Mapping European Development Aid & Population Assistance

EUROMAPPING 2008

a joint project by:

EuroNGO

DSW

German Foundation for World Population (DSW)

EPF

European Parliamentarians on Population & Development

With the generous support of WALLACE GLOBAL FUND For a sustainable future

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Preface

Many developing countries experience low contraceptive prevalence rates and worldwide some 204 million women have an unmet need for family planning services. Annually an estimated 536,000 women die in childbirth worldwide, of which some 66,500 are the result of unsafe abortions. Some 100 million young people are among the 340 million new cases of sexually transmitted infections each year.

In 1994, at the International Conference on Population and Development (ICPD), 179 nations committed themselves to the goal of universal access to reproductive health by the year 2015. Funds needed to meet this goal were estimated at US$ 18,5 billion in 2005, US$ 20,5 billion in 2010, and US$ 21,7 billion in 2015. While reproductive health was not included as one of the Millennium Development Goals (MDGs) in 2001, Heads of Government at the World Summit in 2005 called for this omission to be remedied. As a result the UN Secretary-General has now added Target 5B on reproductive health under MDG5 (Improve Maternal Health).

Despite significant private contributions, most funding for health initiatives around the world still comes from governmental donors, predominately through overseas development assistance (ODA). Thus, monitoring the level and composition of ODA is a means of verifying whether governments are living up to their political and policy commitments.

EuroMapping provides an overview of comparative contributions as well as detailed information about an individual donor country's performance over time. EuroMapping has been and still is the only instrument that combines data from multiple sources such as the European Commission, the Organisation for Economic Cooperation and Development (OECD), the United Nations Population Fund (UNFPA) and the Nederlands Interdisciplinair Demografisch Instituut (NIDI) to produce analysis specifically calibrated to meet the needs of SRHR advocates and decision-makers.

EuroMapping provides advocates and decision-makers with the information they need to compare their government's funding to that of other European countries, to measure it against EU ODA targets, to determine whether it matched political and policy commitments and to make a specific and fact-based case for improvement. For these reasons, care has been taken to ensure EuroMapping is made available to the European and global advocates and decision-makers who most need it.

Introduction

Europe is the world's largest contributor to ODA. Following recent commitments to increase aid, the OECD estimates that European ODA could increase to US$81 billion by 2010, at which point it will comprise 63% of the world's total. As European Union Member States increasingly coordinate their ODA policies with each other via **the European Institutions, the policy and budgeting decisions made at the EU level,** particularly with regard to sexual and reproductive health, will have a progressively larger impact on the world. Already, eight of the top ten contributors to UNFPA are from Europe, as are 8 of the top ten contributors to IPPF. In this context, EuroMapping 2008 monitors the financial flows and their allocation, particularly the ODA spending on health, including sexual and reproductive health and family planning, in order to follow-up on the Government international commitments.

Transparency rhetoric notwithstanding, EU ODA funding flows and development cooperation mechanisms remain complicated and non-transparent, with key pieces of information hidden in various places. The implications of the changing policy and funding environment for SRH/ICPD may turnout to be massive, but it is difficult for advocates to know where the money is going. Will policy commitments issued from the EU supporting the ICPD agenda be undermined by funding mechanisms that re-route funds to other priorities? Will the EU's leadership role in SRH be turned into empty rhetoric? SRH advocates need up to date and scaled-up "watchdog" data and analysis to prevent the serious diminishment of ODA SRH support. As European countries grapple with a generalised economic downturn in 2008, perhaps even a recession, actionable information on ODA becomes ever more important if Europe is to remain committed to meeting the Millennium Development Goals (MDGs). In this context, EuroMapping stands out as the premier vehicle where comparable data on ODA and sexual and reproductive health funding for all major donor countries is compiled in an advocate and decision-maker friendly format.

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Findings and Recommendations

The Steps Ahead

Findings and Recommendations

Main findings

Main findings on EU ODA: good and bad news (ODA change between 2006 and 2007)

The conclusions regarding European ODA are very mixed. The good news is that:

> the European Union (ie. the EC and 27 Member States) accounted for 64% of all ODA in the world in 2007;

> the 'best performers' in ODA are in Europe, with Denmark, Luxemburg, The Netherlands, Norway and Sweden all above the UN target of 0,7% ODA/GNI again in 2007;

> the donors who have 'most improved' are European, with Spain having increased by 50% its ODA and the three Baltic States (Estonia, Latvia and Lithuania) reporting the largest annual increases among Europe's emerging donors, the New Member States.

However, turning to the bad news:

> European aid fell from 0,43% ODA/GNI in 2006 to just 0,40% ODA/GNI in 2007;

> In real terms, EU ODA decreased by €1,6 Billion;

> European donors which relieved larges segments of debt in 2006 were not able to maintain their ODA efforts in following years and reported ODA decreases in 2007 (France, UK, Portugal);

> a significant percentage – 17% - of European ODA is deemed to be 'inflated', with Germany leading at 32% inflated ODA;

> Finally, new ODA disbursement modalities, such as budget support, make monitoring challenging. The resulting lack of transparency and accountability risks undermining health outcomes particularly for sensitive areas as sexual and reproductive health.

Findings and Recommendations

Main findings

Conclusions on European ODA

If the EU lives up to its commitments, EU aid levels would rise throughout 2007 – 2010. Positive economic growth would allow the EU to mobilise an extra €27–30 billion annually compared to 2006, thus more than the €20 billion initially projected.

However, the amounts that Member States are forecasting remain vulnerable to GNI developments and therefore, might not meet the targets. The forecast of several Member States are not yet secured by clear annual budget increases, and still depend on ad hoc developments. Although the EU ODA trend is increasing (year 2007 - €52,7 billion), it is not reflected by real aid disbursement (€46 billion). Also, some EU-12 (the Member States that have joined since 2004) have yet to demonstrate how they intend to further increase their aid volumes in the run-up to 2010.

Findings and Recommendations

Main findings

Main findings on Population assistance

While funding for population assistance increased by 42% in 2005 over the previous year, the overwhelming majority of all population assistance funding is now for HIV/AIDS. Other components of population assistance such as family planning, basic reproductive health services and research are left with ever smaller shares of funding.

In 2005, the largest European donors to population assistance were once more the United Kingdom, followed by the Netherlands and the European Commission replacing France in third position. In terms of generosity, ie, funding for population assistance per capita, Norway led with US$ 41 population spending from the average Norwegian taxpayer, followed by US$ 29 from the Netherlands and Luxembourg. In 2005, Sweden fell to fourth place in generosity with the average Swede spending US$ 24. Among Europe's least generous were Greece, Austria, Portugal and Italy who all spend less that one US$ per capita on population assistance.

Finally, a major challenge has emerged in tracking population funding from European donors. Many European donors are changing the manner in which they disburse ODA in favour of budget support, ie. supporting developing countries by funding directly state budgets globally and on a given issue, such as health. With this manner of funding gaining ground in a number of European donors, whether donor funding contributes to improved sexual and reproductive health is impossible to track.

Findings and Recommendations

Specific findings

Specific findings on Population assistance

European Population Champions:

> European donor support for population funding is strong thanks to the leadership of two countries, namely the United Kingdom and the Netherlands, which together account for 46% of total European spending on population activities. Other European donors are also key supporters of population activities, among them the EC, Sweden, Norway, France and Germany.

Population funding levels:

> In total, 12 European donors increased their spending on population activities between 2004 and 2005 (UK, Netherlands, EC, Sweden, Norway, Germany, Spain, Ireland, Belgium, Switzerland, Greece and Austria), six of these, significantly. Ireland and Spain increased their spending on population assistance relative to ODA the most, earning both countries a place among the 10 most generous European population donors.

> On the other hand, two countries maintained (Denmark and Luxembourg) and three reduced their population assistance spending (Italy, Finland, France)

Population assistance within ODA:

> Spending on population assistance did not keep pace with overall ODA increases. The Netherlands, Norway, the UK, Sweden, Luxembourg, Belgium and Finland all allocated proportionally less to population activities in 2005 than in 2004.

> However, the Netherlands, Ireland, Norway, the UK and Sweden, all allocate 6% or more of ODA to population assistance, demonstrating that they are on track towards meeting the International Parliamentary commitment of allocating 10% of ODA to population assistance, established by the International Parliamentary Conference on Implementation of the ICPD Programme of Action first in 2002 (and reconfirmed in 2004 and 2006).

Findings and Recommendations

Specific findings

HIV/AIDS in Population:

> While funding for population assistance from all DAC donors has quintupled between 1995 and 2005, the vast majority of this new funding has gone to one specific sub-component of population assistance: HIV/AIDS. Relative (ie. %) and absolute funding for all other sub-components of population assistance (family planning services, basic reproductive health services and basic research) have decreased.

Funding to SRHR-related organisations:

> European support to SRHR-related organisations in 2006 increased to US$ 1,75 billion, ie. a 27% increase over 2005.

> The SRHR-related organisations which benefited the most from this boon are UNAIDS and the GFATM. UNFPA, UNIFEM and IPM also benefited from the increase in multi-lateral spending and contributions to the world's largest NGO in the field of population, IPPF, held steady.

> Among EU donors, the champion multilateralists are France, accounting for 17% of all EU contributions to SRHR-related organisations, followed by the United Kingdom and the Netherlands.

> Between 2005 and 2006 European philanthropic spending for HIV/AIDS increased by 18%.

Findings and Recommendations

General recommendations

Advocates and policy-makers should engage with the new aid architecture:

> The architecture governing ODA has changed dramatically in recent years. No longer can ODA be understood as a clear division between bilateral and multilateral aid with key decisions made in European donor capitals. New aid mechanisms have been created and are attracting much of new funding for global health and have the potential to increase funding for population assistance, examples include the GFATM and UNITAID. Moreover, the trend towards budget support places limits on the influence of Northern-based advocates and policy-makers as budget support is, by definition, meant to respond to beneficiary governments' priorities.

Improve financial and outcome data collection consistent with new aid architecture:

> Donors are moving away from output based indicators of ODA performance (such as funding volumes) in favour of indicators based on outcomes, ie. improved health outcomes in developing countries. As existing data on sexual and reproductive health are notoriously incomplete (for example on maternal health), the international community needs to step up efforts to generate reliable and realistic health data at country level. In addition, methodologies to track a beneficiary country's financial support towards sub-sectors within a state budget need to be explored.

Strengthen SRH watchdog capacity in recipient countries:

> As ODA recipient governments in the global South are increasingly empowered by new ODA decision-making modalities, a system of 'checks and balances' as it exists in donor countries must emerge. The 'country-ownership' which many European donors strive to cultivate among their developing country partners should not mean exclusively 'government-ownership' nor 'Executive branch ownership'. Civil society and parliaments must take their rightful place in decision-making, by acting as watchdogs of their governments, as they do in donor countries.

General recommendations

Increase North-South SRH advocacy communication:

> European donors are increasingly delegating much of the decision-making authority on development priority setting to their representatives in developing countries, such as EC delegations and Member State Embassies. Furthermore, agreements at EU level require EU member State representatives in developing countries to cooperate on all aspects of the EU's approach to development in any given country – this is known as the 'EU division of labour'. This new paradigm in EU decision-making on development cooperation requires a dual track approach to advocacy - both in the North in Europe, to be backed-up in the South in developing countries where the EU is present.

Support advocacy to increase overall ODA disbursements:

> Increased efforts are required to reverse the downward trend in European ODA, particularly in those countries where ODA has declined most. With the possibility of a negative economic perspective in Europe in 2008-09, development and population advocates should articulate convincing arguments for the long-term social, economic and security benefits which development aid and population assistance generate.

Support efforts to escalate HIV/AIDS and SRH integration in the field:

> While funding for sexual reproductive health and family planning has decreased in both real and relative support, funding for HIV/AIDS has sky-rocketed. Given that much of HIV/AIDS programming is so intimately linked with various components of reproductive health and family planning, particularly in prevention, education and provision of HIV/AIDS and family planning commodities, exploring how these may be better integrated would increase health outcomes in both sexual and reproductive health and HIV/AIDS.

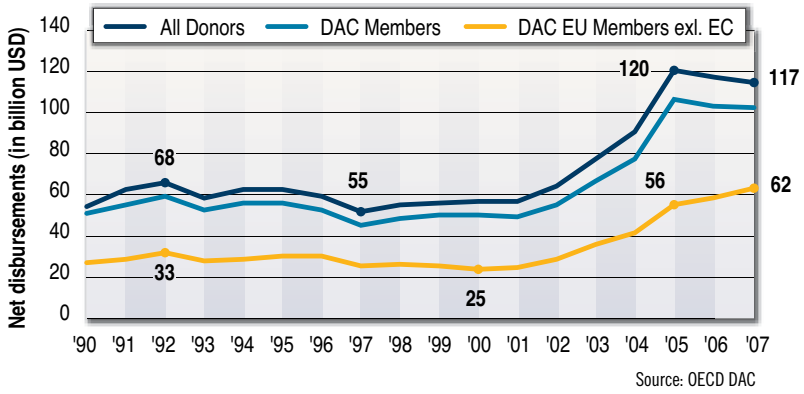
Official Development Assistance

Commitments and Disbursements

Official Development Assistance (ODA)

ODA volume – historical overview:

ODA volume from 1990 to 2007



Source: OECD DAC

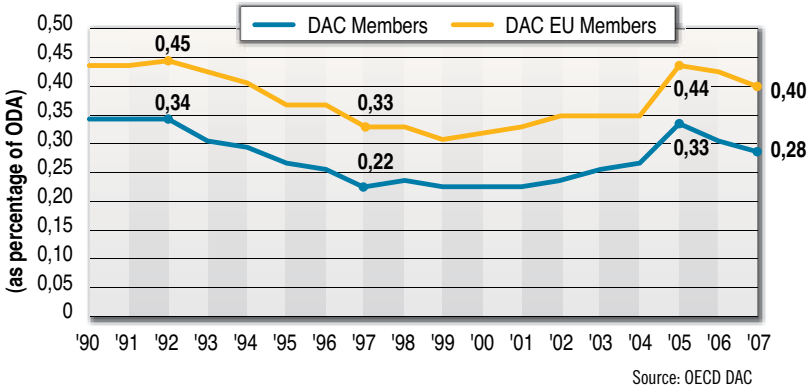
ODA volumes declined for a second year in a row, having peaked in 2005 as a result of the combined effort in debt relief and providing assistance to the countries affected by the Asian tsunami. The decrease is most noticeable in non-EU DAC members as a result of exchange rate fluctuations, specifically the weakening of the US dollar vis-à-vis main European currencies, chief among them the Euro.

As proof, the EU DAC donors appear to increase slightly their US dollar aid volume in 2007 to $62 Billion, but when compared to the Euro original disbursements, the volume disbursed in Euros actually decreased by €1,6 billion between 2006 and 2007.

Official Development Assistance (ODA)

ODA commitment – historical overview:

ODA efforts from 1990 to 2007



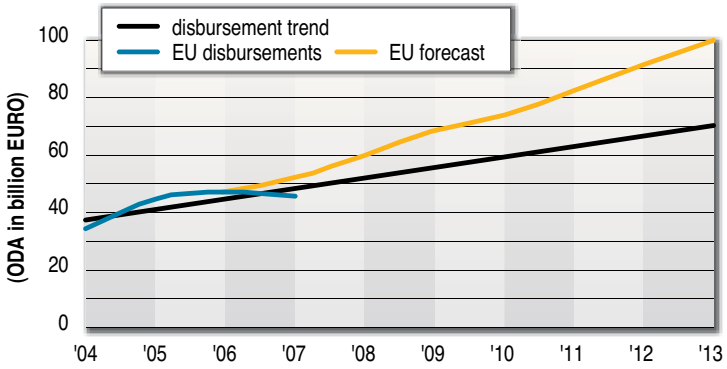
Source: OECD DAC

ODA efforts declined for the second year in a row, down 15% for DAC Members and down 9% for EU DAC Members in 2007 compared to 2006. The downward trend was noticeable among OECD DAC members both within and outside the European Union and follows an ODA peak in 2005 attributable to debt-relief efforts an additional aid following the December 2004 tsunami in Asia. Indeed, in 2007 ODA effort measured in ODA as percentage of Gross National Income (GNI) was roughly equivalent to ODA effort in 1994.

Nonetheless, even if the declining ODA effort is noticeable across DAC donors, European Union DAC donors remain well above the DAC average. While the average ODA/GNI for all DAC members was 0,28% in 2007, in the EU it stood at 0,40%. With a declining performance, the EU remains further away from its stated goal of allocating 0,51% ODA/GNI in 2010 and 0,7% in 2015.

Europe's performance in Euros and Dollars

EU ODA Volume – forecast and disbursed



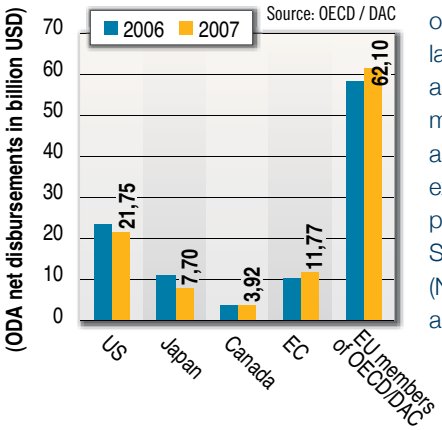
Sources: EC Communication: "Keeping Europe's promises on Financing for DevelopmentApril 2007; EC Communication: "The EU – a global partner for development", 2008

In 2007, the EU only disbursed €46 billion, €1,6 billion decrease in one year, and €6 billion short of expectations of disbursing €52,7 billion. As the Euro disbursements provide a more accurate picture of the level of European effort in ODA than US dollars figures, the decline in actual Euro disbursements should outweigh the appearance of a EU ODA increase in US dollars. The US dollar increase in EU ODA is attributable to the weakening US dollar in 2007. However, over a longer period, the EU has been increasing its ODA disbursement in Euros from €34,7 billion in 2004 to €47,6 billion in 2006.

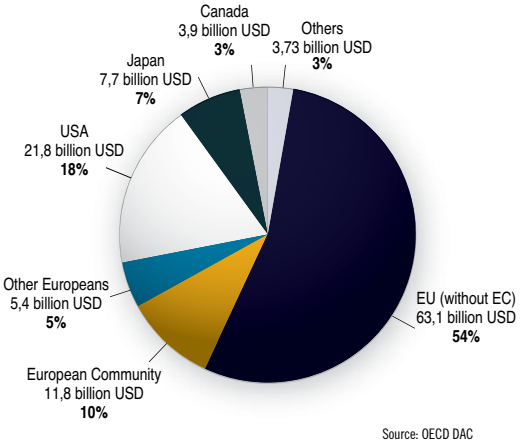
Official Development Assistance (ODA)

ODA volumes : Europe and the world

Top ODA donors



Europe wields a major influence on development as the world's largest donor of official development assistance. The European Commission manages 20% of EU development assistance, and this alone now exceeds World Bank ODA. The aid programmes of the EU, its Member States and other European donors (Norway and Switzerland) account almost 70% of all ODA.



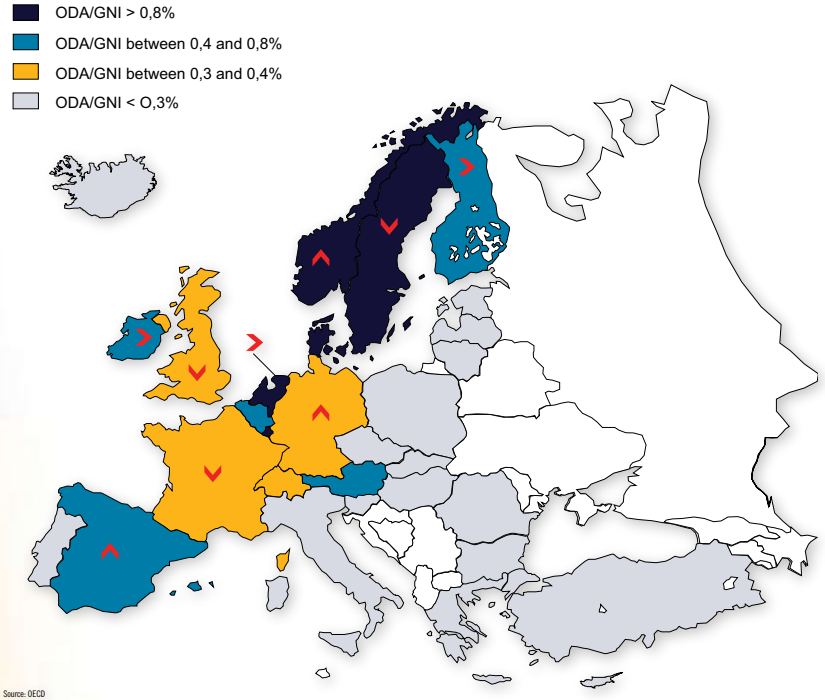
Source: OECD DAC

Official Development Assistance (ODA)

Europe's most committed donors

Five European countries - Sweden, Norway, Luxembourg, The Netherlands and Denmark - have all exceeded the UN commitment to contribute 0,7% of GNI to ODA. Ireland, Spain, Switzerland, Finland and Belgium are well on track to achieve the 0,7% aim within the set time frame, committing currently between 0,4% and 0,7% of their GNI to ODA. The front-runners are the nine Member States that have either achieved the 0,7% target or decided to reach it prior to 2015. Particularly outstanding is the performance of Sweden now allocating 0,93% of its GNI to aid followed by Luxemburg allocating 0,9%.

ODA as % of GNI (2007)



Source: OECD

Official Development Assistance (ODA)

ODA volume: Europe's most generous donors

Luxembourg, Norway and Sweden spend the most per capita on ODA. Moreover, the two most generous donors are also the ones which have increased the most in their generosity: Luxembourg and Norway. Out of 19 European donor countries, 14 have all become more generous between 2006 and 2007 – some significantly so with Luxembourg, Norway, Denmark, Ireland, the Netherlands, Spain, Sweden, Austria, Finland and Germany all increasing their ODA/capita between 2006 and 2007 between US$ 20 and US$ 200.

The least generous donors such as Spain, Italy, Greece and Portugal are improving, albeit slowly. Decreases were recorded in two of the EU largest economies with the United Kingdom providing US$ 43 less per British taxpayer in 2007 and France with US$ 11 less per capita.

Ranking: ODA per capita (2007)

	Country	USD								
1	**Luxembourg**	810	(+196)	8	**Austria**	218	(+36)	14	**Spain**	132 (+44)
2	**Norway**	803	(+164)	9	**Belgium**	187	(-2)	15	**Italy**	67 (+5)
3	**Sweden**	479	(+39)	10	**Finland**	185	(+27)	16	**Greece**	45 (+7)
4	**Denmark**	472	(+62)	11	**UK**	165	(-43)	17	**Portugal**	39 (+2)
5	**Netherlands**	380	(+49)	12	**France**	164	(-11)	18	**Czech Rep**	17 (+1)
6	**Ireland**	297	(+52)	13	**Germany**	149	(+23)			
7	**Switzerland**	226	(+5)							

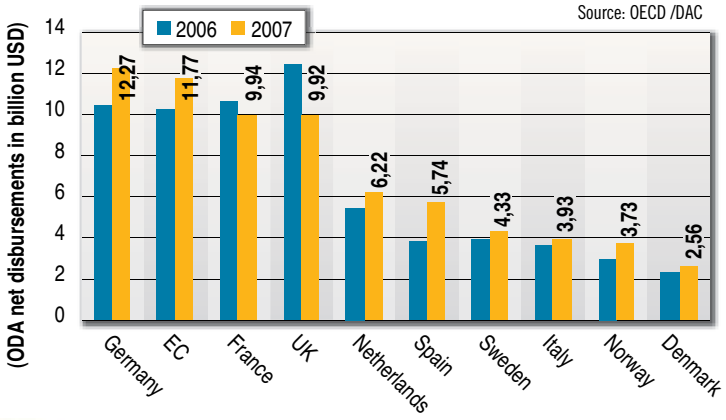
Source: OECD DAC / Euromapping

Official Development Assistance (ODA)

ODA volume: Europe's biggest donors

The top European donors in 2007 remained Europe's large economies, namely Germany, France, United Kingdom and the EC each with an average ODA in the US$ 9-13 billion range. Among the large donors, the good news is an ODA increase from Germany and the EC (increases of 17% and 15% respectively). However, France and the United Kingdom both decreased their ODA, respectively by 10% and 24%.

Top 10 European donors

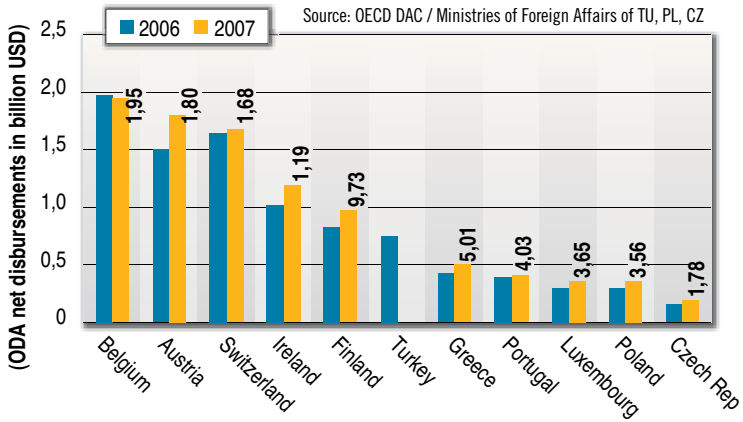


Official Development Assistance (ODA)

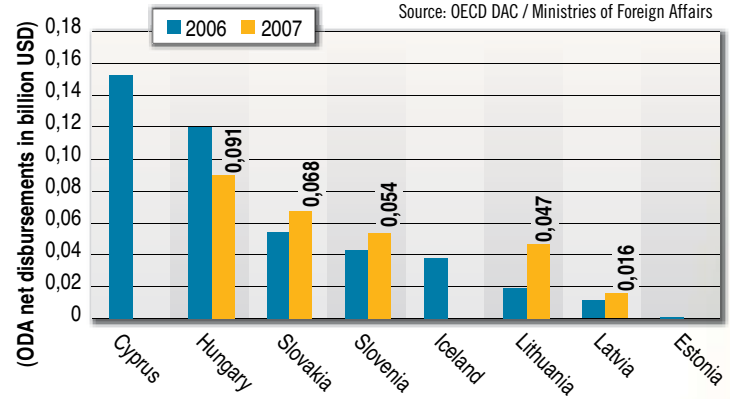
ODA volume: Europe's biggest donors

ODA performance was more consistently promising outside the large economies of Europe, with net increases from the Netherlands, Spain, Sweden, Italy, Norway and Denmark. Spain particularly stands out with an annual ODA increase of 51% between 2006 and 2007.

Middle ground donors



Small donors

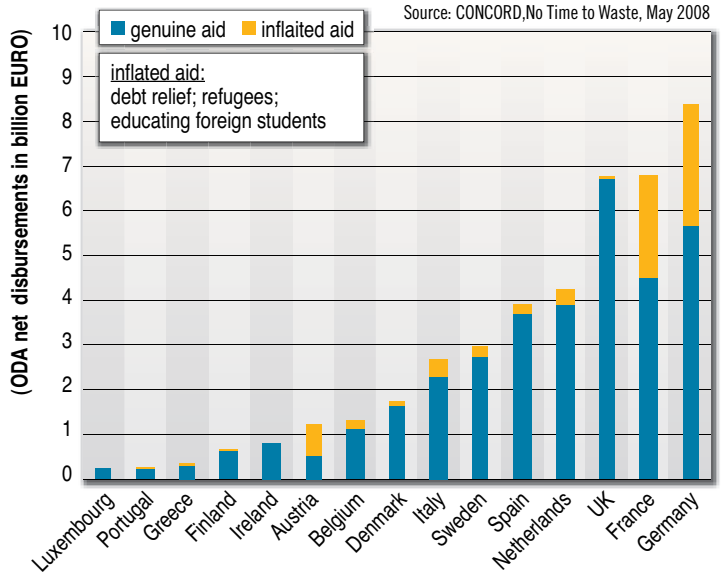


ODA commitment: real commitment versus 'inflated' commitment

A significant proportion of aid is deemed to be 'inflated'. According to the report No time to waste: European Governments behind schedule on aid quantity and quality released in May 2008 by Concord (European NGO Confederation for Relief and Development), most European governments continue distorting their aid figures by counting spending on debt relief, educating foreign students and support to refugees in Europe as part of ODA.

In 2007 European countries spent almost €8 billion on these non-aid items, making up 17% of all European ODA. Debt cancellation is still the majority of the inflated aid with €5 billion spent in 2007. When non-aid items are excluded, the EU 15 countries provided collectively 0,33% of GNI as aid in 2007.

Genuine and inflated aid in 2007



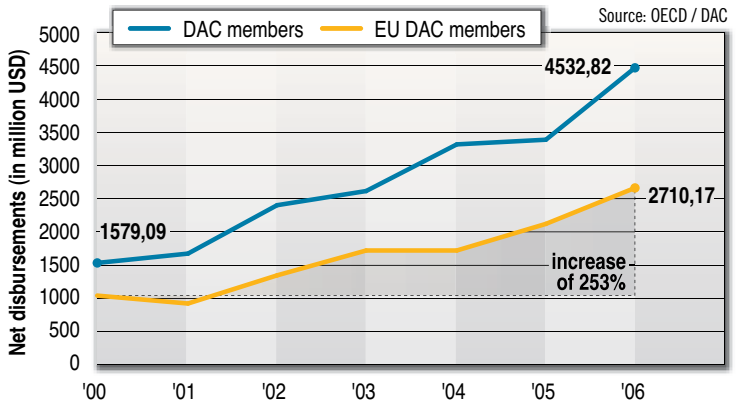
Official Development Assistance (ODA)

On the positive side, the share of inflated aid has declined dramatically in 2007 compared to previous years. This is largely because the ODA figures contain less debt relief than earlier. The UK, for example, does not include refugee costs in its aid accounting and the Spanish government has agreed to exclude debt cancellation from its ODA figures, but only when it reaches the 0,7% level. Finally, not a single EU donor has committed to stop inflating its aid figures.

ODA volume: global health spending

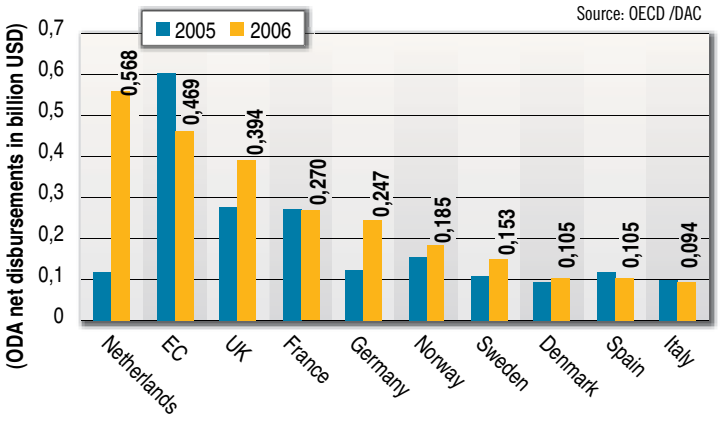
All donor countries have made significant strides in increasing health-related ODA, particularly since 2000, the year when the Millennium Declaration and the MDGs were adopted. Between 2000 and 2006, health ODA increased by 287% among all donors reaching US$ 4.532,82. Among European donors, health ODA increased by 253% over the same period, to reach US$ 2.710,17. In 2006, European donors accounted for 60% of all health ODA.

Health ODA efforts from 2000 to 2006



Global health funding: the main players in Europe

Top 10 European health-donors



European donor support for health ODA is strong, yet unevenly divided among Member States. Until 2005, the EC, the UK and France accounted for over 43% of all European health ODA. Only in 2006 did the Netherlands, Germany and Sweden step up their efforts in health ODA spending, as well as the United Kingdom. The same year saw a significant decrease in health ODA from the EC and a smaller decrease from France.

Official Development Assistance (ODA)

Case study 1:
Budget support – a new trend in disbursing ODA

Many European donors are changing the way they disburse their funds in their application of the Paris Declaration on Aid Effectiveness. A new manner of disbursing funds, known as 'budget support' entails donor governments supporting financially the state budgets globally of partner developing countries and in a given sector, such as health. The UK, Netherlands, Sweden, Ireland and Denmark, all population funding champions, are increasing general budget support as a percentage of their total ODA. The EC plans to allocate 50% of its aid through budget support by 2010 and already €13,5 billion of the 10th European Development Fund (EDF) is channelled through budget support. Major recipients of EC budget support include: Burkina Faso, Mozambique, Tanzania, Niger, Madagascar, Zambia, Mali, Ghana, Cambodia, Lao PDR and Vietnam.

While an advantage of budget support is that it ensures that the funds are aligned with the developing countries' plans and priorities, it does pose some challenges. Among these challenges are, first of all, that it is impossible to track how much funding is allocated to a specific sub-sector, such as population/sexual and reproductive health. Second, given the very nature of sexual and reproductive health and the sensitivity which often surrounds the subject, it is possible that the sexual and reproductive health could be neglected under the cloak of budget support.

HIGHLIGHTS

> **€13,5 billion BS in the 10th EDF**
> **EC plans 50% of its aid through BS by 2010**
> **The UK, Netherlands, Sweden, Ireland and Denmark increasing general budget support as a % of total aid**
> **Germany plans 50% for ODA in Sub-Saharan Africa**
> **Major EC recipients: Burkina Faso, Tanzania, Zambia, Niger, Mozambique, Mali, Madagascar, Ghana and Cambodia, Laos, Viet Nam.**
> **No way to track funding by sector**

Source: DSW Fast Facts "Budget Support Consequences for SRH"

Case study 2:
MDG contracting – the EC's gamble on performance

The EC would like to provide a more long-term and predictable form of general budget support "whenever deemed possible" during the implementation of the 10th EDF. This enhanced form of general budget support will take the form of an "MDG contract" to highlight the contractual nature of its long term financial commitments and its focus on MDG-related results, notably in health and education.

Countries are eligible for MDG Contracting if they have a successful track record in implementing budget support, commitment to monitoring MDGs and improve domestic accountability for budgetary resources, active donor coordination and mechanisms to support performance review and dialogue.

The primary difference between MDG contracting and general budget support is that performance review can only lead to changes in the allocation after the first three years. This increases aid predictability and can deepen the EC's dialogue with its partner countries on poverty reduction outcomes. The EC has begun developing 'MDG contracts' in a limited number of countries. The EC plans to extend MDG contracts to other countries, including Asian countries, at a later point.

HIGHLIGHTS

> **EC piloting in 10 countries, possibly**
- **Benin**
- **Ghana**
- **Mozambique**
- **Rwanda**
- **Uganda**
- **Burkina Faso**
- **Mali**
- **Madagascar**
- **Tanzania**
- **Zambia**

> **Up to 30% variable tranche**
> **Up to 15% of total budget support tied to MDG performance indicators**
> **Reduced volatility?**

Source: DSW Fast Facts "Budget Support Consequences for SRH"

For more information on budget support and MDG contracting, visit : http://www.dsw-online.de/en/Fast_fact_Budget_Support_26_june_2008.pdf

Population Assistance

Funding Trends

Population Assistance

Definitions

According to the OECD, spending on population policies/programmes and reproductive health includes:

> Population policy and administrative management; population/development policies; census work, vital registration; migration data; demographic research/ analysis; reproductive health research; unspecified population activities.

> Reproductive health care; promotion of reproductive health; prenatal and postnatal care including delivery; prevention and treatment of infertility; prevention and management of consequences of abortion; safe motherhood activities.

> Family planning Family planning services including counseling; information, education and communication (IEC) activities; delivery of contraceptives; capacity building and training.

> STD control including HIV/AIDS All activities related to sexually transmitted diseases and HIV/AIDS control e.g. information, education and communication; testing; prevention; treatment, care.

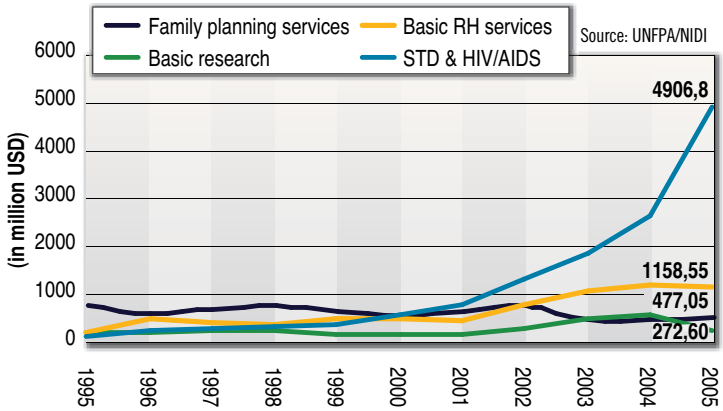
> Personnel development for population and reproductive health; education and training of health staff for population and reproductive health care services

Note: Breakdown of data concerning population spending is only available up to 2005.

Population Assistance

Population assistance: breakdown by sector

While population assistance of OECD Member states dramatically increased from 1995-2005, most of this went to HIV/AIDS (72% of 2005 total). Funds for family planning represent the second smallest % of the total (7% of 2004 total) and have decreased in recent years. Funds for basic RH have remained relatively stable in volume (17% of 2004 total), while funding for population research has decreased to it's lowest level (4% of 2004 total).

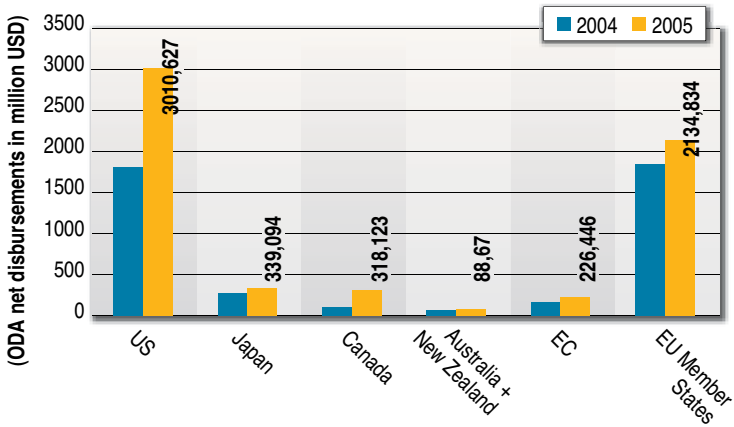


	1995	2000	2004	2005
Family planning services	55%	29%	9%	7%
Basic reproductive health services	18%	29%	22%	17%
STD and HIV/AIDS activities	9%	32%	57%	72%
Basic research	18%	9%	12%	4%
Million USD	1314	1781	4813	6815

Source: OECD DAC / Euromapping

Population assistance:

Spending on population assistance



Source: UNFPA, "Financial Resource Flows for Population Activities in 2005"

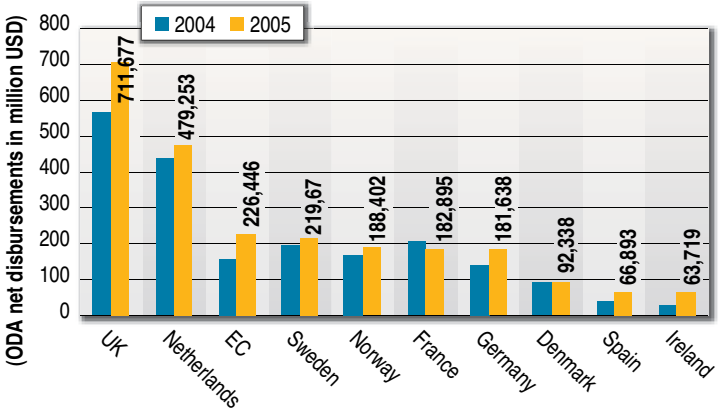
Funding for population assistance from the world's donor countries is roughly evenly divided between Europe on the one hand and the United States on the other, with Japan and Canada also making a significant effort. The increase in US population assistance in 2005 is attributable to the additional funding available through the President's Emergency Plan for AIDS Relief (PEPFAR). Therefore, much of the new US funding for population assistance is earmarked for HIV/AIDS and within this new AIDS funding, the US supports so-called 'abstinence-only' around the world which many advocates believe undermines other sexual and reproductive health/family planning efforts.

For more information, please visit: www.popact.org

Population assistance: Europe's largest donors

The UK was the largest European donor to population assistance in 2005, and also the country which most dramatically increased its funding directed towards population assistance between 2004-2005 with an increase of almost US$ 150 million, reaching US$ 711 million. The Netherlands was the second biggest European donor allocating US$ 479 million to population assistance. All countries increased their funding except for France, Finland, Italy and Luxembourg which decreased and Denmark which spent the same amount directed toward population assistance between 2004-2005.

Spending on population assistance



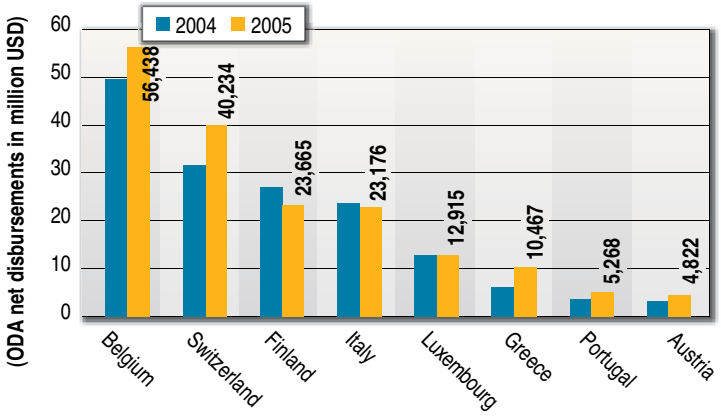
Source: UNFPA, "Financial Resource Flows for Population Activities in 2005"

Population assistance:

Among the middle and small European donors to population spending the trend is generally positive. Belgium, Switzerland, Greece, Portugal and Austria all made net increases in population funding in 2005, while remaining under the US$ 60 million benchmark.

European Parliamentarians, agreed unanimously to allocate at least 10% of development assistance to population and reproductive health programmes at the past three International Parliamentary Conferences on the Implementation of the ICPD Programme of Action (Ottawa in 2002, Strasbourg in 2004 and Bangkok in 2006). This 10% commitment by Parliamentarians sets the foundation upon which Parliamentarians and many NGOs hold their governments to account on their population spending.

Since the original commitment was made in 2002, all European countries have increased the share of ODA they allocate to population. The Netherlands, Ireland, Norway, the United Kingdom and Sweden have all increased their population spending to above 6% of ODA, placing them within sight of the 10% target.



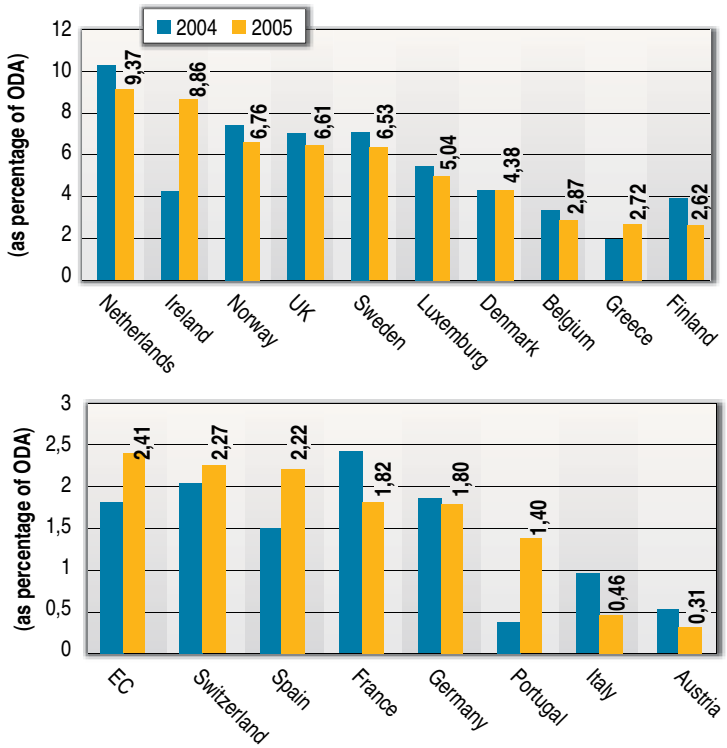
Source: UNFPA, "Financial Resource Flows for Population Activities in 2005"

Population Assistance

During the ODA peak in 2005, most European donors failed to keep up their support of population aid within their increased ODA. This has resulted in smaller proportions of ODA allocated to population activities throughout Europe. After reaching the 10% mark in 2004 (10,52%), the Netherlands missed it in 2005 (9,37%) . From 2004 to 2005, Netherlands, Norway, UK, Sweden, Luxembourg, Belgium, Finland, France, Germany, Italy and Austria decreased the percentage of ODA spent on population assistance.

Ireland, Greece, EC, Switzerland, Spain and Portugal on the other hand increased population spending with Ireland and Portugal standing out in its increase share. Denmark's ODA currently devoted to population and reproductive health programmes has remained on the same level.

Spending on population assistance



Source: UNFPA, "Financial Resource Flows for Population Activities in 2005"

For more information, please visit: www.iepfpd.org

Population Assistance

Population assistance:

Norway, the Netherlands and Luxembourg spend the most per capita on population assistance and reproductive health programmes. In 2005, Ireland and Norway increased their spending on population assistance per capita most significantly. Norway increased the spending per capita to US$ 41 (US$ 36 in 2004). Ireland's per capita spending rose by US$ 9 to US$ 16. Significant differences can be seen between the biggest donors per capita and the smallest, with Norway contributing US$ 41 per capita compared to Italy, Portugal, and Austria which contribute only US$ 0,4, respectively US$ 0,5 and US$ 0,6.

2005 USD per capita (and change vs 2004)

	Country	USD (2005)	
1	**Norway**	41	(+5)
2	**Netherlands**	29	(+2)
3	**Luxembourg**	29	(0)
4	**Sweden**	24	(+2)
5	**Denmark**	17	(-1)
6	**Ireland**	16	(+9)
7	**UK**	12	(+2)

	Country	USD (2004)	
8	**Belgium**	5	(0)
9	**Denmark**	5	(+1)
10	**Finland**	4	(-1)
11	**France**	3	(0)
12	**Germany**	2	(0)
13	**Spain**	1,6	(+0,7)

	Country	USD (2004)	
14	**Greece**	0,9	(+0,5)
15	**Austria**	0,6	(+0,2)
16	**Portugal**	0,5	(+0,1)
17	**Italy**	0,4	(0)

Source: UNFPA, "Financial Resource Flows for Population Activities in 2005"

Case study 3:
EC's financial support for population

The European Commission channels a portion of its ODA through calls for proposals which are open to 'non-state actors' (NSAs), namely non-governmental organisations, inter-governmental organisations and local authorities in developing countries and the European Union. Over the 2007 and 2008 period, 59 such calls for proposals were issued by European Commission and EC delegations around the world, for a total budgetary envelope of €169,29 million. Broadly speaking, the calls were to fund 'actions in developing countries' and 'raising awareness in Europe' of development issues.

Of the 59 calls for proposals, seven prioritised reproductive health, providing a budgetary envelope of €14,98 million, ie. 9% of total funding available under all calls for proposals. These seven calls which prioritised reproductive health were issues by the EC delegations in Cambodia, Kenya, Mozambique, Nepal, The Philippines, Pakistan and Rwanda. No call for proposals issued for awareness raising in Europe prioritised reproductive health/population.

HIGHLIGHTS

> 59 calls for proposals for €165,29 million
> Actions in Developing Countries
> Raising Awareness in Europe
> 7 calls for €14,98 million prioritize RH (9%)
These calls were launched by EC delegations in:
- **Cambodia**
- **Kenya**
- **Mozambique**
- **Nepal**
- **Philippines**
- **Pakistan**
- **Rwanda**

Source: DSW Fast Facts EC's NSA funding and SRHR (in draft)

Population Assistance

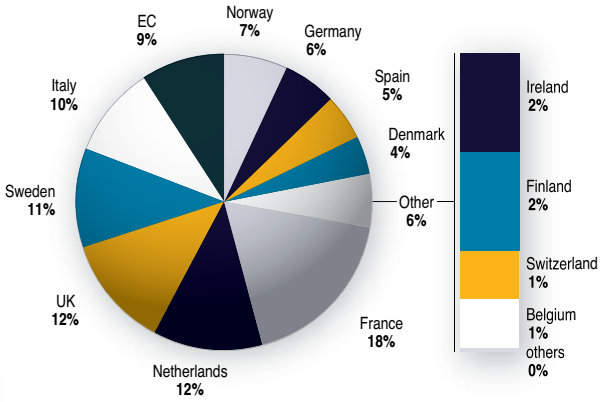
Contributions to SRHR related Organisations

UNFPA, IPPF, GFATM, UNAIDS, UNIFEM & IPM

Contributions to SRHR related Organisations

Population assistance: European champion multilateralists

European disbursements (2006) by donor



Source: UNFPA, IPPF, UNIFEM, UNAIDS, IPM & GFATM donations in 2005 from European countries and the EC

Spending 2006 in mill. USD

Total	2778

Recipients 2006 in mill. USD

UNFPA	377
IPPF	77
UNIFEM	58
UNAIDS	188
IPM	46
Global Fund	2032

Source: UNFPA, IPPF, UNIFEM, UNAIDS, IPM & GFATM donations in 2005 from European countries and the EC

In 2006, France took the lead as the top European donor to SRHR-related organisations accounting for 18% of support to these organisations. The UK and the Netherlands follow, accounting for 12% each. Together with the EC, France is the only donor which increased its contribution to SRHR organisations in 2006. Its aid to the Global Fund (GFATM) increased by almost US$ 112 million to US$ 293 million USD. Ten European Countries – the Netherlands, Sweden, Denmark, Italy, Germany, Switzerland, Belgium, Finland, Ireland and Norway - have decreased their contributions compared to the previous year.

Overall, European disbursements to SRHR organisations increased by almost US$ 287 million between 2005 and 2006 amounting to US$ 1133,97 million in 2006. The Global Fund to fight Aids (GFATM), Tuberculosis and Malaria received the biggest support, followed by UNFPA.

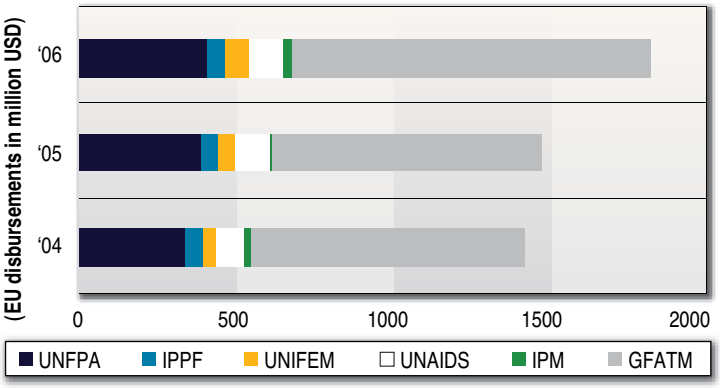
Contributions to SRHR related Organisations

Population assistance: European champion multilateralists

Funding for the GFATM contributes to overall population efforts through its support of HIV/AIDS activities. However, a significant proportion of GFATM has no impact on population assistance, namely the GFATM's support to malaria and tuberculosis activities.

The nature by which the GFATM disburses funds, based on proposals it receives over the course of various funding rounds, makes it challenging to compare contributions to the GFATM with sector specific funding. As an example, in Round seven starting in November 2007, 61% GFATM went to HIV/AIDS, 25% to malaria and 14% to tuberculosis.

European disbursements (2006)



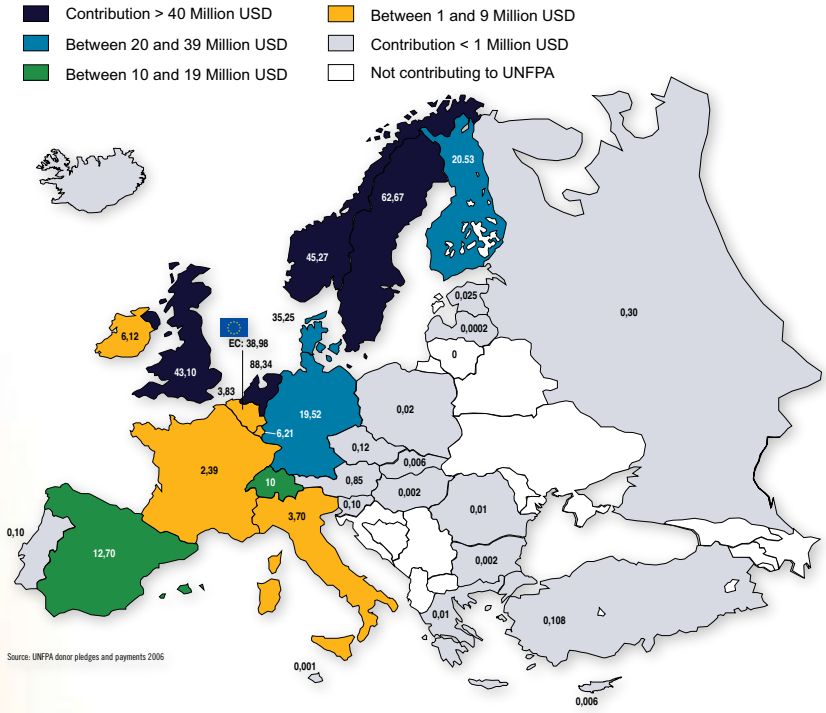
Source: UNFPA, IPPF, UNIFEM, UNAIDS, IPM & GFATM donations in 2005 from European countries and the EC

Contributions to SRHR related Organisations

Population assistance: increasing support to the UN Population Fund (UNFPA)

In 2006, all EU Member States made a voluntary contribution to UNFPA except for Latvia which made a pledge but did not disburse any funds, and Lithuania which made no pledge at all. Sweden, Norway and the Netherlands are the biggest European funders of UNFPA, contributing over US$ 40 million each. Denmark and the UK contribute over US$ 30 million each to UNFPA. Emerging donors around Europe are increasing their support for UNFPA, namely the EU 12 (the countries which have joined the EU since 2004) as well as Turkey and the Russian Federation.

UNFPA 2006 (in million USD)

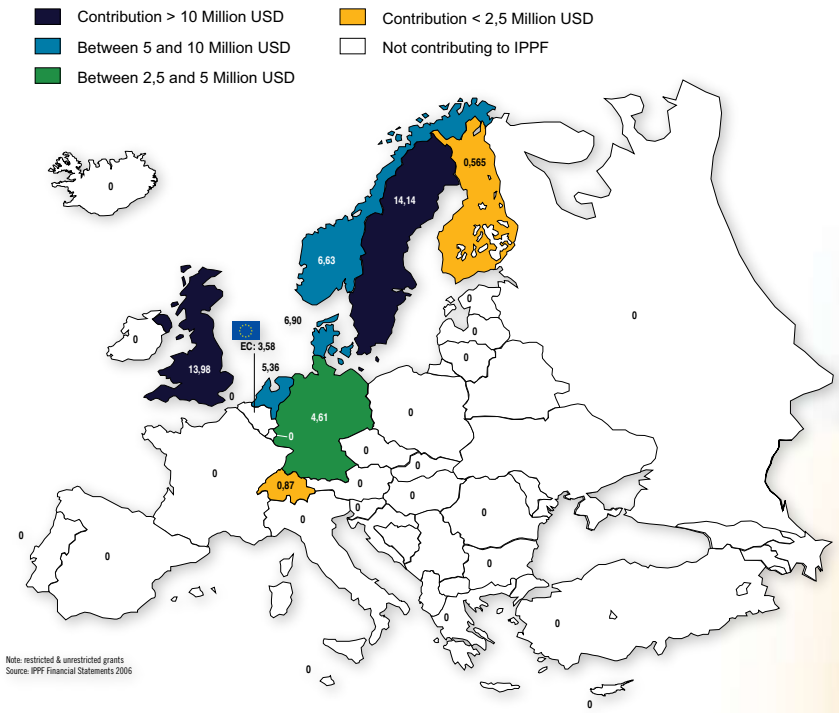


Contributions to SRHR related Organisations

Population assistance: steady support for International Planned Parenthood Federation (IPPF)

The biggest European donors to the International Planned Parenthood Federation in 2006 were the United Kingdom with US$ 13,98 million and Sweden with US$ 10,61 million. In 2006, Sweden again increased its contribution by slightly less than US$ 4 million and UK increased its contribution by US$ 2,71 million. Contributions from Denmark, Norway and the Netherlands have all remained constant.

IPPF 2006 (in million USD)

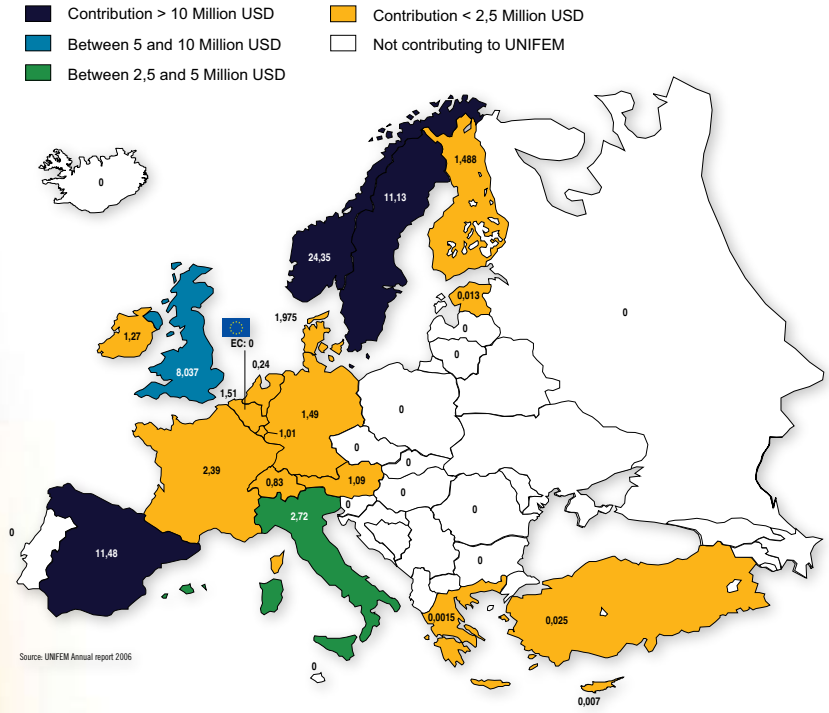


Contributions to SRHR related Organisations

Population assistance: improving European support to the United Nations Development Fund for Women (UNIFEM)

UNIFEM is benefiting from increased European support, although this support is unevenly divided among European donors. While three European donors each provide voluntary contributions of US$ 10 million or more, such as Sweden, Norway and Spain, other large European donors provide not support (EC and France) or proportionally very little (Germany and Netherlands).

UNIFEM 2006 (in million USD)

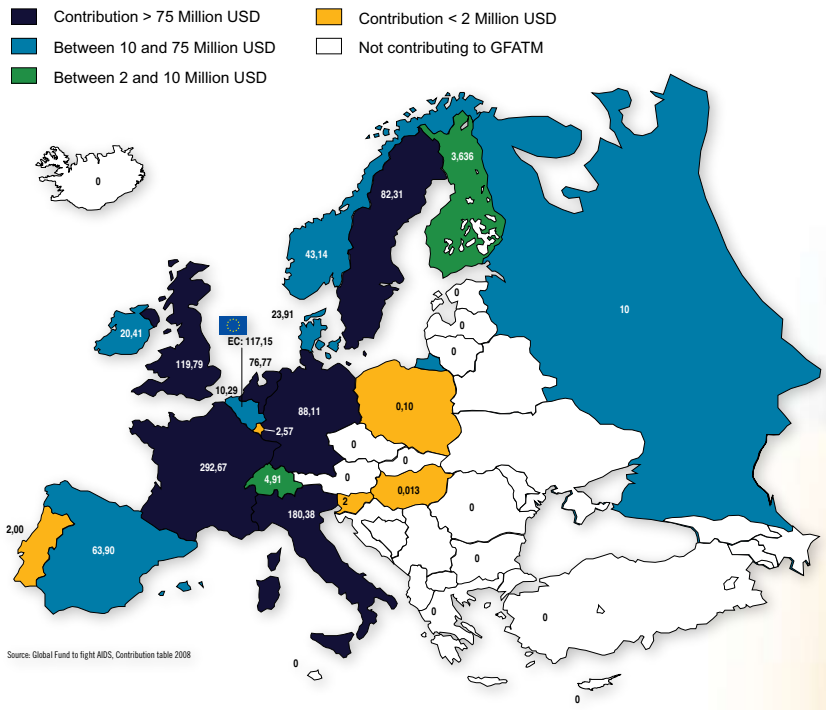


Contributions to SRHR related Organisations

Population assistance: The Global Fund (GFATM) – the big winner in new population-related assistance

France is the biggest European donor to the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), more than quadrupling its contribution between 2003 and 2006, from just over US$ 60 million to almost US$ 300 million. Germany doubled its contribution between 2004-2005. Also Italy made a significant leap forward in its contributions to the GFATM with an increase of almost US$ 80 million between 2005 and 2006.

GFATM 2006 (in million USD)

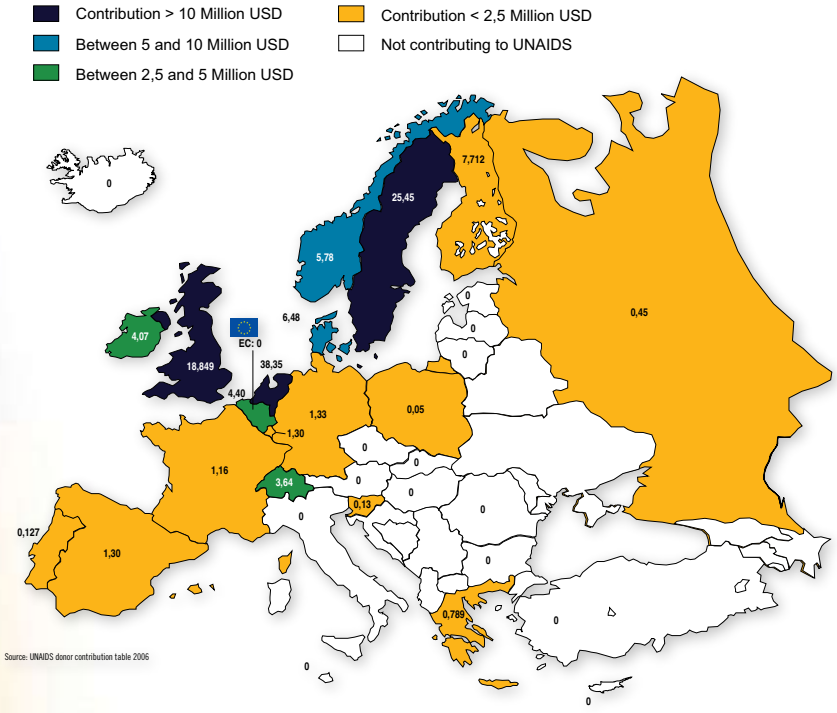


Contributions to SRHR related Organisations

Population assistance: Increasing support for the joint UNAIDS programme

Norway, Sweden, the Netherlands and the UK all contributed over US$ 10 million to UNAIDS in 2006. Norway and Denmark both contributed between US$ 5 and 10 million, whilst Belgium, Ireland and Switzerland donated between US$ 2,5 and 5 million. Donors contributing less than US$ 2,5 million include Poland, the Russian Federation, Germany, Luxembourg, France and Spain, with Portugal and Greece contributing for the first time to UNAIDS. Finland and Norway have decreased their contribution. Italy made no contribution to UNAIDS in 2006.

UNAIDS 2006 (in million USD)



Contributions to SRHR related Organisations

Population assistance: doubling Europe's support for contraceptive research

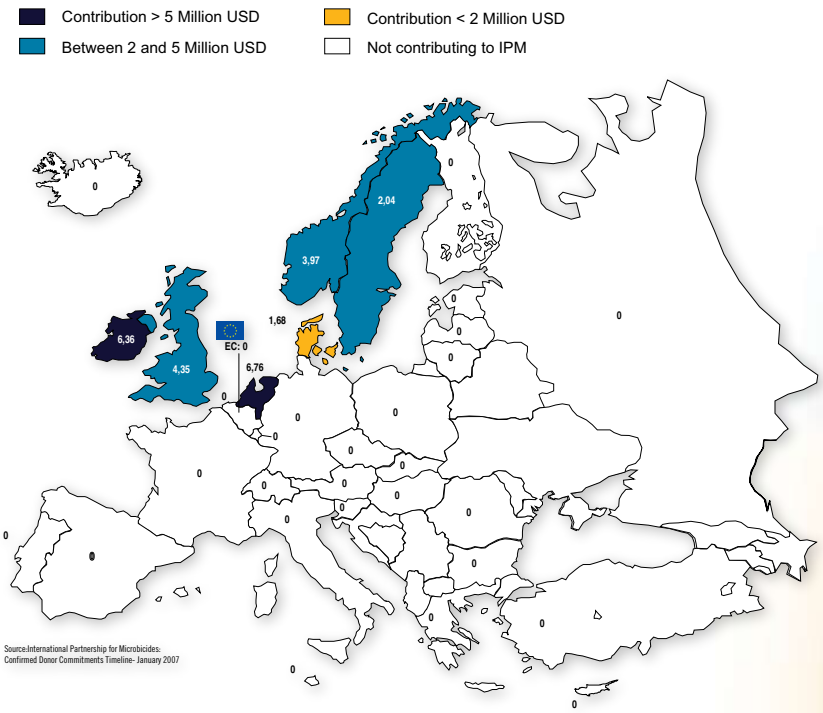
IPM 2005-2006 in mill. USD

Netherlands	0	6,76
Ireland	3,57	6,36
UK	0,51	4,35
Norway	3,14	3,97
Sweden	1,50	2,04
Denmark	1,19	1,68

Source: UNFPA, IPPF, UNIFEM, UNAIDS, IPM & GFATM donations in 2005 from European countries and the EC

In 2006, six European countries contributed to the International Partnership for Microbicides. Their contributions rose significantly compared to the previous year, from 9,91$ in 2005 to 25,16$ in 2006. Out of these six, the Netherlands provided the largest contribution, followed by Ireland and the UK.

IPM 2006 (in million USD)



Contributions to SRHR related Organisations

Case study 4: Philanthropic giving to population assistance

The total of philanthropic HIV/AIDS spending in 2006 reached almost US$ 170 million. Non-Governmental Organisation provided for 37% of the giving, with the International HIV/AIDS Alliance providing the biggest contribution of more than US$ 50 million. The Wellcome Trust provided by far the biggest contribution of European Foundations to combat HIV/AIDS in the developing world in 2006, with a donation of almost US$ 33 million. The Children's Investment Fund Foundation was the second largest contributor, donating almost US$ 13 million. The Comic Relief and The Foundation Bettencourt Schueller contributed between US$ 11-12 million in the fight against HIV/AIDS. Information on spending on sexual and reproductive health/ population assistance exclusive of HIV/AIDS is not available for lack of reliable data.

Estimated 2006 disbursements (in millions) for HIV/AIDS

Foundation	EURO	USD
Wellcome Trust	26,1	32,8
Children's Investment Fund Foundation	11,0	13,6
Comic Relief	9,3	11,8
Fondation Betten-court Schueller	9,0	11,3
Fondation Mérieux	6,5	8,2
Elton John AIDS Foundation (U.K.)	5,7	7,2
Fondation François-Xavier Bagnoud	3,4	4,3
AIDS Fons	3,1	3,9
Sidaction	2,3	2,9
Unidea Unicredit Foundation	1,9	2,4
Deutsche Stiftung Weltbevölkerung (DSW)	1,6	2,0
Bernard van Leer Foundation	1,2	2,0
HopeHIV	1,1	1,4
Aga Khan Foundation	1,0	1,3
Diana, Princess of Wales Memorial Fund	0,9	1,2
International HIV/AIDS Alliance	40,1	50,7
Stichting Novib/Oxfam	6,0	7,6
Marie Stopes International	3,3	4,2

Source: European Foundation Centre (2008): European Philanthropy and HIV/AIDS

Contributions to SRHR related Organisations

Case study 5: MDG contracting in Burkina Faso

Burkina Faso's six-year MDG contract is scheduled to be signed at the end of 2008 by the EC and should start in January 2009. From the total amount of budget support for Burkina Faso for the period 2008-2013 (€ 529 Million), about 60% (€ 320 Million) will be allocated to the MDG Contract. In addition to the 70% fixed / 30% variable ratio, the contract might include the possibility of final bonus (after 6 years) when the overall results are very good. There is no final decision on the indicators yet, but it seems that for the fixed tranche, indicators will be related to good governance, macro-economy, ownership, and tax-income.

HIGHLIGHTS

- **MDG contract should be signed in 2008 and start January 2009**
- **€ 320 million for 2008-2013**
- **70% fixed, 30% variable**
- **Indicators not yet decided**
  - **Fixed tranche indicators: good governance, macro-economy, ownership and tax-income**
  - **Performance tranche: only 1 indicator**
- **No consultation with CSO/national parliament.**
- **No clarity**
  - **on the process to establish indicators**
  - **on independent monitoring for MDG results**
  - **on the changes at mid-term contract in 2010**
- **No benchmark for CSO funding**
  - **to monitor progress**
  - **to implement actions to increase results**
- **15% of the variable performance component to be adjusted after 3 years**
- **Performance tranche is adjusted on a annual basis.**

Source: DSW Fast Facts "Budget Support Consequences for SRH"

Contributions to SRHR related Organisations

Case study 5: MDG contracting in Burkina Faso

Concerns and questions:

> There was no consultation with Civil Society Organisations (CSO) or the national parliament on the MDG contract, and it is not clear whether the process to establish indicators has been truly "country-owned" (led by the government).

> It is unclear how independent monitoring of the MDG results is ensured. Who will monitor progress and who is responsible for the final decision on the performance tranche linked to this review?

> There is no benchmark for CSO funding to monitor progress or implement actions to increase results towards the MDGs.

> Mid-term contract review will take place in 2010, probably together with the review of the Country Strategy Paper. However, it is unclear what kind of changes (indicators or only budgetary allocations etc.) can take place in that review.

For more information on MDG contracting in Burkina Faso, please visit: http://www.dsw-online.de/en/Fast_Facts_Division_of_Labour.pdf

Contributions to SRHR related Organisations

Case study 6: Improving the EU's support to Cambodia

The overarching objective of EC support to Cambodia is the sustainable reduction of poverty. This objective will be achieved mainly through the provision of general budget support (GBS) to the implementation of the Royal Government of Cambodia's (RGC) National Strategic Development Plan (NSDP) and support to basic education.

Aid to Cambodia still suffers from deficiencies in coordination and communication, weak division of labour and strong fragmentation. In order to remedy the lack of coherence in aid, the European Union has established a road map for increased aid effectiveness in Cambodia ("Road Map to Accra"). This document has been established in collaboration with the EC delegation and the Cambodian Ministry of Finance. Civil Society Organizations have not been involved, however.

The "road map" pursues the aims of:

> enhancing aid effectiveness through more EU involvement in the technical working groups;

> strengthening the country leadership in aid effectiveness though monitoring of the NSDP and its implementation; and

> maximising the impact of EU aid through joint sector analysis and studies, training and project evaluation.

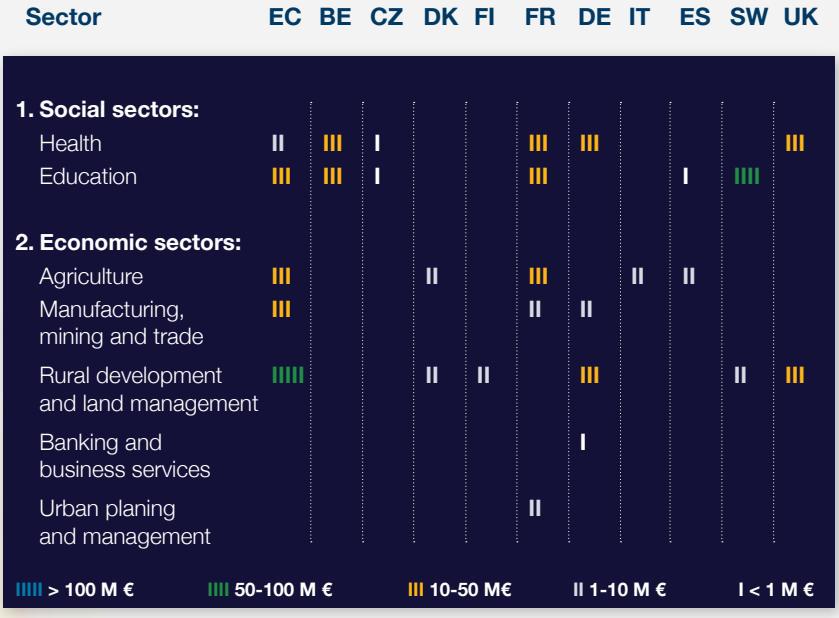
The Harmonisation Action Plan of the Royal Government of Cambodia and the Cambodian version of the Paris Declaration are the benchmarking tools for enhancing aid effectiveness. Progress of aid management can be found in the Cambodian Aid Effectiveness Report. Its source of information are the reports prepared by the Technical Working Groups for the Government-Donor Coordination Committee.

Contributions to SRHR related Organisations

Case Study 6: Improving the EU's support to Cambodia

In the past, EC aid in the health sector had pursued a strategy based on health facilities coverage. In 2002, the Cambodian Government presented its first Health Sector Strategic Plan (HSP) aiming to "enhance health sector development in order to improve the health of the people of Cambodia, especially mothers and children...". The new strategy focuses on outputs and outcomes, with priorities such as maternal and infant health & nutrition, reduced total fertility and decrease of household expenditure on health.

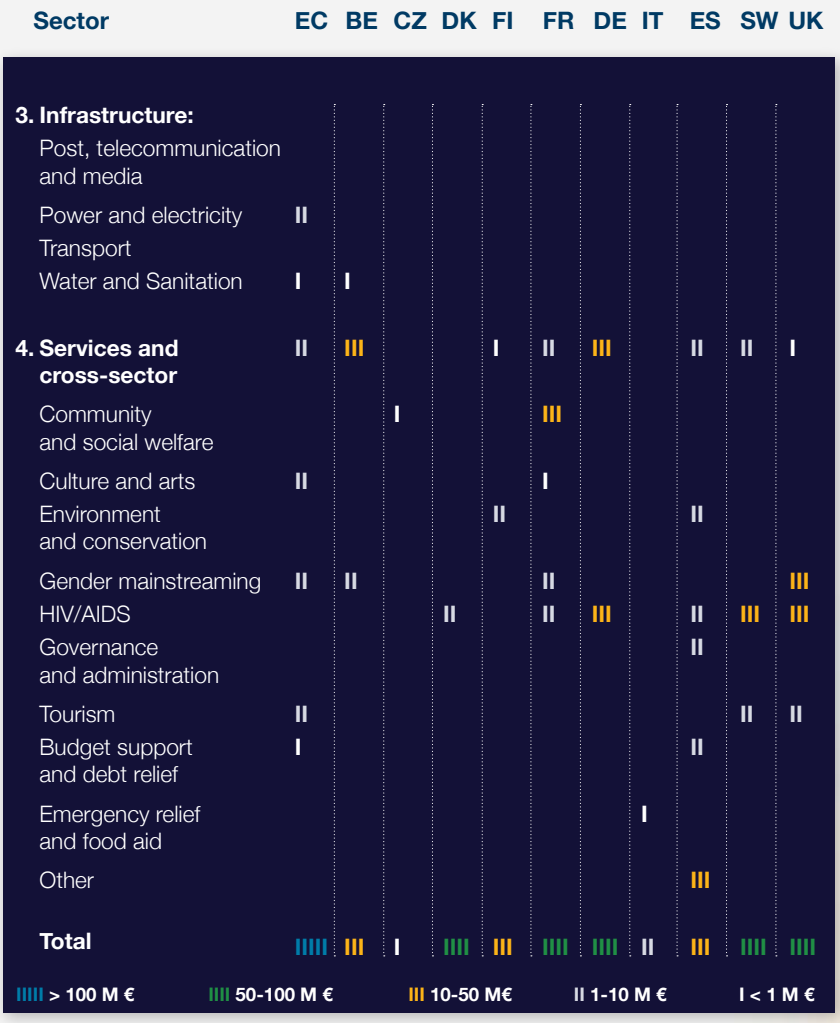
For more information on the EU division of labour in practice in Cambodia, please visit: http://www.dsw-online.de/en/Fast_facts_Cambodia_14_Aug.pdf



Source: European Foundation Centre (2008): European Philanthropy and HIV/AIDS

Contributions to SRHR related Organisations

Case Study 6:
Improving the EU's support to Cambodia



Source: European Foundation Centre (2008): European Philanthropy and HIV/AIDS

Contributions to SRHR related Organisations

Notes

Notes

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