Progress & Promises

TRENDS IN INTERNATIONAL ASSISTANCE FOR REPRODUCTIVE HEALTH AND POPULATION

By Sally Ethelston with Amanda Bechtel, Nada Chaya, Andrew Kantner and Carolyn Gibb Vogel

Population Action INTERNATIONAL

1300 19th Street, NW, Second Floor
Washington, DC 20036 USA
www.populationaction.org

1300 19th Street NW, Second Floor
Washington, DC 20036
USA

Telephone: +1 202.557.3400
Fax: +1 202.728.4177
www.populationaction.org

For copies of this publication, please send an email request to pubinq@popact.org.

Publications Manager: Brian Hewitt

Production Assistant: Jennifer Shatwell

Design and Production: Eason Associates Inc

Creative Director: Sue Gubisch

Printing: Stephenson Printing

Photo credits:
© Curt Carnemark/The World Bank (woman on cover, p. 1)
© Ian Stanley/Alamy (p. 35)
© Jennifer Shatwell (p. 50)
© Rune Rasmussen (p. 57)
© Jess Wendover (pp. 89, 101, 109)
© Genie Ko/PAI (p. 148)

ISBN: 1-889735-72-8
LOC Control Number: 2004099157

Acknowledgements

The authors wish to thank the many colleagues in development agencies, foreign affairs ministries, and nongovernmental organizations in the donor countries profiled in this report for their assistance and cooperation. More than one hundred people provided assistance and we regret that we cannot acknowledge them individually. The authors appreciate the time they spent with the authors in meetings, responding to information requests, and reviewing the individual profiles of their respective countries' and institutions' population assistance programs.

This report draws heavily on data provided by the United Nations Population Fund and the UNFPA/UNAIDS/NIDI Resource Flows Project based at the Netherlands Interdisciplinary Demographic Institute. We appreciate in particular the assistance provided by Ann Pawliczko of UNFPA and by Jacqueline Eckhardt-Gerritsen and Mieke Reuser of NIDI in providing us with data and responding to our questions. Other major documentary sources are listed in the key references, which follow the report, including those published by the Development Assistance Committee of the OECD.

The authors acknowledge with gratitude the input of valued colleagues outside Population Action International, including Sono Aibe, Stan Bernstein, Tamara Fox, Duff Gillespie, Elizabeth Lule, Thomas Merrick, Susan Rich, Sara Seims, Denise Shannon, Steve Sinding, Joseph Speidel, and Eef Wuyts. We extend special thanks to Susannah Mayhew of the London School of Hygiene and Tropical Medicine for her case study on Ghana.

Many colleagues at Population Action International helped make this publication possible. In particular, we would like to acknowledge the editorial support of Terri Bartlett, Dina Bogecho, Amy Coen, Robert Engelman, Sarah Haddock, Elizabeth Leahy and Jennifer Shatwell. A special note of thanks is due Joanne Omang for additional editing of the text.

We would also like to thank the participants in the *Countdown 2015* Global Roundtable for their feedback on a preview edition of *Progress and Promises*.

The authors made every effort to verify the information contained in this report; they regret and take responsibility for any errors that remain.

The authors and Population Action International acknowledge with gratitude the generous support of the Better World Fund, sister organization to the United Nations Foundation, the Winslow Foundation, and the Compton Foundation for this publication and for PAI's Financing Project.

Table of Contents

Illustrations

FIGURES

TABLES

Appendices

Progress & Promises

TRENDS IN INTERNATIONAL ASSISTANCE FOR REPRODUCTIVE HEALTH AND POPULATION

Money matters and policies count. Ten years ago, at the International Conference on Population and Development (ICPD) in Cairo, the international community endorsed an approach to improving reproductive health based on meeting individual needs and respecting human rights. The 179 nations present agreed on a plan for achieving universal access to basic reproductive health care by 2015—and on the financial resources needed to make it a reality. They pledged to share the costs, estimated at US$18.5 billion annually by the year 2005, and donor nations committed to providing one-third of that total.

It is now 10 years since that conference and as 2004 draws to a close, so does the process of taking stock of progress. This report is part of that effort. It examines recent trends in funding and policy and profiles each of the major donor countries, assigning each a grade. It is the third in a series by Population Action International and is also intended to complement the research on financial resource flows by the United Nations Population Fund (UNFPA), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Netherlands Interdisciplinary Demographic Institute (NIDI).

A key finding of this report is reflected in its title: *Progress and Promises*. **In 2002, the world's wealthiest countries made more progress toward fulfilling the financial promises made in Cairo than in either of the two previous years.*** Similarly, donor policies on sexual and reproductive health have strengthened over the last few years, to better reflect the comprehensive approach to meeting reproductive health needs that was at the heart of the ICPD agenda.

Unfortunately, this progress is not uniform across the donor community. A handful of donor countries have yet to contribute even a tiny fraction of their fair share of donor resources, while others need to give substantially more in dollar terms. **Thus, the donor countries together would still need to *triple* their population assistance to meet the funding goal for 2005 agreed to in Cairo.** The grant assistance coming from other donors, primarily foundations, eases this shortfall, while development bank loans also add to the supply of funds and some developing countries provide significant resources. Nevertheless, the need for more resources from donor governments is inescapable.

*2002 is the latest year for which comparable data are available.

KEY FINDINGS

The Policy Environment for Population Assistance

A number of donor governments continue to strongly support efforts to address poor sexual and reproductive health in their development programs, and others are joining their ranks. This support exists despite a lack of depth in public understanding of what their governments actually do for development, including in the area of sexual and reproductive health. The governments of Denmark, the Netherlands, Norway, Sweden and the United Kingdom remain committed to these issues. Canada, a consistent voice in international policy discussions, now has clearly articulated policies addressing sexual and reproductive health needs, as does Germany. Belgium, France and New Zealand have also strengthened their policies, while Luxembourg and Ireland have significantly increased their funding.

The efforts of advocacy groups in the donor countries and the explosion of the HIV/AIDS pandemic have been critical to these advances in policy and funding. Political leadership has also been important, in particular that coming from the Netherlands, the United Kingdom, the European Commission and, indeed, the European Union (EU) as a whole. Countries such as Portugal and Spain have lagged behind, however, while the United States moved backwards, in 2001 reimposing restrictions on its assistance for family planning that had been eliminated eight years earlier.

The policy environment is also affected by the donor community's increasing adherence to the Millennium Development Goals (MDGs). With their overarching goal of poverty reduction and particular goals related to maternal and child health, HIV/AIDS, and gender equality, the MDGs should serve to reinforce donor support for population assistance.

TABLE 1
COUNTRY GRADES

Netherlands	A
Denmark	A
Norway	A
Sweden	A
Finland	A
Luxembourg	A-
United Kingdom	B
Belgium	B
Switzerland	B
Canada	B
Germany	B
New Zealand	B
Japan	B
Australia	C
France	C
United States	C
Ireland	C
Italy	D
Spain	D
Austria	D
Portugal	D

Trends in Population Assistance

Population assistance increased dramatically from 2001 to 2002, from $2.5 billion to $3.2 billion. Assistance from the donor countries alone increased from $1.7 billion to $2.3 billion, the largest one-year increase ever recorded. The backdrop to this increase is the upward trend in official development assistance (ODA) from the major donor countries, as well as their increasing attention to the HIV/AIDS pandemic.

Even with such a significant rise in funding, population assistance continues to lag far behind agreed upon goals, although the funding gap narrowed in 2002. The ICPD goal for funding from donor countries by 2005 is $7.5 billion annually ($6.1 billion in 1993 dollars). Reaching the $7.5 billion goal by 2005 would require a three-fold increase in donor countries' 2002 spending of $2.3 billion.

Total population assistance rose from $1.5 billion in 1996 to $3.2 billion in 2002, an 80 percent increase in real terms. Most donor countries increased their population assistance after 1996, but the sharing of the load remains woefully unequal. Although they are the largest donors in dollar terms, the United States, Japan and the United Kingdom contribute just one-third, or less, of their "fair shares" of the $7.5 billion spending goal for 2005. In contrast, Denmark, Norway and Luxembourg continue to fulfill their fair shares, while the Netherlands stands out as the fifth largest donor country in dollar terms and the third most generous donor relative to the size of its economy.

Private foundations are another source of the significant increase in funds, providing at least $460 million in 2002, compared with less than $100 million in 1996. Development bank commitments averaged at least $450 million annually over the period 1996-2002, but their funds are provided as loans, rather than grants.

Trends over time should be regarded as only *indicative* of progress made, however, given incomplete reporting and changes in the definition of population assistance applied to the tracking of resource flows. Following the ICPD, the definition of the term was changed to encompass a broader reproductive health agenda, with activities grouped in four categories: family planning services, basic reproductive health services, prevention programs for sexually transmitted diseases (STDs), including HIV/AIDS, and population-related research. In 1999, the HIV/AIDS component was redefined to include *all* prevention activities, *plus* treatment, care and support.

Geographic and Program Priorities

The most notable shifts in funding patterns can be seen in the dramatic increase for HIV/AIDS-related activities and for global or inter-regional programs. Expenditures for HIV/AIDS activities have increased slightly less than four-fold, in real terms, since 1996, from $242 million to $1,343 million in 2002. Spending on activities identified as reproductive health and family planning increased by 20 percent, in real terms, from $1,058 million to $1,468 million. Again, it is important to recall the addition of care, treatment and support under STD/HIV/AIDS activities in 1999.

Population assistance spending on global or inter-regional programs increased from 26 percent to 40 percent of the total over the period 1996-2002. At the same time, all regions saw increases in the *volume* of population assistance received between 1996 and 2002, even if their *shares* of funds decreased, as was the case for both the Latin America and Caribbean region and the Asia-Pacific region. Most notable was the doubling of population assistance to sub-Saharan Africa, to more than $850 million, as the donor response to HIV/AIDS and other sexual and reproductive health needs gained strength.

The Netherlands stands out as the fifth largest donor country in dollar terms and the third most generous donor relative to the size of its economy.

As noted above, it is important to keep in mind the indicative nature of the data available. Many donors prefer to support comprehensive reproductive health programs that integrate care in pregnancy, family planning, STD/HIV/AIDS prevention and treatment and other services. Donors are also increasing their support for sector-wide, more systems-oriented approaches to the provision of health care—support that is not captured in the figures presented here.

The tracking of financial flows for specific aspects of sexual and reproductive health—such as services for adolescents, efforts to address unsafe abortion, and reproductive health supplies—is particularly challenging. Many donors shy away from supporting adolescent services or are shifting resources to approaches that have been shown to be ineffective, such as "abstinence-only" rather than comprehensive programs. Most donor governments are reluctant to support the provision of safe abortion services or even post-abortion care. Only a handful of donors provide significant resources for supplies, and thus the gap between the need for donated contraceptives and condoms for HIV/AIDS prevention and available funding is projected to reach hundreds of millions of dollars annually by 2015.

Population Assistance Channels

Donor governments continue to be the largest single source of international population assistance, far outpacing assistance from foundations, the development banks and non-governmental organizations (NGOs). In 2002, the major donor countries (members of the Development Assistance Committee of the Organization for Economic Cooperation and Development) supplied more than two-thirds of all population assistance, utilizing four major channels: bilateral, multilateral, multi-bilateral and NGOs.

Since the mid-1990s, donor governments have tended to channel an increasing volume of population assistance funds through bilateral programs and NGOs. Core funding of multilateral organizations such as UNFPA was only slightly higher in 2002 than in 1996, while donors doubled the amount of bilateral aid channeled to specific projects undertaken in collaboration with multilateral organizations (thus the use of the term "multi-bilateral").

These shifts in funding patterns have coincided with the continued expansion of bilateral programs by several leading donors, including Germany, Japan, the Netherlands and the United Kingdom. Most donor countries that have increased their bilateral programming have also maintained or increased their support for international institutions such as UNFPA, UNAIDS, the International Planned Parenthood Federation (IPPF) and, more recently, the Global Fund to Fight AIDS, Tuberculosis and Malaria. The European Commission is an increasingly important channel for development aid from the EU Member States and its assistance for sexual and reproductive health efforts continues to rise.

KEY RECOMMENDATIONS

Generating the necessary human, financial and other resources required to provide sexual and reproductive health services to all who need them will require commitment, capacity, and coordination, as well as improved methods for measuring success.

- ***Commitment* entails both sound policies and adequate financial resources.** This is the responsibility of *both* donor and developing countries and will require leadership and action by government leaders, parliamentarians, and civil society. In the donor countries, including new and emerging donors, civil society and parliamentarians need to push their governments to allocate *at least* 0.7 percent of national income for official development assistance. They must make the case for adequate resources for sexual and reproductive health, including HIV/AIDS, and insist on concerted action to eliminate the shortfall in reproductive health supplies.
- ***Greater capacity* is needed in both donor and developing countries** in technical aspects of sexual and reproductive health and with respect to the systems for monitoring resource flows, evaluating outcomes, and for the delivery of reproductive health supplies. Government officials, parliamentarians and civil society organizations must be able to participate actively and effectively in resource allocation processes, including those related to health sector reform and poverty reduction strategies. They must be able to demonstrate the economic as well as the social benefits of investing in sexual and reproductive health.
- ***Coordination* must strengthen among donors, developing country governments and institutions, and NGOs** at the national, regional and international levels to ensure the effective use of financial and human resources and that sexual and reproductive health needs in smaller or otherwise disadvantaged countries are not neglected.
- ***Different and better indicators for measuring progress* are needed**, so that donors, aid-receiving governments, institutions and NGOs can be held accountable. Such indicators must take into account inequalities within countries, and the importance of quality of care issues and respect for human rights in the design and delivery of services. Resources must also be made available to improve the tracking and transparency of financial and other resource flows.

WHAT LIES AHEAD

In 2002, donor performance clearly improved when measured against the financial goals adopted at the ICPD in 1994. But population assistance—and assistance to the health sector generally—will have to increase much faster in the future if it is to meet the world's urgent and growing need for sexual and reproductive health services. And the goalposts for assessing performance will need readjusting as well.

A number of donors have made commitments to increase their development assistance relative to the size of their economies. Five countries—Belgium, France, Ireland, Spain and the United Kingdom—have pledged to provide 0.7 percent of gross national income (GNI) for ODA before 2015. Canada, Germany and Italy have also stated their intention to increase aid relative to national income. But the United States and Japan, the world's two largest economies, remain far from the 0.7 percent goal. If they and all the other DAC donor countries were to allocate 0.7 percent of GNI, development assistance would effectively triple, to more than $175 billion dollars annually. That would help bring the Millennium Development Goals and those of the International Conference on Population and Development within reach.

We must be able to demonstrate the economic as well as the social benefits of investing in sexual and reproductive health.

In 1994, at the International Conference on Population and Development (ICPD), the international community endorsed an approach to improving reproductive health based on meeting individual needs and respecting human rights. The 179 nations present agreed on a plan for achieving universal access to basic reproductive health care by 2015—and on the financial resources needed to make it a reality. They pledged to share the costs, estimated at US$18.5 billion annually by the year 2005, and donor nations committed to providing one-third of that total.

At the halfway point to 2015, the target year for the central goals of ICPD, it is time to take stock of how far we have come and how far we have to go. This report is part of that process, examining recent trends in funding and policy and the contributions of the donors involved. It profiles each of the major donor countries and assigns each country a grade based on financial and policy indicators crucial to bringing the promise of ICPD closer to reality. Profiles of the European Commission and the World Bank are also included, together with an overview of the population assistance programs of leading foundations in the private philanthropic community. Complementing this analysis, a case study examines the experience of Ghana vis-à-vis the donor community. This report is the third in a series by Population Action International and is also intended to complement the research on financial resource flows done jointly by the United Nations Population Fund (UNFPA), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Netherlands Interdisciplinary Demographic Institute (NIDI).

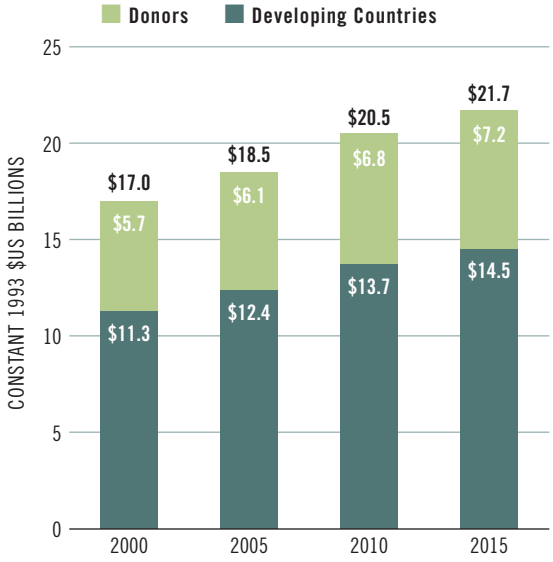
Today, the international community has some cause to celebrate. Population assistance increased by a record amount in 2002, to more than $3 billion.* And while the donor nations still fall far short of the commitments made a decade ago in Cairo, the gap between what was given and what was pledged was smaller in 2002 than in either of the previous two years.

Donor policies on sexual and reproductive health have also strengthened overall. Policy documents increasingly emphasize a health- and rights-based rationale for providing population assistance. A few donors still lack clearly articulated policies, however, while others (notably Australia and the United States) place restrictions on the use of funds that effectively undermine the policies they have.

Ten years after the Cairo conference, some progress toward improving reproductive health has been made, but tremendous challenges remain. The HIV/AIDS pandemic has raced through sub-Saharan Africa and is now hitting Asia and parts of Eastern and Southern Europe hard. Young people are now half the world's population and more than one billion are in their teens. And each year, more than three and a half million women and men die of reproductive health-related causes, including AIDS, pregnancy, childbirth, and unsafe abortion.

Money matters and policies count. Without money, good policies cannot be put into action. Without good policies, money may be spent ineffectively, or worse. The donor nations have made some progress, but still have far to go to fulfill the promise of Cairo: a world in which women and men can make decisions about sex and reproduction in good health, with hope rather than fear.

FIGURE 1
DONOR AND DEVELOPING COUNTRY RESOURCES PLEDGED TO REACH ICPD GOALS



Note: Figures are for annual spending pledged
Source: Programme of Action of the International Conference on Population and Development, paras. 13.15 and 14.11.

*2002 is the most recent year for which comparable data are available.

Chapter 1

Why Population Assistance Matters

At the ICPD in 1994, the right to reproductive health was recognized as part of an individual's right to the highest possible standard of good health. Nations agreed that meeting individual needs was the organizing principle of good reproductive health and population programs, while they also acknowledged the contribution that early stabilization of world population size would make to the achievement of sustainable development.

Ten years later, at the halfway mark in the countdown to 2015, vast differences remain in reproductive health status between rich and poor countries. The HIV/AIDS pandemic has expanded its reach and its toll in human lives and threatens economic growth in some of the world's poorest countries. At the same time, however, population growth still outpaces gains in economic productivity in some countries, adding to the challenge of providing the health care, education, skills and jobs needed by the young to thrive in the future.

These are just a few of the reasons why population assistance still matters and why donors focused on achieving the Millennium Development Goals (MDGs)—and concerned with poverty reduction, human rights, health and development—must help ensure the adequate flow of resources for sexual and reproductive health services.

The Gap in Reproductive Health Status

As was the case more than 10 years ago, 99 percent of deaths to women from pregnancy-related causes still take place in developing countries today. This one statistic captures the impact of poor access to contraception, lack of skilled care in pregnancy and childbirth, as well as pregnancies that occur too early in life, too late or too often. Thus, women in sub-Saharan Africa face a 1 in 16 lifetime risk of dying in pregnancy or childbirth, while the risk for women in developed countries is just 1 in 2,800, according to the World Health Organization (WHO).

The growing demand for contraception has yet to be met. The need for effective methods of contraception continues to grow, as the number of women and men in their childbearing years increases, and as more of them want to plan their families. Indeed, the demand for contraception is projected to increase by 40 percent by 2025. Thus while access to and use of contraceptives has increased more than ten-fold since the 1960s, UNFPA estimates that more than 200 million women still have an unmet need for effective methods of contraception. Unmet need is highest in sub-Saharan Africa, where 46 percent of women at risk of unintended pregnancy are using no method of contraception.

Shortfalls of reproductive health supplies are at crisis levels. The gap between demand and supply for contraceptives, condoms for HIV/AIDS prevention, and other reproductive health supplies is growing. One illustration of this growing crisis is that if all the male condoms made available by donors in sub-Saharan Africa were evenly distributed, each man would have just three or four per year. Yet while the demand for supplies continues to soar, donor funding for both supplies and supply systems continues to fall. (*See the* Special Topic *at the end of this chapter for more information.*)

Lack of care in pregnancy and childbirth is a fact of life—and death. Hundreds of millions of women still lack access to basic care in pregnancy and childbirth. While women in developed countries have almost universal access to care, one-third of pregnant women in developing countries receive no medical care whatsoever. Only half of all deliveries are attended by skilled personnel, a proportion that falls to less than one-third in the least developed countries. And the need continues to grow: currently, the number of women of reproductive age in developing countries is increasing by more than 20 million annually.

HIV/AIDS prevention and treatment remain out of reach. An estimated 38 million people are living with HIV/AIDS, half of them women, and 5 million people were newly infected in 2003. AIDS has already reduced life expectancy in the hardest hit countries and, due to its impact on working-age adults, is projected to reduce national incomes as well. More than three-quarters of HIV infections are transmitted sexually, while 10 percent are due to mother-to-child transmission. Yet proven means of prevention—such as condoms, voluntary testing and counseling and drugs to prevent mother-to-child transmission—are available to less than 20 percent of people with a high risk of infection, according the Global HIV Prevention Working Group. The international community is even further from achieving the goal of treating 3 million people with anti-retrovirals by 2005.

Reproductive Rights are Human Rights

The ICPD Programme of Action broke new ground when it stated that "reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents, and other consensus documents." Going beyond the right to plan one's family, first articulated in 1968, it placed the "right to attain the highest standard of sexual and reproductive health" firmly within the concept of the right to health. Thus population assistance can be seen as being as much about the promotion of human rights as it is about the promotion of human health.

Human rights treaties underpin reproductive rights. Most donor countries have signed the major human rights treaties that lay the foundation for the right to reproductive health. These treaties include the International Covenant on Economic, Social, and Cultural Rights adopted in 1966, which lays out the "right to health" in Article 10.2, and the International Covenant on Civil and Political Rights, also adopted in 1966, which lays out the right to liberty and security of person in Article 9(1). In 1979, the Convention on the Elimination of All Forms of Discrimination Against Women included the right to health care, including information, counseling, and family planning services in Article 14.2(b) and certain other Articles. In 1989, the Convention on the Rights of the Child established the right of women to appropriate maternal health services in Article 24(2)(d).

Population assistance promotes human rights. All of these rights, taken together, build a firm basis for the right to reproductive health. Most importantly, countries that have ratified the above treaties are *legally bound* to protect, promote, and ensure the rights within the treaties—a fact that should encourage donor countries to invest in sexual and reproductive health services as a way to contribute to the exercise of the right to health.

Reproductive Health, Population, and Development

Reproductive illnesses and unintended pregnancies weaken or kill people in their most economically productive years, not only exacting a financial toll on individuals and families but undermining the economic development of nations. The Millennium Development Goals, including both the overarching goal of poverty reduction and particular goals related to maternal and child health, HIV/AIDS, and gender equality, should serve to reinforce donor support for population assistance.

Reproductive illnesses threaten health and impose economic costs. In sub-Saharan Africa, one-third of all disability and premature death among women is due to reproductive illnesses, including complications of unsafe abortion and HIV/AIDS. Among men, one-quarter of the death and disability burden is attributed to reproductive health-related causes. These figures probably understate the impact of poor reproductive health, especially for women. In many developing countries, women earn 40 percent to 60 percent of household income, and grow 80 percent of the food consumed. This economic contribution is lost when a woman dies in pregnancy or is unable to work due to poor reproductive health.

> Poor men and women pay the ultimate price—their lives—for declining funding levels, weak coordination of supply procurement, and a lack of capacity to get supplies where they need to be.

Early pregnancy and lack of education contribute to a vicious cycle. For teenage girls in particular, the birth of a child often brings an end to their education, hurting their prospects for employment and their ability to provide for themselves and their children. Yet girls with a secondary education are between 3 and 13 times less likely to become mothers early in life and tend to have fewer and healthier children. Poorer and less educated women are less likely to have access to reproductive health care, with devastating results. They are more likely to die from pregnancy-related causes, to have to resort to unsafe abortion, or to have children who are malnourished or die from disease. All of these events carry both human and economic costs.

HIV/AIDS exacts a human and financial toll. HIV/AIDS is cutting short the lives of people in some of the world's poorest countries, damaging the prospects for economic development and adding to the financial burden faced by families and societies. Funerals for AIDS-related deaths are a major cause of job absenteeism and family debt in

sub-Saharan Africa. In Zambia alone, more than 2,500 teachers died of AIDS in 2001, the equivalent of 1 in 16 teachers in the country. At the World Economic Forum in 2002, AIDS experts estimated that a country with 15 percent of its population HIV-positive could expect its gross domestic product to decline by about 1 percent annually.

Women's ability to manage their fertility is critical to gender equality and reducing poverty. Access to reproductive health care, including contraceptive services, is crucial if women are to be able to make their own decisions about childbearing and, consequently, other aspects of their lives. In its absence, achieving gender equality and reducing poverty are not possible.

Access to reproductive health care hastens the demographic transition. The shift from short lives and large families to long lives and small families that has occurred in the developed countries and some developing countries is due in part to access to key health interventions, such as antibiotics, immunization, and contraception. The lower birth rates—and thus slower population growth—that resulted are largely the consequence of women and men realizing their own childbearing intentions, but carried benefits for entire societies. Rapid population growth stresses the capacity of a country to feed, educate and otherwise provide for its people. It is a key factor in urban growth and increasing scarcities of water and cropland that, together with increases in working-age and school-age populations, continue to help push human development out of reach in many countries. It is critical to note, however, that in some countries today, rising death rates as a result of the HIV/AIDS pandemic are contributing unacceptably to the slowing of population growth. Access to comprehensive sexual and reproductive health services is thus doubly important to reduce AIDS-related deaths.

Smaller family size supports savings and investment. Research has documented the impact of smaller family size on household savings and investment, and through these, on economic growth generally. The experience of the "Asian Tigers" points to a virtuous cycle in which use of contraception, higher levels of education among girls, and the entry of women into the work force resulted in smaller average family size—and a high ratio of workers to dependent children. This in turn meant that both governments and families could invest more in each child, thereby ensuring their access to education and health care. Over time, both governments and households were able to save more, thereby increasing the pool of capital available for productive investments, and thus stimulating economic growth.

The Cairo Conference and Burden Sharing

The ICPD Programme of Action called on the international community to provide the necessary funds to meet basic reproductive health needs such as family planning, care in pregnancy and childbirth, and services for sexually transmitted diseases (STDs), including HIV/AIDS (with an emphasis on prevention), and to support basic research and policy analysis on population-related issues. The emphasis was on the range of services that could be reasonably provided at the primary health care level, with referral available for more sophisticated services, such as emergency obstetric care. Thus the "costed package" was born: a series of cost estimates for annual spending by 2000, 2005, 2010 and 2015 that would result in universal access to basic reproductive health care in 20 years.

Nations participating in the conference agreed that the costs should be shared, with developing countries and countries in economic transition assuming two-thirds of the costs and the wealthy donor nations taking responsibility for the remaining one-third. **For 2005, the ICPD cost estimates require US$12.4 billion in annual spending by developing countries and $6.1 billion by donor countries. Adjusted for inflation, these figures would equal $15.2 billion and $7.5 billion, respectively.**

Developing country spending is inadequate to the need. Estimates of total spending on sexual and reproductive health by developing countries, whether by governments or individuals, are based on data that are far from complete. UNFPA/NIDI estimate spending at around $8 billion annually from the late 1990s through 2000. Additional data from one country, China, increased that estimate by more than $3 billion for 2003. Even so, no more than a dozen developing countries account for the overwhelming bulk of what is spent—among them Brazil, China, Egypt, India, Iran, Indonesia, Mexico, Pakistan and Turkey—and some of them require very little external assistance. In contrast, all of sub-Saharan Africa accounts for less than 10 percent of these "domestic" expenditures and government spending per capita is inadequate to the need in almost every case. Indeed, per capita spending on sexual and reproductive health varies widely among developing countries in all parts of the world. But with respect to Africa in particular, the impact of HIV/AIDS makes the need for additional donor assistance clear.

The Reproductive Health Supply Challenge

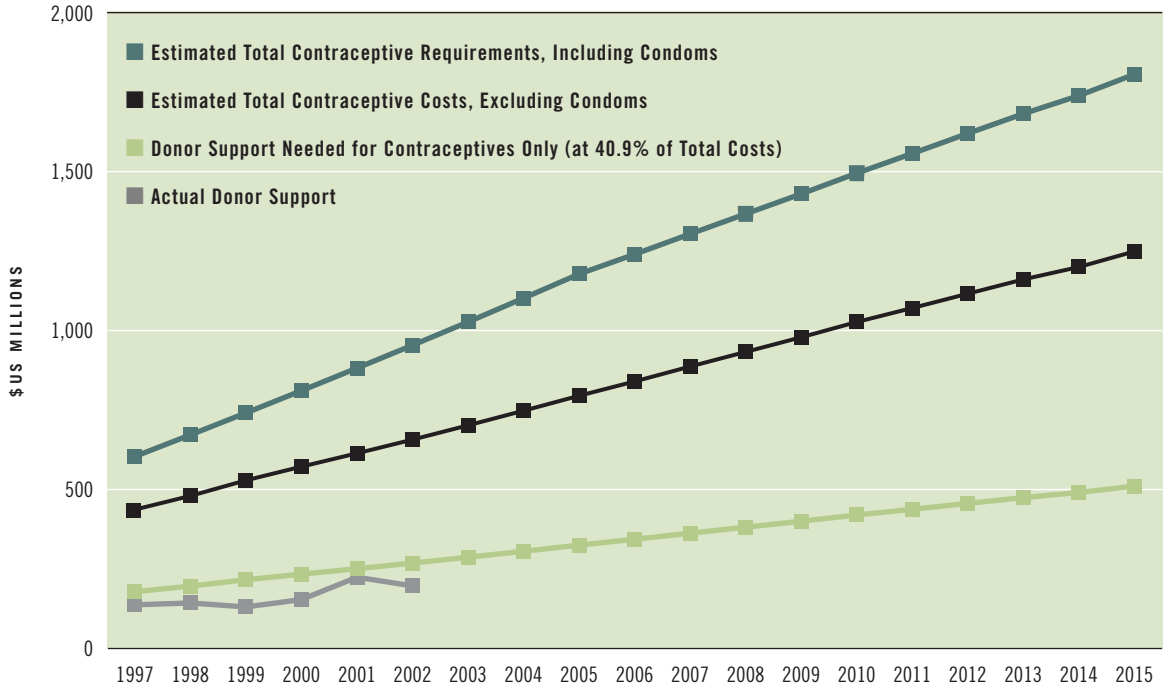
A growing shortfall in the availability of the supplies needed for HIV/AIDS prevention, contraception and other vital sexual and reproductive health care services threatens the well-being of men and women in the developing world. The gap between the need for donated supplies and the funding available to purchase them is projected to reach hundreds of millions of dollars annually by 2015. Supply stock-outs at the clinic level are widespread despite more than 30 years of experience by donors, NGOs, and the public and private sectors. Poor men and women pay the ultimate price—their lives—for declining funding levels, weak coordination of supply procurement, and a lack of capacity to get supplies where they need to be.

Rising Need, Lack of Money among Causes of Crisis

A record number of men and women are now in their reproductive years, or soon will be, due to continued population growth and the largest generation of young people that the world has ever seen. Between 2000 and 2015, the reproductive-age population in developing countries is expected to increase by more than 20 percent, and the number of contraceptive users by more than 40 percent. The devastating spread of HIV/AIDS, especially among young people, has also raised demand for services and protection.

Despite the growing need, the availability of reproductive health supplies has been characterized by inconsistent and inadequate funding, as well as a lack of coordination at the global and national levels. Donor support, which comes from only a handful of bilateral and multilateral donors, has been erratic, and on an overall downward trend since the early 1990s. Many developing country governments have been reluctant to assume the increasing financial burden, while also suffering from a lack of capacity to manage procurement and supply systems.

FIGURE 2
TOTAL SUPPLY NEED AND DONOR SUPPORT



The cost of supplies for family planning and prevention of HIV/AIDS is expected to double by 2015.

Source: UNFPA. 2004. *Donor Support for Contraceptives and Condoms for STI/HIV Prevention 2002.* New York: UNFPA.

Falling Short of Commitments

According to UNFPA, the cost of contraceptive supplies alone (not including condoms for HIV/AIDS prevention) rose from US$222 million in 1992 to an estimated $657 million in 2002, and continues to increase. Yet donor support fell from an estimated 41 percent of total supply costs (between 1992 and 1996) to 30 percent in 2002. Many developing country governments have been unable to fill the growing shortfall of funds.

In addition to contraceptive supplies, the cost of condoms needed to prevent STDs, including HIV/AIDS, will also rise—from $239 million in 2000 to $557 million in 2015—yet in 2000, donors provided barely 19 percent of the number of condoms needed to have a significant impact on the spread of HIV/AIDS.

Thus the combined cost of supplies for family planning and for STD and HIV/AIDS prevention (contraceptives and condoms) is expected to nearly double over the next decade—from $1.0 billion in 2003 to $1.8 billion in 2015, while delivery and related costs will rise to $9 billion. To return to meeting 41 percent of just the needed supplies, donors would have to provide $739 million in 2015.

Meeting the Need

Awareness of this problem began growing in the late 1990s. Since then, a global movement of governments, institutions and individuals has mobilized to encourage governments, businesses, and non-profit groups in both rich and poor countries to take action on this urgent need. Those involved include UNFPA, the International Planned Parenthood Federation (IPPF), bilateral donors (including the United States, United Kingdom, and the Netherlands), foundations, the World Bank, advocacy NGOs and projects such as the Supply Initiative. Progress to date includes the establishment of the Reproductive Health Interchange, a Web-based tool for tracking procurement of supplies and related financial flows. A related initiative, the Reproductive Health Supplies Coalition, focuses on information exchange, mobilizing resources, and efforts to raise awareness and strengthen commitment among donor country governments.

Some donors have shown concern and a willingness to help when called upon. The United Kingdom, the Netherlands and Canada provided additional funds in 2001 in response to an immediate supply crisis at UNFPA. In late 2004, the Netherlands as president of the European Union led another effort by donors to fill the supply gap, together contributing $75 million to UNFPA. Others still fail to grasp just how serious the crisis is, yet it is only through collective action that the growing shortfall of reproductive health supplies will be averted.

The Policy Environment for Population Assistance

Contrary to what is often said by policymakers and pundits, public support for aid to developing countries is very high. Surveys undertaken in 13 major donor nations between 1999 and 2001 show very high levels of support for development assistance. Levels of support range from 71 percent in the United Kingdom and New Zealand to 90 percent and 95 percent in the Netherlands and Ireland, respectively. Public awareness of reproductive health needs in developing countries has also improved, due in part to the HIV/AIDS pandemic. Indeed, surveys suggest that public support for government aid to improve access to family planning and to prevent and treat HIV/AIDS in developing countries is very strong.

At the same time, however, public understanding of development issues and policies in general remains limited. As one observer noted with regard to Australia, public support for development aid is "a mile wide and an inch deep." People tend to think of aid in terms of emergency or humanitarian relief, rather than long term investments in people and infrastructure. Furthermore, most members of the public know very little about what their governments actually do to improve human well-being, including in the area of sexual and reproductive health. Indeed, the term "reproductive health" is not well understood by most members of the public, particularly in comparison with such terms as "family planning" or "contraception."

Donor Commitment Has Strengthened Overall

Despite this lack of depth in public understanding of development issues, many donor governments continue to strongly support efforts to address poor sexual and reproductive health in their development programs, and others are joining their ranks. The governments of Denmark, the Netherlands, Norway, Sweden and the United Kingdom remain committed to these issues. Canada, a consistent voice in international policy discussions, now has clearly articulated policies addressing sexual and reproductive health needs, as does Germany. Other donors have also strengthened their policies, including Belgium, France and New Zealand, while Luxembourg and Ireland have significantly increased their funding for programs.

This increased commitment to reproductive health is not universal, however. In countries such as Portugal and Spain, conservative governments have continued to neglect these issues (although Spain's newly elected government is expected to dramatically change course). In addition, as noted above, the U.S. government has increased restrictions on the use of its funds since 2001, most notably through the reimposition of the Global Gag Rule (also known as the Mexico City Policy), and has attempted to weaken the international consensus around sexual and reproductive health in international meetings.

The efforts of advocacy groups in the donor countries and the explosion of the HIV/AIDS pandemic are two factors critical to the advances in policy and funding noted above. Advocacy groups are having an impact because today, 10 years after Cairo, NGOs are more numerous and have far greater capacity to play a role in the policy process. Whether working with parliamentarians, directly with development officials, or to raise awareness among other audiences, their efforts have increasingly made a difference in the policies and funding of their respective governments. Indeed, NGO advocacy has been critical to the process of bringing the HIV/AIDS pandemic to the forefront of donor concerns. Even those governments with conservative approaches to reproductive health overall, such as Italy and Ireland, have dramatically increased their financial support for the fight against AIDS.

Political leadership has also been important to recent advances in policy and funding, including that coming from Canada, Germany, the Netherlands, Sweden, United Kingdom and from the European Commission in response to the increasingly conservative stance of the U.S. government. The Bush Administration's decision to reimpose the Mexico City Policy (termed the Global Gag Rule by its opponents) in January of 2001 brought a swift reaction from leading European donors, as did the U.S. withdrawal of funding from UNFPA in mid-2002. Several donors pledged to fill what they called the "decency gap" caused by the resulting loss of funds for IPPF (as a result of the Global Gag Rule) and UNFPA. International organizations, most notably UNFPA and UNAIDS, have also exercised leadership by continuing to call attention to the need for financial resources for both programs and supplies.

Challenges in the Policy Arena Are Diverse and Complex

The challenges ahead are significant, as both the landscape and architecture of development assistance changes. Security concerns increasingly stand out in donor governments' new development assistance policies. While framed in terms of contributing to human security, efforts by donors to strengthen the security systems of aid-receiving countries—for example, to manage politically motivated violence and other conflict—have raised human rights concerns and would draw on development resources.

New mechanisms for delivering aid are also having an impact on the flow of development dollars. Leading donors in the sexual and reproductive health field are giving greater support to sector-wide approaches (SWAps) and other mechanisms for channeling aid monies. While these mechanisms are a positive development in terms of their potential impact on health systems and host country ownership of the development process, they increase the difficulty of prioritizing sexual and reproductive health issues.

A different type of challenge is posed by the rise in political opposition to sexual and reproductive health programs. While long a factor in the United States, where anti-abortion groups have sought to link family planning programs to U.S. domestic abortion politics since the 1980s, such activism has been less of a factor in Europe historically. This has begun to change, in part as U.S.-based conservative groups have increasingly reached out to like-minded Europeans. For whatever reasons, opposition to reproductive rights in Europe has intensified, although to varying degrees depending on the country. Within the European Parliament, for example, the number of hostile queries directed at European Commission staff has shot up, as have efforts to portray the Commission's support for reproductive health as "promoting abortion." Adding to the challenge is the expansion of the European Union (EU) in May 2004. The 10 new Member States have limited experience with development assistance and, in some cases, are more conservative with respect to reproductive health and rights. However, many of the most active opponents of sexual and reproductive health and rights in the European Parliament hail from within the 15 pre-accession Member States.

On a positive note, most donor nations have placed poverty reduction and the MDGs at the forefront of development policy. This development should reinforce donor support for population assistance, given the role of good reproductive health in reducing poverty, but also adds to the urgency of increasing the flow of resources for development aid.

RECOMMENDATIONS: Strengthening Support for Population Assistance

Success in securing the financial resources and policies to meet reproductive health needs requires a supportive policy environment in which the contribution of good sexual and reproductive health to overall development is recognized. A key challenge is to ensure that donors recognize sound reproductive health policies and programs as crucial to reducing poverty and achieving the MDGs and, consequently, to human security. ***Achieving this level of understanding will require that:***

- NGOs engaged in advocacy on population and reproductive health and rights issues increase further their effort to inform and influence policymakers in the donor nations, especially parliamentarians and development officials, including those in the relevant institutions of the European Union. To be successful, they must strengthen collaborative relationships with NGOs working in related fields, including HIV/AIDS, human rights, gender, youth and debt relief, as well as development NGOs more generally. NGO should also help educate other key constituencies with influence in the policy process, including environmentalists and those working in security-related fields, about the importance of good sexual and reproductive health.
- Donor governments ensure that their commitment to sexual and reproductive health is communicated not only to their own development agencies, but to other relevant ministries, especially ministries of finance, education, and health, as the latter are increasingly involved in aspects of development cooperation. Donor governments also need to do more to inform and educate their publics about their development cooperation programs, including specific efforts to address sexual and reproductive health needs, and should enlist NGOs and other civil society actors in the effort.
- Those donor governments strongly supportive of population assistance work with other governments to strengthen their commitment. This is another area in which donor country NGOs can play a role, by building and strengthening relationships across borders, and providing technical assistance where necessary, in support of efforts to improve policies and funding in other donor countries, including the new EU Member States.
- Major international organizations, in particular UNFPA, help ensure that sexual and reproductive health are part of policy discussions around development cooperation, both in international meetings and at the country level.

The Impact of U.S. Policies on Sexual and Reproductive Health in Kenya

U.S. policies on family planning funds and funds for the fight against HIV/AIDS have negatively affected the major providers of sexual and reproductive health services in Kenya.

The Mexico City Policy (Global Gag Rule)

In January 2001, the Bush Administration reimposed the Mexico City Policy. Under this policy, no U.S. family planning assistance can be provided to foreign NGOs that use funding from *any other source* to:*

- perform abortions in cases other than a threat to the life of the woman, rape or incest;
- provide counseling and referral for abortion; or
- lobby to make abortion legal or more available in their country.

Noncompliance results in loss of funding from the U.S. Agency for International Development (USAID) for family planning services. As a result of the Mexico City Policy's restrictions on freedom of speech, those who oppose it refer to it as the Global Gag Rule.

Under the Global Gag Rule, funds are denied to foreign NGOs that choose to counsel their patients on a full range of reproductive health options when those options include abortion, even if legal in their own country. When an NGO refuses to accept the gag rule, in addition to losing U.S. family planning funds, it also loses access to USAID-donated contraceptive supplies and technical support. Its ability to form partnerships with other U.S.-funded NGOs in the country also suffers. This loss of supplies, technical support, and partnerships is often more devastating than the loss of funds. (For a detailed update on the impact of the gag rule in Ghana, see the Ghana case study: *"Sexual and Reproductive Health in Ghana and the Role of Donor Assistance—A Case Study"* on page 35.)

The Policy's Impact in Kenya

In Kenya, the effects of the gag rule are far-reaching. The two pioneers in the field of reproductive health, the Family Planning Association of Kenya (FPAK) and Marie Stopes International Kenya (MSI Kenya), refused to accept the terms of the gag rule. As a result, they lost U.S. family planning assistance, which made up a large part of their budgets, and had to close clinics. A total of five family planning clinics (three FPAK and two MSI Kenya clinics) closed in 2001 and 2002. In some cases, these clinics were the only source of health care for local communities. Community-based outreach programs were slashed, and family planning services were scaled back.

FPAK's attempts in the past two years to raise enough money to fill the void left by the gag rule have failed. As of mid-2004, six of their 12 remaining clinics faced imminent closure.

The inability of major family planning providers like FPAK to recover in the wake of the gag rule not only affects access to reproductive health services. Most family planning clinics in Kenya provide a wide range of care in addition to contraceptive counseling, such as Pap smears, child immunizations, and childhood disease management. FPAK, for example, no longer carries out child immunizations due to its budget deficit. The training of nurses has also been shortchanged.

In addition to the budget deficit caused by the gag rule, Kenyan reproductive health service providers are also suffering as a result of the contraceptive supply crisis in the country. Decreased donor support for contraceptive supplies in combination with logistical and distribution problems have led to severe shortages of various contraceptive supplies. Finally, compounding all these problems is the shifting of donor attention generally toward HIV/AIDS and away from basic reproductive health care, including family planning.

U.S. HIV/AIDS Assistance

In recent years, HIV/AIDS has become a focus of many donors, including the United States. Providers such as FPAK face enormous difficulties in fundraising for family planning programs in a climate where HIV/AIDS is receiving all the attention. The U.S. funding available for HIV/AIDS prevention and treatment dwarfs the amounts available for family planning and other reproductive health services in Kenya.

The increased funding for HIV/AIDS treatment and care is critically important, of course, but U.S. HIV assistance is subject to such restrictive guidelines that it does not encourage coordination between HIV/AIDS activities and basic reproductive health services. Given that HIV is predominantly spread through heterosexual sex, a crucial

*The term "family planning assistance" refers to specific U.S. assistance for family planning and thus is different from the more broadly defined term "population assistance" used in this publication.

link exists between HIV/AIDS and sexual and reproductive health care. Unfortunately, U.S. assistance is structured in such a way that coordinating and linking with comprehensive reproductive health activities is virtually impossible, according to Godwin Mzenge, the director of FPAK. Contracts detailing the use of funds are highly restrictive and leave no space for integration of HIV/AIDS prevention or treatment efforts with reproductive health activities—not even in most prevention of mother-to-child transmission (PMTCT) programs, where the link between the two is vital.

> *As for the HIV funds we receive, we cannot use the HIV money for family planning. For example if we are providing VCT [voluntary counseling and testing] services, when our clients come in they want VCT* as well as*…family planning [services]. However, we cannot do this for them.*
>
> —Godwin Mzenge, Director of FPAK

The large influx of funds for HIV/AIDS programs also means that more people are attracted to jobs in this area. Many experts in reproductive health and family planning are moving to focus solely on HIV/AIDS. FPAK has lost almost all its senior staff to well-funded HIV/AIDS programs. "So even if we manage to keep our clinics open, we have no senior personnel to run them," Mzenge said in a recent interview.

Overall, interviews with leading reproductive health service providers in Kenya reveal the general fear that even if the gag rule is lifted, the overwhelming, donor-driven focus on HIV/AIDS—to the detriment of reproductive health services—will remain.

Implications for the Longer Term

What does all this mean for Kenya in the long run? The preliminary report of the 2003 Kenya Demographic Health Survey is ominous. The deterioration of reproductive health care in the country has led to a startling reversal in trends of earlier years. The proportion of women receiving antenatal care from health professionals rose between 1989 and 1993, but consistently declined thereafter. As for skilled attendance in delivery, the share of births attended fell from 50 percent in 1993 to 42 percent of births in 2003. In addition, contraceptive use has stagnated at 39 percent of women—high compared with many other countries in the region, but the same in 2003 as in 1998. And women are having slightly more children, on average, than five years previously: 4.9 in 2003, up from 4.7 children in 1998.

A multitude of factors are to blame for this setback. Health indicators have been in decline for more than a decade in Kenya, while donor attention to sexual and reproductive health in the country has been waning for some time. Thus while the gag rule cannot be blamed solely for the decline in reproductive health indicators, it has certainly not helped.

What the Future May Bring

As this is written, the repeal of the Global Gag Rule is unlikely without some change in the balance of political forces within the United States. Efforts to document the impact of the gag rule are needed, however, in order to provide the kind of evidence base that may prove influential in the U.S. policy arena in the longer term. Stronger advocacy efforts can make a difference too, by encouraging all donors—including the United States—to adequately fund sexual and reproductive health activities in addition to HIV/AIDS.

Advocates can also help move the donor community toward a better understanding of the importance of linking or coordinating reproductive health and HIV/AIDS services—for example, in the testing and treatment of sexually transmitted diseases, when educating people on safer sex, and in prenatal care or PMTCT programs. Existing reproductive health and family planning structures can also be used as an entry point for HIV/AIDS prevention and treatment efforts. Together, HIV/AIDS and reproductive health efforts can more effectively stem the epidemic.

Trends in Population Assistance

Population assistance increased dramatically from 2001 to 2002, from US$2.5 billion to $3.2 billion. This total includes $2.3 billion from donor countries, $460 million from foundations, $328 million in loan commitments by development banks, including the World Bank, and $70 million from NGOs. Assistance from the donor countries alone increased by $594 million, from $1.7 billion to $2.3 billion, the largest one-year increase ever recorded.

The backdrop to this increase in population assistance is the recent upward trend in official development assistance (ODA) from the major donor countries. [These are defined as members of the Development Assistance Committee (DAC) of the Organization for Economic Cooperation and Development (OECD).] After declining in the mid- to late-1990s, ODA turned dramatically upward in 2002 to reach $58.3 billion, an increase in real terms of 7 percent over the previous year. Preliminary figures for 2003 indicate a further 3.9 percent increase to $68.5 billion, the highest level ever in both nominal and real terms, according to the OECD.

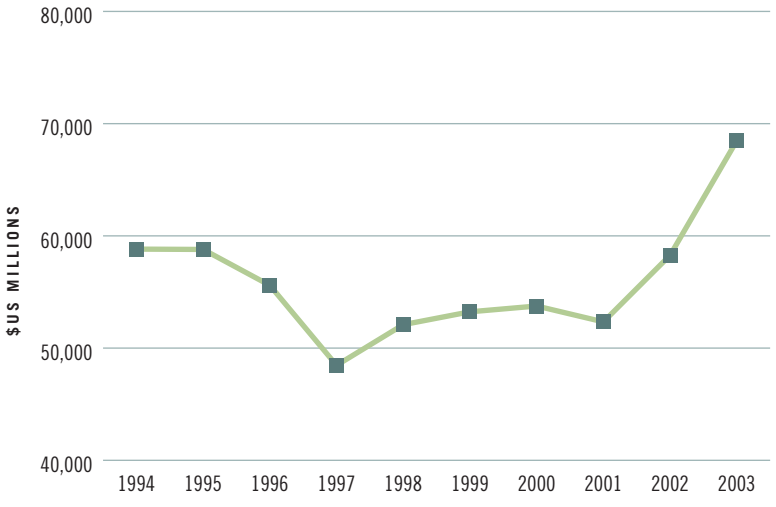
Three additional factors help explain the upsurge in population assistance recorded in 2002. Most important is the increase in spending on activities reported as HIV/AIDS-related, an increase reflected in the population assistance allocations of donor countries and foundations, in particular. Second, reporting by some donor countries appears to have improved. This is partly due to changes in information systems for a few donors, but also to the efforts of individual staff members in donor agencies committed to the reporting process. In addition, increased cooperation among organizations that track resource flows has made cross-checking of data easier. A third factor is the more than doubling of funds from foundations, which in 2002 contributed one of every six dollars of grant population assistance.

Benchmarks of Performance: 0.7 Percent and the "Fair Share" Concept

Putting all these numbers in a broader economic context is important. Aid figures are usually assessed relative to gross national income (GNI), since most of the major donor countries have agreed in principle that ODA should represent 0.7 percent of national income. Donor country population assistance is assessed in a similar manner, as measurements relative to income equalize the advantage very large economies have over small ones. Donor performance in population assistance can also be assessed relative to the spending goals agreed to at the ICPD in 1994. **By combining these two measures—giving relative to income and the donor share of ICPD spending goals—a "fair share" of total donor commitments can be derived for each donor country.** This fair share concept is a key factor in the grade assigned to each donor country in this report.

Data on donor performance reveal that official development assistance represented 0.23 percent of total national income for the DAC donor countries in 2002, and rose to 0.25 percent of GNI in 2003. While this weighted average is still well below the goal of 0.7 percent, it is important to note that the *average effort* among DAC donor countries was much higher, at 0.41 percent of GNI in 2002. This difference is due largely to the very low proportion of national income allocated for development assistance by the United States, the largest donor economy. Indeed

FIGURE 3
TRENDS IN TOTAL OFFICIAL DEVELOPMENT ASSISTANCE, 1994-2003



Source: Organization for Economic Cooperation and Development (OECD). Net ODA from DAC Countries from 1950 to 2002. Available from www.oecd.org; Internet; accessed 5 August 2004.
NB: Data for 2003 are preliminary figures.

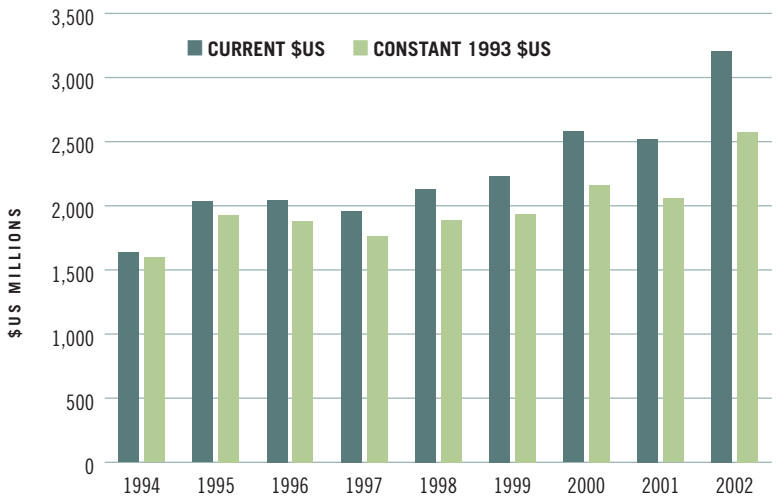
the United States remains the least generous donor relative to its economy, contributing just 0.13 percent of GNI for ODA in 2002 and 0.14 percent in 2003.

The contributions of other large donors of development assistance also appear less generous when compared to national income. Japan, France, Germany and the United Kingdom were the next largest donors after the United States (at $13.3 billion), each providing between $5 billion and $10 billion in ODA in 2002. Yet aid from France and the United Kingdom was less than 0.4 percent of GNI, while that of Japan and Germany was under 0.3 percent of GNI. Only five donor countries have met or exceeded the benchmark 0.7 percent of GNI for official development assistance: Denmark, Norway, Sweden, the Netherlands and Luxembourg.

Fortunately, a number of donors have made commitments to increase their development assistance relative to their economies. Five countries have pledged to provide 0.7 percent of GNI for ODA before 2015: Ireland (by 2007), Belgium (2010), France and Spain (2012), and the United Kingdom (by 2013). Other donors stating their intention to increase aid levels relative to national income include Canada, Germany, and Italy. The fulfillment of these commitments is crucial in light of the donor community's increasing adherence to the Millennium Development Goals, and would no doubt improve the prospects for further increases in population assistance as well.

The absence of such donors as the United States and Japan—the world's two largest economies—from the above list must be noted however, given their potential for significant increases in ODA. **Indeed, if all the DAC donor countries were to allocate 0.7 percent of GNI, development assistance would roughly triple compared with 2002 levels, to more than $175 billion dollars annually.**

FIGURE 4
TOTAL FUNDS FOR POPULATION ASSISTANCE, 1994-2002



Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002.* New York: UNFPA.

Unequal Burden Sharing and the Funding Gap

Unequal burden sharing also characterizes population assistance, which lags behind agreed upon goals. The ICPD goal for donor country funding in 2005 is $7.5 billion ($6.1 billion in 1993 dollars), the equivalent of 0.03 percent of GNI or $300 per million dollars of GNI. Yet donor countries allocated an average of just $93 per million dollars of GNI for population assistance in 2002. Population assistance from the donor countries would need to triple, from the $2.3 billion level of 2002, to reach the goal of $7.5 billion by 2005.

For example, the United States has long been the largest bilateral donor in absolute terms, but its contribution relative to income still lags well behind those of Denmark, Norway, the Netherlands and, more recently, Luxembourg. These four countries contributed an average of $400 per million dollars of GNI for population assistance in 2002. The United States provided just $92 per million dollars of GNI, ranking 11th among the 22 DAC donor countries. Spain, Portugal and Greece contributed less than $5 of population assistance per million dollars of GNI.

The priority accorded to sexual and reproductive health activities can also be seen in the annual percentage of ODA allocated for population assistance. The United States, Finland, and Luxembourg provided the largest share of their ODA budgets for population assistance in 2002, among nine DAC donor countries that allocated more than 4 percent of ODA for this purpose. Seven donors contributed less than 2 percent of ODA for population assistance, most notably France and Italy, while Austria, Spain, Portugal and Greece allocated less than one-half of 1 percent. Together, the 22 DAC donor countries allocated an average of 4 percent of ODA to population assistance. This *weighted* average is less impressive, however, given that total ODA represented just 0.23 percent of GNI in 2002. It is also worth contrasting the weighted average with the average (unweighted) effort by donors, which is just 3 percent of ODA for population assistance.

Trends in Donor Country Contributions

Given the vast differences in the size of donor country economies, the dollars provided for population assistance remain critically important. In 2002, the United

Population assistance from the donor countries would need to triple, from the $2.3 billion level of 2002, to reach the goal of $7.5 billion by 2005.

States contributed a record $963 million in population assistance. Japan, the United Kingdom and the Netherlands each contributed more than $150 million, while Germany provided slightly more than $100 million. The European Commission, an increasingly important channel of development assistance for EU Member States, allocated an estimated $180 million for population activities in 2002.

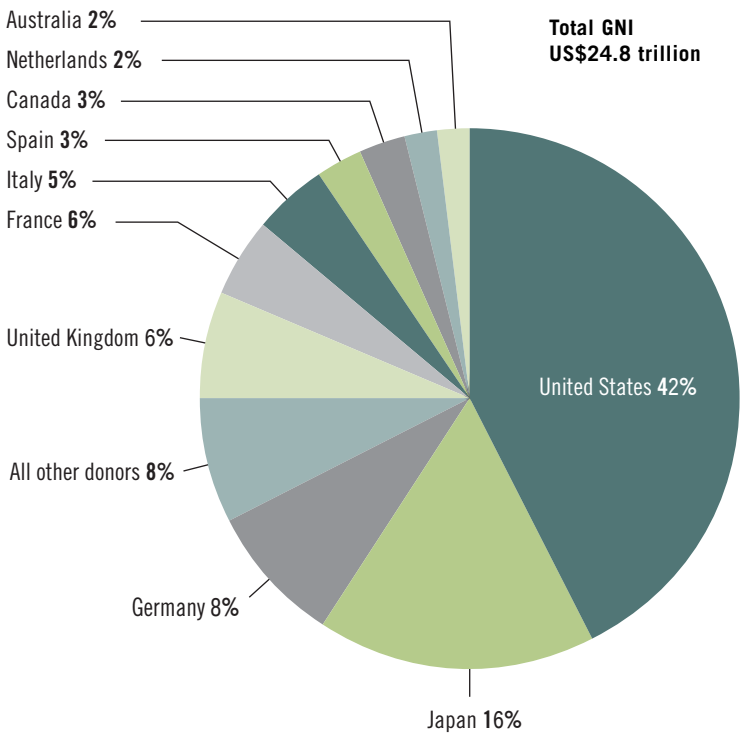
Another five donor countries provided between $50 million and $100 million in population assistance in 2002, of which Norway, Denmark and Sweden are also among the most generous donors relative to the size of their economies. Six donor countries contributed between $10 million and $50 million, including Belgium, Finland and Switzerland. Italy also falls into the group, with population assistance of $22.6 million in 2002. However, it is important to note that this figure represents just 1 percent of Italian development assistance and just $19 per million dollars of GNI. In contrast, the Netherlands stands out as the fifth largest donor in dollar terms and the third most generous donor relative to national income.

Trends are also important, and most donor countries have increased their population assistance since 1996. Large gains were recorded by the United States, Japan, the United Kingdom, the Netherlands, France, Canada, Norway, and Belgium. Others made significant progress relative to 1996 levels. For example, Ireland increased its population assistance more than ten-fold, from less than $1 million to $11.8 million, while Italy and Luxembourg increased their support five times. Only Australia and Spain significantly decreased their support for sexual and reproductive health activities between 1996 and 2002. As noted below, however, incomplete and inconsistent reporting by donors is among the factors that complicate the assessment of trends over time, in particular with respect to Canada, France and Spain.

Foundations, Development Banks and Emerging Donors

Private foundations are another source of the significant increase in funds between 1996 and 2002. Together they provided at least $460 million in 2002, a near doubling of funds over 2001 levels and a five-fold increase since 1996. The bulk of this support has come from U.S.-based foundations, although a small number of foundations in Europe and Japan also make significant contributions to the field. Among the largest donors in 2002 were the Bill & Melinda Gates Foundation, The William and Flora Hewlett Foundation, the United Nations Foundation, and the OPEC Fund for International Development. In contrast to the development banks, which provide their support overwhelmingly in the form of loans, foundations provide grants,

FIGURE 5
RELATIVE SIZE OF DONOR ECONOMIES, 2002
(Percentage of combined donor country GNI)



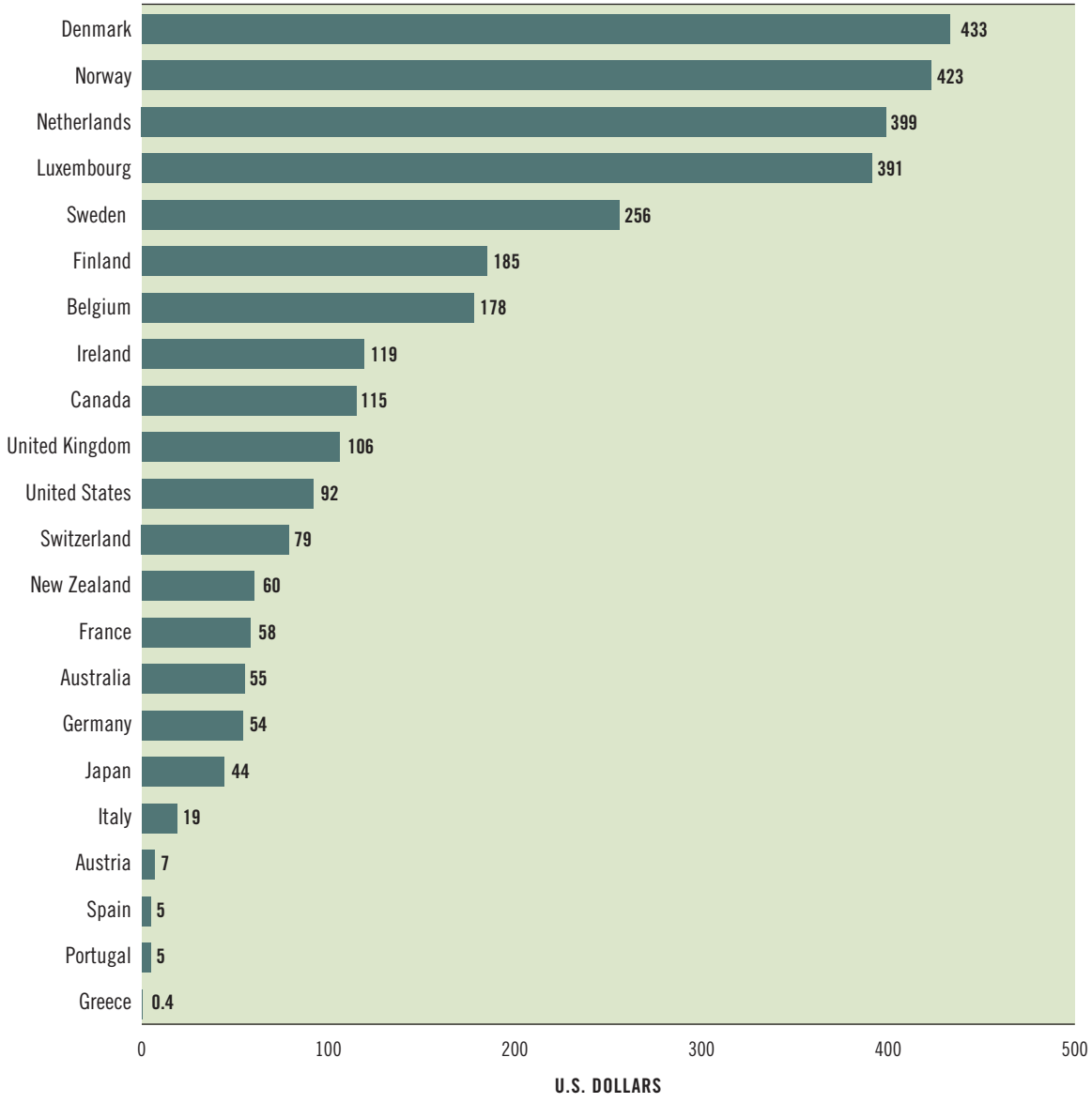
Source: Organization for Economic Cooperation and Development (OECD). 2004. *Development Cooperation 2003 Report.* Paris: OECD.

which in 2002 represented 16 percent of grant population assistance from all sources.

The population assistance loans provided by the development banks are another important source of funds. As loans, they can be viewed as the funds of last resort, but may also be seen as evidence of a borrowing country's commitment to the sexual and reproductive health of its people. Development bank commitments averaged at least $450 million annually over the period 1996-2002, although only World Bank loans were reported in 2002. These totaled $328 million, of which $232 million were highly concessional (low interest) loans from the International Development Association (IDA).

The importance of the charitable foundations and development banks—in particular the World Bank—goes beyond their financial contributions. Foundations have often taken on controversial or neglected issues—such as adolescent rights, sex trafficking, the shortfall in reproductive health supplies, and abortion—that may be avoided by donor governments, and in so doing encouraged government

FIGURE 6
DONOR COUNTRY POPULATION ASSISTANCE PER MILLION DOLLARS OF GNI, 2002

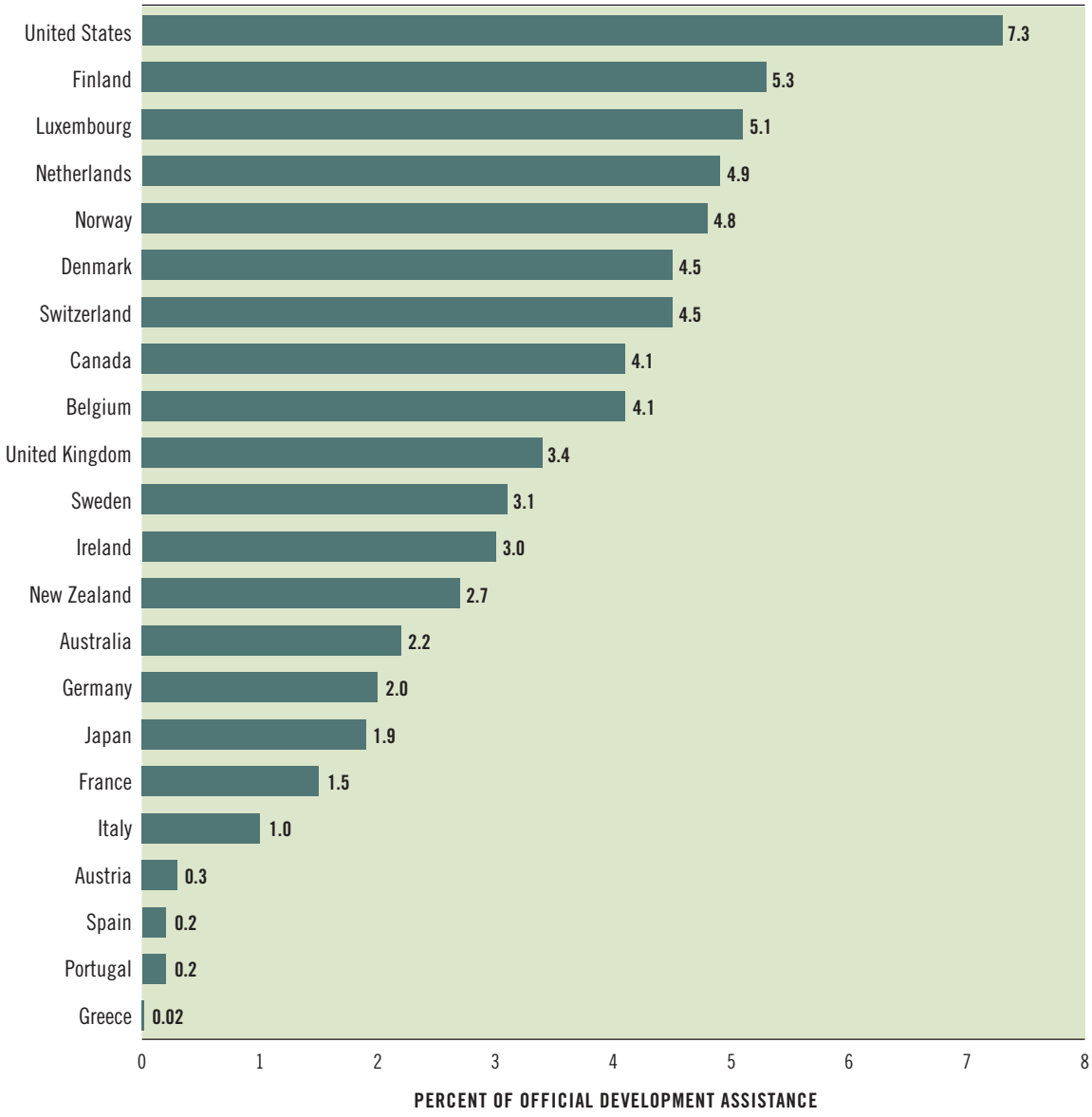


Sources: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002.* New York: UNFPA; and Organization for Economic Cooperation and Development (OECD). 2004. *Development Cooperation 2003 Report.* Paris: OECD.

action. The World Bank exerts significant influence both on other donors and on national-level policies and investments in sexual and reproductive health programs through its important role in the policy process including, for example, with respect to poverty reduction strategies.

In addition to the new EU Member States, other emerging donors could be expected to play a role in the sexual and reproductive health field. For example, the Republic of Korea (South Korea) provided $279 million in development assistance in 2002, more than such countries as Greece, Luxembourg and New Zealand, and Turkey increased its ODA to $73 million. Exchange of technical expertise is another means of sharing resources and was the idea behind the establishment in 1994 of Partners in Population and Development (PPD), a consortium of 20 countries. Thailand, a member of PPD, announced in the fall of 2004 its decision to establish a full-fledged international cooperation and development agency.

FIGURE 7
SHARE OF OFFICIAL DEVELOPMENT ASSISTANCE ALLOCATED TO POPULATION ASSISTANCE, BY COUNTRY, 2002



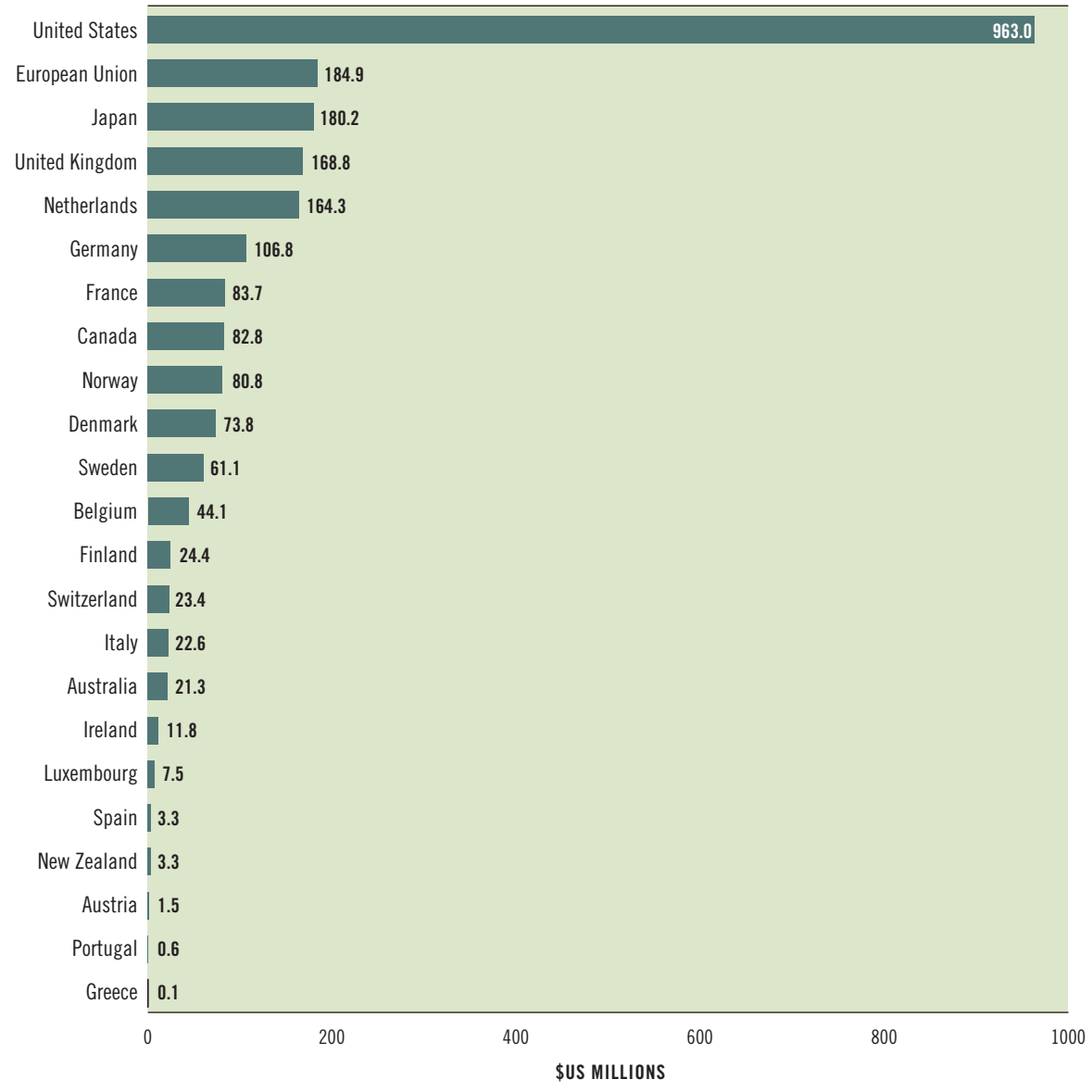
Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002.* New York: UNFPA.

Progress Toward ICPD Goals

The major donor nations deserve praise for the increases in overall development assistance and in support for sexual and reproductive health programs. Recent commitments to future increases in ODA and strong policy statements on sexual and reproductive health issues from certain key donors are also cause for optimism. There is still far to go, however. While donor countries improved their performance in 2002, they would still need to increase their population assistance three-fold, in real terms, to reach the spending goal for donors endorsed at the ICPD. Taking into account all grants for population assistance in 2002, including those from foundations, NGOs, and other sources (but excluding bank loans), the donor community still provided only 40 percent of estimated need as spelled out in the ICPD Programme of Action.

For individual countries, the progress required to achieve a "fair share" of the year 2005 goal of $7.5 billion differs greatly. The United States would need to raise its population assistance by the largest *dollar* amount—more than

FIGURE 8
POPULATION ASSISTANCE BY DONOR COUNTRY, 2002



Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002.* New York: UNFPA.

TABLE 2
RESOURCES NEEDED TO REACH ICPD YEAR 2005 GOAL FOR DONOR POPULATION ASSISTANCE

	2002 Population Assistance ($US millions)	2005 ICPD Goal (1993 $US millions)	2005 ICPD Goal (2002 $US millions)	Multiplier to reach 2005 goal
Denmark	$ 73.8	$ 42.1	$ 51.9	—
Norway	$ 80.8	$ 47.2	$ 58.1	—
Netherlands	$ 164.3	$ 101.7	$ 125.3	—
Luxembourg	$ 7.5	$ 4.7	$ 5.8	—
Sweden	$ 61.1	$ 58.9	$ 72.6	1.2
Finland	$ 24.4	$ 32.4	$ 40.0	1.6
Belgium	$ 44.1	$ 61.2	$ 75.4	1.7
Ireland	$ 11.8	$ 24.4	$ 30.1	2.6
Canada	$ 82.8	$ 177.4	$ 218.5	2.6
United Kingdom	$ 168.8	$ 394.0	$ 485.4	2.9
United States	$ 963.0	$ 2,591.6	$ 3,192.2	3.3
Switzerland	$ 23.4	$ 73.4	$ 90.4	3.9
New Zealand	$ 3.3	$ 13.5	$ 16.7	5.1
France	$ 83.7	$ 355.6	$ 438.0	5.2
Australia	$ 21.3	$ 95.6	$ 117.7	5.5
Germany	$ 106.8	$ 491.0	$ 604.8	5.7
Japan	$ 180.2	$ 1,004.3	$ 1,237.0	6.9
Italy	$ 22.6	$ 290.2	$ 357.4	15.8
Austria	$ 1.5	$ 50.4	$ 62.0	40.8
Spain	$ 3.3	$ 161.0	$ 198.3	60.3
Portugal	$ 0.6	$ 29.3	$ 36.1	63.3
European Commission	$ 184.9	NA	NA	NA
TOTAL	**$ 2,313.8**	**$ 6,100.0**	**$ 7,513.7**	**3.2**

Note: Each donor's share of the $6.1 billion donor target for the year 2005 was estimated based on its proportional share of aggregate 2002 GNI for the donor community. Division of each country's year 2005 goal by its 2002 level of assistance may not be equal to multiplier due to rounding.

Data for population assistance taken from UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002*. New York: UNFPA.

a three-fold increase—from $963 million to $3.2 billion. Japan would need to spend an additional $1 billion, for a total of $1.2 billion. Portugal, Spain and Austria face the largest *relative* shortfall, each needing to increase its budget allocations more than 40 times. Other donors facing large increases if they are to provide their fair share include Germany ($500 million in additional funds), France ($350 million), and both the United Kingdom and Italy (more than $300 million).

While a useful tool for assessing performance, the financial goals agreed to in Cairo were based on projections of resource needs that took into account only a limited range of sexual and reproductive health needs. For example, the ICPD cost estimates did not include the care, treatment and support components necessary to fully address the HIV/AIDS pandemic. Of the $18.5 billion required spending projected for 2005 (equal to about $23 billion if adjusted for inflation), the ICPD Programme of Action allocated $1.4 billion to cover four of the recommended HIV/AIDS prevention interventions. New cost estimates from UNAIDS include $6 billion for the full range of prevention interventions, $3.8 billion for care and treatment programs, and $1.1 billion for support programs, with total resource needs estimated at $12 billion in 2005 and $20 billion for 2007.

Given the scale of resources needed for HIV/AIDS, a more accurate estimate of the financial resources needed to improve sexual and reproductive health overall would incorporate elements of both the original ICPD estimates and UNAIDS estimates. Such a reassessment of total resource requirements is increasingly needed, given that in 1999 the definition of population assistance used in tracking financial flows was broadened to include the full range of HIV/AIDS interventions (*see the section,* Population Assistance: Changing Definitions, *for more details*). Of course, there are synergies that can be realized through improved coordination and, where appropriate, integration of

THE CHANGING ARCHITECTURE OF AID: Poverty Reduction Strategies and Sector-Wide Approaches

Dissatisfaction with the limited success of traditional development aid was reaching a peak even before the adoption in 2000 of the Millennium Development Goals and their overarching goal of poverty reduction. The 1990s were also a time of increasing deterioration of health services in many developing countries, especially in sub-Saharan Africa. Key donors, including the World Bank, European Commission and several Northern European countries, sought a more country-driven way to identify and prioritize development needs.

Two major responses emerged: the poverty reduction strategy (PRS) process and health sector reform. Both have their counterparts in donor financing: a shift away from narrower, project-oriented support and toward "pooled" budget or sector support.

The **poverty reduction strategy (PRS)** process was initiated by the World Bank in 1999. Central to the PRS process is a poverty reduction strategy paper (PRSP) that diagnoses the factors contributing to poverty in a particular country, identifies and prioritizes relevant policies, and details the indicators for measuring progress. Led in theory by country governments, but with significant involvement by donors, PRSP development is supposed to include civil society. PRSPs are the basis for highly concessional loans and/or debt relief from the World Bank and, increasingly, for grant assistance from other donors as well.

The intent of **health sector reform** is to improve a population's health by making health services more affordable, equitable, and responsive to consumer needs. These aims mirror key goals of the ICPD Programme of Action, which emphasized the role of the primary health care *system* in delivering reproductive health services. In practice, a number of obstacles to improving access may arise, given that a primary impetus for reform is inadequate financial resources in the face of increasing demand for services.

For countries significantly dependent on donor assistance, reform may be linked to a "SWAp," a sector-wide approach. In this, donors and country governments agree on a policy and a spending plan, and donors move toward supporting the health sector as a whole, rather than funding specific projects or targeted programs. As in the PRS process, much responsibility is handed to country governments for implementation of reform and administration of aid funds through a set of procedures and guidelines defined collaboratively with donors.

HIV/AIDS interventions with other sexual and reproductive health services. Indeed, such synergy is critical to ensuring the long-term effectiveness of HIV/AIDS and reproductive health interventions, and would result in some cost savings as well.

Challenges to Assessing Donor Contributions

Two key factors further complicate efforts to assess donor progress in support of sexual and reproductive health. First, many donors encounter difficulties in reporting population assistance accurately. This is due in part to complex reporting requirements by organizations that track financial flows, but also to deficiencies in donor information systems and the lack of sufficient administrative staff. Accurate reporting is further challenged by decentralization, which many donors are implementing as a way to shift authority and responsibility for funding and programmatic decisions closer to where the needs are. Again, information systems and staffing are often inadequate to handle reporting needs. Second, leading donors in the field are moving away from providing funds for specific projects, in favor of providing funds to strengthen an entire sector (such as health), or contributing to a government's overall budget. This trend comes on top of the difficulty of reporting, for example, on the reproductive health component of an integrated development project that crosses sectoral lines. In this context, performance will need to be assessed against indicators of outcome and impact, rather than money inflows.

While the second development noted above may complicate tracking of financial flows for specific types of health interventions, it is good news overall. Health systems in many developing countries need to be strengthened, especially in sub-Saharan Africa. The donor community is responding to this need and indeed, aid to the health sector has gone up since 1975, even when overall development assistance trended downward. A more integrated approach to health care delivery is also a key element of the ICPD Programme of Action, which recognized that stand-alone, vertical programs may improve one aspect of health but neglect others—to the detriment of overall health status.

For all the reasons noted above, the bottom line on donor progress toward ICPD goals is not easy to read. Donor performance has clearly improved, but population assistance—and assistance to the health sector generally—will have to increase much faster in the future if it is to meet urgent and growing sexual and reproductive health needs. And the goalposts for assessing performance will need readjusting as well.

RECOMMENDATIONS: Increasing Donor Country Financial Contributions

Generating the financial resources needed to address sexual and reproductive health needs in developing and transition countries will require that:

- Donor countries, including in particular the United States and Japan, increase their allocations of development assistance to meet the goal of 0.7 percent of gross national income for ODA. A majority of donor nations also need to increase the share of development assistance allocated for sexual and reproductive health activities, in particular France, Italy and Spain. Those donor nations needing to increase their population assistance *quickly* should contribute more to international organizations, including UNFPA and IPPF. Together, these steps would allow the burden of population assistance to be more equitably shared among countries.
- NGOs strengthen their advocacy efforts in support of overall development assistance. A bigger pie is needed if social development needs are to be met, and it will be difficult to secure additional funds for sexual and reproductive health programs if other development and humanitarian programs are seen to suffer.
- Donor nations strengthen their information systems and related staffing as needed to ensure accurate tracking of financial transactions. The donor community and developing country governments must work together to increase the technical capacity of developing country institutions to track health expenditures, including sexual and reproductive health spending. A similar effort is needed to strengthen developing country capacity for the collection and analysis of health statistics, especially those identified as indicators for assessing reproductive health status.
- Donors, developing country governments and civil society ensure that sexual and reproductive health needs are addressed in health sector planning and throughout the poverty reduction strategy process, including with regard to identifying and tracking outcomes and impacts. Thus there is a need for capacity building to ensure that government officials, parliamentarians and civil society organizations are able to participate actively and effectively in resource allocation processes. They must be able to demonstrate the economic as well as the social benefits of investing in sexual and reproductive health. At the same time, donors and developing country governments must work together to ensure that civil society (NGOs and others) has a real voice in decision-making processes about health sector and overall budget priorities.
- The increased flow of funds for HIV/AIDS activities be additive to existing funding levels and not take away resources from other critical sexual and reproductive health services, such as maternal health care and family planning.

Population Assistance: Changing Definitions

The ICPD Programme of Action included estimates of financial resource needs for a set of basic reproductive health interventions plus population-related research to be implemented in developing countries and countries in economic transition. The goal was "universal access to a full range of safe and reliable family-planning methods and to related reproductive health services which are not against the law" by 2015.

Total expenditures needed for this so-called "costed package" were estimated in 1994 at US$17.0 billion annually in 2000, rising to $18.5 billion in 2005, $20.5 billion in 2010 and $21.7 billion in 2015 (all figures expressed in 1993 constant dollars). It was agreed that wealthy donor countries should shoulder one-third of the total, while developing and transition countries would shoulder two-thirds. Thus, in 2005, the donor share of the burden would be $6.1 billion, the equivalent of more than $7.5 billion in 2002 dollar terms.

Prior to the 1994 conference, population assistance had primarily been defined as funding for family planning services. After 1994 and in keeping with the Programme of Action, population assistance was redefined to encompass the broader reproductive health agenda, organized around four major components, each comprising specific activities.

The ICPD Costed Package

- **family planning services:** contraceptive supplies and service delivery; capacity building for information, education and communication on family planning, population and development issues; national capacity building through support for training; infrastructure development and upgrading of facilities; policy development and program evaluation; management information systems; basic service statistics; and 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;* information, education, and communication about reproductive health, including sexually transmitted diseases, human sexuality and responsible parenthood, and against harmful practices; adequate counseling; diagnosis and treatment of sexually transmitted diseases (STDs) and other reproductive tract infections, as feasible; prevention of infertility and appropriate treatment where feasible; and referrals, education and counseling services for sexually transmitted diseases, including HIV/AIDS, and for complications of pregnancy and delivery.
- **STD and HIV/AIDS prevention programs:** mass media and in-school education programs; promotion of voluntary sexual abstinence and responsible sexual behavior; and expanded distribution of condoms.
- **basic research, data and population and development policy analysis:** national capacity building through support for demographic and program-related data collection and analysis, research and policy development, and training.

Shifting Categories

Prior to the Cairo conference, UNFPA tracked population spending in two major categories. So-called "core activities" included family planning, population education and communication, population policy, demographic research, other population-related data collection and analysis. A second and much smaller category covered those activities that, while part of population assistance programs, did not meet the definition for core activities, such as efforts to improve women's status. Overall, core activities dominated total population assistance.

Since the ICPD, UNFPA has reformulated the definition of population assistance used in its tracking of resource flows three times. The first change came in 1995, in order to more closely (but not identically) reflect the outcomes of the conference. In 1996, further changes were made, the most important being the shift of those STD/HIV activities previously captured under "basic reproductive health care" to the STD/HIV category, in order to ease the tracking of resource flows for this set of activities. The most recent change in definition occurred in 1999, when the Netherlands Interdisciplinary Demographic Institute (NIDI), which tracks financial resource flows on behalf of UNFPA and (since 1999) UNAIDS, began tracking flows for all AIDS-related activities: prevention, treatment, care and support. At that time, funding for treatment and care accounted for only a small share of HIV/AIDS activities.

These changes in definitions complicate the task of tracking and evaluating funding trends over time, in particular with regard to data prior to 1995 and following the definitional changes of 1999. While other challenges to tracking resource flows are noted elsewhere in this report, it is important to note here the inherent tension between the need for comprehensive and integrated sexual and reproductive health programs in the field and the desire by those monitoring resource flows for disaggregated data.

*As specified in paragraph 8.25 of the ICPD Programme of Action.

Geographic and Program Priorities

The geographic and programmatic allocations of population assistance vary greatly within the donor community. Historical and cultural ties, domestic political considerations, and geopolitical concerns are among the factors influencing decisions about development assistance overall. These factors play a role in allocations of population assistance, as do relative reproductive health needs among partner countries.

The commitment of leading donors to the overarching goal of poverty reduction and to achieving the Millennium Development Goals is reinforcing a needs-based approach to development cooperation. This trend has positive implications for the priority accorded to sexual and reproductive health issues, as does the growing attention paid by donors to issues of governance and human rights. Lastly, the presence of conflict also affects funding decisions, as it can pose a major obstacle to the provision of aid; this has been the case in recent years in such countries as Afghanistan, Côte d'Ivoire, Sierra Leone, Somalia, Sudan and several Central African countries.

Geographic Priorities

The most notable shift in geographic allocations of population assistance was the tripling of spending on global or inter-regional programs between 1996 and 2002, to US$1.2 billion. Far less dramatic are the shifts in proportional funding levels among the regions. For example, while the *shares* of funds going to both the Latin America and Caribbean region and the Asia-Pacific region have declined, the *volume* of funds has still increased. Indeed, all regions have seen their population assistance increase between 1996 and 2002, reflecting the overall increase in expenditures from $1.5 billion to $3.1 billion, an increase of 80 percent in real terms.

The flow of resources to sub-Saharan Africa doubled between 1996 and 2002, to more than $850 million, as the donor response to HIV/AIDS and other sexual and reproductive health needs gained strength. Funding for Eastern and Southern Europe also doubled, although total funds were less than $50 million in 2002. Funds flowing to both the Asia-Pacific and Western Asia/North Africa increased by roughly 50 percent. The volume of funds going to the Asia-Pacific region was much larger, at $562 million in 2002, due to the much larger and poorer population in that region. Finally, population assistance to Latin America and the Caribbean increased by about 25 percent, to more than $250 million in 2002.

At the country level, allocations of population assistance vary much more. Funding levels do not necessarily correspond to either reproductive health needs or the ability of countries to bear more of the costs, due in part to some of the political considerations noted earlier. Also important is the capacity—and willingness—of a host government to prioritize sexual and reproductive health efforts. While an exhaustive analysis is not possible here, Figure 11 shows the top 20 recipients of population assistance on a per capita basis in 1996 and 2002. For example, Uganda continues to be favored by donors, and consistently receives high levels of population assistance in both absolute terms and on a per capita basis, the latter reaching $2.18 per capita in 2002. In contrast, the impact of conflict can be seen in countries such as Somalia and Sudan, which despite abysmal reproductive health indicators receive just pennies per capita. Meanwhile, Mozambique has only recently made it onto the list of leading recipients, despite poor reproductive health among women, high infant mortality, and very low per capita income.

> At the country level, funding does not always correspond to reproductive health needs.

Program Priorities

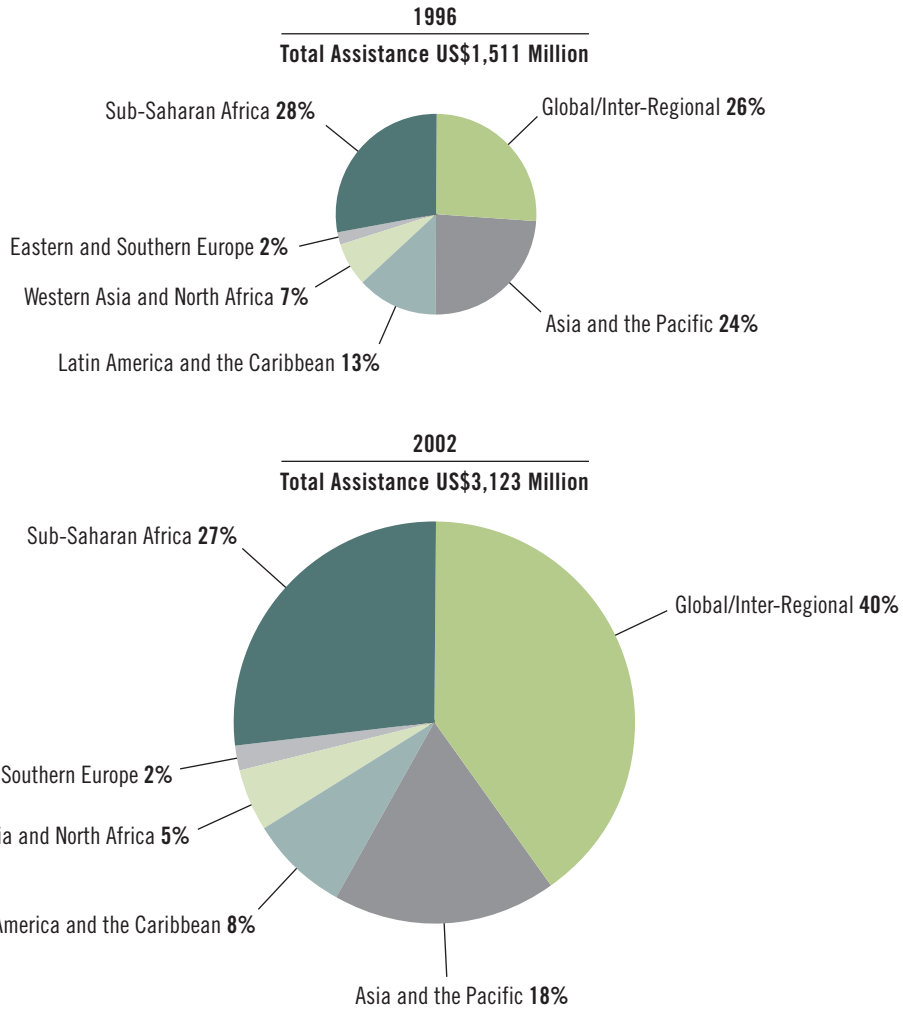
The range of sexual and reproductive health activities supported by different donors is generally more difficult to capture than the geographic allocation of financial resources. For example, multilateral contributions from donor governments are generally not assigned to a spe-

cific type of activity, but to overall support for the organization. Funds passing through NGOs are also often not reported by the donor as to the specific activity being supported. It is possible to see how financial resources are allocated globally, thanks to the work done by UNFPA and NIDI, as well as the OECD/DAC.

While expenditure data are slightly different than the budgetary allocations discussed above, the trend was also solidly upwards in 2002. Final expenditures—excluding loans—reached $3.1 billion in 2002, an increase of $1 billion over the previous year. It is in this data that the impact of the HIV/AIDS epidemic is most clearly visible. Spending on HIV/AIDS activities increased from $800 million in 2001 to $1,343 million in 2002, an increase of more than $500 million. Spending on basic reproductive health service and family planning also increased, from $1,107 million in 2001 to $1,467 million, for an increase of more than $350 million, while research activities absorbed $312 million, again an increase compared with the $164 million spent in 2001.

When compared with 1996 figures, the growth of expenditures for HIV/AIDS activities appears far more dramatic, keeping in mind the expanded range of HIV/AIDS activities (prevention, care, treatment and support) now tracked within population assistance. Thus while spending on reproductive health and family planning together increased by 20 percent, in real terms, HIV/AIDS expenditures witnessed a nearly four-fold increase.

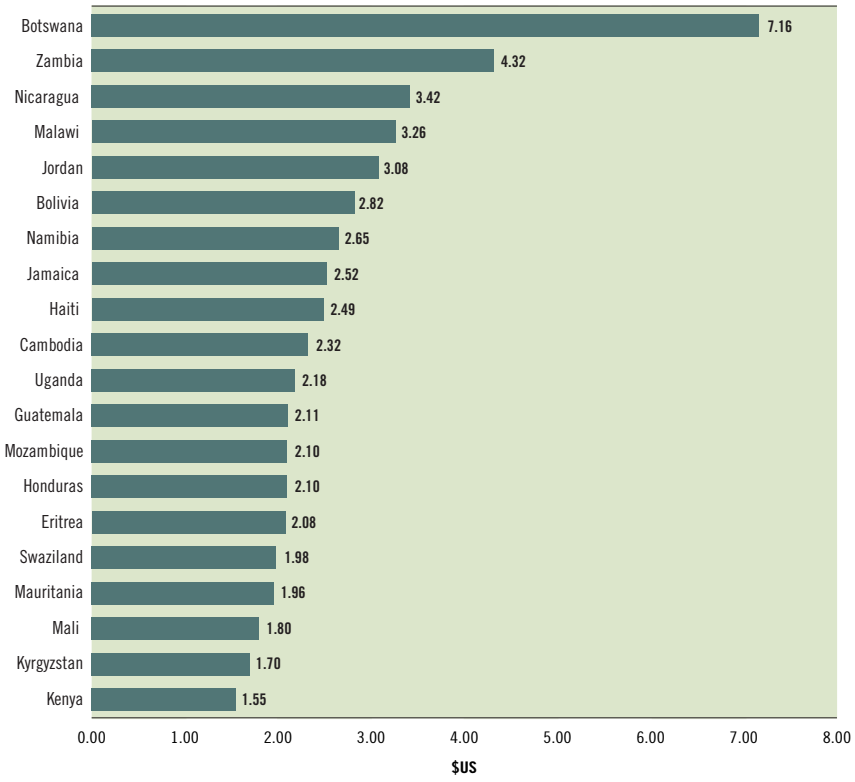
FIGURE 9
DISTRIBUTION OF POPULATION ASSISTANCE BY REGION, 1996 AND 2002



Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002*. New York: UNFPA.

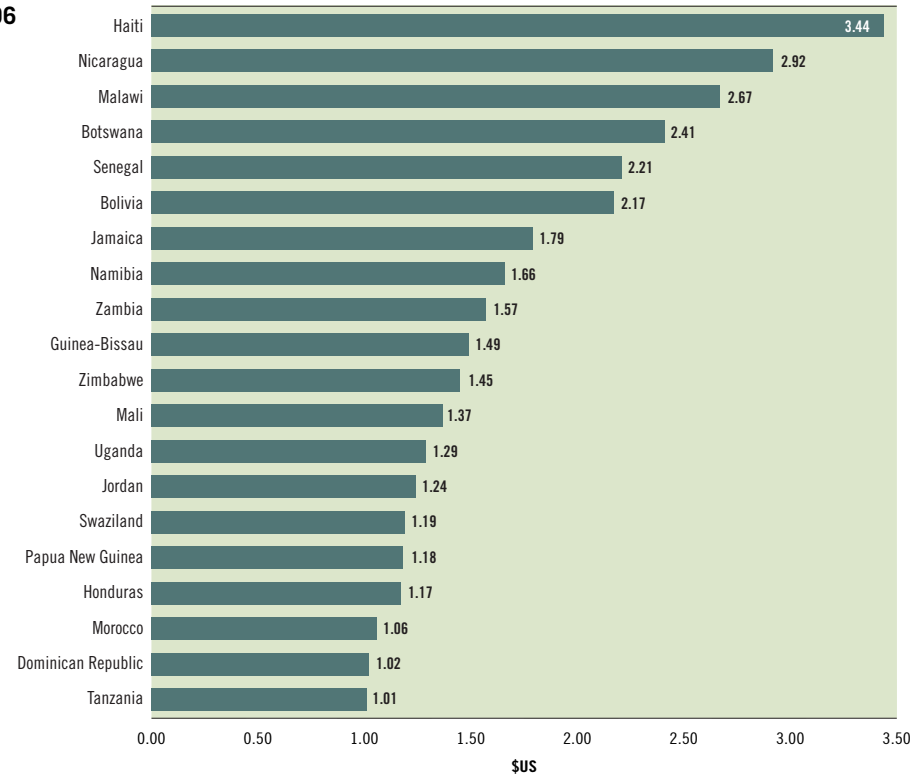
FIGURE 10
TOP TWENTY RECIPIENTS OF POPULATION ASSISTANCE PER CAPITA

2002



Sources: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002*. New York: UNFPA; Population Reference Bureau (PRB). 2002. *2002 World Population Data Sheet*. Washington, DC: PRB.

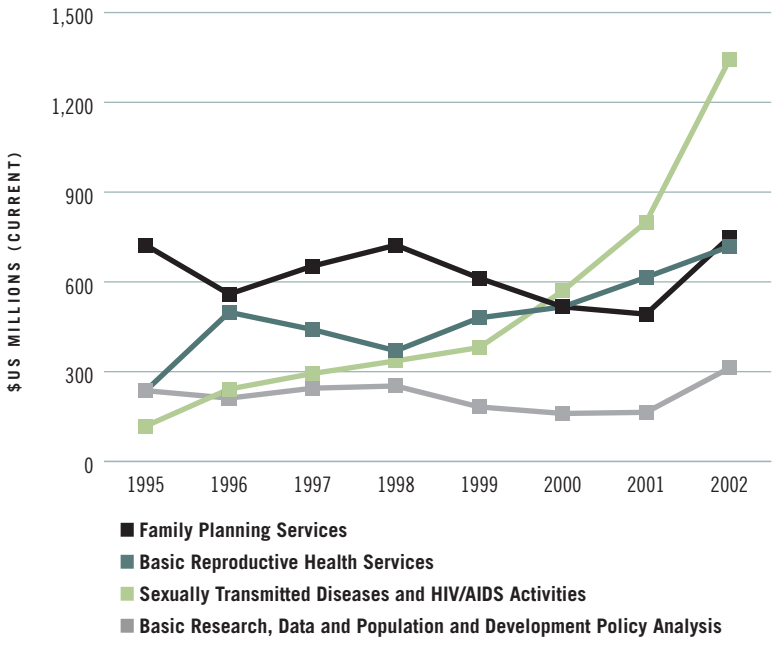
1996



Sources: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002*. New York: UNFPA; Population Reference Bureau (PRB). 1996. *World Population Data Sheet 1996*. Washington, DC: PRB.

More detail on the relative programmatic emphases of different donors can be found in the individual profiles that follow. In general, it is important to note the preference of many donors to support comprehensive reproductive health programs that integrate care in pregnancy, family planning, STD/HIV/AIDS prevention and treatment and other services. Donors are also increasing their support for sector-wide, more systems-oriented approaches to the provision of health care. For these reasons, the breakdown by activity illustrated in Figure 11 does not represent how services are actually delivered. Indeed, some donors no longer report funding for family planning separately from other reproductive health activities, in most cases because they view the ability to control one's own fertility as central to good reproductive health and the exercise of reproductive rights. As the flow of financial resources continues to increase in support of the fight against HIV/AIDS, all donors will face the challenge of ensuring that this kind of comprehensive approach to meeting sexual and reproductive health needs is embraced.

FIGURE 11
FINAL POPULATION ASSISTANCE EXPENDITURES BY TYPE OF ACTIVITY, 1995-2002



Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002.* New York: UNFPA.
NB: The development banks are not included in the final expenditures shown, as the banks' loan agreements are often disbursed over several years. Distribution for Germany in 2002 has been partially estimated based on 2001 percentages. Distribution for Luxembourg in 2002 has been estimated based on 2001 data. Distribution for Italy in 2002 has been estimated based on 2000 data. Distribution for the EU in 2002 has been estimated by NIDI based on data from the European Commission and the DAC Watch of the EU, IPPF, January 2002.

It is important to note that services for adolescents, reproductive health supplies, and unsafe abortion are critical priorities in sexual and reproductive health programming for which the flow of resources is difficult to assess. As noted above, half the world's population of 6.4 billion is under age 25, and more than 1 billion of them are 10 to 19 years old. While several important donors support the provision of information and services to young people, others shy away or, in the case of the United States, are shifting resources to approaches that have been shown to be ineffective.

Supplies are crucial to success in meeting the reproductive health needs of young people, as well as the millions of other women and men with little or no access to services. Yet there is a growing shortfall in the availability of the supplies needed for HIV/AIDS prevention, contraception (including emergency contraception) and other vital reproductive health services. Supply stockouts at the clinic level are widespread, and the gap between the need for donated supplies and the funding available for purchasing them is rising. Only a handful of donors, led by the United States, UNFPA, World Bank, Germany and the United Kingdom, provide ongoing, significant resources for the provision of supplies. Thus the recent efforts by these donors to coordinate activities take on added importance, as do the efforts of the Supply Initiative and private donors to address this problem.

Finally, the continuing toll of unsafe abortion on women's lives and health is one that too few donors address. While increasing access to contraception has been proven to reduce abortions, it is critical that abortion services be safe and accessible to the full extent of the law. This requires supplies, training for doctors and other medical personnel, and adequate facilities. Again, many donors are reluctant to address this area of reproductive health, often hesitating even to support access to post-abortion care.

RECOMMENDATIONS: Improving the Allocation of Population Assistance Funds

There is an urgent need for donors to balance their own population assistance priorities with programmatic needs at the country, regional and international levels. This will require that:

- Donor governments and other donor institutions ensure that population assistance is allocated according to need, taking into account sexual and reproductive health status, income levels, and other relevant indicators. To this end, donors must strengthen coordination at the regional and international levels and support the efforts of developing country governments to strengthen coordinating mechanisms at the country level. Efforts to harmonize aid programs, in terms of reporting and other requirements, are also critically important.
- Donors ensure that population assistance funds embrace the linkages between reproductive health and HIV/AIDS, as well as linkages between reproductive health and broader health issues. For example, family planning and voluntary counseling and testing should be included in programs for prevention of mother-to-child transmission, as recommended in the Glion Call to Action of May 2004. People benefiting from HIV/AIDS programs should also have access to an essential package of sexual and reproductive health information and services, and vice versa, as endorsed in the New York Call to Commitment (June 2004).
- Donor governments and other members of the donor community increase their support for controversial and neglected aspects of sexual and reproductive health programs. This would include funding for reproductive health supplies—including contraceptives and condoms for HIV/AIDS prevention—and to strengthen capacity for logistics in host countries. Another priority should be to ensure that medical and other personnel are adequately trained in critical aspects of reproductive health care, including emergency obstetric care, safe abortion, and post-abortion care, as well as any applicable laws. Donors should also allocate sufficient resources for building and strengthening capacity among partner institutions, including NGOs, to work in unfamiliar aspects of sexual and reproductive health, such as HIV/AIDS, abortion care, female genital mutilation/cutting, and services for young people. NGOs, including IPPF and its member associations, can help these efforts through advocacy in support of reproductive health activities considered controversial by donors or recipient countries.
- All donors and their partners ensure that population assistance funds are not burdened by conditions or restrictions that reduce the effectiveness of service delivery and limit their ability to be used for comprehensive and integrated health programs. Restrictions on funding that violate international human rights standards are also inimical to the effectiveness of population assistance.

Supplies are crucial to success in meeting the reproductive health needs of young people, as well as the millions of other women and men with little or no access to services.

Chapter 5

Population Assistance Channels

The donor community has traditionally relied upon three principal channels in disbursing population assistance funds: bilateral, multilateral, and NGOs. In recent years, the earmarking of bilateral funds by donors for specific projects in collaboration with multilateral organizations, so-called "multi-bilateral" aid, has grown in importance. Various factors influence donor preference for each of these channels, including staff capacity, the capacity of civil society organizations with which they collaborate, and differing perspectives on the role and effectiveness of each.

Donor Government Use of Channels

Donor governments continue to be the largest single source of international population assistance, and in 2002 supplied more than two-thirds of all funds. The donor community provided its US$2.3 billion in assistance through four major channels: bilateral, multilateral, multi-bilateral and NGOs.

- The bilateral channel consists of funds that flow directly from donor governments to recipient country governments;
- The multilateral channel consists of funds not earmarked for specific population activities or projects that are provided to multilateral organizations such as UNAIDS, UNFPA and WHO;
- The multi-bilateral channel consists of bilateral funds that are earmarked for specific activities or projects that are sent through multilateral organizations; and
- The NGO channel consists of general contributions to NGOs active in the field of sexual and reproductive health and bilateral expenditures for specific population activities that are executed by NGOs.

Since the mid-1990s, donor governments have tended to channel an increasing volume of population assistance funds through bilateral programs and NGOs. Core funding of multilateral organizations such as UNFPA was only slightly higher in 2002 than in 1996, while donors doubled their earmarking of funds for activities undertaken in collaboration with multilateral organizations (multi-bilateral aid).

In 2002, donor governments supplied 34 percent of their population assistance through bilateral channels, 18 percent through multilateral organizations, 4 percent as multi-bilateral assistance, and 44 percent went to NGOs. Figure 13 illustrates how the DAC donor countries and European Commission channeled their assistance in 2002.

Bilateral funding increased from slightly more than $500 million in 1996 to nearly $800 million in 2002, while NGOs received nearly $1.2 billion from donor governments, a near doubling of funds since 1996. Donor government contributions to multilateral organizations rose significantly in 2000 and 2001, increasing from $395 million in 1999 to $470 million in 2001, but dropped to an estimated $427 million in 2002 and were thus only slightly higher than in 1996. Finally, use of the multi-bilateral channel, although still the smallest share of assistance, has more than doubled since 1996 to almost $100 million. This indicates the increased use of earmarked funds for activities undertaken in collaboration with multilateral organizations.

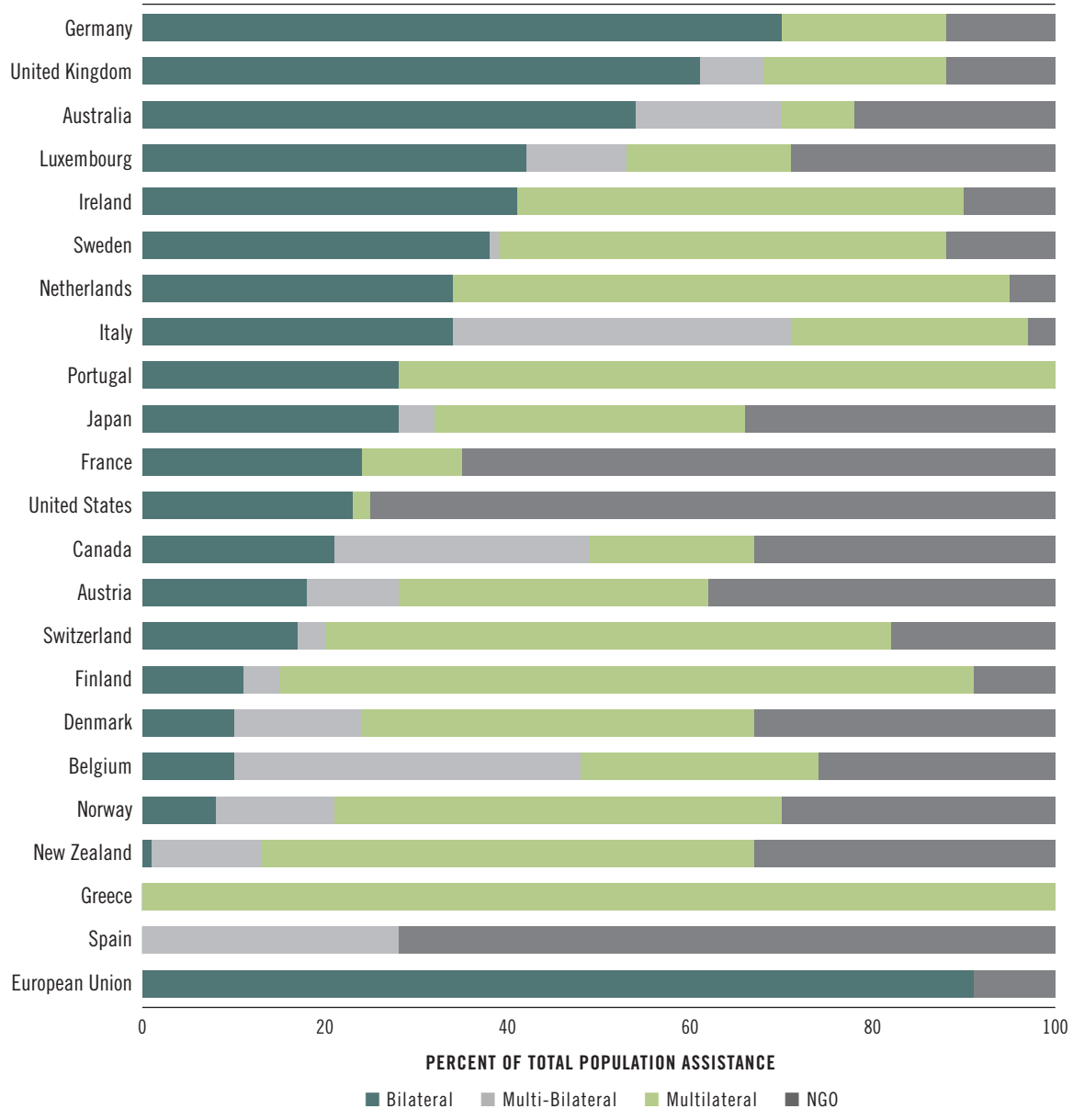
Expenditure data for 2002, which take into account the additional funds channeled to programs by foundations in particular, illustrate even more clearly the role of NGOs in the field. Of the $3.1 billion in expenditures that year, 57 percent ($1.8 billion) went to NGOs.

These shifts in funding patterns have coincided with the continued expansion of bilateral programs by several leading donors, including Germany, Japan, the Netherlands and the United Kingdom. Among donor countries that have increased their bilateral programming, however, most have maintained or even increased their support for multilateral institutions such as UNFPA. Meanwhile, the increased volume of funds passing to NGOs likely reflects three factors: the increased capacity of organizations in donor countries, the growing emphasis on funding NGOs in developing countries, and their role in the fight against HIV/AIDS. Within the NGO community, it is important to note the vital role of international NGOs such as IPPF. Its network of member associations spans the developed and developing world, providing valued services and, increasingly, acting as a forceful advocate for sexual and reproductive health priorities.

Multilateral Organizations and International Partnerships

UNFPA, UNAIDS, WHO and other multilateral organizations also play a crucial role in the sexual and reproductive health field. With programs in 140 countries, UNFPA has broad reach and can help fill the gaps when other donors shift funding priorities. Multilateral organizations are often viewed as more neutral by host country governments and institutions, thereby providing these organizations with an opportunity to influence the development of program agendas. These organizations also have an important role as advocates for their issues in policy discussions, whether at the national, regional or international level. Since its formal launch in 2002, the Global Fund to Fight AIDS, Tuberculosis and Malaria has emerged as another key player in the field, helping to ensure that HIV/AIDS efforts are effectively coordinated and funded at the country level.

FIGURE 12
ALLOCATION OF POPULATION ASSISTANCE FUNDS BY DONOR COUNTRY AND CHANNEL, 2002



Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002*. New York: UNFPA. NB: For notes, see those in Appendix 5.

It is important to note the growth of the European Commission as a channel for development assistance from the EU Member States. While still struggling to increase the efficiency of its complex bureaucracy, EC assistance for sexual and reproductive health efforts continues to increase. **In addition to its population assistance, the EC's role as an agent of change within the European Union is also important, helping move forward the policy process within EU institutions, such as the European Parliament.** EC representatives, in particular former Development Commissioner Poul Nielson, have been vocal and consistent advocates of forward-looking sexual and reproductive health policies. The European Commission's role as both an implementer of programs and a voice on policy issues will be tested over the next few years, as new Member States are incorporated into the Commission's governance and also encouraged to become donors themselves.

RECOMMENDATIONS: Strengthening Population Assistance Channels

The donor countries vary significantly in their approaches to programming of population assistance funds, including their preferred channels of assistance. Given the diverse needs and political contexts of recipient countries, donors should recognize the importance of effective and complementary channels for programming population assistance funds. Strengthening and enhancing the effectiveness of population assistance channels will require that:

- Donor country governments review their contributions to international organizations (UNFPA, UNAIDS, WHO, UNICEF and others) to ensure that their roles in improving sexual and reproductive health are adequately supported and encouraged. Those donor governments that provide little support for UNFPA relative to their economic capacity, in particular France, Italy and Spain, should increase their core funding, in order to reinforce the unique global leadership role of this organization. Donors should fulfill their pledges to the Global Fund to Fight AIDS, Tuberculosis and Malaria and encourage its efforts to ensure comprehensive, country-owned programs that build upon existing reproductive health programs wherever possible. Donors should also increase their core support for IPPF, another organization with a distinct role in both advocacy and program implementation in the sexual and reproductive health field. The United States should resume funding for both UNFPA and IPPF.
- Donors continue their efforts to improve the efficiency and effectiveness of international organizations. European Union Member States should continue to actively monitor and support the European Commission's efforts to expand its population assistance and improve the effectiveness of its aid in this area. At the same time, the European Commission must continue its leadership role as a voice for progressive sexual and reproductive health policies and programs, providing guidance in particular to the new EU Member States. Donors should also support UNFPA's effort to strengthen its representation in the field in order to both increase the effective use of its funds and play a more prominent role in formulating health and development policies, particularly at the country level.
- Donor governments strengthen their own technical expertise and staffing while also encouraging and adequately funding NGOs, in both developed and developing countries, to strengthen their capacity for involvement in international sexual and reproductive health programs. Donor country NGOs should contribute to capacity building among their Southern partners, including that required to advocate for adequate funding and sound policies.
- Advocacy NGOs encourage lagging donor governments to increase support to multilateral organizations and monitor all donor governments to ensure that existing support does not falter. At the same time, NGOs must be a strong and consistent voice calling on multilateral organizations to include civil society in planning and implementation of program activities, and help monitor their effectiveness in the field.

Building on Progress, Fulfilling the Promise

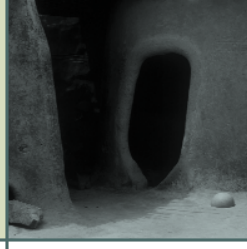
As this is written in late 2004, the international community has some cause to celebrate the progress made in meeting reproductive health needs since the Cairo conference 10 years ago. Within the donor community, the funding gap has narrowed slightly, although donor countries still fall far short of the commitments made in 1994.

Tremendous challenges remain. The distance to ICPD spending goals has narrowed only slightly—and the goalposts need readjusting to reflect the costs of meeting urgent and growing sexual and reproductive health needs, including those related to HIV/AIDS. Both the landscape and architecture of development assistance are changing. Security concerns increasingly stand out in donor governments' new development assistance policies, and new mechanisms for channeling donor assistance are gaining support—two developments that could make the prioritization of reproductive health more difficult. In contrast, reproductive health concerns should benefit from the move by most donor nations to place poverty reduction and the Millennium Development Goals at the forefront of development policy.

Part of the challenge lies in ensuring that donors and their partners in development recognize good reproductive health as essential to reducing poverty and achieving the Millennium Development Goals. Donors must also ensure that reproductive health and HIV/AIDS initiatives are mutually reinforcing: they must embrace—and use—the linkages between reproductive health and HIV/AIDS, as well as linkages between reproductive health and broader health issues.

It is essential that population assistance donors balance their own priorities with the critical reproductive health needs of developing countries. Too often, funding at the country level does not correspond to either reproductive health needs or the ability of countries to bear more of the costs. **Governments and other donors must confront—and take on—controversial issues**, such as youth services and abortion, given the large numbers of young people at risk of unwanted pregnancy and deadly disease, and the tremendous toll exacted by unsafe abortion on millions of women each year. When donors do take on such issues, they must have strong, vocal and consistent support from civil society.

The ability of civil society organizations, especially NGOs, to speak out in support of progressive policies and generous funding is more important than ever. Opposition from conservatives to funding of sexual and reproductive health programs has gained strength in recent years and is not going to evaporate—and governments, including parliamentarians, are under increasing pressure. But the question is clear: can we afford to live in a world where three million people die each year from AIDS, where half a million women die in pregnancy or childbirth, and where millions more live with debilitating health conditions directly related to the lack of reproductive health services? The answer, surely, must be "no."



Sexual and Reproductive Health in Ghana and the Role of Donor Assistance

Overview

Ghana was among the first African countries to formulate a comprehensive population and family planning policy. The country has a generally well-functioning system for delivering health services and has progressive policies on sexual and reproductive health. However, Ghana still faces significant challenges: maternal mortality remains high, as do rates of unsafe abortion; young people have little access to reproductive health care; and family planning is losing out in political commitment to HIV/AIDS interventions. In addition, a recent decision by the oldest and largest family planning organization in Ghana (the Planned Parenthood Association of Ghana) not to comply with the Mexico City Policy/Global Gag Rule[1] and thus forgo much needed U.S. family planning assistance, has created further challenges to the provision of sexual and reproductive health services in the country.

Ghana has one of the most stable political regimes and economies in Africa, but remains heavily dependent upon donor assistance for funding sexual and reproductive health services. This is true even though the Ministry of Health has been more assertive in recent years and government-donor relations are generally good. National coordination of donor assistance is problematic because of donors' diverse funding approaches—through projects, through non-governmental organizations (NGOs), through the health sector, and recent moves to direct budget support—and because of donors' differing points of contact in Ghana's government.

Key to success will be first, an increased political and financial commitment to tackling the challenges outlined above; and second, better coordination of donor and government responses. This requires both donors who support "systems" and donors who support "programs" to better coordinate and integrate their activities at mid-management and service delivery levels. This may involve negotiating ways to include sexual and reproductive health program needs, indicators and earmarked funding within the sector-wide approach. The Ghana Health Service needs to clarify its decentralized authority and support to district managers in order to help them coordinate planning and implementation.

Susannah Mayhew, Ph.D., is a lecturer at the London School of Hygiene and Tropical Medicine.

Ghana's Efforts to Address Sexual and Reproductive Health

Endorsing the 1994 International Conference on Population and Development (ICPD) Programme of Action at Cairo was pivotal in Ghana's approach to sexual and reproductive health. Ghana's family planning policy was first formulated in 1969, but made only limited progress in its first 20 years. Response to other reproductive health issues was also fragmentary, but services have

TABLE G-1
BASIC STATISTICAL AND DEMOGRAPHIC PROFILE OF GHANA

Total population, 2002	20.2 million
GNI per capita (Purchasing Power Parity, $US 2002)	$2,000
Annual health expenditure per capita ($US 2000)	$11
Annual population growth rate (%)	2.2
Population ages 0-24 (%)	62
Literacy among youth ages 15-24 (male/female) (%)	93 / 86
Primary education gross enrollment ratio (male/female)	84 / 74
Secondary education gross enrollment ratio (male/female)	40 / 32

Sources: Countdown 2015. 2004. *Countdown 2015: Sexual & Reproductive Health & Rights for All*. Washington, DC: Family Care International, International Planned Parenthood Federation and Population Action International; Greene, M, Z Rasekh and K Amen. 2002. *In This Generation: Sexual and Reproductive Health Policies for a Youthful World*. Washington, DC: Population Action International; Population Reference Bureau (PRB). 2002. *World Population Data Sheet 2002*. Washington, DC: PRB.

improved since Cairo. Wide regional differences in health status persist, but in general the key challenges are to continue expanding access to family planning and adolescent-friendly reproductive and sexual health services, and to decrease maternal mortality and unsafe abortions. Tables G-1 and G-2 provide a profile of Ghana and its sexual and reproductive health status from 1988 to date.

Policy Development and Service Delivery

Just two years after endorsing the 1994 ICPD Programme of Action, Ghana's government drafted a comprehensive Reproductive Health Policy and Standards document, finalizing it in 2003. It covers the entire spectrum of reproductive health, including maternal death audits, screening for reproductive cancers, and prevention and management of unsafe abortion, and acknowledges the need to address gender-based violence and female genital mutilation/cutting.

The document is a gold standard for what is expected at each level of the health system. Training on its use has begun, but is challenged by resource and capacity constraints together with unclear implementation procedures. Adolescent reproductive health, central to the Cairo declaration, received separate attention in a policy drafted in 1996 that outlines a broad multi-sector approach to adolescents, including links among the Ministry of Education, Youth and Sports and the Ministry of Health. This is not yet fully implemented, and its commitment is weak on addressing adolescent sexuality and the need for dedicated reproductive health services, including access to contraceptives.

In total, three different national bodies produced at least seven separate policy documents on sexual and reproductive health after 1994. While the attention is positive overall, it has confused providers on which guidelines to apply and where accountability and responsibility should lie.[2] Confusion also reigns over the roles of the Ministry of Health (which is expected to handle policy development and monitoring) and of the Ghana Health Service, created in 1996 (which is supposed to take care of implementation, day-to-day management and staffing). This policy-executive split has never been properly defined.

The difficulty with all policies is how to transform them into practice. It involves training on new guidelines and

TABLE G-2
SEXUAL AND REPRODUCTIVE HEALTH INDICATORS FOR GHANA, 1988-2002

Indicator	1988	1993	1998-2002
Average births per woman (total fertility rate)	6.4	5.5	4.5
Births to women aged 15-19 (% of all births)	n/a	22	14
Births to women aged 20-24 (% of all births)	n/a	n/a	27
Contraceptive prevalence rate among currently married women (% use of modern/any contraceptives)	5 / 13	10 / 20	22 / 13
Antenatal care (% of women receiving)	n/a	n/a	98
Skilled attendance at birth (% of births)	n/a	n/a	45
Postnatal care (% of women receiving)	n/a	n/a	54.2
Maternal mortality ratio (deaths per 100,000 live births)	n/a	n/a	540
Abortion ratio (abortions per 100 live births) in four regions	n/a	n/a	27
HIV prevalence (%):			
- national average			4.0
- in females 15-24 (3.0% end-2001)	n/a	n/a	2.4 – 4.4
- in males 15-24 (2.4% end-2001)			0.8 – 2.0
Female genital mutilation/cutting			
- national prevalence (%)	n/a	n/a	9-12 (est.)
- Upper East Region	n/a	n/a	77

Sources: Ghana Statistical Service (GSS) and Macro International, Inc (MI). 1999. *Ghana Demographic and Health Survey 1998*. Calverton, Maryland: GSS and MI; Ghana Statistical Service (GSS) and Macro International, Inc (MI). 1994. *Ghana Demographic and Health Survey 1993*. Calverton, Maryland: GSS and MI; Ghana Statistical Service (GSS) and Institute for Resource Development/Macro Systems, Inc (MI). 1989. *Ghana Demographic and Health Survey 1988*. Columbia, Maryland: GSS and MI; Ghana Ministry of Health Reproductive and Child Health Unit (RCHU). *Annual Report 2002*. Accra: RCHU; Ghana National AIDS Control Programme (NACP). *Annual Report 2002*. Accra: NACP; Ahiadeke, C. 2001. "Incidence of Induced Abortion in Southern Ghana." *International Family Planning Perspectives* (27)2:96-101 & 108; USAID-Ghana. 2001. Post-abortion Care in Ghana. Annex 7 of Global Evaluation of USAID's Post-abortion Care Program. USAID Internal Document, 11/29/2001; Countdown 2015. 2004. *Countdown 2015: Sexual & Reproductive Health & Rights for All*. Washington, DC: Family Care International, International Planned Parenthood Federation and Population Action International; Greene, M, Z Rasekh and K Amen. 2002. *In This Generation: Sexual and Reproductive Health Policies for a Youthful World*. Washington, DC: PAI; Population Reference Bureau (PRB). 2002. *World Population Data Sheet 2002*. Washington, DC: PRB. Adapted from Mayhew & Adjei 2004.

protocols and equipping facilities for the new activities. Table G-3 indicates achievement on this for key sexual and reproductive health activities. The sections below detail Ghana's progress and key remaining challenges.

Family Planning

In 1989, two decades after Ghana passed its population policy, contraceptive use stood at just 13 percent, with only 5 percent of married women using a modern method, despite an apparently comprehensive policy and a high level of contraceptive knowledge (79.4 percent of all married women knew at least one method).[3] Research identified poor political commitment and socio-cultural reasons for this failure.[4] An upsurge in donor support, notably from the U.S. Agency for International Development (USAID) and UN Population Fund (UNFPA), saw the program re-structured and revitalized, and the National Population Council (NPC) was established as a dedicated policy making body and channel for donor funds. The NPC developed the 1996 revised National Population Policy and strategic implementation framework, and by 1998 the data showed a much improved, though still modest, use of family planning (Table G-2).

A number of problems still need to be addressed if family planning use is to rise further. These include waning political commitment; socio-cultural constraints; poor access for adolescents (nearly 25 percent of the population) and unmarried women; and continuing low quality of care.[5]

Maternal Mortality and Abortion

The late 1980s saw greater government and donor commitment to improving safe motherhood services. The maternal and child health program was expanded, and in 1994 the UN Children's Fund (UNICEF) supported development of the Clinical Management Protocol on Safe Motherhood. The inclusion of maternal mortality reduction in the Millennium Development Goals has further increased the profile of this issue and attracted support from a wider group of donors. Ghana has made significant improvements in antenatal coverage and in numbers of babies delivered by skilled attendants. The worryingly high maternal mortality rates persist, however, for reasons that are poorly understood. In 2002, audits of each maternal death were instigated in an attempt to unravel the causes.

Recent research has linked unsafe abortion to the high maternal mortality rates.[6] Abortion is legal for certain clearly defined conditions (e.g. rape, mother's life at risk), when performed at registered clinics by qualified practitioners. The law tends to be interpreted, however, as prohibiting abortion, so availability is extremely limited and not fully understood in the public sector. Unsafe abortion therefore remains widespread, particularly among adolescents.[7] Providers show increasing commitment to post-abortion care, though this is limited at present. Decision makers are reluctant to address the need for accessible safe abortion, especially for adolescents, that could reduce maternal death rates and prevent the need for costly post-abortion care.

Sexually Transmitted Diseases Including HIV/AIDS

The government has had an education campaign to increase awareness of sexually transmitted diseases (STDs) and HIV/AIDS since 1986, so knowledge of HIV issues is high, but behavior changes are not yet apparent.[8] The National AIDS Policy has remained in draft since 1996; HIV surveillance sites are functioning but STD surveillance is almost nonexistent. STDs are reported neither by the Ministry's Reproductive and Child Health Unit nor by the National AIDS Control Program. Some efforts were made in the late 1990s to train family planning and antenatal staff in "syndromic management" of STDs (i.e., diagnosis and treatment based on observable symptoms, not laboratory tests), but it's not clear if this approach is working.[9]

Recent increased donor commitment to reducing HIV/AIDS reflects the issue's status as a key Millennium Development Goal. Ghana has made a high-profile commitment to provide voluntary counseling and testing and antiretroviral drugs (ARVs). In 2001, the National AIDS Commission was established, and in December 2003 Ghana's government received money from the Global Fund to Fight AIDS, Tuberculosis and Malaria to provide ARVs in the three largest cities. AIDS interventions now receive more funding than family planning ever did. This funding for HIV/AIDS treatment is important, but care must be taken to ensure integration with comprehensive HIV prevention efforts. Preventing the spread of HIV/AIDS is particularly crucial in countries like Ghana, where HIV prevalence is currently moderate.

Adolescent Reproductive Health

In general, Ghana remains a relatively conservative country where discussion of sexual issues, abortion and adolescent use of contraceptives are still widely taboo. An adolescent reproductive health policy is in place, but in practice many organizations emphasize abstinence until marriage. This is despite demand from an estimated 22 percent to 27 percent of young people who want to use family planning but do not because they cannot easily obtain contraceptive services.[10] Adolescents often do not know where to go for impartial advice and contraceptives,

TABLE G-3

SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN GHANA: AVAILABILITY OF KEY SERVICES, EXISTENCE OF GUIDELINES/PROTOCOLS AND RELATED TRAINING

Sexual and reproductive health service needs	Number of facilities offering services	Technical guidelines/ protocols exist	Staff training conducted
Primary health care:			
– Family planning	2,289 primary health	Yes	Yes
– Antenatal care	care facilities	Yes	Yes
– Postnatal care		Yes	Yes
Safe motherhood:			
– Skilled delivery	1,583 maternity units	Yes	Yes
– Emergency obstetric care	89 units with blood banks & other emergency equipment	Yes	Yes
Abortion:			
– Safe abortion	n/a	No	No
– Post-abortion care	n/a	No	Yes (42% of providers)
HIV:			
– Voluntary counseling and testing	4 facilities	Limited	50 GHS staff
– Antiretroviral drugs	3 planned for 2003	Yes (2002)	Limited
– Opportunistic infection treatments	n/a	Yes (2002)	No
– Prevention of mother-to-child transmission	2 facilities	Yes	Yes
STI screening/treatment:			
– Syphilis	n/a	Yes for non-specific	Yes for
– Gonorrhea	n/a	syndromic management;	syndromic
– Other	n/a	revised 2003	management
Adolescent reproductive health:			
– Counseling			
– Pregnancy services	4 "adolescent friendly"	In process	Yes–primarily on
– Contraceptives	facilities in Greater Accra Region		"counseling"
Reproductive cancers:			
– Breast cancer	limited to Accra,	Yes	Yes
– Cervical cancer	Kumasi and	Yes	No
– Prostate cancer	Tamale	No	No
Infertility	Private/NGO & teaching hospital only	No	No
Gender-based violence	No, but female police corps established	No	No, but awareness campaign launched
Female genital mutilation/cutting	—	Advocacy	No

Sources: Ghana Ministry of Health Reproductive and Child Health Unit (RCHU). *Annual Report 2002*. Accra: RCHU; Ghana National AIDS Control Programme (NACP). *Annual Report 2002*. Accra: NACP. Adapted from Mayhew & Adjei 2004.

and the number of teen-friendly clinics providing these services is limited, especially outside the main cities.

Challenges Posed by the Global Gag Rule

In addition to the challenges noted above, recent restrictions tied to U.S. family planning assistance have increased the difficulties Ghana faces in promoting the sexual and reproductive health of its citizens. In September 2003, the Planned Parenthood Association of Ghana (PPAG) refused to sign the Mexico City Policy/Global Gag Rule and lost $200,000 in U.S. family planning assistance. Given the country's reliance on donor assistance, this was a huge blow. The loss in funding has been acutely felt in Ghana's peri-urban and rural areas where PPAG was the primary provider of community-based clinic and outreach services, and supplied remote communities with vital family planning services and HIV/AIDS prevention education in addition to other basic reproductive health services. PPAG's rural outreach programs were funded entirely by USAID, and represented a long-term partnership with USAID since the 1970s. The loss of U.S. funds has curtailed rural outreach programs and reduced nursing staff by 40 percent, severely limiting the number of clients served. It is now doubtful whether U.S. population assistance funds can be used effectively in Ghana when the country's largest specialist reproductive health service provider is excluded.

The restrictions imposed by the gag rule also hampered PPAG's efforts to integrate HIV/AIDS activities into its programs, thereby limiting the expansion of such efforts. Worst of all, the gag rule has perpetuated an environment of fear and silence surrounding the topic of abortion in Ghana, which is making it even harder for organizations to address the need for safe abortion and post-abortion care.[11]

Donor Assistance

Ghana is heavily dependent on donor funding, with the most recent data indicating that 48 percent of Ministry of Health income is from donors. Local NGOs working in sexual and reproductive health receive virtually all their income from international donors. Tracking resource flows became much more difficult in the late 1990s with the introduction

TABLE G-4
TOP TEN DONORS IN SEXUAL AND REPRODUCTIVE HEALTH, GHANA 1993-2000

Donor	Program and geographical area	Amount pledged and time-frame ($US unless otherwise stated)
USAID (United States)	Population and AIDS (GHANAPA) National	$45 million, of which: $31 million in project assistance (including $11 million for contraceptives); $14 million in non-project assistance 1995-2000
DFID (United Kingdom)	Health and AIDS National and Volta Region	$30 million ($750,000 to NACP 1995-96) 1993-1996 (post-1996, all funds pooled in the SWAp)
CIDA (Canada)	HIV/AIDS/STDs National	Canadian $ 200,000 1996-2000
WHO	Health and AIDS National	$2.7 million 1993-1995
Danida (Denmark)	Health and AIDS National and Upper West	$22.4 million, incl. $9.7 million for primary health care in Upper West Region 1993-1998
UNDP	AIDS National	$500,000 (through WHO and National AIDS Control Programme) 1996
UNAIDS	AIDS National	$3 million plus 1997-2000
UNFPA	AIDS and Family Planning National	$8 million + contraceptives 1996-2000
UNICEF	AIDS, Population/Family Planning, Safe Motherhood National	$13 million 1996-2000
World Bank	Health, Population/Family Planning National	$27 million 1992-1995

NB: Accurate financial figures are almost impossible to obtain and great caution must be exercised when interpreting these data.
Sources: Donor and Ministry of Health financial documents, various dates.

"I think we make sustainability arguments as if Ghana were self-sufficient. We're not self-sufficient... sustainability has to be seen in the context of how well our systems can absorb the resources and use them and give the donors the confidence to sustain their donations into the country."

—Senior Ministry of Health official[12]

of the sector-wide approach and phase out of earmarked program funding. Until 1996 it was possible to disaggregate donor finances coming to the Ghana Ministry of Health that were earmarked for sexual and reproductive health, but after 2000 there are virtually no disaggregated data.

USAID and UNFPA have given strong support for family planning and related activities since the 1970s, and UNICEF has supported safe motherhood since the 1980s. During the 1990s the donor base expanded in the wake of the ICPD. Chief among new donors were the United Kingdom and Denmark (see Table G-4). Most continue to support "programs" rather than a sector-wide approach; this can create tension and impede coordination.

Program Assistance vs. Systems Assistance

Donor assistance in Ghana has changed substantially over the past decade, with the introduction of the sector-wide approach (SWAp). The SWAp was intended to improve coordination by bringing all donors together in a common framework. Donors favoring structural systems changes (notably the World Bank and United Kingdom) have now pledged to pool their funds through the Ministry of Health according to nationally defined priorities rather than donor-defined programs. (A further possibility is full budget support, in which donor monies go directly to the Treasury for disbursal to different sector ministries.) However, Ghana's key sexual and reproductive health donors, such as USAID and UNFPA, remain committed to program approaches and continue to disburse their funds through separate earmarked channels. The parallel existence of these two channels of funding (non-specific sector-wide channels and program-specific earmarked channels) creates difficulties described below.

Importance of Donors and NGOs

Ghana's dependence on external funding is illustrated by the fact that officials see donors as providing "sustainability" to health programs through their financing.

Funds also come into Ghana through NGOs. More and more local NGOs are establishing themselves, and virtually all are completely funded by international agencies. While inconsistent reporting may be a factor in year-to-year variations, the figures highlight the very large NGO contribution. Many international NGOs also have offices and projects in Ghana, sometimes partnering with local groups. Local NGOs provide key sexual and reproductive health services; the largest partner with the government and are incorporated into the Ministry of Health's own statistics. For example, the Christian Health Association of Ghana (CHAG), an umbrella group for church-managed facilities, has a formal Memorandum of Understanding with the government to provide health services where government facilities are limited. Coverage and use statistics for facilities run by both CHAG and PPAG are included in the Ministry of Health Annual Report, together with those of government clinics.

Challenges of Coordination

Relations between Ghana's government and international donors have improved greatly since the period of political dictatorship and donor intransigence of the 1980s and are now generally cordial and mutually respectful. Relations and coordination among the donors themselves, however, tend to be fragmented along the lines dividing systems and program approaches as described above.

A characteristic of donor-government relations in Ghana is the grouping of different sets of donors with particular parts of the Ministry of Health (MoH). The Reproductive and Child Health Unit (RCHU) has strong and close links with USAID, UNFPA and UNICEF, while the National AIDS Control Programme (NACP) works most closely with UNAIDS. The MoH Reform Group (at central headquarters), which supports the sector-wide approach, links primarily with DFID and the World Bank; the Reform Group also receives some support from Denmark and the Netherlands. The UN agencies have begun to coordinate around a Theme Group on reproductive

health that involves some of the reform donors. But for the most part, donors tend to work within their distinct groupings, without seeking broader collaborations.

The parallel existence of a separate group of program-specific (reproductive health) donors undermines coordinated planning through the SWAp. In the long term, sexual and reproductive health could suffer if the field is seen as the preserve of a particular group of donors rather than as a mainstream health issue. As one senior advisor said: "Coordination of programs at the national level is still not done. There is still competition between programs."

Coordination within the SWAp

Sexual and reproductive health donors are reluctant to pool their funding under the SWAp in part because the SWAp appears to eliminate specialized programs, such as sexual and reproductive health, that require technical knowledge (e.g., capacity to monitor the quality of services such as emergency obstetric care, sterilization or safe abortion). This threatens the delivery of quality services. Under sector-wide planning, supervisors who monitor quality of care must do so for a range of services and are not likely to be trained in the special needs of, say, adolescent counseling. Neither are the provision of specialized adolescent contraceptive services or the importance of quality specialized care reflected in SWAp indicators.

Nevertheless, the SWAp and decentralization policies developed over the past 10 years profoundly affect the way sexual and reproductive health services are organized, managed and financed, whether or not donors choose to get involved. In Ghana, program donors now recognize that their representatives must be involved in negotiating reform structures and indicators if they wish to avoid the potentially negative effects of structural changes. Similarly, reform donors now recognize that SWAp and other national strategies need to incorporate the needs of specialist programs like sexual and reproductive health.[13]

Avoiding Disruption in Implementation

Decentralization of the health system has led to faster, more efficient disbursements directly from central ministry coffers to district and sub-district management teams and hospitals. Districts are required to report on antenatal coverage, family planning uptake, postnatal care and maternal health and death audits, but do not disaggregate spending by these categories.[14] Under the SWAp, districts receive their funds not through program budget lines but split among salaries, capital expenditure, administration and service-related expenses. Earmarked funds from the non-SWAp donors (USAID, UNFPA and other reproductive health donors) also continue to reach districts for specified program activities such as training for family planning providers. These activities are rarely mainstreamed into the district's regular activities, causing disruption to routine service delivery.

While it can be argued that earmarked funds provide necessary security for funding sexual and reproductive health services that may not be a district priority, the parallel functioning of two different systems results in complex administration and reporting systems with substantial duplication. Coherent coordination by the Ghana Health Service (GHS) through its decentralized offices (e.g., District Chief Executives) could go a long way toward integrating donor activities into routine health service delivery. The Ghana Health Service, however, still does not have a clear role vis-à-vis the Ministry of Health, so that it is difficult to plan and implement coherent delivery and supervision of services at the district level.

Successes and Future Perspectives

Significant improvements have been made in the breadth and depth of reproductive health services, and Ghana now has a well-functioning sexual and reproductive health program with specialists at all levels. As noted above, donor support for sexual and reproductive health in Ghana has been strong, and donor-funded NGOs continue to provide a significant proportion of sexual and reproductive health services. So far, improvements in rates of antenatal care and skilled attendance at delivery, as well as modest gains in family planning use and significant declines in average family size show that the long-term commitment of Ghana's government, donors and NGOs has paid off. Nonetheless, this success must be balanced against the recent negative impact of U.S. policies on the Planned Parenthood Association of Ghana.

An issue of particular importance at the present time is how to balance investment in preventive as well as curative services in the face of increasing donor attention to HIV/AIDS. It is difficult to measure the success of prevention efforts, but it is important that expensive HIV/AIDS treatment does not drain financial resources from other health needs and compromise the wider reproductive health gains of the last decade. Such a shift in funding could ultimately impede efforts to slow the HIV/AIDS epidemic, particularly if funds are then short for reproductive health services such as condom promotion, education and counseling on youth sexuality, and prevention of gender-based violence, which all tackle the underlying causes of HIV transmission.

Donors still have difficulties coordinating their efforts, and the reform process has exposed critical ideological

and functional differences among donors favoring structural reform and those still committed to program support. Government planning and implementation within the decentralized Ghana Health Service could integrate these approaches at the district and service delivery levels, but district capacity and power remain weak and the Ghana Health Service role still lacks clarity. Unless addressed soon, these issues could undermine efforts to further improve sexual and reproductive health in Ghana.

The critical challenges facing the Ghanaian government and its donors are therefore two-fold: first, to increase political and financial commitment to tackling key remaining sexual and reproductive health concerns; and second, to better coordinate donor and government efforts.

Greater political and financial commitments could:

- Expand commitment to the provision of family planning services;
- Continue support for maternal health audits and investigation of links between maternal mortality and unsafe abortion, to identify ways to reduce maternal mortality;
- Decrease unsafe abortion by ensuring that the public, medical professionals and lawyers know when abortion is legal, and expanding access to public-sector abortions;
- Consolidate a comprehensive, coordinated response to adolescent sexual and reproductive health needs;
- Tackle HIV/AIDS as part of a holistic approach to sexual and reproductive health, rather than separately from, or in opposition to, broader sexual and reproductive health needs; and
- Continue support for research, advocacy and training in neglected areas such as gender-based violence.

RECOMMENDATIONS

Better coordination of donor and government efforts around sexual and reproductive health will require all donors and government officials to:

- Better coordinate and integrate all donor activities to avoid problems caused by separate approaches;
- Clarify delegation of authority and give particular support to district-level managers to plan and implement services in a coordinated manner;
- Negotiate ways to integrate sexual and reproductive health program needs, indicators and earmarked funding within the sector-wide approach; and
- Remove restrictions on family planning assistance that harm reproductive health service provision, impede access to safe abortion services, and prevent the coordination and/or integration of basic reproductive health services with HIV/AIDS activities.

[1] The Mexico City Policy was re-instated by President George W. Bush in January 2001. Under the policy, no U.S. family planning assistance can be provided to foreign NGOs that use funding from any other source to: perform abortions in cases other than a threat to the life of the woman, rape, or incest; provide counseling and referral for abortion; or lobby to make abortion legal or more available in their country. Noncompliance will result in loss of funding from the U.S Agency for International Development (USAID). Due to its restrictions on the freedom of speech, those who oppose the Mexico City Policy refer to it as the Global Gag Rule. *Access Denied: U.S. Restrictions on International Family Planning*, The Global Gag Rule Impact Project, 2003.

[2] Lush, L, and others. 1999. "Integrating reproductive health: Myth and Ideology." *Bulletin of World Health Organization* 77(9):771-777; Mayhew, S.H. 1999. "Health care in context, policy into practice: a policy analysis of integrating STI/HIV and MCH/FP services in Ghana." PhD thesis, University of London; Mayhew, S.H, and others. 2000. "Integrating component services for reproductive health: the problem of implementation." *Studies in Family Planning* 31(2):151-162; Mayhew, S.H. 2002. "Donor dealings: the impact of international donor aid on sexual and reproductive health. Viewpoint." *International Family Planning Perspectives* 28(4):220-224. December 2002.

[3] Ghana Statistical Service (GSS) and Institute for Resource Development/Macro Systems, Inc (MI). 1989. *Ghana Demographic and Health Survey 1988*. Columbia, Maryland: GSS and MI.

[4] Owusu J.Y. and Baste Z. 1991. "Family planning services in Ghana." *Report of the National Population Conference* 158-183; Binka F. and others. 1994. "The Navrongo community health and family planning project." Presented at the Health Research Unit Third Consultative meeting on Health Research Development, January 13-14. Adongo, P, and others. 1998. "The influence of traditional religion on fertility regulation among the Kassena-Nankana of northern Ghana." *Studies in Family Planning* 29(1):23-40.

[5] Adongo, P, and others. 1997. "Cultural factors constraining the introduction of family planning among the Kassena-Nankana of Northern Ghana." *Social Science and Medicine* 45(12):1789-1804; Adongo, P, and others. 1998. Ibid.; Parr, N. 2002. "Family planning promotion, contraceptive use and fertility decline in Ghana." *African Population Studies* 17(1):83-101.

[6] USAID-Ghana. 2001. *Post-abortion Care in Ghana*. Annex 7 of Global Evaluation of USAID's Post-abortion Care Program. USAID Internal Document, 11/29/2001; Ghana Ministry of Health Reproductive and Child Health Unit (RCHU). 2002. *RCH Annual Report*. Accra: RCHU.

[7] Ibid.

[8] Ghana Statistical Service (GSS) and Macro International, Inc (MI). 1999. *Ghana Demographic and Health Survey 1998*. Calverton, Maryland: GSS and MI.

[9] Mayhew 2000, "Integration of STI services into FP/MCH services: health service and social contexts in rural Ghana." *Reproductive Health Matters* 8(16):112-124. Mayhew et al, 2000 op cit.

[10] Ghana Statistical Service (GSS) and Macro International, Inc (MI). 1999. *Ghana Demographic and Health Survey 1998*. Calverton, Maryland: GSS and MI.

[11] Information from research carried out in the summer of 2004 by Population Action International and the Global Gag Rule Impact Project; available on www.globalgagrule.org in the fall of 2004.

[12] Cited in Mayhew 1999. Ibid p. 209.

[13] Cited in Mayhew S.H. and Adjei S. 2004. "Sexual and reproductive health: challenges for priority setting in Ghana's health reforms." *Health Policy and Planning* Vol 19(Suppl):45-60.

[14] Ghana Ministry of Health (MoH). 2002. *Common Management Arrangements for the implementation of the second health sector five year programme of work 2002-6*.

Donor Report Card

Donor Country Report Card

	20 POINTS		20 POINTS		20 POINTS	
	ODA AS PERCENT OF GNI		POPULATION ASSISTANCE AS PERCENT OF ODA		DISTANCE FROM ICPD 2005 GOAL	
	2000-2002 Average	Score	2000-2002 Average	Score	Multiplier to Reach Goal	Score
Netherlands	0.82	16	4.84	19	0.0	20
Denmark	1.02	20	3.39	14	0.0	20
Norway	0.82	16	4.23	17	0.0	20
Sweden	0.80	16	3.51	14	1.2	19
Finland	0.34	7	5.57	20	1.6	18
Luxembourg	0.75	15	5.84	20	0.0	20
United Kingdom	0.32	6	2.99	12	2.9	17
Belgium	0.39	8	2.75	11	1.7	18
Switzerland	0.33	7	2.30	9	3.9	16
Canada	0.25	5	2.37	9	2.6	17
Germany	0.27	5	2.04	8	5.7	14
New Zealand	0.24	5	2.22	9	5.1	15
Japan	0.25	5	1.36	5	6.9	13
Australia	0.26	5	1.71	7	5.5	14
France	0.34	7	0.68	3	5.2	15
United States	0.11	2	7.40	20	3.3	17
Ireland	0.34	7	2.31	9	2.6	17
Italy	0.16	3	1.44	6	15.8	4
Spain	0.26	5	0.51	2	60.3	0
Austria	0.26	5	0.23	1	40.8	0
Portugal	0.26	5	0.20	1	63.3	0

	40 POINTS							
	POLICIES					TOTAL POINTS & GRADES		
	Population/ SRH Policy	Gender Policy	Policy Restrictions	IPPF/UNFPA Contributions	"Tiedness" of Aid	**Total Score**	**Current Grade**	**Previous Grade (1998)**
	8	8	8	8	8	**96**	**A**	A-
	8	8	8	8	8	**94**	**A**	A
	8	8	8	8	8	**93**	**A**	A
	8	8	8	8	8	**89**	**A**	A-
	8	8	8	8	8	**85**	**A**	B-
	4	4	8	4	8	**83**	**A-**	NA
	8	8	8	8	8	**75**	**B**	B-
	4	8	8	8	8	**73**	**B**	D
	8	8	8	8	8	**72**	**B**	C
	8	8	8	8	5	**69**	**B**	C
	8	8	8	8	8	**68**	**B**	C
	4	8	8	8	8	**65**	**B**	D-
	8	8	8	8	8	**64**	**B**	C-
	6	8	4	8	5	**58**	**C**	C
	4	8	8	4	8	**56**	**C**	F
	4	6	0	0	3	**52**	**C**	B
	0	0	8	4	0	**45**	**C**	F
	4	4	8	4	2	**35**	**D**	F
	4	4	8	4	6	**33**	**D**	F
	0	4	8	4	6	**28**	**D**	F
	4	0	8	4	3	**25**	**D**	F

A= 81-100 **B**= 61-80 **C**= 41-60 **D**= 21-40 **F**= 0-20

Report Card Methodology

This report card assigns letter grades to countries on a scale of "A" to "F" according to their performance as donors, based on the following indicators:

- The generosity of each donor's overall development aid program in relation to the size of that country's economy;
- The proportion of development assistance funds allocated to reproductive health and population programs;
- The distance each donor has to go to reach its "fair share" of the ICPD spending goal for 2005 from 2002 spending levels; and
- The extent to which a country's policies foster the maximum level of impact in addressing the goals of the ICPD Programme of Action based on their official reproductive health and population policies, gender policies, percentage of "tied" aid, and contributions to key United Nations and non-governmental organizations.

As with PAI's 1998 analysis, this grading system emphasizes financial and policy commitments to population assistance, rather than on the quality and type of programs supported. The weighting reflects the focus of this report on financial resources and on the policy environment at the halfway point of the ICPD Programme of Action.

The grading system allocates 20 points to each of the three financial indicators, for a maximum potential score of 60, and 8 points to each of the policy indicators, for a maximum potential score of 40. Thus the total maximum potential score is 100 points. Points are allocated on a relative scale—donors are compared to each other rather than to an objective standard. To minimize bias resulting from a wide distribution of values, the scores for each of the three quantitative indicators were capped at appropriate levels. The grading system was applied to 21 member countries of the Development Assistance Committee of the OECD, excluding Greece, which lacked sufficient data, and the European Commission, to which some of the indicators used to score individual donor countries do not apply.

Indicator #1 Development Assistance as a Share of National Income

The volume of official development assistance (ODA) relative to gross national income (GNI) reflects the generosity of each donor country relative to the size of its economy. This indicator represents each nation's commitment to the developing world. It also reflects donor investments in broader economic and social development that may ultimately benefit reproductive health status through their impact on incomes, educational status, and other aspects of human well-being. Total aid volume also influences the availability of funds for population assistance.

Countries are scored on the average of their development assistance to GNI ratio for the three-year period from 2000 to 2002, and their performance relative to each other. The ratio was capped at 1 percent, with all scores above 1 percent receiving the full 20 points, and all scores below receiving points on a proportional basis. Over this period, the average effort of the 21 donor countries was 0.4 percent of GNI for ODA—slightly lower than the average from 1994 to 1996 and significantly lower than the UN goal of a 0.7 percent annual contribution for each country. Denmark was the only donor country whose development assistance exceeded 1 percent of GNI between 2000 and 2002. Only four other countries met or exceeded the UN goal of 0.7 percent: Norway, Sweden, the Netherlands, and Luxembourg. All other countries gave less than the average donor effort of 0.4 percent of GNI for ODA. The United States and Japan, the two largest donors in total aid volume, allocated only 0.11 and 0.25 percent of GNI, respectively, to development aid over the period 2000-2002.

Indicator #2 Population Assistance as a Share of Development Assistance

The share of overall development assistance allocated to population assistance reflects the level of importance the donor places on these issues within its foreign aid program. This measure gives credit to donors that have demonstrated a financial commitment to population assistance whether they do so through the bilateral, multilateral, multi-bilateral, or NGO channels. At the Amsterdam Forum in 1989, it was recommended that donors allocate 4 percent of their development aid to population assistance (as defined at the time), a percentage also based on donors achieving the international goal of 0.7 percent of GNI for development aid.

Countries are scored on the percentage of development aid they allocated to population assistance, again averaged over the three-year period of 2000 to 2002. The percentages were capped at 5 percent, with all scores above 5 percent receiving the full 20 points and those below receiving points on a proportional basis. The United States ranks highest on this measure, allocating an average of 7.4 percent of its development aid budget to population and reproductive health programs between 2000 and 2002. Luxembourg ranks next highest, giving 5.8 percent of its aid budget for population assistance between 2000 and 2002, followed by Finland, the Netherlands, and Norway—all exceeding the 4 percent goal. Although Japan is a large donor of population assistance in terms of total volume, it gave only 1.4 percent of its development budget on average to population assistance in the period studied.

Indicator #3 Multiplier Required to Reach ICPD Year 2005 Funding Goal

Resources remain central to the challenge of improving reproductive health status worldwide. Each donor's respective share of the US$6.1 billion ICPD goal for donor contributions for 2005 (adjusted for inflation to 2002 $US) was estimated based on its proportional share of aggregate GNI for the donor community. Scores were assigned to each country based on how many times its 2002 funding would need to increase to achieve its 2005 goal. Countries with multipliers of 20 or more receive zero (0) points, while scores for countries with multipliers of less than 20 were calculated by subtracting the multiplier from 20.

Denmark, Norway, the Netherlands, and Luxembourg have met their ICPD 2005 goals, and Sweden is very close. Five others, including the United States, must increase their current levels of assistance two to four times by 2005, and another five countries, including Japan, must increase current levels five to seven times. Italy's fair share for 2005 is 16 times its current level of population assistance, while Spain and Portugal are furthest from their 2005 goals, and would need to increase their assistance more than 60 times.

Indicator #4 Policy Environment

The 40 points awarded to each country based on its policy environment are broken equally into five separate categories: population and reproductive health policy or strategy; gender policy or strategy; restrictions on population assistance; contributions to the United Nations Population Fund and/or the International Planned Parenthood Federation; and "tiedness" of development aid.

- Donor nations committed to population assistance are more likely to have articulated a reproductive health and population policy. The existence of such a policy reflects the importance governments assign to these issues and time invested by aid officials in dialogue and debate on international sexual and reproductive health issues. The scoring system gives 8 points to those donor countries that have published official reproductive health and population policies or strategies. Those countries that have health, HIV/AIDS, or development policies that substantively address reproductive health issues are given 4 points, while zero (0) points are given to those that have no policies or strategies that substantively address sexual and reproductive health. Between 2 and 4 points are deducted from a country's score for the presence of published restrictions that undermine the policy's effectiveness.

- The existence of a gender policy also demonstrates support for population and reproductive health issues. The ICPD Programme of Action emphasized the importance of interventions aimed at improving the status of women, such as increasing the number of girls receiving primary education. Women who are educated and economically active in society generally have greater control over their fertility, while the enhancement of women's status in general is an essential step toward reducing poverty and promoting development. The scoring system is identical to that for reproductive health and population policies; countries with an official, published gender strategy or policy (including strong positions on gender mainstreaming) receive 8 points. Donor countries that significantly address the issue of gender in their development policies but have no formal strategy receive 4 points, and countries that place little emphasis on gender receive zero (0) points. As above, points are deducted from a country's score for the presence of published restrictions that undermine the policy's effectiveness.

- Countries that impose restrictions on their population assistance significantly reduce the effectiveness of their aid. In this category, 8 points are awarded to donor countries with no published restrictions on their population assistance. Countries that place some restrictions, such as not allowing their assistance to be used to perform abortions but without caveats on how recipient agencies use other funds, receive 4 points. Countries that impose more severe restrictions on their population assistance, for example, by requiring compliance with restrictions with respect to the use of other donors' funds, receive zero (0) points.

- Core funding from donor country governments to the United Nations Population Fund (UNFPA) and the International Planned Parenthood Federation (IPPF) is needed in order to support the unique global leadership role these organizations have in the expansion of reproductive health services in the developing world. Countries are awarded 4 points for contributions made to each of the two agencies in 2002.

- Donor countries that "tie" their population assistance with requirements on how it can be spent reduce the effectiveness of their aid. The international community has agreed on the importance of removing requirements that assistance to a recipient country be used to purchase goods and/or services from a donor country. The range of scores is based on the percent of bilateral tied aid reported to DAC in 2002, using the methodology developed by the Center for Global Development, to award each country between zero (0) and 8 points. Higher scores are awarded to the countries that have little or no tied aid.

Donor Country Profiles

Australia

GRADE

C

Australia's population assistance has yet to recover fully from cutbacks imposed after the election in 1996 of John Howard's Liberal/National Party coalition government. While incomplete reporting complicates any assessment of trends over time, the country's support for sexual and reproductive health activities appears to have stagnated in recent years, although the Australian aid agency, AusAID, anticipates a real increase in 2003. Figures reported for 2002, however, place population assistance at little more than 2 percent of overall development assistance. The country's support for UNFPA and other international organizations working in sexual and reproductive health has still not returned to the peak levels of the 1990s.

Australia's support for integrated projects and sector-wide approaches adds to the difficulty of assessing how different aspects of population programming were affected by the funding cuts noted above. Currently, the Australian government gives considerable emphasis to supporting HIV/AIDS interventions (now the largest component of Australian population assistance) in the Asia-Pacific region. Reported figures indicate a smaller share of resources flowing to reproductive health activities, including family planning. While Australia's support for HIV/AIDS is important, the government should ensure that coordination of reproductive health and HIV/AIDS services occurs wherever possible.

Australia is one of the few donor countries making little progress since PAI's last analysis in 1998, largely due to declines in overall development assistance relative to wealth and the smaller share of ODA reported as population assistance. Australia would need to increase its support for sexual and reproductive health activities, including HIV/AIDS, more than five-fold to fulfill its fair share of ICPD funding goals by 2005. In addition, Australia is one of only two donor countries that place explicit restrictions on the use of its funds. Development assistance monies cannot be used for activities that involve abortion training or services, even in countries where abortion is legal.

1 Development Assistance: Policy and Funding

Australia's official development assistance has begun to recover from the sizeable reductions experienced between 1997 and 2000. ODA rose from US$873 million in 2001 (its lowest level in more than 10 years) to $989 million in 2002. This coincided with expansion in Australia's gross national income (GNI), so the ODA/GNI ratio increased only very slightly to 0.26 percent in 2002. While it is encouraging that Australia's ODA is now rising for the first time since 1997, funding has yet to return to its peak levels of the mid-1990s and is still well below the average DAC country effort of 0.41 percent. It is also short of recommended ODA proposed by the 1996 Simmons Committee Report and the 1997 Australian government White Paper, entitled *In the National Interest*, that affirmed the importance of development cooperation in promoting international trade and economic growth, particularly in the Asia-Pacific region.

VITAL STATISTICS

2002 population size:
19.7 million

Total Official Development Assistance (ODA), 2002:
$989 million

ODA as a percentage of GNI, 2002:
0.26%

Total population assistance, 2002:
$21.3 million

Population assistance as percentage of ODA, 2002:
2.15%

Population assistance per $US million GNI, 2002:
$55

Australia has embraced the UN Millennium Development Goals (MDGs) and poverty reduction as overarching rationales for its foreign assistance efforts, which focus on five sectors: health, education, agriculture and rural development, infrastructure investment, and governance (emphasizing peace and conflict resolution). However, the government emphasizes the importance of high-level consultations with host country governments and institutions to identify local needs and priorities. Australia maintains that reproductive health (including family planning) requires attention in order to meet MDG poverty reduction goals. Such issues as gender equality and environmental quality are now "mainstreamed" within Australian development cooperation.

The Australian government makes an effort to highlight the benefits of its aid program for Australians, for example, in terms of employment. And, as is increasingly the case with other donor countries, security concerns are part of the policy framework for development cooperation, with a focus on such regional issues as refugees and migration.

Australia's ODA is administered by the Australian Agency for International Development (AusAID). AusAID's role is to provide policy advice and support to the Minister and Parliamentary Secretary on development issues, and manage Australian development cooperation programs. The Director General of AusAID reports directly to the Minister for Foreign Affairs on all aspects of aid policy and operations. Included within the governing structure of AusAID is the Aid Advisory Council (AAC), an expert advisory body that provides the Minister for Foreign Affairs with independent expert views on the planning and delivery of Australia's aid program. The AAC is made up of 11 Australians from academia, the private sector, NGOs and community groups. In existence since 1998, the AAC is intended to open up Australia's aid program to new ideas and approaches to development that reflect the wider values of the Australian community.

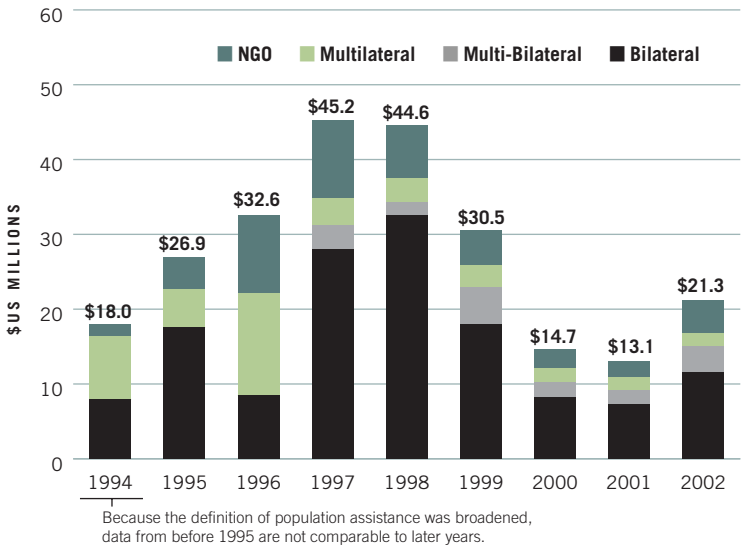
2 The Policy Environment for International Population Assistance

A 1998 national survey found that 84 percent of Australians supported development assistance as a means of addressing humanitarian needs, promoting economic growth, and projecting a positive image of Australia abroad. However, the same survey indicated that many Australians know little about their government's development cooperation efforts, causing some to observe that Australian support is "a mile wide and an inch deep." It is interesting to note, however, the steady upward trend (close to 10 percent annually) in private contributions by Australians to NGOs working in international development between 1998 and 2003.

Australia's domestic family planning and reproductive health programs have encountered determined conservative opposition over the years. This controversy has compromised the ability to fund reproductive health activities abroad, in particular those related to abortion. Generally, however, the Australian public supports reproductive health efforts, particularly promotion of maternal and child health and work against the HIV/AIDS epidemic in Asia and sub-Saharan Africa.

The Australian Reproductive Health Alliance (ARHA), established in 1995, remains a leading NGO engaged in advocacy around international reproductive health and rights. ARHA seeks to promote the goals of the ICPD and as part of its activities provides secretariat support for the All-Party Parliamentary Group on Population and Development. The Alliance is vocal in its support for a

TRENDS IN POPULATION ASSISTANCE 1994-2002: AUSTRALIA



NB: 1999 figures do not include expenditures for the population component in integrated development projects. 2001 program figures are estimated at the 2000 level.
Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002.* New York: UNFPA.

rights-based approach to population-related issues and has, for example, expressed concern for the government's approach to immigration and asylum issues. The IPPF member association, Sexual Health and Family Planning Australia (SH&FPA), is also active in the advocacy arena. Both are part of the Asia Pacific Alliance, a network of NGOs, donor agencies and foundations dedicated to increasing support for the ICPD Programme of Action and the Millennium Development Goals.

While more conservative than the Labor government that preceded it, the coalition government in power since 1996 remains committed to the goals of the ICPD Programme of Action and has been an active member of the Asia Pacific Alliance. While the Programme of Action serves as an important reference point for AusAID in setting policy standards, it does not necessarily determine the design of specific country programs or project activities. These are carried out in consultation with Australia's partner countries and largely reflect indigenous needs and program priorities.

In 2001, AusAID released a list of Guiding Principles for its international assistance in reproductive health, a list largely consistent with ICPD principles. These guidelines stipulate that individuals should be free to choose the number and timing of their children; that women and men should have access to the widest possible range of family planning services; that reproductive health services should be available to all sexually active individuals; and that Australia's assistance should be directed to improving the quality of reproductive health care. The list also includes a prohibition on the use of Australian development assistance for services related to abortion, including training of medical personnel. This prohibition also applies to any activities, including research, that involve abortion drugs. It does not prevent recipients of Australian aid funds from using other monies for this purpose, however, nor does it apply to the use of Australian funds for post-abortion care. The Australian government also specifies the types of contraceptives that can be purchased with Australian aid funds; emergency contraception is among those specified as eligible for purchase.

3 Trends in Funding for Population Assistance

Overall Funding Levels

Australia's population assistance stood at US$21.3 million in 2002. This represented just 2.2 percent of ODA and placed Australia well below the average DAC country effort of 4 percent of ODA for population assistance. Relative to national income (GNI), Australian population assistance places the country 15th among 22 major donor countries, at just $55 per million dollars of GNI, down from more than $80 in 1996.

Incomplete reporting and exchange rate fluctuations complicate any assessment of Australia's performance over time, but data from other sources indicate that the bulk of any increases in population assistance in recent years has gone to HIV/AIDS activities, while funding for other aspects of sexual and reproductive health has risen little or not at all. In 2002, 92 percent of Australia's reported population assistance could be disaggregated by type of activity. Of this amount, 5 percent was provided for family planning, 20 percent for other reproductive health activities, 69 percent for HIV/AIDS, and 6 percent for research. It is important to note, however, that multisectoral projects often contain embedded reproductive health components not included in the accounting of population assistance commitments or expenditures.

Multilateral Funding

Australian support for reproductive health and population activities through multilateral organizations has fallen substantially since the mid-1990s. In 1996, 42 percent went through multilateral channels, but by 2002 only 8 percent did, according to UNFPA. An additional 16 percent was provided for multi-bilateral activities, in which bilateral resources are committed for specific projects as part of multilateral consortium programs.

Australia's contributions to UNFPA have risen slightly in recent years. Australia's UNFPA donation rose from $1.1 million in 2002 to an estimated $1.5 million in 2003. However, these funding levels are still well below Australia's annual contributions of around $4 million in the mid-1990s. Prior to 2004, Australia did not contribute to the Global Fund to Fight AIDS, Tuberculosis and Malaria, deciding to take a "wait and see" approach to Fund activities in the Asia-Pacific region before committing resources. More recently, Australia pledged $18.9 million to the Global Fund for the period 2004-2006. Since UNAIDS' inception in 1995, Australia has been its 14th largest donor. It contributed $1.2 million in 2003, the country's most generous level of support since 1997.

Bilateral Funding

Slightly more than half of Australia's population assistance has been provided through bilateral programs in recent years; it was 54 percent in 2002. AusAID has direct responsibility for managing these funds. Country programs are developed in close consultation with recipient nations and respond to mutually identified needs.

Funding for NGOs

Australian support for NGOs in sexual and reproductive health remains modest and below the average for all DAC countries. In 2002, 21 percent of Australia's population assistance was allocated to NGOs. NGOs funded by AusAID were more active in HIV/AIDS work than in family planning or reproductive health, although NGO involvement in sexual and reproductive health may be greater than suggested by budget information. Australia's contributions to IPPF fell substantially between 1997 and 2001, but rose to $850,000 in 2002, with further increases expected in both 2003 and 2004.

4 Program Priorities

Geographic Priorities

Australia's foreign assistance continues to be concentrated in the Asia-Pacific region, with some going to East Africa. In 2002, Indonesia, Papua New Guinea and China were the largest recipients of Australian population assistance. Post-conflict reconstruction needs have had a major bearing on the geographic allocation of Australia's ODA in recent years. For example, both East Timor and the Solomon Islands have received considerable Australian assistance over the past five years to rebuild their health delivery infrastructures.

Areas of Program Emphasis

Australia's foreign assistance gives priority to addressing child and maternal mortality and morbidity; funding voluntary, non-coercive family planning and reproductive health programs; and providing support for HIV/AIDS prevention and treatment services. Australia has become much more active in HIV/AIDS work since 2001. It convened a meeting of 31 leaders from the Asia-Pacific region in Melbourne in 2001 to identify regional needs and priorities, and that led to formation of the Asia-Pacific Leadership Forum on HIV/AIDS in August 2002. Later that year, Australia announced a major six-year program to support regional HIV/AIDS activities.

Australia is now mainstreaming gender issues in its foreign assistance programs. Development projects increasingly incorporate gender-sensitive initiatives that take women's welfare into account. Greater attention is being given to improving educational opportunities for girls, reducing violence against women, enhancing women's economic empowerment, and securing the human and reproductive rights of women. A key element of AusAID's gender strategy is promoting women's equal participation in decision-making. To help achieve this objective, AusAID is providing funding for women's information and research centers in several countries working to strengthen women's participation in community and national fora.

While Australian foreign assistance gives considerable emphasis to improving health sector managerial efficiency and upgrading health systems, Papua New Guinea is the only country where Australia supports a sector-wide approach (SWAp). It has funded health projects for women and children and initiatives to reduce domestic violence. AusAID works to build capacity in reproductive health by funding medical schools in the Asia-Pacific region and providing long-term professional training opportunities at Australian universities and short-term in-service training programs.

5 Technical Capacity

Staffing

AusAID has undergone substantial restructuring in an effort to improve the quality of its personnel and reduce the high level of staff turnover in recent years. Administrative systems are being revamped to give greater attention to program evaluation and reporting of project results. AusAID has developed a new Multilateral Assessment Framework (MAF) for annual assessments and periodic in-depth reviews of multilateral programs funded with Australian resources. This system will apply to UN-funded activities but, at least initially, not to projects of multilateral development banks (e.g., the World Bank and the Asian Development Bank).

Technical Expertise of Collaborating Institutions

AusAID relies on an experienced network of Australian-based commercial and non-profit firms, NGOs and universities to assist in design and implementation of sexual and reproductive health activities, in particular with respect to HIV/AIDS. For example, Sexual Health and Family Planning Australia provides technical support for a number of reproductive health programs overseas, and the Burnet Institute undertakes international projects on HIV/AIDS. Program development and project delivery work is largely outsourced by AusAID, while quality assurance and evaluation are usually coordinated by technical advisory groups established for specific projects or technical sectors. AusAID's project activities are increasingly reliant on local-hire professional staff. Efforts are being made to increase local participation and move more management and contracting functions to the field.

Austria

GRADE

D

In the ten years since the launch of the ICPD Programme of Action in 1994, Austria has not provided significant resources for international population programs. As of 2002, it provided less than one-half of 1 percent of its ODA for population assistance, a fraction of the average donor country effort of 4 percent.

While Austria supports the ICPD Programme of Action, it has still not developed a formal policy on population assistance. Efforts to promote ICPD objectives are largely focused on education and gender equality rather than on sexual and reproductive health, including HIV/AIDS. Furthermore, Austria does not currently have a formal bilateral international health program, preferring to address this area through its modest contributions to multilateral organizations.

Austria has recently taken steps to reformulate its foreign assistance programs and plans to increase its foreign assistance to 0.33 percent of GNI by 2006. This substantial increase may allow more resources for sexual and reproductive health activities. Early signs of this came in late 2003, when the government announced a significant increase in its core funding for UNFPA, as well as support for specific projects in Nepal, Afghanistan and the Occupied Palestinian Territories.

1 Development Assistance: Policy and Funding

Austria's foreign assistance program is small compared to other European donors. It provided US$520 million in official ODA in 2002, a modest decline from $533 million in 2001, and its 2002 ODA/GNI ratio of 0.26 percent is well below the average DAC country effort of 0.41 percent. The federal government has announced that it plans to increase development assistance to 0.33 percent of GNI by 2006.

Close to one-third of Austria's ODA is channeled through the European Union, development banks and UN agencies. This has curtailed the country's bilateral aid commitments and reduced the need for administrative staff in Vienna, although this may change in light of proposed increases in development aid.

Austria's plan to increase its development assistance is among the outcomes of the new Development Cooperation Act of 2002, an effort to enhance the coherence and impact of the country's aid program. The act also provided the legal basis for the establishment of the new Austrian Development Agency (ADA) in January of 2004 as a government-owned corporation and successor to the Department for Development Cooperation. The ADA will manage the country's bilateral aid programs and cooperation with NGOs, while the overall direction of Austrian development policy will remain the responsibility of the Ministry of Foreign Affairs. Funding for the International Monetary Fund and World Bank is channeled through the Ministry of Finance. Consultative mechanisms coordinate program strategies between these two ministries.

The Development Cooperation Act identifies three primary objectives for Austrian development assistance: poverty reduction, securing peace and security, and improving environmental quality. The main sectors addressed include rural development; governance and human rights; water and sanitation; education; energy;

and investment in small and medium enterprises. These sectors are included in the government's new three-year aid program (2004-2006), which cites them as areas of comparative advantage. Health is not identified as a sector for bilateral support in the current program of work, the government having ended almost all its bilateral international health programming in the early 1990s.

Austria has never had an active population assistance program and the country still has no formal policy on reproductive health and population. Despite its support at the policy level for the ICPD Programme of Action, Austria has shown little interest in supporting most ICPD priorities programmatically, the major exception being education. As noted above, however, the government has recently increased its support for UNFPA and the country's new three-year program enshrines gender equality as a principle of Austrian development policy.

2 The Policy Environment for International Population Assistance

Austria's international development assistance efforts are neither widely publicized nor well known by the general public. There is little public discussion of reproductive health topics, although the global HIV/AIDS epidemic has become a major issue of concern. The Austrian Foundation for World Population and International Cooperation (SWI) was founded in 1999 to help create greater awareness of reproductive health issues and mobilize support for the Cairo Programme of Action. Its efforts and those of the IPPF member association, Österreichische Gesellschaft für Familienplanung (ÖGF), have had some impact—in particular their advocacy efforts vis-à-vis the parliament which helped to secure the increase in support for UNFPA.

3 Trends in Funding for Population Assistance

Overall Funding Levels

Austria has never been a large contributor to international reproductive health and population programs. In 2002, the country provided just $1.5 million for population assistance. This figure is a recovery from support in 2000 and 2001, but is still less than record funding of $1.8 million in 1998. In 2002, Austria only committed 0.29 percent of its total ODA budget for population activities, and spent just $7 per million dollar of GNI on population assistance, one of the lowest funding levels of any European donor.

One-third of Austria's assistance flowed through multilateral organizations in 2002 and thus is not reported by type of activity. The bulk of the remaining two-thirds (more than 90 percent) was classified as supporting reproductive health activities other than family planning and the rest was for HIV/AIDS.

Austria has made only marginal progress since PAI's 1998 analysis and would need to increase its annual population assistance more than 40 times, to $61.2 million, to meet its fair share of ICPD donor commitments by 2005.

Multilateral Funding

In 2002, Austria allocated 34 percent of its population assistance through multilateral organizations, the bulk of which appears to have gone to UNFPA. An additional 10 percent was assigned to multi-bilateral project support. This is a substantial decline compared to the late 1990s, although it is unclear whether these figures reflect all multilateral giving to sexual and reproductive health.

Austria has not been a significant contributor to UNFPA, the major channel for multilateral population assistance,

VITAL STATISTICS

2002 population size:
8.1 million

Total Official Development Assistance (ODA), 2002:
$520 million

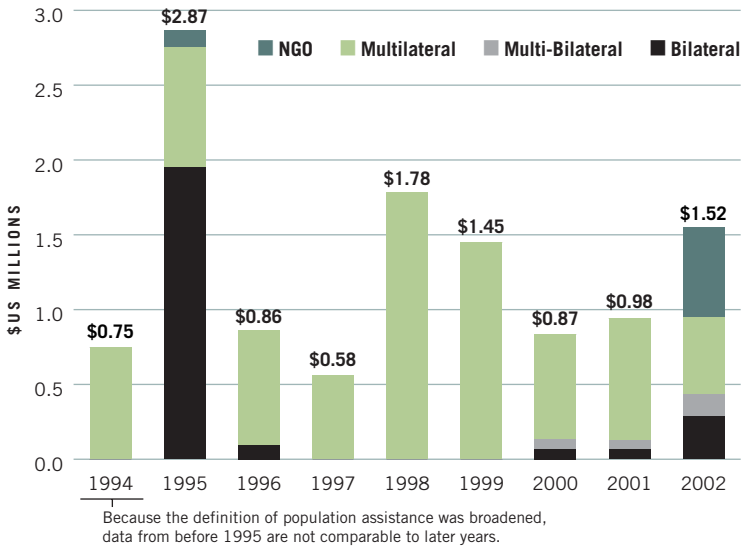
ODA as a percentage of GNI, 2002:
0.26%

Total population assistance, 2002:
$1.5 million

Population assistance as percentage of ODA, 2002:
0.29%

Population assistance per $US million GNI, 2002:
$7

TRENDS IN POPULATION ASSISTANCE 1994-2002: AUSTRIA



NB: In 1999, Austria reported only contributions to multilateral sources. 2001 project and program figures are estimated at the 2000 level.

Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002.* New York: UNFPA.

Austria

D

providing just $515,000 in 2002. However, its contribution is expected to increase in 2004, while additional earmarked funds of $741,000 will support specific UNFPA projects, as noted above. Austria has noted that its increased support is in part a response to the U.S. withdrawal of funds for UNFPA in 2002. While an encouraging development, these increased contributions are still well below those of most major European donors.

Austria's support for other international organizations involved in sexual and reproductive health is also limited. It has given only $131,000 to UNAIDS since the Joint Programme's inception in 1995 and has pledged just $1.1 million since 2002 for the Global Fund to Fight AIDS, Tuberculosis and Malaria. By contrast, Sweden, with an economy roughly the same size as Austria's, has provided $72.8 million to the Global Fund over the same period.

Bilateral Funding

In 2002, 19 percent or $285,000 of Austria's population assistance moved through its bilateral development program. This is a substantial gain compared to previous years, in terms of both relative share and absolute dollar terms: in 2001, only 7 percent of population funding was allocated bilaterally, and in 1999 no bilateral funding was reported. However, given the government's movement away from bilateral health programming, it is unclear whether this support went only to support sexual and reproductive health programming or whether it also included gender-related activities.

Funding for NGOs

Until recently, Austria has not provided significant support to NGOs working in reproductive health and population. However, 2002 may mark an important shift in direction: 38 percent or more than half a million dollars of population funds were reportedly channeled through NGOs, compared to just 4 percent in 2000 and 2001. If accurate, this would be the highest level of support for NGO involvement to date.

The main NGO providing domestic reproductive health services, Österreichische Gesellschaft für Familienplanung (ÖGF), collaborates with the ADA to a limited extent. It advocates for greater government funding for domestic and international reproductive health programs, but does not provide reproductive health services abroad. The Austrian Foundation for World Population (SWI), on the other hand, does carry out some projects abroad, and in 2003 received modest support from ADA for HIV/AIDS prevention and reproductive health activities in Western Kenya. SWI's other field projects in Burkina Faso and Central and Eastern Europe, however, are supported through small private donations. Austria made no contributions to IPPF in either 2001 or 2002, and in general has not been a significant contributor to IPPF in previous years.

4 Program Priorities

Geographic Priorities

Serbia and Montenegro, Cameroon and Bolivia were the three largest recipients of Austrian foreign assistance in 2001 and 2002. However, Austria provides countries such as China and Indonesia with large export concessions that actually exceed its outlays to the largest aid recipients. With respect to population assistance, the Palestinian Territories, Nicaragua, Ethiopia and Afghanistan were among the top recipients of funding in 2002.

Areas of Program Emphasis

Austria supported the 1994 ICPD Programme of Action and recommendations flowing from subsequent UN conferences on women and sustainable development. However, it does not have a formal policy on supporting international reproductive health and population activities. As the ADA no longer maintains a bilateral program in international health, it seems unlikely that Austria will soon become more active in allocating bilateral aid for bilateral sexual and reproductive health programs. This increases the importance of its support for multilateral organizations, such as UNFPA, through which it can continue to make a contribution to the field.

5 Technical Capacity

The ADA does not maintain a professional staff of reproductive health experts. With Austria's withdrawal from bilateral support for international health, it is also unlikely that the ADA possesses much internal capacity in this area. Any Austrian effort to become more active in support of international reproductive health would require upgrading the professional capacity of existing staff.

Given Austria's limited funding for NGOs working in sexual and reproductive health, it is not clear that much technical expertise exists in those organizations. OGF clearly has considerable experience in domestic reproductive health services, but very limited experience in resource-poor developing countries. SWI has advocacy and information skills in reproductive health and population issues, but also has little experience with projects outside Austria. While SWI is collaborating with NGOs in Burkina Faso and Kenya, its ability to become more engaged abroad will depend upon additional resources to strengthen the technical capacity of its staff.

Belgium

GRADE

B

1 Development Assistance: Policy and Funding

Belgium has gradually increased its foreign aid budget over the past decade. In 2002, its ODA reached US$1.1 billion, a 14.8 percent increase in real terms compared to the previous year. While Belgium has not yet attained the goal of providing 0.7 percent of its gross national income (GNI) for development aid, its 2002 ODA/GNI ratio of 0.43 percent was slightly above the average DAC country effort of 0.41 percent. The government has announced it intends to increase its development assistance to 0.7 percent of GNI by 2010.

Belgium's ODA is distinguished by the high percentage of its assistance that goes to the least developed countries. In an effort to make this assistance more focused and effective, the government has recently implemented a number of reforms, such as reducing the number of bilateral partner organizations it supports, and cutting down from 25 to 18 the number of countries receiving bilateral funding. In a similar vein, the government would also like to scale down its funding to multilateral organizations from 22 organizations to just 12, with UNAIDS, the UN Children's Fund (UNICEF), the UN Development Programme (UNDP), and the International Committee of the Red Cross (ICRC) set to be the top four.

Belgium's bilateral development programs are coordinated by the Ministry of Foreign Affairs (MFA) and administered by the Directorate General for Development Cooperation (DGDC). DGDC is responsible for coordinating all elements of Belgium's development assistance, including most policy development and planning functions, while program implementation is the responsibility of a public corporation founded in 1998, the Belgian Technical Cooperation (BTC).

Belgium has adopted poverty alleviation and attainment of the Millennium Development Goals (MDGs) as goals of its foreign assistance. Consequently, the country's

Belgium has dramatically increased its financial support for international sexual and reproductive health programs. Between 1999 and 2002, Belgium's funding rose by over 400 percent, one of the largest percentage gains recorded by any donor country. This substantial gain reflects new policy directions that give greater prominence to reproductive health issues (particularly HIV/AIDS and reproductive rights). Also notable is Belgium's greater engagement with civil society organizations and universities in programming its population resources.

As is the case with several other donors, much of Belgium's new population funding appears to be for HIV/AIDS activities. In 2002, nearly two-thirds of the country's assistance flowing through bilateral, NGO, and multi-bilateral channels supported HIV/AIDS programming, and less than a quarter was provided for reproductive health, including family planning (although these services may be integrated into some HIV/AIDS activities). This increased support for the fight against HIV/AIDS is a welcome development, while highlighting the need to ensure that integration and coordination of reproductive health and HIV/AIDS services occurs wherever possible.

VITAL STATISTICS

2002 population size:
10.3 million

Total Official Development Assistance (ODA), 2002:
$1,072 million

ODA as a percentage of GNI, 2002:
0.43%

Total population assistance, 2002:
$44.1 million

Population assistance as percentage of ODA, 2002:
4.12%

Population assistance per $US million GNI, 2002:
$178

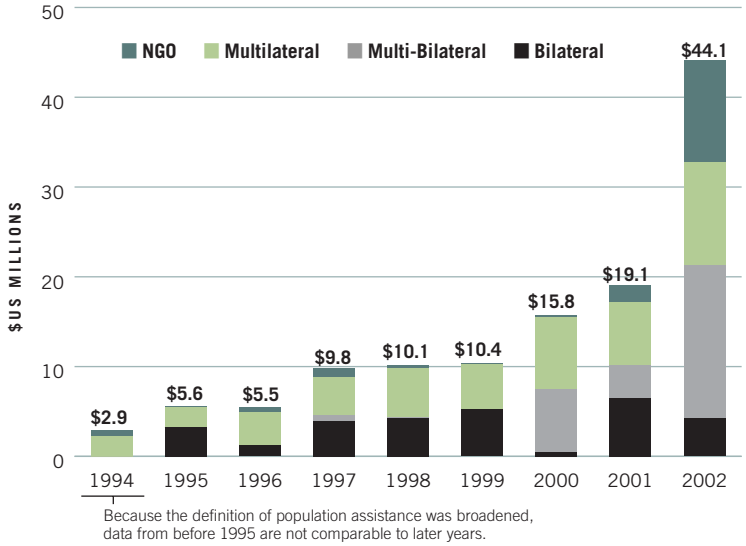
ODA now focuses on health, education, agriculture and food, infrastructure development, conflict prevention and civil society. Three crosscutting themes inform these activities: equality of rights and opportunities for women, environmental quality, and social development. Support for prevention and treatment of HIV/AIDS and other infectious diseases has also become a priority, and a formal international HIV/AIDS strategy is being finalized.

2 The Policy Environment for International Population Assistance

A recent survey reported that Belgians favor increasing their country's development assistance. Funding for sexual and reproductive health (especially funding to combat HIV/AIDS) is widely supported by the general public.

While poverty alleviation and sustainable development are the core objectives of Belgian foreign assistance, the country is raising the priority of reproductive health and HIV/AIDS. A new strategy paper on HIV/AIDS was being developed in 2003, and Belgian NGOs working in health are now encouraged to incorporate HIV/AIDS plans into their proposals for new funding. The increased priority given to health has also been referred to by the Minister for Development Cooperation, who has acknowledged that attention must be given to basic health services in order to achieve reductions in poverty. This emphasis on health, including HIV/AIDS, represents an opportunity for advocacy groups to further encourage the linking of reproductive health with Belgium's HIV/AIDS efforts.

TRENDS IN POPULATION ASSISTANCE 1994-2002: BELGIUM



Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002*. New York: UNFPA.

3 Trends in Funding for Population Assistance

Overall Funding Levels

Belgium has greatly increased its population assistance over the past decade, from US$2.9 million in 1994 to $44.1 million in 2002. The rate of increase has accelerated in recent years, and funding jumped from $19.1 million in 2001 to $44.1 million in 2002. This brings the share of Belgian ODA allocated to population activities to 4.1 percent in 2002, slightly above the 2002 average DAC country effort of 4 percent. Population assistance in 2002 was $178 per million dollars of GNI, the seventh most generous level of support, relative to wealth, among all DAC countries.

In 2002, 74 percent of Belgium's population assistance could be allocated by type of activity. Of this amount, 62 percent went to HIV/AIDS programs, 22 percent was allocated for other reproductive health activities, and 16 percent supported research. Although the government did not report that funding was directly allocated to family planning, it is likely that family planning is integrated into other reproductive health activities supported by Belgium.

Multilateral Funding

Belgium disbursed 65 percent of its population assistance budget through multilateral or multi-bilateral channels in 2002, including UNFPA. Belgium's support for UNFPA reached a low point in the late 1990s at less than $2 million annually, but has since recovered, reaching $4 million in each of 2000 and 2001 and $6.2 million in 2002. These contributions have been further supplemented by funds earmarked for specific projects, as is the case with respect to other multilateral organizations. Belgium has also been a generous supporter of UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria. For the period 2001-2004, Belgium has paid in full its pledges of $29.6 million to the Global Fund and has pledged an additional $18.8 million for the period 2004-2007. Belgium has been the ninth largest contributor to UNAIDS, providing $19.5 million between 1995 and 2003.

Bilateral Funding
The share and volume of Belgium's population assistance flowing through bilateral channels has fluctuated considerably from year to year, most likely due to variable reporting and funding cycles. In general, however, Belgium appears committed to increasing its bilateral programming, given the changes in structure and staffing since the late 1990s.

Funding for NGOs
In 2002, Belgium allocated 26 percent or more than $11 million of its population assistance to NGOs, the highest share since 1994 and by far the highest level of funding for NGOs ever. Prior to 2002, no clear trend had emerged since the ICPD, as NGO funding was never more than 10 percent of the annual total between 1995 and 2001. The size of the increase is further evidence of Belgium's growing engagement with civil society, a positive development given that technical expertise within the country's aid establishment is rather limited. It also reflects the fact that NGOs and university groups are more actively engaged in Belgium's foreign assistance efforts than is common elsewhere. Belgium has generally made modest contributions to IPPF, which received roughly $100,000 in each of 2002 and 2003. At this writing, however, no contribution had been made in 2004.

A further source of funds for both NGOs and multilateral organizations is the Belgian Survival Fund, a parliamentary initiative launched in the early 1980s to combat malnutrition among disadvantaged populations. The Fund's mandate, as defined by law, is to "ensure the survival of people threatened by starvation, malnutrition and underdevelopment in Third World areas having the greatest mortality rates from these causes." Its strategy is based on a multidimensional approach to fight the causes of poverty and food insecurity, with a special focus on gender and improving the status of women.

While Belgium acknowledges the importance of involving civil society in its programming, NGOs are required to provide a share of the financing, as is also the case in a number of other European countries. Not surprisingly, given the government's push for greater collaboration among NGOs, consortium efforts are eligible to receive 85 percent of total funding requirements, while groups working alone receive only 75 percent.

4 Program Priorities

Geographic Priorities
While its former colonies remain among the top recipients of Belgium's development assistance, the country provided aid to some three dozen countries in 2002,

The government has announced it intends to increase its development assistance to 0.7 percent of GNI by 2010.

including the partner countries referenced above. Sub-Saharan Africa received the largest share of Belgian assistance, followed by Asia and Latin America. In 2002, the Republic of Congo, South Africa, Rwanda and Kenya were among the leading recipients of Belgian support for sexual and reproductive health activities.

Areas of Program Emphasis
Since 1997, Belgium has given greater priority to sexual and reproductive health within its health programming. HIV/AIDS prevention and programs to combat other infectious diseases, especially in sub-Saharan Africa, are receiving much greater support. Belgium's bilateral assistance is currently supporting 52 health projects in the developing world, and about one in six has HIV/AIDS prevention and treatment as the primary objective. Many other projects focus on ways to strengthen HIV/AIDS capacities within existing primary health care facilities, and address the needs of vulnerable groups such as women and adolescents. Activities that afford protection to children are also being strengthened.

While resources for family planning appear to have declined in favor of these other reproductive health initiatives, Belgium can enhance its contribution to achieving ICPD goals by linking its HIV/AIDS efforts to reproductive health activities. Integrating these efforts will enable the country to maintain its support for HIV/AIDS, and will also complement its efforts to focus on vulnerable groups such as women and adolescents, as they often make up the bulk of the population seeking reproductive health services.

Belgium is increasingly integrating gender perspectives in its health programming and giving greater attention to development sectors such as education and employment that directly enhance the social welfare of women. Although this integration of gender perspectives is noteworthy, the country's population assistance is not yet

If funding for sexual and reproductive health activities continues to increase, further technical capacity may be required within the country's aid establishment.

shaped by an integrated strategy that articulates programmatic needs in sexuality, reproductive health, and human rights. The absence of such a strategy offers yet another opportunity for advocates seeking to enhance Belgium's contributions to achieving ICPD goals.

5 Technical Capacity

Staffing

Belgium's foreign aid program does not maintain a large permanent staff with professional qualifications in the population and reproductive health sciences. While resident expertise in reproductive health may not be plentiful within the DGDC and BTC, Belgium's foreign assistance work is often able to draw upon relevant skills from other government departments and universities. This ability to draw on external sources for expertise has worked well up to now, but if funding for sexual and reproductive health activities continues to increase, further technical capacity may be required within the country's aid establishment.

Technical Expertise of Collaborating Institutions

Up until recently, Belgium had not relied extensively on NGOs for implementing population programs and consequently did little to promote technical expertise in the NGO community. The NGOs that Belgium does support tend to work in primary health care and HIV/AIDS rather than reproductive health, *per se*. These NGOs also tend to be affiliated with religious institutions that have long histories of supporting primary health care and targeted infectious disease programs. As such, they may neither view reproductive health needs as a priority, nor have the experience to address them.

Belgium supports several domestic NGOs engaged in the fight against HIV/AIDS. Their efforts include treatment and palliative care for AIDS patients and interventions to reduce mother-to-child transmission of HIV. They also stress non-medical initiatives to help individuals (especially adolescents) and communities cope with the epidemic. The Flemish Association for Development Cooperation and Technical Assistance and the Walloon Association for the Promotion of Education and Foreign Training provide some technical assistance, training, and project evaluation services in HIV/AIDS overseas. These organizations are also active in advocacy, as is Sensoa, a Flemish NGO that provides services and expertise in sexual and reproductive health, including HIV/AIDS. Sensoa works through its international division to advocate for increased attention to these issues in Belgian development cooperation, working with parliamentarians and other civil society groups.

Several Flemish universities are also conducting research on HIV/AIDS treatments in South Africa, Mozambique, and Guinea, as well as on mother-to-child transmission in Kenya. Francophone universities in Belgium are doing research on traditional medicine and indigenous pharmacology that may aid in the fight against HIV/AIDS. The Institute of Tropical Medicine also has a broad array of HIV/AIDS research and training activities, including the AIDS Impulse Programme, financed by DGDC, that supports epidemiological and behavioral field work on preventing and treating HIV/AIDS, as well as clinical research on microbicides.

Canada

GRADE

B

1 Development Assistance: Policy and Funding

In 2002, Canadian ODA reached US$2.0 billion, up from just $1.5 billion in 2001 and the highest level of ODA in real terms since 1994. Canada's ODA/GNI ratio also improved from 0.22 percent in 2001 to 0.28 percent in 2002. In line with this progress, the government has announced that it will double its international assistance by 2010, at an 8 percent annual rate of increase. In both 2003 and 2004, these 8 percent gains were likely achieved, and the government anticipates that ODA will reach $2.5 billion (CDN 3.3 billion) in 2005-06.

Nonetheless, Canada's development assistance in relation to GNI is still below the record levels achieved in the mid-1970s (e.g., 0.53 percent in 1975), and its end-of-decade goal is just half the 0.7 percent ODA/GNI target recommended by both the international community and former Canadian Prime Minister Lester B. Pearson. In order to achieve this suggested target of 0.7 percent by 2010, Canada would need to increase ODA by about 13 percent annually, rather than 8 percent.

In addition to increasing its ODA, Canada has made other efforts to re-energize its international development activities. These efforts include trade liberalization (including the elimination of most tariffs on imported goods from the developing world), debt forgiveness, and the untying of foreign aid. Support for the social sector (incorporating support for child protection, HIV/AIDS, education, and health) is also projected to double between 2000 and 2005. These pledges indicate that Canada's current government is serious about increasing development assistance.

Canadian foreign assistance is concentrated in six program areas: basic human needs (including primary health care, education, reproductive health, HIV/AIDS, nutrition, water and sanitation); gender equality; infrastructure services; human rights, democracy and governance; private sector development; and the environment.

Canadian financial support for international sexual and reproductive health programs increased substantially in 2002. This upturn follows a decade of modest support and coincides with the government's promise to increase ODA by 8 percent annually through 2010. If this commitment is fully realized, Canada seems ready to assume a more prominent role in the international sexual and reproductive health arena.

As with many other donors, the increase in population assistance went primarily to HIV/AIDS programs. Although Canada's increased HIV/AIDS activities are valued, the country will need to ensure that every opportunity is taken to integrate its HIV/AIDS efforts with basic reproductive health interventions, including family planning, in order to more effectively respond to the epidemic.

Overall, Canada has played a leading role in supporting the ICPD Programme of Action and other international efforts to promote social development and human rights, especially at the policy level. With respect to its aid program, the government gives particular emphasis to promoting gender equality and the equal participation of women. The country's early support for efforts to combat HIV/AIDS—including through the International AIDS Vaccine Initiative and its work to implement the August 30, 2003 Decision of the World Trade Organization enabling developing countries to access more affordable generic drugs—has also set a positive example for the international community.

VITAL STATISTICS

2002 population size:
31.3 million

Total Official Development Assistance (ODA), 2002:
$2,006 million

ODA as a percentage of GNI, 2002:
0.28%

Total population assistance, 2002:
$82.8 million

Population assistance as percentage of ODA, 2002:
4.13%

Population assistance per $US million GNI, 2002:
$115

In recent years Canada has committed roughly 25 percent of its ODA to the social sector.

At the programmatic level, Canada has signaled its intent to move away from project support toward broader sector-wide program strategies. The Canadian International Development Agency (CIDA) is taking steps to improve the coordination of its country program strategies, give greater emphasis to a smaller number of priority sectors, and recast more of its program assistance as part of sector-wide initiatives.

Canada has also worked to improve the coherence of its aid-related policies. The International Assistance Envelope (IAE) was introduced in the 1991 budget for the purpose of ensuring coherence across departments, among international assistance priorities, and between this assistance and other foreign policy implements, such as diplomacy and defense. While CIDA manages 83.7 percent of the IAE, other major institutions involved in Canada's development work include Foreign Affairs Canada (FAC) and the Ministry of Finance. FAC helps to shape development policies and manage overseas administrative functions, as well as the Canadian Commonwealth Scholarship and Fellowship programs, while the Department of Finance represents Canada to the World Bank Group and to the Poverty Reduction and Growth Facility of the International Monetary Fund. Other government departments that administer portions of the IAE include Health Canada, Public Works and Government Services, Heritage Canada and the Department of National Defense.

2 The Policy Environment for International Population Assistance

Canadians remain favorably disposed to their country's foreign assistance efforts. A 2003 national survey found that 78 percent of the public supported development efforts and 43 percent wanted to see some increase in the foreign assistance budget. Canadians believe their country should be playing a larger role on the international stage and making greater efforts to alleviate poverty and promote political stability in the developing world.

However, this survey also found that most Canadians are not well informed about their government's development programs. For example, roughly 75 percent of those surveyed significantly overestimated the size of the development assistance budget, and 86 percent said they had never heard of the Millennium Development Goals. When asked whether Canadian development resources actually reach "the people who need it most," 82 percent responded that they did not. Many survey respondents stated that they would like to have more information on Canada's foreign assistance programs made more widely available through news outlets and the Internet.

Canada has been a strong advocate for international sexual and reproductive health programs. It played a leading role at the International Conference on Population and Development in 1994, and has been a strong advocate in such fora as the 1995 Fourth World Conference on Women in Beijing, the 2002 UN Special Session on Children, and the 2002 World Summit on Sustainable Development. Canada also advocates on these issues in the less visible regional and international meetings sponsored by various UN bodies. Canada's active role in such fora has been particularly important given the increased conservatism of some other donor countries in recent years.

Canada's efforts in the policy arena have been supported —and monitored—by Action Canada for Population and Development (ACPD). ACPD was established specifically to push the government toward meeting its ICPD commitments, especially the financial targets agreed to in 1994, and works with parliamentarians, policymakers and other Canadian NGOs.

While Canada's voice in support of sexual and reproductive health has been strong in international fora, it has not always been effective over the years in articulating its own policy directions or program priorities. In 1996, CIDA released a report entitled Strategy for Health that affirmed the importance of family planning and reproductive health services for improving the welfare of women in the developing world. Subsequently, CIDA began work in 1998 on developing a comprehensive population, reproductive health, and sustainable development strategy for its overseas programs, but this work was never completed.

The Canadian government has more clearly outlined its health priorities since 2000, beginning with the report, *CIDA's Social Development Priorities: A Framework for Action*. This report outlines Canada's intention to concentrate greater resources in the areas of basic health and nutrition, education, HIV/AIDS, and child protection. CIDA's subsequent Action Plan for Health and Nutrition also affirms the importance of reproductive health and safe motherhood programs and notes that universal access to sexual and reproductive health services, includ-

ing family planning information and care, are key features of its overall health strategy. The Action Plan also gives a prominent place to prevention, diagnosis, and treatment of sexually transmitted diseases, including HIV/AIDS, and is complemented by a specific Action Plan for HIV/AIDS. Lastly, CIDA identifies reproductive rights, gender equity, and the reproductive health needs of youth as crosscutting issues in the design and implementation of all of CIDA's health programming.

2 Trends in Funding for Population Assistance

Overall Funding Levels

Canada's population assistance rose dramatically in 2002, to $82.8 million. This was a doubling of average annual outlays in the latter 1990s, and the highest level of population assistance to date. (It is not possible to assess the scale of the increase in Canadian assistance between 2001 and 2002 since CIDA may not have fully reported its 2001 budget allocations.) Canada's commitment to increase ODA by 8 percent annually between 2003 and 2010 suggests that further gains in population assistance can be anticipated. Future increases are important if Canada is to fulfill its fair share of ICPD funding commitments, which would entail more than a doubling of year-2002 funding by 2005.

In 2002, Canada dedicated 4.1 percent of its ODA to population activities, slightly above the average DAC country effort of 4.0 percent. Relative to wealth, population assistance rose to $115 per million dollars of GNI. Canada was the ninth most generous supporter of sexual and reproductive health programs relative to national income among DAC countries, ahead of such donors as France, Germany, Japan, the United Kingdom, and the United States.

Seventy-nine percent of Canada's 2002 population funding can be disaggregated by type of activity. Of this amount, 8 percent was allocated for family planning, 15 percent for other reproductive health activities, 57 percent for HIV/AIDS, and 20 percent for research. While such attention to HIV/AIDS is critically needed, reproductive health activities should be integrated into HIV/AIDS efforts whenever possible, in order to achieve a more effective HIV/AIDS intervention strategy.

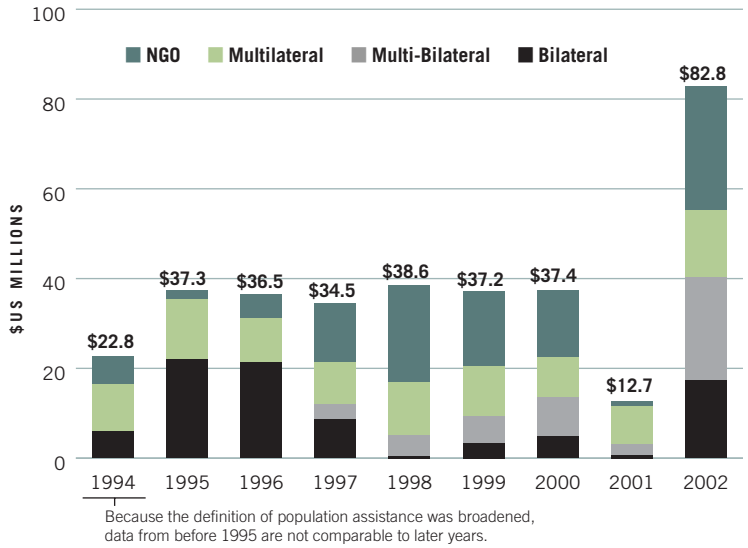
Multilateral Funding

Canada has traditionally directed a significant proportion of its resources for reproductive health and population through multilateral channels. In the early 1990s, nearly half its population assistance went to multilateral organizations, with UNFPA the primary recipient. While the share going to multilateral organizations has fallen substantially since then, actual dollar amounts remained relatively constant until 2002, when funding jumped to $14.9 million.

In 2002, Canada provided $8.3 million (CDN 13.1 million) to UNFPA's regular resources, placing the country among UNFPA's top ten donors. While the same in Canadian dollar terms, its 2003 contribution was estimated at US$9.4 million. In addition, Canada has supplemented its support in response to budget shortfalls for country programs and contraceptive commodity procurements caused in part by the U.S. withdrawal of funding for UNFPA.

Canada was instrumental in the creation of UNAIDS in 1996 and remains a major contributor to that organization. Canada was the eighth largest contributor to UNAIDS between 1995 and 2003, and provided $3.4 million in 2002 and $3.7 million in 2003. It has also been generous in its support for the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, pledging a total of $153 million for the period 2002-2005, of which $100 million has been paid. The government has also made significant contributions to the International AIDS Vaccine Initiative. In addition, Canada was the first country to implement the August 2003 Decision of the World Trade Organization to enable developing countries to access more affordable generic drugs and is a leading contributor to WHO's "3 by 5" initiative to treat 3 million AIDS patients by the end of 2005.

TRENDS IN POPULATION ASSISTANCE 1994-2002: CANADA



Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002*. New York: UNFPA.

Canada

B

Enhancing the number and quality of CIDA staff with global health backgrounds, and in particular recruiting staff with expertise in reproductive health and HIV/AIDS programs, will be essential if Canada is to play a larger role in the field.

Bilateral Funding
The share of Canadian population assistance channeled bilaterally has fluctuated significantly since the early 1990s, reaching a high of more than 50 percent mid-decade. In 2002, Canada provided more than $17 million (21 percent of total funds) in bilateral population assistance, the highest level since 1996. Canada is also making increased use of multi-bilateral channels of assistance in which bilateral resources are used to fund specific project components of larger multilateral programs. In 2002, Canada was the largest contributor to such programs, providing $23 million (or 28 percent of its total population assistance) for such efforts.

Funding for NGOs
Canadian support for NGOs working in sexual and reproductive health has varied from year to year, with a general upward trend over the 1990s. NGO funding increased significantly in 2002, along with overall funding levels, to reach nearly $28 million or 33 percent of total population assistance. Among the Canadian NGOs receiving funding are Planned Parenthood Federation of Canada and the Canadian Society for International Health. Others include the Canadian Public Health Association (CPHA), Canadian Nurses Association (CNA), Society of Obstetricians and Gynecologists (SOGC), and Canadian HIV/AIDS Legal Network. A key area of work is capacity building among their southern counterparts in Asia, the Americas and Africa in support of stronger national health systems. In addition, Canada is a long-term supporter of IPPF and its contributions have remained steady in recent years at 4.1 million Canadian dollars annually, equal to about US$2.8 million in 2002.

4 Program Priorities

Geographic Priorities
In the 1960s and 1970s, much of Canada's development assistance was directed to South Asia; namely, Bangladesh, India, and Pakistan. More recently, foreign aid has become more widely disbursed across a broad range of countries and development sectors. In fact, some critics maintain that Canada's foreign aid has been spread across too many countries, which results in too many small projects and high administrative costs. As of 2002, the three countries receiving the most Canadian foreign aid were Afghanistan, Bangladesh, and Ethiopia.

Steps are now being taken to redirect foreign assistance to fewer countries and give greater priority to a more limited range of development sectors. Approximately 50 percent of Canada's projected ODA increase during the remainder of the decade (or roughly $6 billion) will be directed to sub-Saharan Africa as part of the newly announced G8 Action Plan for Africa. Canada is also expected to be increasing its presence in the newly independent states of Eastern Europe and the former Soviet Union.

Canada's population assistance has gradually shifted away from Asia, Latin America and the Caribbean toward sub-Saharan Africa and Eastern Europe. By 1999, Africa had replaced Asia as the region receiving the largest share of Canadian population funds. Thus in 2002, while just over a third of Canada's total population assistance went to activities that were either global or interregional, more than 20 percent was devoted to sub-Saharan Africa, most notably Nigeria, Zambia and Malawi. In Nigeria, for example, Canada is contributing $4 million toward safe motherhood programs.

Specifically with respect to HIV/AIDS, Canada supports efforts in a number of sub-Saharan African countries, as

well as in such countries as China, India, Russia, and Vietnam. Sexual and reproductive health activities have also featured prominently in assistance to Guatemala and Nicaragua, while Canadian support in Indonesia has been instrumental in securing a reliable supply of affordable contraceptives for the country's family planning program. Also worth noting is Canada's involvement in Bangladesh, where it is providing more than $19 million for health sector reform as part of a large World Bank consortium project.

Areas of Program Emphasis
Canada supports the provision of integrated reproductive health services (combining family planning with other basic reproductive health elements) and the strengthening of safe motherhood programs. It is also becoming far more active in HIV/AIDS work, a trend that will likely accelerate with the implementation of the new G8 Action Plan for Africa. This increased activity in the field of HIV/AIDS is much needed, and if linked to basic reproductive health services, will further improve the effectiveness of Canada's population assistance.

Given the government's focus on HIV/AIDS, many of the country's largest commitments in international health now support HIV/AIDS prevention and treatment programs (e.g., in countries such as India, Russia, and South Africa). Much of this support is now channeled through organizations such as UNAIDS and the Global Fund, but bilateral HIV/AIDS programs involving Canadian NGOs and civil society organizations in partner countries seem likely to become a more prominent feature of Canada's international HIV/AIDS efforts.

Canada also gives considerable emphasis to reproductive rights and gender equity in its population assistance programs. Indeed, gender equality is a crosscutting theme that is integrated into all of CIDA's programming activities and sectors. Some examples of Canada's commitment to gender equality include a CIDA-funded project in Ghana that supported the education of girls, and a model training and awareness program on sexually transmitted diseases in Kenya. In Pakistan, CIDA-funded programs helped raise the profile of women during the country's 2001 elections, while in India, a CIDA-funded study revealed the need for gender-equality education within the judiciary.

Another example of Canadian efforts on gender issues is the Canada Fund for Local Initiatives (CFLI). CFLI resources have been supporting reproductive health training and educational programs for women in Guatemala, Nepal, and Pakistan. In addition, an innovative Civil Society Fund has been established by the Canadian Embassy in Egypt to provide funding to Egyptian NGOs working in reproductive health, legal reform, and the care of street children.

5 Technical Capacity

Staffing
CIDA has a small professional staff dealing with reproductive health and population issues. CIDA personnel assigned to overseas missions tend to have little technical expertise or experience in population or reproductive health, which undercuts CIDA's ability to design, monitor, and evaluate bilateral programs. This lack of technical expertise is a factor that no doubt partly accounts for the low level of direct bilateral implementation of Canada's population assistance budget. Enhancing the number and quality of CIDA staff with global health backgrounds, and in particular recruiting staff with expertise in reproductive health and HIV/AIDS programs, will be essential if Canada is to play a larger role in the field.

Technical Expertise of Collaborating Institutions
CIDA utilizes a small network of Canadian NGOs and universities to implement some of its bilateral sexual and reproductive health programs. Prominent CIDA partners include the Planned Parenthood Federation of Canada, the Canadian Public Health Association, and the Canadian Society for International Health. Health Canada has also recently announced plans to form a new Canadian Public Health Agency (to be modeled in part on the Centers for Disease Control in the United States) that by necessity will become active in international health. In addition, the International Development Research Centre (IDRC), a Canadian Crown Corporation had an active program in population and reproductive health during the 1970s and 1980s, but now focuses primarily on environmental health and the strengthening of health systems.

Canadian universities have generally not played a large role in Canada's population assistance programs, although they have the potential to help with strengthening Canada's expertise in international health and to provide Canadian students and faculty with greater opportunities for collaborating with colleagues from the developing world. The capacity of Canada's universities has been recognized in this regard by the Bill & Melinda Gates Foundation. The Gates Foundation has recently provided significant resources to the University of Montreal for demographic and reproductive health training and collaborative research for Francophone students from West Africa, the Caribbean, and Southeast Asia, and contributed to the University of Manitoba's School of Medicine for its HIV/AIDS prevention and treatment programs in Karnataka, India.

Denmark

GRADE

A

Denmark is the world's most generous contributor to international population programs, in relation to the size of its economy. It continues to be an influential proponent of the ICPD Programme of Action and remains a major contributor to UNFPA. However, several unsettling developments cloud the future of Denmark's population assistance. The new right-of-center coalition government plans to reduce annual ODA from 1 percent to 0.7 percent of GNI. It is not clear how this reduction will affect population assistance. Denmark has also reduced funding for UNAIDS, IPPF, and the Global Fund to Fight AIDS, Tuberculosis and Malaria—cutbacks that seem out of character with the country's traditionally strong support for international reproductive health. One encouraging note is that Denmark intends to increase the share of its bilateral assistance that goes to "social infrastructure" projects, including education and health.

1 Development Assistance: Policy and Funding

Denmark's development assistance remains oriented toward poverty alleviation and attainment of the UN's Millennium Development Goals. It also views development assistance as important in combating global terrorism. Still the most generous donor among DAC member countries, Denmark contributed US$1.6 billion in 2002, and its ODA/GNI ratio was 0.96 percent. However, its conservative coalition government (the Liberal Party and the Conservative People's Party) announced plans in 2002 to reduce foreign assistance by 10 percent and eventually scale back the country's ODA to 0.70 percent of GNI. This is a major shift from Denmark's traditional ODA/GNI earmarking of 1 percent.

The government has also introduced structural changes in an effort to increase the effectiveness of its assistance. Denmark's bilateral development agency, Danida, is being decentralized and more professional staff assigned to overseas postings. It is cutting the number of countries that receive bilateral support from 18 to 15 and limiting the number of sectors funded in each country to no more than four. The position of Minister of Development Cooperation has been abolished, which may signal a lower priority for foreign assistance in the future.

Denmark still prefers to work through the UN system and other international organizations in allocating its development resources. Its "Partnership 2000" strategy stresses "active multilateralism." In 2002, the government released a new policy on the creation of NGO partnerships that emphasizes stronger ties between Danish NGOs and civil society in developing countries, in order to promote broader participation in development programs and more effective information-sharing. The new strategy also proposes ways to simplify administration of NGO programs.

VITAL STATISTICS

2002 population size:
5.4 million

Total Official Development Assistance (ODA), 2002:
$1,643 million

ODA as a percentage of GNI, 2002:
0.96%

Total population assistance, 2002:
$73.8 million

Population assistance as percentage of ODA, 2002:
4.49%

Population assistance per $US million GNI, 2002:
$433

2 The Policy Environment for International Population Assistance

While the public still shows strong support for Denmark's international population programs, concern is growing that plans to cut aid relative to wealth undermine resource flows for reproductive health. The new policy proposals may also signal a weakening commitment to the ICPD Programme of Action, human rights, and environmental issues. However, cutbacks in reproductive health funding have been slow to materialize, and both UNFPA and UNAIDS are expected to receive increased funding through 2008. Denmark has also indicated that it plans to increase bilateral "social infrastructure" spending (now concentrated in education, health, and water supply/sanitation) to 57 percent of total bilateral aid within the next few years. Additional funding for HIV/AIDS programs is expected to be a major part of this renewed emphasis on social development.

3 Trends in Funding for Population Assistance

Overall Funding Levels

Denmark is the world's most generous contributor to international population programs when ranked according to the size of its economy. In 2002, it provided a record $73.8 million in population assistance, or $433 for every million dollars of GNI, and well above the previous high of $63 million in 1996. In 2002, Denmark's population funding was 4.5 percent of its total ODA. The more than 75 percent of Danish population assistance that flows through multilateral organizations and NGOs is not reported by type of activity; the remainder shows a heavy weighting toward HIV/AIDS activities (88 percent), with the rest shared among family planning, other reproductive health activities, and research. While Denmark's contribution for population activities is impressive, the projected cutbacks in ODA likely in coming years cast uncertainty on the country's ability to maintain current funding levels.

Multilateral Funding

Like many European donors, Denmark provides much of its international population assistance to multilateral organizations. In 2002, 43 percent went through multilateral channels, and an additional 14 percent was committed as part of multi-bilateral health programs. The multilateral share is still lower than in the 1990s, when more than 70 percent typically went through multilateral organizations.

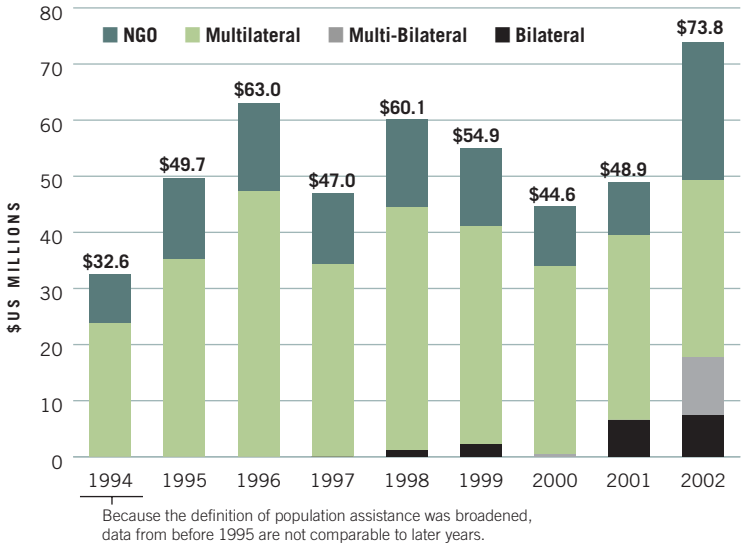
UNFPA is by far the largest recipient of Danish multilateral population funds. Denmark's contribution to UNFPA stayed roughly constant between 2002 and 2003, while rising in dollar terms from $22.2 million to an estimated $25.8 million in 2003. Denmark has been a major contributor to UNFPA for many years, and was the sixth largest donor to the organization in 2004. The government's strategy paper on development assistance between 2004 and 2008 recommends further increases in support for UNFPA.

UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria have also received substantial Danish resources. Since 2001, Denmark has pledged $44.6 million to the Global Fund, a major contribution given the size of its economy, and one the country intends to scale back between 2004 and 2008. Denmark was the sixth largest supporter of UNAIDS from 1995 through 2003, donating a total of $32.9 million. In recent years, however, its annual support for UNAIDS has fallen to about half the peak level of $6.8 million reached in 1996. Denmark's future donations to UNAIDS are scheduled to increase between 2004 and 2008, possibly recovering to $6.2 million by 2008.

Bilateral Funding

In 2002, Denmark provided only 10 percent of its population assistance through bilateral programs, but that is still an increase over the 1990s, when it was no more than 4 percent. A recent policy paper on Denmark's "social infrastructure" assistance recommends new bilateral funding for education, health, water, and sanitation projects in its priority partner countries. How much of this will go to reproductive health and HIV/AIDS activities remains to be seen.

TRENDS IN POPULATION ASSISTANCE 1994-2002: DENMARK



Because the definition of population assistance was broadened, data from before 1995 are not comparable to later years.

Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002*. New York: UNFPA.

Denmark

A

Funding for NGOs

The government's traditionally strong support for NGOs continues. From 1995 through 2000, Denmark allocated 25 percent to 30 percent of its annual population assistance to NGOs. In 2002, the record year for overall population assistance, NGOs were allocated $24.6 million or 33 percent of population funds, although this may reflect how contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria were recorded. However, this increase in support has not held true for IPPF. From 1997 through 2002, Denmark's contributions declined, from $12.8 million to $5.9 million, and it went from being the Federation's second largest donor to fifth place. Danish support recovered somewhat in 2003, to $7.6 million, and is expected to total $6.5 million in 2004.

4 Program Priorities

The Danish government believes that efficient poverty reduction requires critical investments in health, including activities aimed at stemming population growth, and that multilateral organizations have a critical role to play. In 2002, the government emphasized assistance in such areas as women's participation in development and the integration of maternal and child health services in primary health care. Denmark also intends to give greater priority to combating HIV/AIDS through partnerships with host governments, civil society, and multilateral organizations such as UNAIDS. Its 2004-2008 development strategy paper indicates new resources for population and health programs, focusing on promoting reproductive health and rights, improving the status of women, and reducing the incidence of female genital mutilation.

Denmark is increasingly allocating its population assistance through health sector reform initiatives. One potential disadvantage is that this approach may make it more difficult to address priority needs in reproductive health and HIV/AIDS. Sector-wide funding also makes it harder to track funding for specific areas of activity and may reduce the level of direct Danish participation in field activities.

Geographic Priorities

Since much of Denmark's international population assistance flows through multilateral organizations, there is little geographical definition to much of its support. In 2002, 65 percent of Denmark's bilateral development assistance was directed to 15 countries. Out of these, Denmark supported bilateral reproductive health projects in Bhutan, Ghana, Tanzania, Uganda and Zambia, where HIV/AIDS activities will be given priority.

Areas of Program Emphasis

Denmark supports sexual and reproductive health activities consistent with the ICPD Programme of Action. It emphasizes strengthening the coverage and quality of reproductive health services; providing sexuality and reproductive health counseling and services for adolescents; reducing violence against women and the practice of female genital mutilation; and combating the spread of sexually transmitted diseases (STDs) and HIV/AIDS. The government considers the promotion of gender equity, reproductive choice, and human rights to be crosscutting issues that guide all its reproductive health programming. It also supports broader development initiatives in education and employment generation that have a direct bearing on the welfare of women.

Denmark's population assistance places considerable emphasis on integrating family planning and maternal and child health services into primary health care programs. Improving the availability of information on sexuality and reproductive health, particularly among adolescents and more vulnerable women, is a priority for the country and, as part of its population assistance, it funds research on new contraceptive technologies that can enhance client choice and satisfaction. In addition, Denmark gives considerable attention to the critical problem of growing inequality in access to and use of health services by different socio-economic groups.

5 Technical Capacity

Staffing

Danida has recently begun to decentralize its operations and place more staff in field positions. Since this is a new initiative, it is not possible to judge yet how well it is working and whether it might give reproductive health issues a lower priority. Before this decentralization, none of Danida's full-time staff in Copenhagen worked exclusively on reproductive health issues. In all partnering countries with a health sector program, one person at the Danish embassy and one technical advisor usually work on health issues. It is not clear what priority goes to reproductive health, compared to other health concerns, thus highlighting an area for future advocacy by Danish NGOs and their Southern partners.

Technical Expertise of Collaborating Institutions

Denmark has a well-established community of NGOs with extensive experience in health projects in developing countries. In 2002, the six largest Danish NGOs receiving ODA funding were Care Denmark, the Danish Red Cross, the LO-FTF Council, Dan Church Aid, Ibis, and Save the Children Denmark. Many of these are especially adept at providing emergency humanitarian assistance, and the government has made extensive use of this capacity over the past decade. The extent to which Danish NGOs possess technical expertise in population and reproductive health is less clear, although groups such as the Danish Family Planning Association have the ability to become more active internationally.

Finland

GRADE

A

1 Development Assistance: Policy and Funding

Poverty reduction and attainment of the UN's Millennium Development Goals (MDGs) are the principal rationales for Finland's development efforts. The country's specific development goals are to promote global security, human rights and democracy, environmental quality, and dialogues between north and south on economic growth and development. Similar to other Nordic donors, the government asserts that it will be difficult to achieve the MDGs without addressing poor sexual and reproductive health and improving the status of women, among the reasons for these donors' strong support for both gender and sexual and reproductive health and rights in their aid programs. Finland's own Strategy and Action Plan to Promote Gender Equality, prepared in 2002, maintains that promoting women's health and equality—including educational opportunities for girls—creates a lasting basis for all social development.

Finland's bilateral cooperation will be increasingly channeled through poverty reduction programs in low income countries that have supportive policies and governance, and it plans to improve the quality of its future development cooperation by concentrating on fewer countries and larger projects. This approach is reflected in Finland's support for health sector reform and its commitment to improving coordination of donor budget support. Strengthening coherence among the country's investment, trade and development assistance policies is also a priority, and has resulted in the recent merging of separate ministerial positions for trade and aid (creating the new Minister for External Trade and Development Cooperation). In addition, situated within the Ministry of Foreign Affairs is the Department of International Development Cooperation (DIDC, formerly known as FINNIDA), which implements Finland's bilateral development assistance.

Finland continues to give high priority to sexual and reproductive health as part of its international development efforts, consistently allocating more than 4 percent of ODA to population assistance. Cuts in overall development assistance in the 1990s have limited the country's ability to increase the flow of resources to population activities, however, and thus the record-high funding of 2002 was only nominally higher than in 1995. Finland continues to direct the bulk of its population assistance through multilateral organizations, most notably UNFPA, and is thereby able to make a significant contribution to the field, despite limited technical capacity within its own aid establishment.

The small size of Finland's bilateral program limits its impact, but the country has maintained a noteworthy balance among the various types of activities, providing funds for reproductive health and family planning, as well as efforts to combat HIV/AIDS, particularly in sub-Saharan Africa and India. As the need for resources to address the HIV/AIDS pandemic continues to grow, it will be critical for Finland—and other donors—to ensure that programs are designed to respond in a comprehensive manner to the sexual and reproductive health needs of their clients.

VITAL STATISTICS

2002 population size:
5.2 million

Total Official Development Assistance (ODA), 2002:
$462 million

ODA as a percentage of GNI, 2002:
0.35%

Total population assistance, 2002:
$24.4 million

Population assistance as percentage of ODA, 2002:
5.27%

Population assistance per $US million GNI, 2002:
$185

Finland's official development assistance peaked at US$787 million (0.80 percent of GNI) in 1991, after steady growth since the late 1970s. However, economic recession led to drastic cuts in public spending in the 1990s, including development cooperation funds. By 2002, its ODA had recovered to $462 million (or 0.35 percent of GNI). A special committee appointed in 2002 to examine Finland's development aid recommended a gradual increase in funding from the current 0.35 percent of GNI to 0.55 percent by 2007, with the internationally recommended level of 0.7 percent a target for 2010.

2 The Policy Environment for International Population Assistance

Three-quarters of the Finnish public endorse their country's development cooperation policy and believe it is effective and successful, according to a 2003 survey. The same proportion would support an increase in international assistance and consider education and reproductive health the most important sectors for future work. In addition, the high incidence of HIV/AIDS in Russia and Estonia has increased the Finnish public's awareness of the HIV/AIDS pandemic in particular, as well as health issues more generally.

Reproductive health figures prominently in Finnish development cooperation. Priorities include reproductive health and rights (particularly for young adults), gender equality, male involvement in sexuality and reproductive health, and the elimination of violence against women and girls. The government plans to make gender equity an integral part of development cooperation, and in 2002, the Ministry of Foreign Affairs prepared a 2003-2007 Strategy and Action Plan for Gender Equality that aims to improve Finland's effectiveness in promoting gender equality and women's rights.

Finland has made the fight against HIV/AIDS a priority of its development assistance. In 2002, it approved a special HIV/AIDS strategy for development cooperation that stressed the need to provide adolescents with information on sexuality and reproductive health. While Finland plans to spend more on the prevention and treatment of HIV/AIDS in the future, it has also stated that it intends to maintain its support for reproductive health. The government appears to understand the importance of integrating reproductive health and HIV/AIDS activities wherever possible, and to appreciate that a holistic approach to the epidemic is necessary for long-term success.

3 Trends in Funding for Population Assistance

Overall Funding Levels

Finland's support for international population programs has not changed appreciably since 1995. Annual budgets have ranged between $17.3 million (in 1997) and $24.4 million (in 2002). In 2002, it allocated 5.3 percent of its ODA for population assistance, placing the country second after the United States and well above the DAC country average of 4.0 percent. In 2002, Finland spent $185 per $1 million of GNI on population assistance, the sixth highest commitment of DAC member countries.

As with many European donor countries, as well as Japan, Finland's resource flows for reproductive health are becoming more difficult to track, since funds are increasingly integrated with sector-wide reforms. Support for reproductive health and HIV/AIDS activities is also often integrated into larger projects in primary health care, education, and community development—in keeping with the comprehensive approach outlined in Cairo, but one that further complicates the tracking of resource flows. In 2002, the 23 percent of Finland's population funding that could be categorized by type of activity went to family planning (3 percent) and other reproductive health activities (54 percent), followed by research (32 percent) and HIV/AIDS (12 percent).

Multilateral Funding

Finland continues to allocate most of its population and reproductive health assistance through international organizations—77 percent in 2002. Finland does not use

Finland continues to direct the bulk of its population assistance through multilateral organizations, most notably UNFPA.

multi-bilateral channels to any great extent and just 4 percent of the country's population assistance was programmed this way in 2002.

The Finnish government has been a strong supporter of UNFPA. It provided 3.4 percent of UNFPA's operating budget in 2001 ($11.1 million), and increased its support still further in 2002 ($13.6 million) after the Bush administration ended U.S. support that year. In 2003, the country was expected to contribute $14.6 million, making it UNFPA's eighth largest contributor, and it also recently made a supplemental contribution to UNFPA for adolescent reproductive health programs. In addition, Finland ranks 11th in support for UNAIDS since 1995 with a total of $15.5 million donated from 1995 through 2003. Finland's strong commitment to UN agencies in the sexual and reproductive health field may be among the reasons that it has not contributed to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Bilateral Funding

Despite a surge between 1995 and 1998, Finland currently provides little bilateral funding for population activities: only 11 percent of its population resources in 2002. This may understate Finland's bilateral support, however, given the government's support for sector-wide approaches (SWAps), including in the health field. In Mozambique, Nicaragua, and Zambia, Finland participates in SWAps dealing with health, education, and urban development, while in Afghanistan, bilateral funds support an ambitious coordination framework for the health sector. More specific funding for sexual and reproductive health can be seen in Nicaragua, where Finland and other donors are supporting a national program to improve reproductive health status.

Funding for NGOs

Much of Finland's support for NGO goes to community and social development, including efforts to enhance educational opportunities for women and improve their status. In 2002, about half of its total NGO support was directed at African countries. Overall, Finland targets 15 percent of its annual ODA to NGOs, although the share is somewhat smaller within the population field. While Finland has been a consistent donor to IPPF over the past decade, its contributions have fluctuated and it is not a major contributor. It provided $241,000 to IPPF in 2002, a figure expected to increase to more than $400,000 in 2004. In a recent Decision-in-Principle strategy paper, the Finnish government said it hopes to engage civil society organizations more effectively in future years. It has initiated several needs-assessment studies to identify future opportunities for working with NGOs in reproductive health and HIV/AIDS.

4 Program Priorities

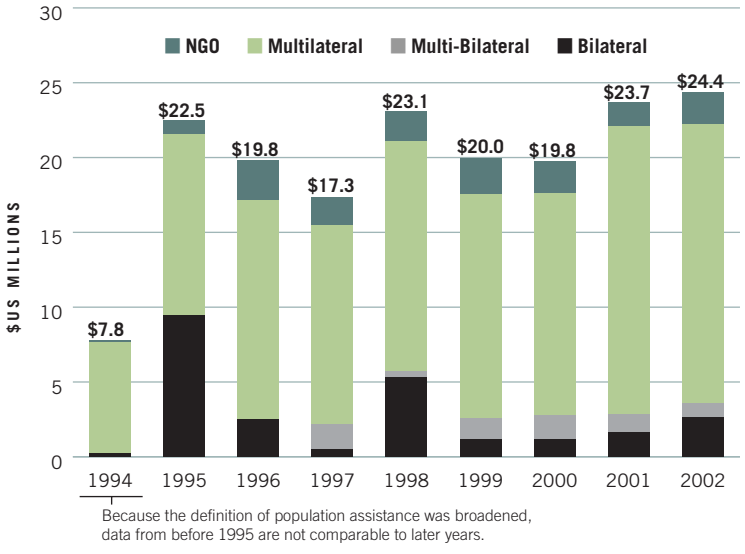
Geographic Priorities

Finland channels the majority of its bilateral ODA to eight long-term partner countries: Ethiopia, Kenya, Mozambique, Namibia, Zambia and Tanzania in sub-Saharan Africa; Nepal and Vietnam in Asia; Nicaragua and Peru in Latin America; and Egypt in North Africa. Many of these countries are also among the leading recipients of Finnish population assistance, including Nepal, Afghanistan, Tanzania and Mozambique. Since 1997, Finland has been funding a "Reproductive Health and Women's Empowerment (SAREM)" project in collaboration with the Nicaraguan Ministry of Health, which addresses adolescent reproductive health needs and the prevention of gender-based violence. Finnish support for the "Integrated RH/MCH Programme" in Afghanistan started in 2002 and builds capacity in population/demographic data-gathering and analysis.

Areas of Program Emphasis

Projects emphasizing capacity building and strengthening health delivery systems have been given greater priority in recent years, in recognition of their importance to long-term improvements in all aspects of health. As noted above, Finland's support for sexual and reproductive health activities includes both basic reproductive health care (including family planning), as in Nicaragua and Nepal, and efforts to combat the spread of HIV/AIDS and other STDs. The government also stresses

TRENDS IN POPULATION ASSISTANCE 1994-2002: FINLAND



Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002*. New York: UNFPA.

Finland

A

Finland has made the fight against HIV/AIDS a priority of its development assistance.

the importance of access to information and services for young people, particularly in the fight against HIV/AIDS. Finland's efforts in these areas are reinforced by its integration of gender concerns and human rights as cross-cutting themes throughout its development assistance program. Taken together, the country's efforts align powerfully with the approach outlined at the ICPD in 1994.

5 Technical Capacity

Staffing

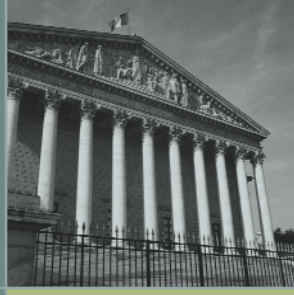
The Department for International Development Policy within the Ministry of Foreign Affairs (MFA) has one full-time adviser for health and population at its headquarters in Helsinki, and one adviser at its embassy in Mozambique. Both have formal training and experience in reproductive health and HIV/AIDS, while other staff members have expertise in development issues related to reproductive health. The department also collaborates with colleagues in the Ministry of Health and other institutions when in-house expertise is not available, and is pursuing a plan to place technical advisors in long-term partner countries. One will be in charge of all social and health projects, while others will deal with gender equality, human rights, and UNFPA program coordination. This effort to generate greater field capacity may be difficult to achieve, however, as the MFA is itself understaffed.

Technical Expertise of Collaborating Institutions

The Service Center for Development Cooperation (Kepa) is an umbrella organization of about 200 Finnish NGOs involved in development cooperation. Kepa has helped to shape Finland's development policies and has worked to promote better coordination between NGOs and the government. Finnish NGOs are often involved in social development activities, with considerable emphasis given to community-level projects in education and the welfare of women.

Several NGOs affiliated with Kepa have specialized expertise in adolescent reproductive health services and HIV/AIDS. For example, the Finnish Red Cross supports field projects dealing with control and treatment of sexually transmitted diseases, including HIV/AIDS. Vaestoliitto (Finland's main domestic family planning organization) advises the MFA on its international sexual and reproductive health activities and provides technical support for field projects in Malawi, Namibia, Mexico, Nepal, and India. Field projects include efforts to supply better information about sexual and reproductive health, HIV/AIDS awareness and prevention, and the social marketing of reproductive health supplies.

France



GRADE

C

The French government's support for sexual and reproductive health efforts increased dramatically in 2002, due in large part to its greater efforts to account for its population assistance than in past years. Most of the growth in funding has been for HIV/AIDS, a priority of the government's new health strategy for development cooperation. The government's support for reproductive health activities, including family planning, is more difficult to assess, although the holistic approach to HIV/AIDS programming spelled out in policy documents indicates an understanding of the importance of linking HIV/AIDS with reproductive health interventions.

France is among the largest donors of official development assistance, ranking third behind the United States and Japan in 2002, and has pledged to meet the international target of allocating 0.7 percent of national income (GNI) to overall aid by 2012. The size of its aid program means that it has the potential to become an influential donor in the sexual and reproductive health arena, although this would also require an increase in the share of aid devoted to population assistance. For while French population assistance in 2002 actually surpassed that of such donors as Norway, Denmark and Sweden in volume, it was a much smaller share of ODA—at little more than 1.5 percent.

As with other donor countries belonging to the European Union, French development assistance channeled through the European Commission cannot be credited back to the original donor by sector or activity. This is particularly significant for France, as it provides roughly one-quarter of the resources for the European Development Fund (EDF), the major channel for EC aid and one that includes population assistance. France is far less generous a supporter of the UN system, however, including in particular UNFPA and UNAIDS. Increasing its support for these two institutions would be one way for the French government to further demonstrate its growing support for efforts in the sexual and reproductive health arena.

1 Development Assistance: Policy and Funding

The French government has significantly increased development assistance since 2001 and pledged to achieve the internationally agreed goal of 0.7 percent of national income (GNI) for ODA by 2012. The country's ODA increased by 21 percent in real terms between 2001 and 2002, rising from $4.2 billion to $5.5 billion. Preliminary figures for 2003 show a further increase to more than $7.3 billion. French development assistance also increased relative to GNI, from 0.32 percent in 2001 to 0.38 percent in 2002, slightly less than the average DAC country effort of 0.41 percent. French ODA has yet to recover to the levels achieved in 1991-1992, however, when it averaged $7.8 billion and 0.62 percent of GNI. Also, future increases in ODA may

VITAL STATISTICS

2002 population size:
59.5 million

Total Official Development Assistance (ODA), 2002:
$5,486 million

ODA as a percentage of GNI, 2002:
0.38%

Total population assistance, 2002:
$83.7 million

Population assistance as percentage of ODA, 2002:
1.53%

Population assistance per $US million GNI, 2002:
$58

be more difficult to achieve, in light of economic constraints at home and the large share of ODA currently in the form of debt relief, rather than new resource flows.

French President Jacques Chirac has made development cooperation a priority of his administration, resulting in positive steps to strengthen French development policy and program management. Poverty reduction and the attainment of the Millennium Development Goals are enshrined as the overarching goals of French development assistance, and priority is given to five sectors: education, health and the fight against HIV/AIDS, water and sanitation, rural development, and infrastructure. Key principles informing French development cooperation include a focus on Africa, governance, preservation of the environment, and the regulation of globalization in support of greater access to markets by poor countries.

France is currently focusing much of its assistance on low income countries that lack good access to international capital markets. These countries are considered to reside in a "Priority Solidarity Zone" (ZSP) and are eligible to receive assistance from France's Solidarity Priority Fund (FSP), the main source of bilateral development assistance. Many Francophone sub-Saharan countries that have been traditional recipients of French assistance will continue to receive support in this newly prioritized scheme. In addition, selected Anglophone countries in Eastern and Southern Africa, the Middle East, Southeast Asia, and the Caribbean are also receiving French support.

France is also playing more of a leadership role in international development, including efforts to harmonize aid procedures and to further enhance the flow of resources to developing countries. It currently chairs the DAC Working Party on Aid Effectiveness and Donor Practices and in 2005 will host a high-level forum on aid effectiveness to follow up on that held in Rome in 2003. France has endorsed the United Kingdom's proposal for an International Finance Facility, and joined with a larger group of donors to flesh out the idea of a tax on international financial transactions as another way to mobilize aid resources.

France has taken steps since 1998 to restructure its development assistance programs, although areas of responsibility continue to overlap in a way that exacerbates inefficiencies in the delivery of aid. The Ministries of Foreign Affairs (MFA) and Economic Affairs, Finance and Industry (MEFI) have overall authority for French development assistance. The MFA has responsibility for development cooperation and cultural programs, as well as diplomatic relations, while MEFI is charged with overseeing investment and trade relations with developing countries, including the management of debt relief. The French Development Agency (AFD) was established in 1999 to serve as the main implementing agency for bilateral assistance, although in 2002, just 10 percent of ODA was managed by AFD, compared with 29 percent by the MFA and 40 percent by MEFI. The Office of Social Development within the MFA is responsible for overseeing France's efforts in population and reproductive health. In addition, the Priority Fund for Solidarity (FSP), situated within the MFA, is responsible for cultural, scientific, and technical exchanges with the developing world.

Two additional organizations involved with French development efforts are important to note. The Interministerial Committee for International Cooperation and Development (CICID) works to better coordinate development activities across relevant ministries. Its secretariat is provided jointly by the MAF and MEFI and is responsible for setting geographical and sectoral development policies and identifying program priorities. The High Council for International Cooperation (HCCI) fosters dialogue among the various parties involved in French development cooperation and has worked to identify new strategies for engaging civil society.

2 The Policy Environment for International Population Assistance

The French government's track record in support of aid for sexual and reproductive health is mixed. An early supporter of efforts to fight the HIV/AIDS pandemic,

France is among the largest donors of official development assistance, ranking third behind the United States and Japan in 2002.

France historically has been reluctant to directly support family planning efforts overseas, preferring instead to address areas it perceived as less controversial, such as maternal health and demographic research. The French government maintains, however, that reproductive health activities are often integrated in broader health programs.

The degree to which the government's reluctance to fund reproductive health activities in the past was based on domestic public opinion is unclear. A more likely source was the perceived unpopularity of family planning in Francophone African countries where much of French ODA was concentrated. This perception has changed in recent years, as the rationale for family planning has shifted away from the demographic in favor of a health- and rights-based approach, and as parliamentarians from Francophone countries have themselves spoken out in support of reproductive health needs.

The increased prominence of sexual and reproductive health issues in aid-receiving countries has been helped by the advocacy of French NGOs, in particular Equilibres et Populations (E&P) and the French IPPF member association, Mouvement Français pour le Planning Familial (MFPF). Both organizations work with parliamentarians and directly with French foreign ministry officials to encourage the allocation of additional resources for population assistance. E&P has organized a number of high-level conferences and other meetings for French and Francophone parliamentarians since its founding in 1994. Both have also been active around the tenth anniversary of ICPD, whether participating in the various regional meetings held under UN auspices, or sponsoring events in France. In March 2004, for example, the Minister of State for Cooperation and Francophonie spoke at one such forum organized by E&P at which he reaffirmed the government's support for population and reproductive health programs.

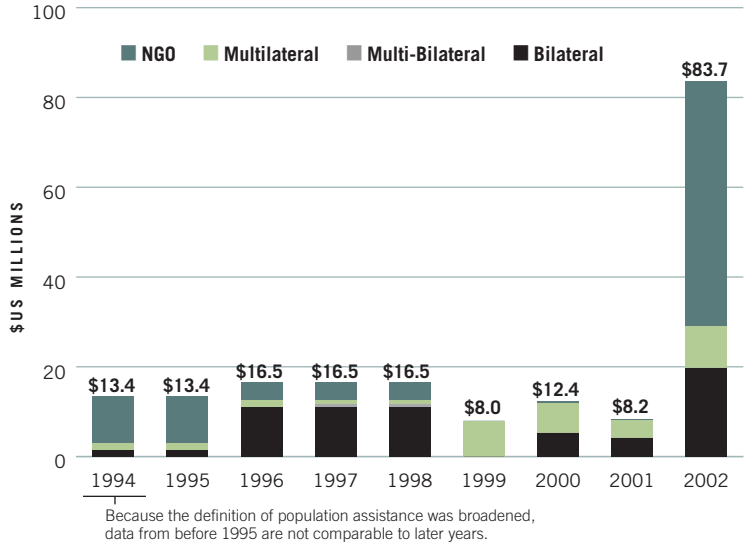
The fruits of these efforts can be seen in several new initiatives supported by France, including support for a Tunisia-Niger South-to-South partnership in reproductive health, more comprehensive programs to reduce maternal mortality, and efforts to end female genital mutilation/cutting (FGM/C). Further signs of change can be seen in French development policy with respect to HIV/AIDS. Policy documents indicate a holistic approach that places sexual transmission in a "broader context," including the need to ensure that couples have the means to control their fertility and express their sexuality "without risk." However, the French government has yet to develop a comprehensive policy along the lines of those on HIV/AIDS or gender that makes clear its commitment to reproductive health as a development priority.

3 Trends in Funding for Population Assistance

Overall Funding Levels

Improved reporting of its support for sexual and reproductive health activities was reflected in a dramatic increase in French population assistance in 2002, while incomplete reporting over the previous decade makes it nearly impossible to assess previous levels of support. Between 2001 and 2002, reported figures show that population funding rose from $8.2 million to $83.7 million, the most dramatic one-year jump of any DAC member country. Despite this sizeable gain, France still only commits 1.5 percent of its total ODA for population assistance, a level below most European donors. While OECD statistics do not capture this increased support, they do show that France committed an average of 4.2 percent of bilateral assistance to health and population over the three-year period 2000-2002, including $152 million in 2002. A large share of population assistance has historically been programmed through multilateral organizations, rather than bilaterally, although this may be due to how contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria were recorded. The dramatic increase in funding in 2002 was reportedly channeled both bilaterally and through NGOs.

TRENDS IN POPULATION ASSISTANCE 1994-2002: FRANCE



NB: 1994 and 1995 expenditures were not reported to UNFPA and were estimated at the 1993 level. 1997 and 1998 expenditures were estimated at the 1996 level. In 1999, only donations to multilateral sources were reported.

Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002*. New York: UNFPA.

C

NGOs have traditionally received only a tiny portion of ODA.

Rising support for HIV/AIDS programs appears to account for much of the increase in French population assistance, although French funds flowing through multilateral and NGO channels are not reported for by type of activity. Of the 26 percent that can be accounted for, 88 percent was allocated for HIV/AIDS, with the remainder going to family planning (2 percent) and other reproductive health activities (6 percent) and research (3 percent).

The French government has long maintained that its population assistance was not fully accounted for and that its support for certain UN agencies (UNIFEM, UNICEF and others) and education, for example, should be counted as population assistance. France also claims that its population assistance has tended to be more holistic than many other donors, and that its approach presaged many of the integrated program directions promoted at the ICPD in 1994.

Multilateral Funding

While France has been a major contributor to such UN agencies as UNDP, UNICEF, UNHCR, and WHO, other UN bodies such as UNFPA and UNAIDS have received little funding. As noted above, France is the leading contributor to the European Development Fund, which in turn is charged with allocating 35 percent of funds to the social sector.

The ten-fold increase in overall population assistance between 2001 and 2002 was not paralleled by increases in French multilateral contributions, which went from just $3.8 million to $9.2 million. France has not been a major contributor to UNFPA over the years and in 2002 gave just $1.2 million, among the smallest contributions of any European DAC donor. This figure was expected to stay roughly constant in 2003 and 2004. In contrast, the country's contribution to UNAIDS has decreased in real terms, from $3.4 million in 1995 to $524,000 in 2003.

France has been more generous in donating resources to the Global Fund to Fight AIDS, Tuberculosis and Malaria. France was an early supporter of the Fund, contributing nearly $60 million in 2001-2002 and another $60 million in 2003. In all, France has pledged more than $650 million to the Global Fund for the period 2002-2006, the largest pledge of any donor nation. (UNFPA has indicated that some Global Fund contributions were not included in its calculations of donor countries' population assistance in 2002.)

Bilateral Funding

Since 2000, France has been providing more of its resources for population programs through bilateral assistance. Twenty-four percent of French population assistance (or $19.8 million) was allocated to bilateral program support in 2002. This is nearly five times the bilateral population assistance budget of $4.2 million in the previous year. While much of this increase is again due to the rapid rise in HIV/AIDS resources, France is also counting more bilateral project elements as part of its overall contribution to reproductive health activities. It is not clear to what extent the rise in France's bilateral assistance is due to higher absolute budgetary allocations, and how much may be due to the reclassification or improved reporting of ongoing project activities.

Funding for NGOs

Given the variations in France's reporting on its population assistance, trends in its support for the NGO sector are difficult to see, although NGOs have tended to receive a major share of funding in the few years when figures were reported to UNFPA. In 2002, support for NGOs rose in keeping with the overall increase in funding, to $54.7 million, or 65 percent of total population assistance. This is likely due to the significant involvement of NGOs in the country's overseas HIV/AIDS activities. Thus this increase appears to reflect favorably on French support for NGOs in this sector and contrasts with the very low support for NGOs in overall French development cooperation. It is important to note that France still does not contribute directly to IPPF, although funds are channeled to individual IPPF member associations, including MFPF.

4 Program Priorities

Geographic Priorities

French ODA continues to be concentrated in French Polynesia and sub-Saharan Africa. In 2001, the three largest aid recipients were French Polynesia, New Caledonia, and Egypt. France reports its population assistance on a regional basis, making it difficult to identify priority countries. France supports maternal health initiatives in Madagascar and the Ivory Coast through multi-bilateral projects undertaken in collaboration with UNFPA; education and reproductive rights projects in

Benin, Burkina Faso, the Ivory Coast, and Mali in partnership with UNICEF; and projects to improve the social status of women in Burkina Faso, Ethiopia, and Vietnam with the ILO. As mentioned above, another project undertaken in collaboration with UNFPA involves South-to-South cooperation between Tunisia and Niger. The goal is to make use of Tunisia's long experience in family planning and reproductive health to help bring about reductions in maternal and infant mortality.

France is also supporting a new 17-country project in sub-Saharan Africa focusing on emergency obstetrical care that will incorporate findings from field research on how to lessen maternal risk. Country-specific population and reproductive health projects reported through the OECD system show support for projects in 22 developing countries, most of them in Africa (including North Africa), followed by Latin America and the Caribbean, and Asia (Vietnam and Cambodia).

Areas of Program Emphasis

French efforts in international health currently concentrate on fighting HIV/AIDS and other sexually transmitted diseases, strengthening the capacity of health systems to provide greater quality of care, and working to make health services more financially sustainable. In addition to increasing its support for HIV/AIDS, France is also giving greater attention to maternal health, sexually transmitted diseases in addition to HIV/AIDS, and reproductive rights (including projects addressing FGM/C and violence against women).

France maintains that it is not given sufficient credit for its development efforts that are responsive to ICPD agendas but fall outside the four "costed" program components used by UNFPA to track international population assistance; namely, family planning, other reproductive health initiatives, STD/HIV/AIDS, and research. For example, a long-standing priority of French foreign assistance has been support for the education of girls. France is the largest contributor to the European Development Fund Schools Programme that supports educational services in developing countries. France has also made education its main priority in the African countries where it is currently active.

5 Technical Capacity

Staffing

France's two main development bodies, the MFA and AFD, have relatively few technical experts in sexual and reproductive health in their headquarters, although the number of staff working on HIV/AIDS programming is increasing. The government reports that nearly 200 of its 1,600 expatriate professional staff are health experts, but it is unclear as to how many of them have specific expertise in reproductive health, although 23 are managing HIV/AIDS projects. As France continues to increase its support for HIV/AIDS programming—and in light of its stated commitment to do more in other aspects of sexual and reproductive health—changes in both the numbers of staff and their areas of expertise will likely be needed.

> The French government's track record in support of aid for sexual and reproductive health is mixed.

Technical Expertise of Collaborating Institutions

France has a long tradition of supporting demographic research and development policy studies both at home and abroad. In France, such organizations as CEPED, CICRED, and INED undertake important research on population dynamics and socioeconomic change. France also provides funding for centers situated in the developing world such as IFORD, CERPOD, and ENSEA that provide training and research opportunities in the population and health sciences.

The French government's support for NGOs working in sexual and reproductive health is not fully documented prior to 2002 and, as noted above, NGOs have traditionally received only a tiny portion of ODA. French NGOs with health and social development orientations are now beginning to emerge as more ODA is made available for civil society organizations. For example, MFPF appears able to channel some funds for international projects. In 2002, it received funding from the World AIDS Foundation for a risk reduction project in Burkina Faso, Cameroon and Madagascar. The French government is encouraging NGOs to apply for ODA grants through the Non-Governmental Cooperation Mission of the Directorate General for International Cooperation and Development (DGCID) situated in the MFA.

Germany

GRADE

B

While Germany continues to be a major provider of population assistance, ranking fifth in overall support among DAC countries in 2002, funding has fallen since the late 1990s. This decline does not necessarily signal any lessening of support for population and reproductive health, but has largely resulted from the overall decline in the country's ODA. Nevertheless, Germany's increased support for UNFPA, UNAIDS, and the Global Fund to Fight AIDS, Tuberculosis and Malaria in recent years are signs of hope for the future.

Among all DAC donors, Germany provides the largest share of its population assistance budget (nearly half) for family planning. It is an effective advocate for the integration of contraceptive and other essential reproductive health services, and is a leader in supporting social marketing programs for reproductive and child health and procuring essential supplies. Germany has maintained a balance between HIV/AIDS and reproductive health programming and its commitment to integration of reproductive health into other health services is welcomed. It signals an understanding of the essential nature of basic reproductive health care in maintaining the health of a population and helping to fight the spread of HIV/AIDS.

Germany remains strongly committed to the ICPD Programme of Action in shaping its population assistance, but German aid officials do note some public confusion about the concept of reproductive health as opposed to family planning. Reproductive health may also be declining as a priority within the countries where Germany works, which may make it more difficult to secure funding in the future. This concern is strongest with respect to Germany's participation in pooled funding mechanisms and sector-wide approaches, where reproductive health may find it difficult to compete against other development priorities. These concerns highlight the need for advocacy in support of sexual and reproductive health as a development priority, particularly in countries where Germany is a major donor.

1 Development Assistance: Policy and Funding

Germany continues to be one of the world's largest contributors to international development programs. In 2002, Germany's ODA stood at US$5.3 billion, the fourth highest commitment among all DAC countries. However, Germany has reduced its international assistance from an average $7.2 billion annually in the early 1990s, in line with overall cutbacks in public spending, a political commitment to balance the federal budget, and the continuing costs of reunification. Germany's 2002 ODA/GNI ratio of 0.27 percent is also below levels achieved by many other European donors and substantially less than the 0.38 percent attained in 1991 and 1992. The government is still aiming to devote 0.35 percent of GNI to development aid by 2006 (halfway to the 0.7 percent mark), but this will require considerably larger annual outlays than is currently the case.

In 2001 the German government approved the 2015 Programme of Action for Poverty Reduction, making poverty alleviation the central objective of its development assistance. The stated aim of this strategy is to reduce extreme poverty around the world by 50 percent by 2015—the same overarching objective as the UN's

VITAL STATISTICS

2002 population size:
82.4 million

Total Official Development Assistance (ODA), 2002:
$5,324 million

ODA as a percentage of GNI, 2002:
0.27%

Total population assistance, 2002:
$106.8 million

Population assistance as percentage of ODA, 2002:
2.01%

Population assistance per $US million GNI, 2002:
$54

Millennium Development Goals. Ten priority program areas are identified for future German development work, including economic growth, food production and agrarian reform, debt reduction, basic social services (including health and education), environmental management, human rights, gender equality, and conflict resolution.

In an effort to improve efficiency, Germany will reduce the number of its priority and partner countries in future years. The number of recipient countries will fall from 118 to 76, with 41 designated as priority countries and 35 as partner countries. Some further realignment may occur in order to more effectively target German assistance toward settings with greatest need. Allocations of German development assistance are also affected by a directive of the parliament (Bundestag) which mandates that two-thirds of all foreign aid be channeled bilaterally and one-third through multilateral organizations. In addition, public-private funding arrangements are being encouraged as a funding mechanism.

German development assistance is coordinated by the Ministry of Economic Cooperation and Development (BMZ), which identifies overall objectives and strategies for German development assistance. Two independent quasi-governmental agencies, GTZ (the German Agency for Technical Cooperation) and KfW Entwicklungsbank (KfW Development Bank), implement Germany's regional and country-level bilateral aid programs. GTZ handles technical assistance and capacity building for the government, while KfW, with its new partner DEG (German Investment and Development Company), functions as a development bank and provides grants, highly concessional loans and investment capital for public and private sector ventures. KfW is also an important provider of resources for contraceptive supplies, including through its support for social marketing initiatives.

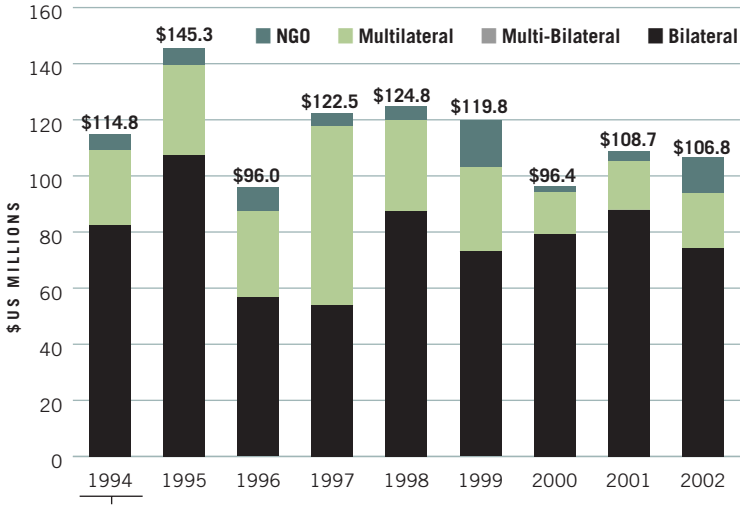
Another major agency in the development field, the German Foundation for International Development (DSE), recently merged with the Carl Duisberg Society (CDG) to form InWEnt (Capacity Building International). Funded largely by BMZ, InWEnt is responsible for building host country capacity through training and mentoring programs, including those in education, public administration and health (with priority for health systems development and health sector reform).

2 The Policy Environment for International Population Assistance

Germany remains a strong supporter of international population assistance and views the ICPD Programme of Action as a sound justification for its commitment to reproductive health. Given this commitment, the government has expressed concern that reproductive health was not explicitly included among the Millennium Development Goals, and sees this as a major omission that could undermine the objective of halving extreme poverty by 2015. In contrast to this support for international population assistance, however, German aid officials have observed that domestically, public support for sexual and reproductive health is not strong. The term *sexual and reproductive health* carries little meaning in German, unlike *family planning*, which is widely recognized and supported. Furthermore, the need to combat HIV/AIDS resonates far more with the German public, as the epidemic gathers force in nearby Russia and Eastern Europe.

Given the broad programmatic reach of German development assistance, some aid officials are concerned that health programs (including sexual and reproductive health) may not secure adequate resources in an increasingly competitive funding environment. A requirement

TRENDS IN POPULATION ASSISTANCE 1994-2002: GERMANY



NB: Family planning assistance in 1995 is included on the basis of reported commitments; for other population activities, expenditure figures were available. Commitments for bilateral projects in 1996 amounted to 168.3 million DM ($US111.8 million). The 1997 figure does not include expenditures for the population component in integrated development projects.

Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002*. New York: UNFPA.

that partner countries identify only three priority areas for German development assistance also serves to reduce demand for population funding. For example, Germany now undertakes no health programming in Latin America because partner countries have not made this sector a formal priority. As further efforts are made to promote program ownership in recipient countries, some German officials worry that social service spending—and health commitments in particular—may increasingly lose out to such priorities as energy, transport and economic reform.

3 Trends in Funding for Population Assistance

Overall Funding Levels

Germany provided $106.8 million in international population assistance in 2002, almost level with 2001 but somewhat below levels of the late 1990s. In 2002, Germany's population assistance budget was 2.01 percent of its total ODA, lower than the average DAC country effort of 4.0 percent. Of this funding, 77 percent can be allocated by type of activity: 47 percent was in support of family planning, 38 percent went for other reproductive health services, and 15 percent went for HIV/AIDS.

Relative to wealth, Germany's population assistance places it in 16th place among the DAC donor countries. The country's 2002 contribution equaled just $54 per million dollars of GNI, about half the level of support provided by the United Kingdom, Canada and Ireland, and well behind the leading donors in the field. Germany would need to increase its funding nearly sixfold by 2005 to fulfill its fair share of donor commitments to ICPD.

Multilateral Funding

Nearly two-thirds of Germany's multilateral population assistance was channeled through UNFPA in 2002 and it is among the agency's top ten donors. Its contribution has remained constant in Euro terms for the last few years, while the dollar value has increased from $13.8 million in 2002 to an estimated $16.2 million in 2003. However, as noted above, the level of support is significantly less than in the mid-1990s and Germany's support for UNFPA is well below that of the Netherlands, Japan, Norway and the United Kingdom. Overall, Germany has been reducing the share of its population assistance channeled through multilateral organizations. In 2002, only 18.3 percent was allocated multilaterally, although this was a slight increase in both share and volume over the previous two years.

Germany has not been a major contributor to UNAIDS, and its level of support has been erratic, rising from $826,000 in 2001 to $2.1 million in 2002, but then falling to $1.4 million in 2003. As for the Global Fund to Fight AIDS, Tuberculosis and Malaria, Germany pledged generously—$353.1 million through 2007—but its total payments to date are only $61.6 million (well below such countries as France and Italy).

Bilateral Funding

In 2002, 70 percent of Germany's population assistance was allocated bilaterally, a modest decline from slightly more than 80 percent in 2000 and 2001. However, in Russia and Eastern Europe, Germany's population funding is managed by the European Union, making it the only region where the country relies primarily on multilateral rather than bilateral assistance.

Funding for NGOs

Germany does not channel much population funding through NGOs, in part because of the small number of German NGOs working in sexual and reproductive health. Since 1994, the government has never provided more than 14 percent of its population assistance to NGOs, and in 2000 and 2001, the total was 3 percent. NGOs fared considerably better in 2002 when their share rose to 12 percent. Over the years, Germany has contributed to IPPF, but it has not been one of IPPF's major donors. This may change, given BMZ's positive view of IPPF's current direction. In 2002, Germany gave $2.4 million to IPPF, equivalent in Euro terms to its contribution the previous year, although less than half its peak annual contributions in the latter 1990s.

4 Program Priorities

Geographic Priorities

Germany's population assistance goes to 25 countries in Africa, 12 countries in Asia (including Central Asia), nine countries in Latin America, and various regional and global projects. Major recipient countries in 2001 were Bangladesh, India, and Pakistan in South Asia; and Cameroon, Kenya, and Malawi in sub-Saharan Africa. It is not clear how current geographic priorities for population assistance will conform to the new country line-ups that may emerge as part of Germany's 2015 poverty reduction program.

Areas of Program Emphasis

Germany's population assistance emphasizes access to family planning services; care for women in pregnancy and delivery; prevention and treatment of STDs, including HIV/AIDS; and information and education. In keeping with its rights-based approach to sexual and reproductive health, BMZ also supports efforts to reduce gender-based violence and female genital mutilation/cutting (FGM/C).

While Germany still provides a large share of its population assistance for direct family planning support, it has been at the forefront of efforts to develop more comprehensive reproductive health services and is becoming more active in its support for adolescent services.

Germany, like a number of other donors, is moving from population project assistance to broader program support oriented toward reducing poverty and strengthening overall health systems. While German aid officials maintain that sexual and reproductive health will remain key elements in their programming, they realize that prioritizing it may become more difficult as basket-funding arrangements and sector-wide approaches (SWAps) become the order of the day. Until now, however, such mechanisms have not precluded provision of technical assistance in countries where capacity is still weak.

Gender- and rights-based approaches are now more prominent features of Germany's international development, including support for projects to combat gender-based violence and trafficking and FGM/C. These are increasingly incorporated in projects focusing on the reproductive health needs of adolescents and young adults. The BMZ supports a "dual track" on gender by (1) screening projects for gender content and projected outcomes, and (2) supporting special activities that address the socio-legal status and rights of women. The importance that Germany attaches to gender is demonstrated by the fact that gender equality is mentioned as a priority objective in its 2015 Programme of Action to Reduce Poverty.

Germany also provides significant support for contraceptive and other reproductive health supplies through the KfW Development Bank. KfW supports both the procurement of contraceptives in public sector programs and the social marketing of reproductive health commodities and micro-nutrient products through pharmacies and private sector outlets. An increasing priority in recent years has been the procurement of condoms to combat HIV/AIDS and hormonal contraceptives. As a result, KfW recently launched a new project to supply oral pills to Kenya's family planning program and a new social marketing initiative for contraceptives in Ethiopia. In addition, STD treatment kits are being provided to the Department of Health in the Philippines, while micronutrient test marketing is under way in Pakistan.

Overall, KfW supports social marketing of contraceptives, including condoms for HIV/AIDS prevention, in 18 African countries, plus Pakistan, Indonesia, and the Philippines. According to UNFPA, BMZ/KfW was the world's third largest donor of contraceptives, including condoms for HIV/AIDS prevention from 1990 to 2002, and in 2002, was among the top five donors, providing $20 million in support.

5 Technical Capacity

Staffing

The BMZ has recently gone through a reorganization, with some staff leaving Bonn for Berlin. In the short run, this may have weakened links within BMZ (e.g., between multilateral units, regional offices, and sectoral divisions). Another current difficulty within BMZ is that population and reproductive health personnel are few in number. As of 2003, fewer than three full-time staff equivalents worked in the health sector (including reproductive health) at BMZ headquarters, and only 25 BMZ staff engaged in development work in embassies overseas. The German government has cut all its staff over the past decade as spending was scaled back by 1 percent to 3 percent annually. BMZ and other development agencies have not been immune from these cutbacks.

Technical expertise on population and reproductive health resides largely within GTZ, with few experts in BMZ, the KfW Group, or InWEnt. However, GTZ appears to be understaffed in relation to the size of its field programs in reproductive and child health. As of 2003, GTZ had only six or seven staff members at headquarters working on sexual and reproductive health, although more GTZ staff now work in overseas missions than in the past. Typically, there is one program manager and several technical support staff in each GTZ mission, but overall, the number of GTZ field staff with expertise in sexual and reproductive health is quite small compared to specialists in other development sectors. InWEnt has even fewer staff in this area. It has little capacity in health, let alone in specializations such as reproductive health.

Technical Expertise of Collaborating Institutions

While civil society plays an important role in Germany's development assistance programs overall, very few NGOs worked on sexual and reproductive health issues until taking on HIV/AIDS as part of their work in the health sector. The German Foundation for World Population (DSW), founded in 1991, is the largest and most active German NGO in international sexual and reproductive health. With funding from a range of donors—including UNFPA, the World Bank, private foundations, corporations, individuals, and BMZ—DSW undertakes projects in Asia and Africa (primarily sub-Saharan Africa), focusing on youth sexual and reproductive health, HIV/AIDS prevention and women's empowerment. It currently has projects in Ethiopia, Kenya, Uganda, Burkina Faso, Nepal, South Africa, Tanzania, Cambodia and the West Africa region. DSW is also active in advocacy and communications to secure greater German and European Union funding for international reproductive health programs, including reproductive health supplies.

Ireland

GRADE

C

Ireland has become one of the more generous DAC countries in terms of development assistance relative to wealth. Population funding has been rising rapidly in recent years, quadrupling between 1999 and 2002. Resources are heavily weighted toward HIV/AIDS prevention and treatment interventions, and present a shift from the country's earlier focus on maternal and child health and control of infectious diseases. These increases in population assistance are a positive sign and provide an opportunity for Ireland to link its growing HIV/AIDS efforts with those in maternal and child health, particularly in areas where rates of HIV transmission from mother to child are high.

Family planning and other basic reproductive health services do not figure prominently in Ireland's current program expenditures, although clearly acknowledged to be relevant components of the country's international population efforts. The country's commitment to reproductive health is best confirmed by its steadily rising contributions to UNFPA, which has occurred in spite of domestic controversy over reproductive health and rights.

Ireland commits a relatively large share of its population assistance bilaterally, but still does not provide much support to NGOs working in sexual and reproductive health. In order to increase the effectiveness of its bilateral efforts, Ireland needs to promote greater collaboration with NGOs (both domestic and in partner countries) and the strengthening of technical expertise within its bilateral aid agency and the NGO community.

1 Development Assistance: Policy and Funding

Ireland's foreign assistance has risen substantially over the past five years. In 2002, ODA reached US$398 million, an increase of more than 25 percent in real terms from 2001. The country's ODA/GNI ratio in 2002 was 0.40 percent, on a par with the average DAC country effort of 0.41 percent. However, Ireland would need to allocate close to $1 billion annually to reach the ODA/GNI goal of 0.7 percent. The Irish government says it remains committed to meeting this goal, despite some recent weakening of the Irish economy.

Ireland's ODA is directed toward reduction of poverty and inequality in least developed countries, and is distinguished by its long-standing support for education and health. Promotion of human rights and gender equity is also a central element, and Ireland has adopted the Millennium Development Goals as its guide in such sectors as education, health, agriculture, and water and sanitation. In addition, cross-sectoral strategies on gender, governance, HIV/AIDS, and the environment also inform the country's overall development efforts.

More than half of Ireland's development assistance is channeled to least developed countries (principally in sub-Saharan Africa), noteworthy as the highest commitment achieved by any DAC member country. Development funds are allocated through regional and local area partnership programs (often involving Irish-based and recipient-country NGOs), multilateral sector-wide approaches, and direct government-to-government budget support.

A number of government bodies are responsible for coordinating the flow of Ireland's development funds. Bilateral development programs are implemented by Development Cooperation Ireland (DCI), which is affiliated with the Ministry of Foreign Affairs. In addition, as part of a recent reordering of development strategies, the Irish government created the Advisory Board of Ireland Aid (ABIA) to help monitor and evaluate project effec-

VITAL STATISTICS

2002 population size:
3.8 million

Total Official Development Assistance (ODA), 2002:
$398 million

ODA as a percentage of GNI, 2002:
0.40%

Total population assistance, 2002:
$11.8 million

Population assistance as percentage of ODA, 2002:
2.96%

Population assistance per $US million GNI, 2002:
$119

tiveness and identify new opportunities for collaboration with partner countries. A third body, the Development Education Advisory Committee, provides the Irish public with information on development efforts. This committee is worth mentioning, as one of the difficulties faced by many donor countries is their publics' lack of awareness regarding development activities.

2 The Policy Environment for International Population Assistance

Recent surveys indicate strong public support for Ireland's international development efforts. The widespread concern about HIV/AIDS has generated awareness about the need to become more active in prevention and treatment. While the Irish government has traditionally shied away from supporting international family planning programs, it has been active in maternal and child health for many years and has recently increased both its support for HIV/AIDS and its contributions to UNFPA.

Future policies on population assistance may be affected by domestic developments. An effort to place further restrictions on abortion in Ireland (the Protection of Human Life in Pregnancy Bill) was defeated in 2002 and suggests that domestic reproductive health policies are gradually becoming more liberal. If so, advocacy groups would have more leverage to push for expanding the range of activities supported by the Irish government overseas.

3 Trends in Funding for Population Assistance

Overall Funding Levels

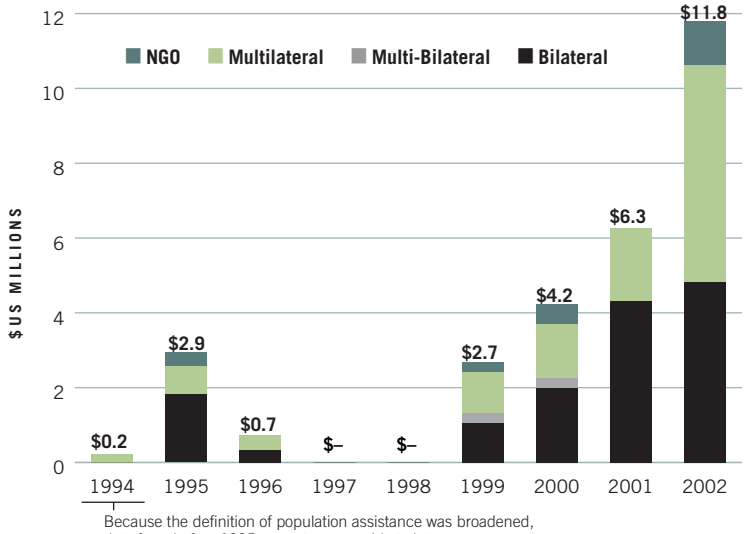
Ireland's support for population and reproductive health activities has increased substantially since 1999, from US$2.7 million to $11.8 million in 2002. By 2002, Ireland was allocating 2.96 percent of its total ODA budget for population activities which, while less than the average DAC country effort of 4.0 percent, represents a dramatically increased share of resources compared to previous years. Population assistance relative to the size of the Irish economy has also become more generous, rising from $54 per million dollars of GNI in 2000 to $119 in 2002 (placing Ireland eighth among all DAC member countries).

In 2002, nearly half the population assistance (the share flowing through multilateral channels) was not classified by type of activity. Of the 51 percent of Ireland's population assistance that was classified, 85 percent was allocated for HIV/AIDS programs, 9 percent for reproductive health activities other than family planning, 4 percent for research, and 2 percent for family planning. As mentioned earlier, the resources flowing to HIV/AIDS efforts present an opportunity to build effective links with programs in reproductive health and maternal health and thus contribute to a more comprehensive HIV/AIDS intervention strategy.

Multilateral Funding

Ireland committed 49 percent of its population funding for multilateral activities in 2002. This is a greater share compared to the previous two years, when just over 30 percent went for multilateral assistance. The country's contributions to UNFPA were also expected to increase significantly, from $1.7 million in 2002 to an estimated $2.9 million in 2003. With respect to HIV/AIDS activities, the government was an early and consistent supporter of the Global Fund to Fight AIDS, Tuberculosis and Malaria. It has pledged $33.1 million since 2002 and has paid much of this amount. Ireland also began making donations to UNAIDS in 1998 and supplied $6.0 million from 1998 through 2003. In addition, it supports other international HIV/AIDS initiatives, including the International AIDS Vaccine Initiative and the International Partnership on Microbicides.

TRENDS IN POPULATION ASSISTANCE 1994-2002: IRELAND



Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002*. New York: UNFPA.

Ireland

C

Bilateral Funding

In recent years Ireland has allocated greater resources for bilateral population assistance. In 2002, bilateral activities represented 41 percent of overall population assistance, and reached their highest level in dollar terms, $4.8 million. As mentioned previously, much of Ireland's bilateral funding has been allocated for HIV/AIDS prevention and treatment in sub-Saharan Africa. However, the Irish government has also modestly increased support for other reproductive health activities, including limited support for the procurement of contraceptive commodities in some country programs.

Funding for NGOs

In 2002, NGOs received about one-sixth of Ireland's total ODA, a high level compared to most other DAC countries. The funds go to NGOs such as Action AID Ireland, Christian Aid Ireland, and Oxfam Ireland. Resource flows for NGOs working in population and reproductive health have not been as generous, however. In 2002, Ireland provided only 10 percent of its total population assistance budget to NGOs, and has yet to make a contribution to IPPF.

Additional ODA resources are expected for five participating NGOs through Ireland's new Multi-Annual Programme Scheme (MAPS), which is designed to promote more effective partnerships between the Irish government and civil society. Funding for education, health, and the environment will be allocated through the MAPS mechanism, and it is hoped that the NGOs will give attention to the linking of reproductive health with HIV/AIDS activities.

4 Program Priorities

Geographic Priorities

Ireland's ODA has traditionally gone to a limited number of least developed countries. In 2002, much of it went to six priority countries in sub-Saharan Africa (Ethiopia, Lesotho, Mozambique, Tanzania, Uganda, and Zambia) and East Timor. As of 2001, Ethiopia, Lesotho, and Mozambique were the leading recipients of Ireland's health spending, while Lesotho, Ethiopia, and Uganda received much of its bilateral HIV/AIDS funding. Some observers are calling on DCI to increase the number of countries receiving Irish ODA, despite concerns that this expansion could dilute the effectiveness of current assistance.

Areas of Program Emphasis

Much of Ireland's health funding is directed toward strengthening primary health care and combating HIV/AIDS. This strategy, first outlined in 1999, is a joint effort of DCI and the Irish Advisory Committee and is reflected in Ireland's strong support for multilateral organizations combating HIV/AIDS. Otherwise, Ireland does not have a formal program of assistance for population and reproductive health, and family planning and other reproductive health efforts do not figure prominently in its bilateral assistance efforts.

5 Technical Capacity

Staffing

DCI continues to face serious human resource constraints. In 2003, it had only 143 staff members either in Dublin or overseas. The organization's human resource situation has been described as dependent on a few key individuals whose departure could seriously compromise the sustainability of certain operations. In addition, the professional qualifications of existing staff are not always adequate for addressing needs in priority technical areas. For example, DCI has recently been encouraged to upgrade the capacity of program staff in HIV/AIDS prevention and treatment protocols. An additional concern is that many senior management positions in DCI are filled by diplomatic staff from the Department of Foreign Affairs, a practice that tends to frustrate the promotion of development specialists within DCI and blur distinctions between foreign affairs and development. Many DCI technical specialists also work on short-term contracts (typically of two-year duration) that compromise the ability to develop long-term core competencies within DCI.

Technical Expertise of Collaborating Institutions

The technical capacity of Ireland's collaborating institutions in reproductive health is difficult to assess, since few NGOs that receive funding from DCI are active in reproductive health. The Irish Family Planning Association, which offers world-class reproductive health care to Irish women, is active in international advocacy for reproductive health and human rights, but is not engaged in delivery of reproductive health services outside Ireland. Several Irish-based NGOs are incorporating HIV/AIDS information and prevention activities into their field projects (e.g., the Irish chapter of World Vision), but such efforts, although noteworthy, are usually not major elements of their field work.

Italy

GRADE

D

1 Development Assistance: Policy and Funding

Italy emerged as a bilateral donor in the 1980s and has had a variable record on overseas development assistance ever since, in both volume and policy. Ranked last among the DAC countries in the late 1970s, Italy increased its aid levels to reach and surpass the DAC average of 0.4 percent of GNI by 1986. Unfortunately, the country did not maintain this trend, and in 1997 aid cuts resulted in an ODA/GNI ratio of just 0.11 percent. In 2002, the country's development aid exceeded US$2 billion (0.16 percent of GNI) for the first time since 1998, only to decline again in real terms in 2003. At least some of this variation is due to slow growth in the Italian economy throughout much of the 1990s and, in 2003, a slip into recession.

The Minister of Foreign Affairs established poverty alleviation as the main priority of the Italian aid program in 2000, and CIPE (Inter-Ministerial Committee for Economic Planning) guidelines provide the policy framework for Italian development assistance, including geographic priorities. Prominent themes include the environment, population, drug abuse, basic education, women in development and the fight against HIV/AIDS.

The Directorate-General for Development Cooperation (DGCS) is responsible for administering bilateral aid under the direction of the Ministry of Foreign Affairs (MFA). A major institutional reform proposed in 2000 was intended to strengthen staff capacity and enable the aid system to manage an increase in ODA, but it was never voted on by parliament, having died in committee. Despite this failure, some structural changes were enacted at the Ministry of Foreign Affairs in January 2000, including the creation of a policy planning unit with a statistical office. This allows the MFA to better collect, process and analyze statistical information on Italy's aid programs. While the creation of this office was a step in the right direction, reporting on its development cooperation programs continues to be a challenge for Italy, at

Italy's contributions to development assistance, including its support for sexual and reproductive health, do not measure up to the size and potential of Italy's economy. The country's population assistance jumped dramatically in 2000, but did not change appreciably in either 2001 or 2002, despite a one-third increase in ODA in real terms between 2001 and 2002. HIV/AIDS now dominates Italy's population assistance program, while support for projects addressing such issues as female genital mutilation/cutting may indicate potential for a more comprehensive approach to sexual and reproductive health. Italy also has the potential to emerge as a leader in multilateral giving and sector-wide funding efforts, but little progress can be made without a significant increase in official development assistance.

Italy has made only limited progress since PAI's last analysis of donor performance (in 1998). With respect to funding alone, the country would need to increase its population assistance more than 15 times over 2002 levels to achieve its fair share of ICPD funding goals for 2005. It should be noted, however, that Italy's significant support for the Global Fund to Fight AIDS, Tuberculosis and Malaria was not reflected in 2002 population assistance figures.

VITAL STATISTICS

2002 population size:
58.1 million

Total Official Development Assistance (ODA), 2002:
$2,332 million

ODA as a percentage of GNI, 2002:
0.20%

Total population assistance, 2002:
$22.6 million

Population assistance as percentage of ODA, 2002:
0.97%

Population assistance per $US million GNI, 2002:
$19

least in part because aid flows from regional, provincial and municipal sources, in addition to the national government.

Unfortunately, Italian development cooperation has suffered a loss in public trust, due in large part to corruption in the awarding of contracts in the 1990s. However, there is strong support for increasing development assistance, particularly among young people. Skepticism about the Italian aid system remains strong, but increased transparency and improvements in monitoring and evaluation could help to restore public trust. Two-thirds of Italians believe that the UN system is the most efficient institution for delivering aid, followed by international and national NGOs.

2 The Policy Environment for International Population Assistance

Having served briefly as Prime Minister in 1994, Silvio Berlusconi was re-elected in 2001 following a series of center-left governments. His coalition government is considerably more conservative and also is expected to be longer-lived than many predecessor governments, and could well last the full five-year term. The influence of the Catholic Church, always strong in Italy, has been increasing, and recent domestic restrictions on fertility treatments were passed with support from Catholics across the political spectrum.

While sexual and reproductive health is mentioned in Italy's bilateral cooperation strategy, funding for population assistance is quite modest. Efforts have been made on specific components of the ICPD Programme of Action, however, and child rights are a top priority for Italian aid. The country has funded bilateral and multilateral efforts in primary education and in prevention of trafficking and sexual exploitation of minors and young women. HIV/AIDS prevention has been part of this effort, with an emphasis on reaching young girls and adolescents. In addition, programs against female genital mutilation/cutting have recently received increased support.

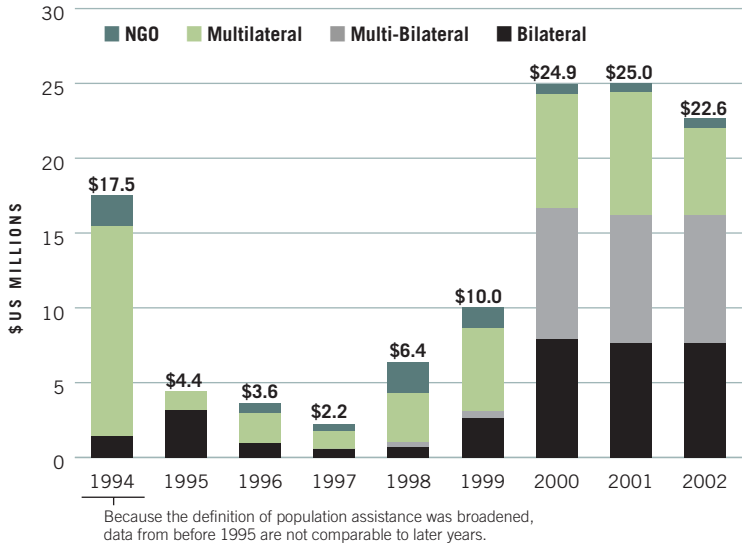
3 Trends in Funding for Population Assistance

Overall Funding Levels

Incomplete reporting makes it difficult to fully assess Italy's funding of sexual and reproductive health activities. Available data indicate a jump in assistance between 1999 and 2000, from $10 million to $25 million, followed by a slight decline to $22.6 million for 2002. Despite these increases, Italy still has one of the lowest funding levels in relation to the size of its economy, providing just $19 in population assistance per million dollars of GNI in 2002. Only Austria, Spain, Portugal and Greece contribute a smaller proportion of national income. Italy's population assistance as a share of total ODA in 2002 was less than 1 percent, well below the average DAC country effort of 4 percent. In 2002, 74 percent of Italy's population funding that flowed through bilateral, NGO and multi-bilateral channels was reported by type of activity. Similar to the pattern of recent years, the bulk of it went to HIV/AIDS activities (82 percent), followed by basic reproductive health (12 percent) and family planning (6 percent).

The Italian development administration appears to have difficulty in reporting annual population-related spending, in part because actual disbursements for projects lag far behind allocations. Furthermore, most of Italy's population-related expenditures are integrated into maternal and child health projects, emergency/relief programs and NGO activities, so it is difficult to disaggregate funding for population activities. Italy's support for sector-wide approaches (SWAps) and other funding mechanisms has

TRENDS IN POPULATION ASSISTANCE 1994-2002: ITALY



NB: 1994 expenditures were not provided to UNFPA and were estimated at the 1993 level. 2001 figures were not fully reported and are estimated at the 2000 level.

Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002*. New York: UNFPA.

only increased the challenge of reporting population-related spending. Italy participated in its first health SWAp in 1997, and has since supported such SWAps in Ethiopia, Mozambique, Angola, Swaziland, and Zimbabwe.

Multilateral Funding
Roughly two-thirds of Italian population aid is channeled either multilaterally (26 percent) or through multi-bilateral arrangements (38 percent). This approach helps situate Italy as a leading donor of several multilateral agencies and initiatives, including the European Commission, the Global Fund to Fight AIDS, Tuberculosis and Malaria and UNIFEM. While this high percentage is due in large part to a lack of bilateral capacity, it does give Italy an opportunity for collaboration and dialogue with the major international institutions.

Italy is a far less generous supporter of UNFPA, providing just $3.0 million in 2002. While this was a welcome increase over its contributions in the late 1990s, Italy has not sustained even this modest level of funding. Its contribution dropped 28 percent in Euro terms in 2003, although changes in exchange rates softened the impact, for an estimated $2.6 million contribution. It should be noted, however, that Italy collaborates with UNFPA to support reproductive health activities in the Middle East and North Africa, in particular in the Occupied Palestinian Territories.

With respect to HIV/AIDS activities, Italy has contributed $200 million to the Global Fund and has pledged an additional $100 million annually for 2003 and 2004. This strong financial support has helped to position the country as a leader on the Global Fund's board. Italy's contributions to UNAIDS, however, have been somewhat more modest: $1.8 million in 2002, placing it 14th among the Joint Programme's donors.

Bilateral Funding
The jump in Italy's overall population assistance is seen in its bilateral aid, which rose from less than $1 million annually in the late 1990s to close to $8 million in 2002. The percentage devoted to bilateral funding also increased, from 26 percent of overall funding in 1996 to 34 percent in 2002.

Funding for NGOs
Italy has channeled a declining share—and fewer dollars—of its population assistance through NGOs since 1998. In 2002, less than 3 percent of support for sexual and reproductive health went to NGOs, little more than $600,000. Italy's apparent disinterest in funding reproductive health NGOs extends to IPPF, to which Italy has never contributed.

Italy still has one of the lowest funding levels in relation to the size of its economy, providing just $19 in population assistance per million dollars of GNI in 2002.

4 Program Priorities

Geographic Priorities
Almost half of Italian bilateral aid distributed in 2000 was for sub-Saharan Africa (45 percent). Other priority areas included the Middle East and North Africa, Latin America and the Caribbean, and the Balkans. Priority countries include those in the greater Horn of Africa—including Eritrea, Ethiopia, Kenya, Uganda and Sudan—plus Mozambique, Tunisia, Morocco, and the Occupied Palestinian Territories. Some of these same countries are leading recipients of Italy's population assistance, such as Ethiopia, Eritrea, and Mozambique, as are Algeria and Nigeria. While Italy did not supply information on the ranking of recipient countries, other sources indicate that these same countries figure prominently in Italy's support for sexual and reproductive health, as do Cuba and several Balkan states.

Areas of Program Emphasis
Poverty reduction and the fight against HIV/AIDS are the two top priorities of Italian development policy. The latter priority is strongly reflected in projects Italy supports in the Balkans, sub-Saharan Africa and the Caribbean (primarily Cuba). Both priorities could benefit by more fully incorporating reproductive health into their programming, as integrating attention to reproductive health into HIV/AIDS activities is important in fighting the spread of the epidemic. In addition, comprehensive reproductive health care plays a vital role in poverty reduction. According to existing gender guidelines, Italy does seek to strengthen women's role in the political process, highlight the role of women in poverty reduc-

Poverty reduction and the fight against HIV/AIDS are the two top priorities of Italian development policy.

tion efforts, and strengthen programs to support reproductive health. Yet it is so far unclear to what extent these policies have been put into practice, highlighting the need for ongoing monitoring by advocacy groups of this and other aspects of Italy's response to the ICPD.

Emergency humanitarian aid continues to be a strength of Italy's development assistance and one area where reproductive health is supported. Through an agreement with the Red Cross, the Italian military uses trained gynecologists and midwives to integrate reproductive health interventions into its peacekeeping efforts. This is particularly important for women refugees, who are often at increased risk of pregnancy and in need of counseling and contraception as well as care in pregnancy and childbirth.

5 Technical Capacity

External observers perceive little technical depth in reproductive health and population within Italy's Ministry of Foreign Affairs. High turnover and the use of career diplomats in management positions continue to challenge staff efficiency and effectiveness. A team at the DGCS focuses exclusively on HIV/AIDS, but observers believe greater efforts are needed if this group is to integrate sexual and reproductive health concerns into its work.

Despite its historically limited reliance on Italian NGOs for population programming, the government has expanded its support for groups working in this field, particularly in HIV/AIDS. A recently created network, the NGO Observatory on HIV/AIDS, brings together nearly two dozen development NGOs that undertake HIV/AIDS projects, many of them supported by the Italian government. The Observatory is actively engaged with the Foreign Affairs Ministry in order to ensure the effectiveness of Italian aid in this area. This has included several missions to evaluate Global Fund initiatives at the local level. Among the NGOs involved in this effort is AIDOS (the Italian Association for Women in Development), which undertakes projects on a range of sexual and reproductive health issues, bringing to bear a holistic, integrated approach to its work. AIDOS is active in the advocacy arena, working to educate policymakers about the importance of sexual and reproductive health to overall development. Due to its efforts, an informal parliamentary support group was established in 2002 to help influence Italian development policy on reproductive health and population issues.

Japan

GRADE

B

Japan's ODA has fallen substantially in recent years as a result of the country's persistent economic downturn. Despite this, the country increased its population assistance to a record high in 2002. Much of this increased funding was allocated to NGO programs, which signals Japan's growing resolve to collaborate with NGOs and civil society organizations working in international reproductive health. This growing support for NGOs may have come at the expense of the country's long tradition of support for multilateral organizations. After being UNFPA's largest contributor during much of the 1990s, Japan has begun to falter in its annual contributions and is now the second largest donor after the Netherlands. It is still the largest donor to IPPF, but its contributions to the Federation have also declined since the 1990s.

Japan remains a strong supporter of the ICPD Programme of Action and is concerned by signs that family planning and reproductive health may be slipping as program priorities within the international community. The Japanese government continues to direct most of its population resources to basic reproductive health (which often includes family planning services) rather than HIV/AIDS, although the share of funding allocated for HIV/AIDS is expected to rise substantially in the near future. Given the government's strong backing of ICPD, it is hoped that future increases in funding for HIV/AIDS activities will be linked with its support for basic reproductive health.

Japan's near-doubling of assistance in 2002 represents a positive sign for the future, but the country still falls far short of meeting its fair share of ICPD spending goals. Given the large size of its economy, Japan would need to increase its 2002 funding nearly seven times by 2005, to more than $1 billion, to fulfill its fair share as a donor.

1 Development Assistance: Policy and Funding

Japan is no longer the world's largest development donor. Between 2000 and 2002, the country's ODA tumbled from US$13.5 billion to $9.3 billion, a decline of more than 28 percent in real terms, while its ODA/GNI ratio fell to 0.23 percent in 2002. Much of this can be attributed to across-the-board reductions in government spending because of the country's decade-long economic recession.

Despite this erosion in ODA, Japan committed substantial resources to combating the Asian economic crisis of the late 1990s, supplying $44 billion in 1997 to the International Monetary Fund (IMF), the Association of Southeast Asian Nations (ASEAN), and national financial reform activities. It also contributed an additional $33 billion through Miyazawa Initiatives to help stabilize the currencies of many Southeast Asian nations, and provided additional help to vulnerable groups most severely affected by the Asian economic downturn.

Today, the Japanese Ministry of Foreign Affairs (MOFA) sees the attainment of the UN's Millennium Development Goals as the primary objective of Japan's foreign assistance. This new orientation places greater importance on human-centered social development programs and is reflected in Japan's recently revised ODA charter, which gives priority to poverty reduction; promotion of sustainable economic growth; addressing environmental and social development issues; and peacebuilding. These concerns are echoed in the country's

VITAL STATISTICS

2002 population size:
127.4 million

Total Official Development Assistance (ODA), 2002:
$9,283 million

ODA as a percentage of GNI, 2002:
0.23%

Total population assistance, 2002:
$180.2 million

Population assistance as percentage of ODA, 2002:
1.94%

Population assistance per $US million GNI, 2002:
$44

championing of untied aid and generosity with regard to debt relief in many developing countries. Japan also gives considerable weight to capacity building through investment in human resources and infrastructure. One aspect of this type of investment is the number of foreign students supported for graduate degrees at Japanese universities.

Even with this reorientation toward investment in human resources, Japanese aid officials sometimes express frustration that their country is not always given sufficient credit for its considerable financial and technical contributions to global development. Japan's reputation is that it concentrates on the "hard side" of infrastructure investment rather than the "soft side" of social development, an emphasis that stems from its own postwar reconstruction experience and the sheer size of its ODA budget.

Japan's ODA is administered through MOFA, the Ministry of Finance (MOF), and the Ministry of Economy, Trade and Industry (METI). Overall policy and financial coordination are jointly managed by MOFA and MOF, which coordinate all Japanese ODA going to the World Bank and other regional development banks, while the Ministry of Foreign Affairs is the primary coordinating body for all Japanese assistance. The Japan International Cooperation Agency (JICA) is responsible for technical cooperation, with final authority on program strategies and project selection falling to MOFA. JICA has recently been reorganized to have more independence and autonomy, but overall program direction will still be approved by MOFA.

With respect to policies concerning how funds are allocated, much of Japan's bilateral foreign assistance to developing countries operates on a "request basis," and projects are designed and implemented with local partners as much as possible. Japan also gives great attention to countries' absorptive capacity when deciding on program allocations, and tries to enhance institutional capacity through training, infrastructure strengthening, and transfer of technology and knowledge.

Japan is not currently participating in sector-wide ("basket") funding mechanisms, although it has provided public-sector budget support to developing countries in the past. The issue of whether future ODA should comingle with other donor resources in sector-wide approaches (SWAps) is under review at MOFA. Given the requirements of Japan's financial reporting systems and difficulty in committing to multi-year funding cycles, SWAp programs are not always practical.

2 The Policy Environment for International Population Assistance

Japanese development assistance declined during the 1990s as economic conditions became more difficult at home. The general public increasingly wants domestic problems to be dealt with first, before the needs of developing countries. This sentiment appears stronger among young people, suggesting that the government needs to do more to inform the public about the objectives and merits of its international development efforts.

Generally, the Japanese public shows broad agreement that progress in family planning and population will require greater efforts to promote overall social development, in particular girls' education. The concept of reproductive health is not well understood by the public, however, as the term cannot be translated easily into Japanese, compared to the more familiar concept of family planning. Opinion polls have found low awareness of the reproductive health concept (although it is unclear whether this response is unusual compared to other countries).

Issues of faraway countries with high fertility and rapid population growth also can seem remote for a country with low fertility and a rapidly aging population. Japanese officials note that Japan's demographic transition to low fertility and mortality occurred without organized national family planning programs or international technical collaboration, which gives rise to the question of why other countries cannot take inspiration from this model.

Nonetheless, Japan continues to support the goals of the ICPD Programme of Action and, indeed, some officials have expressed dismay that reproductive health and family planning are not explicitly part of the UN's Millennium Development Goals. They fear that the Cairo agenda may have lost some of its immediacy, and point

Population assistance still represents a relatively small share of Japan's overall ODA.

out that many elements of the Programme of Action remain critical development priorities.

3 Trends in Funding for Population Assistance

Overall Funding Levels

As mentioned above, despite recent cutbacks in Japan's ODA budget, support for international population and reproductive health programs actually rose: going from $130.7 million in 2000 to $180.2 million in 2002. This is a record for Japan's population assistance and compares well with reported annual outlays of less than $100 million throughout most of the 1990s.

While these recent gains are impressive, population assistance still represents a relatively small share of Japan's overall ODA. In 2002, population funding amounted to just 1.9 percent of total ODA—again, an improvement over earlier levels—but not comparable to such countries as the United States (7.3 percent), Finland (5.3 percent), and the Netherlands (4.9 percent). Japan's support for population programs is also underwhelming when measured against the size of its economy. In 2002, its population assistance was $44 per million of GNI. Only Italy, Austria, Spain, Portugal, and Greece committed fewer resources to this area in relation to the size of their economies.

Much of Japan's population assistance is provided through multilateral organizations, and thus is not identified by type of activity. The one-third that is reported by activity suggests that Japan is placing considerable emphasis on basic reproductive health programs and HIV/AIDS. In 2002, family planning received 5 percent of Japan's allocable resources, other reproductive health programs 71 percent, HIV/AIDS programs 23 percent, and research 1 percent.

As for the future, it remains to be seen whether Japan's international population funding will continue to rise, given the continuing economic recession and downward pressure on ODA budgets. New commitments to provide money for rebuilding Iraq may also compromise resources for health and social development in other regions.

Multilateral Funding

In 2002, 34 percent of Japan's population funding went to multilateral organizations, and an additional 4 percent was supplied through multi-bilateral mechanisms. UNFPA was the largest recipient of Japan's multilateral funding. In 2002, Japan contributed $39.5 million to UNFPA (16.2 percent of the organization's total budget) and was UNFPA's second largest supporter after the Netherlands. However, Japan's level of support in 2002 was considerably below its 2000 contribution of $49.7 million. Japan's annual UNFPA contribution has not recovered to earlier peak levels, remaining at $39.5 million in 2003.

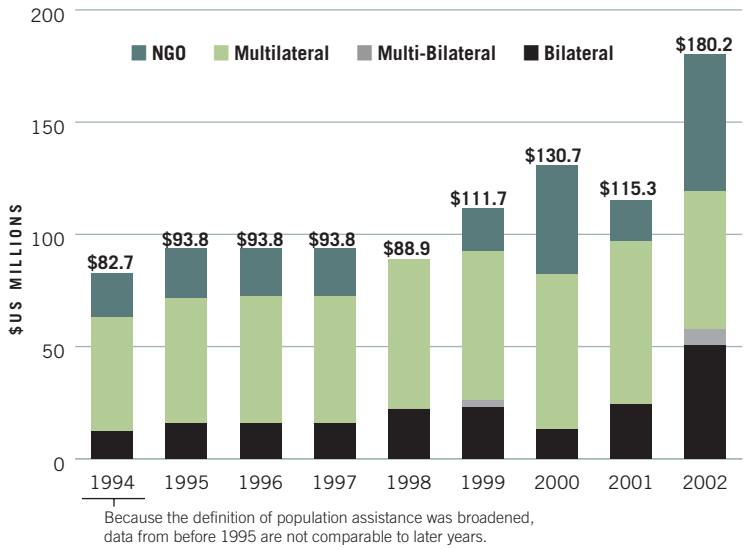
Japan has been a major contributor to the Global Fund to Fight AIDS, Tuberculosis and Malaria since its inception in 2002. It pledged $259.9 million between 2002 and 2004, including a supplemental authorization of $40 million in 2004 announced in December 2003 by Prime Minister Junichiro Koizumi. In addition, the Japanese government has been the seventh largest contributor to UNAIDS since 1995, although its support declined from $5.6 million in 2002 to $4.8 million in 2003. Japan was also instrumental in giving HIV/AIDS and other infectious diseases priority attention at the G8 Kyushu-Okinawa Summit in July 2000.

Multi-bilateral funding mechanisms are also becoming a more common feature of Japanese population assistance. Between 1994 and 2001, JICA worked with UNFPA in 19 countries to support provision of reproductive health services, including the supply of essential equipment and supplies. This was notable in that it was the first time Japanese ODA was used to procure supplies, including contraceptives, as Japanese regulations had previously not allowed ODA resources to be used for this purpose.

Bilateral Funding

In 2002, 28 percent of Japan's population funding was

TRENDS IN POPULATION ASSISTANCE 1994-2002: JAPAN



NB: 1996 and 1997 expenditures were not reported to UNFPA and both were estimated at 1995 level. In 1995, Japan used a broader definition of population assistance than the one used by UNFPA, so its contributions were recalculated to fit UNFPA's definition.

Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002*. New York: UNFPA.

B

The government has voiced strong support for the ICPD Programme of Action and has made noteworthy efforts to incorporate elements of the Cairo agenda into a more "comprehensive" approach to reproductive health programming.

delivered directly through JICA. Given the increase in overall population assistance, this larger share meant more than a doubling of funds, to more than $50 million.

During the 1990s, the Global Issues Initiative in Population and HIV/AIDS (GII) was the centerpiece of Japan's population assistance. The GII grew out of the US-Japan Common Agenda for Cooperation in Global Perspective, which sought to coordinate objectives and pool resources to address priority development issues from 1993 to 2000. It committed a total of $3 billion to developing country programs between 1994 and 2000 and gave direct and indirect support for population activities like family planning, maternal and child health care, primary health care, education (both primary and vocational), the provision of HIV/AIDS testing equipment, and HIV/AIDS surveillance research. The main GII objective was to develop more comprehensive programming and improve coordination of grant aid, including JICA's partnerships with other donors. Much grant aid, including JICA's GII funding, went for materials and equipment, including contraceptive supplies, and 16 priority countries—primarily in Asia and sub-Saharan Africa—received population assistance through GII. JICA and USAID recently signed a new follow-on US-Japan Partnership in International Health, but it is not yet clear what this new partnership will entail, which organizations will participate, or how it will be implemented.

The GII has also been followed by the Okinawa Infectious Disease Initiative (IDI) that focuses on HIV/AIDS, malaria, and tuberculosis. A new Hashimoto initiative on parasitic disease is also being pursued. These new programs respond to newly emerging global health needs, but some activists are concerned that the recast agenda may demote reproductive health and family planning as a program priority.

Funding for NGOs

Through most of the 1990s, the bulk of Japan's population assistance directed to NGOs went to IPPF. This pattern began changing in 2000, when support for NGOs more than doubled. In 2002, NGOs received 34 percent, or more than $60 million, for sexual and reproductive health activities, although this figure may also reflect how Japan's contributions to the Global Fund were recorded. Even so, the general trend indicates Japan's growing openness to supporting NGOs, particularly foreign-based groups, although NGOs registered in Japan also are increasingly encouraged to submit funding proposals to JICA.

Japan continues to be the world's largest contributor to IPPF. In 2002 it provided $14.7 million through a direct government grant and another $1 million through the Japan Trust Fund, providing in total 16.8 percent of IPPF's overall budget. However, despite being the Federation's leading contributor, Japan's contributions actually fell from $19.2 million in 2001 to $15.7 million in 2002, and the level of recent years is also substantially below that achieved during the 1990s.

4 Program Priorities

Geographic Priorities

Japan's ODA is directed primarily to countries in Asia, with China, Indonesia, and Thailand the largest recipients in 2001. In the health sector, Japan's bilateral programs support family planning and health in Bangladesh, Jordan, Laos, and Vietnam; maternal and child health services in Brazil, Indonesia and Mongolia; offer HIV/AIDS diagnosis and treatment in Kenya, Mexico, and Vietnam; and help control infectious disease in Tanzania, Thailand, and Turkey. More Japanese help for sub-Saharan Africa now appears likely, in response to the devastating impact of the HIV/AIDS pandemic.

Areas of Program Emphasis

Japan has provided assistance for international family planning programs since 1969. The country's international cooperation in population has traditionally emphasized family planning education and services as well as

maternal health and child survival. The government has voiced strong support for the ICPD Programme of Action and has made noteworthy efforts to incorporate elements of the Cairo agenda into a more "comprehensive" approach to reproductive health programming. While officials emphasize that Japan remains committed to population assistance, how exactly this will play out in the future is a little unclear, as family planning and reproductive heath are subsumed under maternal and child health efforts.

Some insight into the direction of Japan's population assistance can be gained from JICA's new reproductive health strategy paper that outlines future reproductive health needs and sets program priorities. The report, entitled *Approaches for Systematic Planning of Development Projects (Reproductive Health)*, identifies family planning, safe motherhood, and adolescent services as key components of JICA's future reproductive health assistance. Priority regions will be sub-Saharan Africa, the Middle East, and South Asia. It also recommends a combination of strategies for future reproductive health assistance, including comprehensive problem identification, long-term development of program capacity, gender analysis in planning, advocacy to promote sound program design in recipient countries, and the greater use of multi-sector approaches. The report also states that Japan's future ODA allocations will likely give greater attention to HIV/AIDS and the control of infectious and parasitic diseases.

5 Technical Capacity

Staffing

Japan's foreign assistance programs tend to be understaffed in comparison with other DAC countries. JICA has few technical specialists in population and reproductive health. Instead, it relies for technical support on outside organizations such as the Japanese Organization for International Cooperation in Family Planning (JOICFP), the oldest NGO in this field, and the International Medical Center of Japan (IMCJ). JICA has traditionally coordinated the supply of technical assistance, but it has not been in a position to supply such services directly. The lack of sufficient technical support personnel in JICA's overseas missions is a particular problem, especially with recent efforts to decentralize more management to the field. As a result, program evaluation is a continuing challenge.

Technical Expertise of Collaborating Institutions

JOICFP is the principal collaborating institution supporting JICA's population and reproductive health program. JOICFP in turn supports a network of overseas NGOs that undertake advocacy and program activities. The organization sees implementation of the Cairo Programme of Action as central to its mission. Its main activities include direct project support; advocacy campaigns to promote reproductive health programs among Japanese policymakers and the general public; and human resource development. JOICFP programs range from advocacy and educational activities to reproductive and child health service delivery.

In recent years, JOICFP has collaborated in implementing adolescent sexuality and reproductive health projects in several South and Southeast Asian countries in the Asia-Pacific region. JOICFP also served as the first secretariat of the Asia-Pacific Alliance, a network of NGOs, donor agencies and foundations dedicated to increasing support for the ICPD Programme of Action and the Millennium Development Goals.

While JOICFP provides world-class technical assistance in population and reproductive health advocacy, training, and service provision, other NGOs (both domestic and recipient-country) have broad scope to participate in Japan's development programs. Certainly, greater investment in host country NGOs will be necessary in order to strengthen south-to-south collaboration. The recent jump in Japan's population assistance suggests that the country will require a wider range of technical specializations in the future, highlighting the need for adequate resources focused on capacity building for the NGO community.

In addition to their role as a source of technical expertise, a number of Japanese NGOs are active in the policy arena. The Japan Parliamentarians Federation for Population (JPFP), established in 1974 by former Prime Minister Nobusuke Kishi, provides as important forum for discussion of population and development issues. JPFP has around 140 members in the two houses of Japan's Parliament on various sub-committees dealing with international cooperation. In addition to better informing Japanese parliamentarians about global development needs, JPFP has been instrumental in securing ODA resources for JICA's family planning and reproductive health programs and annual contributions to IPPF and UNFPA. The Asian Population and Development Association (APDA) operates as the secretariat of the JPFP.

Also active on policy issues is NPO 2050. Established in 1994, this organization works to raise awareness among the public and policymakers of population and environment issues, and seeks to mobilize resources for programs to improve the socio-economic status of women, in particular education, micro-enterprise, and reproductive health care.

Luxembourg

GRADE

A-

Luxembourg is becoming a more important donor in sexual and reproductive health, relative to the size of its economy, and its population assistance increased nearly seven-fold between 1996 and 2002. Much of this support went to HIV/AIDS programs in sub-Saharan Africa which, combined with its contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria, illustrates the priority Luxembourg assigns to fighting the pandemic. The country's modest bilateral funding for other aspects of sexual and reproductive health is complemented by its increasingly consistent support for UNFPA.

While Luxembourg supports the ICPD Programme of Action and has taken steps to incorporate gender equality and human rights in its development activities, it still lacks a formal policy on sexual and reproductive health. Developing such a strategy should be an important priority, given the increase in Luxembourg's population assistance and the share of the country's resources allocated through bilateral and NGO channels. Furthermore, ensuring that basic reproductive health services are linked to HIV/AIDS programs will allow the country to both maintain its support for HIV/AIDS, and also address the importance of comprehensive sexual and reproductive health services. Such services are vital in maintaining the health of a population and in stemming the tide of HIV/AIDS.

1 Development Assistance: Policy and Funding

A small donor in absolute terms, Luxembourg has become one of the more generous providers of foreign assistance relative to national income. Its official development assistance has risen by 18 percent since 1995, reaching US$147 million in 2002. In the same year, Luxembourg's ODA/GNI ratio stood at 0.77 percent. Only Denmark, Norway, and the Netherlands can claim to be more charitable relative to the size of their economies. The country intends to increase its development spending to 1 percent of GNI in future years, a commitment reaffirmed by the government elected in June 2004.

The main goal of Luxembourg's foreign aid is to reduce poverty in the world's least-developed countries. It emphasizes a limited number of development sectors—health, education, water and sanitation—while identifying gender and HIV/AIDS as crosscutting priorities. As of 2002, 43 percent of Luxembourg's ODA was allocated to 10 of the world's poorest countries, and 82 percent was spent on the sectors identified above.

The Ministry of Foreign Affairs and Immigration (MAE) coordinates Luxembourg's foreign assistance programs, while Lux-Development (a non-profit private company owned by the government, in partnership with professional associations and private-sector organizations) implements almost all of the country's bilateral aid. This unusual arrangement was adopted in order to allow Lux-Development more autonomy in its operations and greater flexibility in its management.

2 The Policy Environment for International Population Assistance

While Luxembourg's international development assistance has wide public support, it is not clear whether aid for population activities is accorded similar enthusiasm.

VITAL STATISTICS

2002 population size:
0.5 million

Total Official Development Assistance (ODA), 2002:
$147 million

ODA as a percentage of GNI, 2002:
0.77%

Total population assistance, 2002:
$7.5 million

Population assistance as percentage of ODA, 2002:
5.07%

Population assistance per $US million GNI, 2002:
$391

At the policy level, however, Luxembourg appears increasingly willing to take on these issues, as seen in support for UNFPA in the wake of a U.S. decision to stop funding the organization in 2002.

Elections held in June 2004 appear unlikely to affect Luxembourg's current policy direction, whether on development cooperation policy generally or with respect to population assistance. To date, however, Luxembourg does not have a fully developed strategy for its funding of reproductive health or HIV/AIDS activities.

3 Trends in Funding for Population Assistance

Overall Funding Levels

Luxembourg made impressive strides in support for sexual and reproductive health activities during the 1990s. Population assistance rose from little more than $100,000 in 1994 to $10.7 million in 2000. But in the following two years, assistance was significantly lower at $5.6 million in 2001 (4 percent of total ODA) and $7.5 million in 2002 (5 percent). It is not clear whether these declines reflect a shift in priorities or project cycle variations.

Still, Luxembourg remains the world's fourth most generous donor for population programs in terms of its level of economic activity. In 2002, it contributed $391 per million dollars of GNI. Only Denmark, Norway, and the Netherlands had a more impressive record in that year. Luxembourg's population assistance was heavily weighted toward HIV/AIDS activities. Of the 57 percent of the 2002 population budget reported by type of activity, 79 percent was allocated to HIV/AIDS, 11 percent to family planning, and 10 percent to other reproductive health interventions.

Multilateral Funding

Luxembourg provided 18 percent of its population assistance through multilateral channels in 2002. While the country historically has not been a major contributor to UNFPA, it has increased its annual contributions, from half a million dollars in 2002 to an estimated $821,000 in 2003. In 2004, Luxembourg signed a multi-year funding agreement with UNFPA as a sign of its ongoing support for the organization. Multilateral organizations combating HIV/AIDS have also benefited: Luxembourg has donated $4.5 million to the Global Fund to Fight AIDS, Tuberculosis and Malaria since 2002, and $3.4 million to UNAIDS between 1995 and 2003. Given the small size of Luxembourg's economy, these are generous levels of support.

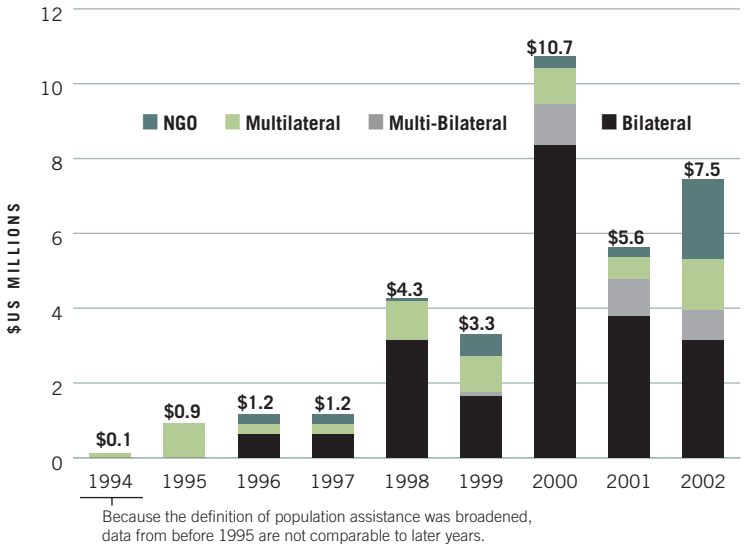
Bilateral Funding

Luxembourg allocated 42 percent of its population assistance through its bilateral aid program in 2002. While lower than in 2000 and 2001, the government appears committed to increasing its bilateral programs over the longer term. It is also making greater use of multi-bilateral arrangements that allow the country's resources to be merged with the funds of other donors and multilateral organizations for specific projects. Eleven percent of its population resources moved through multi-bilateral channels in 2002.

Funding for NGOs

The government has a long history of collaborating with NGOs in partner countries, but its funding levels for NGOs in reproductive health have been highly variable from year to year, whether due to project cycles or inconsistent reporting. For example, in 1996, 24 percent of the country's population assistance flowed through NGOs, only to fall below 6 percent in 2000. In 2002, NGOs received record funding of more than $2 million, which

TRENDS IN POPULATION ASSISTANCE 1994-2002: LUXEMBOURG



NB: Figures on expenditures for 1997 were not provided, and are estimated for that year at the 1996 level. Information on 2001 expenditures was not fully reported, so project and program figures for that year are based on 2000 data.

Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002.* New York: UNFPA.

Luxembourg

A-

Luxembourg remains the world's fourth most generous donor for population programs in terms of its level of economic activity.

represented more than a quarter of total population assistance. Luxembourg does not contribute to IPPF, however.

4 Program Priorities

Geographic Priorities
Luxembourg's ODA is largely dedicated to 10 partner countries and its population assistance is concentrated in these same countries (both bilateral resources and multilateral projects implemented by UNFPA). These countries are Burkina Faso, Cape Verde, El Salvador, Laos, Mali, Namibia, Nicaragua, Niger, Senegal and Vietnam. In recent years, it has also begun to provide funding for HIV/AIDS programs in other sub-Saharan African countries, such as Rwanda.

Areas of Program Emphasis
In 2002, spending on health and social services represented about 30 percent of Luxembourg's bilateral project assistance. Health projects included HIV/AIDS prevention (mainly in sub-Saharan Africa and Vietnam), primary health care, health facility infrastructure, and water/sanitation. Family planning or other reproductive health activities were addressed in Luxembourg's bilateral aid, although resources for these areas were small compared to the rapidly expanding budgets for HIV/AIDS programming.

Luxembourg is among the sponors of the ESTHER initiative (from the French, "Ensemble pour une Solidarité Thérapeutique Hospitalière en Réseau contre le SIDA"). Begun in 2002 by France, Italy, Luxembourg and Spain, ESTHER involves some 60 hospitals in these four countries working in collaboration with hospitals in 22 developing countries in Africa, Asia and Latin America. The initiative is based on the idea that concrete partnerships between Northern and Southern hospitals will allow for a more effective exchange of technical and material assistance in support of comprehensive AIDS treatment programs for larger numbers of people.

Currently, Luxembourg supports the ESTHER initiative in Rwanda, "twinning" two of its hospitals with two in Rwanda, one of which faces a 70 percent HIV prevalence rate among hospitalized patients. In March 2004, Germany, Austria, Belgium and Portugal joined the initiative.

5 Technical Capacity

With the rapid expansion of Luxembourg's ODA in recent years comes concern that technical staff may be insufficient to effectively design and manage the country's bilateral aid program. Lux-Development has doubled its permanent professional staff at headquarters to more than 50 over the past two years, while another 100 expatriate and consultant personnel are also involved with administering its portfolio of development projects.

Close to 80 Luxembourg NGOs are engaged with the government on development policy and programmatic issues, of which more than a dozen have long-term "framework" funding agreements with the Ministry of Foreign Affairs. Currently, for example, the Ministry of Foreign Affairs has two multi-year framework agreements with the Luxembourg section of Médecins sans Frontières that includes support for an integrated HIV/AIDS program in Mozambique. Co-financing agreements and project support are other mechanisms through which the government funds NGOs. Government funding for Luxembourg NGOs working in sexual and reproductive health is limited, however, except with regards to HIV/AIDS, most likely due to the small number of NGOs in the field and their limited ability to undertake activities overseas.

The Netherlands

GRADE

A

The Netherlands has been a generous contributor to international reproductive health programs in the years since the ICPD, and its annual population assistance roughly doubled between 1995 and 2002. The Netherlands also has the distinction of being UNFPA's largest financial supporter, providing slightly more than 20 percent of the agency's budget in 2003. It has greatly increased its funding for HIV/AIDS programs over the past decade, but has made efforts to integrate its reproductive health and HIV/AIDS activities, rather than encouraging the formation of separate programs. This desire for integration ensures that in rising to the challenge posed by HIV/AIDS, sexual and reproductive health services—so essential to the health needs of a population and a necessary part of HIV/AIDS prevention—are not forgotten.

In addition to providing resources for basic reproductive health services (including family planning) and supplies, the Netherlands has taken the lead in supporting activities that other donors have been slow or reluctant to fund, including post-abortion care and programs for adolescents. The country has also been at the forefront of efforts to integrate sexuality, reproductive rights and gender equity into population assistance. Gender is a crosscutting issue throughout Dutch development cooperation.

Political and public support for international population assistance remains strong in the Netherlands.

However, concern is growing that sexual and reproductive health may be receiving less attention in the Dutch foreign aid program. As the government increases support for sector-wide approaches and "basket-funding" mechanisms, it may become more difficult to direct resources to reproductive health activities. The continuing effort to decentralize much development assistance to embassies may also make coordinated reproductive health programs more difficult, while development "theme experts" now assigned to embassies may not always have sufficient technical backgrounds in reproductive health and HIV/AIDS.

1 Development Assistance: Policy and Funding

The Netherlands continues to be one of the world's most generous donor countries relative to the size of its economy. In 2002, it contributed US$3.3 billion in ODA, or 0.81 percent of GNI (second only to Denmark) and has remained close to that percentage for much of the past decade.

Dutch assistance currently places great reliance on sector-wide approaches, which allow recipient countries to choose the form in which to receive aid and to take greater responsibility for executing their own programs. The government has reduced the number of recipient countries in recent years so that resources can be concentrated for greater effectiveness, and has also reduced its focus to fewer sectors. The Netherlands no longer wants to finance a large number of small stand-alone projects.

The Ministry of Foreign Affairs (MFA) coordinates Dutch foreign assistance. Within the MFA, the

VITAL STATISTICS

2002 population size:
16.1 million

Total Official Development Assistance (ODA), 2002:
$3,338 million

ODA as a percentage of GNI, 2002:
0.81%

Total population assistance, 2002:
$164.3 million

Population assistance as percentage of ODA, 2002:
4.68%

Population assistance per $US million GNI, 2002:
$399

Department of Social and Institutional Development (DSI) is responsible for implementing sexual and reproductive health programs, while the Minister for Development Cooperation is responsible for ensuring that foreign assistance funds are spent as specified in the budget and that program strategies are compatible with the overarching goal of reducing poverty.

Development cooperation policies are also guided by the Coalition Agreement of the 1998 Dutch government, which highlights sustainable development and preservation of the environment as priority objectives. In keeping with this policy guidance, health has been selected as a priority area in 12 countries, while other sectors receiving attention are education, water and sanitation, rural development, and small enterprise development. When selecting countries to receive assistance, extreme poverty is the most important Dutch criterion. Other criteria include sound socio-economic policies, good governance, and adherence to human rights.

2 The Policy Environment for International Population Assistance

The Netherlands still ranks as one of the most generous supporters of international reproductive health programs and the ICPD Programme of Action. Dutch leadership in international population assistance is still strongly supported by the Dutch public, and no lessening is evident in the country's resolve to remain engaged internationally. However, policy decisions since 2002 by the new Christian Democrat-led government suggest some weakening in the country's long-standing progressive approach to sexuality and reproductive health issues. Since 2004, Dutch women above the age of 21 have had to pay for contraception, leading to worries that the country's increasing abortion and adolescent pregnancy rates may continue upward, especially among poor and minority women.

In mid-2004, the Netherlands assumed the presidency of the European Union with the intention of using its six-month term to highlight the importance of sexual and reproductive health and rights in the context of development assistance. This kind of activism in support of these issues is important given the expansion of the EU to 25 countries earlier in the year and coming changes in the organization and leadership of the European Commission.

3 Trends in Funding for Population Assistance

Overall Funding Levels

Total population assistance from the Netherlands has increased dramatically since the 1994 ICPD, rising from $43.8 million in 1994 to $164.3 million in 2002. However, substantial annual fluctuations have occurred that may partly reflect yearly shifts in ODA, changes in the methodology used to tally resource flows, and altered project funding requirements. In 2002, the Netherlands allocated 4.9 percent of its total ODA to reproductive health and population programs, the fourth highest allocation after the United States (7.3 percent), Finland (5.3 percent), and Luxembourg (5.1 percent). The Netherlands ranked third among all DAC countries in terms of population funding relative to wealth, contributing $399 per million dollars of GNI. Only Denmark and Norway were more generous. It should be noted that the Netherlands has recently signaled it will not be overly concerned with achieving quantitative goals for its population assistance in future years, but will instead focus more on the effectiveness of its programs.

In 2002, the 66 percent of Dutch population assistance that was channeled through multilateral and NGO organizations was not broken down by type of activity. It is therefore not possible to give a full accounting of the population program areas Dutch aid supports. Of the resources that can be tracked, 56 percent supported HIV/AIDS programs, 41 percent went to reproductive health activities other than family planning, 2 percent went for family planning, and 1 percent for research. Like many European donors, the Netherlands

Total population assistance from the Netherlands has increased dramatically since the 1994 ICPD, rising from $43.8 million in 1994 to $164.3 million in 2002.

appears to be providing fewer resources for family planning than in previous years, although this apparent cutback may be due in part to the increasingly integrated nature of some reproductive health services and confusion on how to report these new program structures.

Multilateral Funding

In both 2001 and 2002, the Netherlands channeled more than $100 million of population assistance to multilateral organizations, the highest level of assistance among all the DAC donor countries, and equal to 61 percent of the country's population assistance in 2002. UNFPA is the single largest recipient of Dutch multilateral population assistance. In recent years, the Netherlands has been the leading contributor to UNFPA, providing $57.1 million in 2002 and an estimated $66 million in 2003. The Dutch government has also supported UNFPA's procurement of contraceptives and condoms, most notably in 2000, when it gave more than $40 million for this purpose. Dutch support for reproductive health is also demonstrated by contributions totaling more than $7 million (from 2000 through 2003) to the World Health Organization's special program of research on human reproduction.

The country is also a major supporter of multilateral efforts to stem the global HIV/AIDS epidemic. The Netherlands is a generous supporter of the Global Fund to Fight AIDS, Tuberculosis and Malaria: it has pledged $159.5 million to the Fund since 2001 and plans greater support in 2004 and 2005. The Netherlands has been the second largest contributor to UNAIDS since 1995, donating $114.9 million from 1995 through 2003. That is just below the amount the United States provided over the same period ($129.4 million). Given the much smaller size of the Dutch economy, the country has been far more generous than the United States.

The Netherlands has taken steps in recent years to reduce the number of multilateral organizations it supports. This led to the temporary suspension of funding for the United Nations Fund for Women (UNIFEM), which some interpreted as a signal that the Dutch government had demoted the status of women as a priority issue. However, the official Dutch position is that gender issues should be incorporated in all UN development agency activities, and that its short-term budget adjustments do not entail any lessening of its longstanding support for women's welfare and human rights.

Bilateral Funding and Funding for NGOs

Since 1995, the Netherlands has never allocated much more than one-third of its population assistance bilaterally. In 2002, 34 percent was bilateral, but as with the country's total population resource flows, year-to-year variation has been considerable.

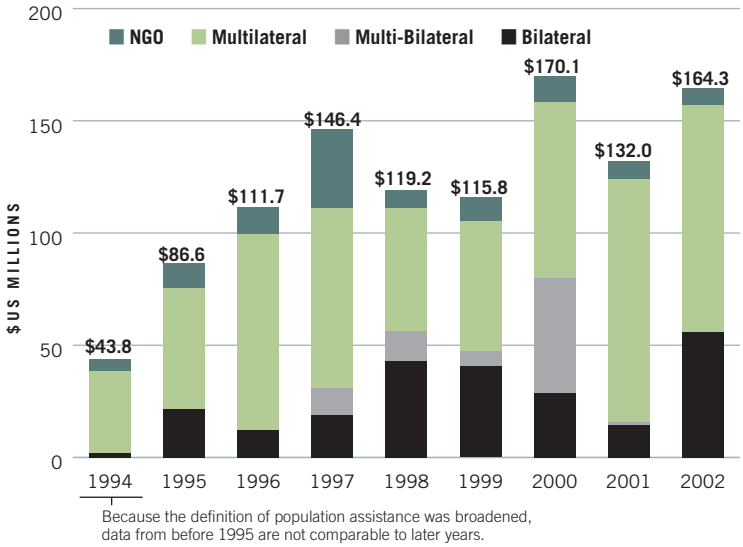
Since 1997, the Netherlands has been reducing support for NGOs working in population and reproductive health. In that year, 24 percent of all Dutch population assistance was contributed to NGOs. By 2002, the NGO share had fallen to less than 5 percent. Despite this, Dutch yearly contributions to IPPF rose by roughly 50 percent between 1998 and 2002, reaching $6.5 million in 2002. However, recent evidence suggests that this funding level was not sustained in 2004, and that IPPF will no longer be funded from the Dutch multilateral account but from the "thematic co-financing allocation" for NGOs.

4 Program Priorities

Geographic Priorities

Dutch bilateral funding for health is now concentrated in 12 "structural development" countries. Reproductive health is given special attention in Burkina Faso, Mali, Nicaragua, and Egypt, while HIV/AIDS activities feature prominently in Ghana, Mozambique, Tanzania, and Zambia. The Netherlands has been curtailing long-term bilateral aid to several countries where it has historic ties, including aid in reproductive health. For example, the country no longer provides bilateral population assistance to Indonesia, has scaled back its commitments in South Africa, and will soon close its bilateral aid program in India altogether.

TRENDS IN POPULATION ASSISTANCE 1994-2002: THE NETHERLANDS



NB: Expenditures for the Netherlands in 1996 do not include contributions to national NGOs that receive core funding for development activities or payment to experts working in the field of population activities overseas.

Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002.* New York: UNFPA.

The Netherlands

A

In both 2001 and 2002, the Netherlands channeled more than $100 million of population assistance to multilateral organizations, the highest level of assistance among all the DAC donor countries.

Areas of Program Emphasis

The main program priorities for the Netherlands are safe motherhood, family planning, prevention and treatment of unsafe abortions, control of sexually transmitted diseases and HIV/AIDS, and promotion of sexual and reproductive rights. Its support for these efforts has also included supplies, including contraceptives and condoms for HIV/AIDS prevention. Adolescent reproductive health information and service needs are also priorities. The Dutch government takes the fight against HIV/AIDS seriously: it was one of the first countries to recognize the HIV/AIDS epidemic as a threat to development, and now provides resources for HIV/AIDS prevention and treatment, programs that battle discrimination against people with HIV/AIDS, and research on the behavioral dimensions of the epidemic.

5 Technical Capacity

Staffing

The Ministry of Foreign Affairs employs a large work force of around 3,000 professional and support personnel. Many of these are diplomats rather than technical staff with expertise in international development. Current technical capacity in reproductive health within the MFA appears quite limited, given the size of the country's funding for international reproductive health. Within the Ministry of Development Cooperation, fewer than a dozen staff members deal with HIV/AIDS activities, reproductive health, child protection and nutrition.

Dutch bilateral cooperation is mainly carried out through its embassies. They are directly involved in the formulation of development strategies and program designs within recipient countries. They are also responsible for estimating financial resources needed to achieve results in specific sectors and for implementing development projects. Currently, 25 embassies have "theme specialists" for women in development activities, and 13 embassies have theme specialists in health. Out of these 13 theme specialists in health, 12 have expertise in reproductive health and HIV/AIDS. However, concern remains that many embassy-based development staff are overly "generalist" in their orientation and may not always give sufficient attention to reproductive health issues.

Technical Expertise of Collaborating Institutions

Dutch civil society has considerable technical expertise in population and reproductive health matters. Organizations active domestically include Rutgers Nisso Group (one of the co-founders of IPPF), the AIDS Fund, the STI Foundation, and the Schorer Foundation. In addition, the World Population Foundation (WPF), Share-Net, and the Royal Tropical Institute (KIT) have made substantial contributions to international health programs. Rutgers Nisso has also implemented several small overseas reproductive health projects over the past five years. The Netherlands Interdisciplinary Demographic Institute (NIDI) is a leading research center on population and development issues and collaborates closely with UNFPA in tracking donor and developing country support for population activities. NGOs are also well represented in the advocacy arena. The World Population Foundation and the newly-formed Netherlands Network on Sexual and Reproductive Health and AIDS (Share-Net) have considerable advocacy expertise on reproductive health and rights issues. These and other NGOs look set to become more active internationally after the Dutch NGO Co-Financing Scheme was unveiled in 2003 to promote greater NGO involvement in the country's foreign assistance efforts.

New Zealand

GRADE

B

1 Development Assistance: Policy and Funding

New Zealand's development assistance (ODA) is still below levels attained in the 1970s, but it has increased in recent years. It rose from US$112 million in 2001 to $124 million in 2002, for an ODA/GNI ratio of 0.23 percent in 2002, well below the average DAC country effort of 0.41 percent and substantially short of the internationally prescribed goal of 0.7 percent.

NGOs are campaigning actively in New Zealand to encourage the government to increase its ODA. The government has resisted concrete targets and has noted that peacekeeping, humanitarian work by the New Zealand Armed Forces and security support (such as community police training) are not included in its official ODA figures.

The government recently established a semi-autonomous agency within the Ministry of Foreign Affairs and Trade, the New Zealand Agency for International Development (NZAID), which will likely result in qualitative improvements in the country's aid program. NZAID was created in mid-2002 and is still evolving, with some remaining staff vacancies and various policies and strategies still under development. Its mission is the elimination of poverty through the strengthening of development partnerships and the achievement of the MDGs. NZAID considers the protection and promotion of human rights, social equity, and participation to be the key operating principles of its development efforts, principles that should support the country's strengthening commitment to sexual and reproductive health programming.

2 The Policy Environment for International Population Assistance

As noted above, NZAID does not have a formal policy on international population and reproductive assistance nor an explicit strategy for implementing the ICPD Programme of Action. However, an inter-agency team has been formed to develop a new health strategy for the

New Zealand's population assistance increased nearly three-fold between 1996 and 2002, although this improvement was tempered by low levels of development assistance overall. Recent information indicates that its support in this area will likely double between 2002 and 2004 as a result of its new resolve to become a more active supporter of sexual and reproductive health programs, particularly in its priority partner countries in the South Pacific region. As of 2002, much of the country's population assistance still went through multilateral organizations and NGOs, rather than bilateral channels, a reasonable approach given the level of funding provided and the low representation of reproductive health experts in many of New Zealand's overseas missions.

New Zealand has been an enthusiastic advocate for the ICPD Programme of Action and the Millennium Development Goals (MDGs). The country has also made recent strides in incorporating gender and human rights as crosscutting issues in its development activities, and has been a strong proponent of collaborating with NGOs in designing and implementing population assistance programs. Although these advances are welcome, New Zealand still does not have an official strategy for incorporating sexual and reproductive health into its poverty reduction efforts. Development of such a strategy is crucial if New Zealand is to carry forward its increasing commitment to the field, as are increases in total development assistance.

VITAL STATISTICS

2002 population size:
3.9 million

Total Official Development Assistance (ODA), 2002:
$122 million

ODA as a percentage of GNI, 2002:
0.22%

Total population assistance, 2002:
$3.3 million

Population assistance as percentage of ODA, 2002:
2.7%

Population assistance per $US million GNI, 2002:
$60

country's international assistance program, and reproductive health and rights are expected to be an area of focus. In addition to providing clearer guidance for health programming, a clearly articulated strategy also could help NZAID in its effort to strengthen public support for development cooperation overall, support which is challenged by doubts about the effectiveness of the country's aid program.

A draft of the new health policy paper was to be released in July 2004, but an indication of its likely direction came in a May 2004 statement by the Minister of Foreign Affairs and Trade, in which he emphasized the high priority placed by the government on the right to reproductive health. He went on to state that if overall development assistance were to increase, so would allocations for sexual and reproductive health—in particular allocations for IPPF, UNFPA and UNAIDS. That same month, a decision to approve new funding of NZ$1 million (US$665,400) each to UNFPA, UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria was also announced, reinforcing hopes for further increases in the future.

Evidence of New Zealand's strengthening commitment to sexual and reproductive health can also be found in the country's active participation in the Asia-Pacific Alliance, a network of NGOs, donor agencies and foundations dedicated to increasing support for the ICPD Programme of Action and the Millennium Development Goals.

3 Trends in Funding for Population Assistance

Overall Funding Levels

Resource allocations for population assistance have increased in recent years, rising between 2000 and 2002 from $2.3 million to $3.3 million. However, New Zealand continues to commit a relatively small share of its ODA for population assistance. In 2002, it allocated 2.7 percent of total ODA to population activities, a substantial increase over past years, but well below the average DAC country effort average of 4.0 percent. The country spent $60 per million dollars of GNI on population programs in 2002, also considerably lower than the DAC country average of $94. Given the large share of its assistance flowing through multilateral and other intermediary organizations, 76 percent of New Zealand's population funds in 2002 are not directly reported by type of activity. Of the amount that is categorized, 5 percent supported family planning, 30 percent other reproductive health services, and 64 percent HIV/AIDS programs.

Recent information provided by NZAID indicates that population funding rose to at least $5.9 million in 2003 and $6.8 million in 2004, the latter figure equal to a doubling of population assistance over 2002 levels. These projected figures do not include a substantial increase for two projects in Papua New Guinea and Vietnam, nor annual contributions for UNFPA, UNAIDS, and the Global Fund.

NZAID's contributions to the broader social and economic objectives of ICPD are difficult to measure, in part because gender issues are mainstreamed into New Zealand's ODA programs. Nevertheless, poverty alleviation, child health and survival, primary health-care delivery, basic education (including education for women and girls), rural development and employment generation are all elements of various projects supported by NZAID that signal its commitment to the broader ICPD agenda. These are undertaken either bilaterally, multilaterally, or through regional collaborative programs, Head of Mission Funds, or through NGOs via the Voluntary Agency Support Scheme (VASS).

Multilateral Funding

In recent years New Zealand has supplied a considerable share of its population assistance through multilateral organizations—54 percent in 2002—while another 12 percent was allocated to multi-bilateral programs. Much of this funding was for UNFPA, which in 2002 received $835,000 from New Zealand. This was less than one-half of 1 percent of UNFPA's 2002 budget, but it was close to one-third of New Zealand's annual outlay for population assistance that year. Contributions to UNFPA have grown modestly since then, reaching an estimated $1 million in 2003.

New Zealand has been increasing its support for HIV/AIDS programs. Since 2002 it has pledged $1.3 million to the Global Fund to Fight AIDS, Tuberculosis and Malaria. In 2003 it made its first contribution to UNAIDS, $713,000. NZAID has also recently committed resources to the UN's

New Zealand continues to commit a relatively small share of its ODA for population assistance.

Comprehensive HIV/AIDS Programme in the Pacific; a UNDP Project on Children and Youth Health and Development in several Pacific island countries; and a UNFPA project involving men in reproductive health in Fiji.

NZAID is reviewing its multilateral funding in relation to the country's development priorities and its own guiding principles. The assessment takes into account the efficiency, effectiveness, partnerships and comparative advantage of each partner organization, and NZAID officials indicate that it is likely that the UN's population and health agencies will benefit overall from this review.

Bilateral Funding

Much of New Zealand's population assistance is disbursed through multilateral organizations (primarily UNFPA), multi-bilateral program mechanisms, and NGOs. In 2002 it allocated only 0.1 percent of its population resources bilaterally, one of the lowest bilateral commitments of any DAC country. However, since 2002, New Zealand has initiated bilateral projects for maternal and child health activities in Papua New Guinea and Vietnam. As noted earlier, it will be difficult for New Zealand to increase its bilateral programming unless the number of technical staff increases.

Funding for NGOs

The government has been generous in its support of NGOs working in international population and reproductive health. During much of the 1990s, between 40 percent and 50 percent of its total population assistance went to NGOs. While the share fell from 50 percent in 2000 to 33 percent in 2002, the dollar figure actually increased, to more than $1 million. New Zealand continues to make modest contributions to IPPF ($400,000 in 2002) and has provided small supplemental grants in support of IPPF's Vision 2000 advocacy work. This level of funding represented a decline from contributions made in 1997 and 1998, but New Zealand is expected to more than double its support in 2004 to more than $850,000.

NZAID also supports the Pacific Regional Health Fund, a $2.6 million allocation that places a high priority on sexual and reproductive health and rights activities. It funds several specific Pacific regional initiatives, and made contributions to three HIV/AIDS-specific initiatives in 2003: the Asia-Pacific Leadership Forum on HIV/AIDS, the Pacific Islands AIDS Foundation (PIAF), and Fiji's AIDS Task Force. In addition, NZAID supports Marie Stopes International's work in sexual and reproductive health in the Asia-Pacific region.

In October 2002, NZAID adopted a strategic policy framework for engagement with New Zealand NGOs that sets out shared principles, mutual understandings and guidelines for interaction. The framework is aimed at strengthening partnerships with civil society both inside and outside New Zealand.

4 Program Priorities

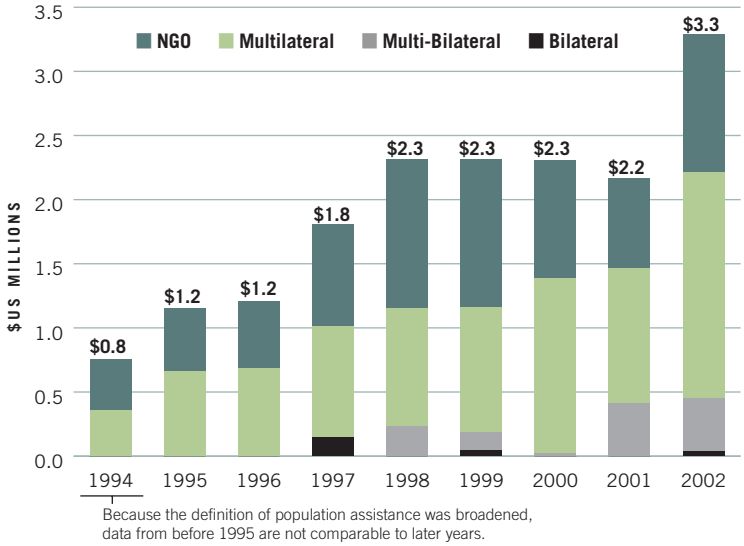
Geographic Priorities

NZAID's geographic focus continues to be the Pacific Island countries and Asia, although it also supports small programs in Africa and Latin America. In recent years, Papua New Guinea and the Solomon Islands received the greatest share of New Zealand's development assistance. Four Pacific states (Samoa, Vanuatu, Tonga, and Tokelau) were tied for third. New Zealand also provides limited funding to several Southeast Asian nations.

Areas of Program Emphasis

New Zealand has embraced the ICPD Programme of Action as the basis for organizing its population and reproductive health assistance, and NZAIDS's efforts in primary health care, gender equality, human rights (including domestic violence), and environmental sustainability directly address priority concerns of the Programme of Action. Gender equity and human rights are promoted as crosscutting themes in the country's foreign assistance efforts, and program priorities within these sectors are responsive to individual country needs and circumstances rather than broad preset agendas.

TRENDS IN POPULATION ASSISTANCE 1994-2002: NEW ZEALAND



Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002*. New York: UNFPA.

New Zealand

B

New Zealand has embraced the ICPD Programme of Action as the basis for organizing its population and reproductive health assistance.

5 Technical Capacity

Staffing

One criticism of New Zealand's international development efforts is that staffing is inadequate in its aid agencies (formally the Development Cooperation Division of the Ministry of Foreign Affairs and now NZAID). It is not uncommon to find New Zealand Embassy and High Commission diplomatic staff directly involved in foreign aid programs, rather than NZAID personnel with experience in development work. Staff members with development expertise are also sometimes engaged on short fixed-term contracts rather than in stable long-term career pathways. This deficiency frustrates New Zealand's ability to attract and retain well-trained and experienced development experts in its overseas operations.

NZAID has recently announced plans to upgrade the skills of its staff. It is anticipated that additional resources will be allocated for staff education and training, new career options, recruitment of additional personnel from Maori and Asian-Pacific minority groups, staff exchanges with other government departments and civil society organizations, and strengthening capacity in counterpart and partner organizations. There are also encouraging signs on the health front. NZAID's new health advisor is a development specialist with expertise in both gender and health. Furthermore, members of NZAID's health team (responsible for developing the new health policy) have worked as midwives, nutritionists and policy analysts in international organizations such as IPPF.

Technical Expertise of Collaborating Institutions

NZAID collaborates with the Family Planning Association of New Zealand in providing technical expertise for its population and reproductive health activities. The Association's International Development Unit (FPAID) offers expertise in such areas as project appraisal and design, implementation and evaluation of project activities, capacity building, and procurement of funding. FPAID works in Cambodia, Fiji, Kiribati and Vanuatu, and plans to begin a project in the Solomon Islands in 2004 to increase men's involvement in sexual and reproductive health and rights. Two FPAID staff members have recently moved to NZAID, including the current NZAID Development Programme Manager for Samoa.

Advocacy initiatives aimed at increasing awareness of international population and reproductive health issues in New Zealand are important elements of FPAID's work. For example, FPAID coordinates and acts as secretariat for the New Zealand Parliamentarians Group for Population and Development (NZPPD), coordinates the UNFPA "Face to Face" campaign, and conducts advocacy directly for ICPD and related issues through NZAID, Members of Parliament, and other NGOs.

Norway

GRADE

A

Norway's population assistance recovered to a record high level in 2002, after several years of declining support. In relation to the size of its economy, Norway was the second-ranking provider of population funding in 2002 (only slightly behind first place Denmark). The country continues to be an important contributor to UNFPA and IPPF, and has greatly expanded its support for multilateral organizations working to combat HIV/AIDS. The country's population assistance is also increasingly distinguished by generous support for domestic and developing country NGOs.

Norway's development assistance continues to give high priority to social development spending relevant to achieving the objectives of the ICPD Programme of Action, in particular for activities that improve women's status, education, and health. Norway has also given strong backing to rights-based approaches in its development efforts, particularly for reproductive health, and was an early advocate for sexual and reproductive health strategies that emphasized the enhancement of individual welfare as opposed to demographic outcomes.

Given Norway's progressive orientation over the years, it is encouraging that its resources for population programs have recently begun to recover. One concern is that the budget may be de-emphasizing resources for family planning and other basic reproductive health services while greatly expanding support for HIV/AIDS programs. For example, in 2002, Norway provided no direct funding for family planning (other than through its support to UNFPA and IPPF). For Norway to remain fully responsive to the ICPD Programme of Action, it will need to ensure that its expanding support for HIV/AIDS encourages the integration of comprehensive sexual and reproductive health services with HIV/AIDS treatment and prevention programs. While rising to the funding challenge posed by the global HIV/AIDS crisis, the vital importance of good sexual and reproductive health must not be underestimated.

1 Development Assistance: Policy and Funding

Norway remains one of the most generous providers of development assistance. In 2002, it provided US$1.7 billion in ODA, an ODA/GNI ratio of 0.89 percent, second only to Denmark and well above the UN's ODA/GNI target of 0.7 percent. Norway's stated goal is to increase its foreign assistance to 1 percent by 2005. The country's foreign assistance is also distinguished by its high level of spending on social development. In 2002, 14.6 percent of Norway's bilateral assistance was committed to education and 11.7 percent to international health.

The goal of Norway's development assistance is to alleviate poverty. Emphasis is given to peace, democracy and human rights; the environment and natural resource management; humanitarian assistance; and women's welfare and gender equality. While Norway's parliament (the Storting) establishes basic policies for development cooperation, the administration of aid is divided between the Ministry of Foreign Affairs (MFA) and the Norwegian Agency for Development

VITAL STATISTICS

2002 population size:
4.5 million

Total Official Development Assistance (ODA), 2002:
$1,696 million

ODA as a percentage of GNI, 2002:
0.89%

Total population assistance, 2002:
$80.8 million

Population assistance as percentage of ODA, 2002:
4.76%

Population assistance per $US million GNI, 2002:
$423

Cooperation (NORAD). The MFA is responsible for overseeing Norway's bilateral aid programs, multilateral assistance, and for coordinating emergency relief and humanitarian aid programs. NORAD, on the other hand, is responsible for bilateral assistance and NGO development cooperation projects.

Norway's foreign assistance is currently being evaluated in order to improve its responsiveness to the Millennium Development Goals. In this effort to "modernize" the country's development process, there will be an increased emphasis on decentralization and simplifying administrative procedures within the public sector. Growing concerns about the effectiveness of aid have also led Norway to adopt a policy of "recipient responsibility." Developing countries are increasingly encouraged to develop sector programs, including the design of projects and the allocation of budgetary resources. The Norwegian government expects this approach to strengthen local ownership of projects, encourage the development of in-country technical know-how, and improve prospects for sustainability.

Greater programmatic harmonization between Norway and other donors is also taking place. In Zambia, for example, seven donors (Norway, Sweden, Denmark, Finland, Ireland, the United Kingdom, and the Netherlands) are working together to finance country-led initiatives. In 2001, as part of the effort to improve donor coherence, a unique form of cooperation was initiated between NORAD and the Swedish International Development Cooperation Agency (Sida), whereby Sweden delegates responsibility to Norway. For example, all Swedish assistance to Malawi is now coordinated by Norway. In Uganda, NORAD also cooperates closely with Sida in providing joint assistance for Uganda's health program.

2 The Policy Environment for International Population Assistance

Norway enjoys broad-based public support for development cooperation, in part because of church involvement, a strong NGO constituency, and ongoing development education efforts. All four of Norway's major political parties, with the possible exception of the Far Right Party, support international aid programs. Norway remains strongly committed to sexual and reproductive health programs in accordance with the ICPD Programme of Action. As the improvement of women's lives is seen as crucial to development, NORAD provides 34.8 percent of its bilateral budget for projects designed to enhance gender equality and the status of women. NORAD also now attempts to incorporate gender into the design, implementation, and evaluation of all program activities.

3 Trends in Funding for Population Assistance

Overall Funding Levels

Norway's support for international population and reproductive health reached a record high in 2002. After falling from $71.4 million in 1998 to $43.0 million in 2001, it rebounded to $80.8 million in 2002. The percentage of Norway's ODA committed to population activities also recovered, to 4.8 percent—the third highest allocation among European donors after Finland and the Netherlands. Norway's 2002 population assistance budget compares even more favorably when considered in terms of the country's level of economic activity. It provided $423 per million dollars of GNI in 2002, a close second to Denmark's first-place ranking. The 51 percent of Norway's 2002 population funding that was allocated by activity went to HIV/AIDS (53 percent), reproductive health activities other than family planning (29 percent), and research (18 percent). Since family planning is increasingly integrated with other reproductive health services, Norway is facing growing difficulties in accounting for family planning expenditures independent of other reproductive health services.

Norway was an early advocate for sexual and reproductive health strategies that emphasized the enhancement of individual welfare as opposed to demographic outcomes.

Multilateral Funding

Like other Nordic countries, Norway channels much of its international population assistance through multilateral organizations. In 2002, 49 percent of Norway's funding for reproductive health was directed to multilateral organizations. Multi-bilateral assistance, or earmarked bilateral funds channeled through multilateral organizations, is also significant. In 2002, 13 percent of Norway's total ODA was multi-bilateral support.

UNFPA is the largest recipient of Norway's multilateral population resources. In 2003, Norway was projected to be the third largest contributor to UNFPA, raising its annual donation from $28.4 million in 2002 to $33.4 million in 2003. These resources are allocated in part to support UNFPA's commodity acquisition program, although Norway does not directly purchase and supply contraceptive commodities.

Norway has also been generous in its support for multilateral organizations involved in the fight against HIV/AIDS. Since 2002, Norway has pledged $53.9 million to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Norway has also been the third largest contributor to UNAIDS since 1995 (after the Netherlands and the United States). Its total contribution between 1995 and 2003 comes to $62.2 million.

Bilateral Funding and Funding for NGOs

Norway began phasing out its bilateral population assistance in the early 1990s, and reported no bilateral support in either 1995 or 1996. However, bilateral population projects were reintroduced in 1997 and by 2002 represented 8 percent of population assistance, or $6.2 million, the highest level of funding since 1993. Involvement in multi-bilateral initiatives continues as a feature of Norwegian assistance, with support rising again in 2002 to more than $10 million, or 13 percent of population assistance.

NGOs received a record $24 million of Norway's increased population funding in 2002, of which a major share went to IPPF. Norway remains among the top ten donors to IPPF and its contributions have stayed steady in Krone terms since the late 1990s, for an average of more than $5.5 million annually since 1999, evidence of the country's conviction that NGOs play an essential role in strengthening civil society and promoting democracy. NGOs are considered important partners for enhancing human resource capacity, local leadership, and institution building in the health systems of developing countries.

4 Program Priorities

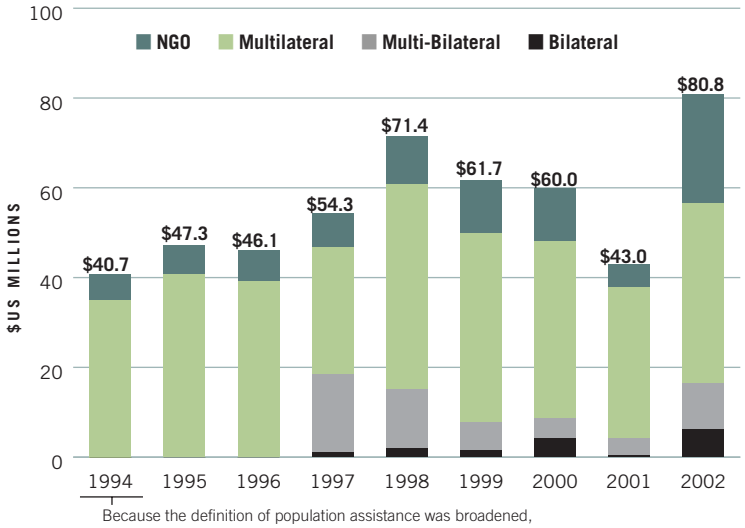
Geographic Priorities

Norway implements development projects in close to 20 developing countries, although resources are concentrated in seven priority partners: Bangladesh, Malawi, Mozambique, Nepal, Tanzania, Uganda, and Zambia. Much of Norway's population assistance is allocated to Africa. In 2002, the three countries receiving the greatest share were Ethiopia, Mozambique, and Zambia. Norway is also becoming more active in supporting HIV/AIDS activities in Russia and Asia. It emphasizes initiatives implemented by civil society and local NGOs in many of its partner countries.

Areas of Program Emphasis

Reproductive health is accorded high priority within Norway's development assistance. Programs deal with sexuality, pregnancy, and childbirth, and emphasize a woman's right to choose the number and spacing of her children. In addition, funding for HIV/AIDS activities is expanding. Norway attaches particular importance to the behavioral factors driving the HIV/AIDS epidemic in developing prevention and treatment programs, and provides support for families victimized by the epidemic. Resources also go to provision of adolescent reproductive health services and elimination of female genital mutilation/cutting. It is anticipated that resources for FGM/C will double over the coming three years.

TRENDS IN POPULATION ASSISTANCE 1994-2002: NORWAY



Because the definition of population assistance was broadened, data from before 1995 are not comparable to later years.

Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002.* New York: UNFPA.

Norway

A

The country views improvement of women's lives as particularly important to international development.

While Norway continues to give priority to reproductive health, it also focuses on strengthening health systems, financial management, and capacity building through sector-wide approaches (SWAps), or "basket-funding" mechanisms. For example, Norway is currently collaborating with the Pan American Health Organization in a health sector SWAp in Nicaragua.

Norway's progressive approach to development is also reflected in its perspective on gender. The country views improvement of women's lives as particularly important to international development. Assistance to enhance gender equality and women's rights is provided by integrating a gender perspective into all bilateral activities as well as through women-centered projects.

5 Technical Capacity

NORAD has few staff working full-time on reproductive health projects: only two in recent years. Technical expertise in reproductive health in Norway's embassies is also weak. Like the Netherlands, Norway has increasingly decentralized responsibility for developing and implementing its development activities to overseas embassy-based personnel.

Numerous public and private organizations in Norway possess technical capacity in reproductive health advocacy and service delivery. Unfortunately, not all of these organizations are active outside the country. The Norwegian Family Planning Association and the Center for Youth Relationships and Sexuality (SUSS) are prominent NGOs providing reproductive health information and services in Norway. Groups such as Aksept and the Norwegian Association Against AIDS provide HIV/AIDS information, testing, and support services. The Norwegian Association for Sexual and Reproductive Rights is participating in UNFPA's "Face to Face" Campaign to advance women's rights, and is also active in other international forums promoting the ICPD Programme of Action and women's rights. Other Norwegian NGOs such as Doctors Without Borders-Norway and the Norwegian Red Cross work abroad with ODA funding, but disaster relief and humanitarian assistance rather than reproductive health tend to figure most prominently in their field work. Public sector institutions such as the Ministry of Health and Social Affairs and the Norwegian Institute of Public Health can also be called upon to provide technical support in reproductive and child health care.

Portugal

GRADE

D

Portugal is a small and relatively new donor whose development cooperation focuses on Lusophone nations in Africa and East Asia (East Timor). Population assistance has never been a priority of the country's development program and has averaged less than one-quarter of 1 percent (0.21 percent) of official development assistance annually between 1996 and 2002. More recently, however, the Portuguese government has significantly increased its support for HIV/AIDS activities, contributing both to UNAIDS and, in 2003 and 2004, to the Global Fund to Fight AIDS, Tuberculosis and Malaria. These developments and an ongoing debate over the country's own abortion laws are providing new opportunities for Portuguese advocates seeking to increase the government's attention to sexual and reproductive health in its development programming.

1 Development Assistance: Policy and Funding

Portugal has one of the smallest economies and the lowest national income (GNI) per capita among the DAC donor countries. In 2002, Portugal's total development assistance amounted to US$323 million, or 0.27 percent of GNI—well below the UN goal of 0.7 percent and the average DAC country effort of 0.41 percent of GNI for official development assistance. Despite stated goals of increasing ODA to 0.36 percent of GNI by 2000 and 0.7 by 2006, the share of ODA in relation to GNI remained stagnant for most of the 1990s.

Poverty reduction is a primary goal of Portuguese development. In order to achieve this goal, assistance has focused largely on debt relief and institutional support (such as scholarships for tertiary education, or assistance for curative health care), rather than on basic social services, such as primary health care and primary education. Recently, however, there has been a shift in attitude. Health and education are now cited as key to addressing poverty, and have become top priorities of Portuguese development. Given these new priorities and the emphasis on poverty reduction, there is greater scope for Portugal to increase the share of ODA going to primary health care and basic education.

Seventy-two percent of Portuguese aid is channeled multilaterally, with the largest share going to the European Commission, followed by the regional development banks. For example, the Asian Development Bank received 32 percent of Portugal's multilateral assistance in 2002. The UN system, by contrast, received 8 percent of Portugal's multilateral assistance that year.

Portugal's aid programming is complicated and highly decentralized, spread among 17 ministries and numerous agencies, universities and municipalities. The resulting challenges to coherence are significant, although several steps have been taken to address these challenges since the late 1990s. First, an Inter-Ministerial Committee for Cooperation was re-instituted in 1997 to clarify and

VITAL STATISTICS

2002 population size:
10.4 million

Total Official Development Assistance (ODA), 2002:
$323 million

ODA as a percentage of GNI, 2002:
0.27%

Total population assistance, 2002:
$0.6 million

Population assistance as percentage of ODA, 2002:
0.18%

Population assistance per $US million GNI, 2002:
$5

reinforce the national policy for cooperation. Second, in 1998, a Council of Ministers for Cooperation Affairs was established to approve the annual aid budget and the annual aid programs of the ministries. Lastly, the Portuguese Institute for Development Assistance (IPAD) was created. IPAD is the implementing agency for cooperation and development, and is responsible for producing policy and strategy papers, and for monitoring and evaluating projects. IPAD merged the responsibilities of the Portuguese Development Support Agency (APAD) and the Portuguese Cooperation Institute (CPI), and falls under the umbrella of the Ministry of Foreign Affairs.

2 The Policy Environment for International Population Assistance

In December 2001 the center-right Social Democratic Party (PSD) won a decisive victory in the national elections. They are currently allied with the conservative Popular Party and form an absolute majority in parliament. This conservative administration has not made efforts to advance the ICPD Programme of Action in its development cooperation thus far.

Nonetheless, there are indications that the environment for sexual and reproductive health programming overseas may be improving, albeit slowly. A number of health projects that focus on such issues as eliminating female genital mutilation/cutting (FGM/C) and HIV prevention among women were approved in 2003 and 2004. Additionally, the Portuguese All-Party Group on Population and Development, which includes Members of Parliament from all political parties, has been actively participating in various activities relating to the tenth anniversary of ICPD.

Further evidence of the Portuguese government's changing attitude is reflected in its public acknowledgment in 2003 that its efforts to address HIV/AIDS, high teen pregnancy rates, and domestic violence at home had failed. The government also announced that the heavy cuts on funding for NGOs working in the field of development had also had a negative impact on programs overseas. These public statements may indicate a growing awareness within the Portuguese government of its domestic and international responsibilities. In addition, the current domestic debate in Portugal over the liberalization of abortion laws may also stimulate discussion on population assistance and reproductive health with respect to development cooperation.

One group playing a key role in promoting discussion of sexual and reproductive health and rights issues is the IPPF member association, Associaçao Para o Planeamento Familiar (APF). Since the mid-1990s in particular, APF has worked to pressure the government to pay more attention to sexual and reproductive health needs in the development arena. Although its efforts have succeeded in bringing attention to this issue domestically, APF's success in regards to Portugal's development policy remains to be seen—not surprising given the limited understanding among the broader public of what Portuguese development cooperation does or does not do.

3 Trends in Funding for Population Assistance

Overall Funding Levels

Portugal's support for international sexual and reproductive health programs has always been very modest. Only in 1998 did the country's annual population assistance exceed US$1 million. In 2002, however, Portugal supplied only $570,000 in population funding (or just $5 per million dollars of GNI), a decline from the previous year both in dollar terms and relative to total ODA. Population assistance represented just 0.18 percent of ODA in 2002, the lowest share of ODA of any DAC country except Greece and well below the average DAC country effort of 4.0 percent.

Given the large share (72 percent) of assistance flowing through multilateral organizations in 2002, only 28 percent of funding was reported by type of activity, all of which went to HIV/AIDS. While Portugal's support for HIV/AIDS programs is valued, linking HIV/AIDS activities to basic reproductive health programs that include family planning would help ensure a more effective HIV/AIDS intervention strategy.

Multilateral Funding

Portugal's small population assistance budget is increasingly being allocated through multilateral organizations. As noted above, 72 percent of Portugal's population funding went to multilateral organizations in 2002—the highest share ever. Portugal contributes to UNFPA, and in fact, stands as one of UNFPA's success stories. Itself a recipient country until the mid-1970s, Portugal's contributions to UNFPA through most of the 1990s were merely symbolic, and often came to less than what many developing countries contributed. Portugal contributed $73,000 to UNFPA in 2002, and an estimated $40,000 in

2003. While these donations are small, there are hopes that Portugal may become a more significant donor to UNFPA in future years. Portugal was more generous vis-à-vis UNAIDS, contributing $360,000 in 2002 and $150,000 in 2003. The government has also pledged $1.2 million to the Global Fund to Fight AIDS, Tuberculosis, and Malaria since 2003, of which $600,000 had been paid through mid-2004.

Bilateral Funding

Funding for bilateral population assistance dropped significantly with the rise in multilateral support. Portugal's bilateral population support fell from $460,000 in 2001 to $160,000 in 2002 (or from 67 percent to 28 percent of the country's total population assistance budget). Portugal's small bilateral population program emphasizes training, HIV/AIDS prevention, and maternal heath care rather than family planning.

NGO Funding

Since 1998, Portugal has not directed any population funding through NGOs. While the government partners with a number of NGOs on development issue, there are currently no domestic or recipient country NGOs receiving funding for sexual and reproductive health activities. In addition, Portugal does not contribute to IPPF.

4 Program Priorities

Geographic Priorities

Portuguese ODA continues to be almost exclusively supplied to Lusophone African countries, Brazil and, more recently, East Timor. Despite attempts since 1999 to broaden this geographical focus, these countries continue to account for about 80 percent of Portuguese development assistance. Nonetheless, despite the limited number of recipients, it is important to note that many of these countries are among the world's poorest countries. An average of more than 90 percent of Portuguese bilateral aid went to the least developed and other low-income countries in 2001 and 2002.

Areas of Program Emphasis

Portugal's development policy is guided by the document, *Portuguese Cooperation at the Dawn of the 21st Century*, released in 1999. Sexual and reproductive health is explicitly mentioned in this document under the chapter on health, which is the second priority area after education. However, in terms of actual funding very little Portuguese ODA goes toward funding population and reproductive health activities, with much of this limited funding going to HIV/AIDS programs.

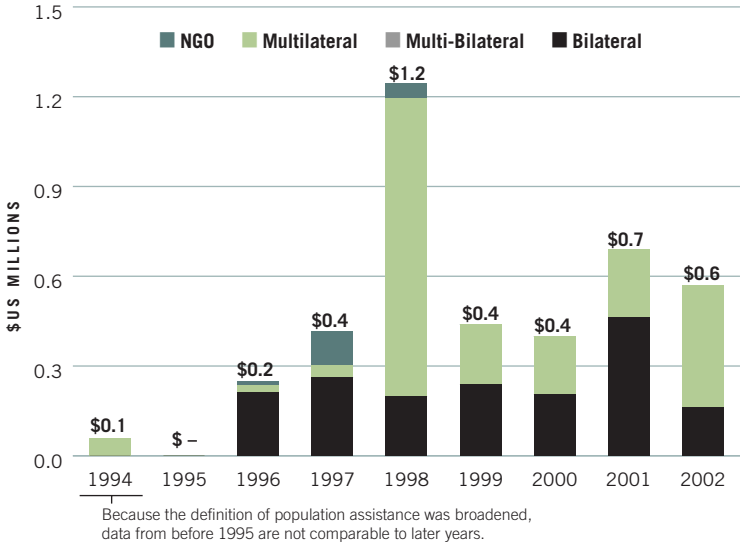
5 Technical Capacity

Staffing continues to be a weakness of Portugal's development assistance program. Especially troubling is the lack of expertise and sensitivity in specific technical areas such as poverty, reproductive health and gender. The Ministry of Health participates in development cooperation by sending medical personnel abroad and by accepting patients from certain recipient countries for individual medical treatment in Portugal. It is unclear, however, how many people within the Ministry of Health may have expertise in reproductive health and rights from a development perspective. In general, staffing information has proven difficult to find.

Transparency and lack of technical expertise are challenges for IPAD more generally. The mechanisms for monitoring how money is spent and evaluating the effectiveness of programs are very weak. This lack of technical capacity hampers the effectiveness of many development programs.

Finally, there is clearly scope for strengthening partnerships with NGOs. Although the Ministries of Health and Education have collaborated with the IPPF member association, APF, on sexual and reproductive health matters within Portugal, this type of cooperation has yet to be replicated overseas. Thus, there is clearly potential for further collaboration in reproductive health policy and program development between the government and APF.

TRENDS IN POPULATION ASSISTANCE 1994-2002: PORTUGAL



Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002*. New York: UNFPA.

Spain

GRADE

D

A relatively recent entrant to the donor community, Spain is still a minor contributor to international population and reproductive health efforts. While Spain's population assistance has never been particularly significant, the figure of $3.3 million for 2002 is an especially drastic decrease from the previous year (less than a quarter of the figure for 2001). This decline was most likely due to problems with reporting, although some decrease in funding may also have occurred.

Over the past decade, Spain has increased its official development assistance, but the figure has remained small in relation to the size of Spain's economy. Progress has been made in other aspects of development assistance, however, as Spain has worked to strengthen both the coherence of its development cooperation strategy and its evaluation of programs. The country is also now substantially in compliance with DAC standards for ODA. In addition, two recent significant achievements include the adoption of a comprehensive Law on International Development Cooperation, and a four-year Master Plan (2001-2004). The Master Plan establishes poverty reduction as the primary goal of development cooperation and highlights gender equality and the environment as priorities to be incorporated throughout the country's development programming.

With respect to sexual and reproductive health, however, eight years of conservative rule by the Popular Party made progress on both policy and spending difficult. As a result, population assistance has remained a tiny proportion of Spanish ODA, reflecting the very low priority assigned to this issue. Although Spain was an active participant at ICPD, the conservative government elected in 1996 neither instituted new policies dealing with the ICPD agenda, nor increased funding for population and reproductive health. Fortunately, the country's priorities are likely to change. The new government elected in early 2004, and the efforts of Spanish NGOs concerned about population and reproductive health, are factors likely to positively affect Spain's future performance in the area of population assistance.

1 Development Assistance: Policy and Funding

Between 2000 and 2001, Spanish ODA increased by 44 percent in real terms, from US$1.2 billion to more than $1.7 billion, primarily due to debt relief for Nicaragua. In 2002, development assistance declined in real terms and declined as a share of national income from 0.30 percent of GNI in 2001 to 0.26 percent in 2002. This is in contrast to the trend among European Union countries as a whole, which together increased their ODA by 2.8 percent in real terms in 2002. At 0.26 percent, Spain's performance is also lower than the average DAC country effort of 0.41 percent of GNI dedicated to ODA.

Between 1996 and early 2004, Spain was governed by the Popular Party. During its tenure, the country made some progress in improving the coherence of Spain's aid program, but the policy environment for population assistance was poor. In the most recent elections, held in March 2004, the Socialists defeated the Popular Party, winning 47 percent of seats in the Congress of Deputies. At this point it is unclear how this change in government will affect development assistance, but there are some promising signs.

2002 population size:
41.3 million

Total Official Development Assistance (ODA), 2002:
$1,712 million

ODA as a percentage of GNI, 2002:
0.26%

Total population assistance, 2002:
$3.3 million

Population assistance as percentage of ODA, 2002:
0.19%

Population assistance per $US million GNI, 2002:
$5

President Jose Luis Rodriguez Zapatero has already created a new position, State Secretary for Development Assistance, which is held by Leire Pajin. Previously the youngest Member of Parliament (2000-2004), Pajin has strong ties to the NGO community and a history of advocacy on gender equality and sexual and reproductive health. She has specifically identified reproductive health and women's rights as issues that will be prioritized by the Socialist administration, and is expected to head a reform effort in regards to development assistance.

In general, the policy framework governing Spanish development assistance is relatively new. It was only in 1998 that Spain passed the International Cooperation Law, which was its first step toward a coherent development policy. This law established sector and geographical priorities, and its implementation is guided by an ODA Master Plan (2001-2004). As the current law expires in 2004, Pajin will have the opportunity to identify new priorities and policies for the country's development cooperation. She has indicated that she wants NGOs to play an active role in this process, thereby opening up an important opportunity for advocacy around sexual and reproductive health issues.

In addition to these upcoming changes to the Master Plan, Spain's new government has announced other positive transformations that it hopes to make in the development field. For example, the Socialist party has announced plans to increase Spain's official development assistance to 0.5 percent of GNI by the end of 2008, with an interim target of 0.3 percent set for 2006, in keeping with agreements reached at the Monterrey Summit in March 2002. During the election campaign, the Socialists also promised to raise the profile of development cooperation and changed the name of the Ministry of Foreign Affairs to the Ministry of Foreign Affairs and Cooperation, as part of efforts to strengthen the management and administration of Spanish assistance.

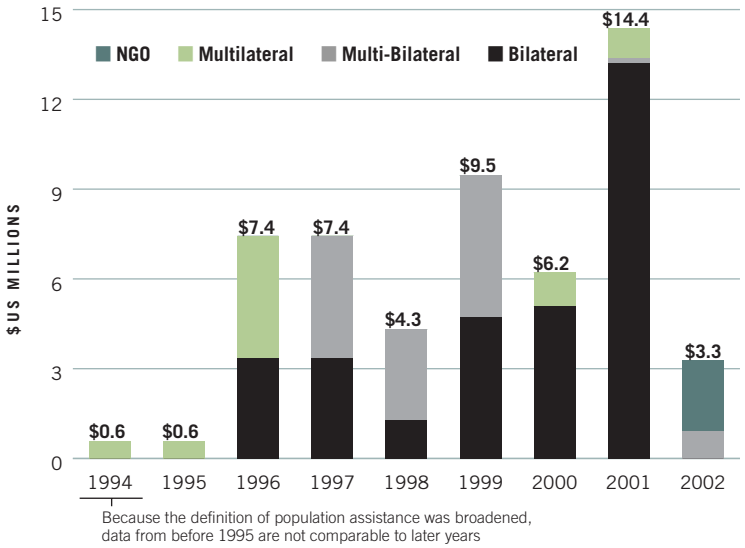
A more precise formulation of Spain's development goals remains to be seen. Under the former government, poverty reduction was the overarching goal of Spanish cooperation, yet a large percentage of aid remained tied to commercial interests. The government had also voiced its support for the Millennium Development Goals and its intention to allocate 20 percent of development aid to social sector spending. However, most of the social sector programs with direct service components have been implemented through NGOs so far.

With respect to the institutions involved in Spain's development assistance, the country has a complicated and decentralized aid structure that includes ministries, autonomous regions, cities and NGOs. At the federal level, Spanish aid is administered through several government departments within two major ministries, the Ministry of Economy and Finance (MEF) and the Ministry of Foreign Affairs (MFA). The Spanish Agency for International Cooperation (AECI) is the implementing body under the MFA. The central government continues to devolve powers to Spain's 17 autonomous regional governments, which will eventually have full responsibility for heath care and education as well as other social programs. These regions often include foreign aid in their budgets and most have their own regulations and laws affecting the disbursement of foreign assistance.

2 The Policy Environment for International Population Assistance

Spain was actively engaged in the ICPD process, although the conservative government elected in 1996 failed to institute new policies reflecting the ICPD agenda or to significantly increase funding levels for repro-

TRENDS IN POPULATION ASSISTANCE 1994-2002: SPAIN



NB: Figures for 1994 and 1995 were not provided, and are estimated at the 1993 level. Figures for 1997 were not reported, and are estimated at the 1996 level.

Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002.* New York: UNFPA.

ductive health programs. Nonetheless, awareness of the importance of sexual and reproductive health needs in the developing world appears to be rising among NGOs and parliamentarians. This rise in awareness can be attributed to advocacy efforts by groups such as the Spanish Interest Group on Population, Reproductive Health and Development (SIG), which is currently chaired by the IPPF member association, Federación de Planificación Familiar de España (FPFE). SIG is also in charge of the Spanish Parliamentary Intergroup on Population, Development, and Reproductive Health. Both SIG and the parliamentary group play an important role in education and advocacy. The Spanish public is actively engaged and supportive of development cooperation. This is due not only to the decentralized system which allows the public and NGOs to become involved at the autonomous levels, but also to advocacy efforts. Spain has a strong, organized political advocacy movement focused specifically on the issue of foreign aid. The "0.7 percent movement" has staged demonstrations and conducted public education activities since 1995 to make the case for increased levels of bilateral aid. Observers in Spain credit the group with increasing public awareness about foreign aid issues and creating a favorable environment for future increases in aid levels.

3 Trends in Funding for Population Assistance

Overall Funding Levels

The significant decline in Spain's population assistance in 2002 appears to be the result of incomplete reporting to UNFPA. Reported funding for population activities fell from $14.4 million in 2001 to just $3.3 million in 2002 (the lowest level of funding since 1995). In contrast to previous years, no bilateral or multilateral funding was reported—reinforcing the conclusion that Spanish reporting was particularly problematic in 2002. This low level of funding represented just $5 per million dollars of GNI and only 0.2 percent of total ODA, placing Spain ahead of only Greece and Portugal on these two indicators of performance. Even taking into account Spain's record level of population assistance in 2001, however, the country still ranks among the five least generous donors of population assistance relative to GNI.

The problems with Spain's reporting in 2002 are not new. Until 1996, trends in the country's population assistance were difficult to assess given the limited data available. While the government has been working to strengthen monitoring and evaluation of aid programs, including reporting on development assistance, problems clearly remain. A significant share of development aid, including aid for sexual and reproductive health, flows from regional and local governments and may not be reported to UNFPA. Indeed, it is worth noting that OECD/DAC statistics show steadily increasing bilateral commitments for population activities between 2000 and 2002, from $4.3 million to $9.0 million.

Given the difficulties referenced above, assessing trends in the types of activities supported by Spanish population assistance is also problematic. A jump in funding for reproductive health activities in 2001 probably reflects in part the integration of family planning efforts previously reported separately. And while HIV/AIDS activities were funded in the 1990s, primarily through UNAIDS and UNICEF, data from UNFPA show no funding until 2000 (see below for further information on multilateral giving).

Spain's official goal is to channel 40 percent of ODA multilaterally and 60 percent bilaterally. Multilateral contributions have been steadily increasing since 1996 and Spain channels three-quarters of its multilateral ODA through the European Commission (only Italy and Greece are contributing a higher proportion of total ODA to the EC). With respect to population assistance, however, 82 percent of Spanish funds in this area were reported as administered bilaterally in 2000, rising to 92 percent in 2001.

Multilateral Funding

Spain's reporting in 2002 omitted any multilateral contributions. However, data from other sources indicate a contribution of $550,000 to UNFPA in 2002 and a similar contribution in 2003. Spain's support for UNFPA is still insignificant compared to other donors with comparable economic capacity. As for HIV/AIDS activities, in 2002, Spain made a modest contribution of slightly less than $300,000 to UNAIDS, making it the 20th largest contributor that year. Spain has shown more generosity to the Global Fund to Fight AIDS, Tuberculosis and Malaria, however, pledging $100 million over the period 2003

Population assistance has remained a tiny proportion of Spanish ODA, reflecting the very low priority assigned to this issue.

through 2006, of which $50 million has been paid through mid-2004.

Spain has traditionally favored bilateral channels for its population funding. However, by increasing its multilateral share, the country could take greater advantage of the technical capacity and program reach of organizations such as UNFPA and UNAIDS, thereby enhancing the impact of its population assistance. Minister Pajin has indicated that, in the future, Spain will be increasing the percentage of assistance channeled multilaterally.

Bilateral Funding
Between 1997 and 2001, much of Spain's population funding reportedly flowed through bilateral channels. In 2001, 92 percent of Spain's allocation of $14.4 million for population activities was supplied bilaterally. However, in 2002, Spain's much reduced budget for population activities did not show any bilateral resources. As noted above, this contrasts with reporting to the OECD which, while reflecting commitments rather than expenditures, shows an increasing trend for bilateral population assistance for 2000 through 2002.

It should be noted that decentralized aid from the autonomous regions and cities is increasing and becoming more significant in the overall Spanish aid system, accounting for about 25 percent of bilateral ODA in 2000. As decentralized aid is not included in figures reported by UNFPA, Spain's contributions on population assistance are likely underestimated to some degree.

NGO Funding
Historically, Spain has not reported any funding for sexual and reproductive health through NGOs. This appears to have changed in 2002, with 72 percent of Spain's greatly reduced population assistance budget directed to NGOs. NGO activities have tended to focus on maternal and child health, shying away from more comprehensive sexual and reproductive health activities, including family planning. Indeed, NGOs report that proposals taking the latter approach were consistently rejected by the former government. This lack of support for more comprehensive approaches to sexual and reproductive health will hopefully change under the new government, given its apparent openness to gender and reproductive rights issues. Spain has also recently indicated its intention to channel additional resources to NGOs and to this end has extended the timeframe for NGO project proposals from one to three years. This increasing openness to NGOs does not carry over to the activities of IPPF, however. As in past years, Spain provided no funding to IPPF in either 2002 or 2003.

The country still ranks among the five least generous donors of population assistance relative to GNI.

4 Program Priorities

Geographic Priorities
Spanish development aid has been closely linked to the Latin America and North Africa regions, where Spain has cultural and historical ties, and to countries where it has strong commercial interests. More than 40 percent of Spanish aid went to lower middle-income countries in 2001-2002, with the Spanish aid agency, AECI, arguing that these countries have a great deal of income disparity and pockets of extreme poverty where health problems are inhibiting development. This concentration on Latin America may soon be broadened, however. The new government intends to start focusing more on Africa in its development efforts, in order to better address meeting the needs of the poorest of the poor. With respect to population assistance, Morocco has been the leading recipient of Spanish support for sexual and reproductive health activities in recent years, followed by the Philippines, Honduras, the Dominican Republic, Ecuador and Algeria. Data from 2002 show Mozambique and Namibia as also among the top recipients of population assistance.

Areas of Program Emphasis
Spanish population assistance has tended to focus on maternal and child health activities. HIV/AIDS has received a growing share of funds in recent years, while funding for family planning has fallen, as noted above. While Spain's growing interest in HIV/AIDS activities is needed, family planning and other reproductive health interventions must be linked to HIV/AIDS as much as possible in order to ensure long-term success in battling the epidemic.

The government has yet to develop a comprehensive approach to population assistance, although a Strategy in the Area of Health put forward by the Ministry of Foreign Affairs in 2003 did address some aspects of sexual and reproductive health. This Health Strategy was among the achievements of the Office of Planning and Evaluation

Spain

D

Spanish development aid has been closely linked to the Latin America and North Africa regions, where Spain has cultural and historical ties, and to countries where it has strong commercial interests.

(OPE) within the Spanish aid agency, AECI. OPE's staff has grown significantly in recent years and it has taken the lead in effort to enhance the coherence and monitoring of projects. OPE has begun developing strategy papers by sector in consultation with regional and municipal representatives, in order to strengthen the coherence and implementation of Spanish aid programs, while maintaining respect for the country's decentralized structure of government. The Health Strategy was one such document, and a strategy on gender was to be completed in 2004. (As noted above, gender is a crosscutting theme for Spanish cooperation, and all government funded projects are required to integrate a gender perspective.)

5 Technical Capacity

Staffing

AECI has 29 Technical Cooperation Offices throughout the world and 12 cultural centers. Levels of core staff within the organization decreased between 1997 and 2000 due to government budget constraints. As of 2001/2002, AECI had a total staff of about 842, with 361 based at the agency's headquarters in Madrid and 481 serving in overseas offices. At AECI headquarters, the majority of staff are career civil servants with senior management positions being held by foreign service staff. In the field, however, positions are filled by contract staff, both expatriate and local. It is unclear how many of these staff have expertise in sexual and reproductive health matters, although given the low priority accorded to population assistance, the level of expertise is likely negligible.

Spain's Ministry of Foreign Affairs has stated its commitment to achieve a higher level of expertise in its offices. In the 2003 Health Strategy, it announced that more specific training had to be provided for those working in the development health sector. The Health Strategy encourages AECI as well as other central government and cooperation institutions in the country to set up training schemes for their technical staff and those responsible for health care issues. Other ministries, including the Ministry of Health and Consumer Affairs, in collaboration with universities, are also encouraged to provide development cooperation training to a selected group of their personnel so that their staff members can play a more relevant role in lending technical assistance to those involved in funding health cooperation projects.

It is hoped that the pool of Spanish development experts working in the field of sexual and reproductive health will grow in future. The appointment of Minister Pajin, with her background in advocacy in reproductive health, is one step in the right direction.

Technical Capacity of Collaborating Institutions

While much of Spain's assistance to social sector programs (e.g., in education and sanitation) is channeled through NGOs, very little funding has been provided to groups for work in reproductive health and population. However, there are several domestic NGOs and academic institutions with expertise in sexual and reproductive health, as well as gender, that have the potential to play a role overseas. Of the NGOs receiving AECI funds in the past, many were faith-based groups and therefore unlikely to embrace a full range of sexual and reproductive health services.

Sweden

GRADE

A

1 Development Assistance: Policy and Funding

Government-wide budget cuts, first implemented in 1995, resulted in declines in total ODA from a high of 1.03 percent of GNI in 1992, among the world's highest, to around 0.7 percent in 1997 and 1998. During this period of austerity, the Swedish government suspended its previous target for ODA allocations to 1 percent of GNI, replacing it with a floor of 0.7 percent. The government said the cuts were temporary and would be rectified after some improvement in Sweden's fiscal situation. By 2002, Sweden's ODA had recovered to $1,991 million (or 0.83 percent of GNI).

The goal of Swedish development cooperation is to raise the standard of living of poor people in the developing world. In addition, the Swedish Parliament has adopted six specific objectives for the country's aid program: economic growth, economic and political independence, economic and social equity, democratic development and security, sustainable use of natural resources and environmental protection, and equality between men and women. This policy guidance is reflected in the four action programs—peace, democracy and human rights, sustainable development and gender equality—that govern Sweden's aid strategy, and in the large share of bilateral and multilateral aid channeled to the social sector. Sweden's commitment to the development process is further reflected in a requirement that all government ministries report annually on their contributions to fulfilling development objectives. As with most European DAC donors, the Swedish government supports the framework of the Millennium Development Goals, but would like to see sexual and reproductive health and rights given more prominence, particularly with respect to reducing maternal and child mortality, given its own strong commitment to these issues.

Sweden was an early pioneer in providing international population assistance and has provided essential financial support for more than four decades. It has been a leader in addressing the more controversial aspects of sexual and reproductive health and rights. In recent years it has been providing greater support for HIV/AIDS interventions, maternity care, safe abortion, adolescent services, and sexuality education. The country has also given considerable emphasis to promoting gender in its programming and to building human resource capacity in the health systems of the developing world.

Despite sizeable funding cutbacks in the 1990s, Sweden also remains one of the world's more generous donors of development assistance and garners praise for its efforts to improve both the effectiveness and human impact of its aid. A large share of its aid is programmed multilaterally, including for sexual and reproductive health, and includes significant support for UNFPA, UNAIDS, and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Indeed, Sweden's support for UNFPA was expected to nearly double between 2002 and 2004. As with other donors, efforts to combat the HIV/AIDS pandemic appear to be absorbing an increasing share of population assistance, but Sweden's long-standing support for sexual and reproductive health and rights and, more recently, for sector-wide approaches to health augur well for its success in ensuring that reproductive health concerns are integrated into all its health-related programming.

VITAL STATISTICS

2002 population size:
8.9 million

Total Official Development Assistance (ODA), 2002:
$1,991 million

ODA as a percentage of GNI, 2002:
0.83%

Total population assistance, 2002:
$61.1 million

Population assistance as percentage of ODA, 2002:
3.07%

Population assistance per $US million GNI, 2002:
$256

The Ministry of Foreign Affairs (MFA) is in charge of setting development policy, and the Swedish International Development Cooperation Agency (Sida) is an independent implementation body that translates policy recommendations into action. The MFA oversees all funding for the UN system. Bilateral assistance, including funding for IPPF and other NGOs, is administered by Sida, which has extensive experience in international sexual and reproductive health and has been a strong advocate for this assistance within the European Union (EU). Sweden also works closely with other "like-minded donors" (e.g., Denmark, Finland, Ireland, the Netherlands, and Norway) to coordinate program strategies and resource allocations for sexual and reproductive health programs.

Sweden's approach to development assistance emphasizes both partnership and improving the effectiveness of aid. The country has helped to pioneer sector-wide approaches and works to ensure accountability for budget support, while simultaneously encouraging partner program ownership. Sweden's commitment to aid effectiveness is also reflected in the decision to form "integrated embassies" that bring together Sida and foreign affairs staff in order to improve both the efficiency and effectiveness of decentralized decision-making. These realigned embassies now exist in most of Sida's main partner countries.

Sida's Department for Cooperation with NGOs (SEKA) has also taken steps to enhance the effectiveness of NGO participation in its development programs. Fourteen major Swedish NGOs ("frame organizations") work with SEKA in developing new activities, monitoring field operations, and evaluating outcomes. The 14 organizations also work with smaller Swedish NGOs to identify new project opportunities. By 2002, Sida supported around 300 NGOs with projects in some 100 countries.

In keeping with the government's emphasis on the social sector, NGO projects in human resource development and technology transfer are preferred over capital-intensive endeavors that do not build sustainable capacity. Swedish NGOs are also expected to raise 20 percent of all project funds from other sources in order to qualify for Sida funding.

2 The Policy Environment for International Population Assistance

While public support for development assistance remains strong enough to sustain high aid levels, some signs of weakening exist. Recent opinion surveys show lower expectations that Swedish ODA will prove effective in reducing poverty. At the same time, pressures are growing for Sweden's own economic interests to be given greater prominence in the country's development program. At a broader level, development cooperation faces potentially competing foreign policy priorities, such as improving relations with the Baltic Sea region and the Balkans and expanding Sweden's role in the EU.

Sweden was one of the first bilateral donors to provide population assistance, initiating funding for contraceptive supplies and services in the 1950s. Over the years, Sweden shifted to support more controversial and challenging needs such as combating unsafe abortion and violence against women, promoting young people's rights and meeting their needs for sexuality education. Its holistic approach preceded and was reinforced by ICPD. Sweden uses the term "fertility regulation" instead of "family planning" in order to expand the concept of reproductive health beyond the family unit to adolescents and unmarried people. Sex education, reproductive health counseling, and the provision of contraception are important components of Sweden's reproductive health assistance. The government also supports human rights, gender equity, maternal and neonatal health, abortion, and programs that combat the spread of HIV/AIDS and other STDs. Indeed, it is worth noting that the Swedish government recently appointed a career diplomat within the MFA to be the country's special ambassador on HIV/AIDS.

3 Trends in Funding for Population Assistance

Overall Funding Levels

Sweden's assistance for international population and reproductive health programs rose gradually between 1994 and 2000, but then retreated. Between 2000 and 2002, population assistance fell from $73.1 million to $61.1 million, well below the peak of $78.3 million in 1998. Similarly, the share of Sweden's ODA allocated for population assistance fell from 4.1 percent to 3.1 percent over this period (compared with the average DAC country effort of 4.0 percent). Despite these reductions, Sweden remains one of the most generous providers of population assistance, at $256 per million dollars of GNI in 2002 (down from $325 in 2000), which places Sweden in fifth place among all DAC member countries.

As with a number of other donors, it is increasingly difficult to track all of Sweden's support for sexual and reproductive health activities due to its growing reliance on sector-wide approaches in health, compared to project-specific activities. Also, the large share of the country's population assistance channeled multilaterally means that only about half was reported by type of activity in 2002, with 18 percent specified as supporting family planning, 26 percent for other basic reproductive health activities, and 55 percent for HIV/AIDS.

Multilateral Funding

Sweden has traditionally channeled much of its population assistance through multilateral organizations. In 2002, 49 percent went directly through multilateral organizations (primarily UNFPA and the European Union) and an additional 1 percent was dedicated to multi-bilateral projects, in which bilateral funding is integrated into projects coordinated by multilateral institutions.

Sweden's contributions to UNFPA have risen substantially in recent years reaching $20.3 million in 2002 and an estimated $36 million in 2004. Long among the top ten donors to UNFPA, Sweden will likely rank in the top five in 2004. The government has indicated that its increased support for UNFPA is partly in response to the withdrawal of U.S. funding in 2002. Sweden's support for reproductive health is also reflected in its continued significant level of support for WHO's special program of research in human reproduction.

Sweden also leads in supplying resources for the fight against HIV/AIDS. Sweden has pledged $72.8 million to the Global Fund to Fight AIDS, Tuberculosis and Malaria since 2002 and has paid all of its commitments to the Fund through 2003. Sweden has also recently announced major increases in its support for the Fund, pledging $38.9 million for 2004—more than double its 2003 commitment. The country is also the fourth largest supporter of UNAIDS, donating $43.1 million between 1995 and 2003.

Bilateral Funding

Both the share and volume of Sweden's population assistance channeled bilaterally reached their lowest levels in a decade in 2000-2001, only to recover in 2002—although this shift may reflect changes in reporting, as well as the impact of decentralization. Slightly more than $23 million in population assistance, or 38 percent of the total, was programmed bilaterally in 2002, levels in keeping with allocations in the mid- to late 1990s.

Funding for NGOs

Sweden's support for NGOs working in sexual and reproductive health has fallen gradually since the mid-nineties. However, the very low share reported for NGO support in 2002 likely reflects a problem with reporting, given that the $7.1 million reportedly allocated for NGOs barely covers the country's contribution to IPPF. Indeed, Sweden has consistently been among IPPF's top donors, its core support staying relatively constant from 1997 onwards, at around $8 million until pledging a significant increase in 2004 to more than $11 million.

4 Program Priorities

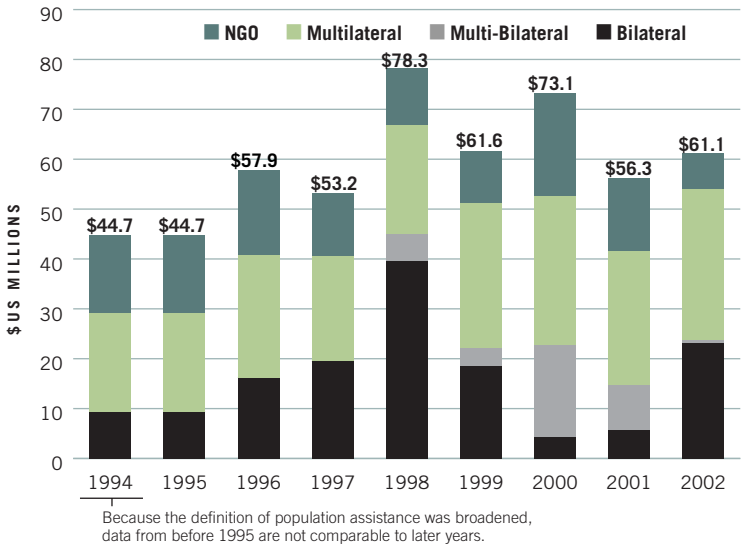
Geographic Priorities

In 2002, Sweden concentrated much of its bilateral population assistance in nine countries, eight of them in Africa: Angola, Ethiopia, Malawi, Namibia, Tanzania, Uganda, Zambia, and Zimbabwe. Sweden also still supports a bilateral program in India, but in terms of population assistance it has become a marginal bilateral presence in most other countries in South and Southeast Asia. In 2003, Burkina Faso became the tenth country receiving bilateral support.

Areas of Program Emphasis

Sida's health programs aim to increase the capacity of developing countries to provide basic health services by strengthening health care delivery systems. Support for sexual and reproductive health focuses on human rights and gender equality; maternal health and newborn care, includ-

TRENDS IN POPULATION ASSISTANCE 1994-2002: SWEDEN



NB: 1995 expenditures were not reported to UNFPA and were estimated at the 1994 level. Sweden's broader definition of population activities in 1996 has been refined to fit with UNFPA's definition.

Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002*. New York: UNFPA.

Sweden

A

Long among the top ten donors to UNFPA, Sweden will likely rank in the top five in 2004.

ing the promotion of breastfeeding; providing high-quality fertility regulation services; promoting access to safe abortion; combating sexually transmitted diseases, including HIV/AIDS; and strengthening adolescent reproductive health programs. Trafficking and female genital mutilation/cutting are also important program areas for Sweden.

As part of its commitment to overall reproductive health, Sweden views the training of midwives to be a key intervention in reducing maternal mortality, and thus continues to give broad support for this work. It is currently funding training for midwives in safe delivery and safe abortion in six African countries—Uganda, Zambia, South Africa, Mozambique, Angola, and Rwanda—as well as in India and Nicaragua.

Male involvement in reproductive health programs is also being given greater prominence. Examples of such initiatives include the Men as Equal Partners projects in Tanzania and Zambia and the new Global Initiative on Father Support (GIFS) program that complements a similar effort on maternal support (GIMS). Sida is preparing a new regional assistance program for sub-Saharan Africa that focuses on the roles of boys and men in reproductive health, entitled "Partnership with Young Men for Reproductive Health and HIV/AIDS Prevention."

Sweden has been an active proponent of safe abortion services in developing countries for many years. It has worked with WHO in developing technical guidelines for abortion and post-abortion care services, and also undertakes work in this area through bilateral assistance. For example, Sida supports a pilot project on medical abortion in Vietnam, while in India the agency is working with the NGO community to improve the quality of abortion services, including the training of paramedics in post-abortion care. In Africa, support for various advocacy and service activities related to abortion is channeled through Ipas and the International Women's Health Coalition, and Sida recently agreed with Reproductive Health Matters on the creation of an International Consortium for Medical Abortion (ICMA). Sweden also collaborates with the World Bank on a broad array of reproductive health issues, including reducing unsafe abortion and increasing contraceptive use.

5 Technical Capacity

Staffing

Given the size of Sida's international population assistance efforts, its Division for Health and Development is relatively small. As of 2002, it had 15 full-time professional staff, with just four primarily engaged in sexual and reproductive health issues. Sida has taken steps to post more of its staff in developing countries, although it is difficult to determine the extent to which field personnel give priority to health issues or are technically proficient in sexual and reproductive health programming. It is hoped that Sida's newly decentralized decision-making structure, with its reliance on "integrated embassies," will increase the ability of technical staff back at headquarters to interact with colleagues in the field.

Technical Expertise of Collaborating Institutions

Many of Sweden's collaborating institutions have long-standing technical competencies in population and reproductive health. The Karolinska Institute is a renowned medical research center that has collaborated with Sida in implementing international health programs. Population research centers at the Universities of Lund and Uppsala have also provided important technical assistance over the years. The Swedish Association for Sex Education (RFSU) has been the principal Swedish NGO working with Sida on sexual and reproductive health and rights activities. An early example of Swedish support for NGOs was a partnership between the RFSU and UMATI (the Family Planning Association of Tanzania) that promoted the sexual health of adolescents. This partnership included support for public debate on issues surrounding teenage pregnancy and the restrictive laws and policies surrounding the sexual and reproductive health of young people. A similar project has been initiated in Zambia with financial support from donors in addition to Sida.

Switzerland

GRADE

B

1 Development Assistance: Policy and Funding

Switzerland's foreign assistance budget has not changed appreciably in recent years. Official development assistance increased only nominally between 2001 and 2002, from US$908 million to $939 million, while the country's ODA/GNI ratio actually declined to 0.32 percent. This figure is less than the average DAC country effort of 0.41 percent and the Swiss government's own target of 0.40 percent. Switzerland has not yet embraced the internationally agreed upon goal of committing 0.7 percent of total GNI to development assistance. In fact, when it fell short of its own ODA/GNI target, there was little public outcry.

The Swiss government has identified poverty alleviation, good governance, and partnerships with developing country institutions as the core elements of its international development efforts in the world's new geopolitical environment. Environmental conservation also features prominently. At the same time, humanitarian assistance remains a prominent part of the Swiss aid program and in 2002 accounted for 20 percent of Switzerland's total ODA budget. By contrast, in that same year education, health, and population activities were allocated only 9 percent of the ODA, one of the lowest levels among DAC member countries. This may change, as basic social services are expected to absorb a larger share of resources as Switzerland moves to fully implement its poverty reduction program.

In line with this goal of poverty reduction, Switzerland has made concerted efforts to concentrate much of its ODA in poorer developing countries. In 2001-2002, 42 percent of all Swiss ODA went to the least developed countries, and an additional 28 percent was directed to other low-income countries. In the latter 1990s, nearly half of Swiss ODA was allocated to 17 priority countries, but an additional ten priority countries have been added since 1999, raising concerns that efforts are becoming too widely dispersed. In 2002, the three largest recipients of Swiss ODA were Serbia and Montenegro, India and Mozambique.

Switzerland officially supports the broad objectives of the ICPD Programme of Action but has been slow to articulate a program strategy on sexual and reproductive health and rights to guide its development assistance. Nonetheless, prospects for generating significantly greater population funding now seem more promising, as the government has recently committed to increasing ODA spending for social development. Switzerland's new strategy paper for international health, *Health Policy for 2002-10*, identifies integrated reproductive health and STD/HIV/AIDS services as important priorities. This acknowledgement of the importance of integrating reproductive health and STD/HIV/AIDS services is welcomed. It reflects a broader understanding of the importance of basic reproductive health care and the vital role it plays in HIV/AIDS prevention and is a positive example for other donors moving into the HIV/AIDS arena.

Switzerland's support for international sexual and reproductive health activities increased by 50 percent in 2001 and stayed at that level in 2002. While the bulk of its assistance has tended to flow through multilateral channels, most of the increase went to NGOs. While the funding increases and policy developments noted above signal a more prominent Swiss presence in international population efforts in the future, significant progress would require higher levels of development assistance overall.

VITAL STATISTICS

2002 population size:
7.3 million

Total Official Development Assistance (ODA), 2002:
$939 million

ODA as a percentage of GNI, 2002:
0.32%

Total population assistance, 2002:
$23.4 million

Population assistance as percentage of ODA, 2002:
2.49%

Population assistance per $US million GNI, 2002:
$79

Switzerland is now becoming more active in the work of the UN's specialized development agencies, in the wake of its decision to join the United Nations in 2002. The government has recently unveiled a strategy for Swiss participation in multilateral organizations that incorporates seven "thematic priorities": multilateral and global governance; crisis prevention and management; governance; social development; labor force development and income generation; natural resource management and the environment; and information technology.

Switzerland's foreign assistance is administered by the Swiss Agency for Development and Cooperation (SDC), situated in the Federal Department of Foreign Affairs, and the State Secretariat for Economic Affairs (SECO) in the Federal Department of Economic Affairs. In 2002, SDC administered 75 percent and SECO 13 percent of the ODA budget, respectively. These two agencies have different strategic objectives and operating principles, with SDC focused more on poverty alleviation and humanitarian assistance and SECO primarily oriented to economic trade, investment, and debt relief. Within the SDC, population activities are handled by two new program divisions, one dealing with social development and poverty alleviation, and the other oriented to governance and human rights.

2 The Policy Environment for International Population Assistance

While Switzerland supports the ICPD Programme of Action and continues to make contributions to UNFPA and IPPF, reproductive health has never figured prominently in the country's bilateral assistance. In part this reflects an independence of mind that has typified Swiss development efforts for many years. In 2003, however, Switzerland prepared a strategy paper entitled *Health Policy for 2002-10* that specifically mentions future programmatic needs in sexual and reproductive health and human rights and promises greater resources for them. The SDC also plans to increase its social development spending in future years, which will likely include more bilateral support for sexual and reproductive health activities, particularly with respect to HIV/AIDS—all welcome developments.

3 Trends in Funding for Population Assistance

Overall Funding Levels

Swiss population funding nearly doubled from $8.2 million in 1994 to $17.1 million in 1995, a substantial gain that may be partly explained by the new definition of population assistance adopted following the ICPD. Population assistance stayed relatively constant until 2001, when another significant increase occurred. The $23.4 million reported for 2002 is only slightly less than in 2001, but is still only 2.5 percent of Switzerland's total ODA (and still well below the average 2002 DAC country effort of 4.0 percent). Switzerland's population assistance was $79 per million dollars of GNI in 2002, higher than during the 1990s but also less than the DAC country average of $93.

Switzerland channels the bulk of its assistance through multilateral organizations and, due in large part to this fact, 79 percent of all population assistance is not reported by type of population activity. The 21 percent that is reported by category went to family planning (28 percent), other reproductive health activities (44 percent), and HIV/AIDS (28 percent).

Multilateral Funding

In 2002, 62 percent of Switzerland's population assistance went to multilateral organizations, a share roughly consistent with the pattern since 1995. Of the $14.5 million channeled multilaterally in 2002, UNFPA received $8.1 million. Since then contributions have remained constant in terms of Swiss Francs, although increasing in dollar terms. Switzerland has also been a generous supporter of multilateral efforts to combat HIV/AIDS. It has been the tenth largest contributor to UNAIDS since its inception in 1995, providing a total of $15.9 million between 1995 and 2003. The Global Fund to Fight AIDS, Tuberculosis and Malaria has also been well supported by the Swiss: they have pledged and paid $10 million since 2002, but at this writing have made no additional commitments for 2004 or subsequent years.

Bilateral Funding

Seventeen percent of Switzerland's population assistance was allocated as part of the country's bilateral aid program in 2002, a share that has not changed appreciably since 1998. Similarly, the share of Swiss population assistance allocated to multi-bilateral funding has also remained relatively constant, increasing slightly to 3.4 percent in 2002. In recent years a growing share of bilateral funding has gone to HIV/AIDS awareness and prevention rather than to family planning and other reproductive health services. In general, Switzerland's bilateral assistance is focused on poverty alleviation, income generation, institutional change, and environmental management rather than repro-

ductive health. Population issues are mostly addressed in relation to these broader development objectives.

Funding for NGOs

While Switzerland recently increased its support for NGOs in population and reproductive health, funding has not been consistent since the ICPD in 1994. In 2002, 18 percent of Switzerland's population assistance was channeled through NGOs. This was slightly below the share reported for 2001, but well above commitments between 1998 and 2000. In both 1999 and 2000, the NGO share of Switzerland's population assistance dropped to just 4 percent. Switzerland remains a consistent, albeit modest contributor to IPPF, providing one million Swiss Francs annually, the equivalent of US$661,000 in 2002.

4 Program Priorities

Geographic Priorities

Switzerland does not provide breakdowns of its population assistance by country of destination. Aid officials maintain that reproductive health activities are integrated into the country's general support for international health. Priority countries that have received considerable Swiss health financing are Benin, Chad, Mali, Mozambique, Nepal, and Tanzania. In addition, Switzerland supports a program of health research in Bangladesh.

Areas of Program Emphasis

The new SDC Health Policy for 2003-2010 has five strategic priorities: strengthening the governance of health systems; developing "pro-poor" health systems; encouraging greater community and user participation in health services; controlling major communicable diseases; and improving reproductive health. With respect to the latter, areas of program emphasis include promotion of reproductive rights, introducing more gender sensitivity in the design of services; integrating reproductive health services with HIV/AIDS and infectious disease control activities; improving maternal and child health; and reducing gender-based violence. This agenda is largely in step with the priorities of the ICPD Programme of Action. Somewhat conspicuous in its absence, however, is any mention of access to contraceptive services for women (including unmarried adolescents) at risk of unintended pregnancy.

5 Technical Capacity

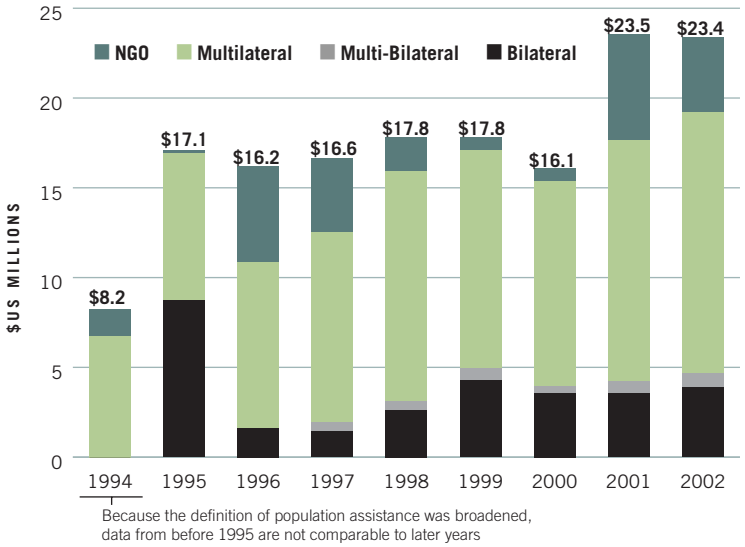
Staffing

Most observers credit Switzerland with having a generous supply of dedicated and technically capable development specialists. The SDC employs around 500 professionals based in Switzerland and abroad, as well as an additional 600 local-hire staff. The world-renowned Swiss Humanitarian Aid Unit (SHA) has an additional 700 employees, many of whom are directly engaged in reconstruction efforts overseas. The number of SDC employees specializing in reproductive health, however, is rather small. The SDC Health Desk is currently staffed with eight health and social development experts, only one of whom specializes in reproductive health. The average age of SDC professional staff is high (a reflection of low staff turnover and inadequate recruitment of junior professionals) and the agency may soon experience constraints as more staff reach retirement age. SECO, on the other hand, has recently recruited many junior-level staff without much development experience. In all, additional time will be needed for new entrants to reach their full professional stride.

Technical Expertise of Collaborating Institutions

Swiss NGOs supported by SDC tend to focus on humanitarian assistance and disaster relief. Intercooperation, Helvetas, and Swisscontact were the three largest Swiss-based NGOs supported by SDC in 2002. Few Swiss NGOs have much technical expertise or programmatic experience in reproductive health, but with the projected expansion of SDC funding for HIV/AIDS programs, more Swiss NGOs are likely to develop capacity. The International Foundation for Population and Development (IFPD) is one Swiss NGO that does support reproductive health care, education and training activities, and advocacy for women's reproductive and human rights. It currently works in the implementation of reproductive health projects in India and West Africa.

TRENDS IN POPULATION ASSISTANCE 1994-2002: SWITZERLAND



Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002.* New York: UNFPA.

United Kingdom

GRADE

B

The United Kingdom has significantly increased its assistance to the world's poorest countries and has emerged as a leader in the development arena. Strong leadership and the establishment of an autonomous Department for International Development (DFID) in 1997 are two factors contributing to the much higher profile of development assistance within the government. The agency's focus on poverty reduction has been coupled with other government initiatives to achieve greater coherence among aid, trade and finance policies. Future challenges will include maintaining an emphasis on health, particularly sexual and reproductive health, within poverty reduction strategy (PRS) and other processes and as decentralization of funding authority to overseas missions continues.

The United Kingdom's commitment to sexual and reproductive health has remained strong at the political level, and DFID's approach to programming has become increasingly strategic and results-oriented. However, former Secretary of State for International Development Clare Short was adamant that DFID primarily support national governments to deliver essential services such as health, leading to a de-emphasis on support for NGOs that included cuts in funding. This approach and the reorganization of DFID's critical Policy Division in 2003 aroused concern for the agency's priorities. Indeed, when the reorganization was first announced, reproductive health was not included as a discrete area of emphasis, although this was later reversed.

DFID's support for sexual and reproductive health received a boost with the appointment in late 2003 of Hilary Benn, MP, as Secretary of State for International Development. In July 2004, DFID released a strong new position paper on sexual and reproductive health and rights. The paper makes clear the government's support for reproductive health for all, and is a powerful reaffirmation of DFID's support for ICPD and the concept of reproductive rights. It has helped to allay concerns over the strength of the agency's commitment on these issues, as have further increases in support for UNFPA, UNAIDS and IPPF announced in 2004. Both Secretary Benn and key agency staff are committed to ensuring that the agency's HIV/AIDS programming integrate sexual and reproductive health activities wherever possible. This is not necessarily an easy task, however, and it will be critical for U.K. advocacy groups to pay close attention to both funding and policy processes at DFID and in those developing countries where the United Kingdom is a major donor.

1 Development Assistance: Policy and Funding

The United Kingdom continues to increase its development assistance and to allocate an increasing share of aid to the world's poorest countries. In 2002, the government contributed US$4.9 billion in official development assistance, of which nearly 50 percent went to sub-Saharan Africa and close to 70 percent to the least developed and other low-income countries. The country's ODA is also an increasing share of national income (GNI) and has averaged above 0.3 percent of GNI for the three years 2000 through 2002. The government appears committed to a

2002 population size:
60.2 million

Total Official Development Assistance (ODA), 2002:
$4,924 million

ODA as a percentage of GNI, 2002:
0.31%

Total population assistance, 2002:
$168.8 million

Population assistance as percentage of ODA, 2002:
3.43%

Population assistance per $US million GNI, 2002:
$106

further increase in aid to 0.4 percent of GNI by fiscal 2005/06 and to the benchmark of 0.7 percent by 2013. This upward trend began with the election of the Labour government in 1997 and is part of the legacy of former Secretary of State for International Development Clare Short, who used her position to gain increasing government support for international development.

In mid-2002, a new International Development Act came into force. It requires that U.K. bilateral assistance contribute to poverty reduction and support sustainable development and human welfare. These requirements are spelled out further in the new Public Service Agreement (for 2003-2006), which governs DFID's work and is the basis for assessing DFID performance. U.K. development policy is also increasingly organized around achieving the Millennium Development Goals. While the importance of achieving universal access to reproductive health services and other key ICPD goals are referenced in a number of DFID's policy and planning documents, the objectives by which DFID's performance is assessed make no mention of ICPD.

DFID administers the bulk of U.K. development funding, under the leadership of a Cabinet-level Secretary of State for International Development. Parliamentary oversight falls to the International Development Committee. Britain's Foreign and Commonwealth Office also manages a limited share of U.K. development aid through its funding of the British Council and related programs, certain contributions to international organizations, and its support for conflict prevention, for example.

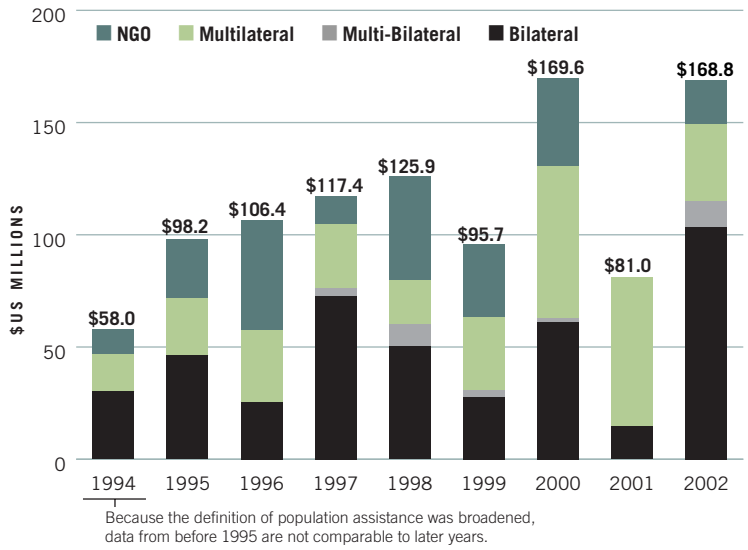
In recent years, DFID has increasingly emphasized bilateral assistance to governments and is a leading proponent of sector and general (direct) budget support. Over the three-year period ending fiscal 2002/03, budget or sector support accounted for 15 percent of British bilateral aid, on average. British aid is also increasingly decentralized: 27 overseas offices, in all but a handful of Britain bilateral "focus" countries, now exercise authority over program and funding decisions.

2 The Policy Environment for International Population Assistance

The British public strongly supports government assistance to developing countries, and a large majority views poverty in developing countries as a moral issue. Public support has strengthened since the Labour government came to power, due at least in part to DFID's own public education efforts. Public support is greatest for health and education interventions, although awareness of what the United Kingdom actually does in these and other sectors remains weak. Public opinion polls conducted on behalf of UNFPA in 1996 and 2001 show that Britons increasingly support their government's overseas assistance for specific reproductive health services, such as family planning, HIV/AIDS prevention and sexuality education. DFID's ability to document the impact of its efforts will become even more important as the U.K. government moves increasingly toward direct budget and sector support in developing countries.

The U.K. government has remained a strong advocate of sexual and reproductive health and rights issues in international fora since the ICPD. However, its strong support for poverty reduction and the Millennium Development Goals over the last few years sometimes made it seem that reproductive health had dropped off the development assistance agenda, despite strong support for HIV/AIDS and maternal health. This perception was at first reinforced by DFID's reorganization, as noted above. One positive outcome of the ensuing turmoil, however, has been a much clearer articulation by sexual and reproductive health NGOs of how good reproductive health contributes to overall development, and the importance of integrating HIV/AIDS and sexual and

TRENDS IN POPULATION ASSISTANCE 1994-2002: UNITED KINGDOM



Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002.* New York: UNFPA.

reproductive health interventions. A second is the new position paper spelling out DFID's stance on these issues, mentioned above. One problem facing DFID, as with other donors, is the paucity of indicators for gauging progress toward universal access to reproductive health services and the limited capacity of many developing countries for data collection and analysis.

3 Trends in Funding for Population Assistance

Overall Funding Levels

Total population assistance from the United Kingdom has increased significantly since the ICPD in 1994, rising from $98 million in 1995 to $168.8 million in 2002, a nearly 50 percent increase in real terms. Year-to-year fluctuations have been substantial, however, whether due to changes in reporting or to the funding cycles for specific programs. In 2002, the United Kingdom allocated 3.4 percent of its total ODA for population assistance, placing it ahead of such donors as Japan and Germany, but tenth among the 21 major donor countries. Using the more telling measure of population assistance relative to national income, the U.K. figure of $106 per million dollar of GNI also places the country in tenth place, ahead of the United States, but well behind Norway, Denmark, Luxembourg and the Netherlands, whose contributions average more than $400 per million dollars of GNI.

The United Kingdom has made progress since PAI's 1998 analysis, based on overall ODA, percentage of aid going to sexual and reproductive health, and absolute levels of population assistance. Still, the country would need to increase its 2002 population assistance nearly three-fold by 2005, to $485 million, to fulfill its fair share of donor commitments to ICPD.

The United Kingdom classified all but 20 percent of its population funding by type of activity in 2002. Nearly 40 percent of total population assistance went to basic reproductive health and a further 18 percent to family planning, while STDs and HIV/AIDS efforts received 21 percent of total funds. As with other donors, the share allocated to fight HIV/AIDS appears to be on the increase, in light of pledges made to the Global Fund to Fight AIDS, Tuberculosis and Malaria and the increasing share of projects that are principally HIV/AIDS-related. In July 2004, the U.K. government announced it would spend at least GBP (British pounds) 1.5 billion, about US$2.7 billion, on HIV/AIDS-related activities over the next three years, including an additional GBP 150 million (US$270 million) contribution to the Global Fund.

Indeed, it is worth noting that DFID is allocating an increasing share of ODA to the health sector: more than 10 percent in 2002 and well ahead of most other major donors. Also, as noted above, DFID appears committed to ensuring integration of HIV/AIDS and other sexual and reproductive health interventions wherever possible. Sexual and reproductive health, including HIV/AIDS, accounted for roughly one-third of DFID's spending on health through fiscal 2002/03. The United Kingdom is also one of the few donors that continue to support the provision of contraceptive and other reproductive health supplies.

Multilateral Funding

Slightly more than 20 percent (almost $35 million) of U.K. population assistance flowed through multilateral organizations in 2002, including $27 million (GBP 15 million) to UNFPA. The government's support for UNFPA is on the rise, with funding of GBP 18 million in 2003 and GBP 20 million (approximately US$36 million) promised annually from 2004 through 2007. The United Kingdom was the fourth largest donor to UNFPA in 2002 and provides GBP 3 million annually to UNAIDS, but will triple the latter contribution to GBP 9 million annually for 2004-2007. The United Kingdom has pledged a total of more than US$450 million to the Global Fund for the period 2001-2007, of which close to $200,000 had been paid by mid-2004.

Bilateral Funding

Sixty-one percent of U.K. population assistance was channeled bilaterally in 2002, the highest percentage since 1997. Significant year-to-year variations make trends hard to discern, especially with the changes in DFID's internal reporting systems over the last few years. Factors in the size of the bilateral share may include the trend toward decentralization—the devolution of deci-

The United Kingdom continues to increase its development assistance and to allocate an increasing share of aid to the world's poorest countries.

sion making authority over bilateral funds to DFID staff in developing countries—as well as the impact of changes to the funding mechanisms through which NGOs qualify for funds.

Funding for NGOs

The share of British population assistance going to NGOs has fluctuated significantly over the past decade, but has trended downward in recent years. U.K.-based NGOs working in sexual and reproductive health are finding it more difficult to qualify for DFID grants through the new funding mechanisms established by the Labour government. DFID's multi-year Partnership Programme Agreements, which accounted for one-quarter of DFID's overall funding of NGOs in fiscal 2002/03, tend to favor large development NGOs that work in more than one sector (such as OXFAM). A further one-quarter of funds were made available through in-country missions. The International HIV/AIDS Alliance has now concluded a multi-year partnership agreement with DFID, the first group working in either sexual or reproductive health to do so.

Grants from the Civil Society Challenge Fund (CSCF), just 4 percent of DFID grants to NGOs, are aimed at building the capacity of poor and otherwise marginalized people to work in the public policy arena. When the fund was first established, it did not award grants for service delivery projects. As a result, smaller U.K.-based NGOs working in reproductive health—most without offices in developing countries and often providing technical or other assistance in support of health service provision—were at a disadvantage. In July 2004, DFID announced that the criteria for CSCF grants would likely expand to include innovative service delivery projects under certain circumstances, such as when governments are unable to provide services. At the same time, however, competition for CSCF funding is increasing, as labor unions, student groups and other civil society actors are also being encouraged to apply for support.

With the phasing out of core funding, even larger NGOs such as IPPF had found it difficult to secure DFID funding. With these difficulties resolved, DFID announced in early 2004 a two-year GBP 12 million (US$22 million) grant for IPPF, an increase of one-third over funding for the previous two years. In the future, U.K.-based sexual and reproductive health NGOs will need to build relationships with country governments, as well as with DFID in-country staff, particularly where sector and budget support programs are significant, as in sub-Saharan Africa.

4 Program Priorities

Geographic Priorities

British development assistance is still influenced by the country's colonial past. India, Pakistan, Bangladesh, and Anglophone sub-Saharan countries still tend to dominate the list of U.K. aid recipients. Among the leading recipients in the reproductive health arena, including HIV/AIDS, are Bangladesh, Bolivia, Cambodia, India, Kenya, Malawi, Mozambique, Nepal, Nigeria, Pakistan, Peru, South Africa, Zambia, and Zimbabwe. In addition to specific project assistance, sexual and reproductive health has been an explicit element of DFID's sector-wide support in several of these countries, including Malawi and Zambia.

Areas of Program Emphasis

The United Kingdom funds a wide range of projects and program interventions in keeping with its commitment to the broader reproductive health agenda that emerged from the ICPD. DFID does not shy away from the more controversial aspects of this agenda, such as adolescent services in sexual and reproductive health, improving access to safe abortion, and post-abortion care. DFID is also one of the few donors providing significant support for contraceptives and condoms for HIV/AIDS prevention, providing nearly 6 percent of all donor support for these supplies from 1990 through 2002. DFID has provided significant support for social marketing of contraceptives and condoms, awarding several large contracts to Population Services International. Unfortunately, DFID's reporting systems are unable to break out specific support for supplies, especially when part of a larger program.

DFID also funds interventions to improve the status and life opportunities of women, including efforts to reduce gender-based violence. In Bangladesh, for example, the mantra is "women and girls first," which translates into support for efforts to raise the age of marriage and increase access to education. DFID's gender programs increasingly focus on influencing laws and policies affecting women, such as marriage, divorce, property and credit laws.

5 Technical Capacity

Staffing

DFID's staff has increased by roughly 50 percent since the Labour government came to power, to more than 1,600, in keeping with its increased commitment to development assistance. However, an increasing number are development generalists without a specific discipli-

nary expertise (such as health, education, or agriculture). Those with a health background number fewer than 100, of whom less than a dozen have explicit expertise in reproductive health, although more have some understanding of it or of the outcomes of ICPD. The current staffing situation is an improvement over earlier years, however.

Increasing numbers of professional staff, including those with health expertise, can be found in country offices as decentralization of bilateral programs continues. The role of headquarters staff has shifted to technical support and policy guidance, a transition reinforced by the 2003 reorganization of the Policy Division. The Policy Division now has more than two dozen interdisciplinary teams organized around five themes. Fewer than a dozen staff members have specific expertise in reproductive health, and they are split among various teams, including HIV/AIDS, Reproductive and Child Health, and Service Delivery. Each of DFID's three regional programs has at least one London-based staff member with significant reproductive health expertise. DFID is now beginning to address the lack of reproductive health expertise in its third major division, which manages research, knowledge-sharing and relations with civil society, including grants, and is also responsible for administration and evaluation. In the meantime, the Policy Division provides technical assistance when needed.

This division of roles and responsibilities increases the challenge of ensuring coherence in DFID's health programming. The reorganization wrested significant financial resources and program authority away from what is now the Policy Division, including responsibility for research programs. While this loss of managerial and budget oversight reinforces the decision making authority of mission staff and serves to streamline DFID's relationships with NGOs and other development partners, it has hurt relations with NGOs and made the sharing of information, expertise and policy guidance with field staff even more difficult. These challenges will likely be overcome over time, but may be somewhat disruptive over the short term.

Lastly, it is important to note that DFID continues to expand its health staff and, in late 2003, recruited for the first time a more senior-level reproductive health adviser for the Policy Division. DFID also has a senior adviser on rights and gender who works to ensure the integration of gender issues across programs.

Technical Expertise of Collaborating Institutions

A wide range of academic, not-for-profit, and for-profit organizations is able to provide significant research and technical expertise in sexual and reproductive health to DFID, due in part to DFID's systematic support of their activities over more than ten years. Research grantees include the London School for Hygiene and Tropical Medicine, the Liverpool School of Tropical Medicine, and the Nuffield Institute at the University of Leeds. U.K. reproductive health NGOs qualifying for DFID grant support include International Family Health, the International Planned Parenthood Federation, Interact Worldwide, John Snow International (UK), Marie Stopes International, and Population Services International/Europe. Contracts tendered in-country represent a major share of DFID spending in sexual and reproductive health and have been awarded to the Futures Group/Europe and Options, among others.

Since 1994, DFID has also entered into multi-year contracts with organizations that serve as resource centers on specific issue areas, including sexual and reproductive health, health systems, and HIV/AIDS. Resource centers are an on-call resource for technical advice and assistance, knowledge, and information management, and may provide managerial support. JSI(UK) served as the resource center for sexual and reproductive health, including HIV/AIDS, from 1999 to 2003. Prior to that, DFID had supported separate resource centers for reproductive health and sexual health (the latter including HIV/AIDS). A further consolidation occurred in 2003, when the Institute for Health Sector Development (IHSD), along with five non-U.K. partners, was awarded the contract to serve as Health Resource Center on a range of health issues, including sexual and reproductive health, maternal and child health, HIV/AIDS, and other communicable diseases. IHSD also manages DFID's Health Systems Resource Center that focuses on strengthening of overall health systems in developing countries.

DFID has also benefited from the advocacy efforts of many of the organizations referred to above. Some 20 organizations make up the U.K. Network on Sexual and Reproductive Health and Rights, working together and separately to influence DFID's policies and programs, directly and through Parliament. The All Party Parliamentary Group on Population, Development and Reproductive Health (APPG) also plays an important advocacy role by placing parliamentary questions, and through the positions some APPG members hold on the International Development Committee, the parliamentary body to which DFID reports. In combination, these groups' efforts have helped to bring about DFID's "recommitment" to sexual and reproductive health and are important to maintaining public support for DFID's work on these issues.

United States

GRADE

C

The United States provides the most development assistance in absolute terms and is likewise the leading donor of population assistance.[1] The U.S. Agency for International Development (USAID), historically the primary implementer of U.S. development assistance, in conjunction with its extensive network of Cooperating Agencies, continues to play an important role in supporting sexual and reproductive health services.

The U.S. government, through both USAID and a new Global AIDS Coordinator housed at the Department of State, is becoming much more active in supporting prevention and treatment programs to combat HIV/AIDS, and USAID has recently announced a major initiative to strengthen the human resource and infrastructure capacity of health systems in partner countries with high HIV/AIDS prevalence levels. USAID remains a leader in procurement of contraceptives, condoms, and other reproductive health supplies.

The United States' leadership in financial terms, however, is less significant when considered in relation to the size of its economy. By this measure, U.S. development assistance is the lowest among all DAC donor nations. Funding for family planning—long the centerpiece of U.S. population assistance—is less now than in 1995, although still greater in dollar terms than any other donor country due to size of the U.S. program overall. Relative to national income (GNI), however, total U.S. population assistance—including contributions in the HIV/AIDS arena—was only one-quarter that of Denmark, Norway, Netherlands or Luxembourg in 2002. The United States is also the only major donor of population assistance that does not provide funding for either UNFPA or IPPF.

Bush Administration policies are compromising the effectiveness of U.S. population assistance. The re-imposition of the Mexico City Policy/Global Gag Rule in 2001 (which disallows U.S. family planning assistance to non-U.S. NGOs that use funds from any source for abortion services, counseling, referral, or advocacy) has undermined local health care networks that USAID spent years building and resulted in a number of foreign NGOs losing funding. At the same time, efforts to integrate or coordinate HIV/AIDS and reproductive health activities in the field are affected by the rigidity of USAID's spending guidelines that may limit the range of reproductive health services that can be supported with HIV/AIDS funds. Indeed, the U.S. strategy for combating HIV/AIDS is increasingly seen as a "go-it-alone" policy, and its emphasis on externally driven policy prescriptions and funding decisions in its assistance to focus countries (including promotion of abstinence-only approaches) has subjected the United States to international criticism, including at the major international AIDS conference held in mid-2004.

While a change in administrations would result in a reversal of these policies, other restrictions on U.S. funding could be imposed by Congress. This was the case in the years after the 1994 elections, when a Republican-controlled Congress succeeded in cutting family planning assistance and, in some years, delayed and/or "metered" the disbursal of funds.

[1]The term "population assistance" is used here in keeping with the definition used by the international community following ICPD and encompasses funds made available for family planning, other reproductive health activities, STD/HIV/AIDS activities and research. Thus it is not the same as either "family planning assistance" or "population planning assistance" as used in the United States.

VITAL STATISTICS

2002 population size:
287.4 million

Total Official Development Assistance (ODA), 2002:
$13,290 million

ODA as a percentage of GNI, 2002:
0.13%

Total population assistance, 2002:
$963.0 million

Population assistance as percentage of ODA, 2002:
7.25%

Population assistance per $US million GNI, 2002:
$92

1 Development Assistance: Policy and Funding

The United States is the largest international development donor in terms of total dollar outlays, accounting for roughly 20 percent of total DAC development assistance. In 2002, the United States contributed $13.3 billion in ODA, an increase of 15 percent in real terms over aid of $11.4 billion in 2001. Of this amount $7.9 billion was channeled through USAID. Despite these impressive absolute sums, the United States continues to be the least generous of the DAC donor countries relative to gross national income (GNI), allocating only 0.13 percent of GNI for official development assistance in 2002, well below both the average DAC country effort of 0.41 percent of GNI and even the weighted average of 0.23 percent of GNI for ODA.

U.S. development assistance strategy is currently centered on supporting long-term and equitable economic growth in developing countries as the principal means of reducing poverty. Priority sectors in which USAID works include agriculture, democracy and governance, economic growth and trade, environment, education, and health. Family planning and reproductive health fall under global health along with child survival, maternal health, HIV/AIDS, infectious diseases, and nutrition programs. Other crosscutting programs work across sectors and include activities related to assisting countries in transition, involving private voluntary organizations and the private sector, "conflict management," urbanization, water and sanitation, and improving women's status. There is little or no formal recognition or incorporation of the Millennium Development Goals into U.S. development policy and programming, notwithstanding the creation of the Millennium Challenge Account in 2003.

While U.S. ODA has risen in recent years, the environment in which foreign assistance is supported has changed in the wake of the terrorist attacks of September 11, 2001. U.S. foreign assistance is increasingly justified in terms of supporting the Bush Administration's National Security Strategy for combating global terrorism. USAID is also now more closely tied with the Department of State, whether through mechanisms such as the Joint Policy Council (established in 2003) or by policy documents, such as the first ever State/USAID Strategic Plan issued in mid-2003, which has its focus the "three Ds": diplomacy, development and defense.

Another significant development since the beginning of the Bush Administration is the much more visible involvement of other federal agencies in U.S. development assistance policy and programs. The most notable example is growing prominence of the Department of Health and Human Services in international health policymaking and its overseas involvement in HIV/AIDS through the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH). Historically, USAID has served as the central locus of coordination of U.S. development assistance, lending a certain degree of policy coherence and isolation from political considerations, both domestic and geopolitical. Indeed, the situating of a Global AIDS Coordinator within the State Department can be seen either as a way to ensure greater coherence and coordination of U.S. efforts vis-à-vis HIV/AIDS, or another way in which USAID's influence over development assistance policy is being undermined.

Other developments point to a possible fragmentation of U.S. development assistance, including the creation of new presidential initiatives that sidestep USAID and other existing channels of U.S. development assistance. Along with the President's Emergency Plan for AIDS Relief (PEPFAR), a five-year, $15 billion initiative to fight the AIDS pandemic, the Millennium Challenge Account (MCA) is the most significant of these new presidential initiatives. With the goal of increasing ODA by $5 billion annually by 2006, the premise of the MCA is to bring a business-model approach to the process of development—an implicit criticism of development as practiced by traditional donor agencies including USAID. The initiative seeks to reward a small number of relatively well-performing countries committed to democracy, free markets, and human rights that meet a set of selection criteria and to encourage private sector involvement in sustainable development activities.

The implications of the MCA for funding to USAID's traditional development assistance programs—including family planning and reproductive health activities—and for the poor countries they attempt to assist remains to be seen. While U.S. development assistance advocates are generally encouraged by the prospect of significantly increased financial resources for ODA, serious concern remains whether funding for the MCA will in fact be additional or whether funding for core development and humanitarian assistance programs will stagnate or decline over time.

The Millennium Challenge Corporation, charged with administering the MCA, was still in formation as of this writing in mid-2004. Its newness makes it difficult to predict how the MCA may evolve and what types of projects, programs, and activities submitted by countries in

their proposals will be awarded funding. The extent to which funds are allocated for sexual and reproductive health activities will likely depend largely on the priority attached to them in proposals received from qualifying countries, given the discomfort of the Bush Administration with these types of programs.

2 The Policy Environment for International Population Assistance

The United States has historically been one of the strongest supporters of international population assistance. The U.S. government established one of the first international population assistance programs in 1965 and helped to create UNFPA a few years later. For much of its history, the program enjoyed strong bipartisan support in Congress and the executive branch, reflecting a consensus that rapid population growth was a serious global problem eroding economic and social progress in developing countries. Today, USAID justifies its support for sexual and reproductive health activities primarily in terms of their contribution to improved health. This rationale is captured in the State/USAID performance goal of "improved global health, including child, maternal and reproductive health, and the reduction of abortion and disease, especially HIV/AIDS, malaria and tuberculosis."

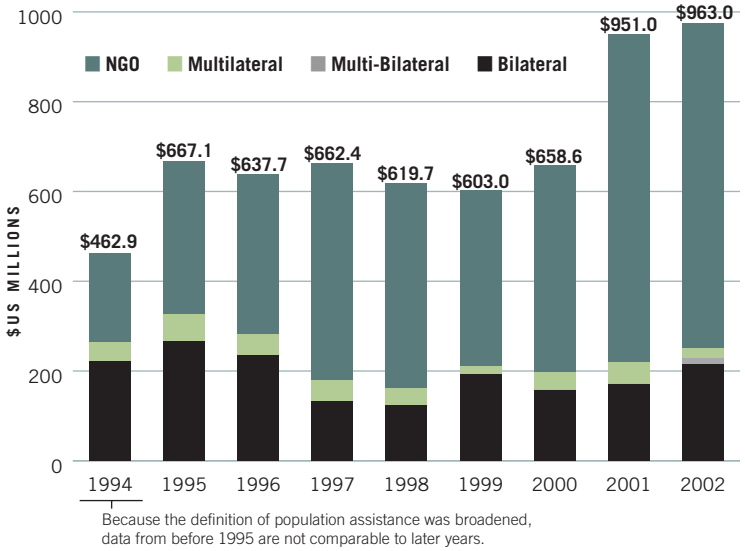
The U.S. political climate began to change in the 1980s, during the Reagan and Bush (senior) Administrations, when anti-abortion groups sought to link international family planning efforts to the domestic politics of abortion. (U.S. law has prohibited the use of U.S. foreign assistance funds for abortion services since 1973.) Despite these political attacks, Congressional support remained strong and population assistance funding increased during this period.

The administration of President Clinton that assumed office in January 1993 was far more supportive of international population assistance, rescinding the Mexico City Policy/Global Gag Rule and thereby restoring a U.S. contribution to IPPF. It also resumed contributions to UNFPA. The United States played a leadership role at the ICPD in 1994 and U.S. funding for family planning and related programs reached an all time high.

Two years into Clinton's presidency, however, mid-term elections resulted in a Republican majority in both houses of the U.S. Congress. Thus since January 1995, leaders of a small but politically powerful social conservative movement and their allies in Congress have systematically sought to undermine U.S. government funding for both domestic and international family planning programs. These groups and members of Congress, who have in common a desire to end the right to legal abortion—and even, for some, access to contraceptives—both in the United States and overseas, have succeeded in imposing funding cuts and other spending restrictions on U.S. family planning assistance. While President Clinton was able to resist most efforts by Congress to impose additional policy restrictions on international family planning funds, he could not forestall cuts in funding. The first such cut came in U.S. fiscal year 1996, when Congress appropriated $356 million in bilateral family planning assistance, down from $542 million the previous year.

Following the 2000 election, President George W. Bush reversed the policies of his Democratic predecessor upon taking office, as President Clinton had overturned those of Bush's father after his 1993 inauguration. As noted above, the Mexico City Policy was reimposed through executive action and IPPF was subsequently defunded. In mid-2002, the administration used a provision of U.S. law to justify a cutoff of funds for UNFPA. Since then, at regional and other UN meetings convened to mark the tenth anniversary of the ICPD, the Bush Administration has sought to distance itself consistently from its predecessor by insisting on redefining previously negotiated terms in the ICPD Programme of Action. Notwithstanding these actions, the administration continues to assert its support for family planning, noting that it has consistently requested $425 million for this element of U.S. health assistance.

TRENDS IN POPULATION ASSISTANCE 1994-2002: UNITED STATES



NB: For 1995 figures, it was not always possible to determine unequivocally the channel of funds distribution.

Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002.* New York: UNFPA.

3 Trends in Funding for Population Assistance

Overall Funding Levels

In 2002, total U.S. population assistance reached $963 million, a modest increase over 2001, but a significant gain over assistance of $659 million in 2000. Much of the 2000-2001 increase went to support HIV/AIDS activities, while support for family planning and other reproductive health efforts rose much more modestly. In 2002, HIV/AIDS spending accounted for 54 percent of the total $963 million, family planning 32 percent, other reproductive health activities less than 8 percent, and research accounted for 4 percent of expenditures. While the increase in HIV/AIDS funding is welcome, current policy restrictions on family planning assistance, rigid spending guidelines overall, and a lack of appreciation among some senior officials for the synergies and added value of sexual and reproductive health activities to HIV/AIDS efforts limits opportunities for achieving greater integration.

The United States committed 7.25 percent of its ODA for population activities in 2002, the highest share among DAC member countries. The scale of U.S. assistance is less impressive when measured against the U.S. economy, however, and equaled just $92 per million dollars of GNI in 2002. While this ratio is (not surprisingly) nearly equivalent to the weighted DAC average of $93, it is below the average effort by other donors, which comes to $140 per million of GNI, and is well below levels at or above $400 attained by such countries as Denmark, Norway, and the Netherlands. Indeed, the United States would need to increase its 2002 funding 3.3 times by 2005, to $3.2 billion, to fulfill its fair share of donor commitments to ICPD.

In future years, an increasing share of U.S. population assistance will be made up of new U.S. financial commitments for HIV/AIDS prevention activities. The President's Emergency Plan for AIDS Relief aims to treat at least 2 million HIV-infected people with anti-retroviral (ARV) therapy, prevent 7 million new infections, and care for 10 million people infected and affected by HIV/AIDS, including orphans and vulnerable children, in 15 focus countries. Funding for these activities will be counted as part of U.S. population assistance and will swell the amounts that the United States contributes toward meeting its Cairo funding goal.

U.S. government allocations for international HIV/AIDS relief are anticipated to increase to $2.4 billion in 2004. Bilateral programs are expected to receive much of this funding, with the 15 Presidential Initiative focus countries provided $637 million and the Global Fund to Fight AIDS, Tuberculosis, and Malaria allocated $547 million. President Bush has proposed increasing HIV/AIDS funding to $2.8 billion in 2005. This plan entails raising funding for the 15 focus countries to $1.5 billion, reducing support in other non-focus countries, and scaling back the annual U.S. contribution to the Global Fund to just $200 million.

To date, most U.S. support for HIV/AIDS has focused on prevention, but it now seems prepared to allocate significant resources for anti-retroviral treatment. Policy guidance passed by Congress, which does not technically become binding until the end of 2005, mandates that 55 percent of future HIV/AIDS funding go to treatment programs, 20 percent for prevention (one-third of which is to be for "abstinence-until-marriage" programs), 15 percent for palliative care, and 10 percent for the support of orphans and other children at risk. These legislative mandates will result in a massive infusion of funding into HIV/AIDS prevention, treatment, and care, including more than $100 million into abstinence-only programs.

HIV/AIDS prevention funding from the U.S. government must adhere to the abstinence, be faithful, and condoms (ABC) approach favored by conservative forces on Capitol Hill and within the Bush Administration. Many organizations working in sexual and reproductive health are concerned that faith-based organizations promoting abstinence-only approaches will be favored when awarding new HIV/AIDS funding, thereby frustrating more effective, multifaceted prevention strategies (which do not preclude provision of condoms) tailored to the specific needs of local communities and populations. Indeed, it is important to note that current law does not require groups receiving HIV/AIDS funds to "endorse, utilize, or participate in a prevention method or treatment program to which the organization has a religious or moral objection;" thus the U.S. version of ABC has been described by some as "A plus B, but not much C."

Multilateral Funding

Very little U.S. funding for reproductive health and population is now sent through multilateral organizations. In 2002, the United States directed only 2.3 percent of its total population assistance through multilateral organizations (the smallest proportion of any DAC member country except Spain). America's support for multilateral programs fell substantially in 2002 when the Bush Administration ended all U.S. contributions to UNFPA in the wake of accusations that UNFPA was supporting coercive abortions in China, a charge dismissed by an external review of the China program commissioned by the U.S. Department of State.

While the United States continues to be the largest contributor to UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria, its level of support is deficient in relation to its available resource base. The United States provided $129 million to UNAIDS between 1995 and 2003, a funding level that is only slightly ahead of the $115 million contributed by the Netherlands during the same period. The United States has pledged nearly $2 billion to the Global Fund, and had paid $980 million by mid-2004. While the United States continues to support aspects of WHO's reproductive health research, it has stopped contributing to WHO's special research program on human reproduction, as was the case under the Reagan and first Bush Administrations.

Bilateral Funding

The United States commits only a small percentage of its population and reproductive health budget to direct bilateral assistance. In 2002, 22 percent of America's total population budget was officially allocated through government-to-government bilateral channels. Much of U.S. population assistance is implemented by U.S.-based Cooperating Agencies (CAs)—defined as NGOs for international accounting purposes. CAs most often operate with funds that originate from USAID's core budgets in Washington or bilateral accounts administered by USAID field missions. It is worth noting that USAID cooperating agencies often provide technical assistance to government agencies and even sub-contract with government-sponsored groups, in effect supplementing direct government-to-government aid.

Funding for NGOs

In 2002, 75 percent of all U.S. population assistance was provided through NGOs, primarily U.S.-based Cooperating Agencies, as noted above. The CA community generally offers an impressive array of program services in reproductive health and provides much of the technical capacity USAID relies upon in implementing its sexual and reproductive health programs. One criticism leveled at this arrangement is that a sizeable percentage of ODA resources provided to CAs never leave the United States. USAID has become far more supportive of foreign NGOs in many of its country programs over the past decade, however, and CAs typically subcontract with local organizations in implementing projects. For example, a recent survey of HIV/AIDS funding found that among the eight largest recipients of funds, an average of 72 percent was used in-country, whether to support local organizations, provide technical assistance, or training.

It is important to note again here the impact of the Global Gag Rule (Mexico City Policy), as USAID Cooperating Agencies must ensure that any foreign NGOs with which they work are in formal compliance with the restrictions. In some cases, the end result has been a loss of funds to foreign NGOs that had the greatest expertise in providing a wide range of reproductive health services.

4 Program Priorities

Geographic Priorities

USAID has been gradually shifting funding from Southeast Asia and Latin America to South Asia and Africa in order to situate funding in countries with greater needs for assistance. In 2002, Bangladesh, the Philippines, India, and Egypt were the top four recipients of assistance for family planning and other reproductive health activities, while HIV/AIDS funding was concentrated in Africa. In 2002, Uganda, Kenya, Zambia, and South Africa received the greatest share of the HIV/AIDS funds channeled through USAID (other HIV/AIDS funds flow through NIH and the Centers for Disease Control).

Areas of Program Emphasis

USAID's assistance for global health is organized around the following program areas: HIV/AIDS (including prevention, care, treatment and support); other major infectious diseases; child survival and maternal health; and family planning and reproductive health.

USAID provides resources for improving the quality of family planning and reproductive health care; integrating family planning with maternal and child health services; disseminating reproductive health information through educational and communication activities; strengthening commodity logistics systems for contraceptives and essential drugs; providing improved contraceptive products; promoting new service delivery approaches including partnerships with the private sector and NGOs; and improving the policy environment for reproductive health. USAID's family planning efforts are also being integrated with efforts to reduce mother-to-child transmission of HIV/AIDS, as well as with voluntary counseling and testing and ARV treatment, and activities to enhance maternal and child health by reducing the number of unintended high risk births, and increasing the spacing of births.

USAID has also made substantial contributions over the years in supporting the collection and analysis of demographic and health statistics, first through its support for the World Fertility Survey in collaboration with UNFPA, and more recently the Demographic and Health Survey Project implemented by Macro International. DHS surveys provide many developing countries with essential information for monitoring demographic outcomes as

well as family planning and child health program performance. USAID also funds a CDC-implemented reproductive health survey program (that includes adolescents) in Europe, Latin America and parts of Asia (Eurasia).

The United States remains the largest single donor of contraceptive and other reproductive health supplies, including condoms for HIV/AIDS prevention, according to UNFPA. Over the period 1990-2002, USAID contributed 39 percent of reported donor resources for contraceptives, including condoms. In 2002, UNFPA reports that USAID contributed $49.6 million for these supplies, or roughly 25 percent of total contributions. However, the impact of U.S. support is lessened by requirements that USAID purchase supplies from U.S. corporations whose prices are generally higher than non-U.S. suppliers, although in 2004 an emergency procurement of condoms outside the United States was approved. U.S. support for condoms was further boosted in 2002 with the establishment of a $25 million Commodity Fund available to USAID missions. As is the case with other donors, however, U.S. overall support for contraceptives (including condoms) tends to fluctuate from year to year and has failed to keep pace with rising demand. Indeed, the level of support provided by USAID for these supplies in 2002 is less than in either 1990 or 1991, even before inflation is taken into account.

Unlike other major donors in the field, USAID is not a major supporter of sector-wide approaches and other budget support and U.S. law now bars the use of this kind of aid instrument in the health sector. The agency does encourage coordination of its activities with those of other donors, however, and has sought to complement these other mechanisms of support. For example, USAID has funded the procurement of contraceptive supplies in Mozambique, technical assistance in Tanzania, and recently announced a major five-year, $250 million project to upgrade the human capacity of health systems in the developing world. This latter effort will focus on improving the quality of pre-service and in-service training for health providers, strengthening health work force planning, and upgrading management systems use to monitor health work force performance.

Bush Administration policies are compromising the effectiveness of U.S. population assistance.

5 Technical Capacity

Staffing

Although it continues to have the largest number of staff devoted to sexual and reproductive health of all donors (both in the field and in Washington), USAID currently faces staff shortages in all sectors. While the staff reductions of the 1990s have ended, stepped-up recruitment of the last few years has not kept pace with the combined impact of retirements and the growth in programming. Fortunately, USAID has been able to partly offset these shortages by relying on individual contractors, local hire staff, and program "fellows" recruited by CAs. However, the dramatic increases in HIV/AIDS funding are having an impact, particularly in the field, as mission staff find themselves torn between the need to program these additional resources and to continue managing existing programs across the sexual and reproductive health field.

Recent plans have been announced to improve USAID's deteriorating human resource position. New junior career staff will now be recruited through the reinstated International Development Intern (IDI) Program and efforts are being made to provide more opportunities for mid-career applicants. In the HIV/AIDS arena, USAID has been given special authority to make "limited-term" (five years) appointments. As these plans proceed, it will be important to ensure that those hired have specific expertise in sexual and reproductive health, rather than a general development or managerial background.

Technical Expertise of Collaborating Institutions

USAID's population and reproductive health programs draw upon a wide range of expertise from its network of Cooperating Agencies. Effective technical support is provided in such areas as family planning commodity logistics management; information, education, and communication programming; in-service training for service providers and program managers; the expansion of new reproductive health services; and operations research and program evaluation. The CA community is highly responsive to USAID's requests for assistance and often provides high-quality technical support, although this reliance on U.S.-based organizations is viewed by some as further evidence of how U.S. development assistance is "tied" to the procurement of U.S. goods and services. Other donors (for example, the United Kingdom) have moved to untie even this aspect of their aid programming. Again, however, it is worth noting that CAs rely on non-U.S. based, often local NGOs in actual project implementation and hire local professionals to staff their operations in country.

Other Donor Profiles

European Commission

The European Commission (EC) has emerged as a strong, progressive voice on sexual and reproductive rights and health policy in recent years. Commission policies illustrate a clear understanding of the principles of the International Conference on Population and Development (ICPD). The EC's position on the issues is important, given its role in moving the policy process forward within institutions of the European Union (EU), such as the Council and Parliament. The Commission's response to changes in U.S. policy under the Bush Administration, including the reimposition of the Global Gag Rule and denial of funds to UNFPA, provides another example of the EC's progressive policy stance. Former Development Commissioner Poul Nielson joined with other European donor countries to help fill the "decency gap" caused by the loss of U.S. funds.

Like a number of other donors, the Commission's population assistance increased dramatically in 2002 compared with previous years, although this increase is at least partly due to improved reporting and changes in the sourcing of aid data. **Even with the increase, however, the Commission still falls short of the financial goals it set for itself in 1994, prior to the ICPD.** In addition, the EC's complex structure and lack of sufficient technical and other staff in Brussels and in country delegations result in slow implementation. Delays in the process are still common, from the issuing of calls for proposals through to the disbursement of funds. Thus EC professional staff working to advance the ICPD health and rights agenda face both financial and human resource constraints.

The future shape of EC policies and funding on sexual and reproductive health and rights will be affected by developments in the political arena. Organized opposition to reproductive rights has intensified in Europe in recent years, including in the European Parliament. This opposition was evident in lengthy parliamentary negotiations over new regulations on sexual and reproductive health in 2002 and 2003, and in the jump in hostile queries directed at Commission staff. Parliamentary elections in 2004 added members identifying with far-right party groupings. Ten new Member States joined the EU in May 2004, most with limited experience in development assistance and, in some cases, more conservative views vis-à-vis reproductive health and rights. All these developments highlight the need for ongoing advocacy by civil society in support of ICPD goals.

1 Development Assistance: Policy and Funding

The European Commission is an increasingly important channel of development assistance for EU Member States, which directed almost 20 percent of their official development assistance through the Commission in 2002. This made the EC, the executive body of the European Union, the third largest donor of development assistance after the United States and Japan in 2002, and responsible for channeling the equivalent of 10 percent

VITAL STATISTICS

2002 population size:
NA

Total Official Development Assistance (ODA), 2002:
US$6,561 million

ODA as a percentage of GNI, 2002:
NA

Total population assistance, 2002:
US$184.9 million

Population assistance as percentage of ODA, 2002:
2.8%

Population assistance per $US million GNI, 2002:
NA

of all aid from the DAC donor countries. While EC development assistance declined sharply after 1995, it recovered to US$6 billion in 2001 and in 2002 reached $6.6 billion, of which an estimated $5.2 billion was disbursed. It is worth noting that the EU Member States *together* provided close to $30 billion in ODA in 2002, fully half (51 percent) of all assistance from the DAC donor countries. In 2003, EC development assistance reached an estimated $8.1 billion.

Reducing poverty is the primary aim of current EC development policy, which has six priority areas: links between trade and development; regional integration and cooperation; support for macroeconomic policies and equitable access to social services; transport; food security and rural development; and institutional capacity building, including good governance and the rule of law. EC development policy also recognizes human rights, gender equality, the environment and conflict prevention as crosscutting issues within EC development cooperation.

Support for health, including sexual and reproductive health, falls under access to social services. The European Parliament, which approves the Commission's general budget, has increased the prominence of these issues by requiring that 35 percent of aid funds go to support the social sector, and that fully 20 percent should go to health and education alone, although these targets have not yet been met. As with other donor governments, aid budgets are under pressure as security concerns (such as terrorism and drug trafficking) have gained prominence in recent years.

In addition to the policy aims underpinning EC development cooperation, the Commission also seeks to promote policy coherence between its aid and other external policies, and to achieve better coordination and complementarity of aid programs between the EC and EU Member States. To this end the EC has encouraged an increase in overall EU aid from 0.32 percent of GNI in 2001 to 0.39 percent by 2006. At the country level, this means that the EC could decide not to fund a sector already well-funded by other donors, or to rely on another donor's delegation for specific expertise rather than adding to its own delegation. The EC's effectiveness in this coordinating role has been challenged both by its own lack of technical expertise and staffing capacity in the field and by the need of many EU Member States for recognition at home of their development-related efforts.

Aid Management

Overall responsibility for EC development assistance lies primarily with the Directorates-General for External Relations (DG Relex) and Development (DG Dev). They are part of the so-called "RELEX Family" which also includes the Directorates-General for Trade and Enlargement, as well as EuropeAid and ECHO, the latter two responsible for the actual implementation of EC development assistance (EuropeAid) and humanitarian assistance (ECHO).

DG Dev is responsible for aid that flows to developing countries in sub-Saharan Africa, the Caribbean, and Pacific regions (the ACP countries) under the European Development Fund (EDF), while DG Relex handles aid for developing countries in the Mediterranean region, Asia and Latin America. DG Relex also handles aid agreements with Eastern Europe, the Balkans, and Central Asia, including Russia and the former Soviet Republics.

Aid Mechanisms

Official development assistance from the EC flows through both geographic and thematic budget lines. The largest share is channeled geographically and funded either through the EC's general budget or through the EDF, which is administered separately.

The EDF provides funds to the ACP countries and is the longest standing aid arrangement, dating back more than 40 years. The EDF is funded in five year tranches, the latest of which is the ninth EDF that provides funds totaling $14.5 billion (EUR 13.5 billion) over the period 2002-2007; an estimated $10 billion in additional funds are carried over from previous EDFs. EDF monies are governed by long-term agreements between the ACP countries and EU Member States. The current agreement, called the Cotonou Agreement, was signed in June 2000 and came into force in April 2003 following ratification.

The EC's general budget is the source of funds for the other geographic areas, including Asia and Latin America (ALA), the Mediterranean region (MEDA), and former Soviet republics (TACIS). The horizontal or thematic budget lines are also funded through the general budget. They address such issues as food security, drug trafficking, the environment, sexual and reproductive health and HIV/AIDS. The thematic budget lines and the NGO co-financing budget line are important sources of funding for European NGOs.

The flow of aid from the EC to recipient countries is largely determined by multi-year regional or national indicative programs (RIPs or NIPs). These programs are

Indeed, the Commission and other European donors pledged to help fill the "decency gap" created by U.S. policies.

developed as part of regional and country support strategies and spell out the areas for spending and how much will be spent. The process is intended to support the poverty reduction strategy (PRS) process in which the World Bank plays a leading role (see the profile of the World Bank for further detail). Similar to the PRS process, country support strategies involve the development of strategy papers (CSPs) which are based around EC/EU cooperation objectives and the policy framework of the beneficiary country. In theory, decisions about which sectors EC aid will address are made on the basis of complementarity with other donors and the comparative advantage of the EC in the country concerned.

Overall, the Commission increasingly favors sector support and budget support for macroeconomic policies over project support, although this varies by region. Budget support represented 7.3 percent of ODA in 1999, rising to 20 percent in 2003. Budget support is most significant in Africa, while sector support has been favored in parts of Asia, the Middle East and North Africa. Nonetheless, only about a dozen countries, including Malawi and Uganda, had received direct budget support through mid-2003, while another 20 countries were then in the planning stage. A half dozen or so countries were receiving health sector support in 2003 of which at least two (Ghana and Zambia) received both sector and budget support.

Budget or sector support tends to be favored for countries with relatively small economies, while for larger economies projects may make more sense. The EC recognizes the sensitivity of sexual and reproductive health activities and remains open to providing project support in more controversial areas such as adolescent services. Projects also are employed in countries lacking institutional capacity or where governance issues are problematic.

Reform and Reorganization

Efforts to reform and reorganize management of the Commission's aid program have been ongoing since the late 1990s. Among the most significant changes was the establishment in January 2001 of the EuropeAid Cooperation Office (referred to as EuropeAid or AIDCO) to implement the bulk of EC development programs. A second important development in aid management at the Commission is deconcentration, the process by which responsibility for the management and programming of development funds is shifted from Commission headquarters in Brussels to EC delegations in recipient countries.

EuropeAid is responsible for Commission aid that is programmed by DG Dev, including the EDF and thematic budget lines, and aid coming from the general Community budget through DG Relex. There are certain exceptions to EuropeAid's role, including assistance provided to the new EU Member States prior to May 2004 (pre-accession assistance), humanitarian aid, and certain other assistance not generally considered as ODA. Thus while DG Relex and DG Dev are responsible for the setting of multiannual policy and overall program guidance, EuropeAid is responsible for all phases of the project cycle (identification, appraisal, preparation of the financing decision, implementation and monitoring, evaluation) and for ensuring that Commission policies are translated into practice at the country level. EuropeAid's responsibilities also include the training of EC delegations to take on all aspects of project management as part of the deconcentration process.

Deconcentration, the second key element of management reform for EC aid, began in 2001. Through this process, the Commission hopes to improve the responsiveness of its aid to the particular needs of the regions and countries concerned and to speed up implementation. As articulated in an oft-repeated quote, "The principle is that what can be better managed and decided on the spot, in the country concerned, should be done there, and not in Brussels." By March 2004, a total of 63 delegations, covering 123 states and territories, were to assume full responsibility for management of EC external assistance, according to EuropeAid. The remaining 17, covering 25 states and territories, were to be devolved by the end of 2004. At the end of 2003, an estimated three-quarters of EC regional and country aid was managed by delegations; 12 percent was managed jointly by EuropeAid and delegations; and 16 percent was still managed from Brussels.

Changes in the management of EC development cooperation are far from over. In late 2003, the Commissioner for Development proposed that the funds of the EDF be "budgetized," or brought into the EC budget under the control of the European Parliament. While this would strengthen parliamentary scrutiny of the EDF, it could result in the diversion of funds. Some in the Commission feel that the current division of responsibilities between EuropeAid and the Directorates-General is incompatible with the way that policy and programming issues inter-

sect in the real world. And of course, the selection of a new Commission, based upon an enlarged European Union, opens up even further the range of possibilities for the restructuring of EC aid over the longer term.

2 The Policy Environment for International Population Assistance

The outlines of EC policy on population assistance can be found in the various regulations (laws) adopted by the Council and Parliament of the European Union, communications from the Commission, and in reports adopted by the European Parliament. These documents illustrate the evolution of the Commission's approach to reproductive health and population issues and, like most other donors, reflect a gradual shift after the Cairo conference toward a more holistic approach to sexual and reproductive health and rights. Policies on HIV/AIDS have evolved from a focus on prevention to encompass treatment and care, as well as activities in other sectors. Regulations spell out actual allocations of monies for specific activities over time.

In broad terms, EC policies aim to expand access to sexual and reproductive health services for women, men and adolescents; ensure access for women to skilled care in pregnancy and childbirth; limit the spread of HIV/AIDS and STDs, while providing care, treatment and support for those living with HIV/AIDS; and to eliminate harmful traditional practices such as female genital mutilation/cutting and child marriage.

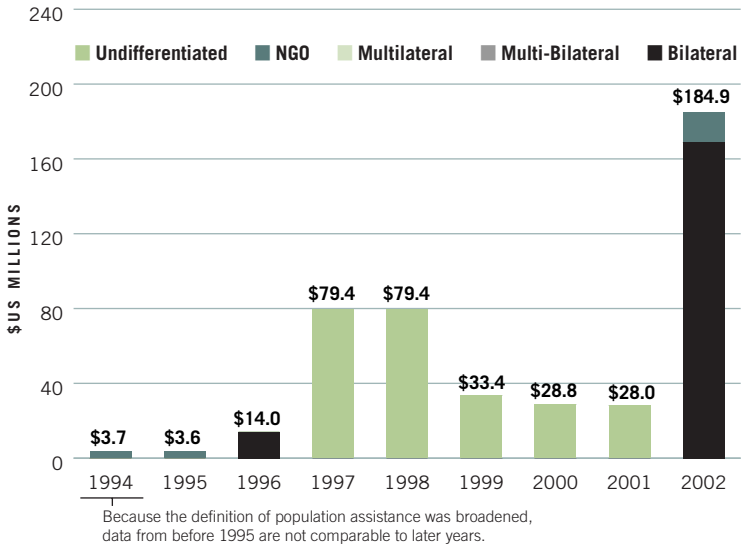
Among the most significant developments of the last few years was the integration, for the first time, of sexual and reproductive health into the agreement that governs the partnership between the EU and ACP countries. Article 25 of the Cotonou Agreement states that cooperation will aim at "integrating population issues into development strategies in order to improve reproductive health, primary health care, family planning and prevention of female genital mutilation," and "promoting the fight against HIV/AIDS."

The most recent regulation on sexual and reproductive health issues came into force in 2003. Regulation 1567/2003 governs policy and funding for reproductive and sexual health and rights. It echoes the areas of emphasis noted above, while stressing the need for ongoing support for affordable, effective, and acceptable methods of contraception and protection against HIV/AIDS. The regulation explicitly references the ICPD Programme of Action and the goal of universal access to reproductive health care services. It provides for funding of about $80 million (EUR 74 million) for the period 2003-2006.

Regulation 1568/2003 provides for aid to fight poverty diseases (HIV/AIDS, tuberculosis and malaria) in developing countries. Framed in terms of the right to health and the goal of reducing poverty, the regulation focuses on the need to "increase the affordability of key pharmaceuticals and diagnostics for the three diseases" and to "increase research and development, including vaccines, microbicides and innovative treatments." It calls for a balance between prevention, treatment and care, "with prevention as a key priority." The regulation provides for funding of about $400 million (EUR 351 million) for the period 2003-2006. Slightly more than half of the funds available each year will go to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

The process for developing and adopting regulations and policy documents is long and complex. In the last few years, however, the process has been subject to increasing political pressure, as political opposition to sexual and reproductive health and rights has intensified in Europe. This rise in opposition may in part be due to the stronger, high-profile stance of the Commission vis-à-vis sexual and reproductive health and rights issues, as evident (for example) in its response to policy changes by the U.S. government under President George W. Bush.

TRENDS IN POPULATION ASSISTANCE 1994-2002: EUROPEAN COMMISSION



NB: Expenditures for 1994 and 1995 were not reported to UNFPA and were obtained from data provided by other respondents. Figures for 1995 also represented multiple-year assistance. In 1996, data exclude NGO co-financed projects. 1997 data are a global estimate based on known payment credits for population, reproductive health and AIDS activities. Expenditures for 1998, 2000 and 2001 were not fully reported to UNFPA and were estimated at the previous year's level. 1999 data are a global estimate based only on the European Commission's commitments for reproductive health and AIDS activities. Figures for 2002 have been estimated by NIDI based on data from the European Commission and the DAC Watch of the European Union, IPPF, January 2002.
Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002.* New York: UNFPA.

When he took office in 2001, President Bush reimposed the Global Gag Rule or Mexico City Policy that denies U.S. assistance for family planning programs to any foreign organization that engages in abortion-related activities—including counseling and advocacy—regardless of the source of funds. IPPF was the first and largest NGO affected by this measure. In mid-2002, the Bush Administration cut off funds to UNFPA in the wake of allegations about its involvement in coercive practices in China that the administration's own fact-finding mission said were unfounded. Both of these decisions prompted an outcry throughout Europe, including from then-Commissioner for Development Nielson. Indeed, the Commission and other European donors pledged to help fill the "decency gap" created by U.S. policies. The EC subsequently provided project funding of more than $30 million (EUR 32 million) to UNFPA and IPPF.

The results of rising opposition to reproductive rights in Europe have been evident in contentious debates in the European Parliament and in the large number of hostile parliamentary queries directed at the Commission. Up until now, however, more progressive voices on these and related issues have largely prevailed. This was the case in late 2004, when incoming EC President José Manuel Barroso withdrew his proposed Commission from consideration due to strong objections by Members of the European Parliament (MEPs) and NGOs to some of the incoming commissioners, one of whom had made statements against homosexuality and women's rights.

As noted earlier, other factors likely to influence future EC policy on sexual and reproductive health issues include the parliamentary elections held in the summer of 2004 and the addition of 10 new EU Member States in May 2004. The elections added to the strength of far-right party groupings, although it is important to note that many of the most active opponents of sexual and reproductive health and rights in the European Parliament hail from within the 15 pre-accession Member States.

All these developments highlight the importance of advocacy efforts by both NGOs and parliamentarians in support of ICPD-friendly policies and funding at the European and national levels. Indeed, parliamentary groups (such as the European Parliament Working Group on Population, Development and Reproductive Health and the Inter-European Parliamentary Forum on Population and Development) and numerous NGOs are already active in Brussels and elsewhere in Europe. Their efforts will be doubly needed to increase awareness and understanding of reproductive health and rights issues among MEPs and national governments, as well as to help ensure that these issues stay on the agenda of EC delegations and countries receiving EC assistance. The Commission also has an important leadership role, especially in helping new Member States develop their aid policies and programs.

3 Trends in Funding for Population Assistance

Overall Funding Levels

An accurate assessment of Commission spending on sexual and reproductive health over time is made difficult by its incomplete and inconsistent reporting of expenditures. However, figures for 2002 show a total of US$184.9 million allocated for population assistance, more than twice the previous high of $79.4 million reported in 1997. As a share of development aid, population assistance was 2.8 percent of total ODA from the EC in 2002.

These figures are similar to those reported by the OECD/DAC, which show commitments of aid by sector, and to figures reported by the Commission in its annual report on EC development policy and funding. The DAC reports at least $158 million in aid committed on a bilateral basis for the population and reproductive health sector in 2002, up from $107 million in 2001. These figures represent 2.4 percent and 1.8 percent of ODA in 2002 and 2001, respectively. The Commission's report shows a similar amount (EUR 170 million) for population assistance in 2002.

As noted above, recent data on population assistance are now available from the Commission's own reports, a result of efforts to improve the transparency of its work. Another source is an external evaluation led by the German consulting firm PARTICIP GmbH, published in 2004, that helps fill out the picture of EC population assistance over time. The latter reflects a detailed analysis of data for the eight-year period 1994-2001. It provides a low-end figure of about $85 million in annual commitments for sexual and reproductive health activities over the period. This compares with UNFPA's figure of about $64 million annually over the period 1996-2002, albeit based on incomplete reports. The high-end figure reported in the evaluation is about $185 million annually, a figure that takes into account other funding commitments of which a proportion is ascribed to sexual and reproductive health activities.

Commitments are not disbursements, however, and the lag between the two remains a problem for the Commission in its aid program overall. Moreover, even the high-end figure for annual spending provided in the evaluation report is far less than the amount pledged by the European Commission in 1994, prior to the ICPD. At the time, the Commission pledged to increase its commitments for pop-

In 1994, the EC pledged to provide $350 million annually for population assistance by 2000, but still falls far short of that goal.

ulation assistance to $350 million annually (in 1994 dollars) by the year 2000. **Thus, while its funding for sexual and reproductive health efforts has increased, the Commission still falls far short of its own goals.**

Channels Used

The European Commission is both a channel and a source of funds. For EU Member States, their support for EC development aid is classified as multilateral assistance, while the EC itself also contributes some funds to multilateral institutions. In 2002, the Commission channeled an estimated $298 million of its total development assistance through multilateral channels, including $170 million to the International Development Association (IDA). In most years, only a very small proportion (less than 4 percent) of EC development assistance is reported as flowing through NGOs; in 2002 no NGO funding was reported at all.

Thus, the data currently available give little indication of how the Commission's population assistance is channeled. The data almost certainly understates the flow of funds earmarked for specific projects with multilateral organizations, as well as for NGOs, even if only because of the funding available to NGOs through specific budget lines for reproductive health, HIV/AIDS, and NGO co-financing.

With regard to EC aid flowing through multilateral channels, for example, the Global Fund to Fight AIDS, Tuberculosis and Malaria reported pledges totaling US$554.5 million (EUR 460.5 million) for the period 2001-2006, of which $137 million was contributed in 2001-02, for a total of some $400 million by mid-2004. Funds have been provided by both the regular Commission budget and the EDF.

4 Program Priorities

Geographic Priorities

More than 70 percent of EC population assistance was directed to sub-Saharan Africa and the Asia-Pacific region in 2002. Less than 20 percent went to the Middle East/North Africa region and less than 10 percent to Latin America and the Caribbean. A number of the projects funded are of a regional nature. Commitments made in 2002, for example, included $25 million for a regional HIV/AIDS project for youth in sub-Saharan Africa, and $20 million for the second phase of a joint reproductive health project with UNFPA in Asia.

These figures are in keeping with historical trends reported in the PARTICIP GmbH evaluation. Over the period 1994-2001, close to 50 percent of aid explicitly identified for ICPD-related health expenditures went to Asia, 33 percent went to ACP countries, and 7 percent each went to MEDA countries and Latin America.

Among the MEDA countries, Yemen has the only active project, since projects in Egypt and Morocco have been completed. With respect to Latin America, the little funding that does flow is in the context of larger social sector projects and to just two countries, Ecuador and Peru. Some reproductive health funds may flow through the NGO co-financing budget line, however.

Areas of Program Emphasis

The figures reported to UNFPA in 2002 were the first since 1996 to show allocation by type of activity. At least 40 percent of EC population assistance flowed to HIV/AIDS activities, 22 percent to family planning, 21 percent to basic reproductive health activities, and 9 percent went to population-related research and policy analysis.

These figures correspond to historical data reported by PARTICIP GmbH. Between 1994 and 2001, slightly more than half (51 percent) of EC population assistance went to activities classified as either family planning, reproductive health or safe motherhood, while 43 percent supported HIV/AIDS activities. The remaining 6 percent supported research and policy activities, mostly in the ACP countries. The mix of activities supported by the EC varied significantly among the regions, however, with HIV/AIDS absorbing nearly 90 percent of commitments in the ACP countries (mainly Africa), while in Asia the bulk of funds went to reproductive health activities in the three categories mentioned above.

Funding commitments made in 2002 provide further insight into the mix of activities funded by the EC. The EC reported $10 million for an HIV/AIDS awareness program in South Africa, $5 million for a regional maternal health program in Africa, and a similar amount for an HIV/AIDS project in Burma. A much larger commitment

totaling more than $30 million—part of the EC's contribution to filling the decency gap mentioned earlier—went to support projects in 22 countries, mostly in Africa, to expand access to reproductive health service, including family planning, pregnancy care, and STD/HIV/AIDS prevention activities.

Another major commitment is the second phase of a multi-year collaboration between the EC, UNFPA and European and local NGOs in South and Southeast Asia. The EC contributed $28 million for the first four-year phase of the project, begun in 1997, that supported reproductive health projects in eight countries. The second agreement was reached in 2002, with a commitment of $20 million by the EC for projects to address the sexual and reproductive health needs of young people. More recently, in late 2003, the Commission issued the first call for proposals for the new budget line on reproductive and sexual health. The call focused on measures to improve maternal health, including care in pregnancy and childbirth and efforts to increase the number of skilled birth attendants.

The Commission's support for reproductive health supplies is also important to note, given the significant and worsening shortfalls of contraceptives, including condoms for HIV/AIDS prevention, in many developing countries. Available data indicate that the EC has contributed tens of millions of dollars for contraceptives and condoms since the early 1990s, including $20 million for a supply project in Bangladesh and another $15 million for Indonesia. In late 2004, the EC joined with EU Member States (led by the Netherlands) to contribute a total of $75 million for reproductive health supplies to UNFPA.

5 Technical Capacity

Staffing

The EC's development assistance program is short-staffed in comparison with the major donor countries, according to the OECD/DAC. This applies to both professional and administrative staff. Indeed, it is worth noting that a number of other major donor countries report administrative costs three to five times higher than those of the EC. While the ongoing process of deconcentration has boosted delegation staff from about 1,000 people in 2000 to roughly 2,500 in 2004, headquarters staff within EuropeAid, DG Dev and DG Relex is down to roughly 1,200 people, compared with 1,500 in 2001.

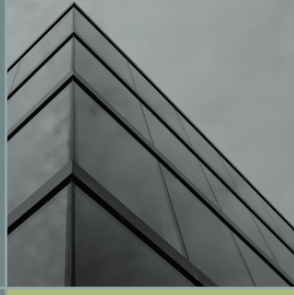
Technical expertise in sexual and reproductive health or population is scarce throughout the Commission. In 2003, EuropeAid had just one person with health expertise in Brussels, down from three. In the MEDA countries, for example, a typical EC delegation would have 50 members. In the entire region, however, there were only three staff members with health expertise, and administrative regulations do not allow a health advisor to serve at the regional level. At the same time, individual sector-specific divisions within the geographic directorates at EuropeAid are being collapsed into larger, multi-sectoral units. Only the MEDA and ACP countries still have separate units on social and human development. The Commission attempts to address this shortfall in expertise by relying on staff seconded by EU Member States and on contract staff, but this does little for institutional memory or building capacity over the long run.

Commission staff are attempting to compensate for the lack of expertise in EC delegations with regional training sessions and electronic fora for information exchange. The challenge is to maintain such efforts at a time when headquarters staff are fewer in number. Another strategy is for EC delegations to rely on the country delegations of other donors. However, the success of this approach depends in part on whether other donors have sufficient expertise themselves. Some at the Commission have noted that this has worked best with the United Kingdom and the Nordic countries, but less well with some other EU Member States.

Technical Expertise of Collaborating Institutions

The Commission has access to a broad range of expertise through collaborating institutions and consultants throughout Europe. Many European NGOs with expertise in reproductive health have accessed EC funding for projects through the reproductive health budget or NGO co-financing budget line. Large regional or country projects have also provided NGOs with access to funds. Those working with the EC include IPPF, the International HIV/AIDS Alliance, the Italian Association for Women in Development (AIDOS), World Population Foundation (both the German and Dutch groups with that name), Marie Stopes International, the London School of Hygiene and Tropical Medicine, the Royal Tropical Institute (the Netherlands) and many others.

European NGOs continue to be frustrated by the long delays in approval of proposals and actual disbursements of funds. For those working in partnership with developing country NGOs, these delays present serious obstacles. Local partners lose patience with a system that can take years to process a proposal. Although the Commission has improved the situation somewhat, delays remain. And while European NGOs now have considerable experience with Commission procedures and the pace of funding decisions, many remain frustrated with the process.



Foundations

Private charitable foundations play a critical role in international population assistance. In 2002, according to UNFPA/NIDI, their contributions of US$460 million represented 16 percent of all grant assistance for population activities that year, a five-fold increase since 1996. * Indeed, when considered individually, a number of foundations provide assistance equal to that of individual donor countries. The bulk of this support has come from U.S.-based foundations, although a small number of foundations in Europe and Japan also make significant contributions to the field.

As with the donor countries, the range of support from foundations varies widely, according to the overall size and priorities of the organizations involved. Areas of program emphasis among foundations also differ and include reproductive rights advocacy, population and reproductive health related research, training, and support for the provision of reproductive health services. Several foundations are active in the HIV/AIDS field and grants relating to HIV/AIDS and other STDs accounted for as much as one-half of all population assistance funds from foundations in 2002. This emphasis is due in large part to the program priorities of the Bill & Melinda Gates Foundation, since 1999 the largest foundation in the field.

Other leading foundations providing significant support for reproductive health and population-related activities include The William and Flora Hewlett Foundation, The John D. and Catherine T. MacArthur Foundation, The David and Lucile Packard Foundation, the United Nations Foundation, and the U.K.-based Wellcome Trust. Early philanthropic pioneers in the population field such as the Ford, Mellon and Rockefeller Foundations have also remained sizeable donors, although it must be noted that the Mellon Foundation is expected to end its support for this area after 2005. Foundations have often taken on controversial or neglected issues—such as adolescent rights, sex trafficking, the shortfall in reproductive health supplies, and abortion—that may be avoided by donor governments, and in so doing have encouraged government action.

According to an analysis by the Funders Network, most major foundations (donors of more than $10 million in 2002) slightly reduced their support from 2002 levels in 2003, and spending in 2004 is likely to remain near the previous year's levels. The activities of the eight largest U.S.-based foundations, in addition to one Japanese and two Europe-based foundations, are summarized here.

* While the UNFPA/UNAIDS/NIDI Resource Flows Project tracks foundation support in the sexual and reproductive health arena, not all foundations active in the field report annually. A second source of information is the U.S.-based Funders Network on Population, Reproductive Health and Rights, which brings together 53 foundations working in the United States and internationally. This analysis draws on data from both sources, although the data are frequently inconsistent. This is because of differences in the definition of population used in the two efforts, varying reporting requirements (disbursements versus awards) and incomplete reporting.

Foundations

The Ford Foundation

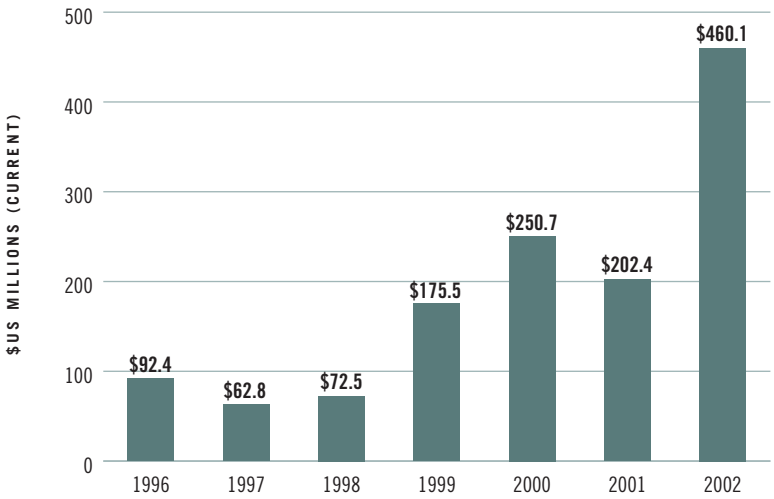
The Ford Foundation was the third largest foundation donor of population assistance in 2000, according to UNFPA, with contributions totaling $20.5 million, somewhat less than in previous years. More recent data from the Funders Network show grants of $39.6 million in 2002. The Ford Foundation's grant making in sexual and reproductive health and rights is administered by all three core program areas: asset building and community development; peace and social justice; and knowledge, creativity and freedom. Grant making emphasizes the importance of reproductive rights as embodied in the ICPD Programme of Action and the need to empower communities, women and youth to participate in decision making on sexual and reproductive health policies and programs. The foundation supports a wide range of initiatives in such areas as HIV/AIDS prevention, promotion of access to reproductive health services and technologies, and halting sex trafficking and sexual violence.

Bill & Melinda Gates Foundation

The Bill & Melinda Gates Foundation was formally established in 2000 and brought together the William H. Gates Foundation and the Gates Learning Foundation. Taking into account grants from 1994 through September 2004, the foundation reports more than $4 billion in assistance for global health programs, including $1.4 billion for HIV/AIDS, tuberculosis control, and reproductive health activities. In 2002, the Gates Foundation reported $300.2 million in population assistance which, according to UNFPA, represented two-thirds of all foundation support that year. In addition to its support for HIV/AIDS prevention and treatment programs, the foundation funds vaccine and microbicide research, and a range of maternal and child health initiatives.

During 2003-2004, the foundation reported that HIV/AIDS prevention and treatment programs was one of top two areas of funding (the other being child immunization). During this period, the Gates Foundation doubled its commitment to HIV prevention in India to $200 million, with grants awarded to several U.S. and Indian NGOs. Major population assistance grants in 2003 also included $60.1 million to the International Partnership for Microbicides and $40 million to The Johns Hopkins University for the establishment of the Bill & Melinda Gates Institute for Population and Reproductive Health.

FIGURE 13
TOTAL INTERNATIONAL POPULATION ASSISTANCE, INCLUDING HIV/AIDS, BY ALL FOUNDATIONS



Source: UNFPA/UNAIDS/NIDI Resource Flows Project database.

The William and Flora Hewlett Foundation

The Hewlett Foundation's population assistance has focused on providing access to reproductive health and family planning information and services that will allow individuals to voluntarily determine their fertility. The foundation provides assistance to four main areas of activity: resource mobilization (to increase government and private sector commitment to funding family planning and reproductive health); improving access to reproductive health information and services; supporting research on health and fertility regulation technology; and training of population and health professionals. It gives considerable support for family planning service provision in developing countries, and has long supported professional training and research opportunities in the population and health sciences at universities in the United States and overseas. In mid-2004, the foundation's board approved an updated strategy for its population program. Beginning in early 2005, grant making will focus on three main goals: improving access to family planning and reproductive health care; mobilizing resources and promoting evidence-based policies for family planning and reproductive health programs; training the next generation of population scientists; and promoting and protecting the reproductive health of people in the United States.

In 2002, the Hewlett Foundation was the third largest foundation donor of population assistance, with contributions of $35.6 million, according to UNFPA. Its grant disbursements have been rising steadily in recent years,

and the 2002 total was nearly triple that of 2001. For 2003, Hewlett reported making its largest grants to IPPF ($3.5 million), Ipas ($3.5 million), and the Alan Guttmacher Institute ($2 million).

The John D. and Catherine T. MacArthur Foundation

The MacArthur Foundation has supported international population activities since 1986. It provides funding for organizations working to promote sexual and reproductive rights and improve the accessibility and quality of reproductive health services. Within this framework, the foundation gives priority to programs for reducing maternal mortality and advancing the sexual rights and reproductive health of adolescents. It has concentrated many of its international programs in Brazil, India, Mexico, and Nigeria.

MacArthur Foundation grants averaged $8.5 million over the period from 1996 through 2002. The foundation reported funding of $9.8 million in 2002 to UNFPA, up from $6.4 million in 2001. Its largest international population and reproductive health grant recipients in 2003 were Sociedad Mexicana Por Derechos de la Mujer (Mexican Society for Women's Rights; $660,000), IPPF ($450,000), and Management Systems International ($450,000).

The Andrew W. Mellon Foundation

A pioneer in the field, the Mellon Foundation's population assistance grants have been falling steadily since the mid-1990s and in 2002 the foundation announced its intention to discontinue funding population activities after December 2005. Population assistance grants totaled $10.5 million in each of 1996 and 1997, but by 2000 stood at $4.3 million. FundersNet shows grants totaling $18.6 million in 2002, although its definitions of qualifying grants are different; in 2003 all of the foundation's population assistance related to forced migration. Mellon Foundation funds have supported research in reproductive biology, contraceptive technology, and the social sciences, as well as population policy analysis and research and training on forced migration issues. Many of the Mellon Foundation's grant recipients are universities; other recipients have included the Alan Guttmacher Institute and the Population Council.

The David and Lucile Packard Foundation

In 2002, the Packard Foundation was the second largest donor of population assistance funds. The foundation's annual grants for population activities averaged around $11 million in the mid- to late 1990s, rising to a high of $48 million in 2002—an increase due in large part to the expansion of the foundation's resources that accompanied the rise in value of Hewlett-Packard stock. The Funders Network estimates that foundation funding for 2004 will equal 2003 levels, which were estimated at $28.9 million. The foundation emphasizes improving the accessibility and quality of family planning and other reproductive health services; mobilizing support for international reproductive health services and rights through education and advocacy activities; and training future leaders in population and reproductive health. The foundation is known for its support for reproductive health information and services for young people and for improved access to safe abortion where legal.

Packard Foundation assistance is channeled mainly through NGOs and universities. Its international programs are centered in five priority countries: Ethiopia, India, Nigeria, Pakistan, and the Philippines. In 2003, the foundation reported its three largest grantees as Pathfinder International ($3.9 million), the National Abortion and Reproductive Rights Action League Foundation ($3 million), and the Public Health Institute ($2.9 million).

The Nippon Foundation

The Nippon Foundation, based in Japan, was founded in 1962 with a primary emphasis on environmental efforts, especially those relating to the maritime industry. Its work later expanded to include a focus on public health and social welfare. In 1997, the foundation awarded $2.4 million in population assistance grants, including $1 million each to family planning and reproductive health programs. However, its funding levels have since fallen steadily, reaching $40,000 in 2002.

OPEC Fund for International Development

The OPEC Fund for International Development, based in Austria and founded by members of the Organization of Petroleum Exporting Countries (OPEC), has become a significant funder of population activities. The Fund's grant population assistance totaled $14.6 million in 2002, compared with little more than $2 million in each of 2000 and 2001. This significant increase in funding was in part the result of the establishment of an HIV/AIDS Special

When considered individually, a number of foundations provide assistance equal to that of individual donor countries.

Account covering various AIDS-related projects and indeed, the bulk of its current assistance is directed towards HIV/AIDS, including support for policy development, and prevention, care and treatment programs. The OPEC Fund contributes to a wide range of international organizations, including WHO, UNICEF and UNFPA. In 2002, for example, the Fund provided $1 million for a joint project with UNFPA aimed at preventing HIV infections in seven Arab countries.

The Rockefeller Foundation

After four decades of population program funding and leadership, the Rockefeller Foundation disbanded its population division in 1999. During much of the 1990s, Rockefeller Foundation population funding averaged around $17 million per year, but began trending downwards in the latter 1990s, reaching an all-time low of $5.8 million in 2001. Current population assistance grants are administered as part of the foundation's program on health equity. Population assistance was reported at $17.8 million in 2002, with almost all of the funds going to HIV/AIDS-related research, in particular the International Partnership on Microbicides. Major grants in the 2002-2003 period include $6.3 million to the International Partnership on Microbicides, $4 million to the Mailman School of Public Health at Columbia University for prevention of mother-to-child HIV transmission and related programs (MTCT-Plus), and $900,000 to the University of Zimbabwe for clinical trials of two anti-retroviral drugs.**

The United Nations Foundation

The United Nations Foundation (UNF) was established by Ted Turner, the American media entrepreneur, to channel resources for population and reproductive health activities and to reform the United Nations system. Turner provided an initial gift of $1 billion for the foundation's work, which has been subsequently supplemented by contributions from other private and public funders. In 2001, UNF's population assistance stood at more than $25 million, a sharp increase from previous years. Funding fell slightly in 2002 to just under $22 million, but UNF was still ranked as the fourth largest foundation donor that year.

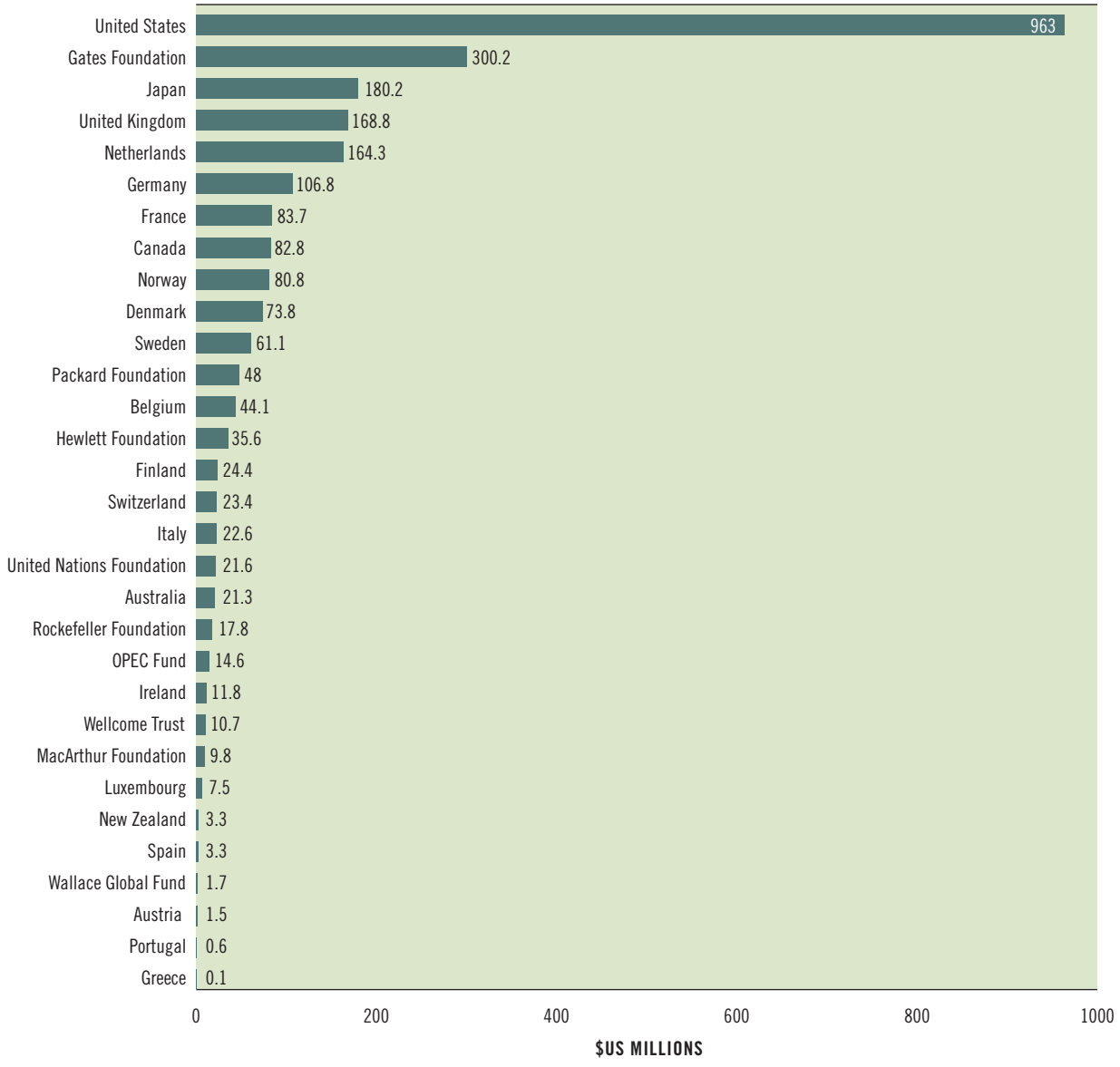
The main program areas supported by UNF are children's health, the environment, peace, security and human rights, and women and population. The foundation's reproductive health projects give special emphasis to improving the quality of care and strengthening adolescent services. UNF is a major contributor to UNFPA and UNAIDS for support of reproductive health and HIV/AIDS activities. (It also provides significant funding to UNICEF, WHO, and the Pan American Health Organization for children's health initiatives and has been instrumental in arranging funding with partner organizations for initiatives to eliminate polio and measles.) Recent major grants include $3.5 million to UNFPA for improving sexual and reproductive health rights of young women in Mexico and $1.5 million to UNAIDS for work on HIV prevention among Russian youth.

The Wellcome Trust

The Wellcome Trust, based in the United Kingdom, provides resources to both developed and developing country organizations undertaking biomedical research on major global diseases. The Trust has also supported a Population Studies Programme, renamed the Health Consequences of Population Change (HCPC) Programme in 2001, which funds studies of the impact of population dynamics on public health and the consequent implications for the provision of health services. The HCPC Programme funds research on five "drivers" of population change: growth, youth and aging, migration, urbanization, and lifestyles. Research into infectious diseases, with a goal of building capacity in research within developing countries, has been a theme of the Trust's work. It has also coordinated a global multilateral initiative on malaria. Total grants awarded by the Wellcome Trust, according to UNFPA, reached a new high of $10.7 million in 2002, up from $5.6 million in 2000.

** It is worth noting that the MTCT-Plus Initiative is funded by eight foundations in total: the Bill & Melinda Gates Foundation, William and Flora Hewlett Foundation, Robert Wood Johnson Foundation, Henry J. Kaiser Family Foundation, John D. and Catherine T. MacArthur Foundation, David and Lucile Packard Foundation, Rockefeller Foundation, Starr Foundation, and United Nations Foundation.

FIGURE 14
POPULATION ASSISTANCE COMPARISON: COUNTRY GOVERNMENTS AND FOUNDATIONS, 2002



Source: UNFPA/UNAIDS/NIDI Resource Flows Project database.

The World Bank

The World Bank wields considerable influence on reproductive health through its impact on national level policies and investments in sexual and reproductive health programs (non-lending activities), and by directly providing resources for such programs in developing countries (lending activities). While most aid receiving countries prefer grant bilateral assistance to World Bank loans, the need for bilateral assistance outstrips available funds, leaving the World Bank as the funding source of last resort.

Bank lending consists of two types of loans: International Bank for Reconstruction and Development (IBRD) loans available to middle-income countries at commercial interest rates; and International Development Association (IDA) credits available only to the poorer countries, which are essentially interest-free and have a long repayment period. Since the early 1970s, the World Bank has committed more than US$4 billion to support sexual and reproductive health programs around the world. IDA credits account for roughly 65 percent of population lending from the World Bank. More recently IDA grants have been made for HIV/AIDS programs. Although it is difficult to determine exactly how much support the World Bank now gives in population assistance, its own estimates show disbursements of about $300 million for reproductive health activities in 2004, with an additional $200 million for HIV/AIDS.

The World Bank supports the achievement of the Millennium Development Goals (MDGs) and their overarching aim of poverty reduction. To this end, the Bank has led the way in supporting countries in the development of poverty alleviation strategies—in particular through the Poverty Reduction Strategy (PRS) process.

While the Bank has had some success in taking advantage of the opportunities afforded by the MDG focus and PRS process to keep reproductive health on the agenda, HIV/AIDS issues have tended to receive far more attention. As with donors of grant assistance, Bank lending for HIV/AIDS activities has increased since 1999-2000. At the same time, reproductive health specialists within the Bank have focused efforts on strengthening the linkages between reproductive health and HIV/AIDS programs.

The Bank's lending for sexual and reproductive health has also been influenced by a series of management and policy changes. On the administrative side, these changes include a reorganization of the Bank, the adoption of matrix management, and decentralization of programming to the country level. Lending policies reflect a growing emphasis on the PRS process, with direct budgetary support as well as sector-wide approaches (SWAps) in the health and other sectors, and on health sector reforms and selectivity in matching lending to the policy context in countries. However, more analysis is needed to fully understand the impact of these initiatives on access to reproductive health services and health outcomes. For example, evidence to date shows a mixed record with respect to the integration of sexual and reproductive health concerns in the PRS process as a whole. This indicates a need for greater involvement by civil society and technical experts to help ensure prioritization of sexual and reproductive health, and especially adolescent reproductive health, throughout the process, including with regard to poverty analysis, the selection of indicators and monitoring and evaluation and resource allocation.

Policy and Management Developments

The World Bank has undergone multiple reorganizations in the past few decades reflecting the changing landscape of development assistance priorities worldwide. These have included internal struggles to keep an institution of its size focused as an effective lending institution. In the 1990s, the Bank shifted its emphasis from provision of basic health services toward improving the policy environment and promoting health sector reforms. In 1996, human development became a pillar of focus encompassing health, nutrition and population (HNP) along with education and social protection. The Bank's approach to sexual and reproductive health is articulated in a sector strategy of 1997 and is further detailed in the 2000 policy note, "Population and the World Bank: Adapting to Change."

After a previous reorganization from a functional to regional structure, the Bank moved to a matrix management structure in 1996. Bank staff are mapped to sectors such as HNP. Country level managers and task team leaders in operations access the expertise of the specialists by "purchasing" their services. Health, Nutrition and Population sector positions are funded from the Bank's core budget (the Bank Budget or BB), whereas their programmatic budgets are mainly supported by funds available through operations and specific trust funds. Trust funds are pots of money given by a donor for a designated purpose and allow the donor to maintain more control over its allocation for specific areas of support. For example, trust funds from the Dutch and Swedish governments both prioritize reproductive health and have mostly been used to support policy, analytical and programmatic work in such areas as poverty and reproductive health, adolescent sexual and reproductive health, maternal health, capacity building, and strengthening linkages between reproductive health and HIV/AIDS.

A 1999 World Bank report, "Investing in Health: Development Effectiveness in the Health, Nutrition, and Population Sector," stated that rapid growth in the scope of the Health, Nutrition and Population portfolio was not met with a corresponding increase in the funding and staff and recommended that HNP seek to do better, not just more, lending. Unfortunately, limited technical capacity and insufficient support for analytical research still plague Bank initiatives. There is only a small core of highly qualified reproductive health specialists within the Bank, while many other reproductive health experts have been moved out of technical support and into management roles. Others are working exclusively on HIV/AIDS activities. Too few specialists are available to tackle the challenge of increasing awareness and knowledge of reproductive health among Bank staff and to engage in policy dialogue with governments.

Moreover, due to the Bank's restructuring in 1996, program budgets were decentralized and moved to field offices. While this has led to an increase in the number of developing country nationals hired and a less top-down approach, central technical groups such as HNP were left without direct control over a programmatic budget. Population specialists must work with operations and country staff to not only sell their services, as noted above, but also convince them to fund activities that they identify as a priority for reproductive health. Further capacity building at the country level is needed to ensure that country staff can engage governments in evidence-based policy dialogue to prioritize sexual and reproductive health where appropriate.

Along with organizational changes, the Bank has also changed the way lending priorities are set. The Bank is increasingly focused on issues of governance and accountability. The trend toward "selectivity" in lending is the most recent manifestation of the 30 year-old debate on the effectiveness of foreign aid. Under selectivity, aid allocations are based on an evaluation of the "development friendliness" of the policy environment of a country. Research has shown that aid is less effective in countries with poor policy environments (poor performers) compared to countries with development-friendly policies.

New Program Priorities and Challenges

Although the ICPD Programme of Action has broadly influenced World Bank lending in the reproductive health sector, the Bank's corporate agenda is increasingly oriented toward the attainment of the internationally agreed targets set out in the Millennium Development Goals. The lack of explicit references to reproductive health and family planning in the Millennium Development Goals has raised concerns among some at the Bank about a shift in lending strategy away from reproductive health. The World Bank's reproductive health specialists are trying to counter this by promoting reproductive health interventions as cost-effective measures to reduce maternal mortality (the fifth of eight MDGs), reduce infant mortality, curb the spread of HIV/AIDS and eradicate extreme poverty.

Some Bank specialists state that issues of population growth and family planning have lost priority among senior Bank officials, perhaps in part due to the substantial declines in fertility seen in the past 20 years and a lack of appreciation for the impact of population

momentum. This tendency is reinforced by the need for greater attention to fighting the HIV/AIDS pandemic. Indeed, funding allocations for HIV/AIDS have outpaced those for other aspects of sexual and reproductive health, and the HIV/AIDS projects do not always address the broader reproductive health interventions that would accelerate prevention of HIV. The challenge for Bank staff is to help demonstrate the relevance of the family planning and reproductive health infrastructure and services to HIV/AIDS programs and the importance of linking programs where possible. The Bank must avoid supporting parallel service delivery structures for HIV/AIDS when reproductive health infrastructures and services already exist. The Bank appears to be addressing this challenge through efforts such as learning activities and policy dialogue on strengthening the linkages between reproductive health and HIV/AIDS programs.

Another influential trend in Bank practice has been the Poverty Reduction Strategy (PRS) process, in which the development of a PRS paper (PRSP) is a critical step. In theory, this is a collaborative process among country governments, development partners and civil society to describe a macroeconomic framework that will promote socio-economic development and reduce poverty. There is room for inclusion of reproductive health in the PRS approach, and HNP is trying to maximize this potential. Thus far, however, the inclusion of reproductive health in PRSPs has been uneven. Some PRSPs are quite strong on the issue, but others fall short, and clear, sound guidelines for developing PRSPs are needed. The available reviews on the PRS process show a need for stronger analytical work, such as making the link between reproductive health and poverty as well as between family planning and better health. The PRSPs themselves often lack good poverty analyses with appropriate policies, coherent indicators and appropriate resource allocations.

The World Bank also supports the PRS process by strengthening the expertise of participants through training programs. For nearly 50 years, the Bank has engaged in capacity building through the World Bank Institute, previously known as the Economic Development Institute (WBI). The WBI, a Vice-Presidential Unit (the Bank's basic structural unit), provides more than 900 learning activities each year for give decision-makers in civil society, government and the development community. Its courses and seminars are offered to World Bank staff, government officials, as well as to members and staff of more than 160 organizations.

Reproductive Health Supplies and Procurement

The World Bank's influence in the field can also be seen in its role as an important donor of reproductive health supplies, representing up to 16 percent of total donated supplies in 1999 and 11 percent (or $21 million) in 2002. UNFPA procures much of the Bank's contributions on its behalf, while the Bank's own procurement is done through essential medicine procurement and through broad country budgets.

The Bank requires country recipients to follow its procurement and international competitive bidding regulations when using loan funds for supplies in order to ensure competition, transparency and fair prices. This policy has been the focus of criticism as some recipient countries see the procedures as overly cumbersome and difficult to implement. These difficulties signal the need for further capacity building and for simplification of procurement procedures.

The World Bank has also taken an active role as part of an international coalition established to address the critical shortages of reproductive health supplies through collaborative strategic thinking and action, joint problem solving and information sharing.

Trends in Population Assistance

World Bank loans represent a significant share of donor population assistance, comprising 11 percent of donor allocations of funding in 2002. While its importance as a

WORLD BANK POPULATION/REPRODUCTIVE HEALTH ASSISTANCE (Millions of US$)

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
World Bank Total	**340**	**423**	**448**	**509**	**233**	**426**	**447**	**538**	**449**	**328**
World Bank IDA loans	195	239	306	253	142	284	265	368	349	232
World Bank IBRD loans	145	184	142	256	92	142	182	170	101	95

Source: UNFPA/UNAIDS/NIDI Resource Flows Project database

Since the early 1970s, the World Bank has committed more than $4 billion to support sexual and reproductive health programs around the world.

source of support is clear, a complete picture of World Bank support for sexual and reproductive health is difficult to grasp. The UNFPA/UNAIDS/NIDI Resource Flows Project tracks levels of lending assistance along with all donors' grant assistance, relying on reporting from the institutions. However, development bank loan commitments are multi-year and are recorded in the year in which they are approved (even though they are dispersed over several years). In addition, the Bank's new coding system makes the Bank's own figures incomparable with those of the UNFPA Resource Flows Project, which are used for this publication, while the use of different fiscal years further complicates comparisons of UNFPA- and World Bank-reported figures. According to UNFPA, World Bank funds for population assistance peaked in 2000, dropping in 2001 and again in 2002. While the Bank's figures are different, due in part to the fiscal year used (as noted above), it appears that population assistance, including for HIV/AIDS activities, increased by nearly $200 million in FY 2003 and represented 2.8 percent of total Bank lending that year.

The World Bank is important for reproductive health not only in terms of the financial resources that it provides, but also in terms of its leadership role. The Bank wields its influence within the larger donor community through its use of different approaches to development cooperation, such as the PRS process, devolution, and the move toward sector-wide approaches and/or direct budget support. Indeed, the way the World Bank manages the new challenges to and opportunities for improving reproductive health—whether due to the MDGs, sector-wide approaches, or the HIV/AIDS pandemic—may impact not only its own goals for reproductive health outcomes, but those of other donors as well. Given this influencing role, efforts by the Bank's reproductive health staff to increase awareness and prioritization of sexual and reproductive health concerns are critically important, including their support for policy analysis, capacity building, and opportunities for learning and dialogue.

Methodology

Data Sources

This report relies heavily on data collected by the UNFPA/UNAIDS/NIDI Resource Flows Project based at the Netherlands Interdisciplinary Demographic Institute, including data from the 2004 report from UNFPA, *Financial Resource Flows for Population Activities in 2002* [in publication]. Financial data are also taken from the OECD's *Development Cooperation* series, in particular the 2001, 2002 and 2003 reports (covering, respectively, 2000, 2001 and 2002), as well as the OECD/DAC online statistical annex of the *Development Cooperation* reports (http://www.oecd.org/ document/9/ 0,2340,en_2649_34485_1893129_1_1_1_1,00.html). Additional reference data were drawn from the OECD's project database (http://www.oecd.org/ dataoecd/50/17/5037721.htm) and from AiDA, a similar database available through the Development Gateway (http://aida.developmentgateway.org/AidaHome.do). Financial data were also taken from UNFPA's Web site and provided by IPPF. A list of other sources of data and information can be found in the Key References.

For ease of reading, references in the text of the report to financial data provided by the UNFPA/UNAIDS/NIDI Resource Flows Project database or drawn from the 2004 report, *Financial Resource Flows for Population Activities in 2002*, cite UNFPA as the source.

Donor Profiles

Two sets of donor profiles are included in this report. The first includes 21 of the 22 donor countries that are members of the Development Assistance Committee of the OECD. The second set comprises profiles of the European Commission (also a DAC member) and World Bank, as well as a brief summary of foundation activities. The profiles of donor countries and the EC update similar profiles on 20 donor nations included in PAI's 1998 report, *Paying Their Fair Share? Donor Countries and International Population Assistance* and in the 1993 report, *Global Population Assistance: A Report Card on the Major Donor Countries*. This report includes a profile of Luxembourg (previous studies did not), which has increased its involvement in population assistance efforts since the previous study. No profile of Greece is included, however, as it has only recently joined the DAC and reported only very limited population assistance in 2001 and 2002.

In addition to the data sources noted above, information for the individual profiles also came from the OECD/DAC peer reviews of each member country's development cooperation program, government documents, and interviews and personal communications with government officials and advocacy colleagues in almost every donor country.

In the case of population assistance provided by the European Commission, it is important to note that this comes from resources provided originally by EU Member States.

Challenges to Data Analysis

As noted elsewhere in this report, data analysis is problematic given incomplete reporting over time by a number of donors and the changes in the definition of population assistance used in tracking resource flows. Incomplete reporting may involve a lack of reporting altogether (in which case UNFPA estimates population assistance at previous-year levels), or partial reporting. Several profiles make reference to incomplete reporting, and graphics and tables include notes on this topic where appropriate.

Inconsistent reporting by donors is also an issue: some donors have not consistently reported allocations by type of activity or the channel used. The rise of new mechanisms for channeling assistance may also complicate reporting. For example, donor country funds channeled to the Global Fund to Fight AIDS, Tuberculosis and Malaria are multilateral aid, but in some cases support for the Fund may have been recorded under the NGO channel.

Exchange rate fluctuations add to the challenge of data analysis over time. While the spending goals of the ICPD are expressed in constant 1993 dollars (unless otherwise noted), all population assistance figures in the text and tables of this report are expressed in current U.S. dollars, again unless otherwise noted. Exchange rate fluctuations affect how trends in donor support may appear when expressed in U.S. dollar terms. Due to the different methodologies used by various organizations in calculating exchange rates, there may be inconsistencies in the data included in this report, in particular for years after 2002.

Appendix 2

Key References

Action Canada for Population and Development (ACPD). 2003. *A Profile of Sexual and Reproductive Health and Rights (SRHR) Projects*. Ottawa: ACPD.

Alan Guttmacher Institute (AGI) and United Nations Population Fund (UNFPA). 2003. *Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care*. New York: AGI and UNFPA.

Australian Agency for International Development (AusAID). 1998. *Health in Australia's Aid Program*. Canberra: AusAID.

_____. 2002. *Family Panning and the Aid Program: A Comprehensive Guide*. Canberra: AusAID.

_____. 2003. *Twelfth Annual Statement to Parliament on Australia's Development Cooperation Program*. Canberra: AusAID.

_____. Key Aid Sectors: Health. Available from http://www.ausaid.gov.au/keyaid/health.cfm; Internet; accessed 9 December 2003.

Austrian Development Cooperation. 1999. *Promising Partnerships*. Salzburg: Federal Ministry for Foreign Affairs.

Belgian Embassy in London. 2004. *Belgian Events*, January-March 2004.

Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung (BMZ). 2003. *Sexual and Reproductive Health (SRH): A Policy Paper of the German Federal Ministry for Economic Cooperation and Development*. Bonn: BMZ.

Canadian International Development Agency (CIDA). 2000. *CIDA's Social Development Priorities: A Framework for Action*. Hull, Quebec: CIDA.

_____. 2001. *CIDA's Action Plan on Health and Nutrition*. Hull, Quebec: CIDA.

_____. 2002. *Canada Making a Difference in the World: Highlights of CIDA's Performance in 2001-2002*. Hull, Quebec: CIDA.

_____, prepared by Environics Research Group. 2004. *Canadian Attitudes Toward Development Assistance*. Gatineau, Quebec: CIDA.

Claeys, V and E Wuyts - International Planned Parenthood Federation European Network. 2004. *Official Development Assistance 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', for the UNECE European Population Forum 2004: Population Challenges and Policy Response, Geneva, 12-14 January.

Conly, S and J Epp. 1997. *Falling Short: The World Bank's Role in Population and Reproductive Health*. Washington, DC: Population Action International.

Department for International Development (DFID). 2003. *Departmental Report 2003*. London: DFID.

_____. 2004. *Departmental Report 2004*. London: DFID.

_____. 2004. *Sexual and Reproductive Rights and Health: A Position Paper*. London: DFID.

DFID Resource Centre for Sexual and Reproductive Health. 2004. *Reproductive Health Background Paper*. London: John Snow, Inc./UK.

Development Gateway. Accessible Information on Development Activities (AiDA). Available from http://aida.developmentgateway.org/AidaHome.do; Internet; accessed 27 October 2004.

European Commission (EC). 2002. *Communication from the Commission to the Council and the European Parliament: Health and Poverty Reduction in Developing Countries*. Brussels: EC.

_____. *General Report on the Activities of the European Union 2002*. Available from http://europa.eu.int/abc/doc/off/rg/en/2002/index.htm; Internet; accessed 15 August 2004.

_____. 2003. *Annual Report 2003 from the Commission to the Council and European Parliament on the EC Development Policy and the Implementation of External Assistance in 2002*. Brussels: EC.

_____. 2003. *The European Union Confronts HIV/AIDS, Malaria and Tuberculosis*. Brussels: EC.

_____. *General Report on the Activities of the European Union 2003*. Available from http://europa.eu.int/abc/doc/off/rg/en/2003/index.htm; Internet; accessed 15 August 2004.

EuropeAid Co-operation Office. *About EuropeAid*. Available from http://www.europa.eu.int/comm/europeaid/general/index_en.htm; Internet; accessed 15 August 2004.

Federal Ministry for Foreign Affairs (MFA). 2000. *Three-Year-Programme 2001-2003 of the Austrian Development Cooperation*. Vienna: MFA.

German Foundation for World Population (DSW). 2004. *Guide to European Population Assistance*. Hannover: DSW.

Global Fund to Fight AIDS, Tuberculosis and Malaria. 2004. Pledges and Contributions [Excel data sheet]. Available at http://www.theglobalfund.org/en/files/pledges&contributions.xls; Internet; accessed 15 August 2004.

International Planned Parenthood Federation European Network (IPPF EN). *DAC Watch: Shadow Peer Reviews*. Brussels: IPPF EN. Various countries and years.

Japan International Cooperation Agency (JICA). 2003. *Capacity Development: Technical Cooperation of JICA in the Health Sector*. Tokyo: JICA.

_____. 2003. *Second Study on the International Cooperation for Population and Development: New Insights from the Japanese Experience*. Tokyo: JICA.

Kenyan Central Bureau of Statistics and Ministry of Health. 2003. *Kenya Demographic and Health Survey 2003: Preliminary Report*. Nairobi: Central Bureau of Statistics.

KfW Entwicklungsbank (KfW Development Bank) and German Investment and Development Company (DEG). 2002. *2001 Annual Report on Financial Cooperation with Developing Countries: Abridged Version*. Frankfurt: KfW.

Market and Opinion Research International (MORI). 2001. *What's Worrying Britain? 2001: A UN Sponsored European-wide Survey on Social Concerns*. New York: Conducted by MORI for UNFPA.

Mc Donnell, I, HS Lecomte and L Wegimont. 2003. *Public Opinion Research, Global Education and Development Co-operation Reform: In Search of a Virtuous Circle*. Working Paper No. 222 for the Europe-Wide Global Education Congress Maastricht, November 15-17. Paris: Organization for Economic Co-operation and Development (OECD).

Ministère des Affaires Étrangères (MAE). 2001. *French Policy on International Cooperation in the Fight Against HIV/AIDS in Developing Countries*. République Française: MAE.

Mzenge, G, Family Planning Association of Kenya. 2004. Telephone interview by Dina Bogecho, Washington, DC, 30 July.

New Zealand Agency for International Development (NZAID). NZAID Policy Framework. Available from http://www.nzaid.govt.nz/aboutus/policy/policyframework.html; Internet; accessed 13 January 2004.

Organization for Economic Cooperation and Development (OECD). CRS Online Database on Aid Activities. Available from http://www.oecd.org/dataoecd/50/17/5037721.htm; Internet; accessed 27 October 2004.

_____. *Development Co-operation Review Series*. Paris: OECD. Various countries and years.

_____. Statistical Annex of the 2003 Development Cooperation Report. Available from http://www.oecd.org/document/9/0,2340,en_2649_34485_1893129_1_1_1_1,00.html; Internet; accessed 27 October 2004.

PARTICIP GmbH. 2004. *Thematic Evaluation of Population and Development Oriented Programmes in EC External Co-operation*. Freiburg: PARTICIP GmbH.

Global Gag Rule Impact Project. 2003. *Access Denied: U.S. Restrictions on International Family Planning*. Washington, DC: Global Gag Rule Impact Project. Also available at www.globalgagrule.org

Secretary of State for International Cooperation and for Latin America. 2003. *Spanish Cooperation Strategy in the Area of Health*. Madrid: Ministry of Foreign Affairs.

Swiss Agency for Development and Cooperation (SDC). 2002. *SDC AIDS Policy 2002-2007*. Berne: SDC.

_____. 2002. *Switzerland's International Cooperation Annual Report 2002*. Berne: SDC.

_____. 2002. *The SDC Multilateral Strategy*. Berne: SDC.

_____. 2003. *SDC Health Policy 2003-2010*. Berne: SDC.

_____. 2003. *SDC Partnerships for the Future*. Berne: SDC.

United Nations (UN). 1995. *Report of the International Conference on Population and Development, Cairo 5-13 September 1994*. New York: United Nations.

_____. 2004. *Implementation of the United Nations Millennium Declaration: Report of the Secretary General* (A/59/282). New York: UN.

_____. 2004. *Report of the Secretary-General to the 37th Session of the Commission on Population and Development* (E/CN.9/2004/4). New York: UN.

United Nations Population Division. 2003. *The Impact of AIDS* [preliminary, unedited version]. New York: UN.

Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO). 2003. *AIDS Epidemic Update December 2003*. Geneva: UNAIDS/WHO. Available from http://www.unaids.org/Unaids/EN/Resources/Publications/corporate+publications/aids+epidemic+update+-+december+2003.asp; Internet; accessed 25 October 2004.

UNAIDS. 2004. *2004 Report on the Global AIDS Epidemic*. Geneva: UNAIDS.

_____. 2004. *Financing the Expanded Response to AIDS*. Geneva: UNAIDS.

_____. 2004. *National Spending for HIV/AIDS 2004*. Geneva: UNAIDS.

United Nations Population Fund (UNFPA). 2004. *Donor Support for Contraceptives and Condoms for STI/HIV Prevention 2002*. New York: UNFPA.

_____. 2004. *Financial Resource Flows for Population Activities in 2002* [in publication]. New York: UNFPA.

_____. 2004. *State of World Population 2004*. New York: UNFPA.

UNFPA and MORI. 2001. *Population Issues in the Developing World: 1996 and 2001 Public Opinion Research*. UK: MORI.

UNFPA/UNAIDS/Netherlands Interdisciplinary Demographic Institute (NIDI). 2004. Resource Flows Project database. For more information, see http://www.resourceflows.org.

United States Agency for International Development (USAID). 2003. *Agency-Wide Expenditures for Family Planning, HIV/AIDS, Health, and Nutrition, FY 2002: A USAID Managers Report*. Washington, DC: PHNI Project for USAID.

_____. 2004. *Guidance on the Definition and Use of the Child Survival and Health Programs Fund and the Global HIV/AIDS Initiative Account: FY 2004 Update*. Washington, DC: USAID.

World Bank. Undated. *Health, Nutrition and Population and the Millennium Development Goals*. Washington, DC: World Bank.

_____. 2000. *Population and the World Bank: Adapting to Change*. Washington, DC: World Bank.

Acronyms

AAC	Aid Advisory Council (Australia)
ABIA	Advisory Board of Ireland Aid
ACP	African, Caribbean and Pacific countries
ACPD	Action Canada for Population and Development
ADA	Austrian Development Agency
AECI	Spanish Agency for International Cooperation
AFD	French Development Agency
AIDOS	Italian Association for Women in Development
AIDS	Acquired Immune Deficiency Syndrome
APA	Asia-Pacific Alliance
APAD	Portuguese Development Support Agency
APDA	Asian Population and Development Association
APEFE	Walloon Association for the Promotion of Education and Foreign Training
APF	Family Planning Association (Portugal)
APPG	All Party Parliamentary Group on Population, Development and Reproductive Health (United Kingdom)
ARHA	Australian Reproductive Health Alliance
ARV	Antiretroviral drug
ASEAN	Association of Southeast Asian Nations
AusAID	Australian Agency for International Development
BMZ	Ministry of Economic Cooperation and Development (Germany)
BTC	Belgian Technical Cooperation
CAs	Cooperating Agencies
CDC	Centers for Disease Control and Prevention (United States)
CDG	Carl Duisberg Society (Germany)
CFLI	Canada Fund for Local Initiatives
CHAG	Christian Health Association of Ghana
CICID	Inter-Ministerial Committee for International Cooperation and Development (France)
CIDA	Canadian International Development Agency
CIPE	Inter-Ministerial Committee for Economic Planning (Italy)
CPI	Portuguese Cooperation Institute
CSCF	Civil Society Challenge Fund (United Kingdom)
CSP	Country Strategy Paper
DAC	Development Assistance Committee
DCC	Department for Development Cooperation (Austria)
DCI	Development Cooperation Ireland
DEG	German Investment and Development Company
DFID	Department for International Development (United Kingdom)
DGCID	Directorate General for International Cooperation and Development (France)
DGCS	Directorate General for Development Cooperation (Italy)
DGDC	Directorate General for Development Cooperation (Belgium)
DG Dev	Directorate-General for Development (European Commission)
DG Relex	Directorate-General for External Relations (European Commission)
DHS	Demographic and Health Survey
DIDC	Department of International Development Cooperation (Finland)
DSE	German Foundation for International Development
DSI	Department of Social and Institutional Development (Netherlands)
DSW	German Foundation for World Population

Non-English acronyms are noted in italics.

EC	European Commission (Commission of the European Community)
EDF	European Development Fund
E&P	Equilibres et Populations (France)
EU	European Union
EuropeAid	EuropeAid Cooperation Office
FAC	Foreign Affairs Canada
FGM/C	Female genital mutilation/cutting
FPAID	Family Planning Association International Development Unit (New Zealand)
FPFE	Family Planning Federation of Spain
FSP	Solidarity Priority Fund (France)
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GHS	Ghana Health Service
GIFS/GIMS	Global Initiative on Father/Mother Support
GII	Global Issues Initiative in Population and HIV/AIDS (Japan)
GNI	Gross national income
GTZ	German Agency for Technical Cooperation
HAP	Health Aid and Population (European Commission)
HCCI	High Council for International Cooperation (France)
HIPC	Heavily-indebted poor countries
HIV	Human Immunodeficiency Virus
HNP	Health, nutrition and population (World Bank)
IBRD	International Bank for Reconstruction and Development
ICMA	International Consortium for Medical Abortion
ICPD	International Conference on Population and Development
ICRC	International Committee for the Red Cross
IDA	International Development Association
IDI	Okinawa Infectious Disease Initiative (Japan)
IDRC	International Development Research Centre (Canada)
IFPD	International Foundation for Population and Development (Switzerland)
IHSD	Institute for Health Sector Development (United Kingdom)
IMCJ	International Medical Center of Japan
IMF	International Monetary Fund
InWEnt	Capacity Building International (Germany)
IPAD	Portuguese Institute for Development Assistance
IPPF	International Planned Parenthood Federation
ITM	Institute of Tropical Medicine (Belgium)
JICA	Japan International Cooperation Agency
JOICFP	Japanese Organization for International Cooperation in Family Planning
JPFP	Japan Parliamentarians Federation for Population
JSI/UK	John Snow International UK
Kepa	Service Center for Development Cooperation (Finland)
KfW	KfW Development Bank (Germany)
KIT	Royal Tropical Institute (Netherlands)
MAE	Ministry of Foreign Affairs and Immigration (Luxembourg)
MAF	Multilateral Assessment Framework
MAPS	Multi-Annual Programme Scheme (Ireland)
MCA	Millennium Challenge Account (United States)
MDGs	Millennium Development Goals
MEF	Ministry of Economy and Finance (Spain)
MEFI	Ministry of Economic Affairs, Finance and Industry (France)
METI	Ministry of Economy, Trade and Industry (Japan)
MFA	Ministry of Foreign Affairs (various countries)
MFPF	French Family Planning Movement
MOFA	Ministry of Foreign Affairs (Japan)
MOF	Ministry of Finance (Japan)
MS	Member State (European Union)

NACP	National AIDS Control Programme (Ghana)
NGO	Non-governmental organization
NIDI	Netherlands Interdisciplinary Demographic Institute
NIH	National Institutes of Health (United States)
NIP	National Indicative Programme
NORAD	Norwegian Agency for Development Cooperation
NPC	National Population Council (Ghana)
NZAID	New Zealand Agency for International Development
NZPPD	New Zealand Parliamentarians Group for Population and Development
ODA	Official development assistance
OECD	Organization for Economic Cooperation and Development
ÖGF	Austrian Family Planning Society
OPE	Office of Planning and Evaluation (Spain)
PAI	Population Action International
PEPFAR	President's Emergency Plan for AIDS Relief (United States)
PIAF	Pacific Islands AIDS Foundation
PPAG	Planned Parenthood Association of Ghana
PRS	Poverty reduction strategy
PSD	Social Democratic Party (Portugal)
RCHU	Reproductive and Child Health Unit (Ghana)
RFSU	Swedish Association for Sex Education
RIP	Regional Indicative Programme
SAARC	South Asian Association for Regional Cooperation
SAREM	Reproductive Health and Women's Empowerment (Finland/Nicaragua)
SDC	Swiss Agency for Development and Cooperation
SECO	State Secretariat for Economic Affairs (Switzerland)
SEKA	Department for Cooperation with NGOs (Sweden)
SHA	Swiss Humanitarian Aid Unit
SH&FPA	Sexual Health and Family Planning Australia
Share-Net	Netherlands Network on Sexual and Reproductive Health and AIDS
Sida	Swedish International Development Cooperation Agency
SIG	Spanish Interest Group on Population, Reproductive Health and Development
STD	Sexually transmitted disease
SUSS	Center for Youth Relationships and Sexuality (Norway)
SWAp	Sector-wide approach
SWI	Austrian Foundation for World Population and International Cooperation
UICEMP	Union of Italian Centers for Marital and Premarital Education
UMATI	Family Planning Association of Tanzania
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Fund for Women
USAID	United States Agency for International Development
VASS	Voluntary Agency Support Scheme (New Zealand)
VVOB	Flemish Association for Development Cooperation and Technical Assistance
WHO	World Health Organization
WID	Women in Development
WPF	World Population Foundation (Netherlands)
ZSP	Priority Solidarity Zone (France)

Appendix 4

PRIMARY FUNDS FOR POPULATION ASSISTANCE, BY MAJOR DONOR CATEGORY, 1992–2002[a]
(Millions of current and constant $US)

Donor category	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Developed countries[b]	766	777	977	1,372	1,369	1,530	1,539	1,411	1,598	1,720	2,314
United Nations system[c]	54	66	107	111[d]	18[e]	49	35[f]	31[g]	77g	96[h]	31
Foundations/NGOs	106	124	117	85	141	106	124	240	299	241	530
Bank grants	NA	NA	NA	6	8	9	10	9	1	3	2
Total (Current $US)	926	966	1,201	1,574	1,535	1,694	1,707	1,691	1,975	2,060	2,878
(Constant 1993 $US)[i]	954	966	1,171	1,492	1,414	1,525	1,513	1,467	1,657	1,680	2,311
Development banks[j]											
World Bank IDA loans	NA	195	239	306	253	142	284	265	368	349	232
World Bank IBRD loans	NA	145	184	142	256	92	142	182	170	101	95
African Development Bank loans	NA	NA	NA	NA	NA	NA	–[k]	–	–	–	
Asian Development Bank loans	NA	4	12	12	NA	33	–[l]	–[m]	66	–	
Inter-American Development Bank loans	NA	NA	NA	NA	NA	NA	–[n]	93	–	12[o]	
Total (Current $US)	107	344	436	460	509	266	426	540	604	461	328
(Constant 1993 $US)[i]	110	344	425	436	469	239	378	468	506	376	263
Grand Total (Current $US)	**1,033**	**1,310**	**1,637**	**2,034**	**2,044**	**1,960**	**2,133**	**2,231**	**2,579**	**2,521**	**3,205**
(Constant 1993 $US)[i]	1,064	1,310	1,596	1,929	1,883	1,765	1,891	1,935	2,163	2,057	2,575

Source: UNFPA. 2004. *Financial Resource Flows for Population Activities 2002*. New York: UNFPA.
a Figures were rounded off and may not add to totals. NA indicates information not available for that year.
b The developed countries category includes the total of UNFPA's income from developed countries, since any contribution to UNFPA is regarded as having been earmarked for population assistance. Beginning with 1994, the European Union is included with developed countries.
c The United Nations system category includes contributions to population activities, mainly from UNAIDS, UNICEF, UNFPA and WHO that are part of general funds (not earmarked for population activities) from developed countries, developing countries and interest earned on income.
d Figures for primary funds for population assistance for UNICEF were not provided for 1995. As a result, 1995 figures are estimated at the 1994 level.
e UNICEF only provided data on project expenditures. Data on income were not provided.
f UNICEF and WHO did not provide data on income.
g WHO did not provide data on income.
h UNICEF did not provide data on income.
i The selection of 1993 as a base year for indicating constant dollars relates to the ICPD costed package year and serves only to permit an estimate of changes in real values, offsetting fluctuations caused by inflation and exchange rate variations.
j The development banks' primary funds are shown separately because they are in the form of loans, which must be repaid.
k The African Development Bank reported approving loans of US$48 million for broad population and health programs.
l The Asian Development Bank reported expending US$183 million in loans for integrated health projects with a population component.
m The Asian Development Bank reported expending US$347 million in loans for primary health programs for which an undetermined amount was earmarked for population activities.
n The Inter-American Development Bank reported expending US$128 million in loans for integrated health projects with a population component.
o The Inter-American Development Bank reported expending US$35 million in loans for integrated health projects with a population component. The figure of US$12 million for population activities is an estimate.

PRIMARY FUNDS OF DONOR COUNTRIES FOR POPULATION ASSISTANCE, 1994-2002 (Current $US Millions)

	1994	1995	1996	1997	1998	1999	2000	2001	2002
Australia	$ 18.0	$ 26.9	$ 32.6	$ 45.2	$ 44.6	$ 30.5[a]	$ 14.7	$ 13.1[b]	$ 21.3
Austria	$ 0.7	$ 2.9	$ 0.9	$ 0.6	$ 1.8	$ 1.4[c]	$ 0.9	$ 1.0[b]	$ 1.5
Belgium	$ 2.9	$ 5.6	$ 5.5	$ 9.8	$ 10.1	$ 10.4	$ 15.8	$ 19.1	$ 44.1
Canada	$ 22.8	$ 37.3	$ 36.5	$ 34.5	$ 38.6	$ 37.2	$ 37.4	$ 12.7	$ 82.8
Denmark	$ 32.6	$ 49.7	$ 63.0	$ 47.0	$ 60.1	$ 54.9	$ 44.6	$ 48.9	$ 73.8
Finland	$ 7.8	$ 22.5	$ 19.8	$ 17.3	$ 23.1	$ 20.0	$ 19.8	$ 23.7	$ 24.4
France	$ 13.4[d]	$ 13.4[e]	$ 16.5	$ 16.5[f]	$ 16.5[g]	$ 8.0[c]	$ 12.4	$ 8.2	$ 83.7
Germany	$ 114.8	$ 145.3[h]	$ 96.0[i]	$ 122.5[j]	$ 124.8	$ 119.8	$ 96.4	$ 108.7	$ 106.8
Greece	—	—	—	—	—	—	—	$ 0.01	$ 0.1
Ireland	$ 0.2	$ 2.9	$ 0.7	—	—	$ 2.7	$ 4.2	$ 6.3	$ 11.8
Italy	$ 17.5[d]	$ 4.4	$ 3.6	$ 2.2	$ 6.4	$ 10.0	$ 24.9	$ 25.0[b]	$ 22.6[k,l]
Japan	$ 82.7	$ 93.8[m]	$ 93.8[n]	$ 93.8[o]	$ 88.9	$ 111.7	$ 130.7	$ 115.3	$ 180.2
Luxembourg	$ 0.1	$ 0.9	$ 1.2	$ 1.2[f]	$ 4.3	$ 3.3	$ 10.7	$ 5.6[b]	$ 7.5[p]
Netherlands	$ 43.8	$ 86.6	$ 111.7[q]	$ 146.4	$ 119.2	$ 115.8	$ 170.1	$ 132.0	$ 164.3
New Zealand	$ 0.8	$ 1.2	$ 1.2	$ 1.8	$ 2.3	$ 2.3	$ 2.3	$ 2.2	$ 3.3
Norway	$ 40.7	$ 47.3	$ 46.1	$ 54.3	$ 71.4	$ 61.7	$ 60.0	$ 43.0	$ 80.8
Portugal	$ 0.1	—	$ 0.2	$ 0.4	$ 1.2	$ 0.4	$ 0.4	$ 0.7	$ 0.6
Spain	$ 0.6[d]	$ 0.6[e]	$ 7.4	$ 7.4[f]	$ 4.3	$ 9.5	$ 6.2	$ 14.4	$ 3.3
Sweden	$ 44.7	$ 44.7[r]	$ 57.9[s]	$ 53.2	$ 78.3	$ 61.6	$ 73.1	$ 56.3	$ 61.1
Switzerland	$ 8.2	$ 17.1	$ 16.2	$ 16.6	$ 17.8	$ 17.8	$ 16.1	$ 23.5	$ 23.4
United Kingdom	$ 58.0	$ 98.2	$ 106.4	$ 117.4	$ 125.9	$ 95.7	$ 169.6	$ 81.0	$ 168.8
United States	$ 462.9	$ 667.1[t]	$ 637.7	$ 662.4	$ 619.7	$ 603.0	$ 658.6	$ 951.0	$ 963.0
European Union	$ 3.7[u]	$ 3.6[v]	$ 14.0[w]	$ 79.4[x]	$ 79.4[y]	$ 33.4[z]	$ 28.9[aa]	$ 28.1[ab]	$ 184.9[ac]
Total[y]	**$977.1**	**$1,372.0**	**$1,369.1**	**$1,529.9**	**$1,538.8**	**$1,411.1**	**$1,597.7**	**$1,719.6**	**$2,314.1**

Source: UNFPA. 2004. *Financial Resource Flows for Population Activities in 2002*. New York: UNFPA.

a The 1999 figure for Australia only includes expenditures for projects exclusively dedicated to population activities and excludes expenditures for the population component in integrated development projects.

b Information on expenditures for population projects and programs was not provided or not fully reported. As a result, 2001 project and program figures are estimated at the 2000 level.

c Austria and France only reported information on contributions to multilateral donors in 1999. No information on project expenditures was reported.

d Figures on expenditures for population assistance for 1994 were not provided. As a result, 1994 figures are estimated at the 1993 level.

e Figures on expenditures for population assistance for 1995 were not provided. As a result, 1995 figures are estimated at the 1993 level, the latest year for which figures were reported.

f Figures on expenditures for population assistance for 1997 were not provided. As a result, 1997 figures are estimated at the 1996 level.

g Figures on expenditures for population assistance for 1998 were not provided. As a result, 1998 figures are estimated at the 1996 level, the latest year for which figures were provided.

h Family planning assistance is reported on the basis of reported commitments; for other population activities, expenditure figures were available.

i Commitments for bilateral projects in Germany in 1996 amount to 168.3 million DM ($US111,842,082).

j The figure for Germany only includes expenditures for population projects and programs and excludes expenditures for the population component in integrated development projects.

k Since 2002 exchange rates are not available, the respective 2001 rates are used.

l Project/program expenditures and channels are estimated based on 2000 data.

m Japan used a broader definition of population assistance than UNFPA. In the interest of comparability, the figures provided were re-calculated to conform to UNFPA's definition of population assistance.

n Figures on expeditures for population assistance for 1996 were not provided. As a result, 1996 figures are estimated at the 1995 level.

o Figures on expenditures for population assistance for 1997 were not provided. As a result, 1997 figures are estimated at the 1995 level, the latest year for which figures were reported.

p Project/program expenditures have been estimated by the Ministry of Foreign Affairs in Luxembourg. Channels are estimated based on 2001 data.

q Expenditures for the Netherlands are without contributions to national NGOs that receive core funding for development activities and without payment to experts working in the field of population activities overseas.

r Figures on expenditures for population assistance for 1995 were not provided. As a result, 1995 figures are estimated at the 1994 level.

s Sweden has a much broader definition of population activities.

t The information provided did not always allow the unequivocal determination of the channel of distribution.

u The European Union did not provide information on expenditures for population assistance in 1994; the figure reported for 1994 was obtained from data provided by other respondents.

v Figures provided for 1995 represent multiple-year assistance. The 1995 figures reported here were obtained from data provided by other respondents.

w Data provided by the European Union exclude NGO co-financed projects.

x Data for the European Union are a global estimate based on known payment credits for population, reproductive health and AIDS activities.

y Figures on expenditures for population assistance for 1998 were not provided. As a result, 1998 figures are estimated at the 1997 level.

z Data for the European Union are a global estimate based only on the European Commission's commitments for reproductive health and AIDS activities.

aa Figures on expenditures for 2000 were not provided. As a result, 2000 figures are estimated at the 1999 level.

ab Figures on expenditures for population assistance for 2001 were not provided. As a result, 2001 figures are estimated at the 1999 level.

ac Figures for the European Union have been estimated by NIDI based on data from the European Commission and the DAC Watch of the European Union, IPPF, January 2002.

ad Figures have been rounded off and may not add to totals.

Population Action International (PAI) is an independent policy research and advocacy group working to strengthen public awareness and political and financial support worldwide for population programs grounded in individual rights. Founded in 1965, PAI is a private, non-profit group and accepts no government funds. At the heart of Population Action International's mission is its commitment to advance universal access to family planning and related health services, and to improve educational and economic opportunities, especially for girls and women. Together, these strategies promise to improve the lives of individual women and their families, while also slowing the world's population growth and helping preserve the environment.

Board of Directors