European Population Forum 2004:
Population Challenges and Policy Responses

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# Official development assistance levels and spending for sexual and reproductive health and rights since the ICPD.

Background paper for the session on:
Global Population and Development Trends: the European View.

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# Official Development Assistance Levels and Spending for Sexual and Reproductive Health and Rights since the ICPD

Background Paper for the Session on
'Global Population and Development Trends: the European View'

**In the context of the UNECE European Population Forum 2004: Population Challenges and Policy Response**

**12-14 January 2004**

**Geneva – Switzerland**

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**28.11.2003**

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# INTRODUCTION

International support for a set of development targets has become universal in the development community since the 1990s. The United Nations (UN) has held a series of conferences over the past decade to address the critical problems facing humanity, such as the 1992 Earth Summit in Rio, the 1995 Copenhagen Summit on Social Development, the Beijing Summit on Women and the 1996 Summit on Human Settlements in Istanbul. Among these conferences was the International Conference on Population and Development (ICPD) in Cairo in 1994, which is seen as a watershed in international thinking and policy-making in the field of sexual and reproductive health and rights (SRHR) and development. After years of population policies aimed at reducing fertility through family planning, at Cairo, the community of nations adopted a new paradigm. It called for the dropping of demographic targets and, in their place, the substitution of services that respond to the full range of reproductive health needs, especially of women. Emphasis was placed on the individual rights and needs of people and the priority became the freedom of choice and improvement of services.

The Programme of Action of the ICPD formulated a number of recommendations and goals, including that government should:

- strive to increase Official Development Assistance (ODA) and budgets for SRHR and development;
- provide access through primary healthcare systems to reproductive health for all individuals of appropriate ages, including safe and reliable family planning methods, as soon as possible and no later than 2015;
- reduce the 1990 rate of infant and children under-five mortality rate by two-thirds and the maternal mortality rate by three-fourths by the year 2015;
- progress towards gender equality and the empowerment of women should be demonstrated by eliminating gender disparity in primary and secondary education by 2005.

Most recently, during the 2000 UN General Assembly, the largest number of government leaders ever to meet adopted the Millennium Declaration, which collectively committed them to work to free the world from extreme poverty. To achieve that end, these governments endorsed the Millennium Development Goals (MDGs)[1], a set of specific development objectives to be achieved by 2015. The MDGs sharpen the focus on alleviating poverty by, among other things, improving specific health and social conditions. Whereas the MDGs do not address certain objectives of the ICPD Programme of Action, such as achieving universal access to reproductive health services by 2015, four of them underline the importance of SRHR. They include improving maternal health, combating HIV/AIDS, promoting gender equality, empowering women and reducing child mortality.

In the context of the European Population Forum 2004 of the United Nations Economic Commission for Europe (UNECE), IPPF European Network (IPPF EN) has been invited to write a background paper for the thematic session on '*Global population and development trends: the European View*'. The aim of the paper is to give a general overview of donors' performances in ODA and SRHR funding since the ICPD. It also describes the trends and evolutions in development which could impact the further implementation of the ICPD Programme of Action. IPPF EN relied on its professional experience and involvement in monitoring donors policies in the context of its DAC Watch[2] project to draft this document. Among other sources, it is based extensively on the research and data gathered for the 'DAC Watch Compilation[3]' and the 'Euromapping[4]' exercise.

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[1] See http://www.developmentgoals.org/ for more detailed information

[2] See background chapter for a description of the DAC Watch project (page 4)

[3] See '*The DAC Watch Compilation: an overview of donors' performance in sexual and reproductive health*', IPPF EN, 2002

## Background: What is the DAC Watch Project?

### ❖ The OECD Peer Review Process

The Peer Review process of the Development Assistance Committee (DAC) of the Organisation for Economic Cooperation and Development (OECD) is a critical evaluation of a country's performance in its overseas development assistance strategy. The DAC[5] conducts these periodic performance assessments "*to improve the individual and collective development co-operation efforts of DAC Members*". The policies and efforts of individual Members are reviewed approximately once every four years and some five programmes are examined annually. The 'Peer Review' is prepared by a team, consisting of representatives of the DAC Secretariat working together with officials from two DAC Members who are designated as examiners.

### ❖ The actual "DAC WATCH" Project and the Shadow Peer Reviews

IPPF EN's "DAC Watch" project broke new grounds in establishing an effective "Watch" of the OECD/DAC peer review process. The goal of this "Watch" is to raise the awareness of donor governments of the need to contribute to sexual and reproductive health and rights (SRHR). By contributing to the 'Peer Review' process of the DAC, IPPF EN strives to ensure that the commitments arising from the ICPD on policy and resource requirements in relation to reproductive health are an integral part of each country's Peer Review.

IPPF EN, in collaboration with relevant national Family Planning Associations (FPA) and other Non-Governmental Organisations (NGOs), initiates independent evaluation known as the "*Shadow Peer Reviews on sexual and reproductive health and rights*". These reports are designed to contribute to the reviewing countries' task, by providing them with accurate and expert information focused on the SRHR aspects of development and cooperation. NGO participation in the DAC Review Process is essential and ensures that final country reports reflect civil society expectations, expertise and agenda.

Each Shadow Peer Review is composed of two sections:

- a short overview of the country's development policy, its main goals
- an assessment of the policies dealing with SRHR and an analysis of the financial contributions to these issues.

The DAC Watch draws its strengths from the expertise IPPF EN brings to the DAC officials, thereby giving them the necessary information to raise SRHR issues in the official review of a donor country.

The Shadow Peer Review is also used by the FPAs and other NGOs to facilitate contact with their national DAC representatives. Its major use is to raise awareness of the country performance at national level. The Shadow Peer Review is widely used in advocacy work.

The Shadow Peer Reviews are moreover recognised as an authoritative source of information on population and SRH issues by other actors, including development research institutions, parliamentarians and other international organisations such as UNFPA. Information from the 'DAC Watch project' has been extensively used to feed in this paper.

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[4] The 'Euromapping' project is a monitoring exercise done by DSW and IPPF EN which aims at strengthening European advocacy and mobilising public funding in the fields of population, sexual and reproductive health and HIV/AIDS. For more information, consult: www.eurongos.org/resources/euromapping/

[5] The DAC is composed of the 23 major donor countries to development assistance: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Japan, Luxembourg, the Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, the United Kingdom, the United States and the Commission of the European Union

# 1. Levels of Official Development Assistance in DAC countries: a decade of history

Development aid became a major feature of international relations and cooperation after the Second World War and especially after the widespread achievement of independence in the late 1950s. Official Development Assistance (ODA) has long been the principal source of funds for financing development and its importance was repeatedly emphasised in the 1990s during the several UN conferences. It was reminded that important levels of aid are required to help finance progress towards the new international development goals. This is particularly true for reaching the objectives of the Programme of Action of the ICPD and the MDGs directly related to SRHR.

The donor community consistently reaffirmed their commitment to dedicated larger shares of their budget to ODA during these years. However, the historical development relating to ODA denies these promises: there is indeed a clear downwards trend in the ODA volumes over the last decade. In order to have an overview, let's analyse how much has been given to aid over time and what the actual situation is. Are these levels sufficient to significantly impact on development? What are the perspectives for the future? These questions are addressed in this chapter on ODA levels.

## 1.1 A long-standing target for ODA: 0.7% of GNI to ODA

Whereas the need for ODA had been early recognised by the donors' community in the 1950s, a consensus on a minimum level to reach in order to have an impact on development has been hard to find. The notion of having such a target for development funding was first suggested in 1958 by an NGO, which proposed that 1% of the developed countries Gross National Product (GNP) be transferred to the developing countries in the form of grants and loans. Ever since, the measurement, content and implementation of a target have been major issues in the development negotiations. Years passed in discussion before the idea was accepted that each developed country should attempt to transfer to developing countries a net amount of at least 0.7% of their GNP for global development. That target was first proposed in 1969 in the Report on International Development, led by former Canadian Prime Minister L. Pearson. This figure has today been widely accepted as a reference target for ODA by the OECD/DAC. Endorsed by the UN General Assembly in 1970[6], it was part of the international development strategy for that decade and it has since then often been reaffirmed at several of the UN conferences of the 1990s, including the 1994 ICPD.

## 1.2 Decline in ODA volumes and ODA/GNI ratio over time[7]

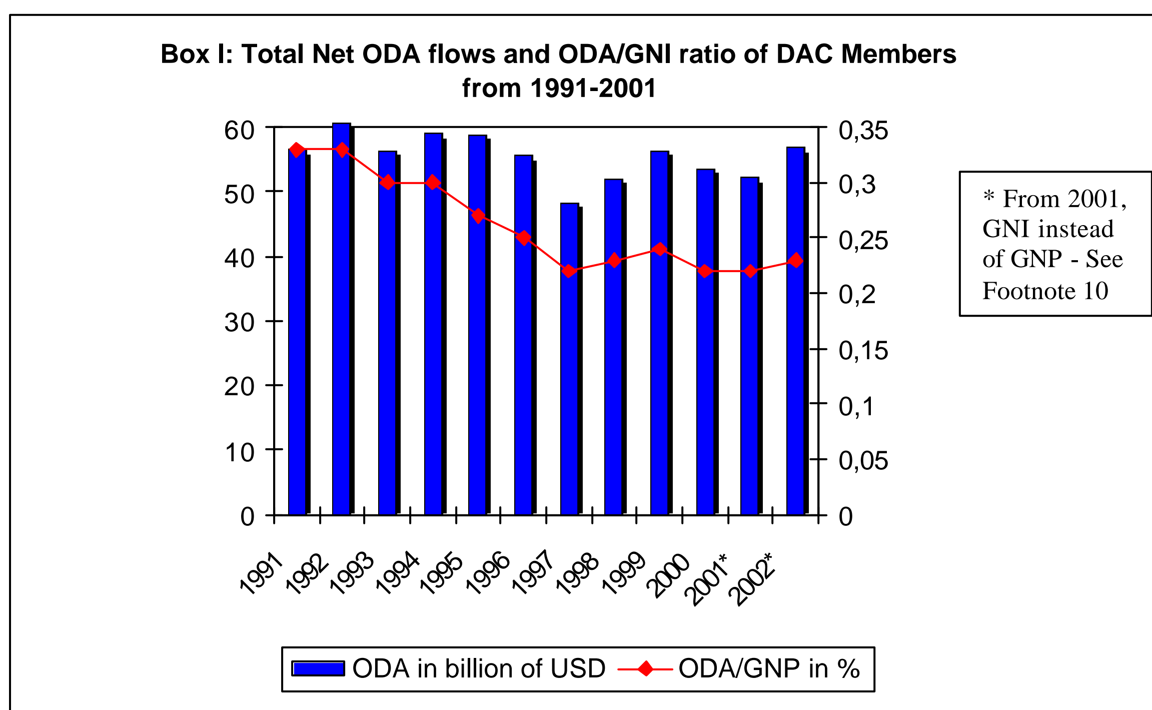
Whereas in the mid-1960s, achieving the UN 0.7% target appeared to be realistic as ODA amounted to about 0.5% of the GNPs of the developed countries, the three next decades offered less optimism. In the 1970's, instead of gradually rising to the target level, aid declined steadily to about 0.29% of GNPs in 1973. Thanks to real increases in ODA volumes in the late 1970s and 1980s, the ODA/GNP ratio experienced a slight jump to around 0.35%.

[6] Not all donors endorsed the UN 0.7% target. The US for example never committed to this figure.

[7] Source: ODA figures from the OECD/DAC (comparable data over time and across countries)

However, from the beginning of the 1990s, total ODA flows started declining. Between 1991 and 1997, net ODA fell by 8 billion USD from 56.6 to 48.4 billion USD. Over this period, the ODA/GNI ratio steadily declined from 0.33% in 1991 to 0.30% in 1993 and finally to 0.22% in 1997. In other words, overall ODA clearly decreased since the ICPD. (Box I)

In the late 1990s and early 2000, ODA flows stopped declining but fluctuated between a high level of 56.4 in 1999 and a low level of 52.3 billion USD in 2001. These changes in ODA volumes did not allow a catching-up with the higher levels of the beginning of the decade (still below the all-time high level of 60.8 billion USD in 1992 and the ODA level given one year after the ICDP (59.1 billion USD)). Neither was there a take up of the ODA/GNI ratio which remained on average at 0.22%. This is the smallest share of donors' GNP given to aid since statistics on aid first began to be collected in the 1950s. A general decrease in the ODA/GNI ratio occurred from 0.33% prior to ICPD to 0.22% in 2001. (Box I)




When looking at 21 DAC donors[8], it comes out that 11 countries increased their ODA after ICPD: Belgium, Denmark, Finland, Ireland, Luxembourg, New Zealand, the Netherlands, Norway, Spain, the UK and the US. However, 10 other decreased it: Australia, Austria, Canada, France, Germany, Italy, Japan, Portugal, Sweden and Switzerland.

## 1.3 The situation in 2002 - The start of a recovery?[9]

### 1.3.1 Overall ODA levels

From 2001 to 2002, DAC member countries increased their ODA levels by 4.9% in real terms. Total ODA amounted to 57 billion USD, equivalent to 0.23% of the total donors'

[8] Excluding Greece (as it entered OECD DAC only in 1999) and the European Community
[9] The 2002 DAC ODA figures are the latest comparable data available.

Gross National Income (GNI)[10]. These figures could mark the beginning of a recovery from the all-time low level of 0.22% of GNI in each of the last 2 years.

### 1.3.2 Distribution of ODA volumes per donor country (Annex I - A)

The donor countries' contributions to ODA are very uneven: only 6 of the 22 countries have an ODA level above 3 billion USD whereas 9 do not even reach a total level of 1 billion USD. Moreover, almost 2/3 of total DAC ODA originates from EU sources (62%).

The US remained the world's largest aid donor in volume terms for the second year running followed by Japan (the US has overtaken Japan for the first time since 1992 in 2001). It is however interesting to note that the total contribution of the EU Member States plus the European Commission payments for ODA (35.6 billion USD) represents an amount more than triple the US spending on ODA (12.9 billion USD). Germany, France and the United Kingdom are the following leading donors after the US and Japan.

2002 is seen as a promising year. 12 of the 22 DAC member countries reported an increase in ODA in real terms (of which 7 are EU Member States (MS)). For 9 of them, the increase was over 10%. The most significant increases were seen in Greece (+34.2%), Italy (+31.5%) and Ireland (+25.4%). Yet, still 10 DAC countries saw a decrease in their aid contributions in real terms but the scale of these decreases was proportionately smaller than the scale of the increases. For only 2 countries was this fall of more than 10%. ODA fell indeed markedly in Austria (-16.5%) and Spain (-15.7%) compared to their 2001 levels[11]. Denmark and Switzerland experienced more modest cuts of respectively 6.4% and 5.6%.

### 1.3.3 Classification of donors according to their ODA/GNI ratio (Annex I – B)

The donor countries can clearly be classified in three major groups according to their generosity. The first group are the best performers. Denmark, Luxembourg, the Netherlands, Norway and Sweden are the only 5 countries to meet the UN ODA target of 0.7% of GNI. Only 2 other countries, Belgium and Ireland, have reached levels above the average country effort of 0.40%. A positive sign is that these countries, together with France, gave a firm date to reach the 0.7% target: Belgium by 2010; Ireland by 2007 and France by 2012. All these countries are located in Europe, mainly in the Northern part.

The second group are the average performers: about 1/3 of the DAC countries have an ODA/GNI ratio between 0.25% and 0.40%, namely countries located in the centre of the Europe (France, Switzerland and Germany) but also the United Kingdom, Finland and Canada.

Finally, a majority of the DAC countries have an ODA/GNI ratio below 0.25%. These least generous countries are mostly located in the southern part of Europe (Portugal, Spain, Italy and Greece) plus Austria. The other countries of this category are DAC members outside of Europe: Australia, New Zeeland, Japan and the US. About the US, it is important to note that whereas it is the major donor in volume terms, it has the lowest ODA/GNI ratio of all DAC countries (0.12%). Even with an increase of its ODA by 11.6% in 2002[12], the US remains the least generous donor in the world and this for the 9th consecutive year.

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[10] GNI: Gross National Income. In 2001, the DAC Members introduced a new system of National Accounts, which takes into account GNI instead of GNP. GNI = GNP + net receipts of primary income from non residents sources. GNI and GNP are however very similar and this change does not make significant differences in the statistics, which remain comparable.

[11] These levels had been boosted by exceptional debt relief operations in 2001.

[12] These increases were mainly due to additional and emergency funds in response to the 11 September 2001 terrorist attacks as well as new aid initiatives, especially in relation to humanitarian aid.

### 1.4 Funding gap, future requirements and recent new commitments

These recent increases in aid are the first results of the general commitments made by donors' countries to increasing their ODA to developing countries in the context of the International Conference on Financing for Development held in Monterrey, Mexico, in March 2002[13]. At this UN gathering, emphasis was laid on the inadequate actual levels of total ODA for reducing poverty and reaching the MDGs. Rough estimated costs for achieving the agreed international goals were presented[14]. An additional ODA of 50 billion USD per year was said to be required for each of the next 12 years. This represents an increase from approximately 57 billion USD of ODA in 2002 to 100 billion USD per year.

#### 1.4.1 New international pledges

These figures provided the foundation for a new political momentum behind aid. To respond to this funding gap, individual countries made positive pledges for the future. Following are some of the major announcements by the non-EU countries:

- Canada promised an increase of 8% per year in ODA to reach the target of 0.7% in the medium term. Canadian ODA/GNI ratio should reach 0.33% in 2006/07.
- The US pledged an additional 5 billion USD over 2003 to 2006. This initiative, called the 'New Compact Development'[15], would be the largest three-year increase in American aid since the last 20 years[16].
- Norway pledged to reach 1% of GNI to ODA by 2005.
- Switzerland plans to reach 0.4% of GNI to ODA by 2010.

#### 1.4.2 The 'Barcelona Commitments'

Another positive sign attributed to the follow-up of the Monterrey Financing for Development Conference is the increased total ODA of the EU countries by 2.8% in real terms in 2002. It is the consequence of a decision taken at the European Union Barcelona Council of March 2001 (and reaffirmed at Monterrey). Indeed, the heads of States of the European Member States (MS) felt then that it was important to arrive with strong common views on increasing ODA at the upcoming Monterrey Conference. They therefore set up 8 commitments (known as the 'Barcelona commitments') for the MS to work on, including increasing ODA levels. It was decided that the European Commission (EC) had to organise dialogues with each EU MS on setting a realistic timetable for reaching higher ODA targets. At the EU Development Council of November 2001, the EC proposed a gradual scenario to increase ODA and was chosen to monitor the progress of the MS' ODA level[17]. The proposal for a 'road map' to reach the financial goals was the following:

❖The EU MS have to reach two different targets in the short term (by 2006):

- one individual: by 2006, all MS should at least reach the 2000 EU average of 0.33% ODA/GNI (Those above 0.33% are expected to increase further as well).

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[13] See http://www.un.org/esa/ffd/ for more details

[14] Source: '*Report of the High level Panel on Financing for Development by E. Zedillo*', Oct. 2001. The World Bank has estimates in the same range: an additional 40 and 60 billion USD per year to reduce poverty (Report given out in February 2002). The Bank also calculated an estimated cost for reaching the health-related MDGs: an additional ODA of 20 to 25 billion USD per year would be required.

[15] This funding will be devoted to projects in nations that govern justly, invest in their people and encourage economic freedom.

[16] Despite this almost 50% increase of American ODA, it is estimated that this input will still not enable the country to take off from its last place in the list of donors in terms of ODA/GNI ratio.

[17] The EC has no mandate to oblige the EU MS to reach higher ODA targets: the agreements are thus not real official commitments but rather good intentions. Nevertheless, it has been noticed in several past cases that when the EC had been given the right to draw up scoreboards on progress made by the EU MS, the countries had felt pushed to react positively.

- one collective: by 2006, the EU average should go up to 0.39% (thanks to the increases of the MS' individual levels).

❖ A long-term gradual process will lead all EU MS to the UN target of 0.7%:

- in 2006, the new EU 0.39% average would become the benchmark for all individual MS to reach by 2010.
- By a potential similar process, the MS could repeat this process of achieving successive realistic milestones until achieving the UN target of 0.7% by 2015.

In May 2003, the EC gave out a first evaluation report[18]. The trend towards the achievements of the first Barcelona commitment on the volume of ODA is positive. The implementation of the scenario has well started despite a difficult budgetary background. In 2003, 10 of the 15 MS met the Barcelona target of 0.33% ODA/GNI[19] (of which 4 reached the UN 0.7% target). The 5 remaining MS have not yet met the target but recommitted to achieve it by 2006[20].

Moreover, most of the MS have established concrete scenarios to increase their ODA to the levels set at Barcelona and some MS even presented commitments going beyond the EC scenario[21]. Denmark, on the contrary, announced a decline in its ODA/GNI ratio as the new right-wing government is not willing to strive for reaching a target of 1% set by the former government. However, the country promised to maintain the overall ODA level above the 0.7% UN target.

## 1.5 Important future challenges

### 1.5.1 Even with these positive signs, still a long way to go…

Despite these positive announcements, according to DAC estimates, fulfilling these promises would raise total ODA in real terms by 31% (about 16 billion USD) and the ODA/GNI ratio would increase to 0.26% by 2006. First, this will still be well below the ratio of 0.33% consistently achieved until 1992 (not even a catching-up effect). Secondly, this increase is representing only a third of the estimated additional funds calculated by the World Bank needed to achieve the MDGs. The prospect of missing the 2015 goals by lack of funding is thus a matter of profound concern. This critical situation is also true for the ICPD goals.

### 1.5.2 Increasing the efficiency of aid

Since the ICPD, the discussion on aid volumes has been paralleled with discussions on the effectiveness of aid. Major donors (Denmark, the US) have over time increasingly criticised the fact that emphasis was laid mainly on how much ODA is available to spend and not enough on how it is spent. Following are examples of critical issues which need to be addressed.

Strong concerns were and are still expressed about the fact that ODA is often used inefficiently due to important absorption constraints faced by aid recipients, in particular due to the lack of institutional and human resource capacities. Most aid recipient countries have indeed fragile political and administrative systems. It is often believed that not enough efforts are made on accompanying measures needed to maximise the impact of ODA.

[18] Source: '*Follow-up to the international Financing for Development (Monterrey 2002) Monitoring the Barcelona Commitments – Summary*' – SEC(2003)569 -15-5-2003

[19] In 2002, Denmark, Luxembourg, the Netherlands, Sweden, Finland, France, Ireland and Belgium reached the goal and in 2003, 2 new MS joined this group: the UK and Austria.

[20] Germany, Greece, Portugal, Spain and Italy

[21] France: to reach 0.7% of GNI/ODA by 2012; Ireland: by 2007; Belgium: by 2010; UK: 0.4 % of GNI/ODA by 2005

Part of the problem has laid also with donors: aid had become too tied, too uncoordinated, too conditioned, too narrowly dispersed and its administration too distant from local decision and needs. Another long-term problem is that donors have often used aid to advance their own trade or foreign policy goals rather than to maximise their impact on poverty reduction or growth.

This situation has started to change since the ICPD: the OECD took significant steps to improve aid effectiveness in the mid-1990s[22] and the World Bank introduced the 'Comprehensive Development Framework'[23] in 1998, an approach by which developed and developing countries establish a long-term relationship based on the ownership by the recipient country of its domestically developed poverty reduction strategy and on a strong partnership among governments, donors, civil society, the private sector, and other development stakeholders in implementing this country strategy. It also recommends donors to put their ODA into a common pool to support the financing of the development strategy which will be fully implemented by the recipient.

Whereas these steps were seen as positive and led to better donor coordination and improved coherence, donors still attempt to use the new system in such a way that they manage to impose their old-fashioned conditionality and the common pool approach is still the exception more than the rule (as donors are afraid to loose control over their financial resources). Further changes in the structures and processes of aid are still needed to enhance development effectiveness. A simple example, among others, would be that the distribution of aid should be determined more systematically by the depth of poverty of the recipient country and by the ability of its policy environment to support poverty eradication measures.

These issues were addressed extensively during the International Conference on Financing for Development in Monterrey in 2002. The outcome of the meeting, the 'Monterrey Consensus'[24], for the first time, includes a strong international commitment towards further improving policies and development strategies, both nationally and internationally to enhance aid effectiveness. The consensus enumerates a series of measures to intensify these efforts and the international community endorsed them. Drastic changes in the attitude of the donors will be needed but this overall recognition can be seen as a first step towards possible major evolutions.

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[22] See the '*OECD/DAC Guidelines: Harmonising Donor Practices for Effective Aid Delivery*' : http://www.oecd.org/department/0,2688,en_2649_3236398_1_1_1_1_1,00.html

[23] See the following web site for a complete explanation: http://web.worldbank.org/WBSITE/EXTERNAL/PROJECTS/STRATEGIES/CDF/0,,contentMDK:20072662~menuPK:60746~pagePK:139301~piPK:139306~theSitePK:140576,00.html

[24] See the full report on http://www.un.org/esa/ffd/aconf198-11.pdf

# 2. Funding for Sexual and Reproductive Health and Rights in Development: an Overview since the ICPD

In 1994, at the ICPD, the participants called upon the international community to: *"…achieve an adequate level of resource mobilization and allocation at the community, national and international levels for population programmes and for other related programmes…"* (Art 13.21 Programme of Action of the ICPD). Dedicating a fair share of each donor's ODA to SRHR issues was internationally recognised as essential in order to achieve the goals of the ICPD. A set of clear financial targets were agreed upon during the conference and donors did make significant financial efforts since 1994. However, the total funding levels for SRHR fall today short of the needs. This chapter will give an historical overview of the evolution of SRHR funding levels. It will also describe the methodological difficulties linked to measuring funding for SRHR and it will present the actual funding shortfall.

## 2.1 International resource goals for Sexual and Reproductive Health and Rights

### 2.1.1 Financial agreements at the ICPD

The Programme of Action of the ICPD (PoA ICPD) specified the financial resources, both domestic and donor funds, necessary to implement the population and reproductive health package over the following 20 years. It has been estimated that the implementation of these programmes in the world would necessitate 17 billion USD by 2000 (Art.13.15 PoA ICPD).

Two third of the projected costs were expected to be provided by domestic sources, representing a total amount of 11.3 billion USD by 2000. One third of the total needs were to come from the international donors countries (Art 13.16 PoA ICPD). These external resources should represent an amount of 5.7 billion USD by 2000 and 6.1 billion USD by 2005. (Art 14.11 PoA ICPD) (Box II)

**Box II: The ICPD resource allocation goals**

Financial Resources required for 2000-2015 in billions of USD

| Years | Domestic Resources | **External Resources** | Total Resources |
|---|---|---|---|
| 2000 | 11.3 | **5.7** | 17.0 |
| 2005 | 12.4 | **6.1** | 18.5 |
| 2010 | 13.7 | **6.8** | 20.5 |
| 2015 | 14.5 | **7.2** | 21.7 |

*Source: Programme of Action of the ICPD, 5-13 September 1994 (Art 13.15 and 14.11)*

### 2.1.2 Population assistance as a share of Official Development Assistance

The share of ODA allocated to population assistance reflects the level of importance each donor assigns to population and reproductive health issues within its development aid policy. The ratio of funding to SRHR with respect to ODA (SRHR/ODA) shows the generosity level of each country towards these issues.

In 1989 in Amsterdam, at the International Forum on Population in the 21st Century, sponsored by the United Nations, the international community was agreeable that donor support for population programs should rise to represent 4% of total ODA. This figure has not become an official international agreement but is widely used by the stakeholders' active in the field, as a benchmark on how much each country should allocate to population assistance in order to provide a fair share to these issues.

## 2.2 Sources and definitions

### 2.2.1 Source of the figures used

The figures used in this paper are taken from a study called '*Financial Resources Flows for Population activities- 2001*". It is the last edition of a report done by the Netherlands Interdisciplinary Demographic Institute (NIDI), under contract with and in collaboration with UNFPA. It presents the outcome of a data collection exercise, aimed at analysing donors' and domestic countries' resource flows in the field of population and SRH.

It is the only source of information providing comparable data on these issues for 22 DAC members (all DAC members except Greece). They are also allowing an historical overview (figures available from 1995 to 2001[25]). Data on donor assistance for population activities were gathered with the use of a uniform detailed questionnaire sent to each country. The collection procedures were done in such a way to avoid double counting and to allow verifications.

### 2.2.2 Definition of the 'Costed Population Package'

The figures record resource flows for several categories of activities, all relevant to SRH. These categories form what is called the "Costed Population Package"[26], and includes all costs related to the following[27]:

- Family Planning services
- Basic Reproductive Health Services
- Sexually Transmitted Diseases-HIV/AIDS: Prevention, Treatment and Care
- Basic Research, Data and Population and Development Policy Analysis

This package will be referred to as "Population assistance" in this paper.

## 2.3 Constraints in monitoring Sexual and Reproductive Health funding flows

The figures shown should be treated as best available estimates. Indeed several factors make the monitoring of population assistance difficult. Why is it so challenging?

### 2.3.1 Difficulty of disaggregating the SRH components

It is difficult to disaggregate and differentiate the SRH components from other elements in larger projects. This is especially the case in the actual development environment where the accent is laid (rightly) on integration. First, the increase in the use of Sector Wide Approaches (SWAPs) makes it difficult to track the level of funding for specific SRH issues within the general health sector approach. The data-recording system does not allow for clear differentiations between the four items of the costed package. Moreover, some donors increasingly encourage the use of direct budget support. Because the donors' funding is then gathered in one basket and managed by the Minister of Finance of the recipient country, it is quasi impossible to distinguish how much each donor has contributed to each sector and even less, to distinguish how much is given to each component of a sector. Finally, there is a growing trend towards the integration of SRH services in general health services, which is

[25] Data for earlier years are available but use a different definition of population and can not therefore be strictly compared.
[26] The "costed population package" has been specified and described in the Programme of Action of the ICPD under paragraph 13.14.
[27] See Annex 2 for a detailed definition of the ICPD "costed population package"

consistent with the ICPD call for the integration of SRH within the basic health services[28]. However, evaluating the amounts of funding specifically dedicated to SRH issues is then a challenging task.

### 2.3.2 Concerns about under-reporting

Some donors are concerns that large amounts of funding go unreported and considerably lower down the actual level of SRH funding. Indeed, several general integrated development projects in social sectors (other than health or education) do include SRH aspects but do not report them as such given the fact that the budget is not split per individual component[29]. Moreover, by adhering to the definition of the costed package, other population related activities, such as education or women's issues… are not included in the calculations.

### 2.3.3 The donors' fatigue

Given the difficulties mentioned above, providing good funding figures is difficult and time costly. Donors become reluctant to spend a lot of time for unsatisfying figures. Many complain that while SRH civil society is pushing on the one hand for more integrated programmes, it is also seeking on the other hand accountability on a categorical level that is beyond the capacity of donor information systems to provide.

### 2.3.4 Questions about future monitoring

For all these reasons, the figures provided are most probably under-estimated. However, even when taking into account the grey zones of unreported funding, the gap between the international commitments and the estimated spending figures remains so important that the strict exactitude of the data will not have an impact on this conclusion.

As the new development trends make it increasingly difficult to monitor financial flows for SRH, donors increasingly believe that the best way to measure the advancement towards the ICPD commitments is monitoring the outcomes of the projects, thanks to result-based SRH indicators. Whereas the benefit of outcome indicators has to be recognised, using only these types of indicators (most of the time, long-term indicators) is not considered as very efficient for direct advocacy work with donors governments. Having a set of comparative funding levels among donors puts far more pressure on the government to convince them to react and live up to their promises. Both kinds of indicators are seen as essential in order to measure the advancement towards the ICPD Programme of Action.

## 2.4 Ten years of international population assistance flows

It is difficult to analysis the evolution of donors' contribution to population assistance consequently to the ICPD because the definition of population assistance has expanded in response to that same conference. Indeed, in 1995, the United Nations Fund for Population Assistance (UNFPA) added two new components to the definition used previously: it included 'expenditures for the fight against HIV/AIDS' and 'maternal care'. When looking at the sum of the population assistance from the developed countries[30] (all DAC members except Greece) from 1994 to 1996, it rose from 977 to 1 372 million USD, allowing the

[28] One example of integration would be that the creation of a new hospital includes the setting-up of a maternity ward.
[29] E.g.: SRH components are often integrated in activities done by the European Commission, activities financed under non-SRH-related budget lines. The food aid or the refugees budget lines for example have specific population activities but the latter are not reported in the total EC SRH funding.
[30] The spending of developed countries includes the UNFPA's income from these countries, since the contributions to UNFPA are regarded as being earmarked for population assistance.

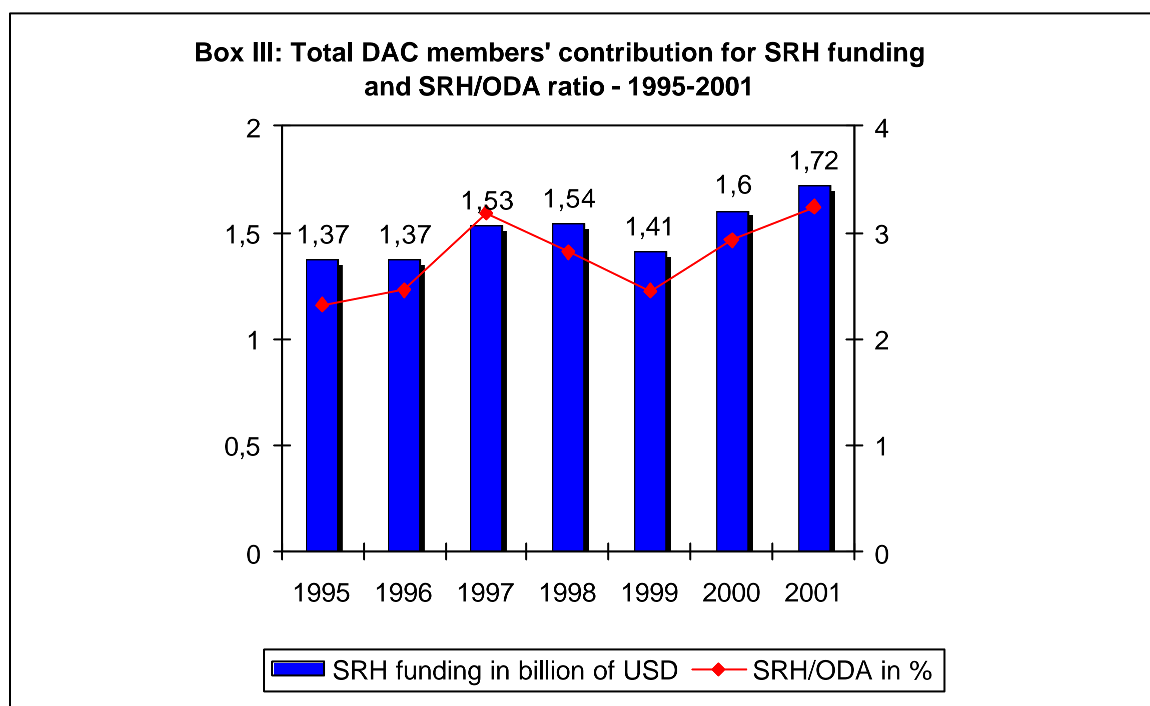
SRH/ODA ratio to grew from 1.7% to 2.5%. Whether this important increase is to be attributed to the change in definition or to the actual reactions after the ICPD (or how much is to be attributed to each of these reasons) is unclear. Therefore, no clear-cut conclusion can be drawn out of these figures.

### 2.4.1 Evolution of DAC members' contributions to SRH in volume from 1995 to 2001

Between 1995 and 2001, the general trend is rather positive. Donors' contributions to SRH funding increased by 25% from 1.37 to 1.71 billion USD. This growth has not been steady: population assistance experienced a first jump in 1997 (from 1.37 to 1.53 billion USD); it stagnated in 1998 (at 1.54 billion USD) before falling in 1999 to 1.41 billion USD. Since then, population assistance is re-increasing. In 2000, it caught up and even over passed the 1997 funding level, reaching 1.6 billion USD. In 2001, population assistance gained another 7.6% and attained 1.72 billion n USD, a record high level since 1995. (Box III)

### 2.4.2 Evolution of the SRH/ODA ratio from 1995 to 2001

As mentioned earlier, a good indicator of commitment to population assistance is the contribution donor countries make relative to the size of their development aid. The ratio SRHR/ODA is therefore looked at in the NIDI study. From 1995 to 2001, population assistance from developed countries rose from 2.32% to 3.24% to ODA, but not without experiencing important fluctuations. (Box III)




Despite these apparent encouraging signs, the analysis of the figures leads to a more nuanced conclusion. Between 1995 and 1997, the ratio increased from 2.38 to 3.18%. This happened in a period when ODA decreased from 58 to 48 billion USD. The same situation occurred in 2000 and 2001 when the SRH/ODA ratio increased (after a two-year decline) to respectively 2.93% and 3.24% but in a context of decreasing ODA. So, in these years, population activities received in fact a larger share of decreasing ODA.

On the contrary, from 1997 to 1999, the SRH/ODA ratio decreased from 3.18 to 2.45% at a time when ODA increased from 48 to 56 billion USD. So, population activities received a

smaller share of increasing ODA. In other words, since 1995, the SRH/ODA ratio never grew thanks to both increases in SRH funding and ODA volumes. Population assistance never received a larger share of a total bigger ODA amount.

## 2.5 The situation in 2001: encouraging signs in a gloomy international context

### 2.5.1 Total international population assistance

When adding to the developed countries' spending, the non-earmarked contributions from the United Nations[31] system, donations from philanthropic foundations and loans of development banks[32], the total international population assistance for 2001 amounts to 2.5 billion USD. It has been cut from the 2000 level of 2.6 billion USD. This fall is mainly attributed to decreases in the loans provided by development banks. The 2001 level remains however a step forward compared to 1999 when total population assistance represented 2.2 billion USD. Moreover, since 1995, this aggregate has increased from 2 to 2.5 billion USD.

### 2.5.2 SRHR funding levels of individual donor countries in 2001

- *In terms of Volume (Annex III.A)*

The countries do not equally share the burden of providing funding for population assistance. On the one side, only a minority of the DAC members (4 out of 22) spend more than 100 million USD per year on SRH issues: the US, the Netherlands, Japan and Germany. Their total contributions represent more than 75% of the total DAC population assistance in 2001. Moreover, the spending of the 5 major donors represents 80% of the total funding for SRHR. (Chart III)

On the other side, the majority of the donors' group (nearly half of the DAC members (10 out of 22)) spend less than 20 million USD per year on these issues. Their total contributions represent 4.8% of the total DAC population assistance in 2001. From these 10, 6 spend less than 10 million USD per year on population assistance. (Box VI)

Six countries and the European Community spend amounts between 80 and 20 million USD per year: they have a share of about 14.5% of the total DAC contributions to population. The figures from the NIDI study about the European Commission are to be taken with caution: indeed, the EC used a very restricted definition of population activities in its reporting to NIDI. The resulting figures are therefore largely under-estimated and do not reflect the real SRH spending level of the EC. More accurate figures for the EC ICPD spending can be found in a research done by J. Edwards in 2000[33]. It covers the period 1990-1998 (latest data available) and estimates that the EC provided 237 million Euros in 1998 to ICPD activities. (Box IV)

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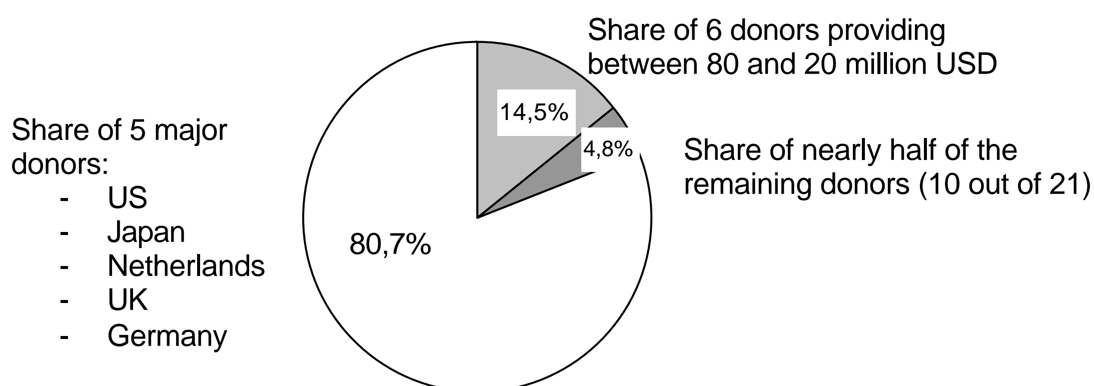
[31] These UN contributions are those contributions to population activities, mainly from UNAIDS, UNICEF, UNFPA and WHO that are part of the general funds, not earmarked for population activities, providing from developed countries, developing countries and interests earned on income (NIDI Resource flow Report 2000)

[32] The development Banks' loans fluctuate widely from year to year and generally, these amounts have to be repaid.

[33] Source: "*The EC's response to the challenge of the International Conference on Population and Development ICPD+5*" (1994-1998) 2000, Co-writer Jason Edwards

**Box IV - Unequal Burden sharing for population funding**

*Total donors' population assistance in 2001: 1.71 billion USD = 100%*




Source: Figures from NIDI and calculations from IPPF European Network

The US is by far the major donor for population assistance in the world. With 951 million USD in 2001, it contributes about seven times more than the second major donor (the Netherlands contributing 132 million USD) and it represents 55% of the total government resources for population. Moreover, the US experienced a major increase of SRH spending by 44% between 2000 and 2001. (Annex III. A)

However, several remarks have to be made. First, the growth in American population assistance can mainly be explained by very large increases in funding to fight the HIV/AIDS pandemic. These amounts doubled indeed from 2000 to 2001. While such funds are crucial, questions are however arising on the content of the American overseas SRHR programmes in the context of the Administration of President G.W Bush. Indeed, the US President is increasingly promoting "abstinence-only" programmes for young people, openly doubts the safety of condoms in preventing HIV/AIDS and strictly bans the use of emergency contraception and abortion. Secondly, the US slightly increased its funding for family planning and basic research while decreasing spending for basic reproductive health services. These are the initial results of the reinstatement of the Mexico City Policy on President Bush's first day of office (Annex IV). According to this rule, non-US NGOs are banned from receiving USAID funding if they in any way promote, provide or refer patients for abortion. In this context, the US government deliberately chooses to provide less funding to reproductive health services which, it estimates, could include abortion-related activities, and focus its funding on family planning[34]. Finally, it is important to note that despite the US's increase in population assistance, IPPF and UNFPA, two of the leading organisations in the field, lost all of their US funding in 2002 due to the Mexico City Policy. (See Chapter 2.6)

[34] As soon as it came to power, the Bush Administration showed its disagreement with the agenda of 'reproductive health services', especially during the Summit for Children (New -York) in May 2002. The delegation insisted on using 'access to family planning and contraception' instead of 'reproductive health' and lobbied to replace 'reproductive health services' with' basic health care'. On the 5th Asia and Pacific Population Conference (Bangkok) in December 2002, the US delegation attempted, unsuccessfully, to change the language of the ICPD Programme of Action.

When looking at the other DAC countries, we notice that the most important decreases from 2000 to 2001 occurred among some of the major donors for population assistance: the UK (-52%), Norway (-28%), Sweden (-23%), the Netherlands (-22%) and Japan (-12%). The reasons are most probably to be found in the fact these countries are the ones which are increasingly implementing SWAPs in health and which therefore are not able to report properly on each component of the sectoral programme. This situation leads to under-reporting. Japan, however, is a different case: the economic crisis obliged the country to reduce drastically its ODA and consequently also its SRH funding.

- *In terms of share of ODA (Annex III.B)*

The SRHR/ODA ratio varies significantly for the different countries, ranging from 0.18% to 8.32%. Only 4 out of the 22 DAC members (The Netherlands, Finland, Luxembourg[35] and the US) reached the target of 4% of their ODA to SRH in 2001. Two other countries, which had reached the 4% target in 2000, fell back below that level: Sweden, Norway. A combination of probable under-reporting of SRH funding due to the use of SWAPs and of decreasing ODA explain these results.

Half of the countries are allocating less than 2% of their ODA to SRHR: this level does not reach half of the required target. Up to 5 DAC countries provide even less than 1% of their ODA to SRHR. For Europe, these countries are mainly located in the South. They also include all the DAC non-EU countries apart from the US.

A group of seven countries, all located in the northern part of Europe, spend over 2% of their ODA on population assistance. Four new countries, considered as average ODA spenders, joined that group in 2001: Belgium, Germany, Ireland and Switzerland. A trend has been noticed between 2000 and 2001: among the Northern countries, the traditionally important spenders saw their SRH/ODA ratio decrease whereas the average spenders saw this same ratio increase. Among the Southern countries however, no major changes were noticed.

The US was, by far, the most generous donor on these issues, with 8.32% of its ODA to SRHR in 2001. However, this performance has to be balanced with the fact that the American ODA level is rather low compared to its national income[36]. Thus, population activities are in fact receiving a large share of a comparatively small ODA. The largest SRH donors in terms of volume are not necessarily the most generous donors in terms of their ODA, as illustrated by the following examples. Whereas the Netherlands is both a large and a generous donor relative to its ODA, Japan is a good illustration of the reverse situation. Despite its ranking among the top 5 donors in volume, Japan's population assistance represents less than 1% of its total ODA. On the contrary, whereas Luxembourg ranks only 18th among the DAC members in volume terms, Luxembourg is among the most generous donor relative to its ODA with a level near to the 4% target (3.99%).

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[35] Luxembourg spent 3.99% of its ODA on SRHR and not 4%. IPPF EN however, decided to include the country on the group of DAC Members which reach the 4% target, given the fact that the figure is nearing so closely the target.
[36] The US, with an ODA/GNI ratio of 0.11%, has the last ranking among the DAC members and is far from the DAC average country effort of 0.40%.

## 2.6 A snapshot of multilateral funding for Sexual and Reproductive Health and Rights: funding for UNFPA and IPPF from 2000 to 2003

Multilateral spending for SRHR is mainly channelled through the United Nations Fund for Population Activities (UNFPA), the leading provider of United Nations assistance in the population field, and the International Planned Parenthood Federation (IPPF), the largest NGO in the field of SRHR[37]. Whereas the total contributions to population assistance are mostly estimated figures using different kinds of definitions, contributions to multilateral channels are reliable and easily comparable figures.

### 2.6.1 Governments' contributions to UNFPA (Annex V)

The Netherlands and Japan are by far the major donors to UNFPA. For the second year running, the Netherlands ranks first (with 66 million USD in 2003), reversing the trend of the 1990s when Japan held that position. The latter sharply decreased its funding to UNFPA in 2002 (48 to 39 million USD) and thereby lost its first ranking. It maintained this lower level in 2003.

The US used to be an important contributor to UNFPA in 2000 and 2001, with a contribution of 21.5 million USD both these years. However, in 2002, due to the false allegation regarding UNFPA's work in China, the Administration of President G.W. Bush decided to de-fund UNFPA. Whereas the American Congress had accepted to give 34 million USD to the Population Fund, the government withdrew this decision. This situation is unlikely to change in the near future given the reinstatement of the Mexico City Policy. The US is the only DAC country, together with Portugal, which is not contributing to UNFPA.

Eight of the DAC countries are contributing less than 3 million USD. The difference of scale between the smallest and the major donors is striking. However, most of the smallest contributors to UNFPA increased their contributions in 2002 and in 2003 compared to 2001. Norway, Sweden and Ireland are the countries with the largest growing contributions to UNFPA.

It is interesting to note that there are developing countries amongst the top 20 donors to UNFPA (China, Pakistan and Saudi Arabia). They are contributing with higher amounts than countries such as Austria or Spain.

### 2.6.2 Governments' donations to IPPF (Annex VI)

While 14 of the DAC Members contribute to IPPF, there are still 8 countries not providing any support to the largest NGO in the field of SRH. From the 14 donor countries to IPPF, only 6 provide more than 5 million USD per year. (Annex VI.B)

Japan is by far the major contributor to IPPF (with 15.7 million USD in 2002), followed by Sweden (with 7.71 million USD) and the Netherlands (with 7.26 million USD). On the other side of the scale, 6 countries contribute less than 1 million USD per year.

A majority of the contributions to IPPF have been decreasing over the last two years mainly as a consequence of the general fall in many countries' ODA: this has been especially the case for Japan, Germany, Denmark, New Zealand and Australia. (Annex VI.A)

[37] Multilateral assistance for population activities consists also of contributions from other UN agencies such as WHO, UNAIDS, UNICEF and other loans and grants from development banks. See the NIDI/UNFPA study for more information. In this paper, the focus is laid only on UNFPA and IPPF multilateral funding.

Due to the reinstatement of the Mexico City Policy (Annex IV), IPPF lost all its income from the US. IPPF, in view of its global mission to save lives of women and fight for reproductive health, has decided not to sign the Mexico City Policy. IPPF lost in early 2001 a total amount of 12 million USD, which at that time represented 20% of the IPPF operating budget[38].

As a reaction to this situation, some countries increased massively their contributions. The Netherlands is the best illustration: the country more than doubled its donation to IPPF from 2000 to 2003 (from 3.2 million to 7.7 million USD). The Dutch Government thereby showed its willingness to fill the gap left by the US Government. Germany, Denmark and Finland are among the other generous donors who reacted after the Mexico City Policy and made effort to compensate the losses.

The European Commission also openly criticised President G.W. Bush for reinstating the Mexico City Policy: as soon as January 2001, the Commissioner for Development Poul Nielson reacted by saying that the European Commission was prepared to "fill the gap in funding". The European Commissioner kept its promise by providing IPPF with 10 million Euros for SRH projects in countries of the African Caribbean Pacific Region.

## 2.7 Unmet needs and funding shortfall

As shown above, the developed countries have made efforts to achieve the goals and objectives of the ICPD after 1994. The total funding level from the developed countries did increase from 1.37 billion USD in 1995 to 1.71 billion USD in 2001. However, the general positive trends from after the ICPD seem to be fading and even reversing. And the level of resource mobilisation in 2000 fell short of the agreed ICPD target for that year.

1. The contributions of the donor countries to international population activities represented only 28% of the 5.7 billion USD target for 2000

2. The contributions from the UN system, the foundations, the development bank loans etc…represented 17.6% of the ICPD target for 2000

3. In total, the total population spending (incl. bank loans and UN system) in 2000 did not even represent half of the ICPD target for that year (45.6%)[39]

When looking at 2001, the increase in SRH funding from the developed countries is seen as encouraging. But the scale of this growth is too small to enable the donor community to catch up with its delay. Moreover, the international population assistance for 2001 decreased to 2.5 billion USD from the 2000 level of 2.6 billion USD. This implies that in 2001, the unmet needs where even more important than in 2000. Reaching the next ICPD goal of 6.1 billion USD by 2005 appears to be only a wishful dream.

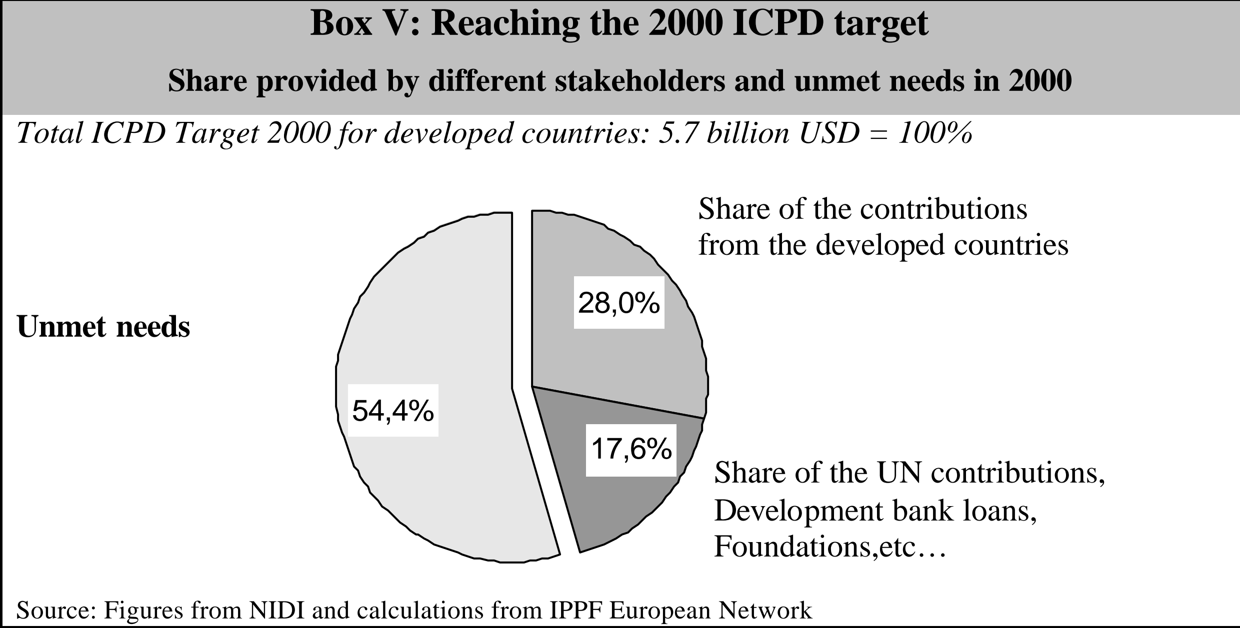
The funding shortfalls of Cairo are especially acute with respect to contraceptives and other reproductive health commodities. Indeed, UNFPA estimates that, while global funding for all SRH requirements was around 45% of the needs, the funding of commodity requirements is

[38] In 1984, when the original Mexico City Policy was imposed, IPPF lost 17 million USD, which at that time represented 25% of its operating budget.
[39] Parallel, in 2000, the developing countries contributed 70% of their 11.3 billion ICPD target for that year, a much larger share of their target than the one given by the developed countries.

meeting only 36% of the needs[40] (in 2001). Indeed, support for the commodities was 224 million USD in 2001 whereas the actual estimated contraceptive costs are 614 million USD. Moreover, since 1997, donors support has been below the average level reached between 1991 and 1996 (40.9% of the requirements), whereas the actual costs and requirements grow rapidly. This situation takes place in a world where the number of contraceptive users from 2000 to 2015 is projected to increase by more than 40% as a consequence of both population growth and an increase in the proportion of people who use contraception. (It is important to keep in mind that between 2000 and 2015 the population in reproductive age in developing countries will grow by 23%). Increased use of contraceptives and condoms for STI/HIV prevention is another factor contributing to rising requirements and a continued need for increasing donor support.

**Box V: Reaching the 2000 ICPD target**

**Share provided by different stakeholders and unmet needs in 2000**




Source: Figures from NIDI and calculations from IPPF European Network

Donors still need to make very important efforts to reach the ICPD goals. The lack of adequate funding remains one of the major constraints to the full implementation of the ICPD Programme of Action. And this in turn has major implications for the achievements of the MDGs. Indeed, SRHR has a strategic role in reducing maternal and child mortality, reducing the incidence of unsafe abortion, preventing HIV infection, reducing poverty and empowering women[41]; which are all crucial elements for the success of the MDGs. In other words, few of the MDGs can be realised if the core goals of the ICPD are not achieved.

The international community was already once faced with the figures showing the unmet needs and was reminded of its ICPD commitments. This happened in 1999 during the event commemorating the five year anniversary of the Cairo Conference. Donor countries then renewed their promises to increase ODA in general and the share relating to SRHR in particular. Unfortunately, another five years later, on the eve of the 10th anniversary of the ICPD, the mobilising of sufficient resources for the SRHR needs in the world remains a major issue.

[40] Source: '*Donors support for contraceptives and logistics 2000*' UNFPA 2002

[41] For more explanation on evidence based analysis of the direct impact of SRHR on the MDGs, see '*Population matters: Demographic change, Economic growth and poverty in the Developing world, 2001*' Oxford, UK: Oxford University Press, N.Birdsall, A.C Kelley, S. W Sinding eds.

# 3. Sexual and Reproductive Health policies in the Development Aid Strategies of European donors' countries (plus Canada and the US)

The Programme of Action of the ICPD did not only require from the developed countries to mobilise resources for population assistance but it also encouraged them to develop a policy which would integrate SRHR issues in their development strategy. Governments were indeed called upon to *' formulate, implement and evaluate national strategies, policies, plans, programmes and projects that address population and development issues,{…} as an integral part of their sectoral, inter-sectoral and overall development planning and implementation process'*. (Art 13.5 PoA of ICPD). The existence of such a policy and the extend to which it has been developed give an idea of the level of importance each donor assigns to SRH issues. Moreover, it is believed that countries with well-established international SRH policies are more likely to provide increased funding to these issues. (But this isn't a rule: see chapter 3.2)

How does the policy map look like 10 years after the ICPD? Did the Programme of Action have an important impact on the policy formulation for population assistance? Was the ICPD the only factors for policy changes and evolutions? This chapter on the SRHR policy overview will address these questions.

## 3.1 Mapping of donors' international SRH policy (Annex V)

Following the Cairo conference, many European countries introduced SRH issues in their development policies and others positively revised their legislation in order to be in line with the ICPD goals. The Programme of Action had indeed a catalyst role for many governments. Unfortunately, this has not been the case for all of them: several countries still lack legislative recognition for the SRH issues due to strong national political opposition or simply due to little interest for the issues. The policy environment for population assistance is strikingly uneven in the region (European countries plus Canada and the US), as the following classification tries to demonstrate:

### 3.1.1 Countries with independent comprehensive SRH policies

Whereas support for SRH issues was already high in most of the Nordic countries (Sweden, Denmark, and Norway) and the Netherlands for a long time before the ICPD, the commitment of their governments deepened further over time. These countries developed strong independent policies, complying with the ICPD goals: they adopted a comprehensive definition of SRHR (recognising its multi-dimensional aspect). These countries are recognised as leaders in taking up some of the most controversial ICPD issues such as sexual rights and the SRH needs of adolescents. Whereas some of them experienced recent decreases in their funding levels for population assistance (mainly due to ODA cuts in difficult economic contexts), they have significantly increased their funding level for population assistance since 1994.

The US has a 30-year long tradition of population assistance and therefore has a clearly defined family planning policy. The latter was recognised by UNFPA as one of the most successful components of American foreign assistance[42]. This success motivated the country

[42] UNFPA Monitoring the ICPD Goals: Selected indicators (May 2001) www.unfpa.org/SWP/1999/pdf/indicators.pdf: UNFPA notes that the US SRH programmes have contributed significantly to increasing the use of modern contraceptive methods from under 10% in the 1960s to 50% in 2001.

to play an active role in international acceptance for population issues: it became a key actor in framing the new agenda of the ICPD[43]. The American delegation to Cairo, working with the US civil society, appeared to be progressive and advocated for increasing emphasis on women's reproductive rights in all SRH policies. However, in terms of the US's own SRH policy, the country failed to adopt the holistic ICPD approach regarding SRHR. It did not broaden its long-standing commitment to a narrow family planning model and did not shift from a demographic approach to a rights-based rationale. After the ICPD, the US experienced an increasing number of attacks against its family planning policy from anti-choice politicians and members of civil society. Since the beginning of the current Bush Presidency, the US government has implemented conservative programmes and limited the distribution of SRH funds (See the Mexico City Policy in Annex IV).

The United Kingdom, Canada and Switzerland each have a well-defined SRHR strategy, which are components of their respective health policies. The integration of the SRHR issues in this sectoral policy is done in such a way that 'non-medical' aspects of SRHR are not neglected[44] and a broader approach to SRHR that goes beyond the sectoral topics is possible. They however still experience some weaknesses in implementing coherent SRHR strategies (especially in the case of Canada), often due to a lack of expert staff in the field. The United Kingdom (it has a long tradition of population support), and to a lesser extend Canada, have been involved in SRH programmes before ICPD but the Cairo Conference motivated them to gradually deepen their policies by broadening their scope and by emphasising their importance. Switzerland, on the contrary, has traditionally been rather reluctant to addressing these issues at a political level[45]. It was only very recently (2003) that the country set up a transparent SRH policy, focusing largely on reproductive rights.

### 3.1.2 Countries which strongly recognise SRHR issues but mainly in a sectoral policy

These are countries which have successfully recognised the importance of SRHR issues in their development policy but mainly in the context of a single sectoral policy (mainly in health or in the general social policy). In that sense, SRH is approached in a somewhat more limited way than recommended in the ICPD Programme of Action: it does not have an independent status but is seen exclusively as an important component of a broader policy.

While some of them have an SRH policy which is bonded to a sectoral policy, its implementation is however more pragmatic and allows for some cross-sectoral activities. This is the case for Germany, Finland and Belgium: their SRH policies are included in their health strategies but they opened their SRH programmes to some 'non-medical' aspects such as education or sensitisation. But these policies have their limits: these countries often still see SRHR and HIV/AIDS as separate issues (esp. Belgium) and have the tendency to disregard the inextricable link between the two. Germany, Finland and Belgium were already dealing with population issues in their development cooperation in the 1970s (mainly family planning) but the new comprehensive vision proposed at the ICPD gave them the opportunity to review their own approaches and to start adapting them. Whereas there is still room for progress, these countries improved significantly their political support for SRH, which has also been reflected in increased funding levels since 1994.

[43] See Introduction for more explanations
[44] Meaning that SRH-related aspects such as male involvement, access to medicine, education etc…are taken into account in other policies
[45] Switzerland however supports UNFPA and IPPF for many years.

Spain and Portugal, on the other hand, are very recent donors and had no tradition of dealing with SRH issues. They both recognised SRH issues in their development policy for the first time after the ICPD[46]. Whereas these countries improved their political support to population, their SRH programmes remain rather small and their governments were not able to show major increases in funding levels.

### 3.1.3 Countries where SRH is not recognised as such in a policy

The remaining six countries do not have a specific SRH policy nor contain clear mentions of the ICPD language in their development policies. Among them, three countries (Austria, Greece and Italy) traditionally neglect SRH issues and only sporadically mention AIDS, family planning or gender concerns in their policies[47]. They did not show any significant changes since the ICPD and their funding levels for population assistance remain low.

France and Luxembourg have both shown a long-standing reluctance to providing direct and open political support to SRH and therefore they do not make any explicit mention to ICPD. However, several specific SRH aspects are well-represented in their different policies. France shows active political support to maternal health, girls' education, the fight against female genital mutilation and the country is a world leader in combating HIV/AIDS. Its contribution to population assistance remain however low and is mainly centred on strict HIV/AIDS activities. Whereas Luxembourg has not been able to show its dedication to RH issues in an outspoken way in legal documents, it did express important recognition by mentionning these questions in political speeches[48]. Moreover, the country is a top donor in terms of generosity for population assistance and these funding levels increased significantly over time.

Ireland has never been able to openly get involved in SRH issues in it development policy, mainly because of the influence of national opposition forces and the strong presence of the Vatican in the country. The ICPD has not change this specific national situation. However, over time, thanks to advocacy campaigns in the country, the general public is gradually showing more interest for the issues and positive signs from the Irish government can be noticed. So, whereas the domestic context of the country does not allow strong political support for the ICPD, in practice, the overall environment shows signs of improvement.

### 3.1.4 Summary

Among the above 19 donors, eight countries have drafted a comprehensive and formal SRH policy (may it be an independent policy or a strong strategy included in a sectoral policy), reflecting the philosophy of the ICPD Programme of Action. Five countries have been able to integrate an SRH strategy in a specific sectoral policy, thereby clearly recognising the importance of these issues but whithout being able to fully endorse the holistic ICPD approach. Finally, six countries do not have any approach to SRH in their policies, among which three do not make references to the ICPD-related activities and three others have only fragmented approaches to specific SRH concerns.

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[46] Spain mentions SRH in its basic social services policy of 1995 and Portugal in its health policy of 1996.

[47] Italy mentions more specifically SRH in its health policy of 1998 but in practice, these issues are given very low priority and very little SRH programmes are implemented.

[48] In its declaration in the Parliament on Cooperation and Relief Policy on 15 November 2001, Luxembourg's Minister for Development, Charles Goerens, expressed the commitments of his country on SRH issues: *"…We want also to contribute to guarantee the right to reproductive health, including the right to choose the number and spacing of children. This is why we reinforce continuously our cooperation with UNFPA…"*

### 3.2 Political support and funding levels: no straightforward conclusions

In general, it can be said that countries with formal SRH policies in a development context are more likely to provide increased funding to these issues. This was indeed the case for a majority of the most advanced countries in terms of political support to population such as the Netherlands or the Nordic countries. For other countries, the more they improved their SRH policy, the more committed they became financially speaking for population assistance: this was the case for Belgium (or Spain but to a lesser extend).

However, this link is not a rule: some countries, which formulated formal policies, do not complement their political engagement with continuous financial increases (e.g. Canada and Portugal). Moreover, other strong political supporters of SRH have lately significantly cut their funding contributions to population (e.g. Denmark, the UK). While these cuts are mainly due to general ODA decreases, they are however signs of a looser commitment towards SRH.

The state of advancement of the formulation of a SRH policy in the development context often depends on the political environment for population issues at a domestic level: when a donor is reluctant to address SRH issues in its own country, generally, it does not have an outspoken international SRH policy (and vice versa[49]). However, this does not prevent countries with a hostile environment to implement SRH-related projects. The examples of Ireland and Luxembourg illustrate this: their governments prefer not to mention openly SRH issues in their policies in order to avoid public controversy while, in the meantime, they do implement SRH programmes and increase their funding levels for population assistance. Depending on the political balances in each country, political support is not always the best prerequisite for improving a country's commitment towards population.

### 3.3 Emergence of a strong civil society after the ICPD

Since the ICPD, the number of NGOs working on advocacy for SRH issues grew significantly in Europe. Such groups were mainly present in the US in the early 1990s: they were essential to fight back the fierce anti-abortion movement active in the country itself but also in the framework of the US development aid. As certain European countries encountered strong opposition following ICPD, it was felt that European civil society needed to build active support for the ICPD Programme of Action in their national countries. Many national family planning associations started working on international advocacy and new NGOs, born after ICPD, also concentrated on such activities. ICPD fostered stronger commitment from civil society in the SRH field: it strengthened its own capacities, organised itself in networks and became more visible on the SRH concerns in a development context.

In many countries, these groups have played an important role in increasing support for international SRH issues. By helping convince parliamentarians to initiate legislation in support to SRH concerns, by raising awareness among the general public and by monitoring how each government is living up to its commitments, NGOs in the field have often been key players in the governments' process to change their policies and to increase their level of funding to population assistance. In other countries, the presence of such groups was important to avoid strong conservative backslashes. Often, the assiduity in the work of these NGOs allowed for a gradual change in perception about SRH issues among traditionally reluctant communities (politicians, civil servant and public opinion).

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[49] Countries with progressive SRH policies at national level mostly drafted comprehensive international population strategies. Moreover, when national legislation on SRH shifts to a more liberal SRH approach, the SRH approach in the cooperation framework tends to evolve as well: this has been the case for Portugal in the early years after Cairo

## 3.4 European snapshots - Individual country tables providing an overview of each donor's commitments on ODA and SRHR

As seen in Chapter 2, the actual SRH policies of each donor is an essential criteria to measure the level of commitment of a country towards SRHR but it is not sufficient to have a comprehensive idea of the country's activities in population issues. The total funding level of ODA, and in particular of SRH, the preferred distribution channels and the geographical spread of the funding are also important elements to judge each donor's dedication to population issues.

In order to have a better idea of these elements, the annex VI presents overview tables for the following countries[50]: Austria, Belgium, Canada, Denmark, the European Community, Finland, France, Germany, Ireland, Italy, Luxembourg, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, the United Kingdom and the United States.

For each country, a table provides statistical data on:

- General ODA information broken down in multilateral and bilateral proportions, the top 10 recipient countries of ODA and the top 3 UN agencies receiving ODA

- Spending on population assistance specifying bilateral and multilateral proportions, the major countries having received health and SRHR funding and the contributions given to UN agencies working in SRH-related fields (UNIFEM, UNAIDS…)

[50] Except Greece as no figures were available

## 4. New trends in development and upcoming political challenges: What are the consequences for the implementation of the ICPD programme of Action?

Whereas the financial questions is a major concern for the implementation of the ICPD Programme of Action, other evolutions in the political arena or new trends in development already impede the road to ICPD or may have an even more important impact on it in the future. This chapter will describe these challenges and explain their potential effects on ICPD.

### 4.1 The present political environment: growing conservatism in the European Institutions

Since the last three to four years, the presence of 'anti-choice' groups[51] in the European institutions became stronger and better organised. For example, in 2001, the year of the reinstatement of the Mexico City Policy, more and more religious organisations have set up offices in Brussels in order to take part in the EU decision making process. (Care for Europe, EuroFam, Commission of the Bishops' conference of the European Community (COMECE)). These groups, which specifically oppose the international agreements that support SRH and the rights-approach linked to it (e.g. the ICPD), clearly intensified their activities. Many of their actions were aimed at stopping the advancement of SRH in Europe[52] or at introducing religious references in major EU legislative texts[53], but they also targeted SRH in the context of development.

The anti-choice groups have been particularly influential in the discussions concerning the "*Regulation on aid for policies and actions on reproductive and sexual health and rights in developing countries",* which started to be debated in the European Parliament in May 2002. This regulation is one of the legislative tools of the EC to implement the ICPD Programme of Action. At the Plenary session of October 2002, Dana Scallon (Irish EPP MEP) tabled a parliamentary question concerning the term "reproductive health", understood as including abortion, and opposed the reference to reproductive health services. (The Commission gave its reply based on the ICPD Programme of Action.) Prior to the vote of the Regulation both in the Development Committee (January 2003) and in Plenary (February 2003), MEPs have been "bombarded" by anti-choice messages from organisations as well as individuals. The regulation has also been the object of misleading information and misinformation. Whereas it has been adopted in the plenary session of the European Parliament on 13 February 2003, the regulation kept being the object of parliamentary questions by anti-choice MEPs until it was formally adopted by the Council of Ministers on 17 June 2003.

In December 2002, another attack was made to the EU budget - particularly to budget line B7-632 on '*Aid for reproductive health in developing countries'*, whereby 160 MEPs blocked the increase of the budget line during its final vote at the plenary session in Strasbourg.

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[51] Opposition in Europe is composed mainly of moral and religious groups, specific anti-choice groups and political parties and individuals. The anti-choice activists in Europe had long operated through a broad tangle of informal 'networks' but in recent years, much of this networking has been spearheaded by US-based organisations which have reached out to like-minded groups in Western and Eastern Europe.

[52] E.g.: In July 2002, the European Parliament adopted the 'Report on SRHR in Europe and Accession countries', an initiative of MEP Anne Van Lancker. This report raised fierce debates in the Women's rights committee and in plenary, a great number of amendments as well as a flood of anti-choice messages.

[53] E.g.: The draft Constitution for the EU proposes a structured dialogue with the Church, giving therefore a privileged status to the Church.

In November 2002, again at the initiative of Dana Scallon, a letter criticising the EC support to SRH in developing countries and to IPPF and UNFPA was signed by 46 anti-choice MEPs and sent to the Commissioner for Development Poul Nielson. Given the fact that the current Commissioner is firmly supporting the ICPD goals, he sent a clear reply to the 46 MEPs, as well as to the Chair of the European Parliament Development Committee and to the President of the Parliament.

All these developments could put in real danger the future implementation of the ICPD Programme of Action and should be watched carefully.

## 4.2 The 2004 European Union enlargement process

The European Commission considered that ten new accession countries will be ready for full membership in May 2004. Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland the Slovak Republic and Slovenia will then join the EU, a process which will have important implications for development aid at the European level.

### 4.2.1 Requirements of the EU enlargement in the context of development aid

The EU development policy being an integral part of the "*Acquis communautaire*"[54], the candidate countries will have to participate in it as soon as they enter the EU, by taking part in the decision-making process and by contributing to the financing of development aid[55]. To be able to comply with these requirements, the accession countries are expected to establish specific and legal administrative frameworks for their own development policies and create specific ODA budget lines. How far do these countries stand today? Are SRHR issues taken into account? What might be the impact of enlargement on SRHR policies and funding?

### 4.2.2 Advancement and content of the accession countries' new development policies

Whereas some countries had a special cooperation policy during the Soviet Period (e.g. Czechoslovakia or Hungary), these policies have been abandoned after the fall of the Communist regime and need a complete modernisation. Moreover, many countries need to create everything, from strategic goals to decision-making bodies. This process is challenging for several reasons. The economic situation remains difficult (they were aid recipient until recently), development is not perceived as a priority and aid issues are hard to address for politicians given the strong public opinion's reluctance.

The accession countries can be classified in 3 categories[56] according to the advancement of each of their development policy. The first group are the countries which already established a legal and administrative framework for development and followed the DAC requirements. These are the Czech Republic, Slovakia, Poland and Estonia. All have specific ODA budget lines and implement projects abroad. Despite some remaining weaknesses, they will be the best prepared to enter the EU development policy.

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[54] The Acquis Communautaire is the body of common rights and obligations which bind all the Member States together within the EU. It is not only the EU law in the strict sense, but also all acts related to home/justice and foreign affairs plus the common objectives lay down in the Treaties. Applicant countries have to accept the Acquis before joining the EU.

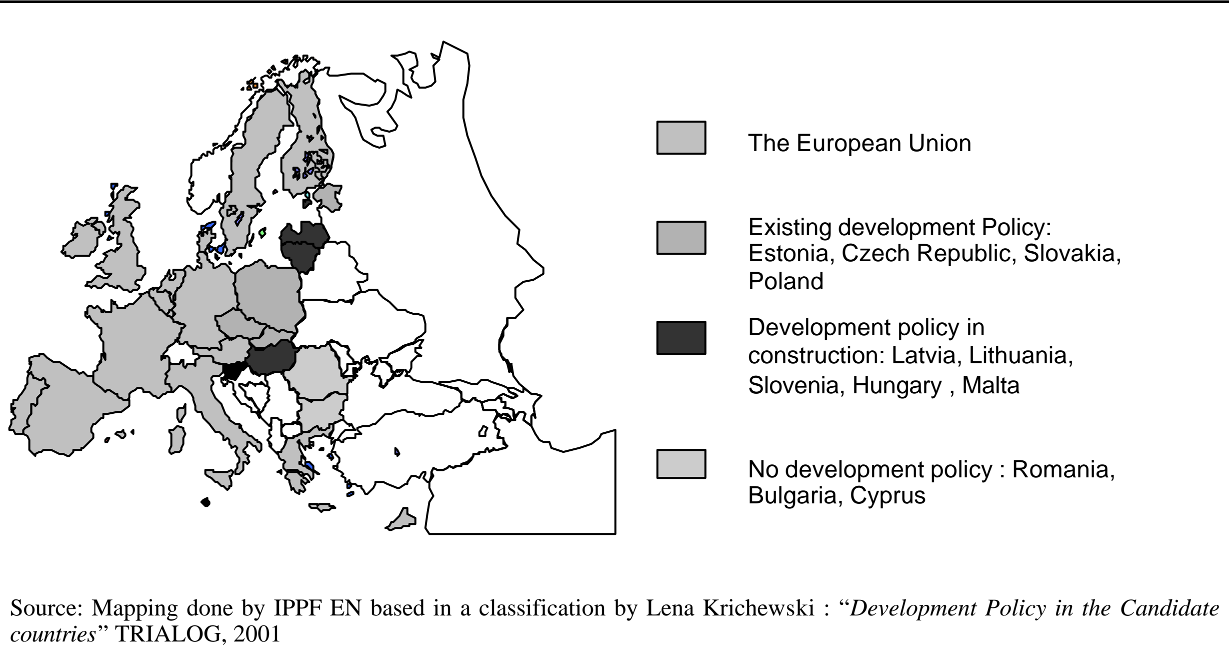
[55] Most new Member States don't have an ODA budget line. However, 4.68% of the total resources the new Member States will provide to the EC budget will automatically take the form of ODA. Moreover, they are expected to contribute to European Development Fund (EDF) from 2006 (as from the 10th EDF).

[56] Classification done by L. Krichewski : "*Development Policy in the Candidate countries*" TRIALOG, 2001

The second group are countries which started the process of creating a legal and administrative framework for development but which still have a long way to go in establishing it. Hungary, Malta, Lithuania and Latvia do not yet have ODA budget lines and give aid on a case by case basis. Slovenia is a special case among these countries as its aid policy has only been implemented in the framework of the Stability Pact of South East Europe.

The third group (Cyprus, Romania, Bulgaria) are the less advanced countries: there is no development policy in place or even in progress, apart from some occasional case by case humanitarian aid.

**Box VI: Accession countries' development policy advancement**




Source: Mapping done by IPPF EN based in a classification by Lena Krichewski : "*Development Policy in the Candidate countries*" TRIALOG, 2001

It is important to note that the nature of the development policies of the accession countries is traditionally different from the EU Member States'. This will have an impact on SRHR activities or policies. Moreover, the political environment in these countries presents strong specificities, which could hinder the implementation of the ICPD Programme of Action.

First, the geographical scope of aid is different: it is directed mainly to bordering countries or the near abroad. Little attention is given to the developing countries in Africa, Latin America and Asia. The Least Developed Countries, where the SRHR needs are the most important, are not chosen as the priority recipients of aid.

Secondly, these countries have other sectoral priorities. The accent is laid on assisting the transition of less advanced ex-communist countries (focus on e.g. good governance, democracy or technical assistance) and on providing humanitarian aid. The fight against poverty is not the first objective. SRH issues do not directly fall under the new MS' major themes: they do not consider health (including SRHR) in development as a priority. When reading the new development policy or concept papers, it comes out that improving health has seldom been chosen as an objective. It is not yet a settled fact as many countries didn't define their policies yet but it appears to be a trend. When health is chosen, it insists mainly on the development of health infrastructure and not on health care or access to services. Education is

often mentioned as an objective but more in the context of providing scholarships to foreign students to come and study in one of the new MS. While the fight against HIV/AIDS and a specific mention to the importance of gender issues are given in the Hungarian concept paper, SRH is nowhere mentioned in any of the policies.

Thirdly, the actual political environment in the accession countries may lead to an undermining of SRH issues in development for several reasons. They are rather traditional countries, which have most of the time conservative views on SRHR in the national context[57]. These views are being suggested and supported by the strong presence of the Catholic Church, known to be very influential in these countries (especially in Poland) and by a growing number of active and well-organised anti-choice groups, mainly spearheaded by US-based organisations. The same reluctance towards SRHR is expected from these governments in the context of development. And the same opposition forces will be present to back them up in an international context.

Whereas this can influence the content of the development policy of each country, it can also have consequences at a European level. The representatives of the accession countries in the European institutions, may it be the new Members of the European Parliament or politicians at the European Council or the Commission, are more likely to have conservative views on SRHR issues. These politicians are nevertheless going to play an active role in the EU decision making. This could lead to a potential negative influence of EU legislation and funding for international SRHR.

Finally, the new MS can not yet rely on civil society for developing a better understanding of the importance of poverty reduction and SRHR issues among the general public and politicians. Indeed, civil society dealing with development is still in an embryonic state in most accession countries. The only existing groups are faith-based organisations, financed by the US, with little experience from the South and often with rather conventional opinions about SRHR topics. The quasi absence of organised advocacy groups to promote SRHR in development in these countries is seen as a major constraint for the future implementation of the ICPD programme of Action.

#### 4.2.3 ODA levels and impact

Funding development aid is another requirement made by the EU to the accession countries. Whereas for a long time, no EU official document defined exactly what was expected from the new MS in terms of ODA volumes, the 'Barcelona commitments' clarified this situation. As they are part of the Acquis, they will also apply to the accession countries. The latter are thus expected to reach the same ODA goals than the EU-15: 0.33% GNI individually and 0.39% GNI collectively by 2006. In turn, this would lead to increased funding for SRHR.

Measuring the total ODA level of the accession countries remains a major challenge as these figures are most often not available. 4 countries out of the 10 do not have a development budget line (no ODA figures recognised as such) and whereas most of the others established ODA budget lines, they have done it recently and the split between ODA and other kinds of funding is seldom clearly set. Following is an overview table of the best estimates available.

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[57] E.g.: Access to abortion is extremely restricted in countries such as Poland and Malta. To protect this, the Polish government asked for a special provision on abortion to be annexed to the accession treaty to the EU. Warsaw put forward a request to the EU to include a declaration safeguarding Polish laws on the 'protection of human life'. Malta also raised religious concerns and asked for a special declaration stating that abortions will remain banned in the Mediterranean Island after it enters the EU.

**Box VII: ODA levels and ODA/GNI ratio of the Accession countries (2000-2001)**

| | ODA (Millions USD) | | ODA/GNI Ratio (%) | | Commitments |
|---|---|---|---|---|---|
| | 2000 | 2001 | 2000 | 2001 | (when dev budget line in place) |
| Czech Republic | 16.2 | 26.5 | 0.03 | 0.05 | ODA/GNI: 0.1% in 2007 |
| Slovakia | 6 | 8 | 0.03 | 0.04 | ODA/GNI: 0.12% in 2012 |
| Poland | 29 | 36 | 0.018 | 0.02 | No specific mention |
| Estonia | 1 | 0.45 | 0.02 | 0.01 | Remain at 0.01% ODA/GNI in 2003 |
| Hungary | n/a | 10 | n/a | 0.02 | No specific mention |
| Latvia | n/a | 0.06 | n/a | ˜ 0 | No dev budget line |
| Lithuania | n/a | 4 | n/a | 0.02 | No specific mention |
| Malta | n/a | n/a | n/a | n/a | No dev budget line |
| Slovenia | 3 | 2 | 0.015 | 0.01 | No dev budget line |
| Cyprus | 0.05 | n/a | ˜ 0 | n/a | No dev budget line |

Sources: Figures are extracted from '*Follow-up to the international Financing for Development (Monterrey 2002) Monitoring the Barcelona Commitments – Summary*' – SEC (2003)569 -15-5-2003 and L. Krichewski : "*Development Policy in the Candidate countries*" TRIALOG, 2001and IPPF members

In 2001, the total funding levels were still very low. While the two most advanced countries reached levels of 0.04% and 0.05% of GNI to ODA (Slovakia and the Czech Republic), only three other countries gave 0.02% (Hungary, Poland and Lithuania) and the remaining ones contributed amounts representing only 0.01% or less. Moreover the future plans of the new MS are not ambitious: either they remain rather realistic or they do not mention anything. Only the two most advanced countries have the specific aim of reaching 0.1% of GNI to ODA in the medium term.

From the above figures, it can be concluded that most acceding countries will be nowhere near the individual target of the 'Barcelona commitments' by 2006. Given the economic and political context, they will face tremendous challenges to even try to increase ODA.

It is also pretty safe to say that in the medium term, the enlargement will not imply any major increase in the total EC budget. Whether the least positive scenario is considered where the new MS will contribute only to the general EC budget[58] or whether a more optimistic one is taken into account, where already higher contributions to development aid and to the EDF from some MS are included, the conclusion remains that the increase in ODA will not compensate for the higher administrative costs linked to a structure having to absorb ten new members[59]. This situation is thus unlikely to provide significant additional funding for SRHR in developing countries.

This general context will call for reactions by the civil society community (in terms of capacity building, political advocacy and awareness raising) in order to defend international SRHR policies and funding in an enlarged EU.

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[58] This would increase total ODA/GNI of EU-25 to only 0.36% by 2006

[59] Regarding the EDF: there is no clear idea of how much the new MS will contribute to the 10th EDF – Only estimate available forecasts that EDF should increase by 4% in 2006.

### 4.3 An increased focus on HIV/AIDS…with what consequence on SRHR funding?

An analysis of a breakdown of spending within the total population assistance[60] shows that funds for family planning and reproductive health services are loosing ground to HIV/AIDS funding. In 2001, nearly 40% of all population assistance was spent for STI/HIV/AIDS activities. This funding increased steadily from 9% of total population assistance in 1995 to 39% in 2001. While family planning enjoyed a dominant position between 1995 and 1999, funding started to shift rapidly towards HIV/AIDS from 2000 (Box VIII).

Funding for family planning and reproductive health services still represents more than half total population assistance in 2001 (54%) but this share is decreasing rapidly. Consistent with the ICPD call for more integration of services, funding for family planning decreased from 55 to 29% between 1995 and 2000, while funding for reproductive health services increased from 18 to 29% in the same period. But the losses in family planning are not compensated by the gains in RH funding. Moreover, in 2001, the share for basic reproductive health services fell to 24%n from 29% in 2000. The difference in funding is in part allocated to 'pure' STI/HIV/AIDS activities.

Over the past 8 years, there is an increasing feeling in the SRHR community that HIV/AIDS funding is more and more substituting family planning and SRH funding instead of complementing it. This major concern expressed is that HIV/AIDS funding is not always used in projects having the same holistic and rights-based approach, consistent with the ICPD programme of action. This has been especially a worry in the US. Whereas the current Bush administration recently made an important increase in HIV/AIDS funds[61], it became clear after the announcement that the government and the right-wing members of the American Congress intend to tunnel the bulk of the new HIV/AIDS funding to religious organizations that have a narrow abstinence-based approach to HIV/AIDS prevention that questions and even excludes the use of condoms[62].

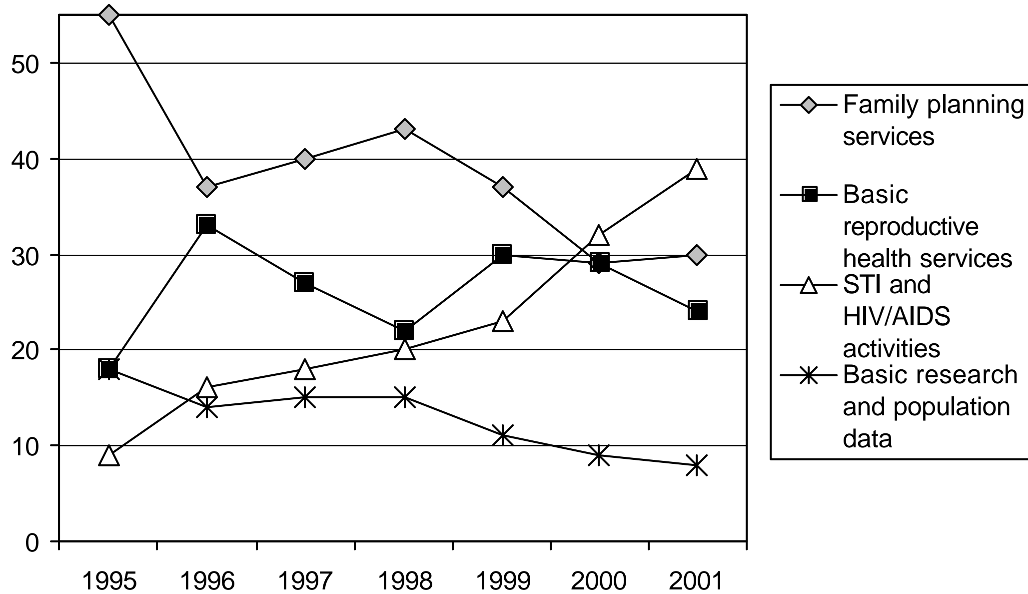
The reproductive health community was among the first ones to call for additional funding to fight the HIV/AIDS pandemic. They claimed that this funding should be used in the framework of comprehensive SRHR projects, including specific HIV/AIDS prevention and care aspects but also broader sexuality education, rights-based activities, information on STIs etc… The integration of HIV/AIDS in holistic SRHR projects, also called upon in the ICPD Programme of Action, is considered as crucial if countries are serious about stopping the spread of the disease. The rise in HIV/AIDS activities treated in isolation of the larger SRH approach can be seen as a threat to reaching a number of MDGs and the ultimate goals of the ICPD.

[60] Source: Figures from the '*Financial Resources flows for population activities in 2001*', NIDI/UNFPA, 2003

[61] In May 2003, President G.W. Bush signed the Global AIDS bill authorizing 15 billion USD over five years, including 10 billion USD in new funds. This funding breaks down to 3 billion USD each year up to 2008. It will start in 2004.

[62] In mid-September 2003, the Bush Administration canceled an 8 million USD grant to a group of Brazilian HIV/AIDS NGOs because they did not limit their programmes to abstinence-only interventions and actively promoted the use of condoms. (Source: DKT International/US Newswire, 15 September 2003)

**Box VIII: Final donor expenditures for population assistance, by category of population activity – 1995 - 2001**




Source: Figures from Financial Resources flows for population activities in 2001, NIDI, UNFPA

## 4.4 SWAPS and Sexual and Reproductive Health: Opportunities and Challenges

The 1980s witnessed major challenges to the traditional approaches to development assistance. Criticisms arose especially about the "project approach", which was considered as leading to aid fragmentation, overwhelming the management capacity of the developing countries and undermining local ownership. The end results of these projects were often seen as limited and unsustainable. (See Chapter I.5.2)

Sector-wide approaches (SWAPs) came as a possible answer to these shortcomings. The SWAP process is meant to improve the impact of development by ensuring national ownership, improving complementarities and policy coherence, strengthening the institutional capacity and enhancing the effectiveness of public sector expenditure. It is *"a method of working between the national government and donors which implies that all significant funding for that sector supports a single sector policy and expenditure programme, under the government leadership, adopting common managerial and procedural approaches across the sector, and progressing towards relying on the government procedures to disburse and account for all funds."*[63]

SRHR issues are generally dealt with by SWAPs in the health sector[64]. As the latter aim at creating a well-functioning health system, they can only be beneficial for SRH. Better health systems are indeed a major prerequisite for ensuring safe motherhood, the treatment of HIV/AIDS and other sexually transmitted infections, for reducing unsafe abortion and complications arising from them and for guaranteeing the provision of family planning. At the same time, given the multi-sectoral nature and the politically sensitivity of SRH, SWAPs can

[63] Foster and Browne, Feb 2000, ODI
[64] But not exclusively. Health is the major sector but other aspects of SRH are dealt with in other sectors such as education, agriculture…

also represent a potential risk for the issues. SRH could be integrated only partially or even left out of the policies due the following factors.

### 4.4.1 Multi-sectoral approach of SRH

SRH is a multi-sectoral issue: it includes a comprehensive package of themes from safe motherhood and contraception to sexual rights, STIs and HIV/AIDS, attention to vulnerable groups and education. While the more "medical aspects" of SRH will most certainly be dealt with in the framework of a SWAP in the health sector, other aspects of SRH, such as sexuality education or AIDS prevention campaigns, risk being left out as they are not part of the Ministry's competences. For example, some target audiences of SRH issues (teenagers, peer educators, sex workers, gays and lesbians…) are different from the general health-sector audience. By including SRH only in the health SWAP, the very concept of SRH could be significantly weakened. Some of the "non-medical" aspects may be integrated in other SWAPs but the comprehensive approach to SRH could lose strength due to fragmentation.

To avoid the watering down of the holistic SRH approach in a SWAP environment, inter-sectoral collaboration becomes essential. Different stakeholders working on relevant issues in other sectors have to be informed about the policies of the health SWAP and work should be coordinated[65]. A sectoral approach should not exclude the option of sometimes choosing a multi-sectoral approach to safeguard the ICPD approach. But there is no simple solution: indeed, when advocating for collaboration, other challenging but legitimate questions may arise: at what level should this collaboration happen? Who should take the lead? How should it happen?

### 4.4.2 Public sector priorities do not necessarily include SRH

In most developing countries, SRH is still a rather new concept at national or local health-sector level and specific agreements to include these services in the public sector have not become policies yet. In the creation of a Health SWAP, no priority can thus be given to SRH, irregardless of the needs.

### 4.4.3 Staff capacity may be over-estimated

In a SWAP in the health sector, the Ministry of Health becomes the leading agency and much is then expected from its staff. They have to take management and strategic decisions and the implementation of the SWAP depends for a great deal on the professional quality of the staff[66]. This situation can be challenging for SRH. In many developing countries, SRH remains a politically sensitive issue and politicians often prefer other priorities to avoid discussions. Whenever SRH is adequately taken into account at the Ministry's levels, the staffs responsible for the implement of SRH programmes needs to have the skills and knowledge in the field and therefore needs to be adequately trained.

Involving external experts in SRH in the creation of the SWAP as well as encouraging the participation of NGOs might provide a solution to these challenges. To achieve this, parallel to the development of the SWAP process, efforts to increase the advocacy capacity of NGOs could be positive so that such organisations are in position to play a real stakeholders' role.

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[65] "*Promoting Reproductive and Sexual Health in the Era of SWAPs*", A. Papineau Salm, Reproductive Health Matters, Volume 8, No 15, May 2000

[66] "*SWAPs in Health, Opportunties, limitations, risks and alternatives*", R. Dubbeldam, ETC Crystal, Presentation made at a Roundtable organised by Sharenet in Sept 2002 on SWAPs and SRH (www.share-net.nl)

#### 4.4.4 Steps forward

SWAPs in the health sector are supposed to improve the countries' health system and SRH will only be gaining from that. However, in order to safeguard the comprehensive aspect of SRH required by the ICPD Programme of Action, SWAPs seems to be insufficient. Accompanying measures are believed to be crucial, such as inter-sector collaboration or NGO capacity building.

Such accompanying measures are even more relevant in a context where direct support to the recipient's country overall budget is increasingly becoming the channel for distributing aid chosen by important donors. The Ministry of Finance becomes then the only manager of aid and allocates the funds according to its national policy, set up in collaboration with donors in the 'Poverty Reduction Strategy Paper'. This 'direct budget support' approach will make it even more difficult to track what is specifically done in the field of SRH. Analysing whether the country is actually active in implementing the ICPD programme of Action and whether it has the capacity to do is, in that context, a real challenge. Monitoring the progress towards the ICPD goals will require new methods in the future: the follow-up of the financial flows of individual donors is becoming more and more irrelevant in the development context of today.

# CONCLUSION

Incontestably, the donor community has significantly improved its commitment to sexual and reproductive health and rights (SRHR) since the International Conference on Population and Development (ICPD) in Cairo in 1994: donors' population assistance has increased by 25% from 1.37 to 1.71 billion USD from 1995 to 2001, while total population assistance, including from development banks and the UN system, increased from 2 to 2.5 billion USD over the same period. In the meantime, many countries reformulated their policies in order to comply with the ICPD recommendations. This expanded political support in turn encouraged increases in financial contributions to SRHR.

However, both political and financial support is strikingly uneven among donor countries. Only a few countries have developed comprehensive SRH policies and reached SRH funding levels in compliance with the internationally accepted target of 4% of ODA. In fact, a majority of donors did not reach even half of this target and were not able to draft formal policies that could allow the existence of SRH activities beyond a narrow medical approach.

Moreover, the level of resource mobilisation in the donor community in 2000 fell short of the agreed ICPD target of 5.7 billion USD for that year. At the same time, the general ODA level has not been increasing enough to cover the costs needed to have an impact on poverty reduction. The analysis of ODA trends does not give much ground for optimism about the future commitment of the development community either to the MDGs or to the ICPD Programme of Action. Indeed, while combating HIV/AIDS now occupies the centre stage in the development field and new resources are increasingly being transferred to countries recently affected by terrorism, funding to realise the objectives of the ICPD and the MDGs is, in fact, declining.

Other new challenges already or will further complicate implementation of the ICPD Programme of Action in Europe. For example, growing opposition forces combined with the upcoming addition of several socially-conservative countries to the European Union will complicate the discussion of international SRH needs in the region. And the increased usage of SWAps in development could undermine SRH and make the monitoring of the ICPD even more challenging than in the initial years after the Conference.

In this context, the donor community should give the ICPD objectives and the MDGs a second look with a view to adopting a better approach to its implementation – an approach that concentrates on implementing strategic interventions that enhance the synergy among several of the related objectives. These include, among other things, focusing on the needs of young people and creating innovative approaches through collaboration with other sectors, such as NGOs and the private sector.

## ***ABBREVIATIONS***

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| DAC | Development Assistance Committee |
| EC | European Commission |
| EU | European Union |
| FGM | Female Genital Mutilation |
| FPA | Family Planning Association |
| FP | Family Planning |
| GNP | Gross National Product |
| GNI | Gross National Income |
| HIV | Human Immunodeficiency Virus |
| ICPD | International Conference on Population and Development |
| IPPF | International Planned Parenthood Federation |
| IPPF EN | IPPF European Network |
| LDC | Least Developed Countries |
| MDG | Millennium Development Goals |
| MS | Member States |
| NGO | Non Governmental Organisation |
| ODA | Official Development Assistance |
| OECD | Organisation for Economic Co-operation and Development |
| PoA | Programme of Action |
| SRH | Sexual and Reproductive Health |
| SRHR | Sexual and Reproductive Health and Rights |
| SWAps | Sector Wide Approaches |
| STI | Sexually Transmitted Infections |
| UN | United Nations |
| UNECE | United Nations Economic Commission for Europe |
| UNFPA | United Nations Population Fund |
| WHO | World Health Organisation |

## ***CORE REFERENCES***

This is only a short inventory of the main sources of information. More specific sources are given in the footnotes of the paper.


- The '*DAC WATCH Compilation – An overview of Donors' performance in Sexual and Reproductive Health and Rights'* – IPPF European Network, 2002
- The '*Euromapping project'* by DSW and IPPF European Netwok, 2003 – on www.eurongos.org/resources/euromapping
- '*The DAC 2002 Annual Report'* - OECD/DAC Development Cooperation Journal, Volume 4, Number 1, 2003 –
- '*Financial Resource flows for population activities in 2000'*, NIDI-UNFPA, 2002
- Preleminary figures of the '*Financial resources flows for population activities in 2001'*, NIDI-UNFPA, 2003


## ***ANNEXES***


**Annex I** **A. Net ODA Volume from DAC Member countries in 2002**
**B. Net ODA in 2002 – as a percentage of GNI**

**Annex II** **Definition of the Costed Population Package**

**Annex III** **A. SRHR Spending in 2000 and 2001**
**B. SRHR/ODA ratio in 2001**

**Annex IV** **The Mexico City policy**

**Annex V** **Donors' Spending for UNFPA (2001-2003)**

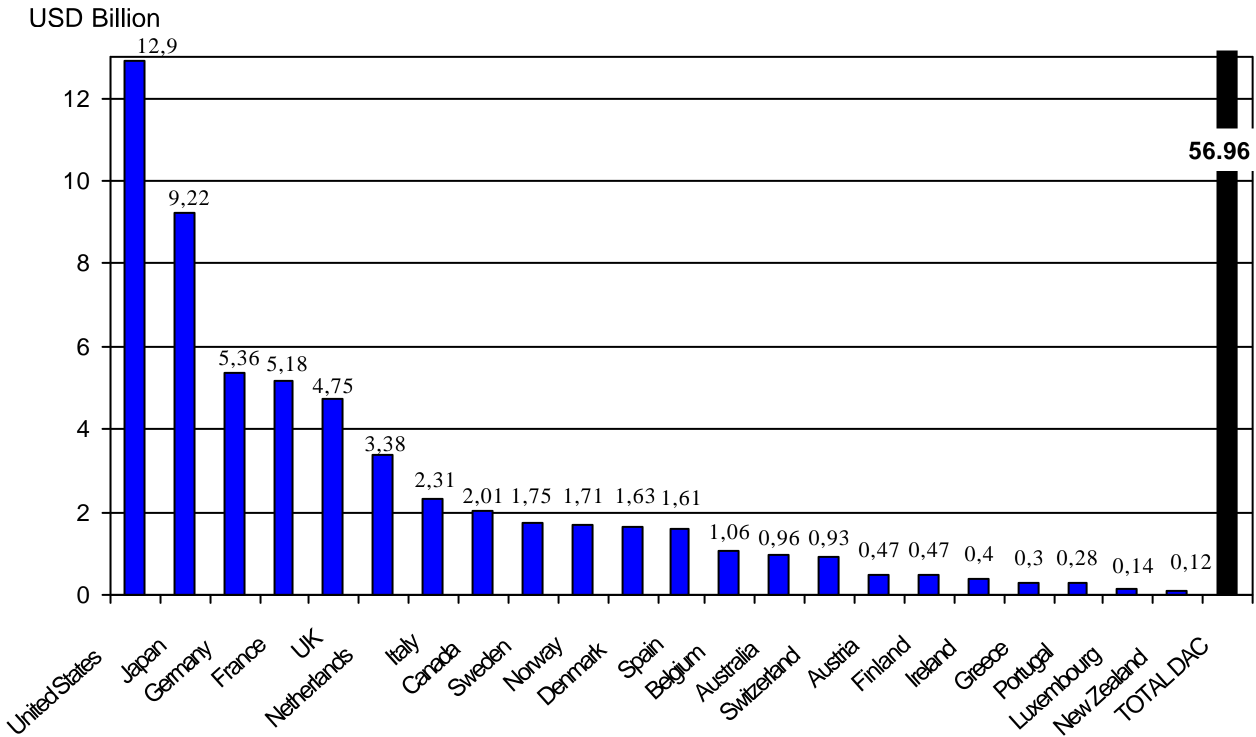
**Annex VI** **Government Grants to IPPF (2000-2002)**

**Annex V** **Mapping of the international sexual and reproductive health policies among European countries (plus Canada and the US)**

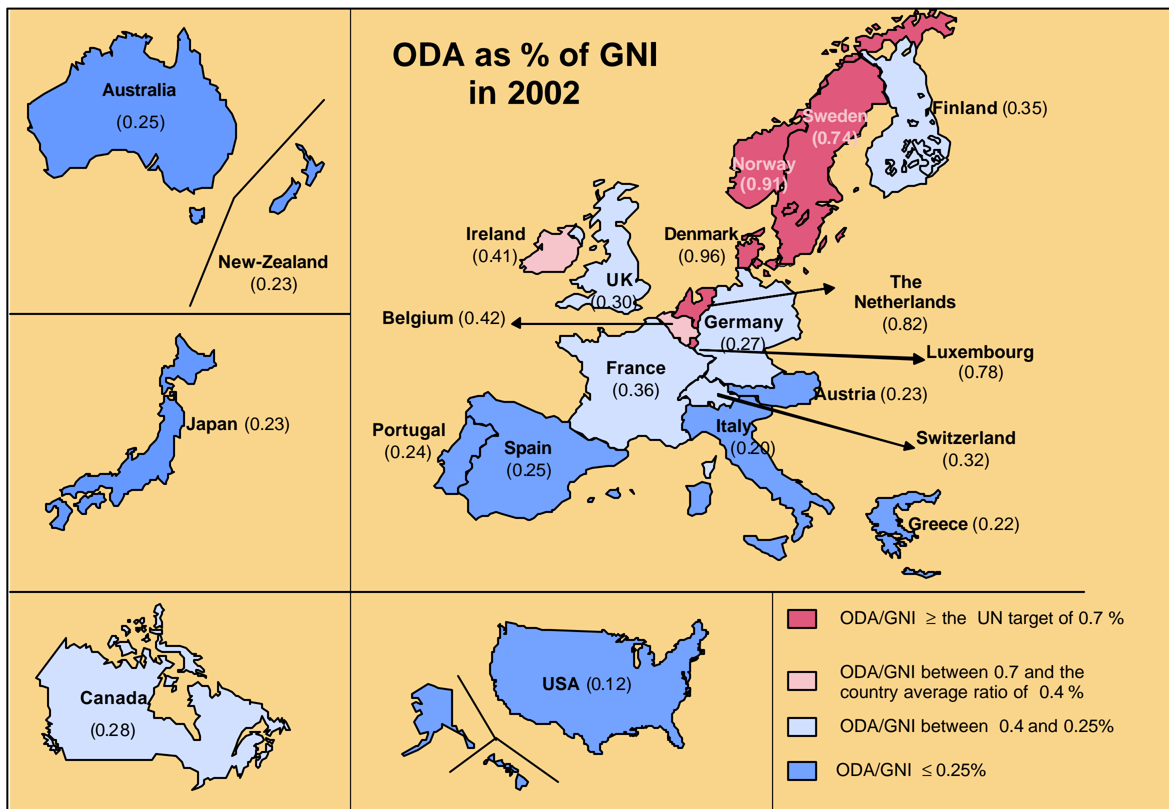
**Annex VI** **European snapshots: Individual country tables providing an overview of each donor's commitments on ODA and SRHR**

**ANNEX I** *(Source: OECD/DAC 2002 figures)*

## A. Net ODA Volume from DAC Member countries in 2002




## B. Net ODA in 2002 – as a percentage of GNI



## ANNEX II: DEFINITION of the COSTED POPULATION PACKAGE

The ICPD "Costed Population Package" includes the following activities:

### FAMILY PLANNING SERVICES

- Contraceptive commodities and service delivery;
- Capacity-building for information, education and communication regarding family planning and population and development issues;
- National capacity-building through support for training;
- Infrastructure development and upgrading of facilities;
- Policy development and programme evaluation;
- Management information systems;
- Basic service statistics;
- Focused efforts to ensure good quality care.

### BASIC REPRODUCTIVE HEALTH SERVICES

- Information and routine services for prenatal, normal and safe delivery and post-natal care;
- Abortion (as specified in paragraph 8.25 of the ICPD Programme of Action);
- Information, education and communication about reproductive health, including sexually transmitted diseases, human sexuality and responsible parenthood, and against harmful practices;
- Adequate counselling;
- Diagnosis and treatment of sexually transmitted diseases (STDs) and other reproductive tract infections, as feasible;
- Prevention of infertility and appropriate treatment, where feasible;
- Referrals, education and counselling services for sexually transmitted diseases, including HIV/AIDS, and for pregnancy and delivery complications.

### SEXUALLY TRANSMITTED DISEASES, HIV/AIDS PREVENTION

- Mass media and in-school education programmes,
- Promotion of voluntary abstinence and responsible sexual behaviour
- Expanded distribution of condoms.

### BASIC RESEARCH, DATA AND POPULATION AND DEVELOPMENT POLICY ANALYSIS

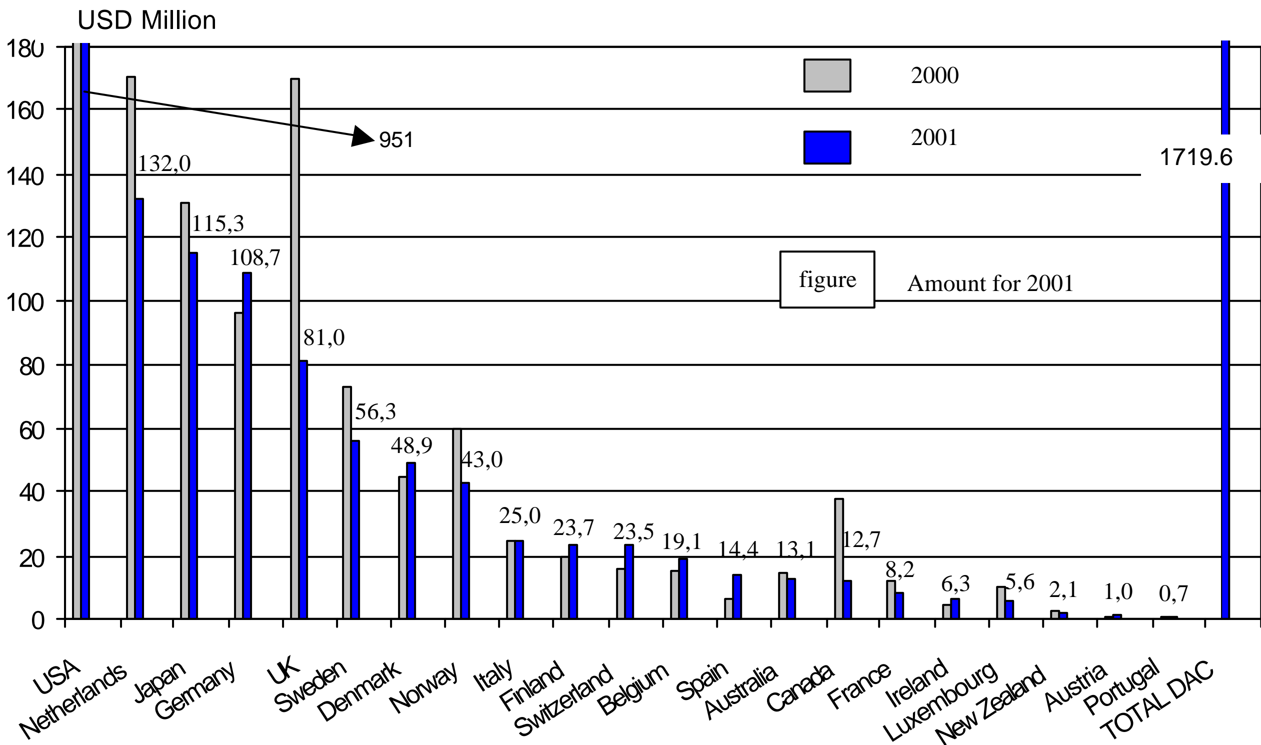
- National capacity-building through support for demographic as well as programme-related data collection
- Analysis, research, policy development
- Training.

*Source: The Programme of Action of the International Conference on Population and Development, Para 13.14*

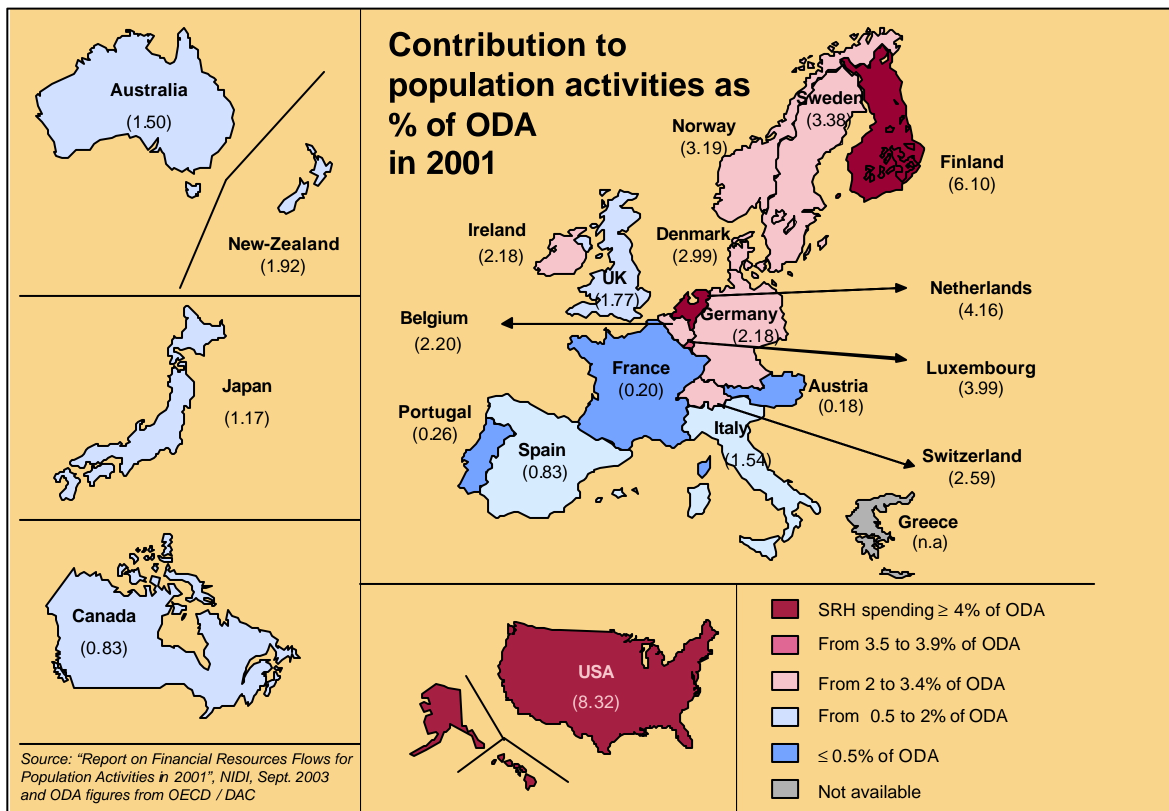
# ANNEX III

## A. SRHR Spending in 2000 and 2001

*Source: NIDI Report on 'Financial Resources for Population activities in 2001'*




## B. SRHR/ODA ratio in 2001



## ANNEX IV: THE MEXICO CITY POLICY

On 22 January 2001, President G.W. Bush re-imposed the Mexico City Policy, which was first introduced by President Ronald Reagan in 1984 but was rescinded by President Bill Clinton in 1993.

### What is the Mexico City Policy?

The Mexico City Policy restricts foreign non-governmental organizations (NGOs) that receive USAID family planning funds from using their own, non-USAID funds to provide any abortion-related activities (ARA). This is a broad category of activities, which includes legal abortion services but also national advocacy for abortion law reform, medical counselling or information regarding abortion. In other words, the US administration is cutting off international aid money from any family planning organisation that engages, directly or indirectly, in ARAs.

President G.W. Bush presented the policy as a means to keep US taxpayers' money from supporting ARA abroad. However, this has been the case since 1973 when the Helms Amendment was adopted, preventing US funds from being used in any ARA. This Amendment has been in force ever since.

Whereas the Helms amendment prevents US funds from being directly spent on ARA, the Mexico City Policy prevents US funds from being given to non-ARA projects of organisations that also provide ARA, even when these ARA are financed by sources other than USAID. Thus, there is a strict condition imposed on NGOs if they wish to receive US funding: NGOs are not allowed to engage in any ARA, regardless of the source of funding.

### What are the consequences of this policy?

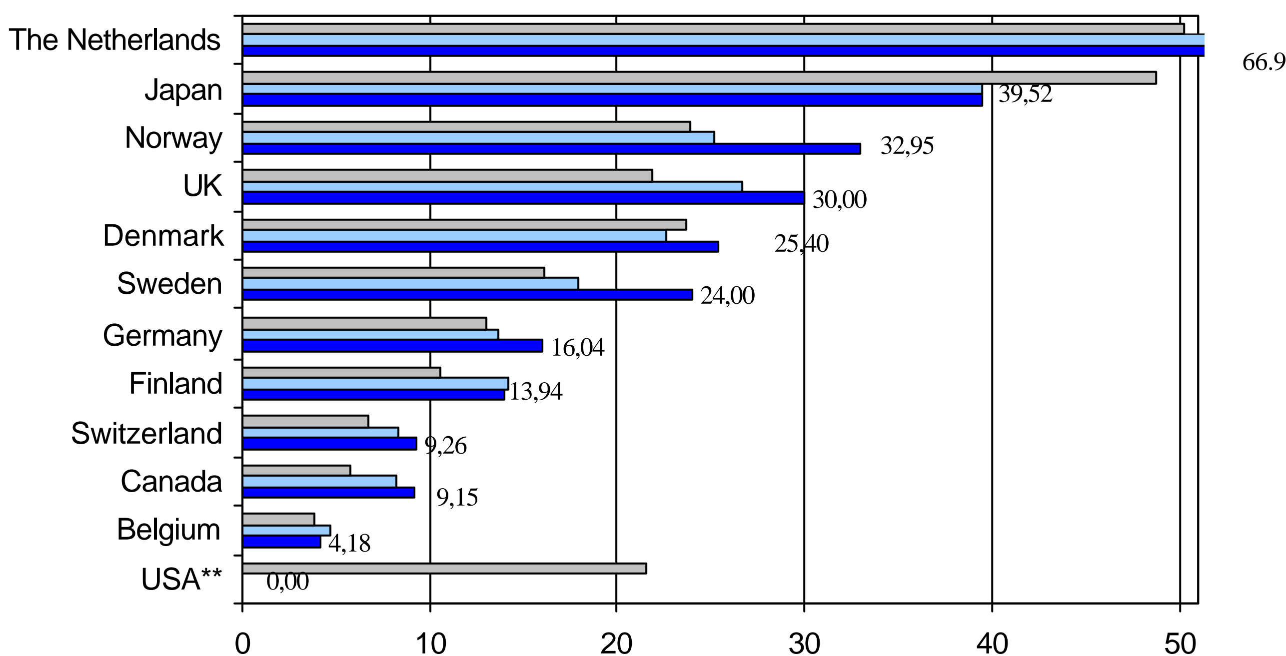
Organisations that do not sign up for the Mexico City Policy will lose all U.S. funding. This funding would have been spent on sexual and reproductive health (SRH) programmes, including family planning, which would have prevented unwanted pregnancy and unsafe abortion. The Mexico City Policy will increase -- not decrease -- the number of unsafe and illegal abortions worldwide.

By limiting the ability of foreign NGOs to advocate with their governments, the policy reduces NGOs' rights to exercise freedom of speech. It also undercuts U.S Foreign Policy objectives by erecting barriers to the development of the democratic process abroad (e.g. by preventing abortion law reforms). It also affects international assistance provided by other donors who will not be able to collaborate with foreign NGOs on ARA projects if those NGOs also receive US funds. The Mexico City Policy challenges foreign governments' sovereignty by constraining their implementation of national health care policy decisions.

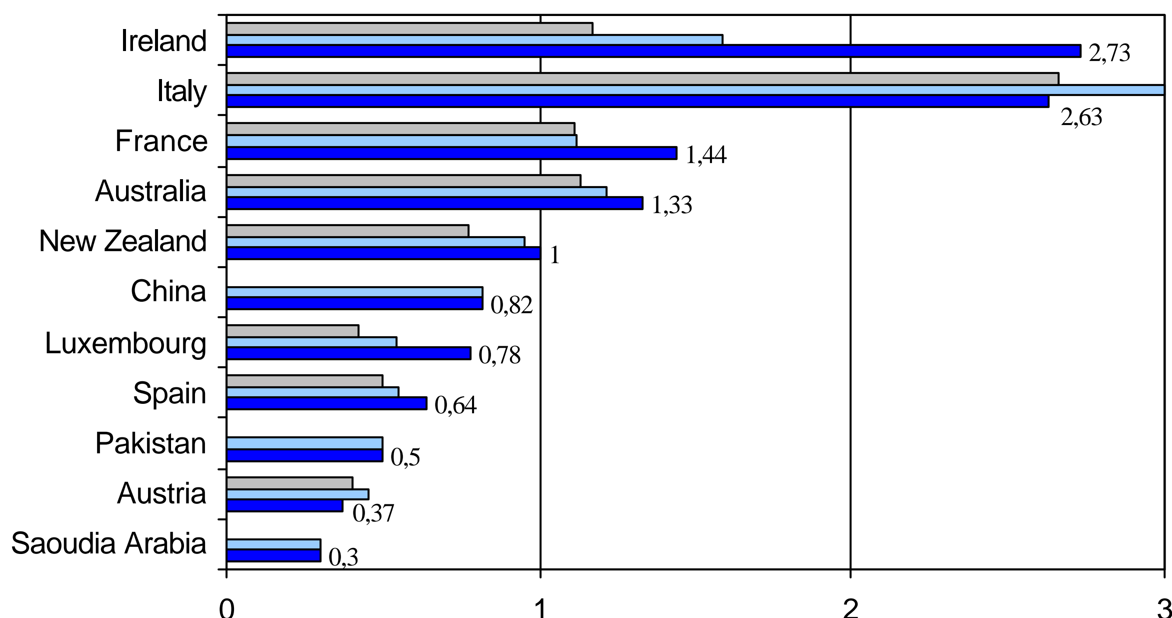
Since the reinstatement of the Mexico City Policy, dozens of organisations have lost funding, including a number that have lost access to basic contraceptive supplies.

**ANNEX V: Donors' Spending for UNFPA*** (Net general Contributions in Millions USD)

## Top 12 Contributors to UNFPA (2001-2003)




## 10 Smallest Contributors to UNFPA (2001-2003)




Sources: OECD/DAC Contributions to UNFPA's Regular Resources for 2001 and 2002", RDB UNFPA

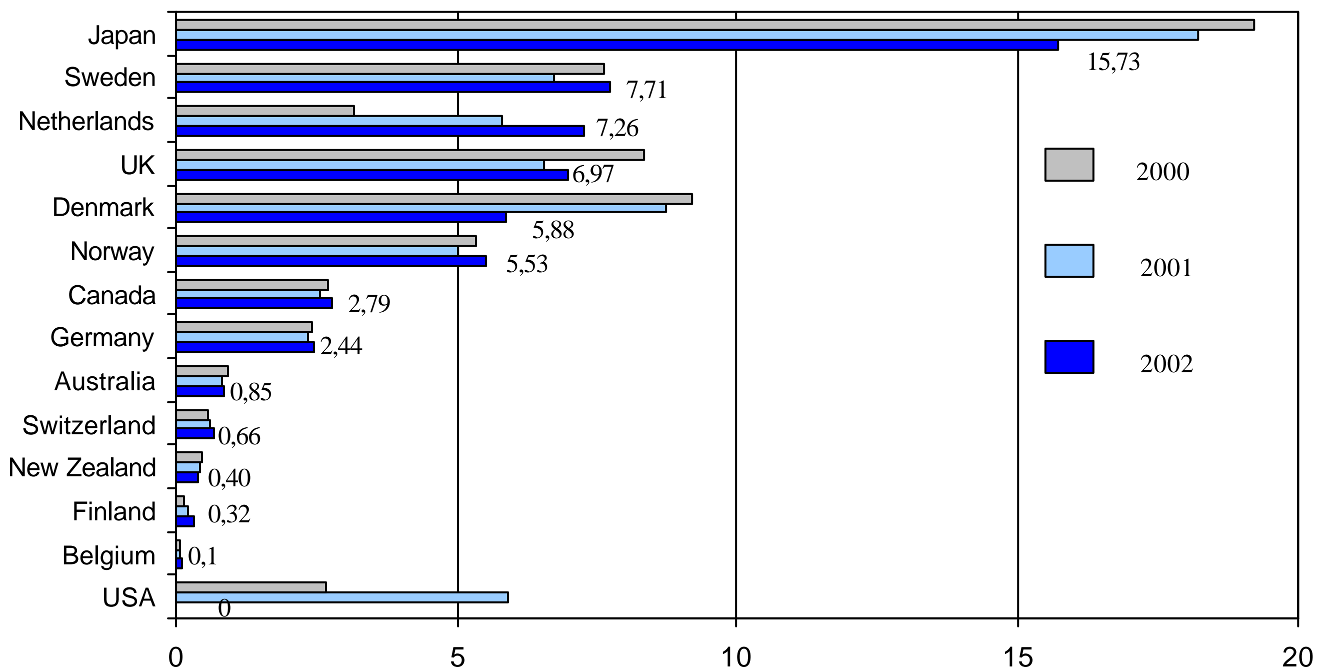
* Bear in mind the scale difference between the two graphs
** The American Congress accepted in December 2001 to give 34 million USD to UNFPA for 2002 but the Administration of President G.W. Bush denied it in July 2002. The US is consequently not funding UNFPA anymore.

2001 2002 2003

**ANNEX VI** *(Source: IPPF Financial Statements 2000, 2001 and 2002)*

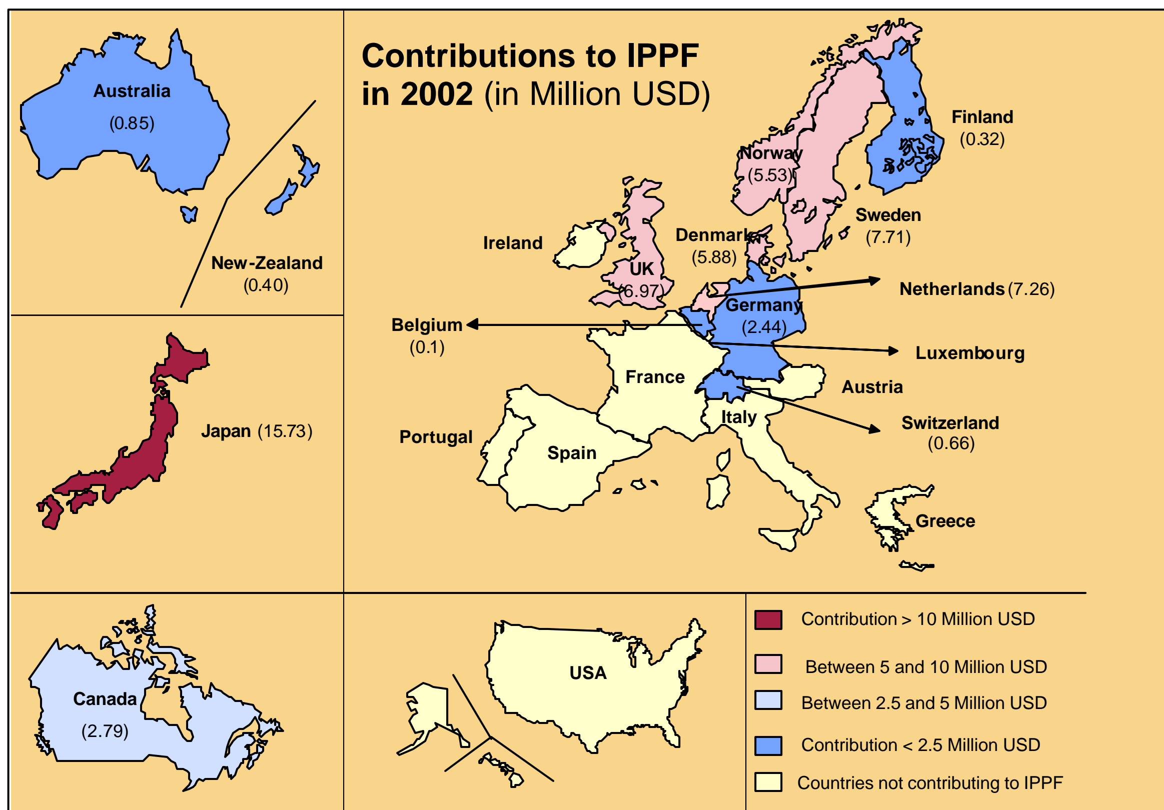
## A. Government Grants* to IPPF (2000 – 2002)

USD Million




* Total restricted and unrestricted
Austria, France, Greece, Ireland, Portugal, Luxemburg, Italy, and Spain are not contributing to IPPF.

## B. Mapping of the contributions to IPPF in 2002



## ANNEX V: Mapping of the international sexual and reproductive health policies among European countries (plus Canada and the US)

| Category of the country's SRH policy | Country | Policy content and country specificity |
|---|---|---|
| 1. Comprehensive and independent SRHR policies - in line with the ICPD goals – or well-integrated in a sectoral policy | - Netherlands (NL) | Long tradition of SRH support, even before ICPD. The actual SRH policy dates from 1994. After ICPD, NL broadened its SRH programmes and adopted a more integrated approach. Became a leading spokes country on controversial issues such as sexual rights and young people SRH needs. Strongly calls for the integration of HIV/AIDS activities in comprehensive SRH programmes. |
| | - Sweden (SE) | Long-standing high political commitment for SRH through specific policies (already since the 1950's). After ICPD, SE increased its support: it attributed more funding and deepened its policies by linking ICPD recommendations with poverty reduction, human rights and sustainable development (1997). It took the lead in addressing sensitive issues such as sexual rights and adolescent needs in SRH. In 2003, SRH became one of the main priorities of the Swedish development policy. |
| | - Denmark (DK) | DK traditionally recognises SRH in its development policy and considers it as a priority. Over time, DK became the leader in imposing SRH as a multi-dimensional concept requiring a multi-sectoral responsibility (1999). DK often recalls that SRH is essential for poverty reduction and the implementation of human rights (2000). |
| | - Norway (NO) | NO is supporting SRH for a very long time: very early on, it closely linked SRH to other development issues such as the environment, sustainable development, human rights. Even before 1994, NO had a multi-dimensional approach to SRH. After ICPD, it adopted a comprehensive 'Strategy for Women and Gender Equality in Development Cooperation' (1997) which not only looks at RH but also at education, economic participation, HIV/AIDS… |
| | - United States of America (US) | The US has a 30-year long tradition in family planning (FP) assistance and played a crucial role in international acceptance for SRH, especially at the ICPD. FP and RH are among the 5 main priorities of the USAID Global Health Strategy (1997). However, since ICPD (especially since the Bush Presidency), the US has not been able to reform its FP policy: it failed to set up a more holistic SRH approach (focusing more on a rights-based rational), it implemented conservative programmes and has limited the distribution of SRH funds (See The Mexico City Policy). |
| | - United Kingdom (UK) | The UK is a long-term supporter of SRH issues but both the 1994 ICPD and the arrival of the new Labour government in 1997 contributed to further enhance the country's commitment. SRH is a priority in the 2000 'Better Health for poor people' strategic paper and is seen as a key element for reducing poverty. A specific department in DfiD deals with population issues and monitors SRH targets. |
| | - Canada (C) | C played a key role in framing the PoA of the ICPD and is active in promoting SRH internationally. The 1996 'Health Strategy' assigns high priority to women's health, HIV/AIDS and FP programmes. In the 2001 'Action Plan on Health', SRH is recognised as one of C's social priorities and a key determinant for poverty reduction. But C doesn't have a detailed strategy to provide guidance for the programming of projects in SRH and it fails to present a fully coherent approach. |
| | - Switzerland (CH) | Over time, CH has largely neglected SRH issues in its policy. This situation did not change directly after the ICPD: whereas CH officially supported the ICPD language, there was no clear policy and it funded SRH mainly through multilateral channels. It is only in the strategic paper 'Health Policy for 2002-10' that CH mentions SRHR as one its five priorities in health. It intends to promote reproductive rights and integrated RH services, including HIV/AIDS and STIs. It is also willing to develop its bilateral SRH projects. |

| | | |
|---|---|---|
| 2. SRH policies integrated in a sectoral strategy (but not an independent status) or explicit mentions of population issues in a sectoral policy | - Germany (D) | FP is a central field for D since the 1980. It had a specific policy on population issues already in 1991. It increased its engagement after the ICPD by better integrating FP in its health policy (1999) and its poverty reduction strategy (2001). Whereas D sees FP as a human right, it does not use the holistic ICPD language on SRH. A large focus is laid on gender issues and HIV/AIDS. In recent years, support for SRH has been decreasing. |
| | - Finland (FI) | FI has over time showed special interest for women's issues and since 2000, SRH figures on a predominant position in the Finnish health development cooperation. It has been given priority, together with HIV/AIDS. FI is also very involved in gender equality and human rights. |
| | - Belgium (B) | B significantly improved its SRH policy since ICPD: FP and RH became priorities in the health sector in the new development policy of 1997. In its '2000 Quality in solidarity' paper, B promises to pay more attention to these issues by broadening its activities (not only by integrating SRH in basic health but also by promoting SRH in education and by increasing funding). The fight against HIV/AIDS is another major Belgian priority. B however still needs to develop an independent SRH policy paper, integrating the fight against HIV/AIDS. |
| | - Spain (S) | SRHR was a concept recognised in the Spanish aid policy only in 1995, as a consequence of the ICPD. While there is no specific SRH policy, these issues (incl. HIV/AIDS) are clearly included in the definition of basic social services, one of the priorities of Spain's aid policy (1998). In the 'Directive Plan 2001-04, it is said that S wants to be active in 4 areas of work of the ICPD PoA. Gender has also been recognised as a cross-cutting issue in 1996. However, there is no specific policy on SRH. |
| | - Portugal (P) | SRH is a rather new concept in the Portuguese development policy. Whereas FP was mentioned in the overall health strategy before the ICPD, P expanded the definition of RH to include maternal and child health and AIDS in 1996. The changes in the Portuguese development policy followed the evolutions in domestic policy regarding SRH: several laws (education (84), abortion (97)) became more liberal in the countries, leaving space for more progressive approaches in cooperation aid. However, the arrival of a conservative right-wing government in 2002 is slowing down these changes. |
| 3. No clear SRH policy or limited and/or very broadly defined mention of population issues in a sectoral policy | - France (F) | F has a long standing reluctance to provide direct and open support to SRH. The ICPD did not bring a clear policy change. In practice, however, F is active in specific ICPD areas: maternal health and women's rights (esp. girls' education and the fights against FGM). It is also a world leader in the fight against HIV/AIDS. But F still fails to provide a holistic SRH approach and to mention SRH in its policy. |
| | - Luxem-bourg (L) | L does not have an SRH strategy nor particular mention of SRH in its 1996 'Cooperation and Development Law'. Whereas the need for RH policies is recognised by the government, it is never done in an explicit way. Gender is however seen as a cross-cutting issue (L has a specific policy paper on 'Women and development (1997)) but the government fails to bring up an outspoken commitment to SRH issues. (At the same time, SRH funding is increasing significantly over time.) |
| | - Ireland (IR) | IR has never been able to openly get involved in SRH issues in it development policy mainly because of strong national opposition forces linked with the dominant influence of the Vatican in the country. None of the Cooperation Strategy papers mention SRH. In the meantime, the general public is gradually showing more interest for the issues and recent increases (2002) in the Irish contributions to UNFPA illustrates this change. |
| | - Italy (I) | Whereas there is a specific mention of SRH within the Italian health policy (in the framework of its poverty reduction strategy 1998), these issues are given a very low priority. SRH areas cover AIDS and the promotion of family planning but little programmes are implemented and no clear action plan is envisaged in the near future. |
| | - Austria (AU) | AU abandoned health as a priority in development and makes no reference to SRH. Empowerment of women is a new priority but no link is made with SRHR. ICPD increased the interest of government administration but no changes in the policies were noticed. |
| | - Greece (G) | No mention of SRH. Implementation of some ad hoc HIV/AIDS projects. Gender equality became one of the cross-cutting priorities in the development policy (1999) |

## ANNEX VI: European snapshots - Individual country tables providing an overview of each donor's commitments on ODA and SRHR

This annex presents overview tables for the following countries[67]:

- Austria
- Belgium
- Denmark
- European Community
- Finland
- France
- Germany
- Ireland
- Italy
- Luxembourg
- Netherlands
- Norway
- Portugal
- Spain
- Sweden
- Switzerland
- United Kingdom

For each country, a table provides statistical data on:

- General ODA information broken down in multilateral and bilateral proportions, the top 10 recipient countries of ODA and the top 3 UN agencies receiving ODA
- Spending on population assistance specifying bilateral and multilateral proportions, the major countries having received health and SRHR funding and the contributions given to UN agencies working in SRH-related fields (UNIFEM, UNAIDS…)

[67] Except Greece as no figures were available

## GENERAL ODA FIGURES of AUSTRIA[68]

| **Total ODA** [69] | | |
|---|---|---|
| | Million USD | % of GNI |
| 2000 | 423 | 0,23 |
| 2001 | 533 | 0,29 |
| 2002 | 475 | 0,23 |

| **Total Bilateral ODA** | | |
|---|---|---|
| | Million USD | % of ODA |
| 2000 | 258,03 | 61 |
| 2001 | 292,93 | 64 |
| 2002 | 332,50 | 70 |

**Top 10 Total ODA Recipients 2000/2001**

1. Poland (OA)
2. Indonesia
3. Cameroon
4. Bolivia
5. Former Republic of Yugoslavia
6. Egypt
7. China
8. Bosnia & Herzegovina
9. Turkey
10. Ghana

| **Total Multilateral ODA** | | |
|---|---|---|
| | Million USD | % of ODA |
| 2000 | 164,97 | 39 |
| 2001 | 164,07 | 36 |
| 2002 | 142,50 | 30 |

| **Top 3 UN Agencies in 2001**[74] (Million USD) | |
|---|---|
| 1. UNDP | 4 |
| 2. WHO | 2 |
| 3. WFP | 1 |

## SPENDING on POPULATION ASSISTANCE of AUSTRIA

| **Total spending on population assistance**[70] | | |
|---|---|---|
| | Million USD | % of ODA |
| 1999 | 1,45[71] | 0,27 |
| 2000 | 0,87 | 0,21 |
| 2001 | 0,98 | 0,18 |

| **Bilateral spending on population assistance** | | |
|---|---|---|
| | Million USD | % of ODA |
| 1999 | 0,00 | 0,00 |
| 2000 | 0,07 | 0,02 |
| 2001 | 0,07 | 0,01 |

**Recipient Countries having received funding for SRH** [72]

the Austrian government provided direct bilateral SRH / population support to:

**in 2000:**

- Zambia

**in 2001:**

- Peru

**in 2002:**

Cameroon
Ecuador
Palestinian Administered Areas
South Africa

**in 2003:**

Afghanistan

| **Multilateral spending on population assistance** (Million USD) | | | |
|---|---|---|---|
| | 2000 | 2001 | 2002 |
| UNFPA[73] | 0,27 | 0,40 | 0,37 |
| IPPF | 0,00 | 0,00 | 0,00 |
| Total of UNFPA and IPPF | 0,27 | 0,40 | 0,37 |

| **SRH-related organisations** (Million USD) | | | |
|---|---|---|---|
| | 2000 | 2001 | 2002 |
| UNIFEM[75] | 0.06 | 0,00 | 0,01 |
| UNAIDS[76] | 0,00 | 0,00 | 0,00 |
| Global AIDS Fund[77] | | 1,08 | |

[68] Source: The DAC Journal, Development Co-operation 2002 Report (2003, Vol 4, N° 1)
[69] for the OECD, ODA figures include the grants and loans to countries in Part I of the DAC List of Aid Recipients provided by the official sector with the promotion of economic development and welfare as main objective
[70] Source: "Financial Resource Flows for Population Activities in 2001", UNFPA/NIDI, September 2003
[71] this figure does not include project expenditures
[72] Source: Heinz Gabler, Information and Communication, Austrian Development Cooperation, Federal Ministry for Foreign Affairs
[73] Source: "OECD/DAC Contributions to UNFPA's Regular Resources for 2001 and 2002", RMB UNFPA
[74] Source: Heinz Gabler, Information and Communication, Austrian Development Cooperation, Federal, Ministry for Foreign Affairs
[75] Source: UNIFEM Annual Report 2002/2003, Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.
[76] Source: UNAIDS Governance, Donor & UN Relations Department, "Donor Contribution Table 2000-2002, the Unified Budget (Core)"
[77] This amount refers to pledges over the period 2001 – 2003. Source: Website of the Global Fund to Fight AIDS, Tuberculosis and Malaria (total pledges until 22 August 2003) (http://www.globalfundatm.org/files/pledges&contributions.xls)

## GENERAL ODA FIGURES of BELGIUM[78]

**Total ODA** [79]

| | Million USD | % of GNI |
|---|---|---|
| 2000 | 820 | 0,36 |
| 2001 | 867 | 0,37 |
| 2002 | 1.061 | 0,42 |

**Total Bilateral ODA**

| | Million USD | % of ODA |
|---|---|---|
| 2000 | 475,60 | 58,0 |
| 2001 | 497,95 | 57,5 |
| 2002 | 658,88 | 62,1 |

**Top 10 Total ODA Recipients 2000/2001**

1. Congo, Dem. Rep
2. Viet Nam
3. Cameroon
4. Rwanda
5. Tanzania
6. Niger
7. Ethiopia
8. Bolivia
9. Burkina Faso
10. Ivory Coast

**Total Multilateral ODA**

| | Million USD | % of ODA |
|---|---|---|
| 2000 | 344,40 | 42,0 |
| 2001 | 268,05 | 42,5 |
| 2002 | 402,12 | 37,9 |

**Top 3 UN Agencies in 2001** (Million USD)

| | |
|---|---|
| 1. UNDP | 14 |
| 2. UNICEF | 3 |
| 3. UNFPA | 3 |

## SPENDING on POPULATION ASSISTANCE of BELGIUM

**Total spending on population assistance** [80]

| | Million USD | % of ODA |
|---|---|---|
| 1999 | 10,44 | 1,37 |
| 2000 | 15,77 | 1,92 |
| 2001 | 19,07 | 2,20 |

**Bilateral spending on population assistance**

| | Million USD | % of ODA |
|---|---|---|
| 1999 | 5,22 | 0,69 |
| 2000 | 0,47 | 0,06 |
| 2001 | 6,48 | 0,75 |

**Top 10 countries which received funding for SRH, including HIV/AIDS** [81]

1. South Africa
2. Kenya
3. Benin
4. Mali
5. Burkina Faso
6. Cuba
7. Ivory Coast
8. Burundi
9. Viet Nam
10. China

**Multilateral spending on population assistance** (Million USD)

| | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNFPA[82] | 2,50 | 3,81 | 2,80 |
| IPPF | 0,08 | 0,08 | 0,10 |
| Total of IPPF and UNFPA | 2,58 | 3,89 | 2,90 |

**SRH-related organisations** (Million USD)

| | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNIFEM[83] | 0,36 | 0,00[84] | 0,00[85] |
| UNAIDS[86] | 2,84[87] | 3,80 | 2,50 |
| Global AIDS Fund[88] | | 19,05 | |

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[78] Source: The DAC Journal, Development Co-operation 2002 Report (2003, Vol 4, N° 1)
[79] In the OECD, ODA figures include the grants and loans to countries on Part I of the DAC list of Aid Recipients, provided by the official sector, having the promotion of economic development and welfare as main objective
[80] Source: "Financial Resource Flows for Population Activities in 2001", UNFPA/NIDI, September 2003
[81] Source: Mr. Geert Deserranno, D12, DGIS
[82] Source: "OECD/DAC Contributions to UNFPA's Regular Resources for 2001 and 2002", RMB UNFPA
[83] Source: UNIFEM Annual Report 2002/2003, Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.
[84] In 2001, Belgium contributed USD 0,46 million through sub-trust funds
[85] In 2002, Belgium contributed USD 1,16 million through sub-trust funds
[86] Source: UNAIDS Governance, Donor & UN Relations Department, "Donor Contribution Table 2000-2002, the Unified Budget (Core)".
[87] In 2000, Belgium paid a contribution of USD 5.76 million to the International Partnership Against AIDS in Africa (IPAA) on top of its contribution to the core funding. In total, Belgium contributed USD 8.4 million to UNAIDS.
[88] This amount refers to pledges over the period 2001 – 2003. Source: Website of the Global Fund to Fight AIDS, Tuberculosis and Malaria (total pledges until 22 August 2003) (http://www.globalfundatm.org/files/pledges&contributions.xls)

## GENERAL ODA FIGURES of CANADA[89]

| Total ODA [90] | | |
|---|---|---|
| | Million USD | % of GNI |
| 2000 | 1 744 | 0.25 |
| 2001 | 1 533 | 0.22 |
| 2002 | 2 013 | 0.28 |

| Total Bilateral ODA | | |
|---|---|---|
| | Million USD | % of ODA |
| 2000 | 1168.5 | 67 |
| 2001 | 1195.7 | 78 |

**Top 10 Total ODA Recipients 2000/2001**

1. Poland (OA)
2. Bangladesh
3. China
4. States of Ex-Yugoslavia
5. India
6. Indonesia
7. Russia (OA)
8. Ukraine (OA)
9. Haiti
10. Ghana

| Total Multilateral ODA | | |
|---|---|---|
| | Million USD | % of ODA |
| 2000 | 575.5 | 33 |
| 2001 | 337.3 | 22 |

**Top 3 UN Agencies in 2001**

1. UNDP
2. UNICEF
3. UNHCR

## SPENDING on POPULATION ASSISTANCE of CANADA

| Total spending on population assistance [91] | | |
|---|---|---|
| | Million USD | % of ODA |
| 1999 | 37.21 | 0.83 |
| 2000 | 37.44 | 2.15 |
| 2001 | 12.68 | 0.83 |

| Bilateral spending on population assistance | | |
|---|---|---|
| | Million USD | % of ODA |
| 1999 | 9.30 | 0.54 |
| 2000 | 13.47 | 0.77 |
| 2001 | 2.91 | 0.18 |

**Percentage of SRH contribution per geographical region – 1998-99[92]**

| Regions | % of SRH contributions |
|---|---|
| Africa | 61.0 |
| Asia | 28.2 |
| Americas | 5.0 |
| Central and Eastern Europe | 5.8 |

**Multilateral spending on population assistance** (Million USD)

| | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNFPA[93] | 6.14 | 5.79 | 5.72 |
| IPPF | 2.70 | 2.58 | 2.79 |
| Total of IPPF and UNFPA | 8.84 | 5.37 | 8.51 |

**SRH-related organisations** (Million USD)

| | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNIFEM[94] | 1.28 | 0.81 | 0.98 |
| UNAIDS[95] | 2.28 | 2.16 | 2.11 |
| Global AIDS Fund[96] | | 50 | |

[89] Source: The DAC Journal, Development Co-operation 2002 Report (2003, Vol 4, N° 1)
[90] In the OECD, ODA figures include the grants and loans to countries on Part I of the DAC list of Aid Recipients, provided by the official sector, having the promotion of economic development and welfare as main objective
[91] Source: "Financial Resource Flows for Population Activities in 2001", UNFPA/NIDI, September 2003
[92] Statistics from CIDA: these are preliminary figures and cannot be considered as exact data. They can however be taken as best estimates of SRH resources allocations.
[93] Source: "OECD/DAC Contributions to UNFPA's Regular Resources for 2001 and 2002", RMB UNFPA
[94] Source: UNIFEM Annual Report 2002/2003, Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.
[95] Source: UNAIDS Governance, Donor & UN Relations Department, "Donor Contribution Table 2000-2002, the Unified Budget (Core)".
[96] This amount refers to pledges over the period 2001 – 2003. Source: Website of the Global Fund to Fight AIDS, Tuberculosis and Malaria (total pledges until 22 August 2003) (http://www.globalfundatm.org/files/pledges&contributions.xls)

## GENERAL ODA FIGURES of DENMARK[97]

| Total ODA[98] | | |
|---|---|---|
| | Million USD | % of GNI |
| 2000 | 1.664 | 1,06 |
| 2001 | 1.634 | 1,03 |
| 2002 | 1.632 | 0.96 |

| Total Bilateral ODA | | |
|---|---|---|
| | Million USD | % of ODA |
| 2000 | 1.031,68 | 62 |
| 2001 | 1.029,42 | 63 |
| 2002 | 1.011,84 | 62 |

| Top 10 Total ODA Recipients 2000/2001 (DAC) | |
|---|---|
| 1. | Tanzania |
| 2. | Uganda |
| 3. | Vietnam |
| 4. | Mozambique |
| 5. | Ghana |
| 6. | Bangladesh |
| 7. | Egypt |
| 8. | Nicaragua |
| 9. | Burkina Faso |
| 10. | Nepal |

| Total Multilateral ODA | | |
|---|---|---|
| | | % of ODA |
| 2000 | 632.32 | 38 |
| 2001 | 604.58 | 37 |
| 2002 | 620.16 | 38 |

| Top 4 UN Agencies in 2002[103] |
|---|
| 1. UNICEF |
| 2. UNDP |
| 3. WFP |
| 4. UNFPA |

## SPENDING on POPULATION ASSISTANCE of DENMARK

| Total Spending on population assistance[99] | | |
|---|---|---|
| | Million USD | % of GNI |
| 1999 | 54,88 | 3,17 |
| 2000 | 44,64 | 2,68 |
| 2001 | 48.85 | 2.99 |

| Bilateral Spending on population assistance | | |
|---|---|---|
| | Million USD | % of ODA |
| 1999 | 2,20 | 0,13 |
| 2000 | 0,00 | 0,00 |
| 2001 | 6.35 | 0.38 |

**Denmark's priority countries with health as a specific priority for 2003[100].**

There are 5 countries out of the 15 priority targets which chose health as a priority

Bhutan
Ghana
Tanzania
Uganda
Zambia

Denmark does not have specific bilateral SRHR projects: SRHR is supposed to be mainstreamed in all projects. According to DANIDA, all projects in Health, Indigenous people, Water and Sanitation, Agriculture, Industry, Energy, Education, Fisheries, Transport, Telecommunications should integrate aspects of SRHR[101].

| Multilateral SRH contributions (Million USD) | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNFPA[102] | 23.88 | 23,67 | 21,46 |
| IPPF | 9.17 | 8,72 | 5,88 |
| Total of UNFPA and IPPF | 33.05 | 32,39 | 27,34 |

| SRH-related organisations (Million USD) | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNIFEM[104] | 0.35 | 0.60 | 0.66 |
| UNAIDS[105] | 2.97 | 3.01 | 3.15 |
| Global Aids Fund[106] | | 27.22 | |

97 Source: The DAC Journal, Development Co-operation 2002 Report (2003, Vol 4, N° 1)
98 For the OECD, ODA figures include the grants and loans to countries on Part I of the DAC list of Aid Recipients, provided by the official sector, having the promotion of economic development and welfare as main objective
99 Source: "Financial Resource Flows for Population Activities in 2001", NIDI, September 2003
100 Source: Danish Development Assistance, Fact and Figures, Ministry of Foreign Affairs
101 Source: "Integrating SRH into a sector wide approach to Danish International Development Assistance" 1999, DANIDA, p 39
102 Source: "OECD/DAC Contributions to UNFPA's Regular Resources for 2000, 2001 and 2002", RMB UNFPA
103 Source: www.um.dk/danida
104 Source: "UNIFEM Annual Report 2002/2003", Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.
105 Source: UNAIDS Governance, Donor & UN Relations Department, "Donor Contribution Table 2000-2002, the Unified Budget"
106 Source: This amount refers to the period 2001-2003 - Website of the Global Fund to Fight AIDS, Tuberculosis and Malaria (total pledges until 22 August 2003): http://www.globalfundatm.org/files/pledges&contributions.xls

## GENERAL ODA FIGURES of the EUROPEAN COMMUNITY[107]

**Total ODA** [108]

| | Million USD | % of GNI |
|---|---|---|
| 2000 | 4.912 | / |
| 2001 | 5.961 | / |
| 2002 | 6.501 | / |

**Top 10 Total ODA Recipients 1999/2000**

1. Poland (OA)
2. Former Republic of Yugoslavia
3. Romania (OA)
4. Czech Republic (OA)
5. Hungary (OA)
6. Turkey
7. Bosnia & Herzegovina
8. Tunisia
9. Morocco
10. Bulgaria (OA)

**Sectoral Breakdown of EC and EDF ODA in 2001**[112]

| Sectors | % of aid |
|---|---|
| Social Infrastructure and services | 30,9 |
| *Of which Population and RH* | 2,9 |
| Production sector | 14,4 |
| Cross-cutting | 19,8 |
| Commodity aid and general programme assistance | 9,5 |

## SPENDING on POPULATION ASSISTANCE of the EUROPEAN COMMUNITY

**Total spending on population assistance**

| | Content | Million USD |
|---|---|---|
| 2000 | Funds for Population Assistance[109] | 28,88 |
| 2001 | | 28,05 |
| 1998 | EC Commitments to the ICPD activities[110] | 237,58 |

**Top 10 Recipients of ICPD related commitments (1994 – 1998)**[111] (Million USD)

| | | |
|---|---|---|
| 1. | India | 246,09 |
| 2. | Egypt | 78,51 |
| 3. | Turkey | 67,97 |
| 4. | Pakistan | 31,64 |
| 5. | Malawi | 29,30 |
| 6. | Philippines | 24,61 |
| 7. | Morocco | 22,27 |
| 8. | South Africa | 21,09 |
| 9. | Kenya | 21,09 |
| 10. | Bangladesh | 19,92 |

**ICPD related commitments by region (1994 –1998)**[113]

| | Names | In Million USD (1994-1998) | % of the total ICPD allocations (1994-1998) |
|---|---|---|---|
| 1. | Asia | 443,54 | 45% |
| 2. | Africa | 266,59 | 27% |
| 3. | Mediterranean | 183,16 | 18% |
| 4. | Latin America | 58,94 | 6% |
| 5. | Global | 29,52 | 3% |
| 6. | Caribbean | 9,84 | 1% |

**NB**: The European Commission also pledged USD 229, 26 million for the period 2001-2003 to the Global Fund to fight AIDS, TBC and malaria[114]

[107] Source: The DAC Journal, Development Co-operation 2002 Report (2003, Vol. 4, N° 1)

[108] In the OECD, ODA figures include the grants and loans to countries on Part I of the DAC list of Aid Recipients, provided by the official sector, having the promotion of economic development and welfare as main objective

[109] Figures to be taken with caution, since they are based on a questionnaire sent to the EC. The EC adopted a very restrictive definition of SRH, when responding to the survey. The figures reported by the EC to NIDI are under-estimated and do not reflect the actual total EC spending for ICPD activities. Source: "Financial Resource Flows for Population Activities in 2001", UNFPA/NIDI, September 2003

[110] Source: "Handbook on European Community Support for Population and Reproductive Health", MSI, 2000, P32. These figures are the last available ones and comprise a broad overview of EC SRH spending. They come from a study made by J. Edwards in 1999 covering the period 1990-98. No further research is planned.

[111] *Source: Jason Edwards, co-writer of "Overview of the EC's Health, AIDS and Population Portfolio in Developing Countries (1990-1999)", October 2000 (Latest source available)*

[112] "Annual Report 2001 on the EC development policy and the implementation of the external assistance", EC, 2002

[113] *Source: Jason Edwards, co-writer of "Overview of the EC's Health, AIDS and Population Portfolio in Developing Countries (1990-1999)", October 2000 (Latest source available)*

[114] Source: Website of the Global Fund to Fight AIDS, Tuberculosis and Malaria (total pledges until 22 August 2003) (http://www.globalfundatm.org/files/pledges&contributions.xls)

## GENERAL ODA FIGURES of FINLAND[115]

| Total ODA [117] | | |
|---|---|---|
| | Million USD | % of GNI |
| 2000 | 371 | 0,31 |
| 2001 | 389 | 0,32 |
| 2002 | 466 | 0,35 |

| Total Bilateral ODA | | |
|---|---|---|
| | Million USD | % of ODA |
| 2000 | 218,89 | 59 |
| 2001 | 209,70 | 54 |
| 2002 | 256,30 | 55 |

**Top 10 Total ODA Recipients 2000/2001**

1. Russia (OA)
2. Tanzania
3. Former Republic of Yugoslavia
4. Mozambique
5. China
6. Nicaragua
7. Afghanistan
8. Namibia
9. Viet Nam
10. Kenya

| Total Multilateral ODA | | |
|---|---|---|
| | Million USD | % of ODA |
| 2000 | 152,11 | 41 |
| 2001 | 179,30 | 46 |
| 2002 | 209,70 | 45 |

| Top 3 UN Agencies in 2002 (Million USD)[120] | |
|---|---|
| 1. UNFPA | 14,4[121] |
| 2. UNDP | 13,5 |
| 3. UNICEF | 12,0 |

## SPENDING on POPULATION ASSISTANCE of FINLAND[116]

| Total spending on population assistance | | |
|---|---|---|
| | Million USD | % of Total ODA |
| 1999 | 19,96 | 4,80 |
| 2000 | 19,77 | 5,33 |
| 2001 | 23,73 | 6,10 |

| Bilateral spending on population assistance | | |
|---|---|---|
| | Million USD | % of ODA |
| 1999 | 1,20 | 0,29 |
| 2000 | 1,19 | 0,32 |
| 2001 | 1,66 | 0,43 |

**Recipient Countries receiving funding for SRH programmes in 2002[118]**

Through direct bilateral support:
- Nicaragua
- Afghanistan

Trough Finnish NGO funding:
- India
- Mexico
- Namibia
- Nepal

Finland also supports IPPF's global programme and Ipas for their "Advancing Access to Safe Abortion Care in Africa" programme.

| Multilateral SRH contributions (Million USD) | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNFPA[119] | 12,49 | 10,60 | 13,60 |
| IPPF | 0,16 | 0,21 | 0,32 |
| Total of UNFPA and IPPF | 12,65 | 10,81 | 13,92 |

| SRH-related organisations (Million USD) | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNAIDS[122] | 1,24 | 2,50 | 2,74 |
| UNIFEM[123] | 0,47 | 0,46 | 0,50 |
| Global AIDS Fund[124] | | 0 | |

[115] Source: The DAC Journal, Development Co-operation 2002 Report (2003, Vol 4, N° 1)
[116] Source: "Financial Resource Flows for Population Activities in 2001", UNFPA/NIDI, September 2003
[117] For the OECD, ODA figures include the grants and loans to countries in Part I of the DAC List of Aid Recipients provided by the official sector with the promotion of economic development and welfare as main objective
[118] Source, Ministry of Foreign Affairs of Finland, Gisela Blumenthal and Tanja Suvilaakso
[119] Source: "OECD/DAC Contributions to UNFPA's Regular Resources for 2001 and 2002", RMB UNFPA
[120] Source: Ministry of Foreign Affairs of Finland, UN Desk
[121] This amount includes an additional Euro 2 million, due to shortfall of expected income.
[122] Source: UNAIDS Governance, Donor & UN Relations Department, "Donor Contribution Table 2000-2002, the Unified Budget (Core)"
[123] Source: "UNIFEM Annual Report 2002/2003", Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.
[124] This amount refers to pledges over the period 2001 – 2003. Source: Website of the Global Fund to Fight AIDS, Tuberculosis and Malaria (total pledges until 22 August 2003) (http://www.globalfundatm.org/files/pledges&contributions.xls)

## GENERAL ODA FIGURES of FRANCE[125]

**Total ODA**[126]

| | Million USD | % of GNI |
|---|---|---|
| 2000 | 4.105 | 0,32 |
| 2001 | 4.198 | 0,32 |
| 2002 | 5.182 | 0.36 |

**Total Bilateral ODA**

| | Million USD | % of ODA |
|---|---|---|
| 2000 | 2.833 | 69 |
| 2001 | 2.602 | 62 |
| 2002 | 3.213 | 62 |

**Top 10 Total ODA Recipients 2000/2001**[129]

1. French Polynesia
2. New Caledonia
3. Egypt
4. Morocco
5. Poland
6. Ivory Coast
7. Senegal
8. Cameroon
9. Tunisia
10. Mayetta

**Total Multilateral ODA**

| | Million USD | % of ODA |
|---|---|---|
| 2000 | 1.272 | 31 |
| 2001 | 1.595 | 38 |
| 2002 | 1.969 | 38 |

**Top 3 UN Agencies in 2001**

1. UNDP
2. UNICEF
3. UNHCR

## SPENDING on POPULATION ASSISTANCE of FRANCE

**Total spending on population assistance**

| NIDI Figures[127] | Millions of USD | % of ODA |
|---|---|---|
| 1999 | 8,00 | 0,14 |
| 2000 | 12,36 | 0,30 |
| 2001 | 8.24 | 0.20 |
| Estimation of the Ministry of Foreign Affairs[128] | | |
| 1999 | 49,54 | 0.87 |

**Bilateral SRH spending in 2000**

| | Million USD | *% of ODA* |
|---|---|---|
| 1999 | 0.00 | 0.00 |
| 2000 | 5,31 | 0,13 |
| 2001 | 4.20 | 0.10 |

**Major Recipient countries of SRH**[130]

France funds population projects on an overall or regional level and cannot, therefore, provide a complete list of priority SRH recipient countries.

However, France does have specific SRH projects in the framework of Multi-bilateral projects with UNFPA in [131]: Madagascar, Niger and Ivory Coast

France has also specific projects on FGM with UNICEF : Benin, Burkina Faso, Ivory Coast, Mali

France is strongly involved in the fight against TB. Malaria and AIDS and is reinforcing its activities for the promotion of international therapeutic solidarity

**Multilateral SRH contributions** (Million USD)

| | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNFPA[132] | 1,16 | 1,11 | 1,12 |
| IPPF[133] | 0,00 | 0,00 | 0.00 |
| Total of IPPF and UNFPA | 1,16 | 1,11 | 1,12 |

**SRH-related organisations** (Million USD)

| | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNIFEM[134] | 0.07 | 0.00 | 0.00 |
| UNAIDS[135] | 0.32 | 0.03 | 0.43 |
| Global AIDS Fund[136] | | 109.15 | |

[125] Source: The DAC Journal, Development Co-operation 2002 Report (2003, Vol 4, N° 1)
[126] For the OECD, ODA figures include the grants and loans to countries on Part I of the DAC list of Aid Recipients, provided by the official sector, having the promotion of economic development and welfare as main objective.
[127] Source: "Financial Resource Flows for Population Activities in 2001", NIDI, September 2003–The population spending of France is highly underestimated in the NIDI study due to poor reporting from the French government.
[128] This figure is issued from estimations from the Office of United Nations and International Organisations of the Ministry of Foreign Affairs. This source reflects better the spending level of France on population issues than the NIDI study since the multilateral programs are included.
[129] Since 2001, French Polynesia and New Caledonia are not considered as ODA recipients anymore.
[130] Ministry of cooperation of France:http://www.france.diplomatie.fr/cooperation/dgcid/direction
[131] This list is not exhaustive and presents only some of the major French projects in the field.
[132] Source: "OECD/DAC Contributions to UNFPA's Regular Resources for 2000, 01, 02" RMB UNFPA
[133] France does not contribute directly to IPPF but does provide funding to its French member "MFPF" (Mouvement Français pour le Planning Familial) and supports other local FPAS (Family Planning Associations), which are often associated with French Development Aid programs. (ex : Madagascar and Ivory Coast)
[134] Source: "UNIFEM Annual Report 2002/2003", Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.
[135] Source: UNAIDS Governance, Donor & UN Relations Department "Donor Contribution Table 2000-2002, the Unified Budget.
[136] Source: This amount refers to the period 2001-2003 - Website of the Global Fund to Fight AIDS, Tuberculosis and Malaria (total pledges until 22 August 2003): http://www.globalfundatm.org/files/pledges&contributions.xls

## GENERAL ODA FIGURES of GERMANY[137]

| Total ODA [139] | | |
|---|---|---|
| | Million USD | % of GNI |
| 2000 | 5.030 | 0,27 |
| 2001 | 4.990 | 0,27 |
| 2002 | 5.359 | 0,27 |

| Total Bilateral ODA | | |
|---|---|---|
| | Million USD | % of ODA |
| 2000 | 2.668 | 53 |
| 2001 | 3.579 | 73 |
| 2002 | 3.589 | 69 |

**Top 10 Total ODA Recipients 2000/2001**

1. China
2. India
3. Indonesia
4. Turkey
5. Egypt
6. Former Republic of Yugoslavia
7. Jordan
8. Peru
9. Bolivia
10. Russia (OA)

| Total Multilateral ODA | | |
|---|---|---|
| | Million USD | % of ODA |
| 2000 | 2.366 | 47 |
| 2001 | 1.300 | 27 |
| 2002 | 1.770 | 31 |

| **Top 3 UN Agencies in 2001** (Million USD) | |
|---|---|
| 1. UNDP | 22 |
| 2. WFP | 21 |
| 3. UNFPA | 13 |

## SPENDING on POPULATION ASSISTANCE of GERMANY[138]

| Total spending on population assistance | | |
|---|---|---|
| | Million USD | % of ODA |
| 1999 | 119,76 | 2,17 |
| 2000 | 96,40 | 1,91 |
| 2001 | 108,66 | 2,18 |

| Bilateral spending on population assistance | | |
|---|---|---|
| | Million USD | % of ODA |
| 1999 | 73,05 | 1.36 |
| 2000 | 79,05 | 1,57 |
| 2001 | 88,01 | 1,76 |

**14 Partner Countries having chosen "Health" (incl. SRH) as priority area of co-operation[140]**

| | |
|---|---|
| Bangladesh | Malawi |
| China | Nepal |
| Cambodia | Pakistan |
| Cameroon | Philippines |
| India | Rwanda |
| Indonesia | Viet Nam |
| Kenya | Yemen |

| **Multilateral SRH contributions** (Million USD) | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNFPA[141] | 9,45 | 13,04 | 13,00 |
| IPPF | 2,50 | 3,60 | 2,44 |
| Total of UNFPA and IPPF | 11,95 | 16,64 | 15,44 |

| **SRH-related organisations** (Million USD) | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNAIDS[142] | 0,88 | 0,83 | 0,00 |
| UNIFEM[143] | 0,75 | 0,74 | 0,76 |
| Global AIDS Fund[144] | | 49,63 | |

[137] Source: The DAC Journal, Development Co-operation 2002 Report (2003, Vol 4, N° 1)
[138] Source: "Financial Resource Flows for Population Activities in 2001", UNFPA/NIDI, September 2003
[139] For the OECD, ODA figures include the grants and loans to countries on Part I of the DAC list of Aid Recipients, provided by the official sector, having the promotion of economic development and welfare as main objective
[140] BMZ Position Paper "Sexual and Reproductive Health" / draft, September 2002
[141] source: "OECD/DAC Contributions to UNFPA's Regular Resources for 2001 and 2002", RMB UNFPA
[142] Source: UNAIDS Governance, Donor & UN Relations Department, "Donor Contribution Table 2000-2002, the Unified Budget (Core)".
[143] Source: UNIFEM Annual Report 2002/2003, Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.
[144] This amount refers to pledges over the period 2001 – 2003. Source: Website of the Global Fund to Fight AIDS, Tuberculosis and Malaria (total pledges until 22 August 2003) (http://www.globalfundatm.org/files/pledges&contributions.xls)

## GENERAL ODA FIGURES of IRELAND[145]

| Total ODA[146] | Million USD | % of GNI |
|---|---|---|
| 2000 | 235 | 0,30 |
| 2001 | 287 | 0,33 |
| 2002 | 397 | 0.41 |

| Total Bilateral ODA | Million USD | % of ODA |
|---|---|---|
| 2000 | 155.10 | 66 |
| 2001 | 183.68 | 64 |

**Top 10 Total ODA Recipients 2000/01**

1. Ethiopia
2. Uganda
3. Mozambique
4. Tanzania
5. Zambia
6. Lesotho
7. South Africa
8. Kenya
9. Afghanistan
10. Bosnia -Herzegovina

| Total Multilateral ODA | Million USD | % of ODA |
|---|---|---|
| 2000 | 79,90 | 34 |
| 2001 | 103.32 | 36 |

| Top 3 UN Agencies in 2001 (Million USD) | |
|---|---|
| 1. UNDP | 6.69 |
| 2. UNICEF | 3.92 |
| 3. UNHCR | 3.80 |

## SPENDING on POPULATION ASSISTANCE of IRELAND

| Total spending on population assistance[147] | Million USD | % of ODA |
|---|---|---|
| 1999 | 2,67 | 1,09 |
| 2000 | 4,24 | 1,80 |
| 2001 | 6.25 | 2.18 |

| Bilateral spending on population assistance | Million USD | % of ODA |
|---|---|---|
| 1999 | 1,04 | 0,42 |
| 2000 | 1,99 | 0,85 |
| 2001 | 4.31 | 1.50 |

| Major recipient of health spending in 2001[148] | Major recipients for HIV/AIDS spending in 2001 |
|---|---|
| Ethiopia | Lesotho |
| Lesotho | Ethiopia |
| Mozambique | Uganda |
| Tanzania | Mozambique |
| Uganda | Tanzania |
| Zambia | Zambia |

| Multilateral spending on population assistance | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNFPA[149] | 0.73 | 1,17 | 1,59 |
| IPPF | 0.00 | 0,00 | 0,00 |
| Total of UNFPA and IPPF | 0.73 | 1,17 | 1,59 |

| SRH-related organisations (Million USD) | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNIFEM[150] | 0.18 | 0.45 | 0.54 |
| UNAIDS[151] | 0.16 | 0.31 | 2.7 |
| Global AIDS Fund [152] | | 20.68 | |

[145] Source: The DAC Journal, Development Co-operation 2002 Report (2003, Vol 4, N° 1)

[146] For the OECD, ODA figures include the grants and loans to countries in Part I of the DAC List of Aid Recipients provided by the official sector with the promotion of economic development and welfare as main objective

[147] Source: "Financial Resource Flows for Population Activities in 2001", NIDI, September 2003

[148] These 6 countries are priority countries for the Development Cooperation Ireland and are all receiving large shares of ODA for health (incl SRH and HIV/AIDS) projects. Classified in order of importance for the health sector - See Irish Aid Annual Report 2001

[149] Source: "OECD/DAC Contributions to UNFPA's Regular Resources for 2000, 01, 02" RMB UNFPA

[150] Source: UNIFEM Annual Reports 2001 and 2002, Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account

[151] Source: UNAIDS Governance, Donor & UN Relations Department, "Donor Contribution Table 2000-2002, the Unified Budget (Core)".

[152] Source: This amount refers to the period 2001-2003 - Website of the Global Fund to Fight AIDS, Tuberculosis and Malaria (total pledges until 22 August 2003): http://www.globalfundatm.org/files/pledges&contributions.xls

## GENERAL ODA FIGURES of ITALY[153]

**Total ODA**[154]

| | Million USD | % of GNI |
|---|---|---|
| 2000 | 1.376 | 0,13 |
| 2001 | 1.627 | 0,15 |
| 2002 | 2.313 | 0,20 |

**Total Bilateral ODA**

| | Million USD | % of ODA |
|---|---|---|
| 2000 | 372 | 27 |
| 2001 | 439 | 27 |

**Top 10 Total ODA Recipients 2000/2001**

1. Russia (OA)
2. Uganda
3. Eritrea
4. Former Republic of Yugoslavia
5. Tunisia
6. Ethiopia
7. Albania
8. Bosnia and Herzegovina
9. Honduras
10. Somalia

**Total Multilateral ODA**

| | Million USD | % of ODA |
|---|---|---|
| 2000 | 1.004 | 73 |
| 2001 | 1.187 | 73 |

**Top 3 UN Agencies in 2001** (Million USD)

| | |
|---|---|
| 1. UNDP | 16 |
| 2. UNICEF | 16 |
| 3. UNHCR | 14 |

## SPENDING on POPULATION ASSISTANCE of ITALY

**Total spending on population assistance**[155]

| | Million USD | % of ODA |
|---|---|---|
| 1999 | 10,04 | 0,56 |
| 2000 | 24,92 | 1,81 |
| 2001 | 25,04 | 1,54 |

**Bilateral spending on population assistance**

| | Million USD | % of ODA |
|---|---|---|
| 1999 | 2,61 | 0,14 |
| 2000 | 7,97 | 0,58 |
| 2001 | 7,76 | 0,48 |

**Top 10 Health and Population Recipients 2001**

n.a

**Multilateral spending on population assistance** (Million USD)

| | 200C | 2001 | 2002 |
|---|---|---|---|
| UNFPA[156] | 2,90 | 2,66 | 3,00 |
| IPPF | 0,00 | 0,00 | 0,00 |
| Total of UNFPA and IPPF | 2,90 | 2,66 | 3,00 |

**SRH-related organisations** (Million USD)

| | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNAIDS[157] | 1,72 | 1,79 | 0,00 |
| UNIFEM[158] | 2,94 | 2,66 | 2,74 |
| Global AIDS Fund[159] | | 200 | |

[153] Source: The DAC Journal, Development Co-operation 2002 Report (2003, Vol 4, N° 1)
[154] the OECD's ODA figures include grants and loans to countries from Part I of the DAC List for A id Recipients provided by the official sector with the promotion of economic development and welfare as main objectives.
[155] Source: "Financial Resource Flows for Population Activities in 2001", UNFPA/NIDI, September 2003
[156] source: "OECD/DAC Contributions to UNFPA's Regular Resources for 2001 and 2002", RMB UNFPA
[157] Source: UNAIDS Governance, Donor & UN Relations Department, "Donor Contribution Table 2000-2002, the Unified Budget (Core)".
[158] Source: UNIFEM Annual Report 2002/2003, Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.
[159] This amount refers to pledges over the period 2001 – 2003. Source: Website of the Global Fund to Fight AIDS, Tuberculosis and Malaria (total pledges until 22 August 2003) (http://www.globalfundatm.org/files/pledges&contributions.xls )

## GENERAL ODA FIGURES of LUXEMBOURG[160]

| Total ODA[161] | | |
|---|---|---|
| | Million USD | % of GNI |
| 2000 | 123 | 0,72 |
| 2001 | 142 | 0,19 |
| 2002 | 143 | 0.78 |

| Total Bilateral ODA | | |
|---|---|---|
| | Million USD | % of ODA |
| 2000 | 93,98 | 74 |
| 2001 | 106.5 | 75 |

**Top 11 Total ODA Recipients 2001 (Luxembourg annual report 2001)[164]**

1. Mali
2. Cap Verde
3. El Salvadore
4. Nicaragua
5. Burkina Faso
6. Vietnam
7. Laos
8. Namibia
9. Niger
10 Palestinian Territories
11. Senegal

| Total Multilateral ODA | | |
|---|---|---|
| | Million USD | % of ODA |
| 2000 | 33,02 | 26 |
| 2001 | 35.5 | 25 |

| **Top 3 UN Agencies in 2001** (Million USD) | |
|---|---|
| 1. WHO | 7.7 |
| 2. UNFPA | 7.0 |
| 3. UNDP | 2.4 |

## SPENDING on POPULATION ASSISTANCE of LUXEMBOURG

| Total spending on population assistance[162] | | |
|---|---|---|
| | Million USD | % of ODA |
| 1999 | 3,13 | 2,63 |
| 2000 | 10,73 | 8,45 |
| 2001[163] | 5.62 | 3.99 |

| Bilateral spending on population assistance | | |
|---|---|---|
| | Million USD | % of ODA |
| 1999 | 1,57 | 1,32 |
| 2000 | 8,37 | 6,60 |
| 2001 | 3.76 | 2.65 |

**The countries among the partner countries[165] having a SRH-related project in 2001-2002 (Million USD) (Projects done through UNFPA)[166]**

Nicaragua, Namibia, Mali, El Salvador, Tunisia, Cape Verde, Vietnam, Niger, Afghanistan, Senegal

AIDS initiatives
In Rwanda: Luxembourg started a new project in 2002 to set up a Treatment and Research AIDS Centre (Total budget: 2.3 million Eur) + a twinning project with hospitals from Rwanda and Luxembourg was established in 2002 to increase Rwandan capacities in the fight against AIDS. (Total budget: 3.2 million Eur)

| Multilateral spending on population assistance (Million USD) | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNFPA[167] | 0.43 | 0,42 | 0,51 |
| IPPF | 0.00 | 0,00 | 0.00 |
| Total of IPPF and UNFPA | 0.43 | 0,42 | 0.51 |

| **SRH-related organisations** (Million USD) | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNIFEM[168] | 0.42 | 0.42 | 0.56 |
| UNAIDS[169] | 0.43 | 0.43 | 0.58 |
| Global AIDS Fund[170] | 2.13 | | |

[160] Source: The DAC Journal, Development Co-operation 2002 Report (2003, Vol 4, N° 1)
[161] For the OECD, ODA figures include the grants and loans to countries on Part I of the DAC list of Aid Recipients, provided by the official sector, having the promotion of economic development and welfare as main objective.
[162] Source: "Financial Resource Flows for Population Activities in 2001", NIDI, September 2003
[163] Figures were not fully reported: as a result, 2001 project and programme figures are estimated on the 2000 levels
[164] Luxembourg is also financing a large project in Ex-Yugoslavia (reconstruction including in Montenegro and Kosovo) for a total amount of 7 million USD over 3 years starting from 2000.
[165] Luxemburg has 10 priority countries (Niger, Senegal, Cape Verde, Namibia, Burkina Faso, Nicaragua, El Salvador, Vietnam, Laos) and some partner countries for specific projects (China, Chili, South Africa, Morocco, Rwanda, Burundi, Tunisia)
[166] Source: "Annual Report 2001", Ministry of Foreign Affairs, External Trade, Co-operation and Defenses, 16 July 2002
[167] Source: "OECD/DAC Contributions to UNFPA's Regular Resources for 200, 01, 02", RMB UNFPA. This is the figure for core contribution and does not take earmarked contributions into account
[168] Source: "UNIFEM Annual Report 2002/2003", Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.
[169] Source: UNAIDS Governance, Donor & UN Relations Department, and "Donor Contribution Table 2000-2002, the Unified Budget (Core). This is the figure for core contribution and does not take earmarked contributions into account
[170] Source: This amount refers to the period of 2001-2003 - Website of the Global Fund to Fight AIDS, Tuberculosis and Malaria (total pledges until 22 August 2003): http://www.globalfundatm.org/files/pledges&contributions.xls

## GENERAL ODA FIGURES of the NETHERLANDS[171]

| Total ODA[172] | | |
|---|---|---|
| | Million USD | % of GNI |
| 2000 | 3.135 | 0,84 |
| 2001 | 3.172 | 0,82 |
| 2002 | 3.377 | 0.82 |

| Total Bilateral ODA | | |
|---|---|---|
| | Million USD | % of ODA |
| 2000 | 2.257,20 | 72 |
| 2001 | 2.220,40 | 70 |
| 2002 | 2.532,75 | 75 |

| Top 10 Total ODA Recipients 2000/2001 | |
|---|---|
| 1. Indonesia | |
| 2. Netherlands Antilles | (OA) |
| 3. Tanzania | |
| 4. India | |
| 5. Mozambique | |
| 6. Ghana | |
| 7. F.R of Yugoslavia | |
| 8. Bolivia | |
| 9. Bosnia and Herzegovina | |
| 10. Uganda | |

| Total Multilateral ODA | | |
|---|---|---|
| | Million USD | % of ODA |
| 2000 | 877,80 | 28 |
| 2001 | 951,60 | 30 |
| 2002 | 844,25 | 25 |

| Top 3 UN Agencies in 2001 | |
|---|---|
| 1. UNDP | |
| 2. UNFPA | |
| 3. UNHCR | |

## SPENDING on POPULATION ASSISTANCE of the NETHERLANDS

| Total spending on population assistance[173] | | |
|---|---|---|
| | Million USD | % of ODA |
| 1999 | 115.78 | 3,69 |
| 2000 | 170.08 | 5,43 |
| 2001 | 132.03 | 4.16 |

| Bilateral spending on population assistance | | |
|---|---|---|
| | Million USD | % of ODA |
| 1999 | 40,52 | 1,29 |
| 2000 | 28,91 | 0,92 |
| 2001 | 14.52 | 0.45 |

| The 12 "structural development partners" for which Health is one of the priority aid policy lines[174] (in 2002) | |
|---|---|
| Bangladesh | Mali |
| Burkina Faso | Mozambique |
| Egypt | Nicaragua |
| Ethiopia | Tanzania |
| Ghana | Viet Nam |
| Yemen | Zambia |
| From which 4 have a specific focus on SRH | |
| Burkina Faso, Mali, Nicaragua and Egypt | |
| From which 4 others have a specific emphasis on HIV/AIDS: Ghana, Mozambique, Tanzania and Zambia | |

| Multilateral SRH contributions (Million USD) | | | |
|---|---|---|---|
| | 2000 | 2001 | 2002 |
| UNFPA[175] | 50.58 | 50,28 | 52,25 |
| IPPF | 3.18 | 6,31 | 7,26 |
| Total of IPPF and UNFPA | 53.76 | 56,59 | 59,51 |

| SRH-related organisations (Million USD) | | | |
|---|---|---|---|
| | 2000 | 2001 | 2002 |
| UNIFEM[176] | 3.07 | 3.25 | 3.31 |
| UNAIDS[177] | 14.98 | 20.22 | 15.47 |
| Global AIDS Fund[178] | | 54.13 | |

[171] Source: The DAC Journal, Development Co-operation 2002 Report (2003, Vol 4, N° 1)
[172] For the OECD ODA figures include the grants and loans to countries on Part I of the DAC list of Aid Recipients, provided by the official sector, having the promotion of economic development and welfare as main objective
[173] Source: "Financial Resource Flows for Population Activities in 2001", NIDI, September 2003
[174] The Dutch government has a long term aid relationship with 22 priority countries, called the structural development partners. Each partner country moreover has to decide to which sectors (3 or4) they want Dutch aid to go to. Above is the list of the countries among the 22 partners who chose health care in general, including SRH as one of their priorities. Source of the list: Ministry of Foreign Affairs, http://www.minbuza.nl/
[175] Source: "OECD/DAC Contributions to UNFPA's Regular Resources for 2000, 01,02"RMB UNFPA
[176] Source: "UNIFEM Annual Report 2002/2003", Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.
[177] Source: UNAIDS Governance, Donor & UN Relations Department, and "Donor Contribution Table 2000-2002, the Unified Budget (Core).
[178] Source: This amount refers to the period 2001-2003 -Website of the Global Fund to Fight AIDS, Tuberculosis and Malaria (total pledges until 22 August 2003): http://www.globalfundatm.org/files/pledges&contributions.xls

## GENERAL ODA FIGURES of NORWAY [179]

| Total ODA [180] | | |
|---|---|---|
| | Million USD | % of GNI |
| 2000 | 1.364 | 0,80 |
| 2001 | 1.346 | 0,80 |
| 2002 | 1.746 | 0,91 |

| Total Bilateral ODA | | |
|---|---|---|
| | Million USD | % of ODA |
| 2000 | 1.013,80 | 74 |
| 2001 | 942,20 | 70 |
| 2002 | 1.222,20 | 70 |

**Top 10 Total ODA Recipients 2000/2001**

1. Former Republic of Yugoslavia
2. Mozambique
3. Tanzania
4. Palestinian Adm. Areas
5. Afghanistan
6. Bosnia and Herzegovina
7. Zambia
8. Uganda
9. Ethiopia
10. Bangladesh

| Total Multilateral ODA | | |
|---|---|---|
| | Million USD | % of ODA |
| 2000 | 356,20 | 26 |
| 2001 | 403,80 | 30 |
| 2002 | 523,80 | 30 |

| Top 3 UN Agencies in 2001 (Million USD) | |
|---|---|
| 1. UNDP | 79 |
| 2. UNICEF | 34 |
| 3. UNFPA | 24 |

## SPENDING on POPULATION ASSISTANCE of NORWAY

| Total spending on population assistance [181] | | |
|---|---|---|
| | Million USD | % of ODA |
| 1999 | 61,67 | 4,50 |
| 2000 | 59,96 | 4,38 |
| 2001 | 42,96 | 3,19 |

| Bilateral spending on population assistance | | |
|---|---|---|
| | Million USD | % of ODA |
| 1999 | 1,23 | 0,09 |
| 2000 | 4,20 | 0,31 |
| 2001 | 0,43 | 0,03 |

| Top 10 SRH and Population Recipients 2000 | % of total SRH and Population aid |
|---|---|
| 1. Uganda | 10,72 |
| 2. Tanzania | 8,78 |
| 3. Zambia | 8,69 |
| 4. Mozambique | 5,53 |
| 5. Nicaragua | 4,14 |
| 6. Zimbabwe | 4,05 |
| 7. Malawi | 3,93 |
| 8. Burkina Faso | 2,02 |
| 9. South Africa | 1,98 |
| 10. Viet Nam | 1,27 |

| Multilateral spending on population assistance (Million USD) | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNFPA [182] | 22,99 | 23,94 | 24,39 |
| IPPF | 5,33 | 5,00 | 5,53 |
| Total of UNFPA and IPPF | 28,32 | 28,94 | 29,92 |

| SRH-related organisations (Million USD) | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNAIDS [183] | 7,56 | 10,75 | 13,08 |
| UNIFEM [184] | 1,95 | 2,02 | 2,02 |
| Global AIDS Fund [185] | | 34,70 | |

[179] Source: The DAC Journal, Development Co-operation 2002 Report (2003, Vol 4, N° 1)
[180] for the OECD, ODA figures include the grants and loans to countries in Part I of the DAC List of Aid Recipients provided by the official sector with the promotion of economic development and welfare as main objective
[181] Source: "Financial Resource Flows for Population Activities in 2001", UNFPA/NIDI, September 2003
[182] source: "OECD/DAC Contributions to UNFPA's Regular Resources for 2001 and 2002", RMB UNFPA
[183] Source: UNAIDS Governance, Donor & UN Relations Department, "Donor Contribution Table 2000-2002, the Unified Budget (Core)".
[184] Source: UNIFEM Annual Report 2002/2003, Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.
[185] This amount refers to pledges over the period 2001 – 2003. Source: Website of the Global Fund to Fight AIDS, Tuberculosis and Malaria (total pledges until 22 August 2003) (http://www.globalfundatm.org/files/pledges&contributions.xls)

## GENERAL ODA FIGURES of PORTUGAL[186]

| Total ODA[187] | Million USD | % of GNI |
|---|---|---|
| 2000 | 271 | 0,26 |
| 2001 | 267 | 0,25 |
| 2002 | 282 | 0.24 |

| Total Bilateral ODA | Million USD | % of ODA |
|---|---|---|
| 2000 | 178,86 | 66 |
| 2001 | 181.56 | 68 |

**Top 10 Total ODA Recipients 2000/2001**

1. Mozambique
2. East Timor
3. Cape Verde
4. Guinea Bissau
5. Angola
6. São Tomé and Principe
7. Macedonia (FYR)
8. Bosnia and Herzegovina
9. Brazil
10. Palestinian Adm. Areas

| Total Multilateral ODA | Million USD | % of ODA |
|---|---|---|
| 1999 | 69,00 | 25 |
| 2000 | 92,14 | 34 |
| 2001 | 85.44 | 32 |

**Top 3 UN organisations (2001)**

1. UNDP
2. WHO
3. UNESCO

## SPENDING on POPULATION ASSISTANCE of PORTUGAL

| Total spending on population assistance[188] | Million USD | % of ODA |
|---|---|---|
| 1999 | 0,44 | 0,16 |
| 2000 | 0,40 | 0,15 |
| 2001 | 0.68 | 0.26 |

| Bilateral spending on population assistance | Million USD | % of ODA |
|---|---|---|
| 1999 | 0,24 | 0,09 |
| 2000 | 0,20 | 0,08 |
| 2001 | 0.46 | 0.17 |

**Health expenditure in the priority countries[189] (1999)**

1. Sao Tome et Principe
2. Mozambique
3. Cape Verde
4. Angola
5. Ginea Bissau
6. East Timor

| Multilateral spending on population assistance (Million USD) | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNFPA[190] | 0.03 | 0,02 | 0.00 |
| IPPF | 0.00 | 0.00 | 0,00 |
| Total of IPPF and UNFPA | 0.03 | 0,02 | 0,00 |

| SRH-related organisations (Million USD) | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNIFEM[191] | 0 | 0 | 0 |
| UNAIDS[192] | 0 | 0 | 0 |
| Global AIDS Fund[193] | | 0 | |

186 Source: The DAC Journal, Development Co-operation 2002 Report (2003, Vol 4, N° 1)
187 For the OECD, ODA figures include the grants and loans to countries in Part I of the DAC List of Aid Recipients provided by the official sector with the promotion of economic development and welfare as main objective
188 Source: "Financial Resource Flows for Population Activities in 2001", NIDI, September 2003
189 Portugal has 5 priority partner for which the cooperation programme is detailed in "Relatorio da Cooperacao Portuguesa 1999" http://www.instcoop.pt/Rel99.doc - No updates were available
190 Source: "OECD/DAC Contributions to UNFPA's Regular Resources for 2000, 01,02"RMB UNFP
191 Source: UNIFEM Annual Report 2001 and 2002, Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account
192 Source: UNAIDS Governance, Donor & UN Relations Department, and Donor Contribution Table 2000-2002, the Unified Budget (Core).
193 Source: This amount refers to the period 2001-2003 -Website of the Global Fund to Fight AIDS, Tuberculosis and Malaria (total pledges until 22 August 2003): http://www.globalfundatm.org/files/pledges&contributions.xls

## GENERAL ODA FIGURES of SPAIN[194]

| Total ODA[195] | | |
|---|---|---|
| | Million USD | % of GNI |
| 2000 | 1.195 | 0,22 |
| 2001 | 1.737 | 0,30 |
| 2002 | 1.608 | 0.25 |

| Total Bilateral ODA | | |
|---|---|---|
| | Million USD | % of ODA |
| 2000 | 717,00 | 60 |
| 2001 | 1.146,42 | 66 |

**Top 10 Total ODA Recipients 2000/2001**

1. Nicargua
2. Indonesia
3. Morocco
4. China
5. Bolivia
6. El Salvador
7. Honduras
8. Bosnia and Herzegovina
9. Ecuador
10. Peru

| Total Multilateral ODA | | |
|---|---|---|
| | Million USD | % of ODA |
| 2000 | 478,00 | 40 |
| 2001 | 590.58 | 34 |

**Top 3 UN Agencies in 2001**

1. UNDP
2. UNICEF
3. WFP/ UNHCR

## SPENDING on POPULATION ASSISTANCE of SPAIN

| Total spending on population assistance[196] | | |
|---|---|---|
| | Million USD | % of ODA |
| 1999 | 9,47 | 0,69 |
| 2000 | 6,21 | 0,52 |
| 2001 | 14.38 | 0.83 |

| Bilateral spending on population assistance | | |
|---|---|---|
| | Million USD | % of ODA |
| 1999 | 4,73 | 0,35 |
| 2000 | 5,09 | 0,43 |
| 2001 | 13.22 | 0.76 |

**Major SRH recipients**

Major Recipient countries of SRH projects financed by the AECI between 1995 and 2000[197] (incl HIV/AIDS) Morocco, Honduras, Dominican Republic, Philippines

Within the 2002 Annual Plan, "Maternal and Child Health" is a priority for the following areas: Ecuador, Central America and the Caribbean, Morocco, Tunisia, and the Palestinian Territories

Actual SRH and HIV/AIDS projects in 2003[198] Bolivia, Ecuador, Peru, El Salvador, Nicaragua, Dominican Republic, Morocco, Angola, Mozambique, Namibia, South Africa,

| Multilateral SRH contributions (Million USD) | | | |
|---|---|---|---|
| | 2000 | 2001 | 2002 |
| UNFPA[199] | 0.50 | 0,49 | 0,55 |
| IPPF | 0.00 | 0,00 | 0,00 |
| Total of IPPF and UNFPA | 0.50 | 0,49 | 0,55 |

| SRH-related organisations (Million USD) | | | |
|---|---|---|---|
| | 2000 | 2001 | 2002 |
| UNIFEM[200] | 0.11 | 0.13 | 0.06 |
| UNAIDS[201] | 0.19 | 0.32 | - |
| Global AIDS Fund[202] | | 35 | |

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[194] Source: The DAC Journal, Development Co-operation 2002 Report (2003, Vol 4, N° 1)
[195] For the OECD, ODA figures include the grants and loans to countries in Part I of the DAC List of Aid Recipients provided by the official sector with the promotion of economic development and welfare as main objective
[196] Source: "Financial Resource Flows for Population Activities in 2001", NIDI, September 2003
[197] Source: La ayuda oficialal desarrollo de Espana en Materia de poblacion y salud Reproductiva 1995-2000 – Un uniform de El Cairo +5 GIE 1998
[198] Source: Oral interview with Ministry of Cooperation and Development
[199] Source: "OECD/DAC Contributions to UNFPA's Regular Resources for 2000, 01, 02" RMB UNFPA
[200] Source: "UNIFEM Annual Report 2002/2003", Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.
[201] Source: UNAIDS Governance, Donor & UN Relations Department, and Donor Contribution Table 2000-2002, the Unified Budget (Core).
[202] Source: This amount refers to the period 2001-2003 - Website of the Global Fund to Fight AIDS, Tuberculosis and Malaria (total pledges until 22 August 2003): http://www.globalfundatm.org/files/pledges&contributions.xls

## GENERAL ODA FIGURES of SWEDEN[203]

| Total ODA [204] | | |
|---|---|---|
| | Million USD | % of GNI |
| 2000 | 1.799 | 0,80 |
| 2001 | 1.666 | 0,77 |
| 2002 | 1.754 | 0,74 |

| Total Bilateral ODA | | |
|---|---|---|
| | Million USD | % of ODA |
| 2000 | 1.241,31 | 69 |
| 2001 | 1.199,52 | 72 |
| 2002[206] | 1.490,90 | 85 |

| Top 10 Total ODA Recipients 2000/2001 |
|---|
| Tanzania |
| Mozambique |
| Honduras |
| Viet Nam |
| Former Republic of Yugoslavia |
| Russia |
| Bangladesh |
| South Africa |
| Nicaragua |
| Palestinian Adm Areas |

| Total Multilateral ODA | | |
|---|---|---|
| | Million USD | % of ODA |
| 2000 | 557,69 | 31 |
| 2001 | 466,48 | 28 |
| 2002 | 263,10 | 15 |

| Top 3 UN Agencies in 2002 (Million USD) | |
|---|---|
| 1. UNDP | 56 |
| 2. UNICEF | 31 |
| 3. UNFPA | 17 |

## SPENDING on POPULATION ASSISTANCE of SWEDEN

| Total spending on population assistance[205] | | |
|---|---|---|
| | Million USD | % of Total ODA |
| 1999 | 61,60 | 3,78 |
| 2000 | 73,14 | 4,07 |
| 2001 | 56,27 | 3,38 |

| Bilateral spending on population assistance | | |
|---|---|---|
| | Million USD | % of ODA |
| 1999 | 19,08 | 1,17 |
| 2000 | 4,39 | 0,24 |
| 2001 | 5,63 | 0,34 |

| Major bilateral SRH recipients in 2002 (SRH and HIV/AIDS)[207] (alphabetic order) |
|---|
| Angola |
| Ethiopia |
| India |
| Malawi |
| Namibia |
| Tanzania |
| Uganda |
| Zambia |
| Zimbabwe |

| Multilateral spending on population assistance (Million USD) | | | |
|---|---|---|---|
| | 2000 | 2001 | 2002 |
| UNFPA208 | 18,43 | 16,07 | 17,04 |
| IPPF | 7,63 | 6,72 | 7,71 |
| Total of UNFPA and IPPF | 26,06 | 22,79 | 24,75 |

| SRH-related organisations (Million USD) | | | |
|---|---|---|---|
| | 2000 | 2001 | 2002 |
| UNIFEM209 | 1,03 | 1,31 | 1,58 |
| UNAIDS210 | 4,01 | 4,60 | 4,97 |
| Global AIDS Fund211 | 46,36 | | |

[203] Source: The DAC Journal, Development Co-operation 2002 Report (2003, Vol 4, N° 1)
[204] for the OECD, ODA figures include the grants and loans to countries in Part I of the DAC List of Aid Recipients provided by the official sector with the promotion of economic development and welfare as main objective
[205] Source: "Financial Resource Flows for Population Activities in 2001", UNFPA/NIDI, September 2003
[206] Source: "Annual Report 2002", SIDA, May 2003
[207] Source: "Fact and figures 2002: Health Sector", SIDA, Health Division by Anders Nordstrom, April 2003. The countries given are the ones which received within bilateral ODA funding for the sub-sectors " Reproductive health and rights" and "Sexual health and Rights including HIV/AIDS"
[208] source: "OECD/DAC Contributions to UNFPA's Regular Resources for 2001 and 2002", RMB UNFPA
[209] Source: UNIFEM Annual Report 2002/2003, Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.
[210] Source: UNAIDS Governance, Donor & UN Relations Department, "Donor Contribution Table 2000-2002, the Unified Budget (Core)".
[211] This amount refers to pledges over the period 2001 – 2003. Source: Website of the Global Fund to Fight AIDS, Tuberculosis and Malaria (total pledges until 22 August 2003) (http://www.globalfundatm.org/files/pledges&contributions.xls)

## GENERAL ODA FIGURES of SWITZERLAND[212]

| Total ODA[213] | | |
|---|---|---|
| | Million USD | % of GNI |
| 2000 | 890 | 0,34 |
| 2001 | 908 | 0,34 |
| 2002 | 933 | 0.32 |

| Total Bilateral ODA | | |
|---|---|---|
| | Million USD | % of ODA |
| 2000 | 623,00 | 70 |
| 2001 | 644,68 | 71 |

**Top 10 Total ODA Recipients 2000/2001**

1. Yugoslavia (incl. Kosovo)
2. Mozambique
3. States of ex- Yugoslavia
4. India
5. Tanzania
6. Bangladesh
7. Burkina Faso
8. Nepal
9. Bosnia Herzegovina
10. Vietnam

| Total Multilateral ODA | | |
|---|---|---|
| | Million USD | % of ODA |
| 2000 | 267,00 | 30 |
| 2001 | 263,32 | 29 |

| Top 3 UN Agencies in 2001 (Million USD) | |
|---|---|
| 1. UNDP | 37 |
| 2. WFP | 21 |
| 3. UNHCR | 17.5 |

## SPENDING on POPULATION ASSISTANCE of SWITZERLAND

| Total spending on population assistance[214] | | |
|---|---|---|
| | Million USD | % of ODA |
| 1999 | 17,80 | 1,81 |
| 2000 | 16,07 | 1,81 |
| 2001 | 23.53 | 2.59 |

| Bilateral spending on population assistance | | |
|---|---|---|
| | Million USD | % of ODA |
| 1999 | 4,27 | 0,43 |
| 2000 | 3,54 | 0,40 |
| 2001 | 3.52 | 0.38 |

**Priority countries where health is a priority**

Benin
Chad
Mali
Mozambique
Nepal
Tanzania

A Swiss official reports that: 'Most health projects develop reproductive health activities but there is still no formal inventory of such RH activities funded by the Swiss Government as broader health and social programmes.

Bangladesh: Switzerland co-funds a health research project, although health is not formally considered a priority sector.

| Multilateral SRH contributions (Million USD) | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNFPA[215] | 6.97 | 6,74 | 8,01 |
| IPPF | 0.58 | 0,61 | 0,66 |
| Total of UNFPA and IPPF | 7.55 | 7,35 | 8,67 |

| SRH-related organisations (Million USD) | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNIFEM[216] | 0.49 | 0.45 | 0.48 |
| UNAIDS[217] | 1.27 | 2.32 | 2.66 |
| Global AIDS Fund[218] | | 10 | |

[212] Source: The DAC Journal, Development Co-operation 2002 Report (2003, Vol 4, N° 1)
[213] For the OECD, ODA figures include the grants and loans to countries in Part I of the DAC List of Aid Recipients provided by the official sector with the promotion of economic development and welfare as main objective
[214] Source: "Financial Resource Flows for Population Activities in 2001", UNFPA/NIDI, September 2003
[215] Source: "OECD/DAC Contributions to UNFPA's Regular Resources for 2000, 01, 02", RMB UNFPA
[216] Source: "UNIFEM Annual Report 2002/2003", Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.
[217] Source: UNAIDS Governance, Donor & UN Relations Department, "Donor Contribution Table 2000-2002, the Unified Budget (Core)".
[218] Source: This amount refers to the period 2001-2003 -Website of the Global Fund to Fight AIDS, Tuberculosis and Malaria (total pledges until 22 August 2003): http://www.globalfundatm.org/files/pledges&contributions.xls

## GENERAL ODA FIGURES of the UK[219]

| Total ODA [220] | | |
|---|---|---|
| | Million USD | % of GNI |
| 2000 | 4.501 | 0,32 |
| 2001 | 4.579 | 0,32 |
| 2002 | 4.749 | 0,30 |

| Total Bilateral ODA | | |
|---|---|---|
| | Million USD | % of ODA |
| 2000 | 2.700,60 | 60 |
| 2001 | 2.610,03 | 57 |
| 2002[222] | 3.086,85 | 65 |

| Top 10 Total ODA Recipients 2000/2001 |
|---|
| 1. Tanzania |
| 2. India |
| 3. Uganda |
| 4. Mozambique |
| 5. Bangladesh |
| 6. Zambia |
| 7. Ghana |
| 8. Malawi |
| 9. Kenya |
| 10. China |

| Total Multilateral ODA | | |
|---|---|---|
| | Million USD | % of GNI |
| 2000 | 1.800,40 | 40 |
| 2001 | 1.968,97 | 43 |
| 2002 | 1.662,15 | 35 |

| Top 3 UN Agencies in 2001[225] | |
|---|---|
| 1. UNDP | 66 |
| 2. UNRWA | 33 |
| 3. UNHCR | 30 |

[228]

## SPENDING on POPULATION ASSISTANCE of the UK

| Total spending on population assistance[221] | | |
|---|---|---|
| | Million USD | % of ODA |
| 1999 | 95,70 | 2,79 |
| 2000 | 169,60 | 3,77 |
| 2001 | 80,97 | 1,77 |

| Bilateral spending on population assistance | | |
|---|---|---|
| | Million USD | % of ODA |
| 1999 | 27,75 | 0,81 |
| 2000 | 61,06 | 1,36 |
| 2001 | 14,57 | 0,32 |

| Top 10 Health and Population Recipients 1999 (DFID)[223] | % of total Health and Population aid |
|---|---|
| 1. India | 15,6 |
| 2. Bangladesh | 8,0 |
| 3. Ghana | 7,2 |
| 4. Kenya | 7,2 |
| 5. Uganda | 6,2 |
| 6. South Africa | 4,9 |
| 7. Tanzania | 4,7 |
| 8. Nigeria | 4,5 |
| 9. Pakistan | 4,3 |
| 10. Zambia | 2,6 |

| Multilateral spending on population assistance (Million USD) | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNFPA[224] | 22,29 | 21,91 | 21,68 |
| IPPF | 8,30 | 6,74 | 6,97 |
| Total of UNFPA and IPPF | 30,59 | 28,65 | 28,65 |

| SRH-related organisations (Million USD) | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNAIDS | 4,62 | 4,32 | 2,36 |
| UNIFEM[226] | 3,84 | 3,56 | 4,45 |
| Global AIDS Fund227 | 118,54 | | |

[219] Source: The DAC Journal, Development Co-operation 2002 Report (2003, Vol 4, N° 1)
[220] for the OECD, ODA figures include the grants and loans to countries in Part I of the DAC List of Aid Recipients provided by the official sector with the promotion of economic development and welfare as main objective
[221] Source: "Financial Resource Flows for Population Activities in 2001", UNFPA/NIDI, September 2003
[222] Source: provisional figures from Mr Ian MacIntosh, Head of Statistical Reporting, DFID
[223] These percentages are calculated on the basis of the total bilateral spending on health, including SRH and population issues. These are thus not SRH specific figures.
[224] source: "OECD/DAC Contributions to UNFPA's Regular Resources for 2001 and 2002", RMB UNFPA
[225] Source: provisional figures from Mr Ian MacIntosh, Head of Statistical Reporting, DFID
[226] Source: UNIFEM Annual Report 2002/2003, Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.
[227] This amount refers to pledges over the period 2001 – 2003. Source: Website of the Global Fund to Fight AIDS, Tuberculosis and Malaria (total pledges until 22 August 2003) (http://www.globalfundatm.org/files/pledges&contributions.xls)
[228] Source: UNAIDS Governance, Donor & UN Relations Department, "Donor Contribution Table 2000-2002, the Unified Budget (Core)".

## GENERAL ODA FIGURES of the UNITED STATES[229]

| Total ODA[230] | | |
|---|---|---|
| | Million USD | % of GNI |
| 2000 | 9 955 | 0.10 |
| 2001 | 11 429 | 0.11 |
| 2002 | 12 900 | 0.12 |

| Total Bilateral ODA | | |
|---|---|---|
| | Million USD | % of ODA |
| 2000 | 7 366 | 74 |
| 2001 | 8 228 | 72 |

**Top 10 Total ODA Recipients 2000/2001**

1. Russia (OA)
2. Egypt
3. Israel (OA)
4. Pakistan
5. Ukraine (OA)
6. Colombia
7. Jordan
8. FR of Yugoslavia
9. Peru
10. Indonesia

| Total Multilateral ODA | | |
|---|---|---|
| | Million USD | % of ODA |
| 2000 | 2 588 | 26 |
| 2001 | 3 200 | 28 |

**Top 3 UN Agencies in 2001** (Million USD)

N.A

## SPENDING on POPULATION ASSISTANCE of the UNITED STATES

| Total spending on population assistance[231] | | |
|---|---|---|
| | Million USD | % of ODA |
| 1999 | 603 | 8.32 |
| 2000 | 658 | 6.62 |
| 2001 | 951 | 8.32 |

| Bilateral spending on population assistance | | |
|---|---|---|
| | Million USD | % of ODA |
| 1999 | 192.9 | 2.1 |
| 2000 | 157.9 | 1.58 |
| 2001 | 172.2 | 1.50 |

**"Joint programming countries" for the Center of Population, health and nutrition[232]**

**Africa:**
Ethiopia, Ghana, Kenya, Nigeria, South Africa,
Tanzania, Uganda

**Asia and North Africa**
Bangladesh, Egypt, India, Indonesia, Morocco, Nepal,
Philippines

**South and Latin America**
Peru

| Multilateral spending on population assistance (Million USD) | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNFPA[233] | 21.5 | 21.5 | 0 |
| IPPF | 2.6 | 2.8 | 0 |
| Total of IPPF and UNFPA | 24.1 | 24.3 | 0 |

| SRH-related organisations (Million USD) | 2000 | 2001 | 2002 |
|---|---|---|---|
| UNIFEM[234] | 1.20 | 2.95 | 2.16 |
| UNAIDS[235] | 15 | 15 | 18 |
| Global AIDS Fund[236] | | 623 | |

[229] Source: The DAC Journal, Development Co-operation 2002 Report (2003, Vol 4, N° 1)
[230] In the OECD, ODA figures include the grants and loans to countries on Part I of the DAC list of Aid Recipients, provided by the official sector, having the promotion of economic development and welfare as main objective
[231] Source: "Financial Resource Flows for Population Activities in 2001", UNFPA/NIDI, September 2003
[232] Countries with the highest potential for worldwide, as well as local or regional, impact across the Population, Health and Nutrition sector. Significant levels of the PHN Center resources will be committed to achieve results.
The USA also identified "Joint planning countries": they are lower priority in terms of their global impact but are sites of PHN activities implemented under USAID field assistance programmes (list of 36 countries)
[233] Source: "OECD/DAC Contributions to UNFPA's Regular Resources for 2001 and 2002", RMB UNFPA
[234] Source: UNIFEM Annual Report 2002/2003, Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.
[235] Source: UNAIDS Governance, Donor & UN Relations Department, "Donor Contribution Table 2000-2002, the Unified Budget (Core)".
[236] This amount refers to pledges over the period 2001 – 2003. Source: Website of the Global Fund to Fight AIDS, Tuberculosis and Malaria (total pledges until 22 August 2003) (http://www.globalfundatm.org/files/pledges&contributions.xls)