EVALUATION DEPARTMENT

REPORT 5/2016

Annex 3: Case study on Norway's Engagement in Global Efforts to Improve Maternal and Child Health

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This report is the product of its authors, and responsibility for the accuracy of data included in this report rests with the authors alone. The findings, interpretations, and conclusions presented in this report do not necessarily reflect the views of the Norad Evaluation Department.

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Introduction

1.1 BACKGROUND AND PURPOSE

This report aims to assess the rationale for and nature of Norway's engagement in global efforts to improve maternal and child health,[1] the outputs and outcomes of this engagement and the main factors driving the achievement or non-achievement of desired change.

It is part of a broader evaluation of Norway's advocacy engagement from 2005 to 2014, conducted between July 2015 and March 2016. This evaluation has four main components: 1) a summary of Norway's main advocacy engagements based on an analysis of the Norwegian Agency for Development Cooperation's (Norad's) database; 2) thematic overviews of 11 issue areas (both presented in the inception report in October 2015); 3) more detailed case studies of four of these issue areas (illicit financial flows, maternal and child health, education and women, peace and security); and 4) an analysis of key trends and patterns across the four areas. The case studies contribute to the four evaluation questions (see synthesis report), including insights into the factors driving the effectiveness and sustainability of the advocacy outcomes.

The aim of the overall evaluation is to identify and understand the role of the main factors that determine the achievement of desired advocacy outcomes, with a particular focus on the role and contribution of the Ministry of Foreign Affairs (MFA), Norad and their external partners in management of the advocacy engagements and the contribution of the decision-making process.

The evaluation will be used as evidence to inform managerial decisions on policy advocacy programming, in particular:

- the timing – that is, at what point in the policy process makes most sense to engage
- the choice of institutional 'channel', or the way Norway could exert its influence
- the design and management of a portfolio of advocacy activities

1.2 METHODOLOGY

Each case study was allocated 14 days. Given the purpose of the evaluation and the time available, they are not exhaustive accounts of these very broad issue areas or Norway's engagement. Rather, they seek to take advantage of existing information, supplemented by a select number of interviews with key actors who could provide insights into decisions and processes that have been less well documented.

This report is based on a review of 73 documents: 24 ministerial statements, reports and speeches, 15 reports, three previous Norad-commissioned evaluations and 31 articles from the grey and academic literature, a review of organisation and initiative websites and semi-structured phone interviews with 23 key informants. Documents were identified through searches on the Norwegian govern-

1 Norway's engagement around this issue focused initially on chid health, later expanded to include maternal health and followed the broader field to subsequently include newborn health and, most recently, reproductive and adolescent health. For simplicity, and to reflect Norway's core focus, we refer to maternal and child health throughout, rather than RMNCAH, although their efforts have covered the broader continuum.

ment's website[2], Pubmed and Google Scholar using search terms: "Norway", "Norwegian" or "Stoltenberg" together with "MDG 4", "MDG 5", "health MDGs", "maternal health" and "child health". Of the speeches, ministerial statements and news reports related to Norwegian support for maternal and child health, we reviewed the five most relevant results for each search combination.

For interviews, we employed a purposive sampling strategy, identifying individuals who were knowledgeable about the issue and evaluation questions and who represented a range of viewpoints. Norad provided initial suggestions of potential interviewees; this was supplemented by recommendations from others in order to provide a more balanced perspective. Most respondents were serving in senior positions – heads of departments, senior advisers or members of international boards. Of the key informants, 10 (43%) were from Norway, eight (35%) were affiliated with the Norwegian government, six were from non-governmental organisations (NGOs), three were from multilateral and two from bilateral agencies, two were from academia, one was from a foundation and one was from the private sector. Except for the two informants from academia, all other key informants (91%) had been involved directly in global efforts. Several interviewees were currently working for different organisations to when their engagement began – initially working for a multilateral organisation and subsequently moving to an international NGO (INGO) and/or to a national government, for example. This movement highlights the sustained involvement of key individuals over time and the variety of types of institutions involved. Compared with the other issue areas covered in the overall evaluation, key informants for this case were more geographically dispersed, based in 10 cities on three continents.

Interviews, lasting approximately 30–45 minutes, were conducted by phone and Skype and followed a standardised guide, adapted slightly to each specific case. Documents and interviews were hand-coded according to the evaluation questions and emergent themes. The Norad focal point reviewed individual case studies to identify any major gaps or misinterpretations.

The approach draws on principles of Outcome Harvesting (Wilson-Grau and Britt, 2012). Rather than focusing on what an organisation does, Outcome Harvesting focuses on what has been achieved and then identifies factors associated with these changes. This approach acknowledges that multiple pathways can lead to multiple outcomes, and helps identify unplanned or unexpected changes.

The evaluation synthesis report discusses the limitations of assessing advocacy and of our overall approach. Specific to this case study, responses may be affected by recall bias, since initial decisions and activities took place a decade ago. A large, dispersed and diverse network of actors are involved in global health: the number of people interviewed comprises a very small proportion of the overall total; interviews with more people from each sector

2 www.regjeringen.no

would provide a more comprehensive and representative perspective.

For quality assurance, each case study and the synthesis report was reviewed by two evaluation experts and by Norad and MFA staff. In April 2016, the Norad Evaluation Department convened a dissemination meeting with staff involved in the four issue areas to discuss findings. Norad subsequently provided a consolidated set of overarching comments, additional documents and detailed comments in the draft maternal and child health case study and synthesis reports. Comments related to staffing, relationship among case study issue areas, political sustainability, sexual and reproductive health, research, knowledge creation and dissemination, the Agreement Framework for the Global Campaign for the Health Millennium Development Goals (MDGs), media, social media, civil society and community mobilisation, support to the Graça Machel Trust's women in media project and the private sector. The draft reports were subsequently revised, where necessary.

1.3 STRUCTURE OF THE REPORT

Section 2 considers the sector context, including key achievements over the past decade.

Section 3 presents an overview of Norway's engagement in global efforts. Section 4 then analyses these efforts, characterising the nature and scope of Norway's engagement, its decision-making process, the timing, the relevance of the engagement to Norway's comparative advantages, achievements and challenges, drivers and constraining factors and the sustainability of the engagement.

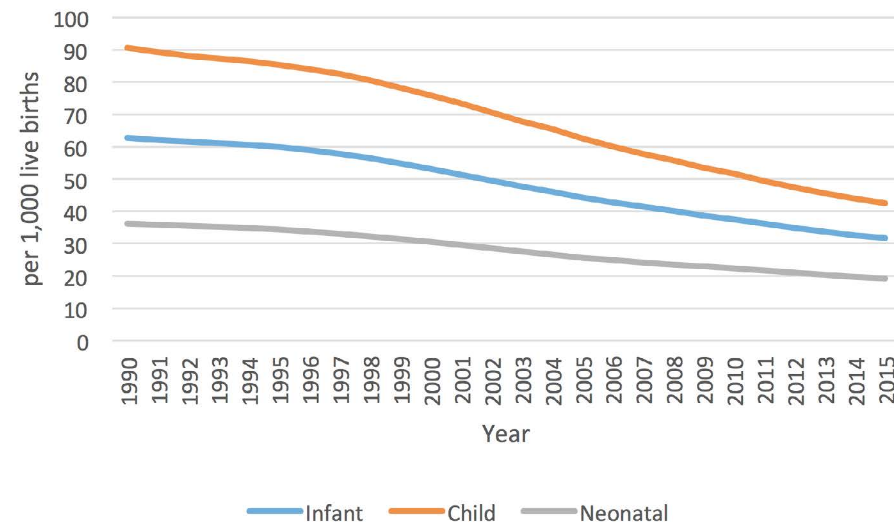
Section 5 presents conclusions and lessons from this engagement that may be relevant for other development areas.

2. Sector context

During the time period under study (2005-2014), four prominent changes have taken place in the field of maternal and child health: significant declines in mortality; new global partnerships, platforms and initiatives; high level attention and commitments; and advances in knowledge and innovation. All of these trends began prior to 2005 and in many cases were true for global health issues more broadly.

Beginning in the mid-1990s, global health began to receive attention more frequently and more prominently (Fidler 2011). Development assistance for health increased from $7.2 billion in 1990 to $36.4 billion in 2015 (IHME 2016). Powerful new actors emerged, most notably the Bill and Melinda Gates Foundation, and new global initiatives were created, including the Global Alliance for Vaccines and Immunization (GAVI) in 2000 and the Global Fund to Fight AIDS, Tuberculosis and Malaria in 2002. Much of this work was framed by the MDGs, three of the eight of which focused specifically on health, aiming to reduce child mortality, improve maternal health and combat HIV/AIDS, malaria and other diseases (Box 1).

FIGURE 1A: GLOBAL TRENDS IN NEONATAL, INFANT AND CHILD MORTALITY RATES, 1990–2015



Source: World Development Indicators

More broadly, changes in the global health arena took place within a broader context of globalisation, development of new technologies, increased access to information and emerging and re-emerging diseases (Fidler and Drager, 2006; Amorim et al., 2007; Sandberg and Andresen, 2010). The initial period under

BOX 1: UN MILLENNIUM DEVELOPMENT GOALS (MDGS)

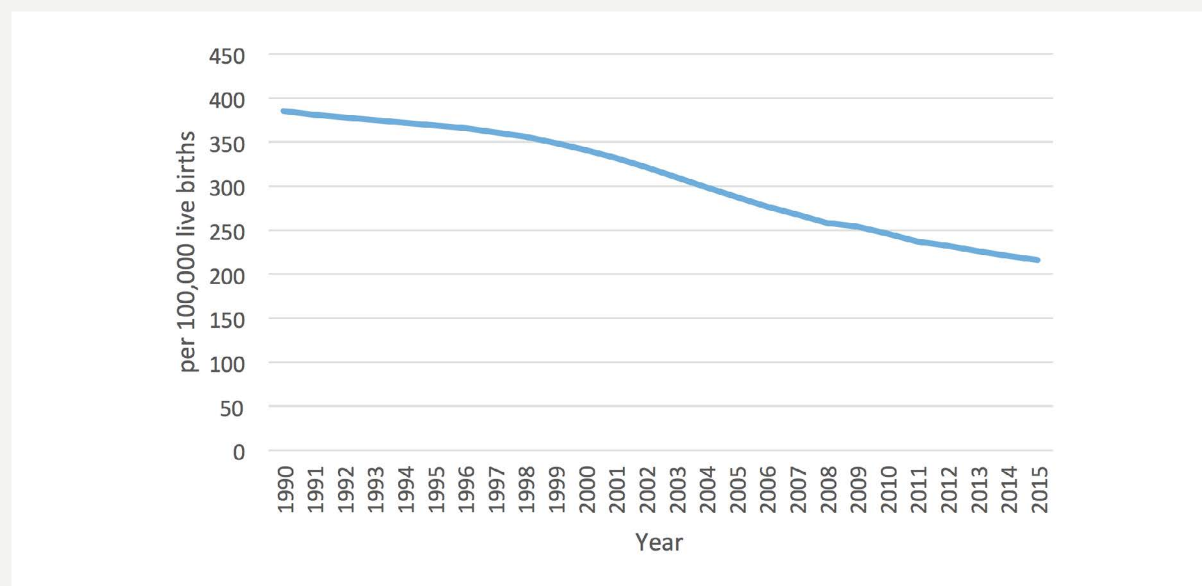
MDG 4: From 1990 to 2015, reduce by two-thirds the under-five mortality rate

MDG 5: From 1990 to 2015, reduce by three-quarters the maternal morality ratio, achieve universal access to reproductive health

study was one of sustained economic growth, followed by the economic downturn towards the end of the decade, which may limit future resources and attention (Conley and Melino, 2013).

Specific to maternal and child health, **mortality has dropped substantially** over the past two and a half decades. Globally, child mortality rates have declined by 53% since 1990, from an estimated rate of 91 deaths to 43 deaths per 1,000 live births, from 12.7 million deaths[3] in 1990 to 6.3 million deaths in 2013. Global maternal mortality ratios have fallen by 45% (Figure 1). The number of annual maternal deaths declined from 523,000 in 1990 to 289,000 in 2015. Moreover, rates of reduction in both child and maternal mortality have accelerated over time (Requejo and Bhutta, 2015; Victora, 2015; WHO, 2015).

FIGURE 1B: GLOBAL TRENDS IN MATERNAL MORTALITY RATIOS, 1990–2015



Source: World Development Indicators

In the past decade, a number of prominent **new global partnerships, platforms and initiatives** have been established, most notably the Partnership for Maternal, Newborn and Child Health (PMNCH) (initially prompted by donors) and Countdown to 2015 in 2005, the Global Strategy for Women's and Children's Health and Every Woman Every Child (EWEC) movement in 2010 and the Global Financing Facility in 2014 (see Box 2). Subsequent global initiatives have developed out of these, such as the Commission on Information and Accountability, the Commission on Lifesaving Commodities, the Every Newborn Action Plan, A Promise Renewed and Family Planning 2020.

3 Absolute numbers of deaths should be interpreted relative to increases in the population over this time period.

As the timeline of key milestones (Annex 1 of this study) illustrates, stakeholders had been working together for decades on maternal health, on child health and later on newborn health. The UN Children's Fund (UNICEF) child survival initiative was launched in 1982 and the Inter-Agency Group for Safe Motherhood formed in 1987. What has been distinct about global platforms in the past decade has been their high-level and diverse support (Sandberg and Andresen, 2010). These cross-sector initiatives have brought together the often-separate maternal, newborn and child health fields; many interviewees registered surprise that it had taken so long to make this connection. New global platforms have also engaged multiple constituency groups working in different sectors: academic, research and teaching institutions, donors and foundations, health care professional associations, multilateral organisations, NGOs, partner countries and the private sector. These networks have expanded beyond actors with technical health expertise to include powerful political advocates (Smith and Rodriguez, 2015).

BOX 2: NEW GLOBAL PARTNERSHIPS AND INITIATIVES

Partnership for Maternal, Newborn and Child Health (PMNCH), launched in September 2005, brought together the Healthy Newborn Partnership established in 2000, based at Save the Children USA; the Child Survival Partnership established in 2004, hosted by UNICEF; and the Partnership for Safe Motherhood and Newborn Health, launched in 2004 (an outgrowth of the Safe Motherhood Inter-Agency Group established in 1987), hosted by the World Health Organization (WHO). PMNCH is an alliance of more than 720 member organisations across seven constituencies that enables partners to share strategies, align objectives and resources and agree on interventions.

Countdown to 2015, launched in London in December 2005, is a global movement of academics, governments, international agencies, health care professional associations, donors and NGOs, with *The Lancet* as a key partner. Hosted by PMNCH, Countdown tracks progress towards achieving MDGs 4 and 5 in in the 75 countries where more than 95% of all maternal and child deaths occur. It assesses coverage of interventions, equity, health systems and financing as a way to promote accountability.

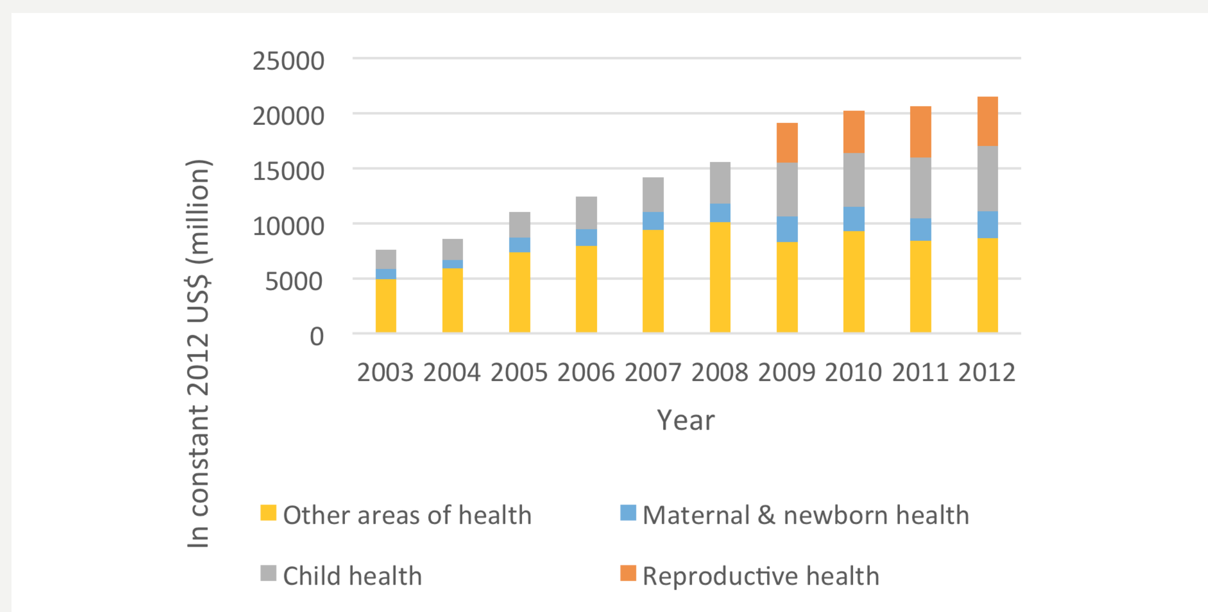
The **Global Strategy for Women's and Children's Health** was launched by UN Secretary-General Ban Ki-moon during the 2010 MDG Summit. Developed through consultations and inputs from hundreds of governments, international and national NGOs, companies, foundations, constituency groups and advocates, it outlines key elements to enhance financing, strengthen policy and improve service delivery: country-led health plans, a comprehensive, integrated package of essential interventions and services, integrated care, health systems strengthening, health workforce capacity-building and coordinated research and innovation.

Every Woman Every Child (EWEC) is a global movement that aims to mobilise and intensify action by governments, multilaterals, the private sector and civil society around the Global Strategy. Thematic groups, including the UN Commission on Information and Accountability, the Commission on Life-Saving Commodities and the Innovation Working Group, have helped identify recommendations and advance progress in specific areas. The independent Expert Review Group provides oversight.

The **Global Financing Facility** in Support of EWEC, announced in September 2014, aims to support the renewed Global Strategy for Women's, Children's and Adolescents' Health by providing smart, scaled and sustainable financing to achieve and measure results at country level. It focuses particularly on issues (e.g. family planning, nutrition, civil registration and vital statistics) and target populations (e.g. adolescents) that have historically been under-funded.

Reductions in maternal and child mortality have been facilitated by **new and renewed attention and commitments**, many of which have been mobilised and channelled through these new global platforms. 2010 was a landmark year. In June, the G8 launched the Muskoka Initiative on Maternal, Newborn and Child Health, committing $7.3 billion in new and additional funding over the next five years. In September, UN Secretary-General Ban Ki-moon launched the Global Strategy, discussed at the World Health Assembly, the UN General Assembly, the Economic and Social Council High-Level Segment, the G8 and G20 summits, the Women Deliver conference, the Pacific Health Summit, the UN Global Compact Meeting, the African Union Summit and the Jakarta Special Ministerial Meeting on the MDGs in Asia and the Pacific. In November, African heads of state made a formal declaration in support of maternal, newborn and child-health. In 2012, the Inter-Parliamentary Union passed a resolution calling for action on MDGs 4 and 5. During these few years, maternal, newborn and child health featured as a major item on the agendas of these

FIGURE 2: PROPORTION OF ODA+ ALLOCATED TO REPRODUCTIVE, MATERNAL, NEWBORN AND CHILD HEALTH, 2003–2012



Note: Data for reproductive health available only since 2009.
Source: Arregoces et al. (2015).

institutions like never before (Shiffman, 2015). By August 2015, 334 stakeholders had made 428 financial, policy, advocacy, service and product delivery commitments to the Global Strategy (PMNCH, 2015).

Accompanying these high-level political commitments have been substantial increases in funding. Of the total amount of ODA+ (official development assistance and grants from the Bill and Melinda Gates Foundation) provided,

the proportion allocated to health increased from 9.7% in 2003 to 14.5% in 2012. Moreover, of the amount allocated to health, the proportion dedicated to reproductive, maternal, newborn and child health has increased substantially (Figure 2) (Arregoces et al., 2015). Since 2010, $22.3 billion in new and additional money has been pledged (EWEC, 2015; Requejo and Bhutta, 2015).

In addition to reductions in mortality, new global partnerships and high-level commitments, key informants identified **advances in knowledge and innovation** as a key achievement of global efforts over the past decade, strongly influenced by GAVI. They spoke of significant progress in the availability, quality and visualisation of data, which has helped reduce knowledge gaps, develop more effective interventions and guide decision-making.

Interviewees commented on a growing recognition that innovation in delivery and financing can make health interventions more affordable, accessible and effective. The 2015 Global Strategy report identifies a research and development pipeline of over a thousand new innovations and $225 million in investments that has been committed since 2010. In October 2014, for example, Norway, the UK, the Gates Foundation and Grand Challenges Canada pledged $50 million for innovative approaches to improve maternal and newborn health.

3. Overview of Norway's engagement

3.1 HISTORY AND PROGRESSION OF NORWAY'S INVOLVEMENT OVER TIME

Norway's involvement in global efforts to improve maternal and child health represents a progressive evolution of global engagement and personal relationships among a small group of individuals over time (Boseley, 2007; Sandberg and Andresen, 2010; MFA, 2012a; Norad, 2013).

The foundations of Norway's commitment to global health have been traced back to over a century ago, with the work of Christian missionaries and later philanthropic efforts of the labour movement following World War II and the establishment of UNICEF and the World Health Organization (WHO) (Boseley, 2007; MFA, 2012a). More recently, former Prime Minister Gro Harlem Brundtland's election as director-general of WHO in 1998 ushered in a new era of Norwegian leadership in global health. At the turn of the millennium, Norway was involved in the creation of GAVI and the Global Fund. This initial focus on immunisation and infectious disease later expanded to cover child health, then maternal health, with a primary focus on MDGs 4 and 5 to reduce child and maternal mortality, respectively. Most recently, Norway's focus has reflected expansion of the broader movement to include newborn, reproductive and adolescent health.

Behind this progressive engagement has been a small, core group of individuals (Sandberg and Andresen, 2010). The time period under study in this evaluation coincides with the beginning of Jens Stoltenberg's second term as prime minister in 2005. Stoltenberg has said that his interest in child health was influenced by Gro Harlem Brundtland, Jonas Gahr Støre and Tore Godal, who had all worked together for several decades (Boseley, 2007). Brundtland is a physician who worked on child health issues in Norway before serving in public office. Støre served as Brundtland's chief of staff at WHO, as Stoltenberg's chief of staff during his first term as prime minister from 2000 to 2001 and as minister of foreign affairs during his second term. Godal worked at WHO for years before being named the first head of GAVI in 2000, and was handpicked by Stoltenberg in 2005 to serve as a special adviser to the prime minister.

Stoltenberg served in Brundtland's administration during the latter's third term as prime minister and on the board of GAVI in 2001. He was Norway's signatory to the UN Millennium Declaration during his first term in office, an experience he often referenced in later speeches. His mother had previously advised on maternal and child health in Norad. Thus, by the time Stoltenberg became prime minister for the second time in 2005, interest and involvement in these issues were preceded by a longer history of Norwegian leadership in international institutions and decades-long relationships.

3.2 KEY ELEMENTS AND ACTIVITIES

Norway identifies the key elements of its global engagement in maternal and child health as political leadership, diplomacy and economic support, later characterised as catalytic funding, intended to attract new and increased sources of financing (MFA, 2012; Norad,

2013).[4] In addition to Norway's work at the global level, it has also invested in bilateral partnerships with India, Nigeria, Pakistan and Tanzania (Stoltenberg, 2007, 2008, 2010; Lie, 2011). It was explicitly intended to pursue these elements as a package – a joint strategy to maximise the impact.

Norway's global engagement efforts aimed primarily to influence other heads of state and governments and multilateral institutions, with a focus on thematic areas identified in the MDGs (MFA, 2012).

Following Stoltenberg's earlier involvement with the MDGs and GAVI, when he took office for the second time in 2005 he saw an opportunity to deepen the country's engagement in child health. Interviewees spoke of his personal commitment to the issue and hands-on approach. Engagement was led by the Office of the Prime Minister, initially intentionally kept separate from regular discussions about development assistance, and then over time integrated into bureaucratic operations.

In 2006, Stoltenberg signalled Norway's intent in a comment in *The Lancet*: 'Our Children: The Key to Our Common Future', which highlighted his aims: cultivating political support, increasing investments and improving coordination and joint action:

Norway is also committed to working together with other countries and their leaders and prime ministers and presidents, particularly the leaders of the G8 countries, in international and global forums. This commitment is not only aimed at ensuring an increased level of investment, but also at better coordinated and more effective action and an honest sharing of lessons learned, not just as we look back but as we proceed… We, as our nations' leaders, need to put our words and our deeds behind our promises… Only these will be the actions we can be judged on by the generations to follow (Stoltenberg, 2006a: 1042–3).

That same year, Norwegian Foreign Minister Støre and French Minister Douste-Blazy launched the **Foreign Policy and Global Health Initiative**. They involved their counterparts in Brazil, Indonesia, Senegal, South Africa and Thailand, who together represented four continents, members of the G8 and G20 and a diversity of interests and roles in global health (Møgedal and Alveberg, 2010; Sandberg and Andresen, 2010; MFA, 2012). The following March, the group produced the 2007 Oslo Ministerial Declaration and Agenda for Action, asserting:

We believe that health is one of the most important, yet still broadly neglected, long-term foreign policy issues of our time. Life and health are our most precious assets. There is a growing awareness that investment in health is fundamental to economic growth and development. It is generally acknowledged that threats to health may compromise a country's stability and security.

In order to increase visibility for maternal and child health, in September 2007 Stoltenberg, together with other leaders, launched the

4 The 2013 Results Report (Norad, 2013) included professional mobilisation between researchers, government officials and civil society as a key element of the work but this was not prominently reflected in other sources so is not discussed here.

Global Campaign for the Health MDGs in New York, just several weeks after the launch of the International Health Partnership. The campaign encompassed several interrelated initiatives, all with the aim of accelerating progress on the health MDGs. The Global Campaign was oriented around *financing survival* of women and children, *organising survival* by reducing bureaucracy and using performance-based financing and *advocacy* for women and children to raise awareness of the problem and cost-effective solutions (Global Campaign, 2007; Office of the Prime Minister, 2007).

As part of the Global Campaign, Stoltenberg created a **Network of Global Leaders**, involving Prime Ministers Balkenende of the Netherlands, Brown of the UK and Rudd of Australia; Presidents Guebuza of Mozambique, Kikwete of Tanzania, Lula da Silva of Brazil, Sirleaf of Liberia, Wade of Senegal and Yudhoyono of Indonesia; and Graça Machel,[5] President and Founder, Foundation for Community Development Mozambique. This network of peers was intended to strengthen their commitments at the national level, engage other heads of state within their regions and promote MDGs 4 and 5 at high-level global events. For instance, in 2008 the leaders sent a joint letter to Prime Minister Fukuda ahead of the G8 Summit in Japan.

The network's country composition and orientation differed from that of the foreign ministers, who were more diverse and operationally oriented in nature. The leaders were selected based on personal relationships, being those thought to be like-minded and committed to moving this agenda forward. Prime Ministers Stoltenberg and Brown, for example, had previously interacted when they had been finance ministers in the late 1990s. The network was supported by a sherpa group: senior advisers to these heads of state and government who met every second month, remotely and in person.

Stoltenberg made visits to Indonesia and Tanzania, as well as India and the US. He developed relationships with and spoke publically alongside President of Afghanistan Hamid Karzai, President of Madagascar Marc Ravalomanana, Her Majesty Queen Rania Al-Abdullah of Jordan, child activist Aminata Palmer of Sierra Leone, UNICEF Executive Director Ann Veneman and President of Chile Michelle Bachelet.

The Global Campaign produced **annual reports** from 2008 to 2011 (and again in 2013) to sustain attention. The report writing process was led by Norad and MFA staff, and each report included a one-page statement from leaders of government, UN agencies, INGOs and corporations, as an explicit strategy to mobilise and publically highlight their support. The reports also tried to respond to what was happening in the external environment; for example, in 2009 the report was themed 'Protecting the Most Vulnerable during the Economic Crisis'. In 2010, Norway, through PMNCH, initiated a five-year global media campaign led by an international public relations firm, which launched 25 media campaigns on maternal, newborn and child health, reaching an estimated 12.5 billion

5 Machel had previously served as chair of the Vaccine Fund Board, GAVI's initial financing arm, following the 2001–2004 inaugural term of Nelson Mandela.

people through radio, television, print, internet and social media. Together, Global Campaign activities were intended to serve as amplifiers, to use leaders' voices and new data to repeatedly raise maternal and child health issues on domestic and international agendas.

From 2008 to 2010, much of Norway's engagement took place through **diplomatic channels**, between high-level officials in targeted countries and institutions. Norwegian advisers met with their counterparts in Germany, a delegation of US congresswomen, including House Speaker Nancy Pelosi, the UN Secretary-General's Office and in Canada prior to its hosting of the G8 and G20 summits in 2010. In 2009, Norway was part of discussions among a small group of people, including those from the Gates Foundation and the UN Secretary-General's Office ahead of the launch of the Global Strategy for Women's and Children's Health and the EWEC movement the following year.

Since 2010, Norway has supported the UN Secretary-General's Office, the UN Foundation and PMNCH to develop a joint work plan for EWEC, as one of the few sources of both financial and technical support. Norway has played an active role in groups supporting implementation of the Global Strategy, with Godal co-chairing the EWEC Innovation Working Group, Stoltenberg co-chairing the Commission on Life-Saving Commodities and Støre serving on the Commission on Information and Accountability. Norad staff have co-facilitated the drafting process for both Global Strategies. Stoltenberg has continued high-level talks, including meeting with Bill Gates in 2011 and hosting Ban Ki-moon in Oslo in 2011 and Bill Gates in Oslo in 2013.

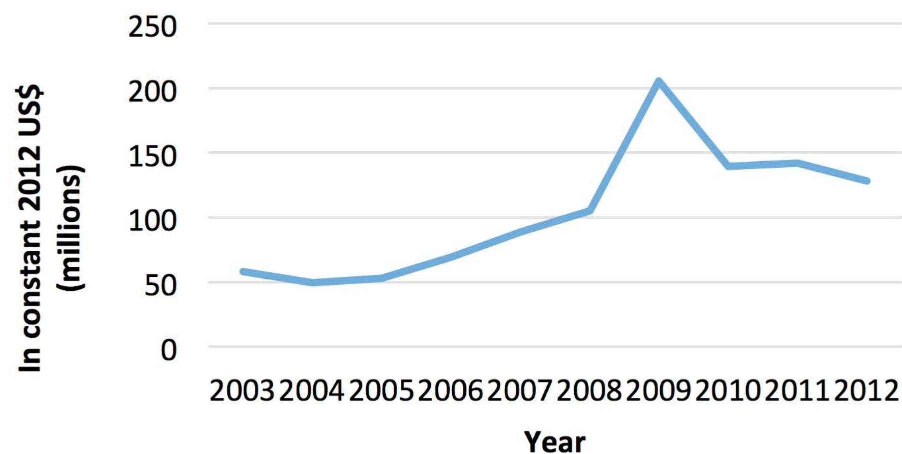
Throughout this overall time period, Norway's **financial contributions** have risen fairly steadily, both ODA as well as funding for reproductive, maternal, newborn and child health specifically. ODA rose from 0.94% of Norway's gross national income (GNI) in 2005 to 0.99% in 2014, with a high of 1.07% in 2013 (OECD 2015). As calculated by Countdown to 2015, Norwegian ODA for RMNCH has more than doubled from $57.8 million in 2003 to $128 million in 2012 (Arregoces et al. 2015). Norad figures on Norway's contributions, based on the G8 Health Working Group methodology to calculate 2010 Muskoka commitments,[6] demonstrate even larger contributions to (R)MNCH, increasing from 1.2 billion NOK (~$145 million) in 2004 to 2.4 billion NOK (~$292 million) in 2012, and reaching nearly 3.4 NOK (~$402 million) in 2014.

In addition to financial resources, Norway has also been active in developing **new health financing mechanisms** and providing kick-start funding. In 2007, the World Bank, Norway and the UK launched the Health Results Innovation Trust Fund. In 2008, Stoltenberg served on the High Level Committee on Innovative Financing for Health, co-chaired by UK Prime Minister Gordon Brown and World Bank President Robert Zoellick. And, at the July 2015 Financing for Development Conference in Addis Ababa, the Global Financing Facility was

6 These figures cover a proportion of contributions to multilateral agencies, global health initiatives, general budget support, disease-specific DAC codes, basic drinking water supply and sanitation, and other health related activities targeting the general population, women of reproductive age and/or children under five.

launched, intended to serve as a key financing platform for the EWEC Global Strategy, with initial support from the UN, the World Bank, Canada, Norway and the US. Both the trust fund and the financing facility were the result of years of planning and negotiation in which Norwegian advisers played a driving role.

FIGURE 3: NORWEGIAN ODA FOR REPRODUCTIVE, MATERNAL, NEWBORN AND CHILD HEALTH, 2003–2012



4. Findings

4.1 NATURE AND SCOPE OF THE ENGAGEMENT

The previous section summarised *what* Norway has done as part of its advocacy efforts to improve maternal and child health. This section characterises *how* it has approached this engagement. In this issue area, Norway has predominantly engaged in direct advocacy. Efforts have been led by state officials themselves, rather than grants being provided to other organisations to conduct work on their behalf.

Three core dimensions underlie Norway's approach: working with others and through multilateral processes, often behind the scenes; promoting evidence-based policy-making; and aiming to be flexible and innovative in trying new ways of working.

Rather than acting alone, Norway aims to **build consensus and mobilise others around international processes** (MFA, 2002; Global Campaign, 2008; Stoltenberg, 2009; Sandberg and Andresen, 2010; Bliss 2011; MFA, 2012, 2014). It works closely with and has been a vocal champion for the UN, particularly WHO and PMNCH; channels a substantial amount of funds through the mechanisms mentioned above; and has oriented its priorities around the jointly agreed MDGs. Norway has deliberately sought to find opportunities for people and organisations to work together towards common goals in ways that also serve their individual mandates and that do not detract attention from their space. Working with others extends also to Norway's style of engagement with low- and middle-income countries: intentionally aiming to follow countries' own development strategies. In order to pursue this approach of working with others, staff carefully selected and attended to partners in order to reduce potential political risks.

This approach often involves **working behind the scenes**, as with much of the diplomacy work. This attitude is exemplified in statements by senior advisers and officials:

Everyone would like to take credit for what has been achieved but we can do that collectively, and by doing so, we can achieve much greater results than one country can achieve.

If Norway needed to take a step back from the limelight and let others shine, [we were willing to do so] as long as we achieved the higher purpose.

Second, Norway pursued an **evidence-based policy** approach, quantifying the magnitude of the problem and making decisions about which interventions to fund and where based on data and performance (Stoltenberg, 2007; Global Campaign, 2008; Sandberg and Andresen, 2010; Lie et al., 2011; Bliss, 2011; MFA, 2012). This approach underpinned much of GAVI's work. Results-based financing is used in the Norwegian health system, familiar to Stoltenberg since his earlier tenure as finance minister. A strong evidence and results orientation was reflected in the campaign's messaging, both domestically to the Parliament and Norwegian electorate and internationally. By calculating how many lives could be saved for each dollar, officials were able to present a compelling rationale, build consensus around a common solution, demonstrate progress and respond to critiques with clear evidence. Providing information helped make processes

and results more transparent, enhancing accountability (MFA, 2014). Norway used publically available data and supported PMNCH, which hosts Countdown to 2015, to improve the evidence base. Norway also financed and contributed to a *Lancet* series on stillbirths in 2011 and on midwifery in 2014, and to the Lancet Commission on Investing in Health in 2013 and the Commission on Sexual and Reproductive Health and Rights in 2015.

Finally, Norway's approach aims to be **flexible and innovative,** taking risks in testing out new approaches (MFA, 2012). Interviewees spoke of its small country advantage, with fewer dense, bureaucratic structures; and its independence as a non-European Union (EU) country, but also one perceived to be non-threatening, which gives Norway and government staff substantial room for manoeuvre. This flexibility was reflected in shifts in how its budget was allocated and activities it undertook to achieve broader goals, aiming to move quickly and be responsive to new evidence and what was happening in the external environment.

Norway has also used its resources to invest in innovation – in terms of new *technologies*, like working with mobile phone operators in Africa and supporting the mHealth Alliance; new *processes,* such as local production and supply chain management; and new *financing mechanisms* like the Global Financing Facility. The government has sought to foster innovation both globally through the EWEC Innovation Working Group and domestically through initiatives like Vision 2030.

4.2 DECISION-MAKING PROCESS AND RATIONALE FOR ENGAGEMENT

How Norway chose to engage in global efforts largely reflects *why* it decided to become involved. Both decisions – to pursue advocacy and to support maternal and child health in particular – were deliberate choices.
Key informants consistently emphasised the importance of targeting efforts and of working with others because of the country's small size relative to the need (Sandberg and Andresen, 2010). They acknowledged that Norway's resources, human and financial, were limited and so aimed to use them strategically to leverage greater resources and take advantage of the unique capacities of others. 'In its foreign and development policy, Norway is working actively to identify niches where we can make a difference, and where Norwegian funding and Norwegian efforts will make an effective contribution' (MFA, 2012: 43). This model of working predominantly at the global level through and with others is distinct from those of donors with a large physical presence in low- and middle-income countries and field offices spread across the world.

Similar to the choice to engage in advocacy, the decision to invest in maternal and child health was explicit, analysed and recommended by technical staff. In the UN's first MDG progress report in 2005, of the 10 reporting regions seven were not expected to achieve the child mortality goal and seven were not expected to achieve the maternal mortality

goal (UN,2005).[7] Thus, the unmet need served as a basis for the decision.

The reasoning given for focusing on maternal and child health, rather than the countless other development needs, was multifaceted. Stoltenberg's 2007 speech at the World Health Assembly illustrates the multiple arguments: the moral imperative, economic benefits, global implications, urgency and feasibility:

I hope that one day we will be able to look back and to say that we did save millions of little children and their mothers, so that millions of families can rejoice over their children growing up as strong and healthy members of their communities… Every 3 seconds a child dies, and every minute a pregnant woman dies in our globalised world. All together over 10 million deaths every year. This is unacceptable. It is a moral imperative that we take corrective action prescribed for us in the Millennium Development Goal.

… No national asset has greater value than a healthy, educated population. Few other investment yields higher rates of return than investment in health and education for all.

… We know that prosperity can bring better health. But we also now know that a healthy population is fundamental to economic growth.

… In a globalized world, disease pathogens, toxic substances as well as bad habits travel without passports and visa at unprecedented speed and scale. HIV/AIDS, drug resistant tuberculosis and new epidemics are a threat to us all. Therefore the health of our people depends profoundly on what happens in the rest of the world. This is why national and global health security has taken on new meaning. Global health security is only as strong as its weakest link.

… The time is right: We are at the half way point between 2000 and 2015. Countries, with the support of the UN, developed plans for reaching the goals on child and maternal health. We have a new Partnership for Maternal, Newborn and Child Health. It is a big challenge but we are seeing progress in many areas.

Stoltenberg repeatedly spoke from multiple perspectives, thus appealing to several logics:

As a father, I have been sensitized to the injustice that all Norwegian infants are immunized, whereas in parts of Asia and Africa only one in five receive the magic shots. As an economist, I could appreciate that immunization is the most cost-effective means of preventing disease and child mortality and that vaccine programmes are key to economic growth in poor countries. As a politician, I have the privilege to do something about it (Stoltenberg, 2006b).

This reasoning offered clear, compelling arguments that were easy to communicate to high-level leaders and the general public. Leaders from countries with high maternal

7 Across the 16 indicators and 10 regions assessed in the 2005 MDG Progress Chart, 60% were not expected to be met by 2015, including those on which no progress had been made or where there had been deterioration or a reversal. Tuberculosis and sanitation projections were similar to those on child and maternal mortality. Projections were most optimistic for girls' enrolment in primary school and improved drinking water indicators, and most pessimistic for halting and reversing HIV. Thus, child and maternal mortality were among, but not the only, areas that were lagging behind MDG targets.

and child mortality rates understood the need first-hand. For leaders in high-income countries with lower mortality rates, being able to demonstrate results of development assistance was considered particularly important, and there were few other areas in which the link between investments and outcomes (both direct and positive spill-over effects) were as visible as with children's vaccinations. Moreover, financing strategies mobilised both public funds from governments and private funds through the Gates Foundation and new financing mechanisms. For these reasons, it was not perceived to be difficult to persuade other leaders to support maternal and child health.

Similar, multifaceted messaging is reflected in statements throughout the past decade, frequently expressing the urgency of the enormous challenge and at the same time highlighting progress and opportunity (Boseley, 2007; Office of the Prime Minister, 2007; Oslo Ministerial Statement 2007; Stoltenberg, 2008, 2012; MFA, 2012; Stoltenberg and Gates, 2013; Office of the Prime Minister, 2015). This narrative is echoed in the Global Strategy (UN Secretary-General, 2010).[8] However, it was not a perspective shared by all: Clemens et al. (2007), for example, question the effectiveness of setting unreasonable expectations about the achievement of the MDGs within a short time period and the role of aid in development.

Underlying Norway's rationale for investing in maternal and child health is a steadfast commitment to and grounding in human rights (Labonte and Schrecker, 2007; Oslo Ministerial Statement 2007; Conley and Melino, 2013; Brattskar, 2014; Granmo, 2015): 'The cornerstone of Norwegian policy is to promote and respect fundamental human rights… Health is a global public good… the government's approach to global health is rights based' (MFA 2012). This commitment includes a focus on sexual and reproductive health and rights, particularly relevant for MDG 5b to achieve universal access to reproductive health, and an issue on which the country strives to be at the forefront of international efforts (MFA, 2012).

8 'With just five years left to achieve the Millennium Development Goals (MDGs), global leaders must intensify their efforts to improve women's and children's health. The world had failed to invest enough in the health of women, adolescent girls, newborns, infants, and children. As a result, millions of preventable deaths occur each year… Yet we now have an opportunity to achieve real, last progress – because global leaders increasingly recognize that the health of women and children is key to progress on all development goals… Innovations in technology, treatment and service delivery are making it easier to provide better and more effective care, and both new and existing financing mechanisms are making care more affordable and accessible' (p.4).

4.3 TIMING OF THE ENGAGEMENT

The timeline (Annex 1) illustrates the long history of efforts to reduce maternal and child mortality and to bring together different stakeholders to initiate joint action, efforts that preceded Norway's active engagement at the global level. As noted earlier, Norway's involvement began before 2005, including Brundtland's and Godal's leadership of WHO and GAVI, and intensified soon after Stoltenberg began his second term as prime minister in 2005.

The launch of the Global Campaign was not in response to a new issue or a dramatic, unexpected focusing event. Rather, it sought to raise attention to a persistent problem, known but perceived to be neglected. The MDG cycle

with its review points, particularly in 2005 and 2010, provided key moments to focus attention on progress and gaps. Prior to 2005, the MDGs were less known; the deadline seemed far away and leaders had not yet made serious efforts to begin addressing them. By 2010, there had been substantial redutions in mortality and interviewees described intervention efforts as getting stuck. Interventions that were easier to implement, like vaccinations, and with populations that were easier to reach, like women already attending clinics, were underway. What was perceived as necessary at that time was a renewed call and extra stimulus to reach the underserved parts of the maternal, newborn and child health continuum. As Section 2 discussed, a series of high-profile commitments were made in 2010, including the Muskoka Initiative and Global Strategy, which Norway had been working towards in the preceding years.

Domestically, the period of Norway's involvement in these global efforts was relatively prosperous and stable time. Key informants noted, that had the financial crisis and heightened attention to migration occurred earlier, Norway's engagement might have been different.

4.4 RELEVANCE OF THE ENGAGEMENT AND NORWAY'S COMPARATIVE ADVANTAGES

Similar to Norway's own characterisation of its more flexible, relatively light bureaucratic structure, external actors described the country's approach as nimble, adaptive, creative and entrepreneurial, and seemingly less constrained by institutional bureaucracies than other countries. This style lends itself well to advocacy, which may require greater adaptation and swift responses, than in policy implementation when rolling out a standard intervention in a predictable context.

Specific to maternal and child health, this issue area was a sector in which Norway had experience and expertise. Previous leadership of WHO and GAVI positioned the country well to coordinate global efforts and laid the foundation for the relationship with the Gates Foundation. Norway's experience with managing results-based financing systems, both domestically and particularly through GAVI, offered lessons in the development of the Health Results Innovation Trust Fund and the Global Financing Facility. And its technical advisers were well respected for their skills and contributions, as a number of interviewees noted.

Thus, advocacy on maternal and child health was an area in which Norway had several comparative advantages. Relative to the other issue areas, its experience and expertise in health was not as specialised as it was in negotiating peace agreements and managing revenue from the oil and gas sectors, in the sense that fewer countries have been involved in the latter two and many other actors are engaged in global health. The country's experience and expertise in health, however, is deeper than it is in education.

4.5 ACHIEVEMENTS AND CHALLENGES OF THE ENGAGEMENT

The aims of Norway's engagement – to cultivate political support, increase investments and improve coordination in order to reduce maternal and child mortality – are very ambitious. Achievements have been substantial but incomplete. MDG 4 sought to reduce by two-thirds the under-five mortality rate. MDG 5 aimed to reduce by three-quarters the maternal morality ratio and achieve universal access to reproductive health. Neither goal was reached by 2015, but the significant declines in both child and maternal mortality are widely considered an enormous accomplishment.

In addition to reductions in mortality, the sector context section highlighted three other key accomplishments over the past decade: the creation of new global partnerships, platforms and initiatives; new and renewed attention and commitments; and advances in knowledge and innovation. As noted, these efforts began prior to Norway's engagement and involved a number of other actors. This section discusses the perceived role and unique contributions of Norway's involvement, according to both its own perceptions and those of others.

Perspectives of the Norwegian Government

The MFA 2012 White Paper on 'Global Health in Foreign and Development Policy' characterises the country as important and visible in global health efforts:

Norway has gained an important position internationally in the field, through its political, diplomatic and technical engagement over a number of years, and we play an important role in international political processes… Today, Norway is highly visible in the field of global health, not only in terms of financial contributions as percentage of GNI, but also in terms of health diplomacy and political mobilisation (MFA, 2012a: 7).

Norad's 2013 Results Report identifies as Norway's contributions the creation of the Network of Global Leaders and contributions to the establishment and implementation of the Global Strategy, the EWEC movement and PMNCH, concluding, 'therefore, it is fair to say that the overall effect of Norwegian development cooperation is greater than the money alone would suggest' (Norad, 2013: 68).

When asked to describe their role relative to others, government representatives were all quite humble, acknowledging the role of other actors. Over the years, several people had received personal feedback from high-level officials in other countries and at the UN recognising Norway's contributions.

Perspectives from External Sources

Multiple scholars and commentators have recognised Norway's influence in global efforts to improve maternal and child health. External sources were largely positive in describing Norway's engagement. They recognised Norway

among a core group of key actors[9] contributing to achievements in maternal and child health at the global level over the past decade. Norway, however, was not noted as an active player in global networks on newborn health (Shiffman, 2015; Shiffman and Smith, 2011) or integrated community case management of childhood illness (Dalglish et al., 2015).

Being relatively early in Norway's involvement, the country and Prime Minister Stoltenberg in particular, have been recognised for their leadership in bringing renewed emphasis on MDGs 4 and 5:

9 Prominent actors mentioned by key informants and in other studies (Lie et al., 2011; Shiffman and Smith, 2011; Conley and Melino, 2013; Darmstadt et al., 2013; Dalglish et al., 2015; Shiffman, 2015; Smith and Rodriguez, 2015) included the Bill and Melinda Gates Foundation, PMNCH, the UN, including WHO, UNICEF and, to a lesser extent, the UN Development Programme (UNDP) and the UN Population Fund (UNFPA), non-governmental and civil society organisations, academic institutions including the London School for Hygiene and Tropical Medicine, Johns Hopkins University and the Institute for Health Metrics and Evaluation. Among bilateral donors, the US, UK and Canada were identified key actors. Japan, Sweden, Germany, France, Australia, the Netherlands and Ireland were mentioned but much less often. Other actors identified infrequently included the World Bank, Richard Horton and The Lancet, the UN Foundation and the African Union. Several respondents identified the role of low- and middle-income countries in global efforts – India, Mexico, Nigeria, South Africa, Tanzania and United Arab Emirates – and many spoke of the importance of leadership at the national level to reduce mortality in high-burden countries.

Bilateral arrangements between nations have enormous power to galvanise policy and action. Such liaisons do not depend on money alone. They are sustained by mutual trust and respect between nation-states. Over many decades Norway has developed a consistently internationalist world view that has been translated into progressive foreign and development policies. Norway's model carries with it important global lessons (Horton, 2006: 1041).

Norway, a country with a population of just 4.5 million, is having a disproportionately big effect on global health… Norway is publicly committed in a way that larger nations are not to the Millennium Development Goal of cutting child deaths (MDG4). Much of this is credited to the leadership of Prime Minister Jens Stoltenberg, who has made the drive for improved global health central to Norway's foreign policy (Boseley, 2007: 1027).

The leadership of current PM Jens Stoltenberg has inspired much of Norway's engagement on global health in the last decade… Norway, under Stoltenberg, played a key role in facilitating the global health and foreign policy meetings in 2006 and as host to the discussions that results in the Oslo Declaration in 2007… In Norway, leadership on global health starts at the top (Bliss, 2011: 14).

Leadership for [maternal health] took place at a higher level and outside the core network that was active in the 1980s and 1990s; in the later period [of the maternal health network], capable, connected and widely respected, Ban, Brown and Stoltenberg provided leadership that drew policy attention at the highest levels of government and resulted in significantly expanded resource commitments to maternal alongside other closely linked health issues. It is unlikely commitments on the scale of the Global Strategy could have been achieved by 2010 without them (Smith and Rodriguez, 2015: 8).

In 2011, Stoltenberg and Godal were included in Women Deliver 100, recognising the most inspiring individuals delivering for women. That same year the UN Foundation presented Stoltenberg the Global Leadership Award.

Previous evaluations found Norway contributed to lasting changes in the international aid architecture and in fostering country ownership (HIV response evaluation 2008) and that the Health Results Innovation Trust Fund contributed to increased awareness of results-based financing within the World Bank and countries where it has given support (trust fund evaluation 2012).

Multiple sources characterised Norway's influence as disproportionate to the country's size, often using the term 'punching above its weight' (Boseley, 2007; Conley and Melino, 2013). Key informants described Norway as a first mover and a leader to emulate. They spoke of individuals' passion for the issue and strong technical skills. Interviewees commented on the persistence and persuasiveness of key individuals who could think outside of the box, embraced an attitude of 'let's get it done' and relentlessly pursued a number of avenues to prompt action – a vision and dedication that was thought very rare.

Norway was seen as playing a convening role, leading from behind, and as a country that recognised the importance of not going it alone – so much so that several people remarked that they did not know Norway's specific actions within broader movements or the details of what happened behind the scenes. Although it was largely seen as collaborative, Norway was perceived to have engaged the private sector less than it had other governments and NGOs, and less than other bilateral agencies. This is reflected in the MFA 2013 report on 'Norwegian Actors' Commitment to Global Health', which includes 20 NGOs, more than a dozen research institutes and universities and two private sector organisations.

Relative to other actors, Norway was perceived as less ideologically driven and pushing its own political agenda; rather, in some cases, it is willing to put the interests of the broader movement above its own. This willingness, along with funding to back up political commitments, was thought to give Norway greater credibility, legitimacy and trust. Some interviewees saw Norway as a strong defender of rights; others expressed disappointment that a rights-based focus was not more prominent in Norway's global health efforts.

When asked about Norway's efforts, external interviewees overwhelmingly referred to **specific individuals and to global initiatives and platforms.** In contrast, external sources seldom mentioned the Global Campaign or the Network of Global Leaders. The Foreign Policy and Global Health Initiative was predominantly discussed in the academic literature and not referenced by interviewees.

As noted, individuals within and outside of Norway consistently cited Stoltenberg's leadership. Many interviewees specifically named Tore Godal and Helga Fogstad, Norad's current director for global health, education and research. In addition to key individuals, informants associated Norway with global initiatives and institutions like GAVI, PMNCH, Countdown, the Global Strategy, WHO and the Global Financing Facility.

When the Global Campaign was mentioned, it was perceived to resonate less well at a country level and to be less influential as a campaign itself relative to specific initiatives in which Norway played a leading role, like the Global Financing Facility and Commission on Life-Saving Commodities. Fidler's (2011) analysis of the Foreign Policy and Global Health Initiative is sceptical of the influence of this effort and its ability to sustain political attention on global health. Academic discussions of health diplomacy appear to have tapered off in recent years.

Associating Norway's role with individuals and institutions rather than specific campaign activities may reflect in part the small number of individuals involved in Norway's global health work and Norway's approach of leading from behind. Sandberg and Andresen (2010) observe that much of Norway's engagement is based on personal relationships, with more formal processes established after initial agreements have been made.

Continued Challenges

Corresponding to three key achievements – declines in child and maternal mortality; new global partnerships, platforms and initiatives; and high-level attention and commitments – are three accompanying challenges: the unfinished agenda; reducing fragmentation and structuring cross-sector collaboration; and maintaining political support and developing sustainable resource flows. These challenges are those confronting the field as a whole, with implications for Norway's engagement.

While encouraged by the significant progress that has been made, a number of interviewees commented on the **unfinished agenda**: the challenge of reducing preventable deaths for millions more women and children. This will entail working in more complex environments, including fragile states and humanitarian settings, where mortality rates are among the highest; working more with health systems and on human resource issues; developing urban health systems that in some places are less organised than those in rural areas; working more closely with private health care providers; addressing gender equality and power imbalances; and better integrating sexual and reproductive health into the maternal, newborn and child health continuum – an issue that has faced greater political resistance in the past. The previous lack of integration of reproductive health and family planning was a theme that emerged prominently in interviews.

New global partnerships, particularly PMNCH and EWEC, have made great headway in reducing silos among separate networks of people working with women, newborns and children. At the same time, key informants noted concerns about the persistent tendency to create new projects, rather than supporting existing initiatives, and the **fragmentation** this causes. They observed some continued competition and protectionism of particular areas. Even among interviewees, they expressed differences of opinion in terms of the relative allocation of resources and in their surprise that some groups have received more and less attention than others.

Interviewees recognised that specific issues within the continuum of care and within health systems may need to be highlighted, but in a coordinated, synergistic way. *'Partners need to come together, each bringing their comparative advantage to the table – each playing their part to create harmonious music like in a philharmonic orchestra instead of random ineffective pieces of noise.'* Working with so many actors raises the potential of role overlap, avoiding which requires a clear division of roles based on the added value of each organisation.

Moreover, there has been increasing recognition of the importance of other development areas in influencing health and the need to address broader economic, social and environmental determinants of health. Half of the decline in child mortality since 1990 is attributed to changes in sectors other than health (Kuruvilla et al., 2014). Expanding **cross-sectoral collaboration** and determining how to structure these interactions and the financing poses a formidable challenge.

Third, interviewees mentioned the need to **maintain political support and develop sustainable resource flows.** Several key leaders who have championed this issue have or will be transitioning out of their current positions, so attention may shift elsewhere. Although resources for maternal and child health have been growing, key informants acknowledged that sustainable resourcing for health would require sufficient and dedicated domestic resources. How best to balance domestic, international and private sector resources and provide health insurance and financial protection for the poor remains an unanswered question.

Finally, although this review was focused on efforts at the global level, many interviewees spoke of the need to **translate global efforts to national and subnational change.** They acknowledge that, while advocacy and building partnerships has been very important, these efforts need to be followed through with visible actions and improvements at the national level, or the movement risks losing momentum and commitments. This shift highlights the importance of leadership at the national level and of investing in capacity. It may involve refocusing attention from the global to national and subnational spaces, and devolving some efforts that have previously taken place through global venues, often based in high-income countries.

4.6 PERCEIVED DRIVERS OF CHANGE

When interviewees were asked what factors had contributed to changes at the global level and why they had happened when they did and not before, later or not at all, they highlighted three interrelated factors: growing momentum of a diverse movement; high-level support accompanied by financial resources and technical capacity; and new information that quantified the problem, solutions and progress – key themes that are reflected throughout this report.

The most commonly mentioned driver of change was the **growing momentum of the maternal and child health movement and formal structures** to push changes forward, particularly PMNCH and EWEC. These networks

are more mature and coordinated than in previous years, and much more diverse. Global efforts have been strengthened by increased investments in advocacy and the involvement of new players, like Bill Gates, who could access heads of state.

Attention to the issue was also at a higher political level than ever before. Previous global convenings involved ministers of health, rather than heads of state and government and ministers of finance and foreign affairs. Compared with requests from a single minister, directives from a head of state can generate faster and greater action, both within their government as well as with the private sector and other governments. Interviewees spoke of the significance of this level of support, of the *'power of a phone call when you talk from one head of state to another'*. As Conley and Melino (2013) note, 'improved coordination mechanisms, greater involvement of CSOs [civil society organisations] or financing innovation will never be a substitute for political leadership' (p.18).

Norway has been able to provide political leadership at the global level because of the **sustained commitment of its highest-level political leaders.** The Norwegian government has expressed consistent support for child and subsequently maternal health over time (MFA, 2008, 2012, Brattskar, 2014; Solberg, 2014, 2015a; MFA, 2015a, 2015b):

Norway is working on all 8 Millennium Development Goals… but we have made the decision to contribute in a special way to actually achieving the MDG No. 4 on reducing child mortality by two-thirds by 2015. I want to see this achieved (Stoltenberg, 2006).

Vaccination programmes for children in the poorest countries is one of the government's main priority areas. The Government has extended these efforts to include maternal health. Norway now plays a leading role internationally to ensure that the Millennium Development Goals on maternal and child health are reached (HM The King, 2009).[10]

Norway is committed to global health and the revised global strategy… Our priority is to lift women, child and adolescents out of poverty by investing in their health (Solberg, 2015).[11]

UN Secretary General Ban Ki-moon and Stoltenberg were committed to the issue from a personal as well as a political perspective, both speaking publically about experiences with their own families. This ability of Norway's leaders and technical team to connect the political to the personal was perceived to have been quite influential.

10 In this 2009 report, maternal and child health was discussed second after statements on the global economy and unemployment, and before addressing efforts to prevent war, poverty, climate change and domestic health.

11 Current Prime Minister Solberg has indicated that her top development priority is education, which she has linked as a determinant of health (2015a, 2015b), enabling people to make informed choices (2014). Some interviewees viewed the focus on health as linked to education as recognition of the importance of a cross-sector, holistic approach; others expressed concern that attention to global health may be waning. Interviewees not affiliated with the government raised the latter perspective. Key informants from Norway, particularly the government, and feedback on the draft case study from Norad and MFA staff asserted and provided examples of continued support for health by the current administration.

Moreover, **significant financial resources and strong technical capacity backed up** this political support. Both government and external interviewees spoke of the important relationship between the three. Norway has aimed to be strategic in how its financial contributions are allocated, often being one of the first donors to provide financing through a new mechanism, as has been the case with GAVI, the Health Results Innovation Trust Fund and the Global Financing Facility. A highly competent team with direct access to the prime minister supported political and financial commitments.

Third, **new information** quantified the magnitude of the problem, cost-effective solutions and progress toward MDG targets. Countdown to 2015 and other sources of information monitored changes, and lack thereof, demonstrating gains that could be achieved within a politician's timeframe. Evidence served as the basis for tailored messaging strategies for different constituency groups, and was perceived to be particularly important in fostering dialogue on these issues among diverse stakeholders.

Together, there was a confluence of interests, who took advantage of a window of opportunity. Advocacy efforts were evidence-based and targeted at the right level in the right place. And the support it generated was not simply financial but also strategic in terms of where and how it was used.

Additional contributing factors mentioned included growing realisation that previous efforts, like sector-wide approaches, had not worked as well as hoped; the change of government in 2005 in Norway; increasing expectations by citizens of their governments and of the right to health; community mobilisation; and behaviour change. International development in general is well supported across the political spectrum and by the Norwegian public; thus, these efforts did not face opposition.

4.7 SUSTAINABILITY OF THE ENGAGEMENT

Norway is still engaged in global efforts to improve maternal and child mortality, so this case is not able to offer insights into how and why engagements end, or to determine the sustainability of Norway's investments following its withdrawal. That said, key characteristics of Norway's advocacy approach and continued challenges identify several opportunities and concerns related to the sustainability of Norway's efforts.

On the one hand, Norway's approach of working with others and creating new platforms and financing mechanisms provides formal, structured ways for activities to continue when Norway is less involved or not at all. Improved data has helped define targets for subsequent initiatives and the Sustainable Development Goals (SDGs) based on what could realistically be expected in a given timeframe, working towards absolute rather than relative changes for example. At the same time, stakeholder participation in these platforms, attention by new political leaders and resourcing the continued inputs needed for health systems

to operate all remain vulnerable to weakening over time. Solberg's prioritisation of education and the combined health goal as one of 17 goals in the SDGs rather than three of eight goals in the MDGs may dilute the focused attention maternal and child health received in the Stoltenberg and MDG eras.

5. Conclusions

Global efforts to improve maternal and child health reflect the growing momentum of a number of actors and networks over the past three decades, peaking in 2010 with the Global Strategy for Women's and Children's Health and the multi-sector EWEC movement. Norway's engagement, too, represents an evolution of the country's involvement and leadership in global health and a core group of individuals, both political and technical, dedicated to these issues for decades and intensifying during Stoltenberg's second term as prime minister. The MDGs provided a framework and timeline for these efforts. Improved data has documented substantial declines in maternal and child mortality since 1990. Challenges remain, including accessing harder-to-reach population groups; structuring cross-sector work to avoid silos and fragmentation; and maintaining political support and developing sustainable resource flows.

For the time period under study (2005–2014), Norway engaged in global efforts through political leadership, diplomacy and economic support, working with others and through multilateral processes, often behind the scenes, promoting evidence-based policy-making and aiming to be flexible and innovative in trying new ways of working and financing. The country's focus on maternal and child health was driven by the availability of cost-effective interventions to address an unmet need, a rights-based moral imperative and the broader economic benefits and global effects of health.

This case highlights the significance of sustained political support at the highest level, accompanied by financial resources and strong technical capacity, in order to set global agendas and mobilise a diverse group of stakeholders. Political support and joint action were facilitated by information that quantified the magnitude of the problem, identified potential solutions and monitored progress towards results. Furthermore, this case illustrates the decades-long timeframe and continuous efforts needed to raise and sustain attention and resources, and to implement programmes to ultimately affect change in people's lives. These lessons are relevant for global and Norwegian efforts in other development areas.

Aspects of maternal and child health both facilitate and complicate advocacy around this issue area. Relative to illicit financial flows and women, peace and security, health is an issue that directly affects everyone. It is relatable and personal, with highly visible consequences that are easy to communicate. Moreover, the cross-border nature of disease epidemics and commodity and health workforce flows is more evident in health than it is in other development issues. Core maternal and child health indicators are relatively straightforward to measure, to calculate the return on investment for and to assess over shorter timeframes compared with education or gender relations. Innovation, which has played a large role in the field of health, may be less straightforward in other areas. For example, some concerns have been raised about the effects of digital tools in education on learning and cognitive development.

At the same time, women and children represent population groups with relatively little power and are less well mobilised. Children cannot vote. Unlike HIV activists, there are no movements of husbands who have lost their wives or parents who have lost their children. Describing in a simple way innovative financing mechanisms like volume guarantees and the use of capital markets to mobilise funds is difficult. There are many subspecialties in health, so other development areas with a more concentrated base may have to devote less attention to developing partnerships.

Two final lessons are worth noting. First, there have been longstanding debates in global health about how best to balance targeted, vertical approaches and horizontal systems strengthening in order to achieve a more integrated 'diagonal' approach (Oliveira-Cruz et al., 2003; Mills, 2005; Uplekar and Raviglione, 2007; Ooms et al., 2008; Behague and Storeng, 2008 Atun et al., 2010; Hafner and Shiffman, 2013). This case illustrates a progressive expansion of what was initially a quite targeted approach, focusing first on vaccines and later expanding to child health more broadly, then to maternal health and subsequently newborn, reproductive and adolescent health; and as an initiative first housed in the Office of the Prime Minister and later integrated into MFA and routine development programming. This experience suggests the importance of starting with a narrower focus in order to secure attention and resources, which is subsequently broadened in scope and integrated in practice to reduce fragmentation and facilitate implementation and sustainability.

Second, Norway's role in global efforts was associated with specific individuals and with global partnerships and platforms, much more so than the particular initiatives the country launched to raise attention to maternal and health: the Global Campaign for the Health MDGs, the Network of Global Leaders and the Foreign Policy and Global Health Initiative. Norway was acknowledged as being among a core group of actors contributing to global achievements. Had Norway focused on showcasing and assessing the *means* (specific initiatives) rather than the *ends* (reductions in mortality, new global platforms, political and financial commitments, advances in knowledge and innovation), it may have distracted attention and potentially reduced its influence. Assessing its progress by counting the number of time the Global Campaign was cited, for example, would have substantially underestimated Norway's involvement. Thus, this case suggests the importance of pursuing a flexible strategy that acknowledges that ultimate goals can be attained in various ways, and of assessing achievements and contributions accordingly.

Annex 1: Timeline

Year	Milestone
1981	Dr Gro Harlem Brundtland takes office as prime minister (subsequent terms 1986–1989, 1990–1996)[1]
1982	Child survival initiative launched, led by UNICEF's James Grant[2]
1987	WHO, World Bank and UNFPA sponsor first international Safe Motherhood Conference; Inter-Agency Group for Safe Motherhood forms and launches global initiative[3]
1990	World Summit for Children[2]
1992	WHO Integrated Management of Childhood Illness strategy developed[4]
1994	International Conference on Population and Development Programme of Action sets maternal mortality reduction goals[3]
1998	Brundtland appointed director-general of WHO[1]
	WHO sponsors World Health Day Call to Action for maternal health[2]
1999	The Bill and Melinda Gates Foundation founded
2000	Jens Stoltenberg takes office as prime minister (2000–2001), declaration addresses global health and child mortality[5]
	GAVI launched, Dr Tore Godal appointed CEO (1999–2004)[1]
	UN Millennium Declaration[1]
	Healthy Newborn Partnership established[1]
2001	WHO Commission on Macroeconomics and Health[1]
2003	*The Lancet* series on child survival[4]
2004	Child Survival Partnership created[1]
	USAID launches ACCESS, a $75 million maternal and newborn health programme[2]
	UK becomes first bilateral donor to publish a maternal health strategy[3]

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Year	Milestone
2005	Stoltenberg takes office as prime minister (2005–2013), Soria Moria Declaration[5]
	Godal recruited as special adviser for global health[5]
	Delhi Declaration on Maternal, Newborn and Child Health issued;[3] PMNCH created[1]
	First Countdown to 2015 conference in London[1]
	WHO World Health Report focuses on maternal, newborn and child health[2]
	First *Lancet* newborn survival series[2]
2006	MDG 4 team in Norad established[5]
	Stoltenberg announces need for a Global Business Plan for Women's and Children's Health in UNICEF High Level Meeting, UN General Assembly side-event[5]
2007	Oslo Ministerial Declaration: Foreign Policy and Global Health
	Technical strategy meeting with DFID in London, planning meeting in Hadeland[5]
	International Health Partnership launched in London[5]
	Global Campaign for the Health MDGs launched in New York[5]
	Network of Global Leaders established[5]
	First Women Deliver conference in London, State Secretary Morten Wetland holds closing address[3]
	MDG Target 5b added: Achieve, by 2015, universal access to reproductive health[1]
	Deliver Now for Women and Children advocacy campaign launched by PMNCH in New York[5]
	Lancet maternal survival series[3]
	World Bank launches Health Results Innovation Trust Fund[1]
2008	Global Campaign for Health MDGs Progress Report released, First Year Report launched at UN General Assembly[5]
	Stoltenberg and President Kikwete launch Deliver Now for Women and Children Tanzania and the One Plan
	Deliver Now Latin America and Caribbean initiative launched by Chilean President Bachelet and Prime Minister Stoltenberg[5]
	High Level Committee on Innovative Financing for Health announced, Stoltenberg a member[5]
	Countdown to 2015 adds newborn and maternal survival to its child survival mandate[3]

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Year	Milestone
2009	Consensus for Maternal, Newborn and Child Health launched at Healthy Women, Healthy Children: Investing in Our Common Future UN event organised by High-Level Task Force on Innovative International Financing for Health Systems and PMNCH
	G8 Declaration includes a section on Promoting Global Health, supports a global consensus on maternal, newborn and child health
	Stoltenberg and US President Obama announce cooperation on health development aid[5]
2010	Global Health Expert retreat hosted by UN Secretary-General in New York, Godal participates
	World Health Assembly: first version of draft Global Strategy for Women’s and Children’s Health presented[5]
	Women Deliver Conference in Washington, DC, Godal presents[5]
	Muskoka Initiative announced at G8 meeting in Canada, pledging $7.3 billion for maternal, newborn and child health[1]
	UN Secretary Ban Ki-moon launches Global Strategy for Women’s and Children’s Health in UN General Assembly, EWEC special event, Stoltenberg speaks at EWEC and MDG summit[5]
	African Union heads of state make formal declaration of support for maternal, newborn and child health[3]
2011	Commission on Information and Accountability announced, Foreign Minister Jonas Gahr Støre a commissioner, presents findings to UN Secretary-General and World Health Assembly, independent Expert Review Group announced to follow up on recommendations and monitor commitments to EWEC[5]
	World Economic Forum in Davos, Stoltenberg speaks on private sector engagement for maternal and child health[5]
	EWEC Innovation Working Group established, co-chaired by Godal[5]
2012	Inter-Parliamentary Union passes resolution calling for parliaments to take action on MDGs 4 and 5[3]
	US, Ethiopia and India convene forum for heads of state on child survival[3]
	A Promise Renewed launched, an initiative to end preventable child deaths[2]
	UN Commission on Life-Saving Commodities launched, co-chaired by Stoltenberg[5]
2013	Accelerating Progress: Saving Women's and Children's Lives conference in Oslo, global health seminar with Bill Gates, Stoltenberg presents Global Campaign report[4]
	Erna Solberg takes office as prime minister
2014	Every Newborn Action Plan endorsed at World Health Assembly, launched by PMNCH[2]
2015	Oslo Summit on Education for Development[5]
	Global Financing Facility launched at Financing for Development summit in in Addis Ababa[5]
	UN General Assembly adopts 2030 Agenda for Sustainable Development[1]

Sources: 1 organisation websites; 2 Shiffman (2015); 3 Smith and Rodriguez (2015); Dalglish et al. (2015); 5 Norad

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Acronyms and abbreviations

CSO	Civil Society Organisation
EU	European Union
EWEC	Every Woman Every Child
GAVI	Global Alliance for Vaccines and Immunization
GNI	Gross National Income
IHME	Institute for Health Metrics and Evaluation
INGO	International NGO
MDG	Millennium Development Goal
MFA	Ministry of Foreign Affairs
NGO	Non-Governmental Organisation
Norad	Norwegian Agency for Development Cooperation
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
PMNCH	Partnership for Maternal, Newborn and Child Health
SDG	Sustainable Development Goal
UK	United Kingdom
UN	United Nations
UNDP	UN Development Programme
UNFPA	UN Population Fund
UNICEF	UN Children's Fund
USAID	US Agency for International Development
US	United States
WHO	World Health Organization