CHAPTER 11

OFFICIAL DEVELOPMENT ASSISTANCE LEVELS AND SPENDING ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS SINCE THE ICPD

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Introduction

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

From Cairo a Programme of Action was formulated, which included a number of recommendations and goals, for instance that governments should:

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

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

In the context of the European Population Forum 2004 under the auspices of the UNECE, IPPF European Network (IPPF EN) was invited to write a background paper for the thematic session on '*Global population and development trends: the European View*'. The aim of this paper is to give a general overview of donor performance in ODA and SRHR funding since the Cairo summit. It also describes the trends and evolution in development aid which could impact the further implementation of the ICPD Programme of Action. IPPF EN exploited its professional experience and involvement in monitoring donor policies in the context of its DAC (Development Assistance Committee) Watch[2] project to draft this document. Among other sources, it is based extensively on the research and data gathered for the 'DAC Watch Compilation' (IPPF European Network,

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

[2] See following section for a description of the DAC Watch project.

2002) and the 'Euromapping[3]' exercise (EuroNGOs, 2003).

Background: What is the DAC Watch Project?

The OECD Peer Review Process

The Peer Review process of the Development Assistance Committee (DAC) of the OECD is a critical evaluation of each country's performance in its overseas development assistance strategy. The DAC[4] conducts these periodic performance assessments "*to improve the individual and collective development cooperation efforts of DAC members*". The policies and efforts of individual members are reviewed approximately once every four years and some five programmes are examined annually. The Peer Review is prepared by a team consisting of representatives of the DAC Secretariat working together with officials from two DAC members who are designated as examiners.

The actual DAC Watch Project and the Shadow Peer Reviews

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

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

Each Shadow Peer Review is composed of two sections:

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

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

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

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

Levels of official development assistance in DAC countries: a decade of history

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

The donor countries consistently reaffirmed their commitment to dedicating larger shares of their budget to ODA during these years. However, the historical development relating to ODA belies these promises: indeed there has been a clear downward trend in ODA over the past decade. In order to give an overview, let us analyse how much aid has been given over time and what the current situation is. Are these levels sufficient to significantly impact development? What are the perspectives for the future? These questions are addressed in this section on ODA levels.

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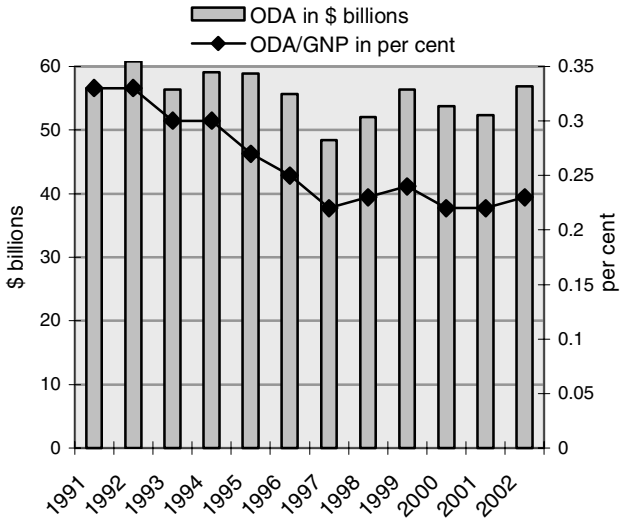
[3] The 'Euromapping' project is a monitoring exercise done by DSW and IPPF EN which aims at strengthening European advocacy and mobilising public funding in the fields of population, sexual and reproductive health and HIV/AIDS. For more information, consult http://www.eurongos.org/resources/euromapping.

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

FIGURE 1

Total net ODA flows and ODA/GNI ratio of all DAC members from 1991-2001



Source: ODA figures from the OECD/DAC.

A long-standing target: 0.7 per cent of GNI to ODA

Although the need for ODA was recognised by the donor community back in the 1950s, a consensus on a minimum level to reach in order to have an impact on development was hard to find. The notion of having such a target for development funding was first suggested in 1958, when it was proposed that one per cent of the developed countries' Gross National Product (GNP) be transferred to the developing countries in the form of grants and loans. Ever since, the measurement, content and implementation of a target have been major issues in development negotiations. Years passed in discussion before the idea was accepted that each developed country should attempt to transfer to developing countries a net amount of at least 0.7 per cent of their GNP for global development. That target was first formally proposed in 1969 by former Canadian Prime Minister L. Pearson in the Report on International Development. Today this figure has been widely accepted as a reference target for ODA by the OECD/DAC. Endorsed by the UN General Assembly in 1970[5] it was part of the international development strategy for that decade and since then it was reaffirmed at several of the UN conferences of the 1990s, including the 1994 ICPD.

Decline in ODA volumes and ODA/GNI ratios over time[6]

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

However, from the beginning of the 1990s, total ODA flows started declining again. Between 1991 and 1997, net ODA fell by over $8 billion from $56.6 to $48.4 billion. Over this period, the ODA/GNI ratio steadily declined from 0.33 per cent in 1991 to 0.30 per cent in 1993 and finally to 0.22 per cent in 1997. In other words, overall ODA has clearly decreased since the ICPD (figure 1).

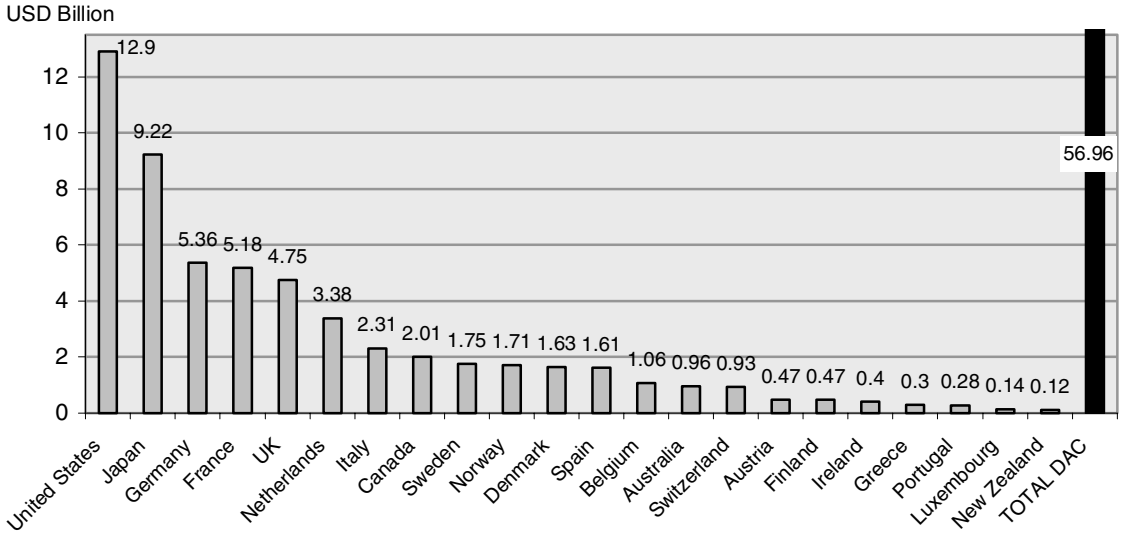
In the late 1990s and early 2000s, ODA flows stopped declining but fluctuated between a high level of $56.4 billion in 1999 and a low level of $52.3 billion in 2001. These changes in ODA volumes showed no sign of catching up with the higher levels of the beginning of the decade (the all-time high was $60.8 billion in 1992 and had declined to $59.1 billion in 1995). Neither was there any improvement of the ODA/GNI ratio which remained on average at 0.22 per cent. This is the smallest

[5] Not all donors endorsed the UN 0.7 per cent target. The United States for example never committed to this figure.

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

FIGURE 2

Net ODA volume from DAC member countries in 2002



Source: OECD/DAC

share of donors' GNP given to aid since statistics on aid first began to be collected in the 1950s. An overall decrease in the ODA/GNI ratio has occurred, from 0.33 per cent prior to 1994 down to 0.22 per cent in 2001 (figure 1).

When looking at 21 DAC donors[7] we see that 11 countries have increased their ODA volume since 1994: Belgium, Denmark, Finland, Ireland, Luxembourg, New Zealand, the Netherlands, Norway, Spain, the United Kingdom and the United States. However, 10 others have decreased it: Australia, Austria, Canada, France, Germany, Italy, Japan, Portugal, Sweden and Switzerland.

The situation in 2002: the start of a recovery?[8]

Overall ODA levels

From 2001 to 2002, DAC member countries increased their ODA levels by 4.9 per cent in real terms. Total ODA amounted to $57 billion, equivalent to 0.23 per cent of the total donors' Gross National Income (GNI).[9] These figures could mark the beginning of a recovery from the all-time low level of 0.22 per cent of GNI of the previous two years.

Distribution of ODA volumes per donor country (figure 2)

The donor countries' contributions to ODA are very uneven: only six of the 22 countries have an ODA level above $3 billion whereas nine do not even reach a total of $1 billion. Moreover, almost two-thirds of total DAC ODA originates from EU sources (62 per cent).

The United States remained the world's largest aid donor in volume terms for the second year running, followed by Japan (the United States overtook Japan for the first time since 1992 in 2001). It is, however, interesting to note that the total contribution of the EU member states - plus the European Commission contributions to ODA – which combined come to $35.6 billion represents an amount more than triple the United States' spending on ODA ($12.9 billion). Germany, France and the United Kingdom are the leading donors after the United States and Japan.

The year 2002 is seen as promising. Twelve of the 22 DAC member countries reported an increase in ODA in real terms (of which seven are EU member states). For nine of them, the increase was over 10 per cent. The most significant increases were seen in Greece (+34.2 per cent), Italy (+31.5 per cent) and Ireland (+25.4 per cent). However, ten DAC countries saw a decrease in their aid contributions in real terms, but fortunately the scale of these decreases was proportionately smaller than the scale of the increases in other countries. For only two countries was this fall more than 10 per cent: Austria (-16.5 per cent) and Spain (-15.7 per cent) compared to

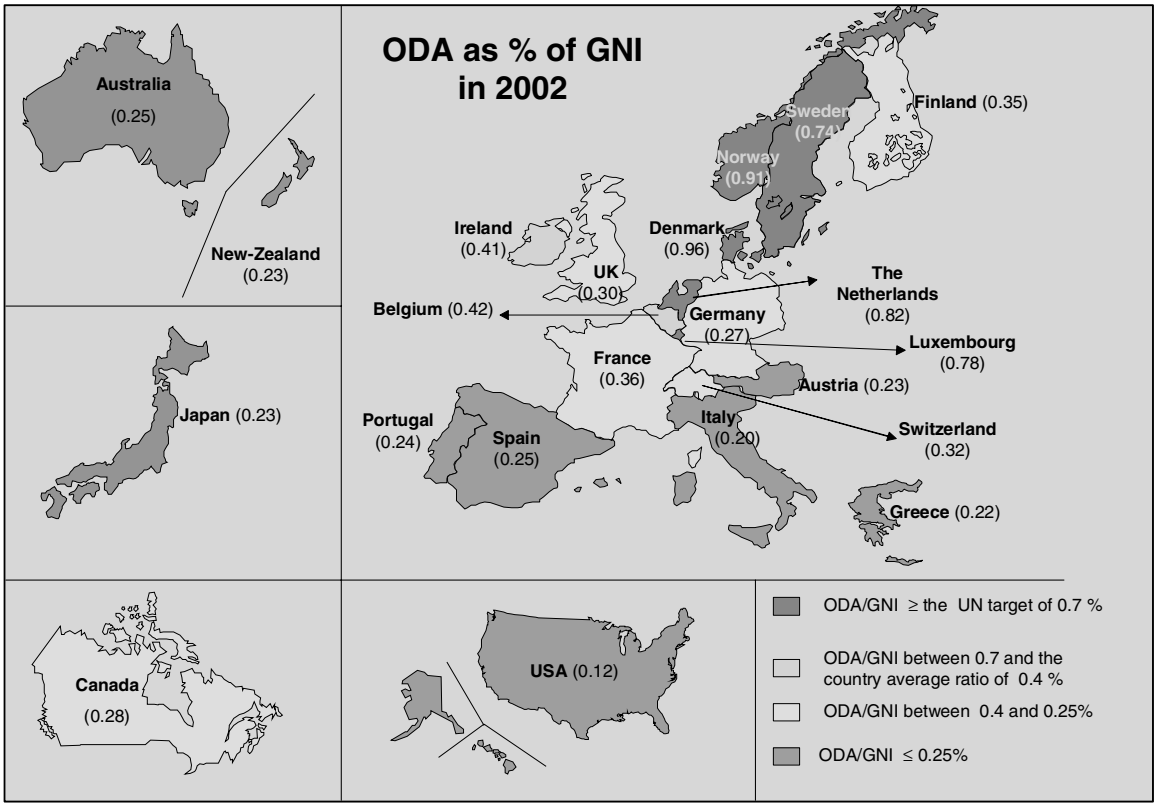
[7] Excluded are Greece (as it only entered the OECD/DAC in 1999) and the European Community.

[8] The DAC ODA figures for 2002 are the latest for when comparable data available.

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

FIGURE 3

Net ODA in 2002 – as a percentage of GNI



Source: OECD/DAC

their 2001 levels.[10] Denmark and Switzerland made more modest cuts of 6.4 per cent and 5.6 per cent respectively.

Classification of donors according to their ODA/GNI ratio (figure 3)

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

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

Finally, the majority of the DAC countries have an ODA/GNI ratio below 0.25 per cent. These least generous countries are mostly located in southern Europe (Portugal, Spain, Italy and Greece) plus Austria. The other countries of this category are DAC members outside Europe: Australia, New Zealand, Japan and the United States. Concerning the United States, it is important to note that whereas it is the major donor in volume terms, it has the lowest ODA/GNI ratio of all DAC countries (0.12 per cent). Even with an increase of its ODA by 11.6 per cent in 2002[11], the United States remains the least generous donor in the world as measured by its ODA/GNI ratio, and this for the ninth consecutive year.

Funding gap, future requirements and recent new commitments

The recent increases in aid are the first results of the general commitments made by donor countries to increasing their ODA to developing countries in the context of the International Conference on Financing for Development held in Monterrey, Mexico, in March

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

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

2002.[12] At this UN gathering, emphasis was laid on the inadequate current levels of total ODA for reducing poverty and reaching the MDGs. Rough estimated costs for achieving the agreed international goals were presented (Zedillo, 2001).[13] An additional ODA of $50 billion per year was said to be required for each of the next 12 years. This represents an increase from approximately $57 billion of ODA in 2002 to $100 billion per year.

New international pledges

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

Canada promised an increase of 8 per cent per year in ODA to reach the target of 0.7 per cent in the medium term. The Canadian ODA/GNI ratio should reach 0.33 per cent in 2006/07.

The United States pledged an additional $5 billion from 2003 to 2006. This initiative, called the New Compact for Development[14] would be the largest three-year increase in American aid in the last 20 years.[15]

Norway pledged to reach 1 per cent of its GNI to ODA by 2005.

Switzerland plans to reach 0.4 per cent of its GNI to ODA by 2010.

The Barcelona Commitments

Another positive sign attributed to the stimulus of the Monterrey Financing for Development Conference was the increase in total ODA of the EU countries by 2.8 per cent in real terms in 2002. It was the consequence of a decision taken at the European Union Barcelona Council of March 2001 (and reaffirmed at Monterrey). Indeed, the heads of state of the European member states felt that at that stage it was important to arrive at the Monterrey Conference with strong common views on increasing ODA. They therefore proposed eight commitments (known as the 'Barcelona commitments') for the member states to work on, including increasing ODA levels. It was decided that the European Commission had to organise dialogue with each EU member state on setting a realistic timetable for reaching higher ODA targets. At the EU Development Council of November 2001, the EC proposed a plan to gradually increase ODA levels and it would also monitor the progress of each country's ODA level.[16] The proposal for a 'road map' to reach the financial goals was the following:

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

- one individual: by 2006, all member states should at least reach the 2000 EU average of 0.33 per cent ODA/GNI (those already above 0.33 per cent are expected to make further increases as well).
- one collective: by 2006, the EU average should go up to 0.39 per cent (thanks to the increases of the individual country levels).

A long-term gradual process will lead all EU member states towards the UN target of 0.7 per cent:

- In 2006, the new EU average of 0.39 per cent would become the benchmark for all individual countries to reach by 2010.
- By a similar process, the member states would repeat this process of achieving successive realistic milestones until the UN target of 0.7 per cent would be met in 2015.

In May 2003, the EC produced a first evaluation report (SEC, 2003).

The trend towards the achievement of the first Barcelona Commitment on the volume of ODA is positive. The implementation of the scenario had started well despite a difficult budgetary background. In 2003, 10 of the 15 member states had met the Barcelona target of 0.33 per cent ODA/GNI[17] (of which four had already reached the UN 0.7 per cent target). The five remaining countries had not yet met the target but recommitted to achieving it by 2006.[18]

Moreover, most of the EU member states have established concrete plans for increasing their ODA to the levels set at Barcelona, and some have even presented

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

[13] The World Bank has estimates in the same range: an additional $40 and $60 billion per year to reduce poverty (report published in February 2002). The Bank also calculated an estimated cost for reaching the health-related MDGs: an additional ODA of $20 to $25 billion per year would be required.

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

[15] Despite this almost 50 per cent increase of American ODA, it is estimated that this will still not enable the country to move up from bottom place in the list of donors in terms of ODA/GNI ratio.

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

[17] In 2002 Denmark, Luxembourg, the Netherlands, Sweden, Finland, France, Ireland and Belgium reached the goal and in 2003 two more joined this group: the United Kingdom and Austria.

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

commitments going beyond the EC targets.[19] Denmark, on the contrary, announced a decrease in its ODA/GNI ratio as the new right-wing government is not willing to strive to reach the target of 1 per cent set by the former government. However, the country has promised to maintain its overall ODA level above the 0.7 per cent UN target.

Major challenges for the future

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

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

Increasing the efficiency of aid

Since the ICPD, the discussion on aid volumes has been in parallel with discussions on the effectiveness of aid. Major donors (e.g. Denmark, the United States) have increasingly criticised the fact that emphasis has been placed mainly on how much ODA is available to spend and not enough on how it is spent. The following are examples of critical issues which need to be addressed.

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

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

This situation has started to change since the ICPD: the OECD took significant steps to improve aid effectiveness in the mid-1990s (OECD, 2004) and the World Bank introduced the Comprehensive Development Framework[20] in 1998. This is an approach by which developed and developing countries establish a long-term relationship; the recipient country develops and so has ownership of its own poverty reduction strategy; and there is a strong partnership between governments, donors, civil society, the private sector and other development stakeholders in implementing this country strategy. The Framework also recommends that donors put their ODA into a common pool to support the financing of the development strategy which will then be fully implemented by the recipient.

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

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

Funding for sexual and reproductive health and rights in development: an overview since the ICPD

In 1994, at the ICPD, the participants called upon the international community to: "…achieve an adequate level of resource mobilization and allocation at the community, national and international levels for

[19] France: to reach 0.7 per cent of GNI/ODA by 2012; Ireland: by 2007; Belgium: by 2010; United Kingdom: 0.4 per cent of GNI/ODA by 2005.

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

TABLE 1

The ICPD resource allocation goals
(Billion dollars)

	Financial resources required for 2000-2015		
	Domestic resources	External resources	Total resources
2000	11.3	5.7	17.0
2005	12.4	6.1	18.5
2010	13.7	6.8	20.5
2015	14.5	7.2	21.7

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

population programmes and for other related programmes…" (Art 13.21 Programme of Action of the ICPD) Dedicating a fair share of each donor's ODA to SRHR programmes was internationally recognised as essential in order to achieve the goals of the ICPD. A set of clear financial targets were agreed upon during the conference and donors have made significant financial efforts since 1994. However, the total funding level for SRHR still falls short of the needs. This section gives an historical overview of the evolution of SRHR funding levels. It also describes the methodological difficulties associated with measuring funding for SRHR, and the actual funding shortfall is outlined.

International resource goals for Sexual and Reproductive Health and Rights

Financial agreements at the ICPD

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

Two-thirds of the projected costs were expected to be provided by domestic sources, representing a total amount of $11.3 billion by 2000. One third of the total needs were to come from the international donor countries (art 13.16 PoA ICPD). These external resources should have amounted to $5.7 billion by 2000 and $6.1 billion by 2005. (art 14.11 PoA ICPD) (table 1).

Population assistance as a share of Official Development Assistance

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

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

Sources and definitions

Source of the figures used

The figures used in this paper are taken from a study called *Financial Resource Flows for Population activities in 2001* (NIDI/UNFPA, 2003). It is the final edition of a series of reports done by the Netherlands Interdisciplinary Demographic Institute (NIDI), under contract to and in collaboration with UNFPA. It presents the results of a data collection exercise, aimed at analysing donors' and domestic countries' resource flows in the field of population and SRH.

It is the only source of information which provides comparable data on these issues for 22 DAC members (all DAC members except Greece). The data also allow historical comparisons to be made (figures are available from 1995 to 2001.[21]) Data on donor assistance for population activities were gathered using a uniform detailed questionnaire sent to each country. The collection procedures were done in such a way as to avoid double counting and to allow verification.

Definition of the 'Costed Population Package'

The figures record resource flows for several categories of activities, all relevant to SRH. These categories form what is called the "Costed Population Package"[22], and includes all costs related to the following:[23]:

- Family planning services;
- Basic reproductive health services;
- Sexually transmitted diseases - HIV/AIDS: prevention, treatment and care;

[21] Data for earlier years are available but a different definition of population aid was used then and so cannot therefore be strictly compared.

[22] The "costed population package" was specified and described in the Programme of Action of the ICPD under paragraph 13.14.

[23] See Appendix 1 for a detailed definition of the ICPD "costed population package".

- Basic research: data analysis, development of population policy.

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

Constraints in monitoring sexual and reproductive health funding flows

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

Difficulty of disaggregating the SRH components

It is difficult to disaggregate and differentiate the SRH components from other elements in larger projects. This is especially the case in the actual development environment where the emphasis is made (rightly) on integration. First, the increased use of Sector Wide Approaches (SWAps) makes it difficult to track the level of funding for specific SRH issues within the general health sector. The data recording system does not allow for clear differentiation between the four items of the costed package. Moreover, some donors are increasingly encouraging the use of direct budget support. Because the donors' funding is then gathered in one basket and managed by the Minister of Finance of the recipient country, it is almost impossible to distinguish how much each donor has contributed to each sector, and even less to distinguish how much was given to each component of a sector. Finally, there is a growing trend towards the integration of SRH services into general health services, which is consistent with the call for this made at the ICPD.[24] However, evaluating the amount of funding specifically dedicated to SRH issues is then a challenging task.

Concerns about underreporting

Some donors are concerned that a great deal of funding goes unreported, with the reported level being considerably lower than the actual level of SRH funding. Indeed, several integrated development projects in the social sectors (other than health or education) do include SRH aspects but they are not reported as such, given the fact that the budget is not split per individual component.[25] Moreover, by adhering to the definition of the costed package, other population-related activities, such as education or women's issues, are not included in the calculations.

Difficulties with monitoring

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

Questions about future monitoring

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

As new development trends are making it increasingly difficult to monitor financial flows into SRH, donors are suggesting that the best way to measure progress towards the ICPD commitments is by monitoring the outcome of projects, based on results-based SRH indicators. While the benefit of outcome indicators has to be recognised, using only these types of indicators (which most of the time are long-term indicators) is not considered as very effective for direct advocacy work with donor governments. Having a set of comparative funding levels for all donors puts far more pressure on governments to convince them to react and live up to their promises. Both kinds of indicators are seen as essential in order to measure the progress with the ICPD Programme of Action.

Ten years of international population assistance flows

It is difficult to analyse the evolution of donor contributions to population assistance following the ICPD, partly because the definition of population assistance has expanded in response to the proposals made at that conference. For example, in 1995 the United Nations Fund for Population Assistance (UNFPA) added two new components to the definition used previously: these were 'expenditures for the fight against HIV/AIDS' and 'maternal care'. When looking at the sum of all population assistance from the developed countries[26] (for all DAC members except Greece) from

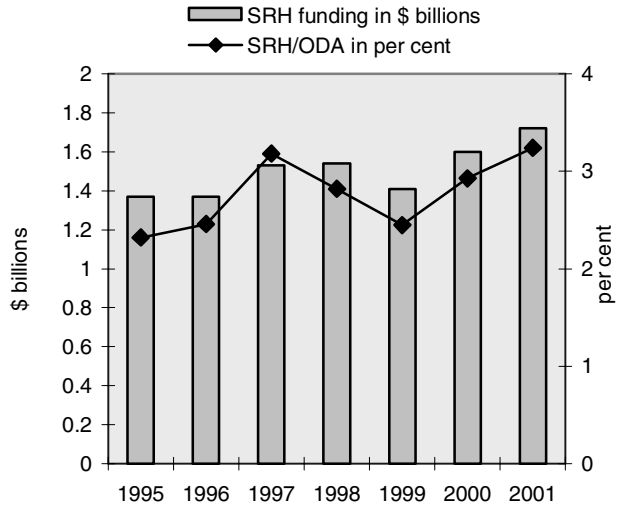
[24] One example of integration would be in the building of a new hospital which would include a maternity ward.

[25] e.g. SRH components are often integrated into programmes sponsored by the European Commission, where SRH activities are financed from non-SRH-related budgets. For example food aid or the refugee budget have specific population components, but these are not reported in the total EC SRH funding.

[26] The spending of developed countries includes the UNFPA's income from these countries, since the contributions to UNFPA are regarded as being earmarked for population assistance.

FIGURE 4

Total DAC members' contributions for SRH funding and SRH/ODA ratio (1995-2001)



Source: NIDI/UNFPA, 2003

1994 to 1996, it rose from 977 to $1,372 million, and the SRH/ODA ratio grew from 1.7 to 2.5 per cent. Whether this significant increase is to be attributed more to the change in definition or more to actual responses to the ICPD proposals (or partly to each of these reasons) is unclear. Therefore, no clear-cut conclusion can be drawn from these figures.

Evolution of DAC member contributions to SRH in volume from 1995 to 2001

Between 1995 and 2001, the general trend has been rather positive. Donor contributions to SRH funding increased by 25 per cent from $1.37 to $1.71 billion. This growth has not been steady: population assistance experienced an initial jump in 1997 (from $1.37 to $1.53 billion); it stagnated in 1998 (at $1.54 billion) before falling in 1999 to $1.41 billion. Since then, population assistance has started increasing again. In 2000, it caught up and even surpassed the 1997 funding level, reaching $1.6 billion. In 2001, population assistance grew again by 7.6 per cent and attained $1.72 billion, a record high since 1995 (figure 4).

Evolution of the SRH/ODA ratio from 1995 to 2001

As mentioned earlier, a good indicator of commitment to population assistance is the contribution that donor countries make to SRH relative to the total amount of their development aid. The ratio SRH/ODA is therefore examined in the NIDI study. From 1995 to 2001, population assistance from developed countries rose from 2.32 to 3.24 per cent of total ODA, although it experienced marked fluctuations (figure 4).

Despite these apparently encouraging signs, further analysis of the figures leads to a more nuanced conclusion. Between 1995 and 1997, the ratio increased from 2.38 to 3.18 per cent. This, however, happened in a period when ODA decreased from $58 to $48 billion. The same situation occurred in 2000 and 2001 when the SRH/ODA ratio increased (after a two year decline) to respectively 2.93 and 3.24 per cent - but again in the context of decreasing ODA. So, the share of SRH spending has increased in the years when the overall ODA budget has declined.

We see the opposite effect between 1997 and 1999, when the SRH/ODA ratio decreased from 3.18 to 2.45 per cent at a time when ODA increased from $48 to $56 billion. In those years, population activities received a smaller share of an increasing ODA. In other words, since 1995, the SRH/ODA ratio never grew thanks to both increases in SRH funding and ODA volumes. Population assistance has never received a bigger share of a larger total ODA amount, although there has been a general upward trend in raw volume.

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

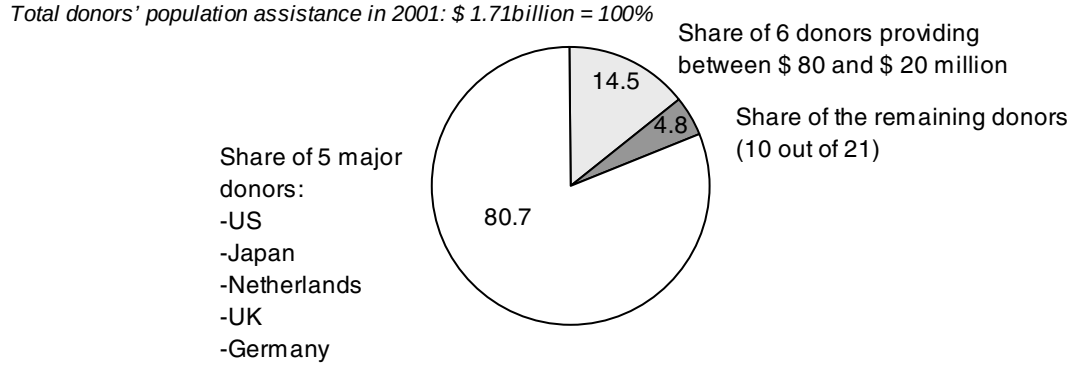
Total international population assistance

When summing together the developed countries' spending, the non-earmarked contributions from the United Nations[27] system, donations from philanthropic

[27] These UN contributions include those contributions to population activities - mainly from UNAIDS, UNICEF, UNFPA and WHO - that come from the general funds, not earmarked for population activities, as

FIGURE 5

Unequal burden sharing for population funding



Source: Figures from NIDI and calculations from IPPF European Network

foundations and loans of development banks,[28] the total international population assistance for 2001 amounted to $2.5 billion. This was somewhat lower than the 2000 level of $2.6 billion. The fall is mainly attributable to decreases in the loans provided by development banks. The 2001 level remains, however, a step forward compared to 1999 when total population assistance was only $2.2 billion. Moreover, since 1995, this aggregate has increased from $2 to $2.5 billion.

SRHR funding levels of individual donor countries in 2001

- *In terms of volume*

The developed countries do not share the burden equally of providing funding for population assistance. On the one hand, only a minority of DAC members (4 out of 22) donate more than $100 million per year to SRH issues: the United States, the Netherlands, Japan and Germany. Their combined contributions represented more than 75 per cent of the total DAC population assistance in 2001. Moreover, the spending of the five major donors represents 80 per cent of the total funding for SRHR (figure 5).

On the other hand nearly half of the DAC members (10 out of 22) donate less than $20 million per year to these issues. Their total contributions represent just 4.8 per cent of the total DAC population assistance in 2001. Of these ten, six spent less than $10 million per year on population assistance (figure 5).

Six countries and the European Community spent between $20 and $80 million per year: they supply about 14.5 per cent of the total DAC contributions to population. The figures from the NIDI study concerning the European Commission are to be read with caution: indeed, the EC used a very restricted definition of population activities in its reporting to NIDI. The resulting figures are therefore considerable underestimates and do not reflect the true SRH spending level of the EC. More accurate figures for the EC ICPD spending can be found in the research paper published by Edwards (2000). It covers the period 1990-1998 (latest data available) and he estimates that in 1998 the EC provided 237 million Euros to ICPD activities.

The United States is by far the major donor to population assistance in the world. At $951 million in 2001, it contributed about seven times more than the second major donor (the Netherlands, which contributed $132 million) and this represents 55 per cent of total governmental giving for population assistance. Moreover, the United States made a major increase in SRH spending of 44 per cent between 2000 and 2001 (figure 6).

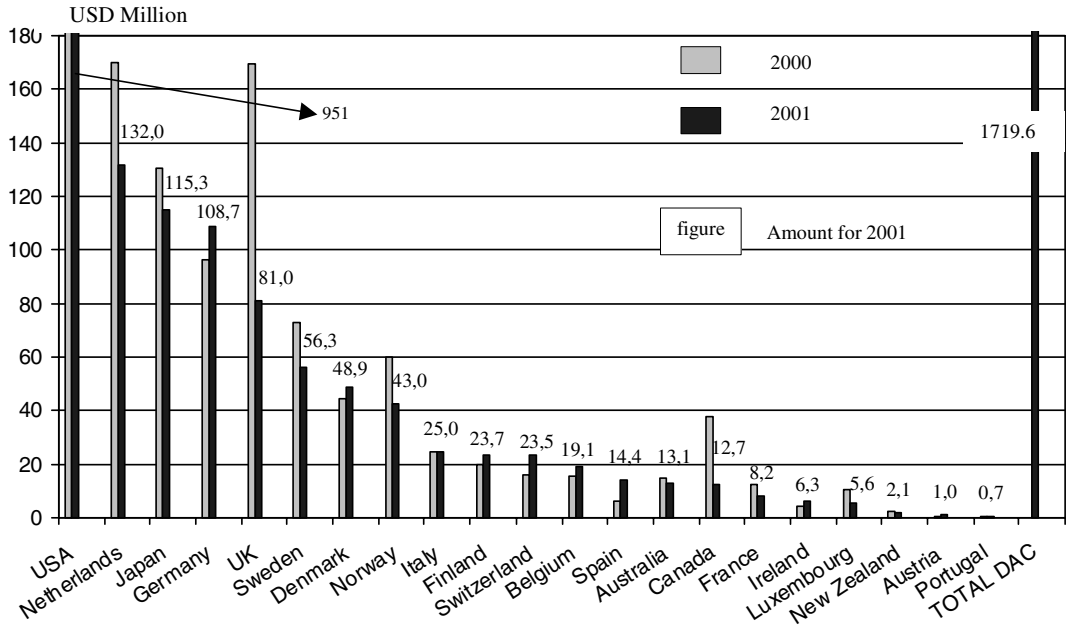
However, several remarks have to be made. First, the growth in American population assistance can mainly be explained by very large increases in funding to fight the HIV/AIDS pandemic. These amounts actually doubled from 2000 to 2001. While such funds are crucial, questions are being raised on the content of the American overseas SRHR programmes in the context of the Administration of President G.W. Bush. Indeed, the United States President is increasingly promoting "abstinence-only" programmes for young people, he openly doubts the safety of condoms in preventing HIV/AIDS and he strictly bans funding of emergency contraception and abortion. Secondly, although the United States slightly increased its funding for family planning and basic research it decreased its spending on basic reproductive health services. These are the initial results of the reinstatement of the Mexico City Policy from President Bush's first day in office (Appendix 2). According to this rule, non-United States NGOs are banned from receiving USAID funding if they in any way

supplied by developed countries, developing countries and interest earned on income (NIDI/ UNFPA, 2003).

[28] The development bank loans fluctuate widely from year to year and generally these loans have to be repaid.

FIGURE 6

SRHR spending in 2000 and 2001



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

promote, provide or refer patients for abortion. In this context, the United States government deliberately chooses to provide less funding to reproductive health services which, it estimates, could include abortion-related activities, and instead focuses its funding on family planning.[29] Finally, it is important to note that despite the United States' increase in population assistance, IPPF and UNFPA, two of the leading organisations in the field, lost all of their United States funding in 2002 due to the Mexico City Policy (see following section for more explanation).

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

- *In terms of share of ODA (figure 7)*

The SRHR/ODA ratio varies significantly between countries, ranging from 0.18 to 8.32 per cent. Only four of the 22 DAC members (the Netherlands, Finland, Luxembourg[30] and the United States) reached the target of 4 per cent of their ODA being given to SRH in 2001. Two other countries, which had reached the 4 per cent target in 2000, fell back below that level: Sweden and Norway. A combination of probable underreporting of SRH funding due to the use of SWAps and of decreasing ODA explain these results.

Half of the countries are allocating less than 2 per cent of their ODA to SRHR: this level is less than half of the required target. Up to five DAC countries give even less than 1 per cent of their ODA to SRHR. For Europe, these countries are mainly located in the south. They also include all the DAC non-EU countries apart from the United States (Australia, New Zealand, Japan and Canada).

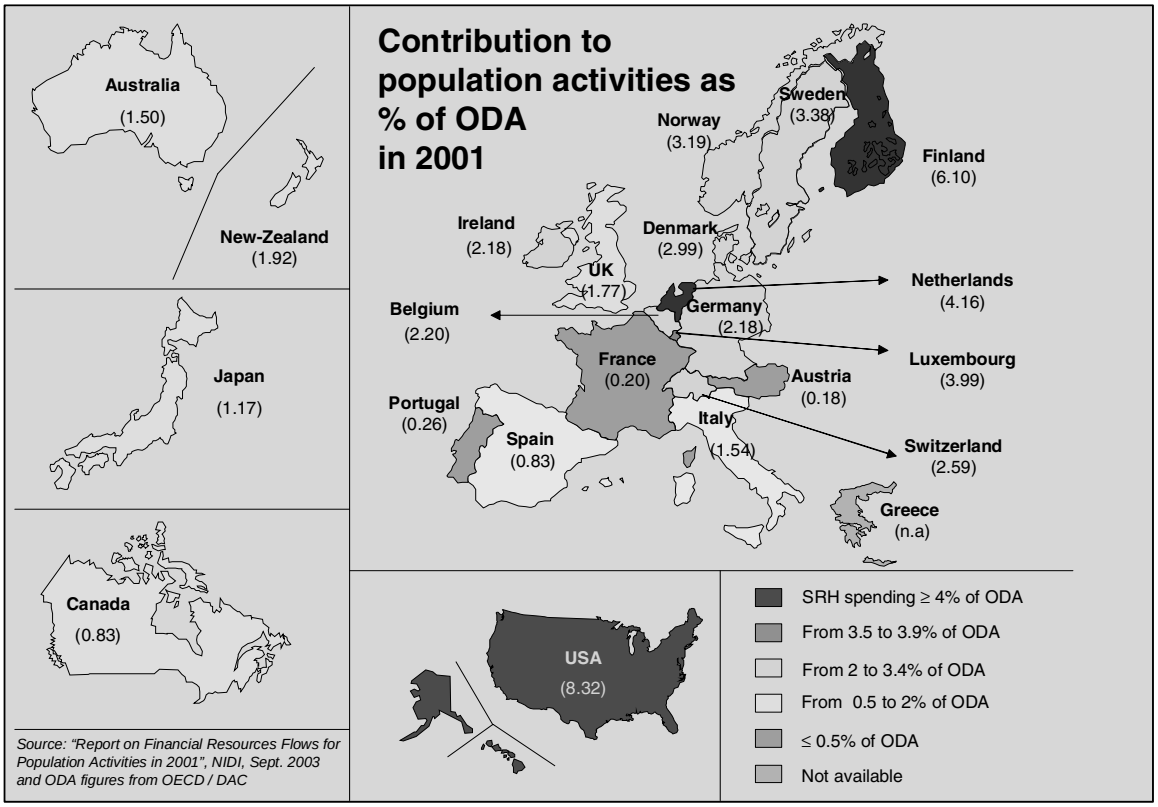
A group of seven countries, all located in the northern part of Europe, spend over 2 per cent of their ODA on population assistance. Four new countries,

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

[30] Luxembourg spent 3.99 per cent of its ODA on SRHR and not 4 per cent. IPPF EN, however, decided to include the country in the group that had reached the target, given the fact that the figure was so close.

FIGURE 7

SRHR/ODA ratio in 2001



considered as average ODA spenders, joined that group in 2001: Belgium, Germany, Ireland and Switzerland. A trend has been seen between 2000 and 2001: among the northern countries, the traditionally bigger spenders saw their SRH/ODA ratio decrease whereas the average spenders saw this same ratio increase. Among the southern countries however, no major changes were noticed.

The United States was - by far - the most generous donor to SRHR, with 8.32 per cent of its ODA going to SRHR in 2001. However, this performance has to be balanced with the fact that the American ODA level is low compared to its national income.[31] Thus, population activities are receiving a large share of a comparatively small ODA. The largest SRH donors in terms of volume are not necessarily the most generous donors in terms of their overall ODA, as illustrated by the following examples. Whereas the Netherlands is both a large and a generous donor relative to its ODA, Japan is a good illustration of the reverse situation. Despite its ranking among the top five donors in volume, Japan's population assistance represents less than 1 per cent of its total ODA. On the contrary, whereas Luxembourg ranks only 18th among the DAC members in volume terms, Luxembourg is among the most generous donors relative to its ODA, with a level close to the 4 per cent target (3.99 per cent).

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

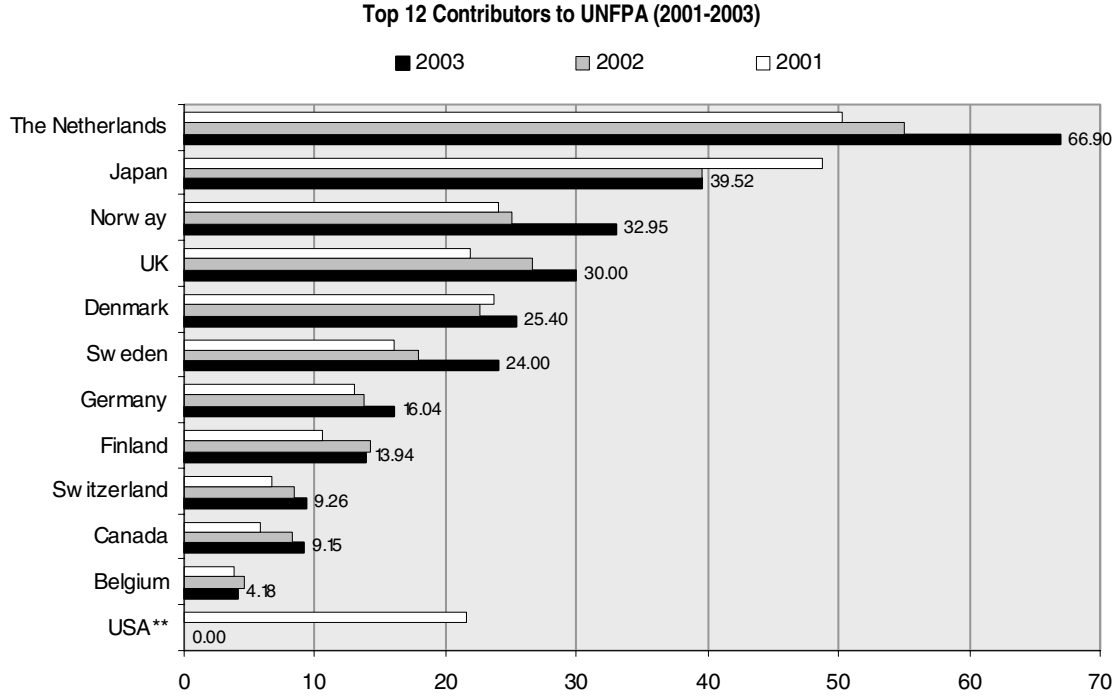
Multilateral spending on SRHR is mainly channelled through the United Nations Population Fund (UNFPA), the leading provider of United Nations assistance in the population field, and the International Planned Parenthood Federation (IPPF), the largest NGO in the field of SRHR.[32] Whereas the total contributions to population assistance are mostly estimated figures using a range of definitions, contributions to these organisations are reliable and easily comparable figures.

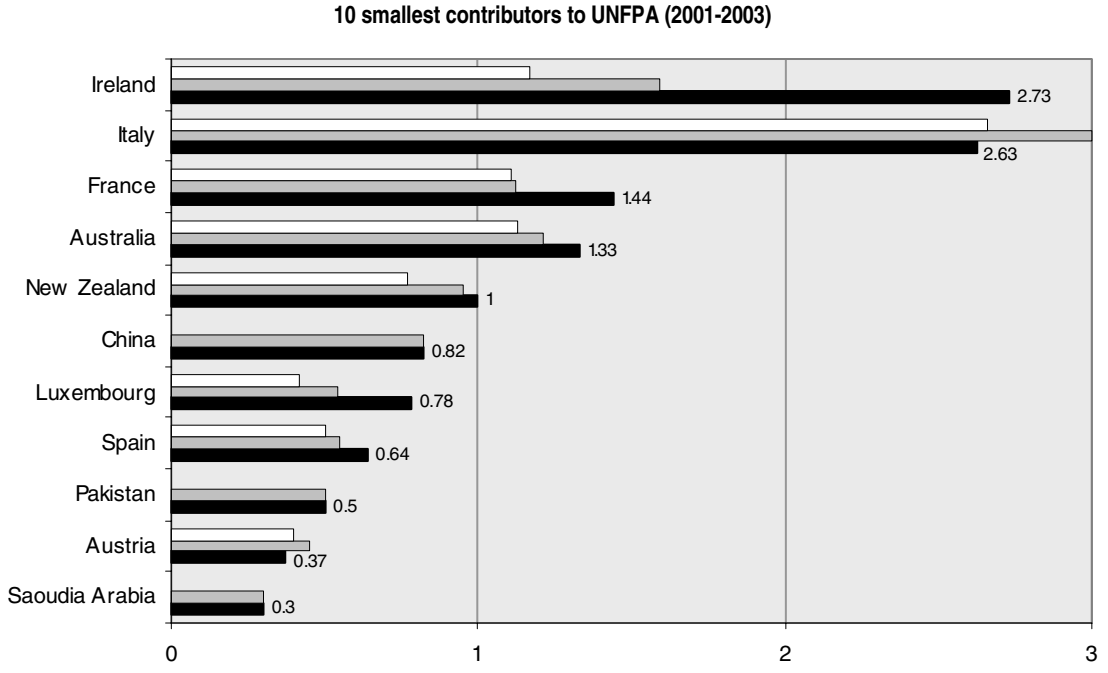
[31] The United States, with an ODA/GNI ratio of 0.11 per cent, has the lowest ranking among DAC members and is far below the DAC average country contribution of 0.40 per cent.

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

FIGURE 8

Donors spending for UNFPA (Net general contributions in $ millions)





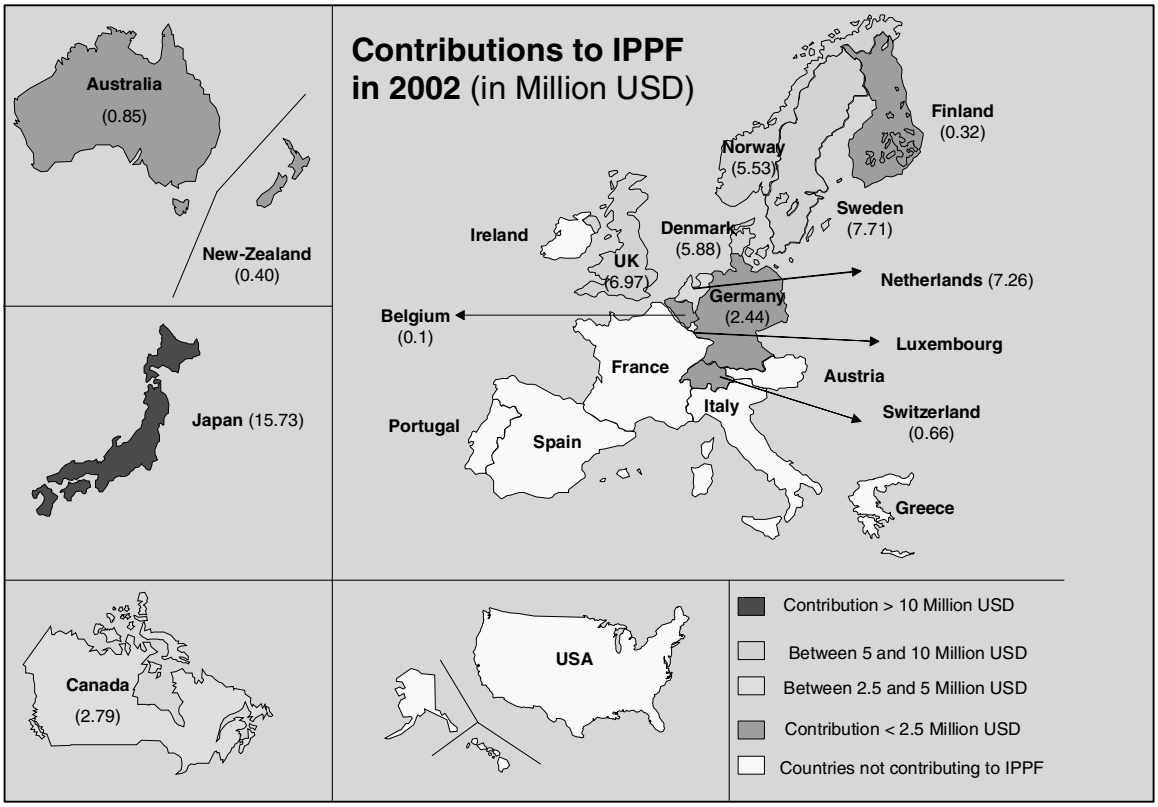
Source: OECD/DAC Contributions to UNFPA's Regular Resources for 2001 and 2002, RDB UNFPA

Note: * Bear in mind the scale difference between the two graphs.

** The American Congress accepted in December 2001 to give $34 million to UNFPA for 2002 but the Administration of President G.W. Bush denied it in July 2002. The US is consequently not funding UNFPA any more.

FIGURE 9

Mapping of the contributions to IPPF in 2002



Source: NIDI/UNFPA, 2003

Governmental contributions to UNFPA (figure 8)

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

The United States was a major contributor to UNFPA in 2000 and 2001, with a contribution of $21.5 million in both these years. However, in 2002, due to false allegations regarding UNFPA's work in China, the Bush Administration decided to stop funding the UNFPA. Although the American Congress had agreed to give $34 million to the Population Fund, the government withdrew this decision. Until there is a new Administration, this situation is unlikely to change given the reinstatement of the Mexico City Policy. The United States is the only DAC country, together with Portugal, which is not contributing to UNFPA.

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

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

Governmental donations to IPPF

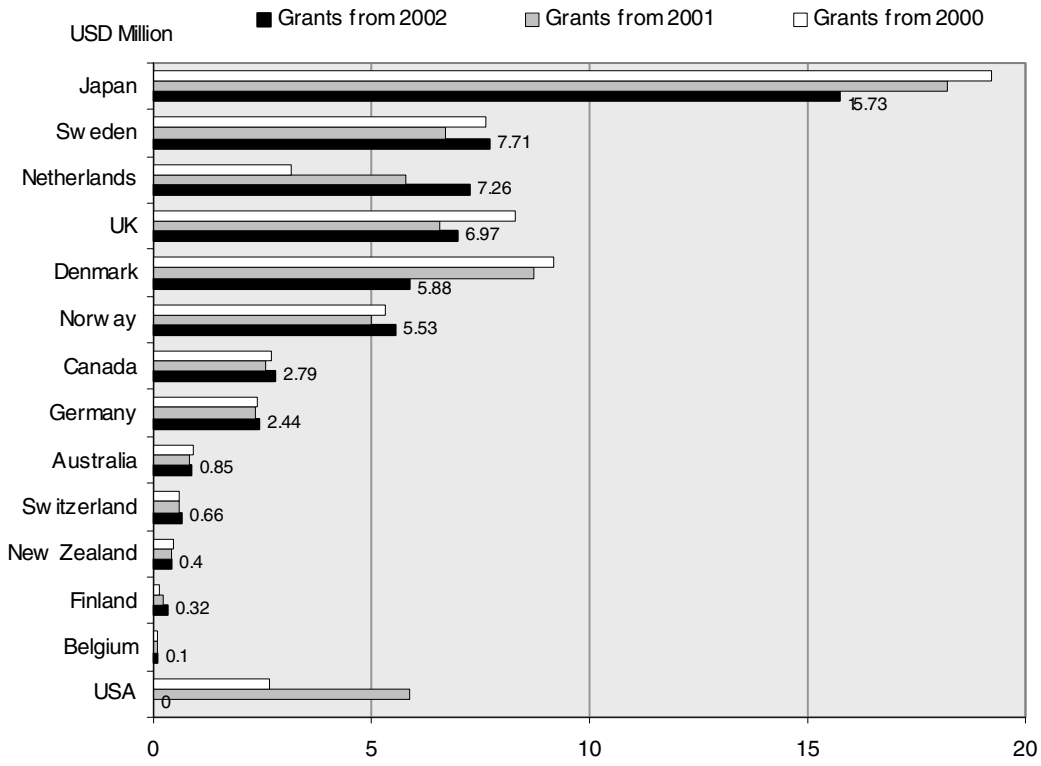
While 14 of the DAC members contribute to IPPF, there are still eight which do not provide any support to the largest NGO in the field of SRH. Of the 14 donor countries to IPPF, only six provide more than $5 million per year (figure 9).

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

A majority of the country contributions to IPPF have decreased over the last two years, mainly as a consequence of the general fall in many countries' ODA: this has been especially the case for Japan, Germany, Denmark, New Zealand and Australia (figure 10).

FIGURE 10

Government grants* to IPPF (2000 -2002)



Source: NIDI/UNFPA, 2003

Note: * Total restricted and unrestricted.

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

Due to the reinstatement of the Mexico City Policy (Appendix 2), IPPF lost all its income from the United States. IPPF, in view of its global mission to save the lives of women and fight for reproductive health, decided not to sign the Mexico City Policy. One of IPPF's primary objectives is the elimination of unsafe abortion, through information, advocacy and access to family planning and safe abortion. To achieve this, IPPF and its member associations seek to promote certain activities (such as advocating for legislative change, or providing training to health professionals in safe abortion) which are contrary to the Bush Administration's anti-abortion stance. Consequently in early 2001, IPPF lost a total amount of $12 million, which at that time represented 20 per cent of its operating budget.[33]

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

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

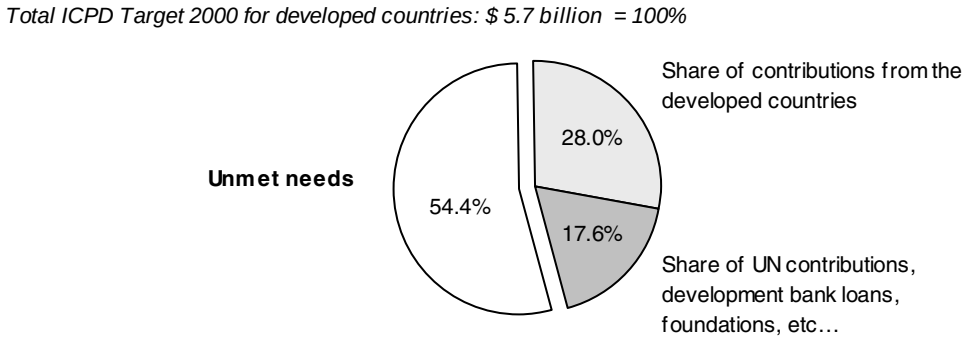
Unmet needs and funding shortfall

As shown above, the developed countries have made significant efforts to achieve the goals and objectives of the ICPD since 1994. The total funding level from the developed countries increased from $1.37 billion in 1995 to $1.71 billion in 2001. However, the general positive trends seen in the years after the ICPD seem to be fading and even reversing. And the level of contributions in 2000 fell well short of the agreed ICPD target for that year (figure 11).

[33] In 1984, when the original Mexico City Policy was imposed, IPPF lost $17 million, which at that time represented 25 per cent of its operating budget.

FIGURE 11

Reaching the 2000 ICPD target – shares provided by different stakeholders in 2000



Source: Figures from NIDI and calculations from IPPF European Network.

1. The actual contributions of the donor countries to international population activities represented only 28 per cent of the $5.7 billion target for 2000
2. Contributions from the UN system plus foundations and development bank loans etc. represented 17.6 per cent of the ICPD target for 2000.
3. Overall, the total population spending (including bank loans and UN system) in 2000 did not represent even half of the ICPD target for that year (45.6 per cent).[34]

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

The funding shortfalls to the Cairo commitments are especially acute with respect to contraceptives and other reproductive health commodities. Indeed, UNFPA estimates that, while global funding for all SRH requirements was around 45 per cent of the needs, the funding of commodity requirements was meeting only 36 per cent of the needs in 2001 (UNFPA, 2001b). Indeed, support for commodities was $224 million in 2001 whereas the actual estimated contraceptive costs were $614 million. Moreover, since 1997, donor support has been below the average level reached between 1991 and 1996 (40.9 per cent of the requirements), whereas the actual costs and requirements grew rapidly. This situation is taking place in a world where the number of contraceptive users is projected to increase by more than 40 per cent from 2000 to 2015 as a consequence of both population growth and an increase in the proportion of people who are aware of and wish to use contraception. (It is important to bear in mind that between 2000 and 2015 the population of reproductive age in developing countries will grow by 23 per cent). Increased use of contraceptives and condoms for STI/HIV prevention is another factor contributing to rising requirements and a continued need for increasing donor support.

Donors still need to continue to strive to reach the ICPD goals. Lack of adequate funding remains one of the major constraints to the full implementation of the ICPD Programme of Action. And this in turn has major implications for the achievement of the MDGs. Indeed, SRHR has a strategic role in reducing maternal and child mortality, reducing the incidence of unsafe abortion, preventing HIV infection, reducing poverty and empowering women (see Birdsall, Kelley and Sinding, 2001, for more explanation on evidence-based analysis of the direct impact of SRHR on the MDGs); these are all crucial elements for the achievement of the MDGs. In other words, few of the MDGs can be realised if the core goals of the ICPD are not achieved.

At the five-year anniversary meeting of the Cairo Conference in 1999, the international community was presented with figures showing the unmet needs and was reminded of its ICPD commitments. Donor countries then renewed their promises to increase ODA in general and the share relating to SRHR in particular. Unfortunately, another five years have passed, and on the eve of the 10th anniversary of the ICPD the mobilising of sufficient resources for the SRHR needs of the world remains a major issue.

Sexual and Reproductive Health policies as part of the development aid strategies of European donor countries (plus Canada and the United States)

The Programme of Action of the ICPD not only required the developed countries to mobilise resources

for population assistance, it also encouraged them to develop a policy which would integrate SRHR issues into their development strategy. Governments were called upon to *"formulate, implement and evaluate national strategies, policies, plans, programmes and projects that address population and development issues,{…} as an integral part of their sectoral, inter-sectoral and overall development planning and implementation process"*. (art 13.5 PoA of the ICPD). The existence of a country policy and the extent to which it has been developed give an idea of the level of importance each donor assigns to SRH issues. Moreover, it is generally assumed that countries with well-established international SRH policies are more likely to provide greater funding for these issues. (But this isn't a rule: see later section.)

So how does the policy map look ten years after the ICPD? Did the Programme of Action have a significant impact on policy formulation for population assistance? Was the ICPD the only factor affecting policy change and development? This section giving an SRHR policy overview will address these questions.

Regional variations of international SRH policies of donors (Appendix 3)

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

Countries with independent and comprehensive SRH policies

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

The United States has a 30-year long tradition of population assistance and therefore has a clearly defined family planning policy. The latter was recognised by UNFPA as one of the most successful components of American foreign assistance (UNFPA, 2001a).[34] This success motivated the country to play an active role in international acceptance for population issues: it became a key actor in framing the agenda of the ICPD.[35] The American delegation to Cairo, working with United States' civil society, appeared to be progressive and advocated increasing the emphasis on women's reproductive rights in all SRH policies. However, in terms of the United States' own SRH policy, the country failed to adopt a holistic ICPD approach regarding SRHR. It did not broaden its long-standing commitment to a narrow family planning model and it did not shift from a demographic approach of simply looking at population numbers to a rights-based rationale whereby women are free to choose the number and spacing of their children. After the ICPD, the United States experienced an increasing number of attacks against its family planning policy from 'anti-choice'[36] politicians and members of civil society. Since the start of the current Bush presidency, the United States' government has implemented conservative programmes and limited the distribution of SRH funds (see details of the Mexico City Policy in Appendix 2).

The United Kingdom, Canada and Switzerland each have a well-defined SRHR strategy, which are components of their respective health policies. The integration of SRHR issues into their health policies is done in such a way that the 'non-medical' aspects of SRHR are not neglected[37] and they have a broader approach to SRHR that goes beyond reproductive health care. However, they still show some weaknesses in implementing coherent SRHR strategies (especially in the case of Canada), often due to a lack of expert staff in the field. The United Kingdom (which has a long tradition of population support), and to a lesser extent Canada, have been involved in SRH programmes since before ICPD but the Cairo Conference motivated them to gradually expand their policies by broadening their scope and by emphasising their importance. Switzerland, on the other hand, had traditionally been rather reluctant to address these issues at a political level.[38] It was only very

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[34] UNFPA notes that the United States' SRH programmes have contributed significantly to increasing the use of modern contraceptive methods from under 10 per cent in the 1960s to 50 per cent in 2001.

[35] See the Introduction for more explanation.

[36] 'Anti-choice' includes negative standpoints on abortion, sexual rights, comprehensive sex education, homosexuality, etc.

[37] This means that SRH-related aspects such as male involvement, access to medicine, education etc. are taken into account in other policies

[38] Switzerland, however, has supported UNFPA and IPPF for many years.

recently (2003) that the country formulated a transparent SRH policy, which focuses largely on reproductive rights.

Countries which recognise SRHR issues but mainly within other sectors

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

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

Spain and Portugal, on the other hand, are very recent donors and have had no tradition of dealing with SRH issues. They both included SRH issues in their development policy for the first time after the ICPD.[39] Although these countries improved their political support for population assistance, their SRH programmes remain rather small and their governments were not able to make major increases in funding levels.

Countries where SRH as a policy is not recognised as such

The remaining six countries do not have a specific SRH policy nor do they contain clear statements of ICPD concepts in their development policies. Among them, three countries (Austria, Greece and Italy) traditionally neglect SRH issues and only sporadically mention AIDS, family planning or gender concerns in their policies.[40] They have not shown any significant changes since the ICPD and their funding levels for population assistance remain low.

France and Luxembourg have both shown a long-standing reluctance to provide direct and open political support to SRH and therefore they do not make any explicit mention of ICPD issues. However, several specific SRH aspects are well-represented in their different policies. France shows active political support to maternal health, girls' education and the fight against female genital mutilation, and the country is a world leader in fighting to combat HIV/AIDS. Its contribution to population assistance however remains low and is mainly focused on strict HIV/AIDS activities. Luxembourg has not demonstrated its commitment to RH issues in official government policy documents, but it has expressed its interest in the topic in a number of political speeches.[41] Moreover, the country is a top donor in terms of generosity for population assistance and these funding levels have increased significantly over time.

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

Summary

Of the above 19 donors, eight countries have drafted a comprehensive and formal SRH policy (either as an independent policy or as a integrated part of a sectoral policy), which reflects the philosophy of the ICPD Programme of Action. An additional five countries have been able to integrate their SRH strategy into a specific sectoral policy, thereby clearly recognising the importance of these issues, though not fully endorsing the holistic ICPD approach. Finally, six countries do not have any inclusion of SRH in their policies, among which three do not make any reference to ICPD-related

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

[40] Italy mentioned SRH specifically in its health policy of 1998, but in practice these issues are given very low priority and very few SRH programmes are implemented.

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

activities and three others have only fragmented mentions about specific SRH concerns.

Political support and funding levels: no straightforward conclusions

In general, it can be said that countries with formal SRH policies in a development context are more likely to provide higher funding for these issues. This has indeed been the case for the majority of the most advanced countries in terms of political support to population, such as the Netherlands and the Nordic countries. For other countries, the more they have developed their SRH policy, the more committed they have become financially to population assistance: this has been the case for Belgium (and Spain to a lesser extent).

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

The state of advancement in the formulation of an SRH policy in the development context often depends on the political environment towards population issues at a domestic level: when a donor is reluctant to address SRH issues in their own country, it generally does not have an outspoken international SRH policy (and vice versa).[42]) However, this does not prevent countries with an unsympathetic environment from implementing SRH-related projects. The examples of Ireland and Luxembourg illustrate this: their governments prefer not to mention SRH issues openly in their policies in order to avoid public controversy while, in the meantime, they are implementing SRH programmes and increasing their funding levels for population assistance. Depending on the political balance in each country, political support is not always the best prerequisite for improving a country's commitment towards population issues.

Emergence of a strong civil society after the ICPD

Since the ICPD, the number of NGOs working on advocacy for SRH issues has grown significantly in Europe. Such groups were already present in the United States in the early 1990s: they grew first as a compensating force to the anti-abortion movement which was active in the country itself, but also became active in trying to frame the United States' development aid. As certain European countries also started to encounter strong opposition following the ICPD, it was felt that European civil society needed to build active support for the ICPD Programme of Action in their national countries. Many national family planning associations started working on international advocacy and new NGOs, born after the ICPD, also concentrated on such activities. The ICPD fostered stronger commitment from civil society in the SRH field: support organisations strengthened their own capacities, organised themselves into networks and became more vocal on SRH concerns in a development context.

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

European snapshots - individual country tables provide an overview of each donor's commitment to ODA and SRHR

As described earlier, the actual SRH policies of each donor are an important criteria by which to measure the level of commitment of a country towards SRHR. However, these alone are not sufficient to give a comprehensive idea of each country's involvement in population issues. The total funding level of ODA, in particular to SRH, together with their preferred distribution channels and the geographical spread of funding are also important elements for judging each donor's dedication to population issues.

In order to have a better idea of each of these elements, Appendix 4 presents overview tables for Austria, Belgium, Canada, Denmark, the European Community, Finland, France, Germany, Ireland, Italy, Luxembourg, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, the United Kingdom and the United States.[43.]

For each country, the table provides statistical data on:

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[42] Countries with progressive SRH policies at national level have also generally drafted comprehensive international population strategies. Moreover, when national legislation on SRH shifts towards a more liberal SRH approach, the interest in SRH within the cooperation framework tends to evolve as well: this was the case for Portugal in the years soon after Cairo.

[43] Greece is not included as no figures were available.

- General ODA information broken down into multilateral and bilateral proportions, the top ten recipient countries of ODA and the top three UN agencies receiving ODA;
- Spending on population assistance, specifying bilateral and multilateral proportions, the major countries who have received health and SRHR funding and the contributions given to UN agencies working in SRH-related fields (UNIFEM, UNAIDS, etc.).

New trends in development and upcoming political challenges: what are the consequences for the implementation of the ICPD Programme of Action?

While financial questions continue to be a major concern for the implementation of the ICPD Programme of Action, other changes in the political arena and new trends in development are already impeding the road to achieving the ICPD goals and these may have an even bigger impact in the future. This section will describe these challenges and explain their potential effects on ICPD.

The present political environment: growing conservatism in the European institutions

In the last three to four years, the presence of various 'anti-choice' groups[44] in the European institutions has become stronger and better organised. For example, since 2001, the year of the reinstatement of the Mexico City Policy, a number of religious organisations have set up offices in Brussels in order to take part in the EU decision-making process (e.g. Care for Europe, EuroFam, Commission of the Bishops' Conferences of the European Community (COMECE)). These groups, which specifically oppose the international agreements that support a rights-based approach to SRH (e.g. the ICPD), have clearly intensified their activities. Many of their actions have been aimed at stopping the advancement of SRH in Europe[45] or at introducing religious references in major EU legislative texts[46] but they have also targeted SRH in the context of development.

Anti-choice groups have been particularly influential in discussions concerning the "*Regulation on aid for policies and actions on reproductive and sexual health and rights in developing countries",* which started to be debated in the European Parliament in May 2002. This regulation is one of the legislative tools of the EC to enable it to implement the ICPD Programme of Action. At the plenary session of October 2002, Dana Scallon (Irish EPP MEP) tabled a parliamentary question concerning the term 'reproductive health', and she opposed the reference to 'reproductive health services', which could be construed as including abortion clinics. (The Commission gave its reply based on the text of the ICPD Programme of Action. This states that abortion should not be promoted as a method of family planning but that where abortion is legal it should be safe. Prior to the vote on the Regulation both in the Development Committee (January 2003) and in plenary (February 2003), MEPs were 'bombarded' with anti-choice messages from organisations as well as individuals. The regulation has also been the object of misleading information and misinformation. Although it was adopted in the plenary session of the European Parliament on 13 February 2003, it kept being the object of parliamentary questions until it was formally adopted by the Council of Ministers on 17 June 2003.

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

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

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

The 2004 European Union enlargement process

The European Commission expects that ten new accession countries will be ready for full membership on 1 May 2004. Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia will then join the EU, a process which will have important implications for development aid at the European level.

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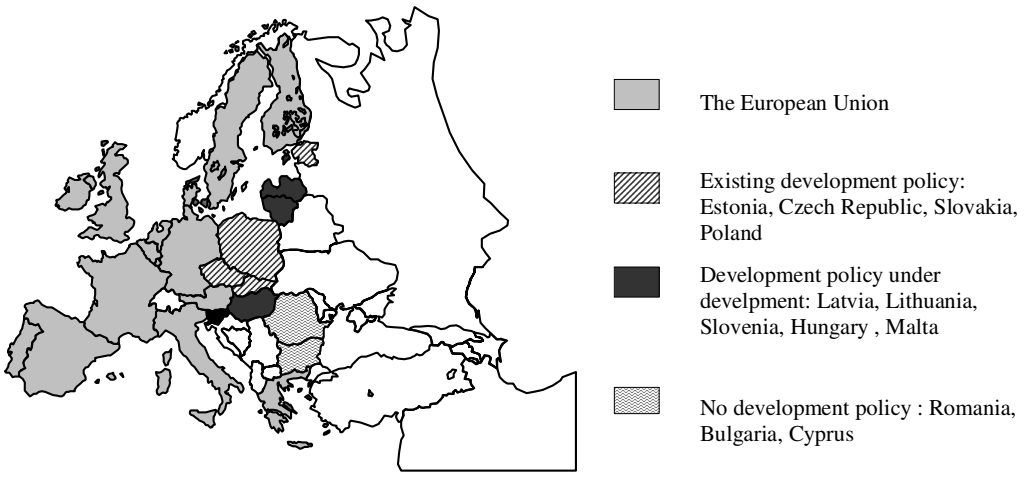
[44] Opposition in Europe is composed mainly of ethical and religious groups, specific anti-choice groups and political parties and individuals. The various anti-choice groups in Europe have long worked together in informal networks, but in recent years much of this networking has been spearheaded by United States-based organisations which have reached out to like-minded groups in Western and Eastern Europe.

[45] e.g. in July 2002, the European Parliament adopted the 'Report on SRHR in Europe and Accession countries', an initiative of MEP Anne Van Lancker. This report provoked fierce debates in the Women's Rights Committee and in plenary, a large number of amendments were added by anti-choice MEPs.

[46] e.g. the draft Constitution for the EU proposes a structured dialogue with the churches thereby giving them a privileged status.

FIGURE 12

Accession countries' development policy advancement



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

Requirements of the EU enlargement in the context of development aid

As EU development policy is an integral part of the '*Acquis communautaire*'[47] the candidate countries will have to participate in it as soon as they enter the EU, both by taking part in the decision-making process and by contributing to the financing of development aid.[48] To be able to comply with these requirements, the accession countries are expected to establish specific legal and administrative frameworks for their own development policies and create specific ODA budget lines. So where do these countries stand today? Are SRHR issues already being taken into account? What might be the impact of enlargement on SRHR policies and funding?

Development and content of the accession countries' new ODA policies

Although some countries had a special cooperation policy during the Soviet period (e.g. Czechoslovakia and Hungary), these policies were abandoned after the fall of the communist regime and now need to be brought up-to-date. Moreover, many countries need to create everything from scratch, from strategic goals to decision-making bodies. This process is challenging for several reasons. Their economic situation remains difficult (they were aid recipients until recently), external aid is not perceived as a priority, and therefore aid issues are hard to address for politicians given the lack of public interest.

The accession countries can be classified into three categories (Krichewsky, 2001) according to the level of progress of their development policies (figure 12). The first group are the countries which have already established a legal and administrative framework for development and followed the DAC requirements. These are the Czech Republic, Slovakia, Poland and Estonia. All have specific ODA budgets and already implement projects abroad. Despite some remaining weaknesses, they will be the best prepared to embrace the EU development policy.

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

The third group (Cyprus, Romania and Bulgaria) are the least advanced countries: they have no development policy in place or even in progress; their only ODA is occasional case-by-case humanitarian aid.

It is important to note that the nature of development policies of the accession countries is traditionally different from the existing EU member

[47] The "*Acquis Communautaire*" is the body of common rights and obligations which bind all the member states together within the EU. It is not only EU law in the strict sense, but it also includes all acts related to home/justice and foreign affairs plus common objectives, as laid down in the Treaties. Applicant countries have to accept the *Acquis* before joining the EU.

[48] Most new member states do not have an ODA budget. However, 4.68 per cent of the total resources that the new member states will provide to the EC budget will automatically take the form of ODA. Moreover, they are expected to contribute to the European Development Fund (EDF) as from 2006 (to the 10th EDF).

states in several aspects. This will have an impact on SRHR activities and policies. Moreover, the specific political environment in these countries could hinder the implementation of the ICPD Programme of Action.

First, the geographical scope of their aid is traditionally different: it is directed mainly towards bordering countries and those not far beyond. Little attention has been given to the developing countries of Africa, Latin America or Asia. The Least Developed Countries, where the SRHR needs are greatest, have not been seen as priority recipients of aid.

Secondly, these countries have other sectoral priorities. The accent has been on assisting the transition of less advanced ex-communist countries to focus on, for instance, good governance and democracy, and on providing humanitarian aid or technical assistance. The fight against worldwide poverty is not their first objective. SRH issues are not major themes which have been taken up by the accession countries: they do not consider health (including SRHR) in development as a priority. When reading their new development policy or concept papers, it becomes clear that improving health has seldom been chosen as a primary objective. This stance is not yet set in stone, as many countries have not yet defined their policies, but it appears to be a trend. When health is mentioned as an objective, the emphasis is mainly on the development of health infrastructure and not on health care or access to services. Education is often mentioned as an objective, but more in the context of providing scholarships to foreign students to come and study in their country. As an example, in the Hungarian concept paper, although the fight against HIV/AIDS and the importance of gender issues are discussed, SRH is not mentioned at all.

Thirdly, the actual political environment in the accession countries may lead to an undermining of SRH issues in development for several reasons. Many of these are rather traditional countries, which may have rather conservative views on SRHR in the national context.[49] These views are being put forward and supported by the strong presence of the Catholic Church, which is very influential in some of these countries (especially Poland), and by a growing number of active and well-organised anti-choice groups, mainly spearheaded by United States-based organisations. The same ambivalence towards SRHR can be expected from these governments in the context of development. And the same opposition forces will be present to back them up in an international context.

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

Finally, the new member states cannot yet rely on civil society for promoting the importance of poverty reduction and SRHR issues among the general public and politicians. Indeed, NGOs supporting the developing world are still in an embryonic state in most accession countries. The only existing groups are faith-based organisations, often funded primarily by the United States, which have little experience of working in developing countries and often have rather conventional opinions about SRHR topics. The almost complete absence of organised advocacy groups to promote SRHR in development in these countries is seen as a major constraint for the future implementation of the ICPD Programme of Action.

ODA levels and impact

Funding development aid is another requirement made by the EU of the accession countries. Although for a long time no EU official document defined exactly what was expected from the new member states in terms of ODA volumes, the 'Barcelona commitments' clarified this situation. As they are part of the *Acquis*, they will apply to all the accession countries. The latter are thus expected to reach the same ODA goals as the EU 15: 0.33 per cent of GNI individually and 0.39 per cent of GNI collectively by 2006. Of itself, this will lead to increased funding for SRHR.

Measuring the total ODA level of the accession countries remains a major challenge, as these figures are often simply not available. Four countries out of the 10 do not have any development budget (no ODA figures recognised as such) and although most of the others have established ODA budgets, they have done it very recently and so the division between ODA and other kinds of funding is seldom clearly set. Table 2 gives an overview of the best estimates available.

In 2001, total funding levels were still very low. While the two most advanced countries reached levels of 0.04 and 0.05 per cent of GNI to ODA (Slovakia and the Czech Republic), only three other countries gave 0.02 per cent (Hungary, Poland and Lithuania) and the remaining ones contributed amounts representing 0.01 per cent or less. Moreover the future plans of the new member states are not ambitious: either they forecast these low levels continuing or they do not mention anything. Only the

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

TABLE 2

ODA levels and ODA/GNI ratio of the accession countries, 2000-2001
(Million dollars, per cent)

	ODA		ODA/GNI Ratio		Commitments
	2000	2001	2000	2001	(When development budget line in place)
Czech Republic	16.20	26.50	0.030	0.05	ODA/GNI: 0.1 per cent in 2007
Slovakia	6.00	8.00	0.030	0.04	ODA/GNI: 0.12 per cent in 2012
Poland	29.00	36.00	0.018	0.02	No specific mention
Estonia	1.00	0.45	0.020	0.01	Remain at 0.01 per cent ODA/GNI in 2003
Hungary	..	10.00	..	0.02	No specific mention
Latvia	..	0.06	..	–	No development budget line
Lithuania	..	4.00	..	0.02	No specific mention
Malta	..	..	..	..	No development budget line
Slovenia	3.00	2.00	0.015	0.01	No development budget line
Cyprus	0.05	..	_	..	No development budget line

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

two most advanced countries have the specific aim of reaching 0.1 per cent of GNI to ODA in the medium term.

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

It is also pretty safe to say that in the medium term, enlargement is not likely to lead to any major increase in the total EC budget. Whether the least positive scenario is considered, where the new member states only contribute to the general EC budget,[50] or whether a more optimistic one is taken into account, where higher contributions to development aid and the European Development Fund from some countries are included, the conclusion remains that any increase in ODA is likely to be offset by the higher administrative costs linked to a structure having to absorb ten new members.[51] EU growth is thus unlikely to provide significant additional funding for SRHR in developing countries.

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

An increased focus on HIV/AIDS: what consequences on SRHR funding?

An analysis of the breakdown of spending within the total population assistance funding (NIDI/UNFPA, 2003) shows that family planning and reproductive health services are loosing ground to HIV/AIDS. In 2001, nearly 40 per cent of all population assistance was spent on STI/HIV/AIDS activities. This funding had increased steadily from 9 per cent in 1995 to 39 per cent in 2001. While family planning enjoyed a dominant position between 1995 and 1999, funding started to shift rapidly towards HIV/AIDS from 2000 (figure 13).

Funding for family planning and reproductive health services still represented more than half total population assistance in 2001 (54 per cent) but this share is decreasing rapidly. Consistent with the ICPD call for more integration of services, funding for family planning per se decreased from 55 to 29 per cent between 1995 and 2000, while funding for reproductive health services increased from 18 to 29 per cent in the same period. Thus, the losses in family planning (-26 per cent) are not compensated by gains in RH funding (+11 per cent). Moreover, in 2001, the share for basic reproductive health services fell to 24 per cent in 2001 from 29 per cent in 2000. The difference in funding is in part attributable to 'pure' STI/HIV/AIDS activities.

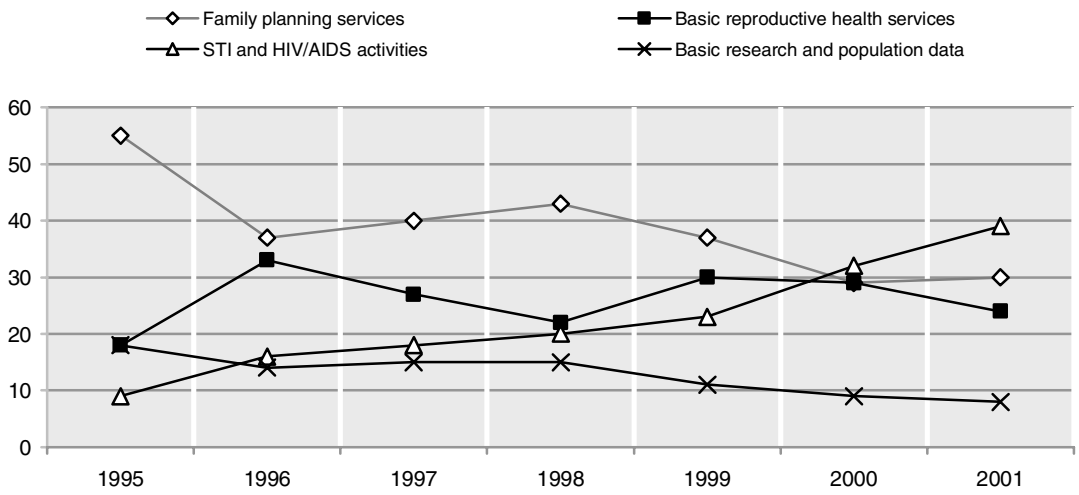
There is an increasing feeling in the SRHR community that, over the past eight years, HIV/AIDS funding is more and more 'stealing' funding for family planning and SRH instead of complementing them. The major concern expressed is that HIV/AIDS funding is not always used in projects having the same holistic and rights-based approach, consistent with the ICPD Programme of Action. This has especially been a worry in the United States. Although the current Bush

[50] This would increase the ratio of total ODA/GNI of the EU 25 to only 0.36 per cent by 2006.

[51] Regarding the EDF: there is no clear idea of how much the new member states will contribute to the 10th EDF – the only estimate available forecasts that the EDF should increase by 4 per cent in 2006.

FIGURE 13

Final donor expenditures for population assistance, by category of population activity - 1995-2001 (in percentages)



Source: Figures from Financial Resource Flows for Population Activities in 2001, NIDI/UNFPA, 2003.

administration recently made a major increase in HIV/AIDS funding,[52] it became clear after the announcement that the government and right-wing members of the American Congress intend to channel the bulk of the new HIV/AIDS funding to religious organisations, that have a narrow abstinence-based approach to HIV/AIDS prevention that questions and even excludes the use of condoms.[53.]

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

SWAps and sexual and reproductive health: opportunities and challenges

The 1980s witnessed major challenges to the traditional piecemeal approach to development assistance. Criticisms arose especially about the 'project approach', which was seen as leading to aid fragmentation, overwhelming the management capacity of the developing countries and undermining local ownership. The end result of these projects were often seen as limited and unsustainable (see earlier section).

Sector-wide approaches (SWAps) were introduced as a possible answer to these shortcomings. The SWAp process is meant to improve the impact of development by ensuring national ownership, improving complementarities and policy coherence, strengthening the institutional capacity and enhancing the effectiveness of public sector expenditure. It is *"a method of working between the national government and donors which implies that all significant funding for that sector supports a single sector policy and expenditure programme, under the government leadership, adopting common managerial and procedural approaches across the sector, and progressing towards relying on the government procedures to disburse and account for all funds"* (Foster et al., 2000).

SRHR issues are generally dealt with by SWAps as part of the health sector.[54] As this sector aims at creating

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

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

[54] But not exclusively. Health is the major sector but other aspects of SRH are dealt with in other sectors such as education, agriculture, etc.

a well-functioning health system, this can only be beneficial for SRH. Better health systems are indeed a major prerequisite for ensuring safe motherhood, for the treatment of HIV/AIDS and other sexually transmitted infections, for reducing unsafe abortion and complications arising from them, and for provision of family planning. At the same time, given the multi-sectoral nature and the political sensitivity of SRH, SWAps can also represent a potential risk for these issues. SRH can be integrated only partially or even left out of SWAps for the following reasons.

Multi-sectoral approach of SRH

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

To avoid the watering down of a holistic SRH approach in a SWAp environment, inter-sectoral collaboration becomes essential. Different stakeholders working on relevant issues in other sectors have to be informed about the policies of the health SWAp and their work should be coordinated (Papineau Salm, 2000). A single sectoral approach should not exclude the option of sometimes choosing a multi-sectoral approach to safeguard the ICPD approach. But there is no simple solution: indeed, when advocating collaboration, other challenging but legitimate questions may arise: at what level should this collaboration happen? Who should take the lead? How should it happen?

Public sector priorities do not necessarily include SRH

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

Staff capacity may be over-estimated

In a SWAp in the health sector, the Ministry of Health becomes the leading agency and much is then expected from its staff. They have to take management and strategic decisions and the effective implementation of the SWAp depends to a great deal on the professional quality of its staff (Dubbeldam, 2002). This situation can be challenging for SRH. In many developing countries, SRH remains a politically sensitive issue and politicians often prefer to focus on other priorities to avoid time-consuming discussions. Whenever SRH is adequately taken into account at the Ministry's levels, the staff responsible for the implementation of SRH programmes need to have skills and knowledge in the field and therefore need to be adequately trained.

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

Steps forward

SWAps in the health sector are designed to improve developing countries' health systems and SRH can only gain from that. However, in order to safeguard the wider aspects of SRH required by the ICPD Programme of Action, SWAps seem to be insufficient. Accompanying measures are believed to be crucial, such as inter-sector collaboration and NGO capacity building.

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

Conclusion

Incontestably, the donor community has significantly improved its commitment to sexual and reproductive health and rights (SRHR) since the International Conference on Population and Development (ICPD) in Cairo in 1994: donors' population assistance increased by 25 per cent from $1.37 to $1.71 billion between 1995 and 2001, while total population assistance, including that from development banks and the UN system, increased from $2 to $2.5 billion over the same period. At the same time, many countries

reformulated their policies in order to comply with the ICPD recommendations. This expanded political support in turn encouraged increases in financial contributions to SRHR.

However, both political and financial support is strikingly uneven between donor countries. Only a few countries have developed comprehensive SRH policies and reached SRH funding levels in compliance with the internationally accepted target of 4 per cent of ODA. In fact, the majority of donors did not reach even half of this target nor have they drafted formal policies that would acknowledge the potential existence of SRH activities beyond a narrow medical approach.

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

Other new challenges are already complicating the implementation of the ICPD Programme of Action in Europe, or may do in the future. For example, the growth of opposition forces to SRHR, combined with the addition of several socially conservative countries to the European Union, will complicate the discussion of international SRH needs in the region. Furthermore, the increased use of SWAps in development could undermine SRH work in some countries and make monitoring of the ICPD even more challenging than in the initial years after the conference.

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

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Appendix 1

Definition of the costed population package

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

Family planning services

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

Basic reproductive health services

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

Sexually transmitted diseases, HIV/AIDS prevention

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

Basic research, data and population and development policy analysis

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

Source:: The Programme of Action of the International Conference on Population and Development, para. 13.14.

Appendix 2

The Mexico City Policy

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

What is the Mexico City Policy?

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

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

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

What are the consequences of this policy?

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

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

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

Appendix 3

Description of the international sexual and reproductive health policies of European countries, Canada and the United States

Category of the country's SRH policy	*Country*	*Policy content and country specificity*
Comprehensive and independent SRHR policies in line with the ICPD goals or well-integrated within a sectoral policy	Netherlands	The Netherlands has a long tradition of SRH support, even before ICPD. Their actual SRH policy dates from 1994. After the ICPD, the Netherlands broadened its SRH programmes and adopted a more integrated approach. It became a leading country to speak out on controversial issues such as sexual rights and the SRH needs of young people. Calls strongly for the integration of HIV/AIDS activities within comprehensive SRH programmes.
	Sweden	Sweden has had a major long-standing political commitment to SRH through specific policies since the 1950s. After the ICPD, Sweden increased its support: it attributed more funding and broadened its policies by linking ICPD recommendations with poverty reduction, human rights and sustainable development (1997). It took the lead in addressing sensitive issues such as sexual rights and adolescent needs in SRH. In 2003, SRH became one of the main priorities of Swedish development policy.
	Denmark	Denmark has traditionally recognised SRH in its development policy and considers it as a priority. Over time, Denmark became the leader in promoting SRH as a multi-dimensional concept requiring multi-sectoral responsibility (1999). Denmark often advocates that SRH is essential for poverty reduction and the implementation of human rights (2000).
	Norway	Norway has been supporting SRH for a very long time: very early on, it closely linked SRH to other development issues such as the environment, sustainable development and human rights. Even before 1994, Norway had a multi-dimensional approach to SRH. After the ICPD, it adopted a comprehensive "Strategy for Women and Gender Equality in Development Cooperation" (1997) which not only looks at RH but also at education, economic participation and HIV/AIDS.
	United States	The United States has a 30-year long tradition in family planning (FP) assistance and played a crucial role in international acceptance for SRH, especially at the ICPD. FP and RH were among the 5 main priorities of the USAID Global Health Strategy (1997). However, since the ICPD (and especially since the Bush Presidency), the United States has not been able to reform its FP policy: it has failed to set up a more holistic SRH approach (focusing more on a rights-based rational), it has implemented conservative programmes and has limited the distribution of SRH funds (See The Mexico City Policy, Appendix 2).
	United Kingdom	The United Kingdom is a long-term supporter of SRH issues but both the 1994 ICPD and the arrival of the new Labour government in 1997 contributed to further enhancing the country's commitment. SRH is a priority in the 2000 "Better health for poor people" Strategic Paper and is seen as a key element for reducing poverty. A specific department in DFID deals with population issues and monitors SRH targets.
	Canada	Canada played a key role in framing the PoA of the ICPD and is active in promoting SRH internationally. The 1996 "Health Strategy" assigns high priority to women's health, HIV/AIDS and FP programmes. In the 2001 "Action Plan on Health", SRH is recognised as one of Canada's social priorities and a key determinant for poverty reduction. However, it does not have a detailed strategy providing guidance for the programming of projects in SRH and it fails to present a fully coherent approach.
	Switzerland	Over time, Switzerland has increasingly neglected SRH issues in its policy. This situation did not change directly after the ICPD: although Switzerland officially supported the ICPD proposals, there was no clear policy and it funded SRH mainly through multilateral channels. It was only in the Strategic Paper "Health Policy for 2002-2010" that Switzerland mentioned SRHR as one its five priorities in health. In this, it intends to promote reproductive rights and integrated RH services, including HIV/AIDS and STIs. It also intends to develop its bilateral SRH projects.
SRH policies integrated within a sectoral strategy (but not having independent status), or explicit mentions of population issues within a sectoral policy	Germany	FP has been a central issue for Germany since 1980. It first developed a specific policy on population issues in 1991. It increased its commitment after the ICPD by better integrating FP in its health policy (1999) and its poverty reduction strategy (2001). Although Germany sees FP as a human right, it does not use the holistic ICPD approach to SRH. A large focus is on gender issues and HIV/AIDS. In recent years, support for SRH has been decreasing.

Appendix 3 (concluded)

Description of the international sexual and reproductive health policies of European countries, Canada and the United States

Category of the country's SRH policy	*Country*	*Policy content and country specificity*
SRH policies integrated within a sectoral strategy (but not having independent status), or explicit mentions of population issues within a sectoral policy	Finland	Finland has, over time, shown special interest in women's issues, and since 2000 SRH has become a primary issue in Finnish health development cooperation. It has been given particular priority, together with HIV/AIDS. Finland is also very involved in gender equality and human rights.
	Belgium	Belgium significantly improved its SRH policy after the ICPD: FP and RH became priorities in the health sector in the new development policy of 1997. In its 2000 "Quality in Solidarity" paper, Belgium committed to paying more attention to these issues by broadening its activities (not only by integrating SRH in basic health but also by promoting SRH in education and by increasing funding). The fight against HIV/AIDS is another major Belgian priority. However, it still needs to develop an independent SRH policy paper, in which to integrate its fight against HIV/AIDS.
	Spain	SRHR was only recognised as a concept in Spanish aid policy in 1995, as a consequence of the ICPD. While there is no specific SRH policy, these issues (including HIV/AIDS) are clearly included in the definition of basic social services, one of the priorities of Spain's aid policy (1998). In the "Directive Plan 2001-2004", it is stated that Spain wants to be active in 4 areas of work of the ICPD PoA. Gender was also recognised as a cross-cutting issue in 1996. However, there is no specific policy on SRH.
	Portugal	SRH is a rather new concept in Portuguese development policy. Although FP was mentioned in its overall health strategy before the ICPD, Portugal expanded its definition of RH to include maternal and child health and AIDS in 1996. The changes in Portuguese development policy followed development in domestic policy regarding SRH: several laws (education (1984), abortion (1997)) became more liberal, preparing the way for more progressive approaches in cooperation aid. However, the arrival of a conservative right-wing government in 2002 is slowing down these changes.
No clear SRH policy or limited and/or very broadly defined mention of population issues within a sectoral policy	France	France has had a long-standing reluctance to provide direct and open support to SRH. The ICPD did not bring a clear policy change. In practice, however, France is active in specific ICPD areas: maternal health and women's rights (especially girls' education and the fights against FGM). It is also a world leader in the fight against HIV/AIDS. But France still fails to provide a holistic SRH approach or to mention SRH in its policy.
	Luxembourg	Luxembourg does not have an SRH strategy nor is there a specific mention of SRH in its 1996 "Cooperation and Development Law". Although the need for RH policies is recognised by the government, it is never done in an explicit way. Gender is however seen as a cross-cutting issue (Luxembourg has a specific policy paper on "Women and development" (1997)) but the government has failed to make an outspoken commitment to SRH issues. (At the same time, SRH funding has been increasing significantly over time.)
	Ireland	Ireland has never been able to openly get involved in SRH issues in its development policy mainly because of strong national opposition forces linked to the dominant influence of the Vatican in the country. None of the Cooperation Strategy Papers mention SRH. In the meantime, the general public is gradually showing more interest in the issues and recent increases (2002) in the Irish contributions to UNFPA illustrate this change.
	Italy	Although there is a specific mention of SRH within the Italian health policy (within the framework of its poverty reduction strategy paper of 1998), these issues are given very low priority. SRH areas cover AIDS and the promotion of family planning but few programmes are implemented and no clear action plan is envisaged in the near future.
	Austria	Austria has abandoned health as a priority in development and makes no reference to SRH. Empowerment of women is a new priority but no link is made with SRHR. The ICPD increased the interest of the government administration but no changes in policies have been seen.
	Greece	No mention of SRH. Implementation of some ad hoc HIV/AIDS projects. Gender equality became one of the cross-cutting priorities in their development policy (1999).

Appendix 4

Individual country tables providing an overview of each donor's commitments to ODA and SRHR

This appendix presents overview tables for the following countries*

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

For each country, a table provides statistical data on

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

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

* Greece not included as no figures were available.

GENERAL ODA FIGURES of AUSTRIA[a]

Total ODA[b]

	Million dollars	Per cent of GNI
2000	423	0.23
2001	533	0.29
2002	475	0.23

Total bilateral ODA

	Million dollars	Per cent of ODA
2000	258.03	61
2001	292.93	64
2002	332.50	70

Top 10 total ODA recipients 2000/2001

1. Poland (OA)
2. Indonesia
3. Cameroon
4. Bolivia
5. Serbia and Montenegro
6. Egypt
7. China
8. Bosnia and Herzegovina
9. Turkey
10. Ghana

Total multilateral ODA

	Million dollars	Per cent of ODA
2000	164.97	39
2001	164.07	36
2002	142.50	30

Top 3 UN agencies in 2001[g] (Million dollars)

1. UNDP	4
2. WHO	2
3. WFP	1

SPENDING on POPULATION ASSISTANCE of AUSTRIA

Total spending on population assistance[c]

	Million dollars	Per cent of ODA
1999	1.45[d]	0.27
2000	0.87	0.21
2001	0.98	0.18

Bilateral spending on population assistance

	Million dollars	Per cent of ODA
1999	–	–
2000	0.07	0.02
2001	0.07	0.01

Recipient countries having received funding for SRH[e]

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

2000	Zambia
2001	Peru
2002	Cameroon
	Ecuador
	Palestinian Administered Areas
	South Africa
2003	Afghanistan

Multilateral spending on population assistance (Million dollars)

	2000	2001	2002
UNFPA[f]	0.27	0.40	0.37
IPPF	0.00	0.00	0.00
Total of UNFPA and IPPF	0.27	0.40	0.37

SRH-related organizations (Million dollars)

	2000	2001	2002
UNIFEM[h]	0.06	–	0.01
UNAIDS[i]	–	–	–
Global AIDS Fund[j]	..	1.08	..

a The DAC Journal, Development Co-operation 2002 Report, Vol. 4, No. 1 (2003).

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

c UNFPA/NIDI, *Financial Resource Flows for Population Activities in 2001*, September 2003.

d This figure does not include project expenditures.

e Heinz Gabler, Information and Communication, Austrian Development Cooperation, Federal Ministry for Foreign Affairs.

f OECD/DAC, *Contributions to UNFPA's Regular Resources for 2001 and 2002*, RMB UNFPA.

g Heinz Gabler, Information and Communication, Austrian Development Cooperation, Federal, Ministry for Foreign Affairs.

h UNIFEM, *Annual Report 2002/2003*, Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.

i UNAIDS Governance, Donor & UN Relations Department, *Donor Contribution Table 2000-2002, the Unified Budget (Core).*

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

GENERAL ODA FIGURES of BELGIUM[a]

Total ODA[b]		
	Million dollars	*Per cent of GNI*
2000	820	0.36
2001	867	0.37
2002	1 061	0.42

Total bilateral ODA		
	Million dollars	*Per cent of ODA*
2000	475.60	58.0
2001	497.5	57.5
2002	658.88	62.1

Top 10 total ODA recipients 2000/2001

1. Democratic Republic of the Congo
2. Viet Nam
3. Cameroon
4. Rwanda
5. Tanzania
6. Niger
7. Ethiopia
8. Bolivia
9. Burkina Faso
10. Ivory Coast

Total multilateral ODA		
	Million dollars	*Per cent of ODA*
2000	344.40	42.0
2001	268.05	42.5
2002	402.12	37.9

Top 3 UN agencies in 2001 (Million dollars)

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

SPENDING on POPULATION ASSISTANCE of BELGIUM

Total spending on population assistance[c]		
	Million dollars	*Per cent of ODA*
1999	10.44	1.37
2000	15.77	1.92
2001	19.07	2.20

Bilateral spending on population assistance		
	Million dollars	*Per cent of ODA*
1999	5.22	0.69
2000	0.47	0.06
2001	6.48	0.75

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

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

Multilateral spending on population assistance (Million dollars)

	2000	*2001*	*2002*
UNFPA[e]	2.50	3.81	2.80
IPPF	0.08	0.08	0.10
Total of UNFPA and IPPF	2.58	3.89	2.90

SRH-related organizations (Million dollars)

	2000	*2001*	*2002*
UNIFEM[f]	0.36	–[g]	–[h]
UNAIDS[i]	2.84[j]	3.80	2.50
Global AIDS Fund[k]	..	19.05	..

a The DAC Journal, *Development Co-operation 2002 Report* , Vol. 4, No.1 (2003).

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

c UNFPA/NIDI, *Financial Resource Flows for Population Activities in 2001* (September 2003).

d Mr. Geert Deserranno, D12, DGIS.

e OECD/DAC, *Contributions to UNFPA's Regular Resources for 2001 and 2002*, RMB UNFPA.

f UNIFEM, *Annual Report 2002/2003, Contributions from governments.* This is the figure for core contribution and does not take earmarked contributions into account.

g In 2001, Belgium contributed $0.46 m through sub-trust funds.

h In 2002, Belgium contributed $1.16 m through sub-trust funds.

i UNAIDS Governance, Donor & UN Relations Department, *Donor Contribution Table 2000-2002, the Unified Budget (Core).*

j In 2000, Belgium paid a contribution of $5.76 m to the International Partnership Against AIDS in Africa (IPAA) on top of its contribution to the core funding. In total, Belgium contributed $8.4 m to UNAIDS.

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

GENERAL ODA FIGURES of CANADA[a]

Total ODA[b]

	Million dollars	Per cent of GNI
2000	1 744	0.25
2001	1 533	0.22
2002	2 013	0.28

Total bilateral ODA

	Million dollars	Per cent of ODA
2000	1 168.5	67
2001	1 195.7	78

Top 10 total ODA recipients 2000/2001

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

Total multilateral ODA

	Million dollars	Per cent of ODA
2000	575.5	33
2001	337.3	22

Top 3 UN agencies in 2001

1. UNDP
2. UNICEF
3. WFP

SPENDING on POPULATION ASSISTANCE of CANADA

Total spending on population assistance[c]

	Million dollars	Per cent of ODA
1999	37.21	0.83
2000	37.44	2.15
2001	12.68	0.83

Bilateral spending on population assistance

	Million dollars	Per cent of ODA
1999	9.30	0.54
2000	13.47	0.77
2001	2.91	0.18

Percentage of SRH contribution per geographical region-1998-1999[d]

Regions	Per cent of SRH contributions
Africa	61.0
Asia	28.2
Americas	5.0
Central and eastern Europe	5.8

Multilateral spending on population assistance (Million dollars)

	2000	2001	2002
UNFPA[e]	6.14	5.79	572
IPPF	2.70	2.58	2.79
Total of UNFPA and IPPF	8.84	5.37	8.51

SRH-related organizations (Million dollars)

	2000	2001	2002
UNIFEM[f]	1.28	0.81	0.98
UNAIDS[g]	2.28	2.16	2.11
Global AIDS Fund[h]	–	50	–

a The DAC Journal, Development Co-operation 2002 Report, Vol. 4, No.1 (2003).

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

c UNFPA/NIDI, *Financial Resource Flows for Population Activities in 2001* (September 2003).

d Statistics from CIDA: these are preliminary figures and cannot be considered as exact data. They can however be taken as best estimates of SRH resources allocations.

e OECD/DAC, *Contributions to UNFPA's Regular Resources for 2001 and 2002*, RMB UNFPA.

f UNIFEM, *Annual Report 2002/2003*, *Contributions from governments*. This is the figure for core contribution and does not take earmarked contributions into account.

g UNAIDS Governance, Donor & UN Relations Department, *Donor Contribution Table 2000-2002*, *the Unified Budget (Core*).

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

GENERAL ODA FIGURES of DENMARK[a]

Total ODA[b]		
	Million dollars	*Per cent of GNI*
2000	1 664	1.06
2001	1 634	1.03
2002	1 632	0.96

Total bilateral ODA		
	Million dollars	*Per cent of ODA*
2000	1 031.68	62
2001	1 029.42	63
2002	1 011.84	62

Top 10 total ODA recipients 2000/2001(DAC)

1. Tanzania
2. Uganda
3. Viet Nam
4. Mozambique
5. Ghana
6. Bangladesh
7. Egypt
8. Nicaragua
9. Burkina Faso
10. Nepal

Total multilateral ODA		
	Million dollars	*Per cent of ODA*
2000	632.32	38
2001	604.58	37
2002	620.16	38

Top 4 UN agencies in 2002[g]

1. UNICEF
2. UNDP
3. WFP
4. UNFPA

SPENDING on POPULATION ASSISTANCE of DENMARK

Total spending on population assistance[c]		
	Million dollars	*Per cent of ODA*
1999	54.88	3.17
2000	44.64	2.68
2001	48.85	2.99

Bilateral spending on population assistance		
	Million dollars	*Per cent of ODA*
1999	2.20	0.13
2000	–	–
2001	6.35	0.38

Denmark's priority countries with health as a specific priority for 2003[d]

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

Bhutan
Ghana
Tanzania
Uganda
Zambia

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

Multilateral spending on population assistance (Million dollars)

	2000	*2001*	*2002*
UNFPA[f]	23.88	23.67	21.46
IPPF	9.17	8.72	5.88
Total of UNFPA and IPPF	33.05	32.39	27.34

SRH-related organizations (Million dollars)

	2000	*2001*	*2002*
UNIFEM[h]	0.35	0.60	0.66
UNAIDS[i]	2.97	3.01	3.15
Global AIDS Fund[j]	–	27.22	–

a The DAC Journal, *Development Co-operation 2002 Report*, Vol. 4, No. 1 (2003).

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

c NIDI, *Financial Resource Flows for Population Activities in 2001* (September 2003).

d Ministry of Foreign Affairs, *Danish Development Assistance, Fact and Figures*.

e DANIDA, *Integrating SRH into a sector wide approach to Danish International Development Assistance*, p. 39 (1999).

f OECD/DAC, *Contributions to UNFPA's Regular Resources for 2000, 2001 and 2002*, RMB UNFPA.

g www.um.dk/danida

h UNIFEM, *Annual Report 2002/2003,* Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.

i UNAIDS Governance, Donor & UN Relations Department, *Donor Contribution Table 2000-2002, the Unified Budget*.

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

GENERAL ODA FIGURES of EUROPEAN COMMUNITY[a]

Total ODA[b]

	Million dollars	Per cent of GNI
2000	4 912	..
2001	5 961	..
2002	6 501	..

Top 10 total ODA recipients 1999/2000

1. Poland (OA)
2. Serbia and Montenegro
3. Romania (OA)
4. Czech Republic (OA)
5. Hungary (OA)
6. Turkey
7. Bosnia and Herzegovina
8. Tunisia
9. Morocco
10. Bulgaria (OA)

Sectoral breakdown of EC and EDF ODA in 2001[f]

Sectors	Per cent of aid
Social infrastructure and services	30.9
Of which population and RH	2.9
Production sector	14.4
Cross-cutting	19.8
Commodity aid and general programme assistance	9.5

SPENDING on POPULATION ASSISTANCE of the EUROPEAN COMMUNITY

Total spending on population assistance

	Content	Million dollars
2000	Funds for population	28.88
2001	Assistance[c]	28.05
1998	EC commitments to the ICPD activities[d]	237.58

Top 10 recipients of ICPD related commitments (1994-1998)[e]

	Million dollars
India	246.09
Egypt	78.51
Turkey	67.97
Pakistan	31.64
Malawi	29.30
Philippines	24.61
Morocco	22.27
South Africa	21.09
Kenya	21.09
Bangladesh	19.92

ICPD-related commitments by region (1994-1998)[g]

Names	Million dollars (1994-1998)	Per cent of the total ICPD allocations (1994-1998)
Asia	443.54	45
Africa	266.59	27
Mediterranean	183.16	18
Latin America	58.94	6
Global	29.52	3
Caribbean	9.84	1

Note: The European Commission also pledged $229 m, $26 m for the period 2001-2003 to the Global Fund to fight AIDS, TBC and malaria.[h]

a The DAC Journal, *Development Co-operation 2002* Report, Vol. 4, No. 1 (2003).

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

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

d MSI, *Handbook on European Community Support for Population and Reproductive Hea*lth, p. 32 (2000). These figures are the last available ones and comprise a broad overview of EC SRH spending. They come from a study made by J. Edwards in 1999 covering the period 1990-98. No further research is planned.

e Jason Edwards, co-writer of *Overview of the EC's Health, AIDS and Population Portfolio in Developing Countries (1990-1999),* (October 2000), (latest source available).

f EC, *Annual Report 2001 on the EC development policy and the implementation of the external assistance* (2002).

g Jason Edwards, co-writer of *Overview of the EC's Health, AIDS and Population Portfolio in Developing Countries (1990-1999)*, (October 2000) (latest source available).

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

GENERAL ODA FIGURES of FINLAND[a]

Total ODA[c]

	Million dollars	*Per cent of GNI*
2000	371	0.31
2001	389	0.32
2002	466	0.35

Total bilateral ODA

	Million dollars	*Per cent of ODA*
2000	218.89	59
2001	209.70	54
2002	256.30	55

Top 10 total ODA recipients 2000/2001

1. Russian Federation
2. Tanzania
3. Serbia and Montenegro
4. Mozambique
5. China
6. Nicaragua
7. Afghanistan
8. Namibia
9. Viet Nam
10. Kenya

Total multilateral ODA

	Million dollars	*Per cent of ODA*
2000	152.11	41
2001	179.30	46
2002	209.70	45

Top 3 UN agencies in 2001 (Million dollars)[f]

1. UNFPA	14.4[g]
2. UNDP	13.5
3. UNICEF	12.0

SPENDING on POPULATION ASSISTANCE of FINLAND[b]

Total spending on population assistance

	Million dollars	*Per cent of ODA*
1999	19.96	4.80
2000	19.77	5.33
2001	23.73	6.10

Bilateral spending on population assistance

	Million dollars	*Per cent of ODA*
1999	1.20	0.29
2000	1.19	0.32
2001	1.66	0.43

Recipient countries having received funding for SRH programmes in 2002[d]

Through direct bilateral support ..... Nicaragua
Afghanistan

Through Finnish NGO funding ..... India
Mexico
Namibia
Nepal

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

Multilateral spending on population assistance (Million dollars)

	2000	*2001*	*2002*
UNFPA[e]	12.49	10.60	13.60
IPPF	0.16	0.21	0.32
Total of UNFPA and IPPF	12.65	10.81	13.92

SRH-related organizations (Million dollars)

	2000	*2001*	*2002*
UNAIDS[h]	1.24	2.50	2.74
UNIFEM[i]	0.47	0.46	0.50
Global AIDS Fund[j]	..	–	..

a The DAC Journal, *Development Co-operation 2002 Report*, Vol. 4, No. 1 (2003).

b UNFPA/NIDI, *Financial Resource Flows for Population Activities in 2001* (September 2003).

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

d Ministry of Foreign Affairs of Finland, Gisela Blumenthal and Tanja Suvilaakso.

e OECD/DAC, *Contributions to UNFPA's Regular Resources for 2001 and 2002*, RMB UNFPA.

f Ministry of Foreign Affairs of Finland, UN Desk.

g This amount includes an additional €2 million, due to shortfall of expected income.

h UNAIDS Governance, Donor & UN Relations Department, *Donor Contribution Table 2000-2002, the Unified Budget (Core).*

I UNIFEM, *Annual Report 2002/2003.* Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.

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

GENERAL ODA FIGURES of FRANCE[a]

Total ODA[b]

	Million dollars	Per cent of GNI
2000	4 105	0.32
2001	4 198	0.32
2002	5 182	0.36

Total bilateral ODA

	Million dollars	Per cent of ODA
2000	2 833	69
2001	2 602	62
2002	3 213	62

Top 10 total ODA recipients 2000/2001[e]

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

Total multilateral ODA

	Million dollars	Per cent of ODA
2000	1 272	31
2001	1 595	38
2002	1 969	38

Top 3 UN agencies in 2001 (Million dollars)

1. UNDP
2. UNICEF
3. UNHCR

SPENDING on POPULATION ASSISTANCE of FRANCE

Total spending on population assistance

NIDI figures	Million dollars	Per cent of ODA
1999	8.00	0.14
2000	12.36	0.30
2001	8.24	0.20

Estimation of the Ministry of Foreign Affairs[d]

1999	49.54	0.87

Bilateral SRH spending in 2000

	Million dollars	Per cent of ODA
1999	–	–
2000	5.31	0.13
2001	4.20	0.10

Major recipient countries of SRH[f]

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

However, France does have specific SRH projects in the framework of multibilateral projects with UNFPA in[g] Madagascar, Niger and Ivory Coast.

France has also specific projects on FGM with UNICEF in Benin, Burkina Faso, Ivory Coast, Mali.
France is strongly involved in the fight against TB, malaria and AIDS and is reinforcing its activities for the promotion of international therapeutic solidarity.

Multilateral spending on population assistance (Million dollars)

	2000	2001	2002
UNFPA[h]	1.16	1.11	1.12
IPPF[i]			
Total of UNFPA and IPPF	1.16	1.11	1.12

SRH-related organizations (Million dollars)

	2000	2001	2002
UNIFEM[j]	0.07	–	–
UNAIDS[k]	0.32	0.03	0.43
Global AIDS Fund[l]	..	109.15	..

a The DAC Journal, *Development Co-operation 2002 Report,* Vol. 4, No. 1 (2003).

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

c NIDI, *Financial Resource Flows for Population Activities in 2001* (September 2003). The population spending of France is highly underestimated in the NIDI study due to poor reporting from the French government.

d This figure is issued from estimations from the Office of United Nations and International Organizations of the Ministry of Foreign Affairs. This source reflects better the spending level of France on population issues than the NIDI study since the multilateral programs are included.

e Since 2001, French Polynesia and New Caledonia are not considered as ODA recipients anymore.

f Ministry of Cooperation of France:http://www.france.diplomatie.fr/cooperation/dgcid/direction.

g This list is not exhaustive and presents only some of the major French projects in the field.

h OECD/DAC, *Contributions to UNFPA's Regular Resources for 2000, 2001, 2002* , RMB UNFPA.

i France does not contribute directly to IPPF but does provide funding to its French member "MFPF" (Mouvement Français pour le Planning Familial) and supports other local FPAs (Family Planning Associations), which are often associated with French Development Aid programs (e.g. Madagascar and Ivory Coast).

j UNIFEM, *Annual Report 2002/2003,* Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.

k UNAIDS Governance, Donor & UN Relations Department, *Donor Contribution Table 2000-2002, the Unified Budget.*

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

GENERAL ODA FIGURES of GERMANY[a]

Total ODA[c]		
	Million dollars	*Per cent of GNI*
2000	5 030	0.27
2001	4 990	0.27
2002	5 359	0.27

Total bilateral ODA		
	Million dollars	*Per cent of ODA*
2000	2 668	53
2001	3 579	73
2002	3 589	69

Top 10 total ODA recipients 2000/2001

1. China
2. India
3. Indonesia
4. Turkey
5. Egypt
6. Serbia and Montenegro
7. Jordan
8. Peru
9. Bolivia
10. Russian Federation (OA)

Total multilateral ODA		
	Million dollars	*Per cent of ODA*
2000	2 366	47
2001	1 300	27
2002	1 770	31

Top 3 UN agencies in 2001 (Million dollars)

1. UNFPA	22
2. UNDP	21
3. UNICEF	13

SPENDING on POPULATION ASSISTANCE of GERMANY[b]

Total spending on population assistance		
	Million dollars	*Per cent of ODA*
1999	119.76	2.17
2000	96.40	1.91
2001	108.66	2.18

Bilateral spending on population assistance		
	Million dollars	*Per cent of ODA*
1999	73.05	1.36
2000	79.05	1.57
2001	88.01	1.76

14 partner countries having chosen "Health" (incl. SRH) as priority area of cooperation[d]

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

Multilateral spending on population assistance (Million dollars)

	2000	*2001*	*2002*
UNFPA[e]	9.45	13.04	13.00
IPPF	2.50	3.60	2.44
Total of UNFPA and IPPF	11.95	16.64	15.44

SRH-related organizations (Million dollars)

	2000	*2001*	*2002*
UNAIDS[f]	0.88	0.83	–
UNIFEM[g]	0.75	0.74	0.76
Global AIDS Fund[h]		49.63	

a The DAC Journal, *Development Co-operation 2002 Report,* Vol. 4, No. 1 (2003).

b UNFPA/NIDI, *Financial Resource Flows for Population Activities in 2001* (September 2003).

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

d BMZ Position Paper, *Sexual and Reproductive Health* (draft) (September 2002).

e OECD/DAC, *Contributions to UNFPA's Regular Resources for 2001 and 2002*, RMB UNFPA.

f UNAIDS Governance, Donor & UN Relations Department, *Donor Contribution Table 2000-2002, the Unified Budget (Core).*

g UNIFEM, *Annual Report 2002/2003.* Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.

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

GENERAL ODA FIGURES of IRELAND[a]

Total ODA[b]		
	Million dollars	Per cent of GNI
2000	235	0.30
2001	287	0.33
2002	397	0.41

Total bilateral ODA		
	Million dollars	Per cent of ODA
2000	155.10	66
2001	183.68	64

Top 10 total ODA recipients 2000/2001
1. Ethiopia
2. Uganda
3. Mozambique
4. Tanzania
5. Zambia
6. Lesotho
7. South Africa
8. Kenya
9. Afghanistan
10. Bosnia and Herzegovina

Total multilateral ODA		
	Million dollars	Per cent of ODA
2000	79.90	34
2001	103.32	36

Top 3 UN agencies in 2001 (Million dollars)	
1. UNDP	6.69
2. UNICEF	3.92
3. UNHCR	3.80

SPENDING on POPULATION ASSISTANCE of IRELAND

Total spending on population assistance[c]		
	Million dollars	Per cent of ODA
1999	2.67	1.09
2000	4.24	1.80
2001	6.25	2.18

Bilateral spending on population assistance		
	Million dollars	Per cent of ODA
1999	1.04	0.42
2000	1.99	0.85
2001	4.31	1.50

Major recipient of health spending in 2001[d]
Ethiopia
Lesotho
Mozambique
Tanzania
Uganda
Zambia

Major recipients for HIV/AIDS spending in 2001
Lesotho
Ethiopia
Uganda
Mozambique
Tanzania
Zambia

Multilateral spending on population assistance			
	2000	2001	2002
UNFPA[e]	0.73	1.17	1.59
IPPF	–	–	–
Total of UNFPA and IPPF	0.73	1.17	1.59

SRH-related organizations (Million dollars)			
	2000	2001	2002
UNAIDS[f]	0.18	0.45	0.54
UNIFEM[g]	0.16	0.31	2.7
Global AIDS Fund[h]	..	20.68	..

a The DAC Journal, *Development Co-operation 2002 Report*, Vol. 4, No. 1 (2003).

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

c NIDI, *Financial Resource Flows for Population Activities in 2001* (September 2003).

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

e OECD/DAC, *Contributions to UNFPA's Regular Resources for 2000, 2001, 2002,* RMB UNFPA.

f UNAIDS Governance, Donor & UN Relations Department, *Donor Contribution Table 2000-2002, the Unified Budget (Core).*

g UNIFEM, *Annual Reports 2001 and 2002.* Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.

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

GENERAL ODA FIGURES of ITALY[a]

Total ODA[b]		
	Million dollars	*Per cent of GNI*
2000	1 376	0.13
2001	1 627	0.15
2002	2 313	0.20

Total bilateral ODA		
	Million dollars	*Per cent of ODA*
2000	372	27
2001	439	27

Top 10 total ODA recipients 2000/2001

1. Russian Federation (OA)
2. Uganda
3. Eritrea
4. Serbia and Montenegro
5. Tunisia
6. Ethiopia
7. Albania
8. Bosnia and Herzegovina
9. Honduras
10. Somalia

Total multilateral ODA		
	Million dollars	*Per cent of ODA*
2000	1 004	73
2001	1 187	73

Top 3 UN agencies in 2001 (Million dollars)	
1. UNDP	16
2. UNICEF	16
3. UNHCR	14

SPENDING on POPULATION ASSISTANCE of ITALY

Total spending on population assistance[c]		
	Million dollars	*Per cent of ODA*
1999	10.04	0.56
2000	24.92	1.81
2001	25.04	1.54

Bilateral spending on population assistance		
	Million dollars	*Per cent of ODA*
1999	2.61	0.14
2000	7.97	0.58
2001	7.76	0.48

Top 10 health and population recipients 2001

..

Multilateral spending on population assistance (Million dollars)			
	2000	*2001*	*2002*
UNFPA[d]	2.90	2.66	3.00
IPPF	–	–	–
Total of UNFPA and IPPF	2.90	2.66	3.00

SRH-related organizations (Million dollars)			
	2000	*2001*	*2002*
UNAIDS[e]	1.72	1.79	–
UNIFEM[f]	2.94	2.66	2.74
Global AIDS Fund[g]	–	200	–

a The DAC Journal, *Development Co-operation 2002 Report*, Vol. 4, No. 1 (2003).

b The OECD's ODA figures include grants and loans to countries from Part I of the DAC List for Aid Recipients provided by the official sector with the promotion of economic development and welfare as main objectives.

c UNFPA/NIDI, *Financial Resource Flows for Population Activities in 2001* (September 2003).

d OECD/DAC, *Contributions to UNFPA's Regular Resources for 2001 and 2002*, RMB UNFPA.

e UNAIDS Governance, Donor & UN Relations Department, *Donor Contribution Table 2000-2002, the Unified Budget (Core).*

f UNIFEM, *Annual Report 2002/2003.* Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.

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

GENERAL ODA FIGURES of LUXEMBOURG[a]

Total ODA[b]		
	Million dollars	*Per cent of GNI*
2000	123	0.72
2001	142	0.19
2002	143	0.78

Total bilateral ODA		
	Million dollars	*Per cent of ODA*
2000	93.98	74
2001	106.5	75

Top 11 total ODA recipients 2001 (Luxembourg annual report 2001)[e]

1. Mali
2. Cape Verde
3. El Salvador
4. Nicaragua
5. Burkina Faso
6. Viet Nam
7. Laos
8. Namibia
9. Niger
10. Palestinian Territories
11. Senegal

Total multilateral ODA		
	Million dollars	*Per cent of ODA*
2000	33.02	26
2001	35.5	25

Top 3 UN agencies in 2001 (Million dollars)

1. WHO	7.7
2. UNFPA	7.0
3. UNDP	2.4

SPENDING on POPULATION ASSISTANCE of LUXEMBOURG

Total spending on population assistance[c]		
	Million dollars	*Per cent of ODA*
1999	3.13	2.63
2000	10.73	8.45
2001[d]	5.62	3.99

Bilateral spending on population assistance		
	Million dollars	*Per cent of ODA*
1999	1.57	1.32
2000	8.37	6.60
2001	3.76	2.65

The countries among the partner countries[f] having a SRH-related project in 2001-2002 (Million dollars) (projects done through UNFPA)[g]

Nicaragua	Cape Verde
Namibia	Viet Nam
Mali	Niger
El Salvador	Afghanistan
Tunisia	Senegal

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

Multilateral spending on population assistance (Million dollars)

	2000	*2001*	*2002*
UNFPA[h]	0.43	0.42	0.51
IPPF	–	–	–
Total of UNFPA and IPPF	0.43	0.42	0.51

SRH-related organizations (Million dollars)

	2000	*2001*	*2002*
UNIFEM[i]	0.42	0.42	0.56
UNAIDS[j]	0.43	0.43	0.58
Global AIDS Fund[k]	2.13		

a The DAC Journal, *Development Co-operation 2002 Report,* Vol. 4, No. 1 (2003).

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

c NIDI, *Financial Resource Flows for Population Activities in 2001* (September 2003)

d Figures were not fully reported: as a result, 2001 project and programme figures are estimated on the 2000 levels.

e Luxembourg is also financing a large project in Serbia and Montenegro (reconstruction including in Kosovo) for a total amount of $7 m dollars over 3 years starting from 2000.

f Luxemburg has 10 priority countries (Niger, Senegal, Cape Verde, Namibia, Burkina Faso, Nicaragua, El Salvador, Vietnam, Laos) and some partner countries for specific projects (China, Chili, South Africa, Morocco, Rwanda, Burundi, Tunisia).

g Ministry of Foreign Affairs, External Trade, Co-operation and Defenses, *Annual Report 2001* (16 July 2002).

h OECD/DAC, *Contributions to UNFPA's Regular Resources for 200, 2001, 2002*, RMB UNFPA. This is the figure for core contribution and does not take earmarked contributions into account.

i UNIFEM, *Annual Report 2002/2003.* Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.

j UNAIDS Governance, Donor & UN Relations Department, *Donor Contribution Table 2000-2002, the Unified Budget (Core).* This is the figure for core contribution and does not take earmarked contributions into account.

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

GENERAL ODA FIGURES of NETHERLANDS[a]

Total ODA[b]

	Million dollars	Per cent of GNI
2000	3 135	0.84
2001	3 172	0.82
2002	3 377	0.82

Total bilateral ODA

	Million dollars	Per cent of ODA
2000	2 257.20	72
2001	2 220.40	70
2002	2 532.75	75

Top 10 total ODA recipients 2000/2001

1. Indonesia
2. Netherlands Antilles (OA)
3. Tanzania
4. India
5. Mozambique
6. Ghana
7. Serbia and Montenegro
8. Bolivia
9. Bosnia and Herzegovina
10. Uganda

Total multilateral ODA

	Million dollars	Per cent of ODA
2000	877.80	28
2001	951.60	30
2002	844.25	25

Top 3 UN agencies in 2001

1. UNDP
2. UNFPA
3. UNHCR

SPENDING on POPULATION ASSISTANCE of NETHERLANDS

Total spending on population assistance[c]

	Million dollars	Per cent of ODA
1999	115.78	3.69
2000	170.08	5.43
2001	132.03	4.16

Bilateral spending on population assistance

	Million dollars	Per cent of ODA
1999	40.52	1.29
2000	28.91	0.92
2001	14.52	0.45

The 12 "structural development partners" for which Health is one of the priority aid policy lines[d] (in 2002)

Bangladesh	Mali
Burkina Faso	Mozambique
Egypt	Nicaragua
Ethiopia	Tanzania
Ghana	Viet Nam
Yemen	Zambia

Countries with specific focus on SRH

Burkina Faso	Nicaragua
Mali	Egypt

Countries with specific emphasis on HIV/AIDS

Ghana	Tanzania
Mozambique	Zambia

Multilateral spending on population assistance (Million dollars)

	2000	2001	2002
UNFPA[e]	50.58	50.28	52.25
IPPF	3.18	6.31	7.26
Total of UNFPA and IPPF	53.76	56.59	59.51

SRH-related organizations (Million dollars)

	2000	2001	2002
UNIFEM[f]	3.07	3.25	3.31
UNAIDS[g]	14.98	20.22	15.47
Global AIDS Fund[h]	..	54.13	..

a The DAC Journal, Development Co-operation 2002 Report, Vol. 4, No. 1 (2003).

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

c NIDI, *Financial Resource Flows for Population Activities in 2001* (September 2003).

d Ministry of Foreign Affairs. The Dutch government has a long-term aid relationship with 22 priority countries, called the structural development partners. Each partner country moreover has to decide to which sectors (3 or 4) they want Dutch aid to go to. Above is the list of the countries among the 22 partners who chose health care in general, including SRH as one of their priorities. http://www.minbuza.nl/.

e OECD/DAC, *Contributions to UNFPA's Regular Resources for 2000, 2001,2002,*RMB UNFPA.

f UNIFEM, *Annual Report 2002/2003.* Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.

g UNAIDS Governance, Donor & UN Relations Department, Donor Contribution Table 2000-2002, the Unified Budget (Core).

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

GENERAL ODA FIGURES of NORWAY[a]

Total ODA[b]		
	Million dollars	Per cent of GNI
2000	1 364	0.80
2001	1 346	0.80
2002	1 746	0.91

Total bilateral ODA		
	Million dollars	Per cent of ODA
2000	1 013.80	74
2001	942.20	70
2002	1 222.20	70

Top 10 total ODA recipients 2000/2001
1. Serbia and Montenegro
2. Mozambique
3. Tanzania
4. Palestinian Adm. Areas
5. Afghanistan
6. Bosnia and Herzegovina
7. Zambia
8. Uganda
9. Ethiopia
10. Bangladesh

Total multilateral ODA		
	Million dollars	Per cent of ODA
2000	356.20	26
2001	403.80	30
2002	523.80	30

Top 3 UN agencies in 2001(Million dollars)	
1. UNFPA	79
2. UNICEF	34
3. UNFPA	24

SPENDING on POPULATION ASSISTANCE of NORWAY

Total spending on population assistance[c]		
	Million dollars	Per cent of ODA
1999	61.67	4.50
2000	59.96	4.38
2001	42.96	3.19

Bilateral spending on population assistance		
	Million dollars	Per cent of ODA
1999	1.23	0.09
2000	4.20	0.31
2001	0.43	0.03

Top 10 SRH and population recipients 2000	
	Per cent of total SRH and population aid
1. Uganda	10.72
2. Tanzania	8.78
3. Zambia	8.69
4. Mozambique	5.53
5. Nicaragua	4.14
6. Zimbabwe	4.05
7. Malawi	3.93
8. Burkina Faso	2.02
9. South Africa	1.98
10. Viet Nam	1.27

Multilateral spending on population assistance (Million dollars)			
	2000	2001	2002
UNFPA[d]	22.99	23.94	24.39
IPPF	5.33	5.00	5.53
Total of UNFPA and IPPF	28.32	28.94	29.92

SRH-related organizations (Million dollars)			
	2000	2001	2002
UNAIDS[e]	7.56	10.75	13.08
UNIFEM[f]	1.95	2.02	2.02
Global AIDS Fund[g]	..	34.70	..

[a] The DAC Journal, *Development Co-operation 2002 Report,* Vol. 4, No.1 (2003).

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

[c] *UNFPA/NIDI, Financial Resource Flows for Population Activities in 2001* (September 2003).

[d] OECD/DAC, *Contributions to UNFPA's Regular Resources for 2001 and 2002*, RMB UNFPA.

[e] UNAIDS Governance, Donor & UN Relations Department, *Donor Contribution Table 2000-2002, the Unified Budget (Core).*

[f] UNIFEM, *Annual Report 2002/2003.* Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.

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

GENERAL ODA FIGURES of PORTUGAL[a]

Total ODA[b]

	Million dollars	*Per cent of GNI*
2000	271	0.26
2001	267	0.25
2002	282	0.24

Total bilateral ODA

	Million dollars	*Per cent of ODA*
2000	178.86	66
2001	181.56	68

Top 10 total ODA recipients 2000/2001

1. Mozambique
2. Timor-Leste
3. Cape Verde
4. Guinea Bissau
5. Angola
6. São Tomé and Principe
7. The former Yugoslav Republic of Macedonia
8. Bosnia and Herzegovina
9. Brazil
10. Palestinian Adm. Areas

Total multilateral ODA

	Million dollars	*Per cent of ODA*
1999	69.00	25
2000	92.14	34
2001	85.44	32

Top 3 UN agencies in 2001 (Million dollars)

1. UNDP
2. WHO
3. UNESCO

SPENDING on POPULATION ASSISTANCE of PORTUGAL

Total spending on population assistance[c]

	Million dollars	*Per cent of ODA*
1999	0.44	0.16
2000	0.40	0.15
2001	0.68	0.26

Bilateral spending on population assistance

	Million dollars	*Per cent of ODA*
1999	0.24	0.09
2000	0.20	0.08
2001	0.46	0.17

Health expenditure in the priority countries[d] (1999)

1. Sao Tome and Principe
2. Mozambique
3. Cape Verde
4. Angola
5. Guinea Bissau
6. Timor-Leste

Multilateral spending on population assistance (Million dollars)

	2000	*2001*	*2002*
UNFPA[e]	0.03	0.02	–
IPPF	–	–	–
Total of UNFPA and IPPF	0.03	0.02	–

SRH-related organizations (Million dollars)

	2000	*2001*	*2002*
UNAIDS	–	–	–
UNIFEM	–	–	–
Global AIDS Fund	–	–	–

a The DAC Journal, *Development Co-operation 2002 Report*, Vol. 4, No. 1 (2003).

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

c NIDI, *Financial Resource Flows for Population Activities in 2001* (September 2003).

d Portugal has 5 priority partner for which the cooperation programme is detailed in *Relatorio da Cooperacao Portuguesa 1999* http://www.instcoop.pt/Rel99.doc. No updates were available

e OECD/DAC, *Contributions to UNFPA's Regular Resources for 2000, 2001,2002*, RMB UNFPA.

GENERAL ODA FIGURES of SPAIN[a]

Total ODA[b]		
	Million dollars	Per cent of GNI
2000	1 195	0.22
2001	1 737	0.30
2002	1 608	0.25

Total bilateral ODA		
	Million dollars	Per cent of ODA
2000	717.00	60
2001	1 146.42	66

Top 10 total ODA recipients 2000/2001
1. Nicaragua
2. Indonesia
3. Morocco
4. China
5. Bolivia
6. El Salvador
7. Honduras
8. Bosnia and Herzegovina
9. Ecuador
10. Peru

Total multilateral ODA		
	Million dollars	Per cent of ODA
2000	478.00	40
2001	590.58	34

Top 3 UN agencies in 2001
1. UNDP
2. UNICEF
3. WFP/UNHCR

SPENDING on POPULATION ASSISTANCE of SPAIN

Total spending on population assistance[c]		
	Million dollars	Per cent of ODA
1999	9.47	0.69
2000	6.21	0.52
2001	14.38	0.83

Bilateral spending on population assistance		
	Million dollars	Per cent of ODA
1999	4.73	0.35
2000	5.09	0.43
2001	13.22	0.76

Major SRH recipients
Major recipient countries of SRH projects financed by the AECI between 1995 and 2000[d] (including HIV/AIDS): Morocco, Honduras, Dominican Republic, Philippines.
Within the 2002 Annual Plan, "Maternal and child health" is a priority for the following areas: Ecuador, Central America and the Caribbean, Morocco, Tunisia and the Palestinian Territories.
Actual SRH and HIV/AIDS projects in 2003[e]: Bolivia, Ecuador, Peru, El Salvador, Nicaragua, Dominican Republic, Morocco, Angola, Mozambique, Namibia, South Africa.

Multilateral spending on population assistance (Million dollars)			
	2000	2001	2002
UNFPA[f]	0.50	0.49	0.55
IPPF	–	–	–
Total of UNFPA and IPPF	0.50	0.49	0.55

SRH-related organizations (Million dollars)			
	2000	2001	2002
UNIFEM[g]	0.11	0.13	0.06
UNAIDS[h]	0.19	0.32	..
Global AIDS Fund[i]	..	35	..

a The DAC Journal, *Development Co-operation 2002 Report,* Vol. 4, No. 1 (2003).

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

c NIDI, *Financial Resource Flows for Population Activities in 2001* (September 2003).

d La ayuda oficial al desarrollo de Espana en Materia de poblacion y salud Reproductiva 1995-2000 – Un uniform de El Cairo +5 GIE 1998.

e Oral interview with Ministry of Cooperation and Development.

f OECD/DAC, *Contributions to UNFPA's Regular Resources for 2000, 2001, 2002,* RMB UNFPA.

g UNIFEM, *Annual Report 2002/2003*. Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.

h UNAIDS Governance, Donor & UN Relations Department, *Donor Contribution Table 2000-2002, the Unified Budget (Core).*

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

GENERAL ODA FIGURES of SWEDEN[a]

Total ODA[b]		
	Million dollars	*Per cent of GNI*
2000	1 799	0.80
2001	1 666	0.77
2002	1 754	0.74

Total bilateral ODA		
	Million dollars	*Per cent of ODA*
2000	1 241.31	69
2001	1 199.52	72
2002[d]	1 490.90	85

Top 10 total ODA recipients 2000/2001

1. Tanzania
2. Mozambique
3. Honduras
4. Viet Nam
5. Serbia and Montenegro
6. Russian Federation
7. Bangladesh
8. South Africa
9. Nicaragua
10. Palestinian Adm Areas

Total multilateral ODA		
	Million dollars	*Per cent of ODA*
2000	557.69	31
2001	466.48	28
2002	263.10	15

Top 3 UN agencies in 2001 (Million dollars)	
1. UNDP	56
2. UNICEF	31
3. UNFPA	17

SPENDING on POPULATION ASSISTANCE of SWEDEN

Total spending on population assistance[c]		
	Million dollars	*Per cent of ODA*
1999	61.60	3.78
2000	73.14	4.07
2001	56.27	3.38

Bilateral spending on population assistance		
	Million dollars	*Per cent of ODA*
1999	19.08	1.17
2000	4.39	0.24
2001	5.63	0.34

Major bilateral SRH recipients in 2002 (SRH and HIV/AIDS)[e] (alphabetic order)

Angola
Ethiopia
India
Malawi
Namibia
Tanzania
Uganda
Zambia
Zimbabwe

Multilateral spending on population assistance (Million dollars)

	2000	*2001*	*2002*
UNFPA[f]	18.43	16.07	17.04
IPPF	7.63	6.72	7.71
Total of UNFPA and IPPF	26.06	22.79	24.75

SRH-related organizations (Million dollars)

	2000	*2001*	*2002*
UNIFEM[g]	1.03	1.31	1.58
UNAIDS[h]	4.01	4.60	4.97
Global AIDS Fund[i]	46.36	..	..

a The DAC Journal, *Development Co-operation 2002 Report*, Vol. 4, No. 1 (2003).

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

c UNFPA/NIDI, *Financial Resource Flows for Population Activities in 2001* (September 2003).

d SIDA, *Annual Report 2002* (May 2003).

e SIDA, Health Division by Anders Nordstrom, *Fact and figures 2002: Health Sector* (April 2003). The countries given are the ones which received within bilateral ODA funding for the sub-sectors " Reproductive health and rights" and "Sexual health and Rights including HIV/AIDS"

f OECD/DAhC, *Contributions to UNFPA's Regular Resources for 2001 and 2002*, RMB UNFPA.

g UNIFEM, *Annual Report 2002/2003.* Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.

h UNAIDS Governance, Donor & UN Relations Department, *Donor Contribution Table 2000-2002, the Unified Budget (Core).*

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

GENERAL ODA FIGURES of SWITZERLAND[a]

Total ODA[b]		
	Million dollars	*Per cent of GNI*
2000	890	0.34
2001	890	0.34
2002	933	0.32

Total bilateral ODA		
	Million dollars	*Per cent of ODA*
2000	623.00	70
2001	644.68	71

Top 10 total ODA recipients 2000/2001

1. Serbia and Montenegro (including Kosovo)
2. Mozambique
3. States of Serbia and Montenegro
4. India
5. Tanzania
6. Bangladesh
7. Burkina Faso
8. Nepal
9. Bosnia and Herzegovina
10. Viet Nam

Total multilateral ODA		
	Million dollars	*Per cent of ODA*
2000	267.00	30
2001	263.32	29

Top 3 UN agencies in 2001 (Million dollars)

1. UNDP	37
2. WFP	21
3. UNHCR	17.5

SPENDING on POPULATION ASSISTANCE of SWITZERLAND

Total spending on population assistance[c]		
	Million dollars	*Per cent of ODA*
1999	17.80	1.81
2000	16.07	1.81
2001	23.53	2.59

Bilateral spending on population assistance		
	Million dollars	*Per cent of ODA*
1999	4.27	0.43
2000	3.54	0.40
2001	3.52	0.38

Priority countries where health is a priority

Benin	Mozambique
Chad	Nepal
Mali	Tanzania

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

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

Multilateral spending on population assistance (Million dollars)

	2000	*2001*	*2002*
UNFPA[d]	6.97	6.74	8.01
IPPF	0.58	0.61	0.66
Total of UNFPA and IPPF	7.55	7.35	8.67

SRH-related organizations (Million dollars)

	2000	*2001*	*2002*
UNIFEM[e]	0.49	0.45	0.48
UNAIDS[f]	1.27	2.32	2.66
Global AIDS Fund[g]	..	..	10

a The DAC Journal, *Development Co-operation 2002 Report*, Vol. 4, No. 1 (2003).

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

c UNFPA/NIDI, *Financial Resource Flows for Population Activities in 2001* (September 2003).

d OECD/DAC, *Contributions to UNFPA's Regular Resources for 2000, 2001, 2002*, RMB UNFPA.

e UNIFEM, *Annual Report 2002/2003*. Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.

f UNAIDS Governance, Donor & UN Relations Department, *Donor Contribution Table 2000-2002, the Unified Budget (Core).*

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

GENERAL ODA FIGURES of the UNITED KINGDOM[a]

Total ODA[b]		
	Million dollars	*Per cent of GNI*
2000	4 501	0.32
2001	4 579	0.32
2002	4 749	0.30

Total bilateral ODA		
	Million dollars	*Per cent of ODA*
2000	2 700.60	60
2001	2 610.03	57
2002[d]	3 086.85	65

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

Total multilateral ODA		
	Million dollars	*Per cent of ODA*
2000	1 800.40	40
2001	1 968.97	43
2002	1 662.15	35

Top 3 UN agencies in 2001 (Million dollars)[g]	
1. UNDP	66
2. UNRWA	33
3. UNHCR	30

SPENDING on POPULATION ASSISTANCE of the UNITED KINGDOM

Total spending on population assistance[c]		
	Million dollars	*Per cent of ODA*
1999	95.70	2.79
2000	169.60	3.77
2001	80.97	1.77

Bilateral spending on population assistance		
	Million dollars	*Per cent of ODA*
1999	27.75	0.81
2000	61.06	1.36
2001	14.57	0.32

Top 10 health and population recipients 1999 (DFID)[e]	Per cent of total health and population aid
1. India	15.6
2. Bangladesh	8.0
3. Ghana	7.2
4. Kenya	7.2
5. Uganda	6.2
6. South Africa	4.9
7. Tanzania	4.7
8. Nigeria	4.5
9. Pakistan	4.3
10. Zambia	2.6

Multilateral spending on population assistance (Million dollars)			
	2000	*2001*	*2002*
UNFPA[f]	22.29	21.91	21.68
IPPF	8.30	6.74	6.97
Total of UNFPA and IPPF	30.59	28.65	28.65

SRH-related organizations (Million dollars)			
	2000	*2001*	*2002*
UNAIDS[h]	4.62	4.32	2.36
UNIFEM[i]	3.84	3.56	4.45
Global AIDS Fund[j]	118.54	..	..

a The DAC Journal, *Development Co-operation 2002 Report* , Vol. 4, No. 1 (2003).

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

c UNFPA/NIDI, *Financial Resource Flows for Population Activities in 2001* (September 2003).

d Provisional figures from Mr Ian MacIntosh, Head of Statistical Reporting, DFID.

e These percentages are calculated on the basis of the total bilateral spending on health, including SRH and population issues. These are thus not SRH specific figures.

f OECD/DAC, *Contributions to UNFPA's Regular Resources for 2001 and 2002*, RMB UNFPA

g Provisional figures from Mr Ian MacIntosh, Head of Statistical Reporting, DFID.

h UNAIDS Governance, Donor & UN Relations Department, *Donor Contribution Table 2000-2002, the Unified Budget (Core).*

i UNIFEM, *Annual Report 2002/2003.* Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.

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

GENERAL ODA FIGURES of the UNITED STATES[a]

Total ODA[b]		
	Million dollars	*Per cent of GNI*
2000	9 955	0.10
2001	11 429	0.11
2002	12 900	0.12

Total bilateral ODA		
	Million dollars	*Per cent of ODA*
2000	7 366	74
2001	8 228	72

Top 10 total ODA recipients 2000/2001

1. Russian Federation (OA)
2. Egypt
3. Israel (OA)
4. Pakistan
5. Ukraine (OA)
6. Colombia
7. Jordan
8. Serbia and Montenegro
9. Peru
10. Indonesia

Total Multilateral ODA		
	Million dollars	*Per cent of ODA*
2000	2 588	26
2001	3 200	28

Top 3 UN agencies in 2001 (Million dollars)

..

SPENDING on POPULATION ASSISTANCE of the UNITED STATES

Total spending on population assistance[c]		
	Million dollars	*Per cent of ODA*
1999	603	8.32
2000	658	6.62
2001	951	8.32

Bilateral spending on population assistance		
	Million dollars	*Per cent of ODA*
1999	192.9	2.1
2000	157.9	1.58
2001	172.2	1.50

"Joint programming countries" for the Center of Population, Health and Nutrition[d]

Africa	Ethiopia, Ghana, Kenya, Nigeria, South Africa, Tanzania, Uganda
Asia and North Africa	Bangladesh, Egypt, India, Indonesia, Morocco, Nepal, Philippines
South and Latin America	Peru

Multilateral spending on population assistance (Million dollars)

	2000	*2001*	*2002*
UNFPA[e]	21.5	21.5	–
IPPF	2.6	2.8	–
Total of UNFPA and IPPF	24.1	24.3	–

SRH-related organizations (Million dollars)

	2000	*2001*	*2002*
UNAIDS[f]	1.20	2.95	2.16
UNIFEM[g]	15	15	18
Global AIDS Fund[h]	..	623	..

a The DAC Journal, *Development Co-operation 2002 Report*, Vol. 4, No. 1 (2003).

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

c UNFPA/NIDI, *Financial Resource Flows for Population Activities in 2001* (September 2003).

d Countries with the highest potential for worldwide, as well as local or regional, impact across the Population, Health and Nutrition sector. Significant levels of the PHN Center resources will be committed to achieve results. The USA also identified "Joint planning countries": they are lower priority in terms of their global impact but are sites of PHN activities implemented under USAID field assistance programmes (list of 36 countries)

e OECD/DAC, *Contributions to UNFPA's Regular Resources for 2001 and 2002*, RMB UNFPA.

f UNIFEM, *Annual Report 2002/2003*. Contributions from governments. This is the figure for core contribution and does not take earmarked contributions into account.

g UNAIDS Governance, Donor & UN Relations Department, *Donor Contribution Table 2000-2002, the Unified Budget (Core).*

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