



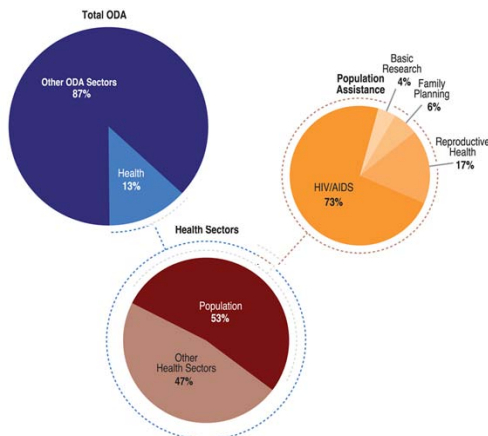
UNFPA/NIDI Resource Flows Newsletter, February 2011

The purpose of the UNFPA/NIDI Resource Flows Newsletter is to inform donor and developing country governments, public and private organisations, research institutes, universities and civil society about resource tracking for population and AIDS activities in general and the role of the Resource Flows (RF) project in particular.

1. EUROMAPPING 2010 : Mapping European Development Aid & Population Assistance

How are European countries since the crisis living up to their international funding commitments to support developing countries' population efforts? 2009 is the first year with a visible crisis effect on the level of development assistance. Overall, global Official Development Aid (ODA) has markedly decreased, a trend also seen among EU donors. However, the EU as a whole has remained the leading donor worldwide. From 2008 to 2009 several EU Member States increased their aid, but some large donors remain far below the EU target. A few donors have reduced ODA after several years of increases. EU estimates for 2010 are therefore not encouraging. The recently released publication, Euromapping 2010, sheds light on recent ODA performances.

Official Development Assistance



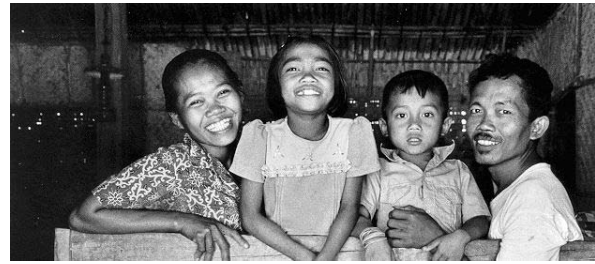
Source: Pavao & Ongil (2010), Euromapping 2010, pp. 13, 21 and 25

General ODA

In 2009 Europe remained the largest donor region in the world. Together, the individual EU Member States, the (supranational) European Union and some other European countries (such as Norway, Turkey or Switzerland) contributed 65% of all global Official Development Aid (ODA); the United States follows with 21% and Japan with 7%; Canada, Australia, Korea and others make up for the rest. Only 12 EU Member States increased their contributions, but 2009 was also the first year to show a drop in ODA since the Millennium Declaration was signed in 2000.

The economic crisis brought about a paradox: while absolute numbers of dollars are decreasing, national ODA relative to a donor's Gross National Income (GNI) has increased. With only one year before 2010 – the EU's target year to reach a collective GNI of 0.56% – the EU is still over €18 billion away from reaching that target. In particular, the European capacity to reach that collective target relies on the largest of European economies as they provide the bulk of European aid and continue to fall short. Italy –€4.5 billion below its commitments– is responsible for the greatest gap, followed by Germany (€2.6 billion) and France (€800 million). All three of these countries are not likely to reach the EU targets of 0.51% for 2010. Nevertheless, gradual increases have been made: France, for example, has surpassed Germany now as the largest European donor country. Very close behind are the United Kingdom and Spain. Spain has since surpassed the Netherlands to become the fifth largest European donor. Italy, on the other hand, cut €90 million and has been surpassed by Sweden and Norway.

The ten countries likely to meet the 0.51% interim target for 2010 are Sweden, Luxembourg, Denmark, Netherlands, and Norway (which are by far the most generous donors, all providing over 0.7% of their GNI towards ODA), while Belgium, United Kingdom, Finland, Ireland and Spain are making considerable progress. The interim target for the new Member States is 0.17% but



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Definition of Family Planning according to the ICPD Programme of Action

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; and focussed efforts to ensure good quality care.

despite significant increases in countries like Hungary and Poland, only Cyprus has reached this level.

The top five per capita donors coincide with the five countries that are already providing more than 0.7% of their GNI towards ODA: Norway and Luxembourg provide over US\$ 800 per capita, while Denmark, Sweden and the Netherlands contribute within the range of US\$ 390-510. The 14 largest donors are all European, followed by Australia, Canada, Iceland and the United States (with contributions ranging between US\$ 93-130). The lowest per capita contributions are from the new Member States, Turkey and Korea and are below US\$ 38.

2009 was the first year of the new Millennium during which decreases in global ODA have been registered. After a hopeful increase of 10% in 2008, the run-up to 2015 now looks bleaker than ever. In 2009, it was largely the EU-15 which was responsible for decreases in global ODA. But, surprisingly, when compared in relative terms, the generosity of EU and all donors actually appeared to have increased over the past two years. This must be considered alongside the contraction of Western economies as a reaction to the financial and economic crisis. An important observation also is that European

donors continue to report debt relief as ODA. The end of important debt relief schemes has undermined the level of aid reported by countries that are especially reliant on it, such as Germany, Austria or Japan.

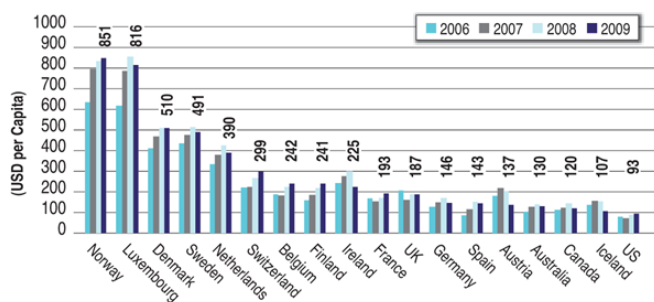
Health ODA

Health ODA refers to disbursements reported under OECD/DAC sector codes that explicitly relate to population and health issues. DAC stands for Development Assistance Committee and the publication *Euromapping 2010* gives in an Annex more details about these codes.

Fair, strong and accessible health systems are an important vehicle to obtain better results in the area of population and health assistance. Health ODA makes up about 13% of total ODA, i.e. ODA mainly goes to other sectors like education, economic infrastructure and services, production sectors, environmental protection, humanitarian aid, and action relating to debt. The total health sector is divided into population (represents 53% of the total health sector spending) and other health sectors (47%). Subdividing this last mentioned 47% further we come to basic health issues –including basic health care and health infrastructure, and basic nutrition– make up 18% while infectious diseases –including malaria and tuberculosis– receive 13% of the spending. Other health related issues are health policy and administration (10%), and medical and health services, research, education, training and personnel development (6%).

The most important overall observation is that health ODA grew in 2008, the most recent year for which data are available, for both European and non-European donors. The trend of individual donors however seems erratic and unpredictable. Compared with general ODA, European donors contribute substantially less on health issues than other donors. The aggregate share of the (supranational) EU, its Member States plus the other European donors accounted in 2008 for 39% of health ODA, and that is 1% less than in the previous year. In fact the United States surpassed European donors for the first time, and can now be considered the leading donor country in absolute health

National ODA per Capita – Largest donors



Source: Pavao & Ongil (2010), *Euromapping 2010*, p. 18



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Definition of Reproductive Health according to the ICPD Programme of Action

Information and routine services for prenatal, normal and safe delivery and post-natal care; abortion (as specified in paragraph 8.2 of the ICPD Programme of Action); information, education and communication about reproductive health, including sexually transmitted diseases (STDs), human sexuality and responsible parenthood, and against harmful practices; adequate counselling; diagnosis and treatment of STDs and other reproductive tract infections; prevention of infertility and appropriate treatment, where feasible; and referrals, education and counselling services for STDs, including HIV/AIDS, and for pregnancy and delivery complications.

disbursements. Among the European contributors the (supranational) EU plus the EU-15 Member States remain the major donors, although not keeping pace with other donors. However, each year Europe's share of global health ODA contribution gets smaller.

In absolute terms the United Kingdom remained the leading European donor to health, followed by the EU, Germany, Spain, the Netherlands and France. Although the United Kingdom contributed in 2008 slightly less than in 2007 most of the larger European donors increased their disbursements in 2008.

European spending in the health area provides a very different picture of European health sector funding: it is Luxembourg that provides the greatest per capita contributions (US\$ 118 per inhabitant). Norway, Ireland and Sweden follow with contributions ranging between US\$ 27-53.

Population Assistance

Population assistance which makes up 53% of the total health ODA, while as we saw total health ODA makes up 13% of total ODA. Within the population sector 73% of the disbursements go to sexually transmitted diseases and HIV/AIDS, reproductive health receives 17%, family

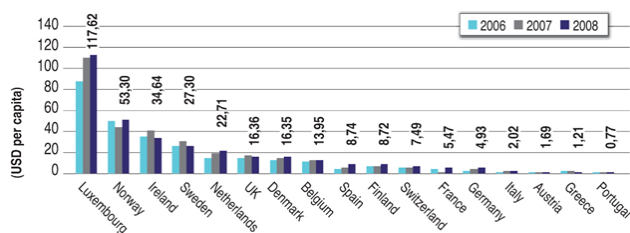
planning 6% and basic research 4%. In 2008 the United States has regained its leadership as the largest donor to population assistance. Nonetheless, the EU remains large and influential in the field. In fact, if one takes together the United States, the EU and its Member States, they account for 81% of all global population assistance.

Since the year 2000 total population assistance has increased significantly, mainly due to increased disbursements for HIV/AIDS. Recently, UN Secretary General Ban Ki-moon announced a global strategy for women and children's health that aims at raising US\$ 40 billion.

Most of the new funding has been allocated to sexually transmitted diseases (STD) and HIV/AIDS, while vital components of reproductive health and family planning remain underfunded. For example, primary funding aimed at family planning dropped from 55% (of the total primary funds for population assistance) in 1995 to only 6% in 2008. HIV/AIDS on the other hand saw a significant increase, and reproductive health saw some increase, contrasting to the stagnation in family planning funding (which in absolute terms increased only from US\$ 517 million in 2000 to US\$ 572 million in 2008).

European donors continue to lead in population assistance, with Luxembourg once again in first place. However, the variation in per capita contributions within Europe is considerable: Italy, Greece and Portugal each give less than one US dollar per inhabitant while Luxembourg and Norway donate more than US\$ 50. The largest donors are also the most committed: the United Kingdom, Luxembourg, Ireland, Netherlands, Sweden and Norway all are likely to reach their target of allocating 10% of ODA towards population assistance. This target was established and reaffirmed in the outcome declarations of the International Parliamentary Conference on the Implementation of the ICPD that took place in 2002, 2006 and 2009. The United States is providing nearly one fifth of its ODA towards population assistance.

Health ODA per Capita from 2006 to 2008



Source: Pavao & Ongil (2010), Euromapping 2010, p. 24



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Why fund population activities?

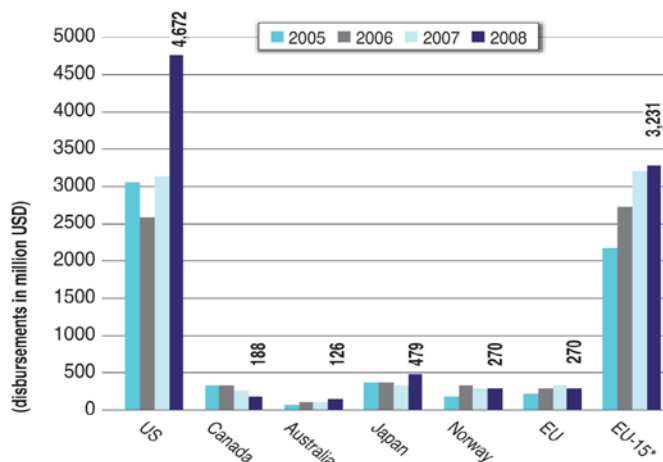
Population dynamics and reproductive health are central to development and must be an integral part of development planning and poverty reduction strategies. The Millennium Development Goals (MDG), especially the eradication of extreme poverty and hunger, will not be achieved if issues of population and reproductive health are not adequately addressed. Implementing the ICPD Programme of Action (PoA), especially the reproductive health goal, is essential for meeting the MDGs directly related to health, including child mortality, maternal health and HIV/AIDS prevention, and social and economic outcomes, including gender equality and poverty eradication.

In absolute terms, the United States is by far the largest donor for family planning, as well as to reproductive health in 2008 (See boxes with definitions of family planning and reproductive health according to the ICPD Programme of Action). For family planning the United States is followed by Germany and the Netherlands, for reproductive health, Spain and the (supranational) EU are the runner-ups.

The funding gap in population assistance

The United Nations Population Fund (UNFPA) revised the cost estimates for the four categories of the ICPD costed population package (para. 13.14). These revised estimates were presented to the 42nd session of the Commission on Population and Development in 2009. The revision was

Top Donors of Population Assistance



*There is no data on the population assistance contributions of all EU Member States; therefore, the EU-15 represents EU MS contributions from this point forward.

Source: Pavao & Ongil (2010), *Euromapping* 2010, p. 27

necessary as the costs and needs to ensure the achievement of the ICPD had changed in the past 15 years of implementation (see: <http://www.un.org/esa/population/cpd/cpd2009/comm2009.htm>). While maternal mortality dropped by a third between 1990 and 2008, this is insufficient to meet Millennium Development Goal number 5 (MDG5), which calls for a decline of 75% in the maternal mortality ratio. 215 million women still suffer from unmet needs for family planning and out of 123 million women that give birth every year, only half of them are attended by skilled health workers (Singh *et al.*, 2010).

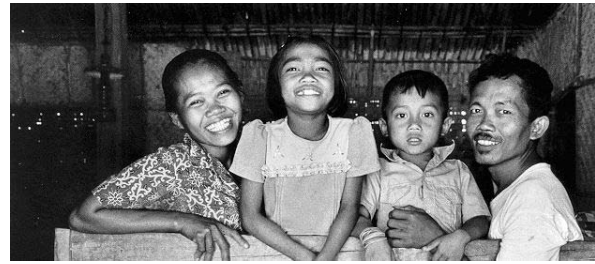
According to the ICPD Programme of Action, two-thirds of these expenditures should be mobilized by developing countries while one-third was to come from developed countries. Analysis of the donor share of the ICPD package –and assuming that expenditures will not decrease from 2008 levels– indicates that additional funding must be mobilised by 2015.

If 2010 estimates hold and the international community contributed US\$ 10 billion and developing countries mobilized US\$ 31 billion, the total amount would be US\$ 24 billion short of what is needed in 2010 to finance population programmes in developing countries.

Because MDG5 is the MDG furthest from being met, this fact has prompted –during the UN High-Level meeting on the Millennium Development Goals, 19-22 September 2010 in New York– the launch of the US\$ 40 billion rescue plan for maternal and child health announced by the UN Secretary General Ban Ki-Moon as *the Global Strategy on Women and Children Health*, aimed at saving the lives of 16 million women, children and newborns. It is worth noting that the US\$ 40 billion figure is very close to the funding gap estimates for the period 2011-2015.

Source

Andrew Pavao & Miguel Ongil (2010), *Euromapping 2010, Mapping European Development Aid &*



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What did Cairo say about funding to achieve the ICPD objectives?

At the 1994 ICPD the international community agreed that US\$ 17 billion would be needed in 2000, US\$ 18.5 billion in 2005, US\$ 20.5 billion in 2010 and US\$ 21.7 billion in 2015 to finance programmes in the area of population dynamics, reproductive health, including family planning, maternal health and the prevention of sexually transmitted diseases (STDs), as well as programmes that address the collection, analysis and dissemination of population data. Two thirds of the required amount would be mobilized by developing countries themselves and one third, or US\$ 5.7 billion in 2000, US\$ 6.1 billion in 2005, US\$ 6.8 billion in 2010 and US\$ 7.2 billion in 2015 was to come from the international community.

Population Assistance. Brussels / Hanover: German Foundation for World Population (DSW) etc.

Shusheela Singh *et al.* (2010), *Adding it up: the benefits of investing in sexual and reproductive health care.* New York & Washington DC: The Alan Guttmacher Institute & UNFPA.

2 REVISED COST ESTIMATES FOR POPULATION ACTIVITIES:

Resource requirements for population activities in the various world regions

To ensure adequate funding for the implementation of the ICPD Programme of Action, the United Nations Population Fund (UNFPA) reviewed the existing estimates for the four categories of the ICPD funded population package (ICPD para 13.14). Subsequently the estimates were revised to meet current needs. These revised estimates are much higher than the original ICPD targets agreed upon in 1994 because they take into account both current needs and costs which means that they now also include interventions like AIDS treatment and care, and reproductive cancer screening and treatment. The revisions are considered minimum estimates required to finance interventions in the areas of family planning, reproductive health, STDs, HIV / AIDS, and basic research, data, and population and development policy analysis.

Global progress towards ICPD financial commitments

By 2008, international population assistance increased to US\$ 10.4 billion worldwide. This includes funding from developed countries, the United Nations system, foundations, NGOs, and development banks. Based on past trends, the amount is projected to increase in the following years. However, given the current global

financial and economic crisis the prospects for an increasing trend are not encouraging.

A large proportion of total population assistance nowadays goes to funds for HIV/AIDS activities. In fact, measured in absolute US dollars funding for family planning services was in 2008 even lower than in 1995 when UNFPA first began monitoring resource flows by the four ICPD funded population categories. The Resource Flows project estimates that developing countries and countries in transition mobilized US\$ 23.2 billion for population activities in 2008, more than twice as much as international population assistance. Domestic resources include governments, national NGOs and private out-of-pocket expenditures. ICPD stated that donors should contribute one third and developing countries should mobilize two-thirds of the required amount.

The global figure of domestic expenditures reflects the commitment of developing countries, regardless of the amount mobilized, although significant variation exists among countries in their ability to mobilize resources for population activities. Most domestic resources originate in a few large countries. Many countries, especially among the least developed countries many of which are located in sub-Saharan Africa, are not able to generate the necessary resources to finance their own population programmes. They continue to rely on donor assistance to a large extent.

Financial resource flows in the various world regions

Sub-Saharan Africa: In 2008 countries in sub-Saharan Africa received US\$ 4,179 million for population assistance. The largest recipient was South Africa (US\$ 409 million), followed by Nigeria (US\$ 383 million), Ethiopia (US\$ 362 million) and Kenya (US\$ 348 million). Botswana is the country with the highest per capita population assistance (US\$ 15.8 per inhabitant). 76% of this region's assistance arrived from OECD/DAC donor countries, while UN organizations contributed 19%, and international NGOs 4%. Developments banks, foundations



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and private non-profit organizations made up for the remaining 1%. Of the total amount spent on population assistance in sub-Saharan Africa in 2008, 35% was channelled through bilateral programmes, 22% through multilateral organizations and 43% was spent via international NGOs.

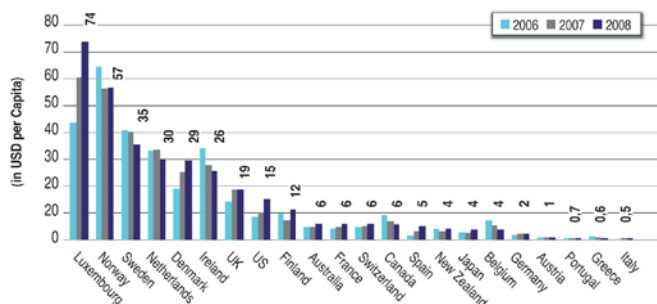
A large share went to STDs and HIV/AIDS (84%), followed by reproductive health (11%), family planning (3%) while research, data, and population and development policy analysis received 2%.

Arab States (Western Asia and North Africa): In 2008 countries in the Arab States region received US\$ 242 million for population assistance. The largest recipient was Sudan (US\$ 68 million), followed by Egypt (US\$ 52 million), and Yemen (US\$ 29 million). Djibouti is the country with the highest per capita population assistance (US\$ 5.0 per inhabitant). 60% of this region's assistance arrived from OECD/DAC donor countries, while UN organizations contributed 12%, international NGOs 13%, and developments banks another 13%. Foundations and private non-profit organizations made up for the remaining 2%.

Of the total amount spent on population assistance in the Arab States region in 2008, 27% was channelled through bilateral programmes, 32% through multilateral organizations and 41% was spent via international NGOs.

A large share went to reproductive health (50%), followed by STDs and HIV/AIDS (24%), family planning (18%) while research, data, and population and development policy analysis received 8%.

National ODA Per Capita for Population Assistance



Source: Pavao & Ongil (2010), Euromapping 2010, p. 29

Asia and the Pacific: In 2008 countries in Asia and the Pacific received US\$ 1.1 billion for population assistance. The largest recipient was India (US\$ 169 million), followed by Bangladesh (US\$ 93 million) and Viet Nam (US\$ 88 million). Palau is the country with the highest per capita population assistance (US\$ 10.8 per inhabitant). 61% of this region's assistance arrived from OECD/DAC donor countries, while UN organizations contributed 23%, international NGOs 6%, and foundations and private non-profit organizations made up for the remaining 10%.

Of the total amount spent on population assistance in the Asia and Pacific States region in 2008, 18% was channelled through bilateral programmes, 38% through multilateral organizations and 44% was spent via international NGOs.

A large share went to STDs and HIV/AIDS (57%), followed by reproductive health (31%), family planning (9%) while research, data, and population and development policy analysis received 3%.

Latin America and the Caribbean: In 2008 countries in Latin America and the Caribbean received US\$ 519 million for population assistance. The largest recipient was Haiti (US\$ 126 million), followed by Guatemala (US\$ 40 million), and Nicaragua (US\$ 37 million). Guyana is the country with the highest per capita population assistance (US\$ 36.4 per inhabitant). 68% of this region's assistance arrived from OECD/DAC donor countries, while UN organizations contributed 27%, international NGOs 4%, and foundations and private non-profit organizations made up for the remaining 1%.

Of the total amount spent on population assistance in the Latin America and Caribbean region in 2008, 28% was channelled through bilateral programmes, 38% through multilateral organizations and 34% was spent via international NGOs.

A large share went to STDs and HIV/AIDS (58%), followed by reproductive health (31%), family planning (8%) while research, data, and population and development policy analysis received 3%.

Eastern Europe and Central Asia: In 2008 countries in Eastern Europe and Central Asia received US\$ 245 million for population assistance. The largest recipient was the Russian Federation (US\$ 60 million), followed by Ukraine (US\$ 52 million) and Kyrgyzstan (US\$ 15 million). Georgia is the country with the highest per capita population assistance (US\$ 2.9 per inhabitant). 33% of this



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region's assistance arrived from OECD/DAC donor countries, while UN organizations contributed 63%, international NGOs 3%, and development banks made up for the remaining 1%.

Of the total amount spent on population assistance in the Eastern Europe and Central Asia region in 2008, 10% was channelled through bilateral programmes, 70% through

multilateral organizations and 20% was spent via international NGOs.

A large share went to STDs and HIV/AIDS (75%), followed by reproductive health (12%), family planning (6%) while research, data, and population and development policy analysis received 7%.

Table 1: Estimated domestic expenditures for population activities by region and source of funds, 2008 (millions US\$)

	Government	NGO	Consumers*	Total	Percentage spent on STD / HIV/AIDS
Africa (sub-Saharan)	1,382	131	1,494	3,007	79
Asia and the Pacific	4,497	148	11,170	15,815	15
Latin America and the Caribbean	1,608	79	863	2,550	80
Western Asia and North Africa	579	58	374	1,010	22
Eastern and Southern Europe	537	16	276	829	83
Total	8,603	432	14,177	23,211	33

*Consumer spending on population activities covers only out-of-pocket expenditures and is based on the average amount per region for health care spending in general as measured by the WHO. For each region, the ratio of private out-of-pocket versus per capita government expenditures was used to derive consumer expenditures as a proxy for population activities.

Source: Maja Micevska Sharf & Annemarie Ersten (2010), *Projections of funds for population and AIDS activities, 2008-2010*. The Hague: NIDI.

Domestic resources for population activities

Domestic financial resources for population activities originate from the following major sources: Governments, NGOs, the private sector and consumers. The number and complexity of sources make it much more difficult to monitor domestic resource flows than international assistance for population. Although it is possible to collect information from Governments and NGOs, it is more difficult to track this information from the private sector and individual consumers due to insufficient data. Table 1 provides estimates of domestic expenditures for population activities by source of funds.

Key areas requiring further action

Current funding levels are far below what is required to meet needs. Given the current global financial crisis and the uncertainty of future levels, full implementation of the ICPD Programme of Action (PoA) may be in jeopardy. To

accelerate the implementation of the Cairo agenda and to achieve the Millennium Development Goals (MDGs) the international community should continue to:

- Ensure that population and reproductive health are seen as an integral part of the achievement of the MDGs and that they figure prominently in national and development programmes and poverty reduction strategies,
- Mobilize sufficient resources to fully implement the PoA and ensure that family planning and reproductive health issues receive the attention they deserve at a time when the increased focus is on combating HIV/AIDS,
- Establish an effective partnership of donor and recipient countries based on mutual trust,
- accountability and donor coordination in support of country goals,
- Increase attention to cost-effectiveness and programme efficiency so that resources reach all segments of the population, especially those that are most in need,



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- Enhance the role of the private sector in the mobilization of resources for population and development, in monitoring population expenditures and ensuring that financial targets and equity objectives are met,
- Establish a system of monitoring of resource flows to identify funding gaps and for budgeting and planning purposes. Governments are urged to make a special effort to monitor all expenditures going to population activities, including those at subnational levels and those that are part of integrated social and health projects and sector-wide approaches so that all efforts at resource mobilization can be captured in UNFPA's annual reports.

The success of the ICPD depends greatly on the willingness of Governments, local communities, the non-governmental sector, the international community and all concerned organizations and individuals to turn the ICPD recommendations into action.

The challenge for the international community is to mobilize the additional resources required in all areas of the ICPD funded population package: family planning services, reproductive health services, STD and HIV/AIDS activities, and basic research, data and population and development policy analysis. To meet current needs both international and domestic allocation of resources to population activities have to increase from the present levels.

Source

UNFPA (forthcoming), *Financial resource flows and revised cost estimates for population activities: Updated regional summaries, on Sub-Saharan Africa, Arab States, Asia and the Pacific, Latin America and the Caribbean, Eastern Europe and Central Asia*. New York & The Hague: UNFPA & NIDI (see <http://www.unfpa.org/public/site/global/lang/en/pid/3935> and/or <http://www.resourceflows.org/index.php/articles/c87/>)