorities, parliamentarians, religious leaders and civil society. This work has contributed to the preparation of stronger legislation regarding the theme of SRHR in Tanzania. The law is still under review by Parliament. AIM has also developed and taken into use a system which monitors the implementation of national and international SRHR obligations in the country.

Mali: Gender Relationships and Use of Contraceptives
CARE completed in 2011 a survey in Mopti to assess how relations between genders influence SRHR. The results show that women's access to and use of reproductive health services has a close connection with their financial positions and their power relationships within the household, in the village and with religious leaders. The survey was used as a platform for engaging men and to increase awareness surrounding the relationships between women's reproductive health and traditional and cultural inequalities. In the programme's focus area, the use of modern contraceptives increased from 17 per cent in 2009 to 37 per cent in 2011. Reports also show that traditional and religious leaders have contributed to increased knowledge and awareness regarding gender-based violence and discrimination of women.

Myanmar: Training of Midwives
The need for better SRHR services in Myanmar is huge. This need is emphasised in the dialogue with local communities and with women in particular. CARE contributed to the training of 40 local midwives in SRHR, gender and equality during 2010-2011. CARE has also established collaboration with authorities, local communities, and partners such as Marie Stopes International, to increase access to better sexual and reproductive health services.

Engaging Men in the Work with SRHR
SRHR is a key theme in CARE's work with engaging men for gender equality and women's rights. By mobilising men and leaders in local communities as village agents, CARE reaches out to more households and local communities. In Niger, the village leaders signed a zero-tolerance declaration against gender-based violence which has also had a positive effect on girls' and women's SRHR. In Burundi and Rwanda, the work with engaging men has led to an increase in the use of sexual and reproductive health services including family planning and HIV testing and treatment. From Burundi there are also reports that men are increasingly taking part in housework, care of children and that they accompany their wives to the health centres for SRHR-related consultations. In Burundi, CARE has also used outdoor mobile cinemas to mobilise men in the work with SRHR.

Work Against Gender-based Violence
CARE Norway has worked for a long time against gender-based violence in several countries, and also contributed to mapping health-related consequences and costs of this violence. CARE will continue to put violence in context with women's rights, equality, participation and health.

Torhild Skogsholm
Secretary General

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FIAN

FIAN's vision is a world free from hunger, in which every woman, man and child can fully enjoy their human rights in dignity, particularly the right to adequate food, as laid down in the Universal Declaration of Human Rights and other international human rights instruments.

FIAN's mission is to expose violations of people's right to food wherever they may occur. We stand up against unjust and oppressive practices that prevent people from feeding themselves. The struggle against gender discrimination and other forms of exclusion is an integral part of our mission. We strive to secure people's access to the resources that they need in order to feed themselves, now and in the future.

FIAN has been instrumental in bringing forward and strengthening the economic, social and cultural rights, especially the right to food, at the UN and in Norwegian foreign policy. At the same time, we use these tools to support those fighting for their rights. FIAN analyses and documents individual cases where the right to food is violated. In addition, we communicate knowledge about the right to food to social movements, civil society organizations and to the authorities.

Midday Meals in Indian Schools

With the support of Norad, FIAN Norway has had a close cooperation with FIAN India since 2003. In 2004 this cooperation contributed to 18 million children being ensured midday meals at public school in India's most populated federal state, Uttar Pradesh. When this programme is carried out in accordance with the law, it contributes to children receiving increased intake of calories, proteins and vitamins. This is important for children's health and also contributes to better learning. In addition, the midday meals programme has contributed to increased participation of children, especially girls, at the schools in Uttar Pradesh. It is an important programme for fighting caste-related discrimination. At first, FIAN fought for the Indian government to order all public schools to serve food. We have subsequently contributed so that the authorities in Uttar Pradesh have increased the budget for the programme, enabling the children to have a varied diet, including lentils and fruit.

Creating long-term political changes is vulnerable to changes in government personnel and lack of follow-up of political promises.

Advocacy Work in India

For the past few years, FIAN has focused on access to angawadi centres (health centres) in India, especially in Uttar Pradesh. Indian authorities have several good welfare schemes to improve nutrition. Midday meals and the integrated child development schemes (including the angawadi centres) are two of these schemes. At the angawadi centres, all children aged 0-6, teenage girls, pregnant women and lactating mothers shall be offered a daily hot meal. They shall also be given information regarding breastfeeding, diet, hygiene and reproductive health. The angawadi centres also have a vaccination programme. These centres are the authorities' most important first line measure for monitoring malnutrition, in that height and weight of babies and children are measured regularly. An Indian report dated 2012 states that nevertheless almost half of all Indian children are undernourished. This represents 1/3 of the world's undernourished children. To show how discrimination limits access of the poor to the programme, FIAN has supported locally-organized Dalit women in their fight for an angawadi centre in Jalalpur, a village in the Lakhimpur District, Uttar Pradesh, since 2009. FIAN Norway has had meetings with the women in Jalalpur on several occasions, with local and state authorities, and has had wide press coverage for the women's demands for a health centre. This has been submitted to the Ministry for Women's and Children's Development in Uttar Pradesh.

As a result of this lobby and advocacy work, a health worker and assistant are now employed to carry out some of the tasks of the angawadi centre, including cooking food every day and weighing the children. We still advocate for a building so that the two new employees will have a place to carry out their work. In addition, the employees need training so that they can carry out all aspects of the job at an angawadi centre. FIAN's goal is universal access to health centres meeting the legal requirements.

Resolving individual cases requires good documentation, strategic lobby and advocacy work, and access to the authorities. The latter can come as a result of contacts within the state apparatus, pressure by the media, a united civil society or representatives from the international society. Creating long-term political changes is vulnerable to changes in government personnel and lack of follow-up of political promises. Defenders of human rights can put themselves in danger in cases where there is strong disagreement between the claimants of rights and the authorities.

Strengthening of Economic, Social and Cultural Rights in the UN
Since the mid-1980s, FIAN has worked strategically to guarantee the UN Convention on Economic, Social and Cultural Rights in general, and the right to food in particular. Margret Vidar, Legal Adviser at FAO, summarizes it as follows:

"Fifteen years ago, FAO was considerably less open for contributions from the civil society than it is today, for which thanks are due to FIAN. I remember one of the very first meetings we had at the FAO regarding the right to food, in the wake of the World Food Summit in 1996. The two external participants were Philip Alston, at that time a member of the UN Committee for Economic, Social and Cultural Rights, and FIAN's Michael Windfuhr. The further work resulted in three expert consultations, adoption of General Comment No. 12 and the adoption at the FAO in 2004 of the Voluntary Guidelines on the Right to Food in the context of national food security. FIAN was a totally necessary actor throughout the whole process."

Challenges and Opportunities
The work with the World Food Summits in 1996 and 2002 have been door-openers for strengthening the economic, social and cultural rights globally. The challenge is to get this work to make a difference for those who suffer from malnutrition. Malnutrition is closely connected to the right to food, water, sanitation and health. Without better access to productive resources, smallholders and the landless will continue to be over-represented in the hunger statistics, which in turn contributes to weakened health.

Kristin Kjæret
Executive Director

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Forum for Women and Development (FOKUS)

FOKUS consists of 75 member organizations and includes women's organizations, diaspora organizations, women's committees in political parties, trade unions, solidarity and development aid organizations.

FOKUS activities consist of three main pillars: advocacy and communication, programme and project cooperation, and knowledge and resource centre function. Global health efforts are carried out within all of these areas.

Since 2011, FOKUS has also functioned as a national committee for UN Women.

Right to Participation
Strengthening of women's sexual and reproductive health and rights (SRHR) is one of six thematic priorities. Through programme and advocacy work, FOKUS promotes the development of legislation that ensures women's SRHR. We see this in relation to the right to participation, economic independence, strengthening of women's and girls' knowledge about SRHR and the involvement of men and boys in instances where it can strengthen the achievement of these rights.

FOKUS also supports access for young women, lesbian, bi-sexual and transgender persons to equitable, inclusive health care and access to safer pregnancy-related health services, contraception and legal and safe abortions. It is also an objective to contribute to the integration of HIV and SRHR efforts.

As an umbrella organization for a wide variety of 75 member organizations – including several faith-based organizations – FOKUS seeks to initiate discussions and encourage dialogue between actors having different viewpoints on sensitive questions such as abortion.

Internationally there is a focus towards the UN system with an emphasis on the Commission on the Status of Women (CSW) annual meetings, the Commission on Population and Development (CPD), the General Assembly meetings, and UN Women.

Several of FOKUS member and partner organizations in the south are working actively with promoting women's sexual and reproductive health and rights. Some of them are also engaged in thematic working groups. As an umbrella organization for a wide variety of 75 member organizations – including several faith-based organizations – FOKUS seeks to initiate discussions and encourage dialogue between actors having different viewpoints on sensitive questions such as abortion. FOKUS is also represented in the Norwegian SRHR Network's core group, and has contributed to joint advocacy initiatives towards Norwegian authorities, departments and agencies.

Between 20 and 30 of FOKUS member organizations are involved in programme or project collaboration with partner organizations in the South.

Midwife Training and Organization-Building in Afghanistan
Afghanistan is one of the countries in the world where most women die during pregnancy and childbirth. In cooperation with the Norwegian Afghanistan Committee, FOKUS supports a midwifery school in Jalalabad in the Nangarhar Province. During the last decade approximately 10 per cent of the midwives in Afghanistan have been trained at this school. Twenty-five midwives graduate annually. For the last three years, the Norwegian Association of Midwives and the Afghan Midwives Association (AMA) have been included as cooperation partners. AMA is the first trade union for women in Afghanistan. Organization-building and quality assurance of midwife training in Afghanistan are important goals. The latest statistical surveys indicate that the mortality rate is gradually declining, and the education of qualified health personnel has contributed to this positive development.

Organization-Building in Ethiopia
One of Ethiopia's most serious social problems is the country's poor health services. The project's overall objective is to establish a sister organization to the Norwegian Women's Public Health Association in Ethiopia

which will be a clear and strong voice for women's rights, health issues and against various forms of violence against women and girls. By 2012, local divisions have been established in seven regions in Ethiopia.

Work Regarding Female Genital Mutilation (FGM)
The programme consists of two projects in Kenya and two in Tanzania. It includes several actors both at home and abroad: YWCA Kenya, KFUK-KFUM Global, MICONTRAP, Pan-African Women's Association, SIAC, DIAC and the Women's Front, Norway.

The projects increase knowledge regarding female genital mutilation in areas where FGM is practiced, and mobilize for resistance against the practice in their own local communities. Schooling of traditional and religious leaders and improvement of the health stations' understanding of the effects of female genital mutilation are other important priority areas. Through cooperation with local authorities, work is being done to improve enforcement of legislation enacted against female genital mutilation.

FOKUS also supports work against female genital mutilation in Gardo District in Puntland through the Somali Association for Women and Children and the partner Garwonet. Central means are information activities on radio, awareness-building through discussion groups and lobby activities. The project's aim of changing people's perception of genital mutilation and to create a more open debate on this theme is also challenged by some religious authorities. However, there are some indications that people's attitudes are changing. A milestone was reached towards the end of 2011 when the local administration in Puntland introduced a legal prohibition against female genital mutilation.

Sexual Violence in Uganda
With support from FOKUS and the Norwegian Council for Africa, the global network Isis WICCE (Women's International Cross-Cultural Exchange) has worked with strengthening women's competence and self-confidence in participating in peace processes. In addition, they work especially with preventing and fighting sexual violence during armed conflict. The health aspect is connected to the enormous need women and girls have for both physical and psychological assistance after rapes committed during war. A central point for Isis WICCE is that sexual violence during war not only seriously affects each individual woman's physical and mental health, but also that it leads to a collective humiliation at society level. It is therefore a great hindrance to women's participation in peace and post-conflict reconstruction processes.

Legal Advice in Guatemala
By bringing cases before the courts, the legal organization Mujeres Transformando el Mundo (MTM) seeks to make the perpetrators for sexual assaults on women in Guatemala accountable for their actions. Through the cooperation with FOKUS and Legal Advice for Women (JURK), they also support the women affected in their efforts to receive the compensation and the social recognition they deserve and need. MTM is one of very few organizations in Guatemala that work with this theme. In addition to preparing and conducting cases before the courts, the organization provides psychosocial support to the women affected.

Radio Information in Peru
With support from FOKUS and the Women's Front in Norway, WARMI Peru is starting up a new radio information programme in 2013. WARMI will produce and broadcast weekly radio programmes with an SRHR focus. In addition, they will produce radio programmes broadcast on the internet, especially directed towards young listeners. They will also collect and summarise SRHR-related research and news articles for use by public institutions, other voluntary organizations and academia. WARMI has previously used radio information programmes to increase knowledge and change attitudes regarding violence against women, with great success.

Information Project in Tanzania
This educational project aims at engaging women and young girls in 12 rural districts in Tanzania to talk about SRHR and the use of modern contraceptives to prevent unwanted pregnancies, sexually transmitted infections and HIV. The Women's Promotion Centre has extensive experience with providing comprehensive and knowledge-based SRHR education and in 2013 they will be entering into a new cooperation with the Women's Front in Norway and FOKUS.

Gro Lindstad
Director

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FORUT – Campaign for Solidarity and Development

Alcohol is the third largest risk factor for poor health. FORUT addresses global health through the "Alcohol, Drugs and Development" (ADD) programme.

Through advocacy, competence-building and cooperation with partners on local prevention FORUT contributes to reducing alcohol problems and improving public health. Alcohol is set in a broader context within global health, including within the fields of HIV and AIDS, tuberculosis, noncommunicable diseases, accidents and social problems. Global commercial interests contribute to the spreading of health problems connected to tobacco, alcohol and unhealthy food. FORUT participates in international networks and acts as a counterbalance to these multinational companies.

The Global Burden of Disease Study (2010) found that alcohol was the third leading risk factor for death and disability, accounting for 5.5 per cent of disability-adjusted life years (DALYs) lost globally. Alcohol was the leading risk factor for death and disability in large parts of the world including southern Africa, Eastern Europe and most of Latin America. In southern Africa, alcohol-related road traffic, unintentional and intentional injuries together with alcohol-related tuberculosis played a key role in alcohol contributing so greatly to death and disability. If the impact of alcohol on HIV and AIDS had been included, alcohol-attributable burden in this region would have been even higher.

Advocacy

Global advocacy is an important part of FORUT's work, both through its partner network in the project countries and through the Global Alcohol Policy Alliance (GAPA), where FORUT has one Board member and is the Secretariat. In 2010, the World Health Organization (WHO) adopted the Global Strategy to Reduce the Harmful Use of Alcohol and in 2011, the UN adopted a Declaration on the Prevention and Control of Noncommunicable Diseases. FORUT has been an active advocate in both these political processes and engaged in a good dialogue with the Norwegian government through commenting on policy drafts and participation in dialogue meetings under the direction of the Ministry of Foreign Affairs, the Ministry of Health and Care Services, and the Directorate of Health. Norway's period on the WHO Executive Board was one such opportunity for constructive communication. FORUT and GAPA have been present at several of WHO's Executive Board meetings and the World Health Assembly for the past few years. A representative of FORUT represented GAPA at WHO's Moscow Meeting on Combating Noncommunicable Diseases and was a civil society observer in the Norwegian delegation at the UN's High Level Meeting on Noncommunicable Diseases in 2011.

FORUT has contributed to developing and spreading knowledge regarding alcohol harm and promoting the active use of alcohol policy measures in our partner countries and globally.

FORUT emphasizes that public health policy must be developed without interference from the vested interests that are better served by weak and ineffective policy measures. The international alcohol producers are among these interests but there are many sectors where profit often is given preference to public health. This has resulted in an ad hoc network of like-minded organisations from many fields that cooperate in a "Conflict of Interest Coalition" which has been a voice in several debates within WHO.

National Policy and Local Prevention

WHO's global alcohol strategy recommends action in many sectors. Prevention through an active alcohol policy is put forward as a good instrument. Such policies will include regulating the price of alcohol through taxation, limiting the availability through age limits. and limits to the number of sales outlets and licensed premises, as well as limitations on marketing. FORUT has contributed to developing and spreading knowledge regarding alcohol-related harm and promoting the active use of alcohol policy measures in our partner countries and globally.

In Malawi, Drug Fight Malawi, supported by FORUT, has mobilized for development of a national alcohol policy in a manner which is being considered for inclusion as a "best practice" by WHO's Regional Office for Africa. FORUT has been involved in a similar process together with partners in Zambia, where the tax question has been on the agenda. FORUT has contributed to the process by facilitating the creation of national networks in Sri Lanka, Nepal, Malawi and Zambia, as well as a regional alcohol policy alliance in Southern Africa.

FORUT's partner organizations in the South are involved in local prevention work in many areas: street children, gender equality, masculinity, youth and village development.

FORUT is a member of the network MenEngage which engages men in the fight for gender equality and against gender-based violence.

Competence Development
Policy advocacy is about transforming research evidence into practical action. In 2012, FORUT was a cosponsor of a global conference on alcohol policy in Bangkok, co-organized by the Thai public health authorities, the Thai Health Promotion Foundation, GAPA, and WHO. The conference was also a part of WHO's official follow-up of the global alcohol strategy. All of FORUT's development partners participated in the conference.

FORUT's continuous cooperation with researchers contributes to increasing the knowledge base on alcohol harm in low- and middle-income countries. In 2012, SINTEF Health conducted a large population-based survey regarding alcohol and drug problems in Malawi. The study is funded by the Research Council of Norway based on a pre-study financed by FORUT. Previously FORUT has contributed to several studies in Sri Lanka, Nepal and Sierra Leone, though not of this scale.

FORUT is in close contact with several groups of researchers and has on several occasions invited internationally renowned researchers to their events. Linking to the general global health debate is key and in 2012 FORUT's senior adviser participated in the "Global Health Law and Governance" course at Georgetown University in Washington.

The transformation of the evidence base into a comprehensive public health policy is also the basis for a training project run in cooperation between FORUT and the Norwegian Blue Cross. Training modules have been developed for the development of active alcohol policy in order to limit alcohol related harm.

Training courses have been conducted in six African countries: Malawi, Botswana, Namibia, Lesotho, Madagascar and Chad, with participation from both civil society and the public sector.

Morten Lønstad
Secretary General

www.forut.no

Health & Development International (HDI Norway)

HDI is a small organization with minimal administrative costs, which was established to carry out prevention of diseases that can be eradicated.

HDI has worked with countries from Senegal in the west to South Sudan, Yemen, and Pakistan in the east, also countries where more peace is needed, where improved health and socio-economic development can contribute. The result in Niger is significantly reduced maternal and infant mortality and the prevention of lasting, degrading birth-related morbidity among over 250,000 people in essentially road-less pilot areas the size of Rogaland county.

After working with disease eradication for many years, HDI has expanded its efforts to include preventing infant mortality, and preventing obstetric fistula, with support from among others Norad and the Norwegian Kavli Trust. HDI's programmes are always carried out under the auspices of national authorities, in cooperation with local leaders and the population as a whole. Monthly follow-up and data-collection allows for rapid course adjustment and feedback to the population about what they are achieving.

Niger

With the Health Minister and the country's First Lady in the lead, Niger's authorities decided in February 2013 to adopt a new initiative proposed to them by HDI. By using medication that costs about NOK 1 per dose, research indicates that Niger can achieve almost a 90 per cent reduction in the number of women who bleed to death at childbirth. The medication is administered immediately after the child is born.

More than 20 years of experience with disease eradication and ten years of experience in preventing death and injury during childbirth make it possible for HDI to contribute in important ways, even though it is a small organization.

The estimated annual financial gain of NOK 44.6 million will be a real advantage for families where most earn about NOK 6, or USD 1, a day. Niger is one of the world's poorest countries. In addition to financial gain through prevented death, and prevented months of weakness due to severe anaemia suffered by many, who lose a lot of blood but survive, comes the most important: all the suffering and sorrow which the initiative is expected to prevent.

The financial gain looks to be as indicated above, even if only 75 per cent of women who give birth are reached. The authorities chose an even more ambitious approach than HDI had envisioned, by deciding to also distribute medication to women giving birth at home.

By comparison, programme costs are approximately NOK 1.5 million annually.

Aiming to Test in Other Countries
HDI's other aim is to now test its original, successful village-based project for protecting women and babies at childbirth in other countries. There are many places where far too many women and babies die at birth and where far too many women who survive a blocked birth end up with lifelong obstetric fistula. One also needs to expand the programme to other areas in Niger. And since birth-related infant mortality has been reduced as much as possible through measures for saving the mothers, we also plan to introduce "Helping Babies Breathe", a cheap, effective plan developed by the American Pediatric Association and the Norwegian company Laerdal Global Health.

When a programme almost reaches Millennium Development Goals 4 and 5 within three years in such a large and challenging area, it should also be possible to achieve similar progress in other places where birth-related maternal and infant mortality are unacceptably high. The challenge is finding good ways to organize this, ways that allow necessary oversight and control of the funds.

HDI depends on close collaboration with other agencies to replicate this work if these successful projects are to be carried out in other locations where they can be useful in a global context. More than 20 years of experience with disease eradication and ten years of experience in preventing death and injury during childbirth make it possible for HDI to contribute in important ways, even though it is a small organization.

HDI Norway has a sister organization in the US, which, like HDI Norway is supported by private individuals, companies, and foundations large and small. Like HDI Norway, the American branch of HDI has also achieved trust and financial support from government authorities for its work. The basic principles and objectives are the same: best possible health-related, economic and social development outcomes, especially for women and children. This is done using funds that are modest compared to the benefits being achieved.

Anders Seim
Executive Director

www.hdi.no

HimalPartner

HimalPartner (formerly the Tibet Mission) is a small mission organisation known for its work with water power and social development.

HimalPartner's work is concentrated in Tibetan areas in China and Nepal. Our thematic focus is on mental health and industrial development as well as interdisciplinary work related to education and environmental issues. HimalPartner collaborates with many local partners.

HimalPartner has been active in capacity building and strengthening primary health services in Nepal since the 1950s and in China since the 1990s. Together with collaborating partners we have worked on projects related to mental health for many years. The specific focus on mental health began in 2011 when HimalPartner was granted development funds through Digni. The network was established and technical cooperation was organized in both Norway and Nepal. Several of the partners in Nepal have applied for Norad/Digni funds for specific mental health projects in 2013.

Global mental health
There are presently few international actors within the field of mental health, especially within aid development. HimalPartner has collaborated with several Norwegian health organisations to reconcile evidence and knowledge related to mental health and development. Our general belief in this area is to tread carefully and consider the local context in order to ensure that one does not do more damage than good.

Focus on mental health
In Norway HimalPartner has been an active advocate to get mental health included in the White Paper. Mental health includes all the three prioritised areas highlighted in the White Paper. The challenge is what practical and budget-related consequences this will have.

Mental health is an underestimated area within development work. Low donor funding in this area has influenced national priorities in developing countries, which also remain low. In their comments to the White Paper the Parliament pointed out that this is an area which Norwegian authorities must contribute to change.

Low donor funding in this area has influenced national priorities in developing countries, which also remain low.

Capacity building of global mental health in Norway is done through Digni for their member organizations. Further we are the Coordinator of the "Norwegian Network for Global Health", where members are updated through monthly newsletters, conferences and seminars. Experience related to capacity strengthening is ensured internally through the use of Norwegian professional experts.

HimalPartner supports a similar network in Nepal called "National Mental Health Network – Nepal", which was established in 2012. The purpose of this network is to co-ordinate efforts conducted by the many actors in the field of mental health. The network is co-ordinated by the United Mission to Nepal. The network works alone and jointly with partners to influence the authorities to develop national legislation and strategies to enhance evidence and rights related to mental health.

As of 2013 HimalPartner will also support the user organisation Koshish's advocacy work as well as their rehabilitation centre.

Preventive work
Healthy minds are ensured at an early age. We provide support to the Early Childhood Education Centre (ECEC), which ensures training of pre-school teachers and parents in childhood development. We also look for possibilities to integrate the International Child Development Program (ICDP) in national plans. Our work in China in this field will most probably result in an international collaboration with several organisations.

Through the United Mission to Nepal we also support an extensive peace and reconciliation project, which promotes mental health in several districts in Nepal. Given the painful civil war in Nepal, it has been important to also focus on mental trauma. Much of the information and preventive work takes place through existing networks at the grass root level such as women's groups, health stations and religious leaders.

Treatment
Access to quality health services in villages in Nepal is challenging. In a country with only 56 psychiatrists, training of primary health personnel and training of unskilled health workers is central. Partners of HimalPartner have established contact with international experts to acquire knowledge on best practises related to mental health work in countries without relevant specialities. This includes the World Health Organization and Sangath in Goa in India and the London School of Hygiene and Tropical Medicine. The United Mission to Nepal is starting a project in 2013 which will be working for improved access to treatment through strengthening the existing primary health services. Further, in 2009 several religious congregations established a resource centre for pastoral care and counselling – Bethesda – in Pokhara. Last year 200 members of the congregations received training. This has been important work towards healing the wounds after the civil war. In 2012 Higher Ground established an advisory centre in connection with work for women who had been exposed to human trafficking.

Research
HimalPartner contributes indirectly to research by supporting the research centre in Health Bergen in a relevant project in Nepal and Health Stavanger.

Challenge
With reference to the comments made by the Standing Committee of Parliament, HimalPartner would like to challenge Norwegian authorities to play a role in the World Health Organization and to dedicate support to relevant projects in this area, which is rapidly gaining more momentum internationally.

Heidi Westborg Steel
Secretary General

www.himalpartner.no

Norwegian Church Aid

The right to health is one of Norwegian Church Aid's main focus areas in the present strategy period 2011-2015.

The right to health consists of programmes for HIV and AIDS and health. In addition, we have health components in several of our programmes with the focus on genital mutilation, gender-based violence, water, sanitation and hygiene.

In 2012, Norwegian Church Aid had health programmes in the following countries: Vietnam, Myanmar, Palestine, Sudan, South Sudan, Malawi, Angola, Zambia, Thailand, Laos and Ethiopia. These programmes are mainly supported by Norwegian authorities. Several of the health programmes are carried out in areas marked by war and political unrest. Where the target group is refugees, we work to ensure a comprehensive health approach focusing on women and children. In countries which are more politically stable we have long-term health programmes with a focus on improving the quality of health services provided to the population.

Nursing Success in Malawi

Norwegian Church Aid has carried out a large health project in Malawi since 2005, the aim of which is to improve the quality and increase the number of health workers in the country. At the beginning of the project, Malawi's health system was in a great crisis. The lack of health personnel was one of the many challenges. Together with our partner Christian Health Association (CHAM), extensive work with the infrastructure was started in order to increase the capacity at CHAM's nursing schools. Six colleges in Norway were invited to contribute to increasing the professional quality of the education. The objective was to double the number of students and then get them to continue to work in Malawi after they qualified.

There has been an increase of nursing students from 3 456 to 5 899 between 2004 and 2011.

The project has been a great success. There has been an increase of nursing students from 3,456 to 5,899 between 2004 and 2011. All the CHAM colleges have received new clinical skill labs. A new curriculum with focus on the gender perspective, human rights and ethics has been prepared. New textbooks have been purchased. In addition, there is a computer room available for students at all the colleges.

The second phase of the project was concluded in 2012, with a large international conference in Malawi with 200 participants from 14 countries. The title of the conference was "Nursing Education in Africa – Changes and Challenges" and it was unique because it focused on nursing education in Africa. The quality of the work that was presented was of a high professional standard, and much of the research that was presented was by Malawian students and teachers who had been with the project from the start. In total, Norwegian authorities have contributed to this work with NOK 108 million. In November 2012, the project was extended by three years with financing from the Norwegian Embassy in Malawi. In this new phase, research will be one of the main focus areas.

Gender-Based Violence in War and Conflict

Gender-based violence threatens the health of women and girls. Increased access to health services for victims of gender-based violence is necessary. Knowledge of treatment of both physical injuries such as fistula and psychological trauma treatment is decisive for women's health. Norwegian Church Aid supports work in this area in several countries: DR Congo, Mali, Sudan (Darfur) and Palestine.

Work with survivors of gender-based violence in war and conflict zones is best exemplified by the work that the Norwegian Church Aid does in DR Congo. Since 2010, we have contributed to strengthening 585 accredited health centres in the north and south in Kivu by training one nurse from each health centre in psychosocial work. The aim is to make them able to identify traumatized patients needing assistance in addition to medical support. They shall ensure that the patients who need further treatment are referred to health institutions with relevant competence.

For many years, Norwegian Church Aid has worked to attain zero tolerance for harmful traditions, child marriages and violence in close relationships. Challenging religious and traditional leaders concerning their responsibility is an important part of this work. In Ethiopia, faith-based and local organizations, as well as religious leaders, carry out measures in most of the regions in order to gain agreement locally to abolish the custom. Victims of genital mutilation are motivated to seek out health services which they do not visit due to the stigma. This is part of an extensive programme in cooperation with Save the Children. The Norwegian Embassy has supported this since 2006. There are demonstrable results in the reduction of the number of girls who have undergone female genital mutilation and parents who do not subject their daughters to female genital mutilation. Nevertheless, there are still challenges with religious interpretation of the necessity of certain forms of genital mutilation, also known as sunna. Training of health workers, traditional circumcisers and midwives is important to reduce the extent of it.

HIV Work in Prisons

Norwegian Church Aid's HIV and AIDS programmes have had the objective of engaging and qualifying partners to fight stigma and discrimination, and provide help and support to those who are infected by HIV and their close relatives. We emphasize youth in particular. In Vietnam, Norwegian Church Aid is the only NGO with an extensive HIV and AIDS programme in prisons. The programme started in 2000 and includes preventive work, competence-building of the employees and inmates, and direct health services to those infected with HIV. The programme includes ten prisons in six provinces in the northern and central parts of Vietnam.

In 2012, Norwegian Church Aid extended the work in prisons with a project having the main focus on early diagnosis of tuberculosis in inmates infected with HIV and AIDS. It has been challenging to obtain the necessary permits, but the work is now extended to include 17 prisons and 30,000 inmates. The project is carried out in cooperation with Vietnam's national tuberculosis programme. In addition to early diagnosis, the main focus is on establishing health systems in prisons that can provide the necessary follow-up and treatment of patients. The aim is to examine 25,000 inmates by March 2013. This work is supported by funds from the World Health Organization.

The Right to Water

Access to clean water and good hygiene is crucial for good health. In Angola, Norwegian Church Aid has had a conscious strategy for reaching out with a programme focusing on water, sanitation and hygiene in isolated areas. Norwegian Church Aid has adapted its programme to the Government's plan "Water for Everyone". A total of 6,586 entitled people received clean water in the municipalities of Baia Farta in Benguela and Cariango in Angola in 2011.

Anne Marie Helland
Secretary General

www.nca.no

The Norwegian Cancer Society

Cancer causes more than eight million deaths every year globally. More than 70 per cent of these deaths occur in low- and middle-income countries.

Cancer kills more people than AIDS, tuberculosis and malaria combined. It is expected that the number of people who die of cancer annually will increase to 12 million by 2030.

The comprehensive report "Global Burden of Disease 2010" emphasizes the need to raise cancer and noncommunicable diseases (NCDs) higher on the global health and development agendas.

In many low and middle income countries, the health systems are not very well developed and access to cancer treatment is inadequate. Focus on preventive measures is therefore critical to reduce the burden of disease. Tobacco control is clearly the single most important measure to prevent cancer. Strategies to prevent obesity and reduced alcohol consumption are also important priorities.

The increasing incidence of noncommunicable diseases results in reduced life expectancy, more years with disability and reduced quality of life. This constitutes a significant obstacle to development if we do not implement effective preventive measures.

The Norwegian Cancer Society's International Activities
The Norwegian Cancer Society allocates one to two per cent of its annual budget to international work. Tobacco control has been the focus of the NCS's international efforts, through local and regional projects, and tobacco advocacy. In recent years, NCS has gotten more involved in global and international processes related to the prevention and control of noncommunicable diseases (NCDs).

The Norwegian Cancer Society played an important role before, during and after the United Nations High Level Meeting on NCDs in September 2011. The Union for International Cancer Control (UICC) is a key partner for the Norwegian Cancer Society in its efforts to put cancer more clearly on the global agenda. In addition, NCS is a member of the European Cancer League (ECL) and the Nordic Cancer Union (NCU), two networks where exchange of knowledge and cooperation in cancer care and research are central. NCS is also an active member of the international cancer control legal network McCabe Centre for Law and Cancer, and is a coordinator for European network members.

Health promotion and the prevention and control of noncommunicable diseases, including cancer, should be Norwegian development assistance and development policy priorities.

Tobacco Control
Worldwide, more than a billion people use tobacco daily. Tobacco is the single most important cause of avoidable illnesses and death. More than half of all tobacco users die of tobacco-related diseases. In low- and middle-income countries, tobacco production and use have enormous social and economic consequences, in addition to diseases and health problems. They hinder development and contribute to maintain a cycle of disease, poverty and food insecurity.

The Norwegian Cancer Society's Ambitions:
- Strengthen international tobacco control efforts
- Contribute to the implementation of the WHO Framework Convention on Tobacco Convention (FCTC) at country level
- Contribute to counter the tobacco industry's influence and efforts to undermine the implementation of the FCTC
- Contribute to strengthened tobacco policy through advocacy and cooperation
- Integrate tobacco control into existing global health and development agendas

Since 2005, the Norwegian Cancer Society has been supporting tobacco control activities and initiatives in Russia and Africa (in countries like Ghana, Niger, Zambia, Gabon and Cameroon) to

combat the tobacco epidemic. NCS works through global and local civil society organisations. NCS has allocated more than USD 1.3 million to tobacco control initiatives in these countries. The Norwegian Cancer Society's support has contributed significantly to the implementation of specific projects, and to strengthened civil society organisations and networks. The cooperation with the organisation Vision of Alternative Development (VALD) in Ghana is an example; it has resulted in the enactment of stricter legislations and measures when it comes to marketing of tobacco products and accessories in Ghana.

Combatting Breast Cancer in Peru
The Norwegian Cancer Society (NCS) and the Norwegian Breast Cancer Society (NBCS) support a breast cancer early-detection project in Peru with USD 0.3 million from the Pink Ribbon campaign. The three-year pilot project started in 2011, and was conducted by PATH, a global organization that promotes better health.

The funds allocated by NCS and NBCS enabled PATH to develop information and campaign material to raise awareness on breast cancer, in close cooperation with Peruvian oncologists, doctors, midwives and nurses. When women help and motivate other women, they visit their doctors sooner for further examinations when they detect abnormalities in their breasts. The project has also contributed to building the capacity of doctors in breast examination and breast cancer diagnosis at the local hospitals.

Norwegian Cancer Society's Advocacy: the HPV Vaccine in Immunization Programmes
Cervical cancer is the second most common cancer in women worldwide. Cervical cancer affects almost 530,000 women and kills 275,000 women globally every year. Approximately 85 per cent of women who are diagnosed with cervical cancer live in low- and-middle income countries. The Human papillomavirus (HPV) is a sexually transmissible virus and an important factor in the occurrence of cervical cancer and other cancers.

The incidence of cervical cancer and other HPV-related cancers is likely to increase significantly, especially in low- and middle-income countries considering the expected demographic changes with relatively younger populations in these countries. The HPV vaccine is particularly important in these countries because mass examination and treatment services and programmes are non-existent. There is evidence that up to 70 per cent of all cervical cancers can be prevented through effective HPV immunisation.

The Norwegian Cancer Society has long advocated for the inclusion of the HPV vaccine into the portfolio of GAVI, the international alliance for vaccines and immunization. This is now a reality and up to 30 million girls will receive the vaccine by 2020. Through the Union for International Cancer Control (UICC), NCS also supports an initiative to have the HPV vaccine included in national cancer plans.

The Way Forward:
- Health promotion and the prevention and control of noncommunicable diseases, including cancer, should be Norwegian development assistance and development policy priorities.
- Norway should advocate for the strengthening of prevention and control of noncommunicable diseases in global health and development fora, and for the allocation of necessary financial resources to achieve this objective.
- Norway should continue to work for the implementation of the Framework Convention on Tobacco Convention (FCTC) internationally.
- Norway should be a driving force for the revision of international agreements such as the Trade Related Intellectual Property Rights (TRIPS) in order to better address global health challenges.
- Norway must work for the inclusion of noncommunicable diseases in the successor development goals after the current Millennium Development Goals expire in 2015.

Anne Lise Ryel
Secretary General

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Médecins Sans Frontières – MSF (Doctors Without Borders)

MSF is the world's largest medical humanitarian organization, with projects in 70 countries. MSF provides medical assistance in areas of conflict, during epidemics and after natural disasters.

The primary emphasis of projects supported by the Ministry of Foreign Affairs and Norad is to deliver primary health care in settings where the national health system is non-existent, or providing treatment in contexts where the health infrastructure is unable to handle a massive health crisis such as the HIV/AIDS pandemic.

Internationally, MSF has been a leader in the global health field by offering:

- Qualified and skilled birth attendants in countries with extreme maternal mortality rates
- Innovative nutrition programmes for malnourished children
- HIV and AIDS medication in low-income countries and advocating for cheaper drugs
- Mass vaccination against neglected diseases and epidemics in inaccessible regions
- Treatment of victims of sexual and gender based violence in conflict and war

Mobilizing for Women and Children's Health

Women and children make up approximately 80 per cent of all MSF's patients. The organization has taken a lead in the efforts towards Millennium Development Goals 4 and 5 by developing specialized competence regarding the reduction of extreme maternal mortality through qualified and skilled birth attendants and prevention of child mortality with the help of nutritional programmes and vaccination. MSF assisted with 192,000 births in 2011. In South Sudan and DR Congo, MSF run primary health services in some of the country's most inaccessible regions. Both states experience weak central governments and lack of public health systems. Médecins Sans Frontières provides free health services such as maternity care, vaccination and epidemic response to groups at risk, including displaced persons.

Through its HIV-programmes, MSF has shown that the HIV-epidemic is reversible. Advocacy has been an important part of the strategy.

In 2012, a report from two projects in Burundi and Sierra Leone was published. In each project, the Millennium Development Goal on reducing maternal mortality has been realized. After emergency obstetric care was introduced, the mortality rate fell by 74 per cent.

For a long period, MSF has worked in the Sahel region to develop more effective strategies for treating malnourished children. During the last food crisis in the summer of 2012, MSF performed Norwegian-supported nutrition projects in Niger and among Mali refugees in Mauritania.

Reducing the Burden of Disease with the Emphasis on Prevention

Médecins Sans Frontières was the first organization to implement large-scale HIV treatment in low-income countries. By 2012, MSF had 230,000 HIV patients on treatment. Thirty thousand of these are enrolled in Norad-supported projects in Malawi and Swaziland. Treatment is combined with preventive strategies such as awareness campaigns, prevention of mother-to-child transmission and voluntary male circumcision. The two Norad-funded projects also prioritize opportunistic infections among HIV patients. Every year 2,500 patients are cured for tuberculosis.

In Myanmar, Médecins Sans Frontières is the largest provider of ARVs. In Kachin and Rakhine, low-intensity conflicts between minority groups and the national army have been ongoing for decades, with sporadic escalations such as in Rakhine in the summer of 2012. Médecins Sans Frontières offers HIV treatment and primary health care services to population groups on both sides of the conflict.

Through its HIV-programmes, MSF has shown that the HIV-epidemic is reversible. Advocacy has been an important part of the strategy. After new research has found that HIV treatment reduces the chance of HIV transmission by up to 95 per cent, Médecins Sans Frontières has promoted "treatment as prevention". By offering ARVs to everyone who needs it by 2015, new HIV infections can be prevented and the pandemic stopped.

Vaccination programmes remain an important element in Médecins Sans Frontières' disaster preparedness. In 2011, over five million people were vaccinated against measles, and during the cholera outbreak in Haiti the year before, MSF treated over 170,000 patients.

Promoting Human Security Through Health
MSF continuously strives to improve access to life-saving medicines for patients in the global South. The organization has contributed to the clinical development of new treatment methods, but also exerts pressure on pharmaceutical companies to lower their prices. The price of HIV medicines has fallen to less than 1/100 during the last decade.

MSF shares Norway's concern for victims of sexual violence. During 2011, the organization treated over 15,000 cases, both women and men. In addition to treating injuries and providing protection against sexually transmitted diseases, the organization offers legal affidavits. Norwegian-supported projects in DR Congo and the Kibera slum in Kenya both provide treatment and information about sexual violence.

In order to provide medical care to those in greatest need, MSF is dependent on that humanitarian principles are being respected in war and conflict. Access to injured and displaced and the freedom to prioritize those in most need of treatment require a viable humanitarian space. The politicization of humanitarian aid means that the independence and neutrality of humanitarian actors is compromised. A humanitarian space under pressure presents a significant challenge to MSF's operational freedom.

It has gradually become more dangerous to be a humanitarian aid worker. Intimidation and the risk of kidnapping mean that MSF must withdraw or reduce the presence of expatriate staff. The result is that medical humanitarian aid often does not reach those in greatest need.

Anne-Cecilie Kaltenborn
Secretary General

www.msf.no

The Norwegian Heart and Lung Patient Organization (LHL) LHL International Tuberculosis Foundation (LHL International)

LHL International Tuberculosis Foundation (LHL International) cooperates with patient organizations, national health authorities and research institutions both internationally and in Norway.

In the centre are patient rights, prevention, information to the public, capacity-building, organizational development and operational research.

In 2011, 8.7 million people were diagnosed with tuberculosis (TB). Approximately 1.4 million died. A total of 500,000 women die from TB and it is estimated that 10 million children are orphaned due to the disease. Tuberculosis is the greatest cause of death among HIV-positive people.

The main challenges regarding global TB control is poverty, people being infected by both TB and HIV, the development of resistant forms of TB, stigmatization, the need for a new and effective TB vaccine, and the need for better diagnostic tools and medicines. An important aspect is that the treatment can be from 6 to 24 months. Therefore there are many who do not complete the treatment.

Awareness of gender roles and the understanding of how prevention and treatment must be tailored to women and men's different needs are essential in order to reduce morbidity and death

Mobilization for Women's and Children's Health and Rights
Awareness of gender roles and understanding of how prevention and treatment must be tailored to women and men's different needs is essential in order to reduce morbidity and death. Tuberculosis affects young people of reproductive age to a great extent. Health personnel and volunteers in the project cooperation in Tanzania and Sudan have taken courses with special focus related to gender and TB. Gender awareness is a cross-cutting issue throughout our project portfolio.

Access to Health Services
Support to national and regional tuberculosis programmes in Nepal, Sudan, Tanzania (Temeke), Zambia (Copperbelt) and Russia (Arkhangelsk) increases the access to treatment for women and children. The World Health Organization's figures from 2011 show that 74,000 new patients were diagnosed with tuberculosis and received treatment in the countries and regions where LHL International supports tuberculosis programmes. The global goal of 85 per cent successful treatment results by 2014 has already been achieved for these countries, apart from Arkhangelsk (Russia), where Multi Drug Resistant Tuberculosis (MDR-TB) poses a great challenge. This affects the treatment results negatively. LHL International contributes to patient organizations being able to do information work locally and teach volunteer treatment assistants who reach women and children in their homes. In Tanzania, the patient organization "Mukikute" offers outreach information services to the population, including HIV testing from a bus that travels to different villages. Training of laboratory personnel in Nepal and Sudan leads to quality assurance of both diagnosis and treatment. In addition the continuity among local health personnel is strengthened.

Nutrition, Health and Living Conditions
Serving of food, distribution of food packages, as well as training and information about the importance of a healthy diet in tuberculosis treatment and prevention of tuberculosis, are activities that are carried out by several of LHL International's partners. According to the health authorities in Arkhangelsk, distribution of food packages and hygienic articles, as well as support for transport has led to better treatment results. In several places, patients are also taught how to establish income

generating activities. Patients thus get the opportunity to improve the standard of living for themselves and their families. In this way, women are also given the opportunity to earn their own income, which again enhances independence. In Nepal, such activities have meant that patients admitted with MDR-TB experience greater financial security and are therefore motivated to complete the treatment.

Reducing the Burden of Disease with the Emphasis on Prevention
A five-day interactive programme in health communication is conducted for health workers and treatment assistants in all our countries of cooperation. Since 2006, LHL International has qualified 56 Trainers of Trainers (ToTs), who in turn have held trainings for approximately 1,000 health workers and treatment assistants. Feedback from partners indicates that better communication between the health worker and the patient makes it easier for the patient to complete the treatment. Development and distribution of information materials, which are adapted to the patients in their own language, result in better knowledge of patient rights and how to recover from TB. It also contributes to less stigma related to the disease. The patient organization "Chep" in Zambia shows through a survey that having a TB treatment assistant contributes to the patients being more open about the disease and makes them more motivated to take medication daily until the treatment is completed.

Tuberculosis and HIV
Coordination of treatment of patients who have both TB and HIV is central in the international strategy for tuberculosis control. LHL International supports cooperation between public- and private actors to coordinate treatment of TB and HIV. In cooperation with the research institution "REACH Trust" in Malawi, LHL International has contributed to the development of a health system model which ensures that persons with TB and HIV receive antiretroviral treatment. A study illustrating the prevalence of both TB and HIV in disabled persons has also been carried out in an area of Lilongwe.

New Tuberculosis Vaccine
A new and more effective vaccine is the best way to prevent and fight tuberculosis. LHL International cooperates with the global product development partnership Aeras which works to develop several new tuberculosis vaccines. Globally, six of 11 vaccines belong to Aeras' portfolio. One of Aeras' strengths is that they contribute to developing local competence in the countries where new vaccine candidates are being tested. The partnership has as its goal that new vaccines shall be produced locally where they are most needed.

Promoting Human Security Through Health
There are more cases of tuberculosis infection when people live closely together. In addition, people with a poor health and nutritional status develop the disease more easily. Refugees are therefore especially at risk. In Nepal the National Tuberculosis Programme works effectively in camps with refugees from Bhutan in East Nepal. Outreach work is also done with displaced persons in temporary living areas in Kathmandu. Partners in Sudan are working with refugees in many states, including Darfur.

Migration and TB is also a focus area in LHL International's work in Norway, where we do outreach information work regarding TB and Norwegian health care services among immigrant groups who are at particular risk. The majority of those who fall ill in Norway, and therefore are infectious, are immigrants. Increased knowledge about TB contributes to the fight against stigma and thereby fighting the disease.

Trude Bang
Managing Director

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Norwegian Red Cross

Norwegian Red Cross (Norcross) works together with the International Federation of the Red Cross and Red Crescent Societies (IFRC) and the International Committee of the Red Cross (ICRC) in the field of health contributing to achieving the Millennium Development Goals (MDGs).

We also have directly bilateral co-operation with a number of Red Cross and Red Crescent national societies. The key areas for Norcross' support on global health are health prevention and promotion, social mobilisation and behaviour change, first aid and provision of health services in emergencies and conflict.

Norcross' thematic priority areas are water, sanitation, maternal, new-born and child health, malaria, HIV and AIDS and psycho-social support. In addition Norcross has developed pilot projects addressing violence prevention among youth in high risk areas and safe access to health services. In countries with particularly challenges, such as Somalia and Afghanistan, support to hospitals, clinics and training of health personnel are provided. In addition we work in areas hit by disasters.

Mobilising for women's and children's health and rights
The Norwegian Red Cross has been a central contributor in developing the Red Cross movement's gender strategy which gives guidelines for, and ensures women's rights and involvement in the design of projects and activities. The international conference of the Red Cross and Red Crescent societies in 2011 adopted Resolution 6 "Health inequities with a focus on women and children", which prioritises increased focus on programmes that include maternal and child health.
The principal activities of the Red Cross within maternal, newborn and child health are directed towards:

- training and information at community and household level.
- mobilisation and referral for follow up of women during pregnancies and deliveries.
- referral and transport to health centres and hospitals
- mobilisation for vaccination through the national vaccination programme and campaigns

IFRC is hosting GAVI's civil society constituency group of civil society organisations and has advocated for the involvement of NGOs and civil society at local level to be involved in addressing vaccine preventable diseases.

New innovative approaches regarding Integrated Community Case Management (ICCM) addressing early and local access to treatment of malaria, diarrhoea and respiratory infections, and use of mobile technology will strengthen the reporting of results.

Reducing the burden of disease with the emphasis on prevention
Health program activities are carried out by volunteers. They receive training from the Red Cross/Red Crescent national society and work in their own local community. The primary focus are health prevention and promotion of infectious diseases. The Red Cross and Red Crescent health programs are based on the Community Based Health and First Aid (CBHFA) concept.

The CBHFA includes water, sanitation, hygiene, malaria, psycho-social health, HIV and AIDS and mother, newborn and child health. A separate module for non-communicable diseases (NCD) is under development.

Local establishment of the Red Cross and co-operation with the health authorities in different countries gives possibilities for contributing more and better in the bridge-building between informal and formal health systems.

Vaccination
More than 67 000 volunteers have contributed to mobilisation for vaccination, reaching more than 4.5 million families with information and contributed to 37.5 million children being vaccinated. Between 2000 and 2010, the measles mortality rates have been reduced by 90 per cent globally. Polio has been reduced by 99 per cent.

Malaria
Distribution of insecticide treated mosquito nets started in 2002. By 2011, more than 21.5 million

mosquito nets have been distributed, protecting more than 38.7 million people. High coverage of treated nets can reduce new cases of malaria by 50 per cent. Home visits by volunteers increases the use of mosquito nets by 10-23 per cent. In 2011, 18 900 Red Cross volunteers reached more than 8.1 million people with malaria preventive interventions.

Health information and health-promotion
In 2011, 85 national societies, 3 000 supervisors and 24 000 volunteers, were involved implementing health prevention activities. More than 30 million people received support from Red Cross health information and preventive health work.

HIV and AIDS
57 national societies are members of the Red Cross and Red Crescent HIV and AIDS global alliance. 240 000 volunteers are trained and approximately 50 million working hours have been invested to reach 60 million people through campaigns and targeted programme activities. There is special emphasis towards involving key populations as advisors in the development of HIV/AIDS programs. Fighting stigma and discrimination is a priority within the Red Cross and Red Crescent HIV /AIDS programmes.

Promoting human security through health
Climate changes lead to more frequent droughts, floods and outbreaks of epidemics in exposed areas As a response to this, the "Disaster Risk Reduction "(DDR) program concept has an integrated program approach which includes health prevention, food security and access to clean water.

The IFRC global water and sanitation initiative (GWSI) was established in 2005 and has implemented programmes in 55 countries and reached 5.5 million people between 2005 and 2012. The Norwegian Red Cross supports GWSI and DDR programmes in eleven countries.

The Norwegian Red Cross has the capacity to run hospitals, health clinics and deploy mobile health teams when needed. Between 2011 and 2012 the Norwegian Red Cross contributed with health-promoting activities during the cholera epidemic in Haiti, the crisis in Libya, support with fire-fighting competence during explosions in Kenya as well as providing support to the cholera epidemic in Sierra Leone and the floods in the Philippines.

Challenges
Climate changes and the increase of non-communicable diseases requires additional competence and capacity of the national societies as well as the national / local health authorities.

New programme concepts such as ICCM require that national strategies are in place, in addition to sound technical support and follow-up. Legal liability must be clarified. Lack of sufficient data collection and co-ordination can result in a limited overview and understanding of the health situation. Lessons learnt from the Red Cross, is that during emergencies and smaller disasters, it may be need for external support from specialist. For example, Sierra Leone Red Cross received support from the Norwegian Red Cross during the cholera epidemic in 2012 through a small health team which contributed with advice, as well as financing of health-promoting activities at the local level.

It is important to maintain preparedness capacity to respond to disaster where the health infrastructure is destroyed as well as developing response capacity where there is a need for lesser interventions.

Possibilities and contributions
The presence of the Red Cross at local level and having an auxiliary role to the health authorities in different countries gives possibilities for contributing more and bridging the gap between informal and formal health systems. Task shifting can ensure access to life-saving treatment within 24 hours and transport in emergency situations can be provided. Ensuring access to health services contributes to achieving equity between income groups. The Red Cross is in process of integrating mobile technology in the development programme`s and emergency operations to facilitate for early warning, disease monitoring, and mapping of health needs and results.

Åsne Havnelid
Secretary General

www.redcross.no

Norwegian Lutheran Mission (NLM)

NLM works in fifteen countries in Africa, Asia and South America. Of the NOK 70 million in the international budget, NOK 39 million is spent on development work.

Health has always been an important part of our development work. The interventions have gradually changed from providing health services to capacity-building of public health systems. Health information, prevention, and maternal and child health care have always been in focus.

In 2012, we had three large health projects. In addition, health information is a part of many of our community-based projects. "Reducing Maternal Mortality" in Ethiopia collaborates with health authorities on improving care for women giving birth through the entire continuum of care chain. Central in our work is training of health workers within decentralized health centres, so that women receive quality maternity services and comprehensive emergency obstetric care without having to travel too far. "Capacity-Building Within Health" cooperates with the authorities in Somaliland on education and clinical practise for medical, nursing and midwifery students, as well as technical guidance to health personnel in hospitals. "Strengthening Primary Healthcare" cooperates with Mongolian authorities on improving primary health care, through health information and post-graduate training of doctors.

The objective of "Reducing Maternal Mortality" (RMM) is to improve women's access to emergency obstetric care, and improved the referral chain within the health system. The project has a time frame of 2008-2016 and is supported by NOK 25 million through Digni's framework agreement with Norad. The major part of the operating expenses is covered by the Ethiopian government.

RMM has increased the number of institutions that can provide routine maternity services and emergency obstetric care from one per two million inhabitants to one per 250,000 inhabitants. The most important result is reducing maternal mortality by 50 per cent in two provinces in the south of Ethiopia. These figures are based on population-based birth registrations.

We feel it is strategic to contribute to strengthening tomorrow's leaders and establishing robust health and educational institutions, while visible results will only be apparent in the long term.

In addition, 40 technicians, anaesthesia nurses, and OR nurses have received training. Several hundred midwives have also received post-basic training. Over 300 health extension workers have received further training so that they may assist with normal births at a health post and give timely referral to women needing more assistance. These efforts, in addition to effective collaboration with local politicians have led to the increased use of health services. In some areas, 50 per cent of women give birth at a clinic or hospital today, compared to only 10 per cent two years ago.

The results are for the two counties where the programme started. NLM is now expanding this work to three other counties upon request by the Ethiopian authorities.

The project collaborates with the University of Bergen. A PhD candidate is working with various methods of measuring maternal mortality. Four Master degree students are looking at possible ways of improving the access to essential maternal health services.

Better Public Health Systems

"Capacity-Building Within Health" (CBH) in Somaliland contributes to strengthening the public health system by training medical, midwifery and nursing students on maternal, newborn and child care. This is done by:

- Development of curriculum
- Support for faculty capacity building at the University of Hargeisa

- Teaching
- Strengthening institutional administration
- Making medical research based knowledge more available

The project has a pilot phase from 2010-2013, and is supported with approximately NOK 9 million from Norad, through the framework agreement with Digni. The most important partner is the Ministry of Health. We feel it is strategic to contribute to strengthening tomorrow's leaders and establishing robust health and educational institutions, while visible results will only be apparent in the long term.

Results So Far:
- Education of a new generation of health workers and leaders
- Improvement of structures for leadership of institutions for health education
- Public health research
- Establishment of specialist education in OR nursing and anaesthesia nursing.

A primary challenge is that the extent of this work is very small compared to the great need in the country.

"Strengthening Primary Healthcare" (SPH) has its primary focus on strengthening the primary health care service in three provinces in West Mongolia through capacity-building and strengthening of already existing health infrastructure. This is done in cooperation with the Ministry of Health in Mongolia. The cooperation with national, regional and local authorities is excellent, which gives good opportunities for local ownership and sustainability.

Activities:
- Capacity-building of administration and health personnel through courses, fellowships and professional fora
- Development of distance learning and regular professional updating of health personnel in the primary health care service
- Health campaigns and health education for schools and kindergartens as well as through the mass media and by the use of information materials

The duration of the project is 2008–2017. NOK 35 million is estimated in grants for a period of ten years through Norad's framework agreement with Digni.

Results:
- Improved capacity in province health administrations when it comes to management, monitoring and evaluation
- Strengthened cooperation between the health and educational administrations in the provinces
- Health centres are built to be models for others areas
- Better management of the health centres
- Strengthened gender-sensitive public health information from primary health workers to the local population
- Strengthened exchange of experiences between health personnel
- Strengthened professional development of personnel within primary health services
- Increased knowledge and awareness regarding children's health, dental health, healthy life-style, environmental health and correct use of pharmaceuticals by the local population

The infrastructure with buildings, materiel and equipment in the primary health service is old, out-dated and requires updating at the same time as the focus of SPH on capacity-building and system development to obtain the best all-round results. The strengthened economy in Mongolia gives hope that this is possible, but this requires prioritizing by the authorities.

Øyvind Åsland
Secretary General

www.nlm.no

The Norwegian Nurses Organisation (NNO)

The Norwegian Nurses Organisation's (NNO) 100-year history is characterized by efforts not only for Norwegian nurses and a qualitatively good health care system in Norway, but also for health care personnel, health care services and people outside Norway.

Through membership in numerous organizations, NNO participates in the design of health care policy on a Scandinavian, European and global level.

In Africa, NNO's contribution to global health is best expressed through the efforts for nurses in several African countries. Since the end of the 1980s, NNO with financial support from Norad, has completed several successful aid and development projects in Southern and South-eastern Africa. Initially focus was directed mostly towards HIV-positive nurses. As health care workers, African nurses were reluctant to seek treatment and stand in a queue together with their patients. Stigmatization led to many nurses not receiving treatment, falling ill and dying. It was therefore important to support this exposed group of professionals through a project called "Caring for the Care-Givers".

The long-term development objective for NNO is to establish professionally strong, bold and self-sustaining national nurses' organizations in Southern Africa and Southeastern Africa.

Nurses' Associations
In Zambia, NNO, in cooperation with Zambia Union of Nurses Organization, contributed to over 5,000 nurses taking courses on HIV and AIDS: providing information about infection, preventive measures and treatment. Over 100 local support groups were established where HIV-positive nurses and family members could seek guidance and obtain moral and financial support.

In Malawi, the National Organisation of Nurses and Midwives of Malawi, with financial and professional support from NNO, has become the country's largest professional health care organization. Over 90 per cent of the country's nurses are members.

In Uganda, NNO in cooperation with Uganda Nurses and Midwives Union, has contributed to the successful merging of two international nurses' organizations. One common organization can more successfully safeguard nurses' professional and socio-economic interests, as well as being an effective "watchdog" of health authorities and how they prioritize.

In Rwanda, NNO has recently entered into cooperation with the Rwanda Nurses and Midwives Association, also with the objective of contributing to the development of an effective, bold national nurses' association. NNO also contributes with professional and financial support to a regional network of national nurses' associations with trade union status.

Design of National Health Policy
NNO's focus has now shifted more in the direction of professional assistance and organizational development of strong national nurses' associations. The long-term development objective for NNO is to establish professionally strong, bold and self-sustaining national nurses' organizations in Southern Africa and Southeastern Africa.

A central part of NNO's present efforts is to assist national nurses' organizations in Africa in obtaining legal status as trade unions. With trade union status, national nurses' organizations have the right to negotiate with employers regarding pay and working conditions. Based on the same legal provisions, national health authorities are obligated to include nurses' associations when preparing and designing national health care policy. As an example, in Zambia, the Zambia Union of Nurses Organisation has become a respected and recognized professional organization with over 7,000 members. The country's authorities have recently doubled the annual intake of nursing students and increased nurses' pay from 17 to 76 per cent. NNO can with a reasonable degree of certainty claim that this would not have happened without the influence and pressure from a strong and recognised Zambian nurses' union.

NNO's effort with the development of a strong national nurses' union also has direct influence on gender equality, democracy-building and strengthening of civil society in Africa. NNO sees clear signs that several nurses' organizations in Africa are gaining recognition for their efforts in development of a professionally sound health care service. In Africa, nurses constitute 70 to 75 per cent of the personnel in the health care sector. When viewed from an historical perspective, nurses' influence has not even been close to what such an overwhelming majority position indicates. This is now changing.

Health Care and Workplace Policy
NNO also lobbies to influence health care policy internationally, with a clear national influence. NNO is in a unique position as a professional and interest-political organization and has developed extensive knowledge, networking and important international positions.

In recent years, NNO has placed particular emphasis on increasing its engagement within health, labour and social politics in the EU/EEA area. The background for this is that the EU is continually introducing directives and regulations in these areas. In order to safeguard our interest-political area towards the EU, NNO has chosen membership and active participation in international organizations. NNO has participated actively in the development of these directives through commenting on procedures and engagement in European organizations. This has put NNO in a position to influence EU's policy in the health care sector.

Solidarity Projects
Another important dimension in NNO's international engagement is solidarity projects. The primary focus has been to assist sister organizations in Eastern and Central Europe with building professional and trade union organizations, and to contribute in the process by regulating nursing education and the nursing profession in relation to requirements set by the EU to existing and future member countries.
The solidarity projects are threefold at present:

- Montenegro
- SENS – South Eastern Nursing Skills
- TICC Tanga International Competance Center

NNO has cooperated with the Montenegran Nurses Association since 2007, and has assisted in the process of reforming educational standards for nursing and regulation requirements in order to meet EU requirements for future membership. The Bill, which NNO has helped to prepare for regulation, education and practice for nurses and midwives, was passed in 2010.

The professional organization in Montenegro is growing and future focus is on development of a national regulative body, as well as how the organization can become a trade union. In 2010, as a further development of the cooperation in Montenegro, NNO established a regional cooperation network consisting of nurses' organizations from Montenegro, Croatia, Macedonia and Serbia. They are all applicant states to the EU and must adapt the level, length and content of their nursing educations and regulations of the nursing profession to meet EU requirements.

Solidarity Stay in Tanga
TICC was established in 2006 and contributes to growth and development in the Tanga region in Tanzania within health, education and tourism. NNO has contributed professionally and financially to the centre, which is managed by the Norwegian nurse Ruth Nesje. TICC arranges international courses and conferences. Several Norwegian colleges and universities have completed study and research stays in cooperation with the Centre and local institutions. Norwegian nursing students have taken part of their education through a study stay in Tanga. In 2011 and 2012, three Norwegian nurses completed solidarity stays at the Centre and contributed to the development of local health-care services.

Eli Gunhild By
President

www.sykepleierforbundet.no

Plan Norway

Plan Norway is a part of Plan International Inc. which carries out programmes in 50 countries in Latin America, Asia and Africa.

Plan Norway's global health efforts are covered in three of its eight prioritized programme areas, namely: Early childhood care and development, sexual and reproductive health, and water and sanitation.

Early Childhood Care and Development
The aim of this programme area is to ensure that children realize their right to a healthy start in life and early learning. This project aims to ensure a healthy development of children, especially those under the age of five years. The interventions include activities which aim to improve children's nutrition and improve the access to mother and child primary health care services. Vaccination and growth monitoring are core areas of this work.

Sexual and Reproductive Health
The main objective of this program is to ensure that children and youth realize their right to sexual and reproductive health, including prevention of HIV, care and treatment. Typical measures include information on sexual and reproductive health (SRH), education and access to SRH services, as well as lobbying decision-makers and service providers to ensure that sexual and reproductive health services are youth-friendly. These interventions are aiming to include young people where it is appropriate, particularly in the advocacy work. For example, through the project supported by Norad on children's participation in Uganda, young people are involved in lobbying decision-makers to make sexual and reproductive health youth-friendly in Uganda.

Water and Sanitation
In this area Plan works to ensure that children and young people realize their right to better health and well-being by improving basic sanitation and hygiene. Improving access by households to safe and affordable drinking water is also central in this programme. These activities markedly reduce waterborne diseases which affect and kill many children under the age of five. Women's participation in these interventions is also pivotal. Plan works with local communities to ensure they have the skills to manage and maintain safe water and sanitation facilities.

Plan has learned through experience that improving women's living conditions and situations has positive effects on their reproductive health and well-being, including on their children's health.

Plan Norway contributes to two of the three prioritized areas in Norway's global health agenda: Mobilization of women's and children's health and rights, and to reducing the burden of disease with the emphasis on prevention.

The majority of Plan's work on health is financed by our 120,000 sponsors. This support is channelled through Plan International to our 50 country offices in Latin America, Asia and Africa. Based on Plan International's final accounts, including the contribution from Plan Norway in Fiscal Years 2011 and 2012, we estimate that Plan Norway's contribution to the global health programs was accounted for approximately NOK 75 million in 2011 and NOK 96 million in 2012. In addition, Plan Norway has projects which are carried out in direct cooperation with Plan's country offices, financed by Norad, the Ministry of Foreign Affairs, and other private donors.

Voluntary Health Workers
In 2012, Plan Norway (through Plan International) contributed to the training of almost 240,000 voluntary health workers in early childhood and health management, training of 86,800 health workers and traditional midwives at the local community level and improved access to sanitation and water installations to more than 417,000 households.

Plan has learned through experience that improving women's living conditions and situations will have positive effects on their reproductive health and well-being, including on their children's health. Plan Norway's economic security programme, has contributed to capacity-building and support to women's microfinance groups. Supported by private gifts, Plan Norway works with Plan Rwanda to include sexual and reproductive health services, including HIV and AIDS and prevention, in their microfinance project. These projects are directed first and foremost towards young people and women.

Through the projects that are financed by Norad, Plan Norway works with partners at local level to increase awareness and knowledge of families, local communities and authorities regarding children's rights to protection and participation. In several communities where Plan works, girls are regarded as having less value and are exposed to discrimination at many levels. Girls are often targets for sexual assault. That is the reason to focus on prevention of violence against children, and to challenge patriarchal attitudes and harmful traditional practices such as child marriages. The aim is to ensure that girls receive the same rights as boys, and that they are empowered to take control over their own bodies.

Survival of Children
Plan Norway supports a child survival project called "Give Me Five" in Senegal. The aim is, amongst other, to build the capacity of health workers and mothers to improve survival of children under the age of five. Typical activities include supporting vaccination programmes, hygiene measures and activities directed towards early childhood and development, such as learning and stimulation. The programme also promotes increased access to family planning for women of reproductive age.

Plan works at grass root level, district level, national level and at international level. At the grass root level there are still challenges related to knowledge with regards to survival of children. As well, it is our experience that children living in remote areas often are excluded from access to health services. Plan works with partners, including public health services, to make primary health care available to excluded groups by supporting the authorities' vaccination campaigns and health centres.

More Health Personnel are needed
It remains a great challenge that there are too few qualified health personnel in relation to the number of adults and children in need of health services. In addition, there is often limited capacity and lack of right tools and equipment to deliver effective health services to women and children. It is therefore important that national authorities and international cooperation work to increase the capacity of health personnel, particularly those who work on the front line. It is at this level most of the health-related challenges exist for women and children.

Helen Bjørnøy
Secretary General

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Save the Children

Save the Children Norway (Redd Barna) is a member of Save the Children International, delivering change for children in 120 countries. Through the "EVERY ONE" campaign, we are running extensive programmes, and do information and advocacy work to reduce child mortality. Save the Children's work is based on children's rights in line with the definition used in the UN Convention on the Rights of the Child.

Save the Children Norway has participated in developing Save the Children International's global campaign "EVERY ONE". We are centrally placed in the design of strategies and plans for the campaign. Save the Children International's advocacy work targets international processes for global health, such as "Every Woman Every Child". In addition, advocacy work is done at national level in several countries, for example in Nigeria, India, Pakistan, Bolivia and Norway. Internally and externally, Save the Children emphasizes the importance of basing work with children's survival and health on the UN Convention on the Rights of the Child. We place particular emphasis on obligations of states, equal and fair access to health services and the necessity of increased investment in health workers.

We have initiated a dialogue with the UN Committee on the Rights of the Child on the need for clarifying the obligations of states vis-à-vis children's right to health. This has resulted in the UN Committee on the Rights of the Child and the UN Human Rights Council taking steps to issue a general comment and a resolution in early 2013, which will more clearly define children's right to health. With these statements, the Committee and the Council will clarify the obligations that states have and how they should meet these obligations.

We often combine our programmatic work with advocacy and capacity-building of local and national authorities to fight for the rights of vulnerable children.

In Norway, we have intensified our political advocacy work towards Norwegian authorities and international processes connected to children's survival and health. Through political dialogue and media and campaign activities, we emphasize the significance of further investment on maternal and child health in Norway's development policy and assistance. We have also requested increased investments in health workers, neonatal health, nutrition and equal access to health services for all women and children. We collaborate with several health organizations in Norway, as well as other aid organizations to demand greater investments in health workers and strengthening health systems in Norway's development aid policies. Save the Children has launched several reports on maternal and child health that take up issues of insufficient numbers of qualified midwives and health workers, and situations of the world's mothers and premature babies. In 2012, we started focusing more on awareness of the importance of nutrition for reducing child mortality.

Save the Children Norway's Advocacy Work

The follow-up of the White Paper 11(Stortingsmelding 11) is important to Save the Children. The Report stated that there is a broad agreement in Parliament for Norway to prioritize women's and child health, and that the rights perspective should be the foundation to ensuring that all women and children have access to fundamental health services.

We will especially work for fulfilment of Parliament's recommendation of "the necessity of stronger investment in building up health services for pregnant women, for those giving birth and for newborn babies, and the importance of new investments in direct nutritional measures targeting mothers and children that have documented effects on reducing child mortality". In addition, we will work for better health worker coverage by ensuring that Norway prioritizes and "contributes to increasing the countries' capacity to educate, recruit, distribute, manage and retain necessary health personnel", as well as that "Norway gives high priority to investments in national plans that ensure everyone's access to health workers and health services".

Save the Children advocacy is directed towards Government officials and the majority of members in the Parliament to make sure they follow up foreign- and development policy commitments, and invest appropriately in aid budgets. Further, our work focuses on ensuring that Norway follows up on the resolution on universal health coverage and the pending resolution from the Human Rights Council on children's right to health. In cooperation with other organizations and Save the Children International, we continue our work in international processes to hold states accountable for the obligations they have under Human Rights Conventions and "Every Woman Every Child". The fight against child mortality will also be central to Save the Children's engagement in work with post-2015 development goals.

From 2013 onwards, we will strengthen our work within nutrition and food security. In 2012, on assignment from Save the Children, Fafo completed an evaluation of nutrition in Norwegian aid policy "Nutrition – Everybody's Business and Nobody's Business". Save the Children will use this study and our own experiences as a basis for preparing a new advocacy strategy for nutrition. We carry out campaign activities directed towards the broad public to increase knowledge and popular engagement on global child health. To accomplish this, we cooperate with the Bill and Melinda Gates Foundation and Norad. In 2013, we will launch a signature campaign that focuses on the lack of health workers in the world.

Save the Children's Programme Work
Children's right to health: Save the Children International carries out extensive programme work directly and indirectly to ensure the fulfilment of children's right to health. We often combine our programmatic work with advocacy and capacity-building of local and national authorities to fight for the rights of vulnerable children. An example of Save the Children Norway's work is the HIV and AIDS programme in Zimbabwe. The programme focuses on orphans and vulnerable children. Using a holistic approach, we emphasize local protection systems, and health and educational interventions. In recent years, we have focused more on preventive work with youth, as well as prevention of mother-to-child transmission.

Prevention: Save the Children has for many years worked in Zimbabwe with training of health personnel in clinics receiving victims of sexual abuse. Training is given in physical and mental treatment and care, as well as in legal aspects to ensure victims' rights. Training for better treatment of victims has also been provided systematically to the police and judicial authorities. This experience and training model has also been used in Ethiopia and Mozambique. Engaging boys and men in preventive work against gender discrimination and assault is also a central feature of several programmes. In Ethiopia, Save the Children has worked with the Norwegian Embassy to reduce female genital mutilation.

Street children in Vietnam: With funds from the Ministry of Foreign Affairs, Save the Children Norway has cooperated with Save the Children Vietnam and the Institute for Studies of Society, Economy and Environment in Vietnam on a study of LGBTI (lesbian, gay, bisexual, transgender or intersex) among street children in Vietnam. The study found that these street children are strongly stigmatized by the police, local health authorities and society in general. The study also found that these children do not have access to basic health services and other necessary social rights. They also experience considerable physical and mental violence. Save the Children has now applied to the Ministry of Foreign Affairs for funds to work to strengthen the rights of this group of Vietnamese children.

Tove R. Wang
Secretary General

www.reddbarna.no

The Norwegian Council for Mental Health

The National Council for Mental Health (NCMH) is a humanitarian organization which includes the most important actors within the mental health sector. Among the members are employee associations within the health sector, universities and colleges, other humanitarian organizations, and organizations for users and relatives.

We work to ensure that children and adults with mental problems, including their close relatives, have good quality of life. Our aim therefore is to promote increased knowledge about mental health, research and better treatment. We will also contribute towards this internationally.

Since our first National Telethon in 1992, we have had an international engagement with cooperating partners and projects in Latvia, Bosnia, Croatia, Vietnam, Nepal, Cambodia, Zimbabwe, Palestine, Lebanon and the Middle East. We have also had a domestic engagement for global mental health. We publish the magazine Psykisk Helse (Mental Health) and offer many other resources through our website and in social media.

Mental Health Globally

In Norway, it has taken many years to reach a holistic approach to health policy where somatic and mental health are equal and integrated in the professional health work. When the Government's Report (white paper) No. 11 to the Storting (2011-2012) on Global Health in foreign and development policy was presented, we prepared a written submission in which we expressed concern because mental health as a theme and health-political challenge was not given priority. Among other issues, we emphasized that mental illnesses represent a burden of disease which over the past decade has been prioritized by the World Health Organization (WHO), most recently by a resolution on the Global Burden of Mental Health (January 2012) that Norway, through WHO's Board, to a great extent influenced the formulation of. We pointed out that activity within mental health abroad, in other cultures, gives significant returns in relation to a multicultural society in Norway.

We pointed out that activity within mental health abroad, in other cultures, gives significant returns in relation to a multicultural society here in Norway.

It was therefore gratifying that during consideration, there were remarks made both by the minority and majority of the Standing Committee on Foreign Affairs that strongly emphasized the significance of mental health in the global health work. In Norway, the Council participates in a newly established Network for Global Mental Health. We hope to continue this engagement, and the cooperation with Norad and other Norwegian actors, for a new conference on the theme Mental Health in Humanitarian Settings. The first conference on this theme was held in Oslo in 2007.

International Work Since the TV Campaign in 1992

Several of the projects which the Norwegian Council for Mental Health was involved in during the 1990s were carried out in cooperation with Norwegian institutions, aid organizations and local partners. One example is the exchange between Norwegian hospitals and Jelgava Hospital in Latvia supporting a training programme stretching over six years.

In cooperation with Save the Children, social welfare workers within the school and health-care system in Nepal received training during a three-year period. In Vietnam, the Council financed an evaluation of a repatriation programme under the direction of the Norwegian Refugee Council (NRC). In Croatia and Bosnia, psychosocial programmes for refugees, mental health work with psychologist assistance, and research have been carried out in cooperation with Norwegian People's Aid, the University of Oslo and local partners.

The largest single project in the 1990s consisted of developing psychiatric education in Cambodia. That was carried out in cooperation with professionals from the University of Oslo, the Psychosocial Centre for Refugees, and the International Organization for Migration (IOM). From 1993-1996, the Council implemented a training programme at Gaza Community Mental Health Programme (GCMHP) in cooperation with Norwegian People's Aid and Norwegian sector professionals. The projects in Cambodia and Gaza received substantial support from the Ministry of Foreign Affairs.

Middle East – Mental Health for a New Generation
Since the TV campaign in 2004, the Council's international engagement has been concentrated mostly in the Middle East with a regional programme led by Arab Resource Collective (ARC) in Lebanon. The programme Mental Health for a New Generation, supported by Norad, has partners from the entire region.

The programme started in 2005. It is enabling children and young people, teachers and health personnel to deal with mental health in a better way. Our partner in Beirut develops reports, professional literature and informational materials on mental health in Arabic. For example, ARC has published a bibliography of literature on mental health in Arabic, and reports on how mental health is dealt with in nine Arab countries. Reports have also been published on mental health in the health legislation in Egypt, Palestine and Lebanon. An Arabic edition of the Norwegian lower secondary school project "Everyone has Mental Health" has also been developed. Targeted to health personnel, the first Arabic edition of the well-known Indian psychiatrist Vikram Patel's barefoot psychiatry "Where there is no psychiatrist" was translated and adapted.

The Health Sector in New EU Countries
In cooperation with the Norwegian Institute of Public Health (FHI), the Council is planning to contribute to the development of the mental health sector in several new EU countries, with the emphasis on new members such as Estonia, Hungary, Czech Republic and Slovenia. A large share of Norwegian EEA funds are spent on development of the health sector in these countries. Some of the funds are earmarked for mental health. The plan is to contribute to the programme applications from several of these countries. Initially we have Memorandums of Understanding with Hungary and Estonia. On the Council's side, we will also contribute with Norwegian experts in bilateral expert panels that will report on the work with mental health and reforms in this field. We also plan to contribute to different low-threshold alternatives for treatment.

Tove Gundersen
Secretary General

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The Norwegian Association for Sexual and Reproductive Health and Rights (Sex og Politikk)

The Norwegian Association for Sexual and Reproductive Health and Rights' work is mainly directed towards the following goals:

- Achieving gender equality
- Ensuring the fulfillment of every human being's right to make free and responsible decisions on matters related to their bodies and sexuality
- Ensuring equal access to high quality, affordable sexual and reproductive health services, information and education - regardless of age, sex, marital and socio-economic status

The Norwegian Association for Sexual and Reproductive Health and Rights is the Norwegian member association of International Planned Parenthood Federation (IPPF).

The core objectives of the Association's work are to protect and promote sexual and reproductive rights, and ensure equal access to high quality and affordable sexual and reproductive health services, including access to a wide range of contraceptives, safe and legal abortions, comprehensive sexuality education and information about sexuality for all human beings.

Our international work consists mainly of advocacy and information activities, and primarily falls under paragraph 1 in the White Paper on Global Health: "Mobilizing for women's and children's health and rights". Advocacy for increased political and financial support to sexual and reproductive health and rights (SRHR) constitutes one of the Association's main priorities within our international work. We also work to strengthen international advocacy efforts for SRHR through increased cooperation, exchange of information and coordination with other civil society organizations both nationally and internationally – one of the main reasons for our participation in several international and national networks. We also hold information events about SRHR and development in Norway, and aim to be a source of knowledge and information that other institutions and organizations can make use of in their work.

Some Main Activities within our International Work

- Monitor and provide input to Norwegian authorities' work with SRHR
- Mapping of Norwegian ODA funding to reproductive health and family planning, in cooperation with the Countdown 2015 Europe network
- Act as the secretariat for the informal All Party Parliamentary Group (APPG) on SRHR
- Information activities directed towards youth parties and young politicians
- Information activities directed towards the general public in Norway
- Coordination and main responsibility for information events
- Exchange of information, participation in working groups and joint advocacy efforts with the aim of mobilizing broadly for SRHR, and counteract conservative groups' intensive lobbying in different contexts (mainly related to the Commission for Population and Development/CPD, ICPD+20, the post-2015 agenda and the UN Commission on the Status of Women)

Despite Strong Opposition, Achieving Good Results is Possible

"Adolescents and Youth" was the topic during the 45th UN Commission on Population and Development (CPD) in 2012. Despite strong opposition, a strong resolution which recognizes the importance of securing youth and adolescents' reproductive rights and access to sexual and reproductive health, and comprehensive sexuality education was adopted. The Norwegian Association for SRHR was one of many organizations contributing to this result, through mobilization and joint advocacy efforts both prior to and during the CPD.

Some 220 million women in developing countries lack access to modern contraceptives. In 2012, the Family Planning Summit was hosted in London by the UK Government and the Bill and Melinda Gates Foundation with UNFPA and other partners. The purpose was to raise awareness about the lack

of access to family planning in developing countries, and to mobilize for increased efforts aiming to secure that an additional 120 million women in the world's poorest countries get access to modern contraceptives by 2020. We applaud the initiative and the goal that was set forth, but would like to emphasize the importance of ensuring that young, unmarried, poor and marginalized girls and women are included in the initiative and the efforts made, even though these groups often are the most difficult and most expensive to reach.

Challenges
There are enormous differences in health outcomes and access to sexual and reproductive health services of high quality, not only between but also within countries. Differences related to sexual and reproductive health and rights constitute one of many factors contributing to exacerbate the inequalities between rich and poor women and girls.

Lack of access to legal and safe abortions is still a great problem - both from a public health perspective, from a gender perspective and on an individual level. Globally, unsafe abortions account for approximately 13 per cent of the maternal mortality. It is thus necessary to dedicate more attention to unsafe abortions in the international efforts to reduce maternal mortality.

Differences related to sexual and reproductive health and rights constitute one of many factors contributing to exacerbate the inequalities between rich and poor women and girls.

Young people are often neglected in Norwegian policy papers on development and foreign policies. Many young people live in uncertain financial circumstances and have large unmet needs when it comes to comprehensive sexuality education, access to contraception and affordable sexual and reproductive health services. Complications from pregnancy and childbirth are a leading cause of death among girls aged 15–19 years in low and middle income countries, according to WHO. Furthermore, 2 million girls under the age of 15 give birth every year, and approximately 16 million girls between the ages of 15 and 19 have unsafe abortions each year. These numbers illustrate the urgent need for strengthened efforts directed towards youth and adolescents' sexual and reproductive health and rights – particularly to meet the needs of girls and young women. There should be an increased focus on comprehensive sexuality education, securing access to contraceptives of their choice and access to affordable sexual and reproductive health services, including access to legal and safe abortions. Work to prevent early and forced marriage as well as a continued focus on girls' education are also of high importance.

An ageing population and a subsequent fear of a decrease in fertility rates, and an increased religious opposition and influence are factors that have led to increased efforts to undermine women's rights and access to SRHR in several European countries over the last years. The consequences for the women who live in these countries, as well as the political consequences on a regional and international level are of grave concern to us.

The opposition to SRHR during international negotiations has increased over the past few years, as was proved during the UN Commission on the Status of Women (CSW) in 2012. Working to protect and promote gender equality and SRHR in such a climate is both labour-intensive and difficult. In addition, there are a series of ongoing processes up to 2015 that are of high importance for the future international development framework, but which are also very time- and resource-consuming to monitor and provide input to. Sexual and reproductive health and rights, and gender equality are topics that must be included in the post-2015 agenda. In order to contribute to a successful mobilization for gender equality and sexual and reproductive health and rights for all, we therefore hope that Norwegian authorities will increase its support to progressive civil society organizations and to the work for gender equality and SRHR in the coming years.

Solveig Hokstad
Executive Director

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SOS Children's Villages

Through a diversity of programmes in 133 countries worldwide, the aim of SOS Children's Villages is to create a positive framework for the development of the most vulnerable children – those who have lost, or are at risk of losing parental care.

Healthy child development is central to the work of SOS Children's Villages. Health is given a holistic approach in our programmes where we:

- Ensure access to family and child-friendly health services for families who fall outside the formal health insurance systems
- Carry out training and information campaigns, and support authorities in implementing preventive health measures
- Improve the psychosocial and mental health of families and children through therapy, guidance and promotion of good family relations.

Health Services

SOS Children's Villages usually works together with public authorities to offer good health services in our programmes and therefore works with promoting families' access to national and local health services. In many places, however, these services are not available and this has resulted in the establishment of SOS Children's Villages Medical Centres, primarily in Africa and the Middle East. As service provider, SOS Children's Villages focuses on the most widespread diseases, both in terms of prevention and treatment. In areas where we have few and small clinics, the offer is primarily initial aid and consultations for primary health services. The larger medical centres include outpatient services, admissions, surgery and maternity wards. The services vary, but the focus is always on health-promoting measures and on awareness-raising.

• • • in poor areas people do not consult health services before the signs of diseases are already showing, especially where the health services are expensive or services are not easily available. This substantiates the necessity of improving education for promoting the health of families.

Information Activities

Our information work in schools and local communities gives children and their carers increased knowledge about nutrition, family planning, prevention of sexually transmissible diseases and general health-promoting measures. This knowledge strengthens the family's ability to take care of its children. Adapted sexuality education and guidance on family planning helps prevent unwanted pregnancies and sexual transmission of diseases such as HIV and AIDS in couples. Educated mothers improve the family's health and survival through knowledge, enabling them to make good decisions for the family, to both know of the possibility and use existing social services, and to use improved skills to provide quality care for children.

Millennium Development Goals

Thanks to a Norwegian sponsor, SOS Children's Villages' Medical Centre in Lusaka could purchase a CD4 machine in 2006. A CD4 machine measures the level of antivirus cells in the blood of a HIV-positive person, and is crucial in evaluating the need for and level of ARV medication. With the help of the machine, the medical centre could ensure life-prolonging medicines for 3,255 people in 2010. This has led to great changes in the lives of adults, children and local communities in Lusaka since it means improved quality of life, thus stagnating numbers of children without adequate care, and directly leads to children growing up with persons who can give secure and lasting care. SOS Children's Villages has also noticed a reduction in the needs of the local community which can be traced back to these life-prolonging medications. With the necessary expertise and experience in the use of the CD4 machine in Lusaka, the Zambia National AIDS Network (ZNAN) has contributed with funds for an equivalent machine for the SOS Children's Villages Medical Centre in Kitwe.

Family Strengthening Programme in Zimbabwe
In 2005, SOS Children's Villages established a family programme in Harare where material support such as food packages and school money are combined to improve children's access to public health services and where medical expenses are covered in cooperation with local pharmacies. Perhaps even more important is the programme's focus on capacity-building of children, families and the local community. The programme promotes knowledge about HIV and AIDS prevention. It focuses on relations between parents and children and works with grief therapy. Children and young people are taught to give advice on children's rights to expand the support structures in society. The problems surrounding HIV and AIDS are demystified and discussed. The programme also works with building lasting social protection mechanisms in the society and therefore builds the capacity of organizations in the local community so that they themselves can support families in this area. Quality of life and health have been improved for 2,674 children (2011) as a result of improved nutrition, changes in life-style and greater emotional stability.

Prevention of Cervical Cancer in Africa
Cervical cancer is the second most common cancer affecting women all over the world, and it is the most common type of cancer among women in Africa. On a global basis 500,000 women are diagnosed with this cancer every year. Over 250,000 of them die, despite the fact that if the disease is diagnosed at an early stage, it is perfectly possible to treat. Eighty-five per cent of these women are young mothers who live in developing countries. SOS Children's Villages, together with the Female Cancer Foundation, have recently launched the programme "Save my Mother". Expertise in diagnosing cervical cancer combined with SOS Children's Villages' medical infrastructure and well-established cooperation with local communities gives strong synergy. The short-term goal for "Save my Mother" is to reach 400,000 women with an information campaign, and screen a total of 100,000 women. The long-term goal is to influence the decision-makers in the national health ministries in the countries to establish national programmes for prevention of cervical cancer.

Challenges and Opportunities
In poor areas people often do not consult health services before the signs of diseases are already showing, especially where the health services are expensive or services are not easily available. This substantiates the necessity of improving education for promoting the health of families. Many children under the age of five die of causes that can be prevented. Increased focus on preventive measures can do much to improve maternal and child health. But even where medical treatment is free of charge, preventive measures must not be underestimated. Surveys in three African countries showed that about one third of children with sufficient access to medical assistance were nevertheless ill relatively often, with symptoms related to malnourishment and inadequate living conditions. These are problems that require preventive measures.

The psychosocial components in preventive health services can also have long-term effects. It can strengthen the individual who in time can increase his or her ability to take care of him or herself, as well as increase the local community's understanding and abilities to help. For example, preventive measures for HIV and AIDS for children and young people can include ways to help them to better tackle despair and grief over having lost caregivers.

It is important to recognize the role the men play in the current context. Men are often more difficult to reach through these programmes, yet a lot of change is dependent on them in their roles as fathers, husbands, and in many contexts, heads of families or community leaders.

Dagne Hordvei
Head of Programmes

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Norwegian Students' and Academics' International Assistance Fund (SAIH)

SAIH is the development and solidarity organization of students and academics in Norway. We cooperate with local organizations that work with training and higher education in Southern Africa and Latin America

Many of our partners work actively with information, education in sexual and reproductive health and rights (SRHR) and preventive work connected to HIV and AIDS. SAIH emphasizes the importance of youth participation, having young people decide, implement and benefit from the work both in Norway and the South.

The work with global health is particularly connected to the first two priorities in White Paper 11: Mobilize for women and children's health and rights, and reduce the burden of disease with the emphasis on prevention.

Mobilizing for Women's and Children's Health and Rights
SAIH places great emphasis of the significance of holistic sexuality education. Education and knowledge about sex and sexuality is decisive to young people being able to realize their rights. A holistic approach to sexuality education, including a focus on gender roles, power structure, personal and collective identity is important. Sexuality education must emphasize a comprehensive gender perspective and shall promote respect for and knowledge about the rights of sexual minorities. Young people who are gay, lesbian, bisexual and transpersons shall be met with knowledge and respect in the search for their own identity and sexuality. SAIH's partners have experienced that it is entirely necessary to strengthen the competence of teachers so that they have the knowledge and the educational methods to be able to give good education on sensitive topics.

The results show that young people have become more aware of their own rights, they make their own choices and are more secure with regards to their own identity and sexuality.

Many of SAIH's partners use informal education as a tool in their work with SRHR. This is an important addition to public education, particularly where the quality of the public sexuality education is poor or lacking. By using participatory methods where young people themselves are those who teach and lead discussions, confidence is created and young people dare to ask questions they would otherwise not have asked in an ordinary classroom. Leadership training is also an important initiative to give young people the possibility of identifying challenges, find good solutions and make demands on authorities and those having responsibility.

Awareness of Rights
A large group of young people between the ages of 15 and 25 in Bolivia (approximately 2,500), Nicaragua (approximately 600), Zambia (350), Zimbabwe (approximately 3,000) and South Africa (275) have received, on an annual basis over the past four years, informal education in questions connected to SRHR, women's rights, sexuality and leadership training. A particularly important target group in this work is young women. The results show that young people have become more aware of their own rights, they make their own choices and are more secure with regards to their own identity and sexuality. Further, they have used the knowledge to make authorities accountable and demand changes.

Katswe Sistahood is a feminist organization that mobilizes young women in Zimbabwe to challenge taboos and norms surrounding sexuality and women's rights. They use creative methods, including their own versions of the Vagina monologues. This method of giving young women a voice has resulted in the public authorities in Zimbabwe to invite Katswe Sistahood to start discussions around questions that are taboo.

Young people are in a position where they can be important actors for change. It is decisive that youth are admitted to where the decisions are made and are allowed to participate in designing policies and measures. Many countries in the North have their own schemes which finance youth delegates at various high level meetings and international processes. This is important and good, but at the same time it is a challenge that there are very few young delegates from countries in the South at these arenas. On several occasions SAIH has contributed financially so that young representatives from partner organizations have been given the possibility to travel and be present at high level meetings regarding health.

Reducing the Burden of Disease with the Emphasis on Prevention
SAIH supports a rights-based approach to SRHR where one of the primary focuses is HIV and AIDS. Knowledge and engagement of students concerning prevention and rights related to the fight against HIV is important for further positive development. Through knowledge, discussions and research, SAIH's university partners in Southern Africa have played an active role in driving the HIV work further in their countries. Realization of rights for lesbians, gay, bisexuals and transpersons (LGBT) is a continuous perspective in much of the work SAIH supports. An important result of this work has been that youth organizations have strengthened the integration of LGBT perspectives in their work. Sexual orientation and gender identity must be integrated in all the work related to sexual and reproductive rights and health. There is still much remaining, but the work is progressing.

Anja Bakken Rise
Leader

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Laerdal Global Health

Despite having reduced maternal and child mortality by half since 1990, death rates are still unacceptably high – especially on the day of birth – which constitutes over 20 per cent of deaths of children under the age of five.

Laerdal Global Health was established to address this problem. In only two years, the company's training and therapy products have been adopted and utilized in more than 50 developing countries. Through important alliances and international cooperation, more than 100,000 birth attendants have been trained to be effective life-savers.

250,000 More Lives Will be Saved – Every Year
Laerdal Global Health builds on experiences gained by its better known sister company Laerdal Medical which over the past 50 years has contributed to the training of more than 300 million life-savers in western countries.

The foundation of Laerdal Global Health is:

- Teaching must be culturally adapted and focused on what is essential. Knowledge and skills gained must be maintained through regular clinical use and/or regular simulation-based refresher training. Those who are trained must have access to the correct equipment.
- The greatest opportunities for innovation in global health are within effective implementation of sustainable programmes, not in new technology. Many times it is a question of better use of what we already know. This cannot be achieved by a small Norwegian company alone, but requires cooperation with the right alliance partners and national health authorities.

Laerdal Global Health achieves its goals through the initiation of innovative teaching alliances. This takes place through development of teaching materials (flip-charts, learner manuals and action posters) for the programmes "Helping Babies Breathe" and "Helping Mothers Survive". Available in more than 20 languages, the materials are being used extensively worldwide. Laerdal Global Health also provides training and therapy products to supplement these programmes such as:

As of January 2013, more than 100,000 birth attendants in 50 countries have been trained in Helping Babies Breathe.

NeoNatalie Newborn Simulator: This allows role play-based teaching of simple measures to help neonates to breathe. As of January 2013, almost 40,000 units have been delivered.

Penguin Suction: This is used to clean airways of neonates. The device can be re-used hundreds of times as it withstands boiling in water, contrary to other available bulb suctions which are made as single-use products for western countries.

Ventilation Bag: Easier to use and clean.

MamaNatalie Birthing Simulator: Worn like an "apron" by the instructor, MamaNatalie makes it simple to simulate both normal and complicated births. The model is particularly suitable for training how to control bleeding after birth (the leading cause of maternal deaths), and to practise good communication with the mother and others who may be present at the birth.

Mama-U Postpartum Uterus Model: This is used for training the insertion of an intrapartum uterus device just after birth, as well as insertion of a balloon tamponade to stop bleeding after birth.

Several of the products are described as important innovations within global health by the World Health Organization (WHO).

Training and Equipment for More Than One Million Birth Attendants
Laerdal Global Health cooperates with several leading organisations within global health.

- **The Helping Babies Breathe Alliance** was established in 2010 to reduce the near one million deaths among neonates who do not start to breathe by themselves. The initiators were USAID, the American National Institutes of Health (NIH), Save the Children, the American Academy of Pediatrics and Laerdal. As of January 2013, more than 100,000 birth attendants in more than 50 countries have been trained in Helping Babies Breathe. A recently published research report from eight hospitals in Tanzania shows that the programme has led to a dramatic reduction (nearly 50 per cent) of mortality among neonates.
- **The Survive & Thrive Alliance** was established in 2012 to contribute to effective implementation of the most highly prioritised interventions for maternal and child health. The initiators are the same as for the Helping Babies Breathe Alliance, with the addition of the American professional associations for obstetricians, nurses and midwives.
- **Helping Mothers Survive – Bleeding After Birth** is a training programme developed by Jhpiego (a not-for-profit affiliate of Johns Hopkins University in Baltimore and internationally recognized for its work on maternal health) in cooperation with Laerdal. The training programme will be launched in 2013 in cooperation with UNFPA, and FIGO and ICM (International organizations for obstetricians and midwives, respectively) and the American Academy of Pediatrics.
- **The Day of Birth Alliance** was established with Jhpiego and Johns Hopkins University to develop and secure widespread use of innovative products to help reduce child and maternal mortality. Laerdal also cooperates with Stanford India, and has established a satellite development group to be in closer contact with the needs of India, which alone accounts for 30 per cent of global maternal and neonatal mortality.

Not-for-Profit Activity
The financial goal for Laerdal Global Health is to be self-sustaining by 2015. Until then the company will be supplied with at least NOK 100 million in grants for operation and investments from the sister company Laerdal Medical. For the years 2010-2015, the Laerdal Foundation for Acute Medicine has earmarked an almost equivalent amount in support of research projects which can contribute to the achievement of the United Nation's Millennium Development Goals 4 and 5, with particular emphasis on projects that promote effective teaching and implementation.

Tore Lærdal
Managing Director

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Telenor Group

Mobile technology can play an important role in the development and improvement of health services in all of Telenor Group's markets.

The overall objective for our efforts regarding mobile health services (m-health) is to utilize mobile technology to ensure larger parts of the population access to health services, and a more optimal and cost-efficient usage of health personnel. Telenor is involved in several m-health initiatives. In Serbia, we contribute to advance living conditions for the Roma population through distribution of health information. In Bangladesh, we increase access to knowledge about maternal and child health for new parents, and in Thailand, we assist the authorities with monitoring outbreaks of disease.

The market for m-health services has a great potential but is still in a nascent phase. In order to succeed, more competence is required about the services, and sustainable business models must be developed. The solutions require a closer cooperation with other actors in the healthcare system.

Telenor Group's Efforts for the Development of M-Health Services

Telenor Group has mobile activity in eleven countries that stretch from Scandinavia and Central Europe to Asia. In all of our markets, m-health can play an important role in the development of health services both for society and the individual. In developing countries, m-health can contribute to strengthening the population's access to fundamental health services. In mature markets, m-health has the potential to reallocate resources in care of the elderly and in treatment of chronic illnesses.

The market for m-health services has great potential but is still in a nascent phase. In order to succeed, more competence is required about the services, and sustainable business models must be developed.

Telenor Group is involved in m-health initiatives in most of the markets where we are present. The overall objective for these initiatives is to utilize mobile technology to ensure larger parts of the population access to health services and more cost-efficient usage of health personnel. We are of the opinion that it is important that m-health services are sustainable both socially and commercially. We experience that many pilot initiatives are established, but do not succeed in scaling up.

The market for m-health services is still in an early phase. The main obstacles to effective utilization of m-health services, in our experience, are lack of knowledge regarding services and absence of sustainable business models. We are of the opinion that these challenges can be resolved through a closer cooperation with other actors in the health care system. Therefore, Telenor is a member of the Innovation Working Group, which is a working group that contributes to support the global strategy "Every Woman Every Child" for women's and children's health.

Better Health Services for Serbia's Roma Population

Together with UNICEF Serbia and the Serbian Ministry of Health, Telenor Serbia has worked to ensure the Roma population access to health services and information.

Through "The Povezivanje Project", about 75 women from the Roma population have received training as health mediators. These women work as bridge-builders between the formal Serbian health system and the Roma society. Using laptop computers, mobile telephones, the Internet, software and training provided by Telenor, these health mediators can communicate better with each other and with the Roma population. For example, the mediators can give critical health information on issues such as vaccination and fetus health via SMS to Roma families. Thanks to databases developed as a part of the project there is now also reliable information about the Roma population and their living conditions, which can be used by other governmental institutions.

Since the initiative was launched in April 2010, Telenor has seen a continuous increase in the use of mobile services and improved communication between health mediators and the Roma population.

Focus on Women's and Children's Health in Bangladesh
Telenor's subsidiary in Bangladesh – Grameenphone – participates in the Mobile Alliance for Maternal Action (the MAMA initiative) to ensure new parents access to health information.

The initiative is a public-private partnership run by several international organizations and private companies in cooperation with the authorities in Bangladesh. The MAMA initiative also uses mobile phones to deliver preventive health information to new and future parents via speech and SMS services.

When a future mother is registered, the health services will inform them how they can look after themselves during pregnancy, disprove myths and erroneous perceptions, warn of danger signals, connect women to local health stations, increase knowledge about breastfeeding, explain the advantages of contraception, and give information about other ways they can take care of a newborn baby.

A pilot service was launched nationally in May 2012. In the test phase this service will be used by over 1,300 parents.

Monitoring of Outbreaks of Disease in Thailand
The Geo Chat programme is the first SMS-based service for monitoring outbreaks of disease in Thailand. Telenor's subsidiary, Dtac, has entered into cooperation with several other international actors on delivery of the first mobile-based SMS service to the public health services monitoring system. This new SMS warning system is specially developed to give the public health service in Thailand notification of an outbreak of disease at an early stage. Geo Chat uses the Internet and the mobile phone's messaging system to communicate, which facilitates immediate updates on diseases, i.e. the spreading of the H1N1 influenza in different parts of the country.

Geo Chat public health stations in remote parts of Thailand allow better access to, and sharing of, health information in a simpler manner. As a part of this cooperation, Dtac distributed SIM cards to employees in the public health service. They can use these SIM cards in their mobile phones to report on the disease situation directly to the Ministry for disease control.

Tom Riege
Head of Governmental Relations

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Appendix 1

The UN Millennium Development Goals Relating to Health

Good health is a human right and one of the most important prerequisites for a meaningful and active life. Ensuring good health among poor people is also a prerequisite for poverty-eradication, sustainable development and increased value creation.

From a development policy point of view, the UN Millennium Development Goals (MDGs) forms the foundation for our Government's development cooperation health assistance. Despite progress in recent years, the Goals related to maternal and child health are among those that are lagging most behind and will be difficult to achieve by 2015.

Millennium Development Goal 4 – Reducing child mortality

Reduce by two thirds, between 1990 and 2015, the under-five mortality rate

Status: In 1990, 12 million children under the age of five died. In 2011, the corresponding number was 6.9 million child deaths. Despite increased population growth, the reduction in death rate was 41 per cent.

North Africa has reached this Millennium Development Goal and reduced the death rate by 67 per cent. Sub-Saharan Africa and Oceania are far behind, the reduction being 30 per cent. While the number of deaths among children under the age of five is falling, the percentage of those who die in the first month after birth has risen from 37 per cent in 1990 to 40 per cent in 2010.

Vaccines are an important way to reduce child mortality. In 1990, 69 per cent of all infants were vaccinated against measles. The corresponding figure for 2011 was 84 per cent. During the period 2000-2011, vaccinations led to a reduction in deaths of 71 per cent. More than 95 per cent of deaths caused by measles occurred in low-income countries with poor health infrastructures.

Millennium Development Goal 5 – Improving maternal health

Millennium Development Goal 5A –Reduce by three-quarters the maternal mortality ratio

Status: In 1990, 540,000 women died as a result of pregnancy and childbirth complications. The corresponding figure for 2010 was 287,000, a reduction of 47 per cent.

The challenges are greatest in sub-Saharan Africa and South Asia, which account for 85 per cent of all maternal deaths in the world in 2010.

The number of births attended by a professional health care worker in developing countries increased from 55 per cent in 1990 to 65 per cent in 2010. In sub-Saharan Africa, this percentage was 42 per cent in 1990, only increasing to 45 per cent in 2010.

Millennium Development Goal 5B – Achieving universal reproductive health coverage.

Status: Unmet need for family planning (prevention methods) in developing countries was reduced from 13.5 per cent in 2000 to 12.8 per cent in 2010.

Unmet need in sub-Saharan Africa was reduced from 26 per cent in 2000 to 25 per cent in 2010. Statistics from developing countries show that in 2000, 60 per cent of women between the ages of 15 and 49 who were either married or in a relationship used birth control methods. The equivalent figure for 2010 was 62 per cent. In sub-Saharan Africa the rate of use of birth control methods was 18 per cent in 2000. This rate increased to 25 per cent in 2010.

Teenage pregnancies among girls between the ages of 15 and 19 fell from 55 per 1.000 in 2000 to 52 per 1,000 in 2010. Figures for sub-Saharan Africa show a reduction in teenage pregnancies from 122 per 1,000 in 2000 to 120 per 1,000 in 2009.

Millennium Development Goal 6 – Combating HIV/AIDS, malaria and other diseases

Millennium Development Goal 6A. –Have halted by 2015 and begun to reverse the spread of HIV/AIDS

Status: In 2001, a total of 3.2 million people were infected with HIV. The corresponding figure for 2011 was 2.5 million people, a reduction of 20 per cent.

Regarding children infected with HIV, the number was 550,000 in 2001. In 2011, the number was reduced to 330,000 children, a reduction of 40 per cent.

During the same period in 25 countries, there was a reduction of over 50 per cent in number of newly-infected persons. However, progress has not taken place everywhere. Since 2001, the number of newly-infected persons in the Middle East and North Africa has increased by more than 35 per cent. There has also been an increase in Central Asia and Eastern Europe, while the reduction in new infections in sub-Saharan Africa between 2001 and 2011 was 25 per cent. Yet it is here that most people are affected. 60 per cent of all those who are HIV-positive live in this region. In 2011, young people between the ages of 15 and 24 constituted 40 per cent of all newly-infected persons among adults. At the same time, statistics show that the percentage of young people infected with HIV fell 27 per cent during the period 2001–2011. Progress has been greatest in South- and Southeast Asia, with a 50 per cent reduction. In sub-Saharan Africa the reduction was 35 per cent.

Millennium Development Goal 6B. –Achieving by 2010, universal access to treatment for HIV/AIDS for all those who need it

Status: The percentage of HIV-infected persons in developing countries needing treatment and who receive medication was 53 per cent in 2011. From 2009 to 2011, the number receiving HIV treatment increased by 63 per cent.

The percentage of HIV-infected children in developing countries needing treatment and receiving medication was 28 per cent in 2011. In 2011, 56 per cent of all those needing treatment in sub-Saharan Africa had access to treatment. Nevertheless, there are large differences between countries. For example only 20 per cent of those needing treatment in Southern Sudan had access to treatment. The percentages for Malawi and Botswana were respectively 60 and 80 per cent.

Millennium Development Goal 6C Having halted by 2015 and begun to reverse the incidence of malaria and other major diseases.

Status: In 2010, 216 million people had malaria. 660,000 people died of the illness, representing a reduction of 25 per cent in number of deaths since 2000.

In 2011, 8.7 million people became ill with tuberculosis and 1.4 million died. The reduction in deaths due to this illness is 41 per cent since 1990.

Sources: UN and the World Health Organization

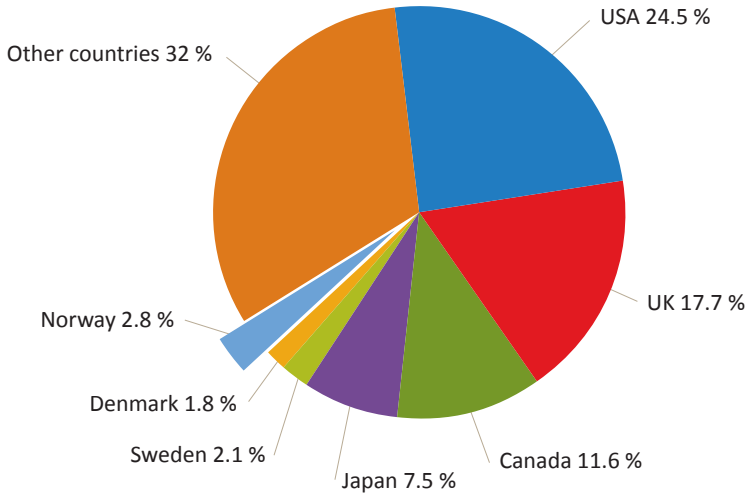
Appendix 2

Norwegian Health Aid Statistics for the Period 1999 – 2011

A significant part of Norwegian efforts within global health is connected to development cooperation and the development health assistance budget. Since figures for actual expenditure are not yet available for 2012, expenditures from 2011 are used for presentation purposes despite this being the same year that the White Paper No. 11 was issued. The statistics are available on Norad's website[1]. According to OECD-DAC calculations, Norway's development health assistance amounts to 2.8 per cent of all health aid given. The United States is the largest single contributor, followed by the United Kingdom, Canada and Japan. Norway is ranked number 11. Using current NOK (Norwegian krone) values, total Norwegian development assistance for health has more than tripled since 1999. In 2011, it amounted to just under NOK 3.5 billion, constituting approximately 13 per cent of Norway's total aid budget (vs. a share of approximately 10 per cent of the total in 1999).

A large share of the health aid budget is allocated to global health and vaccine initiatives, i.e. approximately NOK 1.7 billion, which also includes bilateral assistance for maternal and child health initiatives in five countries (Tanzania, India, Nigeria, Pakistan and Malawi), GAVI[2], and the Global Fund[3]. The remaining NOK 1.8 billion is allocated to other budget lines that include support to multilateral organizations and civil society organizations. It is important to note that these figures only include aid categorized as ODA[4], while other monies such as own contributions by non-governmental organizations (NGOs) and funds from other budget lines come in addition.

Figure 1. Norway's Share of Total Health Assistance (ODA) 2011



In accordance with the Cabinet's Soria Moria Declaration of 2009, which called for increased use of the UN as a channel for Norwegian aid, two thirds of Norway's health assistance in 2011 was channelled to multilateral organizations, while a quarter was channelled to bilateral organizations, non-governmental organizations and research institutes. Remaining monies were allocated to so-called multi-bilateral channels (earmarked bilateral funds disbursed through multilateral channels).

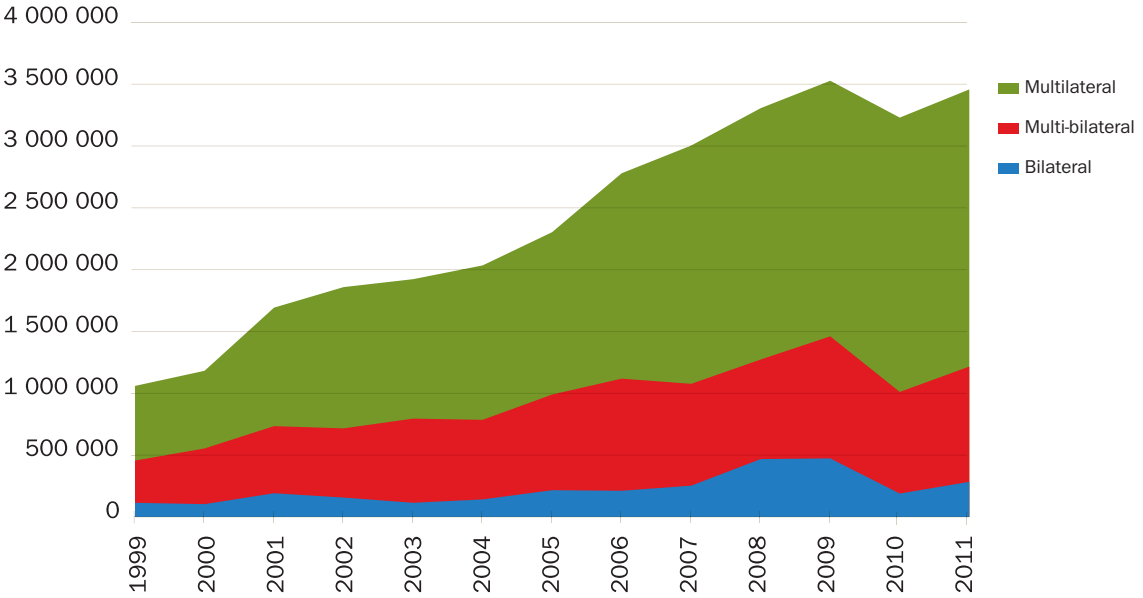
Norway's health assistance reached an all-time high in 2009 (ref. Figure 2) due to a single advance payment to a World Bank Trust Fund (HRITF; Health Results Innovation Trust Fund). This payment is meant to cover several years of multi-bi contribution of relatively equal annual allocations during the period 2009-2011.

1 http://www.norad.no/en/tools-and-publications/norwegian-aid-statistics
2 GAVI Alliance (formerly the "Global Alliance for Vaccines and Immunization")
3 GFATM: the Global Fund to Fight AIDS, Tuberculosis and Malaria
4 Official development assistance

Table 1, Norwegian Health Assistance by Funding Channel (NOK 1,000)

	1999	%	2011	%
Bilateral	341 313	*32*	931 850	*27*
Multi-bi	114 634	*11*	284 338	*8*
Multilateral	603 907	*57*	2 256 359	*65*
Total Health Assistance	**1 059 854**	***100***	**3 472 547**	***100***

Figure 2. Channels for Norwegian Health Assistance, 1999 – 2011



Bilateral Health Assistance

Norwegian bilateral health assistance increased from NOK 341 million in 1999 to NOK 932 million in 2011. Despite this increase, the health share of the total budget has been reduced from one third to one quarter. Table 2 provides an overview of the largest recipients of bilateral assistance. At present Malawi is the only country that Norway has a normal sector cooperation agreement with, though Norway does have bilateral cooperation related to Millennium Development Goals 4 and 5 Partnership Initiatives in five countries (Nigeria, Tanzania, Malawi, Pakistan and India). Norway has financed these and other country initiatives through various channels, including through other donor partners such as Sida[5] and DFID[6]) in individual countries or regions. Similarly, other partners are used to manage funds on behalf of Norway (e.g. the UN Foundation and the Research Council of Norway), or to function as umbrella organizations for other partner organizations (e.g. Digni (formerly Norsk Misjons Bistandsnemnd) and IPPF[7]).

Multi-bilateral assistance is classified as bilateral aid. The largest recipients of such assistance in 2011 were UNICEF (NOK 116 million) and WHO (NOK 97 million), followed by UNFPA and UNOPS. As shown in Figure 2, this category of assistance amounted in 2008 and 2009 to approximately NOK 470 million, to a large extent due to the previously-mentioned advance Trust Fund payment to World Bank. It has since been reduced slightly.

5 Swedish International Development Cooperation Agency
6 UK Department for International Development
7 International Planned Parenthood Federation

Table 2. Largest Recipients of Bilateral Health Assistance, 2011 (NOK 1,000)

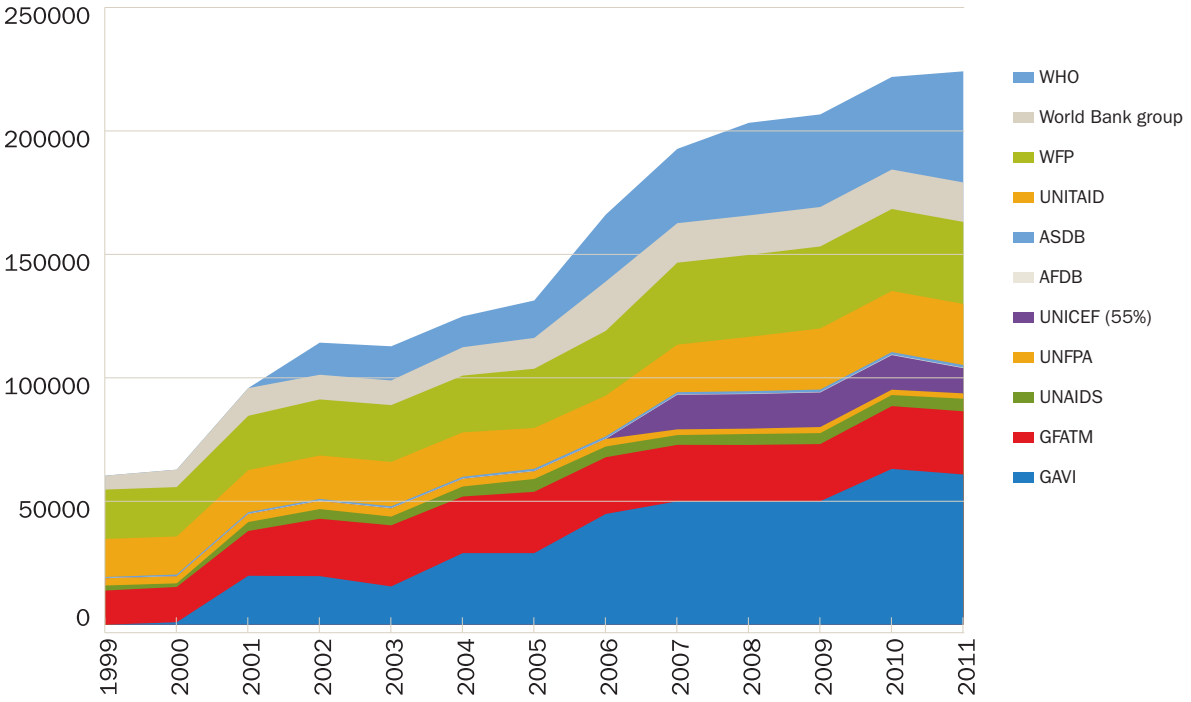
Bilateral Co-operation	NOK
Malawi - sector cooperation	94 000
Nigeria – NNPI	50 000
Tanzania – NTPI	47 010
India – NIPI	37 398
Pakistan – NPPI	30 000
Swedish-Norwegian Regional Team for HIV/AIDS (Lusaka)	35 000
Research / professional work	
Research Council of Norway	60 100
UiO – University of Oslo	13 830
SIU – Norwegian Centre for International Cooperation in Education	13 815
INGO	
IPPF – International Planned Parenthood Federation	55 500
IPM – International Partnership for Microbicides	15 000
NGO	
Norwegian Red Cross	44 891
CRN – Christian Relief Network	31 623
Digni – formerly Norsk Misjons Bistandsnemnda	31 538
Atlas Alliance	25 681
Norwac - Norwegian Aid Committee	24 295
BLM - Banja la Mtsogolo	21 500
Norwegian Church Aid	21 387
Haydom Lutheran Hospital	15 300
Miscellaneous	
UN Foundation	148 500
CHAI - Clinton Health Access Initiative	15 594
Haukeland University Hospital	12 805
Other	242 509

Multilateral Health Aid

As mentioned above, multilateral health assistance increased significantly from NOK 603 million to NOK 2,129 million during the period 1999 – 2011, with total share of the health assistance budget increasing from 57 to 65 per cent. Similar to bilateral health assistance allocations, multilateral grant allocations largely reflect a focus on the health-related Millennium Development Goals. GAVI, including Advanced Market Commitments (AMC) and the International Finance Facility for Immunization (IFFIm), is the largest recipient, receiving over NOK 600 million. The Global Fund is among largest recipients, receiving NOK 450 million, followed by WHO and UNFPA. Of the total grant to UNICEF, it is estimated that 55 per cent[8] goes to health.

8 Based on the MUSKOKA Initiative's recommendationA

Figure 3 Multilateral Health Assistance During the Period 1999 – 2011 (NOK 1,000)



Health Research

Preliminary figures indicate that Norwegian investments in health research in 2012 amounted to approximately NOK 235 million, which supported product development, innovation, clinical research, operational research, implementation research, dissemination and use of research findings, and capacity-building of researcher or research institutions in developing countries. Most funds are channelled through the Research Council of Norway's Programme for Global Health and Vaccination Research (GLOBVAC) and Norad's own capacity-building programme, NORHED (the Norwegian Programme for Capacity Development in Higher Education and Research for Development). Other support is channelled through multilateral organizations e.g. Special research programmes such as HRP and TDR hosted by WHO).

It is to be noted that there is uncertainty in the numbers cited above; especially those related to research conducted in multilateral organizations receiving Norwegian core support, and those related to the health sub-programme under NORHED, where main applications for funding will first be received in second- and third-quarter 2013. Contributions through multilateral organizations are roughly estimated based on total core support or specific project/earmarked support based on the organizations' own estimates of share of budget for such activities. The level of detail varies according to source and circumstance, and continues to be followed closely.

Table 3 Grants to Health Research 2012 (NOK 1,000)

Type of Research	2012
Product development (IAVI, IPM, UNITAID)	25 000
Biomedical / clinical research (mainly on vaccines through GLOBVAC)	50 500
Health system / implementation research	127 300
Capacity building for research	22 000
Knowledge summaries	10 200
TOTAL	**235 000**

* Includes Advanced Market Commitments (AMC) and International Finance Facility for Immunization (IFFIm)

References

Several articles had references and footnotes in the text. These have been removed in this document, but are available on Norad's webpage, see www.norad.no/globalhealth

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The work towards global health holds a high priority for our Government. The Government's political platform takes special responsibility for Millennium Development Goals 4 and 5 on reducing child mortality and improving maternity health. The Prime Minister has flagged this as one of his priority areas.

Espen Barth Eide, Minister of Foreign Affairs
Heikki Eidsvoll Holmås, Minister of International Development
Jonas Gahr Støre, Minister of Health and Care Services

The result in Niger is significantly reduced maternal and infant mortality and the prevention of lasting, degrading birth-related morbidity among over 250,000 people in essentially road-less pilot areas the size of Rogaland county.

Anders Seim, Executive Director
Health & Development International, Norway

With a potential coverage of more than 1.3 billion people with its services, DHIS2 is evaluated as one of the largest and most successful global health information systems according to an external evaluation for Norad.

Professor Morten Dæhlen, Dean
Health Information Systems Programme, UiO