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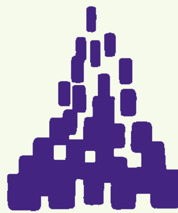
Donor Report Card and Country Profiles



DONOR REPORT CARD

	ODA AS PERCENT OF GNP		POPULATION ASSISTANCE AS PERCENT OF ODA		DISTANCE FROM ICPD Y2000 GOAL IN 1996		POPULATION ASSISTANCE POLICY
	1994–96 Average	Score	1994–96 Average	Score	Multiplier to Reach Goal	Score	Classification*
Norway	0.92	23	3.63	18	0.0	25	a
Denmark	1.01	25	2.96	15	0.0	25	a
Sweden	0.86	21	2.66	13	1.1	24	a
Netherlands	0.79	20	2.62	13	0.0	25	a
United States	0.12	3	6.84	25	3.1	22	a
Finland	0.32	8	4.44	22	1.5	24	c
United Kingdom	0.29	7	2.75	14	2.8	22	a
Australia	0.33	8	2.31	12	3.0	22	b
Germany	0.33	8	1.62	8	6.3	19	a
Switzerland	0.35	9	1.33	7	4.8	20	b
Canada	0.38	9	1.61	8	4.0	21	c
Japan	0.26	6	0.75	4	12.8	12	a
Belgium	0.35	9	0.51	3	12.6	12	c
New Zealand	0.23	6	0.87	4	12.5	13	d
Austria	0.30	8	2.31	12	68.3	0	d
France	0.56	14	0.18	1	24.0	1	d
Ireland	0.28	7	0.84	4	20.5	5	d
Spain	0.25	6	0.22	1	19.9	5	d
Portugal	0.28	7	0.04	0	109.8	0	d
Italy	0.21	5	0.36	2	86.8	0	d
	INDICATOR #1		INDICATOR #2		INDICATOR #3		INDICATOR

*POLICY CLASSIFICATION

a: The donor nation has a published reproductive health and population policy or strategy (25 points).

b: The donor nation is currently (at the time of writing) developing a reproductive health or population policy or strategy (20 points).

c: The donor nation has a health or development policy or strategy in place which substantively deals with reproductive health and population issues (15 points).

d: The donor has no written policies on reproductive health or population (0 points)

GRADES

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

ODA = Official Development Assistance

The grade "A" is high, "F" is low.

Report Card on the Donor Countries

Score	Total Score	Grade
25	91	A
25	90	A
25	84	A-
25	83	A-
25	75	B
15	69	B-
25	68	B-
20	62	C
25	60	C
20	56	C
15	53	C
25	47	C-
15	39	D
0	23	D-
0	19	F
0	16	F
0	16	F
0	12	F
0	7	F
0	7	F

#4

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

- the generosity of each donor's overall development aid program in relation to the size of that country's economy;
- the proportion of development assistance funds allocated to population-related programs;
- the distance each donor has to go to reach its "fair share" of the ICPD year 2000 goal from 1996 population spending levels; and
- the extent to which each donor has developed an official statement of its international population and reproductive health assistance policy.

The emphasis of this grading system is on financial and policy commitments to population assistance, rather than on the quality and type of programs supported. The weighting reflects the focus of this report on financial resources and on the funding environment for population assistance following the Cairo conference. Without significant resources, quality programs will not have an impact on global reproductive health status.

The grading system does not include a measure of program effectiveness, primarily because of the difficulty in identifying simple, objective indicators of program quality. Moreover, any such indicators would almost inevitably favor one approach to programming funds over another. While some donors commit significant resources to building technical capacity in reproductive health within bilateral aid agencies, others contribute most of their funds through multilateral organizations and international NGOs. Even if both types of donors are strongly committed to population assistance, they would likely score very differently on any conceivable programmatic measure.

The grading system allocates 25 points to each of the four indicators, for a maximum potential score of 100. Points are allocated on a relative scale—donors are compared to each other rather than to an objective standard. To minimize bias resulting from a wide distribution of values, the scores for each of the three quantitative indicators were capped at appropriate levels. The grading system was applied to the 20 member countries of the OECD/DAC, excluding Luxembourg, which is not included among the individual donor profiles, and the European Commission, to which some of the indicators used to score individual donor countries do not apply.

INDICATOR #1:
Development Assistance as a Share of National Income

The volume of overall development assistance relative to gross national product (GNP) reflects the generosity of each donor country relative to the size of its economy. This indicator represents each nation's commitment to the developing world. It also reflects donor investments in broader economic and social development that may ultimately benefit population and reproductive health through increased income, education, well-being and smaller family size. Total aid volume also influences the availability of funds for population assistance.

Countries are scored on the average of their development assistance to GNP ratio for the three-year period 1994 to 1996, and their performance relative to each other. The ratio was capped at 1 percent, with all scores above 1 percent receiving the full 25 points, and all scores below receiving points on a proportional basis. Over this period, the 20 donor countries averaged a development assistance to GNP ratio of 0.42 percent—significantly lower than the ***UN goal of a 0.7 percent annual contribution from each country.*** However, Denmark far exceeded this goal, leading the donor community by giving over 1 percent of GNP in development aid between 1994 and 1996. Only three other countries met or exceeded the UN goal of 0.7 percent—Sweden, Norway and the Netherlands. Apart from France, which had an aid to GNP ratio of 0.5 percent, all other countries gave less than the 0.4 percent donor average. Two of the largest donors in total aid volume, the United States and Japan, allocated only 0.12 and 0.25 percent of GNP respectively to development aid.

INDICATOR #2:
Population Assistance as a Share of Development Assistance

The share of overall development assistance allocated to population assistance reflects the level of importance each donor nation assigns to population and reproductive health issues within its foreign aid program. This measure gives credit to donors that have demonstrated a financial commitment to population assistance whether they do so through the bilateral, multilateral or NGO channels. A 1989 international meeting in Amsterdam recommended that donor countries allocate four percent of development assistance to population and family planning. The Netherlands has adopted a four percent target for reproductive health spending as national policy.

Countries are scored on the percentage of development aid they allocated to population assistance, again averaged over the three-year period 1994 to 1996. The percentages were capped at 5, with all scores above 5 percent receiving the full 25 points and those below receiving points on a proportional basis. The United States ranks highest on this measure, allocating an average of close to 7 percent of its development aid budget to population related programs between 1994 and 1996. Finland and Norway follow at some distance, giving 4.4 and 3.6 percent of their development aid to population respectively. Australia, Denmark, the Netherlands, Sweden and the United Kingdom all gave between 2 and 3 percent of their aid budgets to population assistance during this period.

Although Japan is a large population donor in terms of total volume, it gave only 0.75 percent of its development budget on average to population assistance in the period studied. Other major development assistance donors contributed very limited funds to population activities—for example, France gave on average less than one-fifth of one percent of its overall development assistance during this period, while Italy gave only one-third of one percent.

INDICATOR #3: Multiplier Required to Reach ICPD Year 2000 Funding Goals

Resources remain central to the challenge of improving reproductive health status and slowing population growth worldwide. The extent to which donors have progressed toward meeting the financial goals for the year 2000 established at the ICPD reflects their commitment to these goals and to population and reproductive health programs.

Each donor's respective share of the $5.7 billion ICPD goal for donor contributions in the year 2000 (unadjusted for inflation) was estimated based on its proportional share of aggregate GNP for the donor community. Scores were assigned to each country based on the multiplier required to increase 1996 funding levels to achieve that country's year 2000 goal. The multipliers were capped at 25, with all multipliers above that receiving zero points. Since a low multiplier warranted a higher point score, scores were calculated by subtracting the multiplier from 25.

Four countries have met or are very close to meeting their respective year 2000 goals: the Netherlands, Denmark, Sweden and Norway. Another five countries need to increase their current levels of assistance two to four times by the year 2000: the United States, the United Kingdom, Canada, Australia and Finland. A few large population donors lag further behind their goals—Germany needs to increase its 1996 level of assistance six times to reach its goal, while Japan needs to increase its assistance thirteen-fold. France needs to increase its funding twenty-four-fold. Portugal and Italy are furthest from their year 2000 targets, needing to increase their assistance 110 times and 87 times respectively.

INDICATOR #4: Formulation of a Reproductive Health and Population Policy

Donor nations committed to population assistance are more likely to have articulated a reproductive health and population policy. The existence of such a policy reflects the importance governments assign to these issues and time invested by aid officials in dialogue and debate on international population policy issues. Population assistance policies developed in response to the ICPD are also likely be responsive to the goals and recommendations of the conference.

The scoring system gives full credit to those donor countries that have published official reproductive health and population policies or strategies. To account for differences in the policy formulation process among donors, the scoring system gives partial credit to donors having health or development policies that substantively address reproductive health and population issues. It also gives partial credit to countries that at the time of writing were reported to be developing population and reproductive health policies.

Of the 20 donors evaluated, 8 countries—Denmark, Germany, Japan, the Netherlands, Norway, Sweden, the United Kingdom and the United States—have all published documents reflecting current government policy on international population and reproductive health assistance. Aid officials in Switzerland and Australia report that their governments are currently developing such policies. Canada, Belgium and Finland have development policies that make reference to population and reproductive health. The other countries do not appear to have formal policies on assistance in the area of population and reproductive health.

DONOR GRADES

Norway and Denmark receive the highest scores and a grade of "A". Sweden and the **Netherlands** follow at some distance with a grade of **A-.** All four countries receive close to the maximum scores in every category except the share of overall aid allocated to population assistance.

The United States, the United Kingdom and Finland all follow with grades in the "B" range. All three countries lose points for their lack of overall generosity in development cooperation. The United Kingdom also loses points for the low proportion of development aid funds allocated to population compared to some other donors. On this indicator, the United States sets the standard, receiving the maximum score for the share of total development assistance allocated to population and reproductive health.

Australia, Germany, Switzerland and Canada all perform in the middle range, rating a grade of "C." All lose points for their low aid to GNP ratios and the low priority they give to population assistance within their overall foreign aid programs. **Japan** earns a **C-** for its relatively poor performance on all three financial indicators.

Belgium and New Zealand receive grades in the "D" range, gaining some points based on their relative proximity to their year 2000 goals. Belgium's score reflects the recent adoption of a policy statement on population and reproductive health in its overall development cooperation policy.

France, Ireland, Spain, Austria, Portugal and Italy score relatively low in all categories, receiving a grade of "F."

In summary, only a handful of countries have performed at a satisfactory level as population donors in the years following the ICPD.

METHODOLOGICAL NOTE FOR COUNTRY PROFILES

The country profiles provide an update on the population and reproductive health assistance programs of the 20 donor nations included in PAI's 1993 report, *Global Population Assistance: A Report Card on the Major Donor Countries.* No profile of Luxembourg, also a member of the Development Assistance Committee of the OECD, is included owing to its relatively small population size (less than one million people) and low level of involvement in population assistance. However, the profiles include the European Commission, the only institutional member of the DAC, in light of its emerging importance and great potential as a donor in the population sector.

All the donor profiles draw on UNFPA's annual *Global Population Assistance Reports* (GPARs); *The Reality of Aid: An Independent Review of Development Cooperation,* published by a coalition of European nongovernmental organizations; and the OECD's *Development Co-operation 1997 Report.* Information for the individual profiles also came from the OECD/DAC peer reviews of each member country's development cooperation program, government documents, and interviews and personal communications with aid officials and advocacy colleagues in each donor country.

The country profiles also draw on reports submitted by donor governments to the Netherlands Interdisciplinary Demographic Institute (NIDI) for UNPFA's Global Resource Flows for Population Project, for information on the geographic and programmatic allocation of 1996 population funds.

Data analysis also faced a number of limitations. In some cases, reporting is incomplete. For example, UNFPA's GPAR for 1996 estimates Japan's population assistance based on 1995 levels and includes only partial data for European Commission funding, excluding NGO cofinanced projects. In some cases, limitations are methodological. While most of the profiles use the GPAR data to discuss trends in population assistance, because of changes in definitions, data on donor funding for 1995 and 1996 are not strictly comparable either to each other or to 1994 and earlier years. Moreover, some donors appear to be using a far broader definition of population assistance than the standard definition used by UNFPA.

Readers should note that all population assistance figures throughout the text and tables of this report reflect current U.S. dollars unless otherwise stated.

A U S T R A L I A

Australia reports a five-fold increase **in population assistance since 1990, but its contributions still lag far behind the most generous donors.**

GRADE

AUSTRALIA

POPULATION AND REPRODUCTIVE HEALTH ASSISTANCE

OVERALL ASSESSMENT

Australian population assistance in 1996 was five times the 1990 level, among the largest percentage increases in donor contributions over this period. However, Australia lags far behind smaller donor nations such as Denmark and Norway in its contributions to population programs, both in absolute terms and relative to GNP. Some of the reported increase in Australian population funding reflects the broader definition of population aid introduced by UNFPA in 1995. Nevertheless, about a third of funding for bilateral and NGO population programs is focused on family planning services. Australia's strength as a reproductive health donor is largely a reflection of the concentration of these increased resources in Asia and the Pacific, where it has a long-standing presence as a donor and in-depth knowledge of local conditions.

Recent political changes could reverse some of the advances Australia has made as a reproductive health donor. The political environment for population assistance is less favorable than in the past, reflecting both a change in government and active political opposition to family planning assistance programs. Funding for reproductive health is further jeopardized by recent declines in development aid. However, government sources report some recovery in aid allocations planned for the upcoming budget year—and predict that reproductive health funding levels will be maintained.

1 DEVELOPMENT ASSISTANCE: POLICY AND FUNDING

Australia has recently reviewed its long-standing approach to development cooperation in order to improve aid effectiveness. Australia has traditionally been a large bilateral donor to Asian and Pacific countries. The Australian Agency for International Development (AusAID) has focused its efforts on programs to spur economic growth and alleviate poverty in recipient countries. In 1997, the government released the first comprehensive review of Australia's foreign aid policy in over a decade. The report, commissioned by the Minister of Foreign Affairs, is officially titled *One Clear Objective: Poverty Reduction through Sustainable Development,* but unofficially referred to as the Simons Report.

The Simons report recommends various reforms to the aid program including a clearer focus on a single objective—long-term poverty reduction. Additional recommendations include: increased aid concentration through "graduation" of more countries from the aid program and reallocation of resources based on need; increased sectoral concentration; untying the aid program from

AUSTRALIA

VITAL STATISTICS

1996 population size:	18.1 million
Total Official Development Assistance (ODA), 1996:	$1,074 million
ODA as a percentage of GNP, 1996:	0.28%
Total population assistance, 1996:	$32.6 million
Population assistance as percentage of ODA, 1996:	3.03%
Population assistance per $US million GNP, 1996:	$86

Population Action International's Country Grade

commercial interests; and a greater focus on evaluation and aid effectiveness. If the government implements these recommendations, Australia's aid program will likely become more focused, both sectorally and geographically.

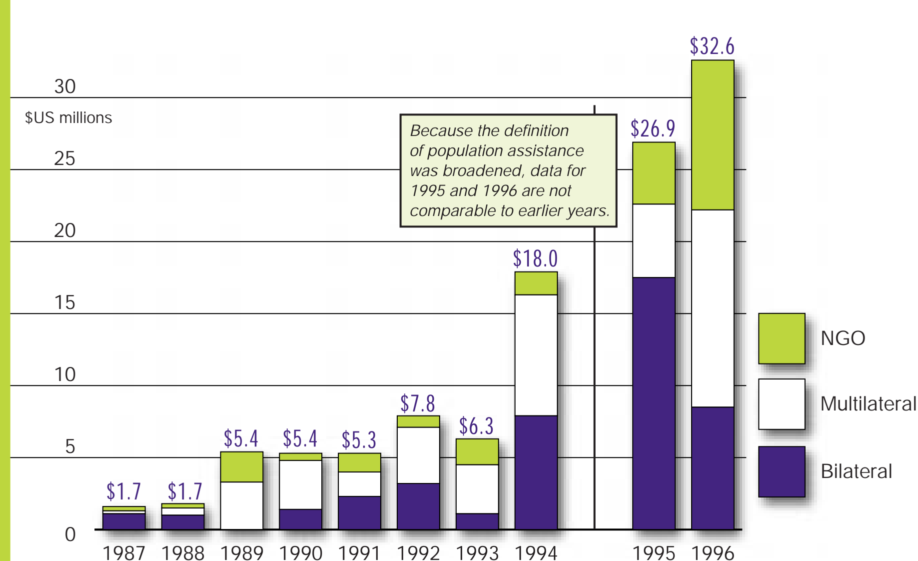
Despite overall budget cuts, current Australian policy identifies reproductive health as a priority and indicates that funding for the health sector will be protected. As a result of across the board deficit cutting measures, the government reduced the 1996-97 foreign aid budget by 10 percent from the previous year. These budget reductions were largely realized by discontinuing a relatively ineffective mixed credit scheme designed to benefit Australian business and develop the private sector in recipient countries. However, other areas of the Australian aid program still experienced a budget reduction of about 2 percent.

This decrease brought Australia's ratio of development assistance to GNP down to a record low of 0.28 percent in 1996 and 1997—well below the 0.4 percent donor average and the 0.7 percent UN target for development aid. However, as funds committed in previous budget years are still being disbursed, actual expenditures on some development programs—as distinct from budget allocations—have declined only slightly and do not yet fully reflect these reductions. Australian government sources predict a reversal of the negative trend in development aid in the upcoming budget year, and project an increase in the aid budget of 0.5 percent in inflation adjusted terms in 1998-99. Still, the anticipated aid to GNP ratio of 0.27 percent will remain significantly below the 1995 level of 0.35 percent.

2 THE POLICY ENVIRONMENT FOR INTERNATIONAL POPULATION ASSISTANCE

The current political environment for population assistance in Australia is less favorable than in the past. The policy environment has deteriorated from the early 1990s when the former Labour government initiated a four-year $105 million "Population Initiative" between 1993 and 1996, although key foreign policy officials remain supportive. While the current coalition government has not acted to cut funding for reproduc-

TRENDS IN POPULATION ASSISTANCE 1987–1996



Sources: Population assistance: UNFPA. Vital statistics: UNFPA, UN Population Division, OECD.

Two recent aid reviews identify population and family planning assistance as among the most cost-effective aid investments available to AusAID.

tive health programs, there is active opposition to international family planning assistance from a few conservative members of parliament.

However, two recent aid reviews identify population and family planning assistance as among the most cost-effective aid investments available to AusAID. The recent Simons Report recommends that Australia take on an expanded role as a population donor: "population activities, including voluntary family planning, should be at least maintained and possibly increased in real terms in the interests of advancing health, human rights and development objectives…" *The Independent Inquiry into Population and Development* also endorses this view.

Despite these recommendations, the Australian government has not sustained the pace of recent increases in family planning funding. Australian reproductive health advocates believe that increased allocations to broader health programs have masked declines in actual funding for family planning. The government has officially accepted the recommendations of the Simons report, but with the caveat that funding levels for population activities will be determined by availability of resources in the overall aid budget and "the priorities of partner governments."

AusAID activities in the population sector are governed by a statement of guiding principles and the use of a "population checklist" for monitoring and reporting purposes. The guiding principles emphasize freedom of choice, broad access to reproductive health services, and a commitment to improving quality of care. The population checklist is a tool developed by AusAID—in response to a Ministerial initiative—to screen proposed activities, and for monitoring and reporting purposes.

The checklist focuses on the social appropriateness of the reproductive health intervention, and requires certification as to the voluntary nature of family planning, and the exclusion of abortion-related training and services. Although AusAID supports contraceptive supplies in only a few of its family planning projects, the checklist restricts the use of Australian funds to purchasing pills, condoms, Depo-Provera and two types of IUDs.

The Australian Reproductive Health Alliance (ARHA), established in 1995, is the main NGO involved in advocacy for international reproductive health. ARHA's mandate is to ensure Australian support for the goals of the International Conference on Population and Development. ARHA provides support to the All-Party Parliamentary Group for Population and Development and engages in public education activities aimed at increasing Australian population assistance through both bilateral and multilateral channels.

3 TRENDS IN FUNDING FOR POPULATION ASSISTANCE

OVERALL FUNDING LEVELS: Australian funding for population programs has increased dramatically, but it is unclear if current funding levels will be maintained in the future. Australian assistance to population programs rose from about $5 million a year in the early 1990s to about $18 million in 1994—largely as a result of the "Population Initiative." Population assistance levels continued to increase in subsequent years, reaching $32 million in 1996. At this level, Australia provides about $86 per million dollars of GNP in population assistance—roughly comparable to the level provided by the United States, but far below the contribution of the Nordic countries and the Netherlands.

Australian government sources estimate funding for direct population and family planning activities in 1997-98 at about $16 million. According to the government's own broad definition of population activities, which includes maternal and child health and health worker training programs, the total would approach $29 million. The budget for 1998-99 maintains this level of expenditure on population activities, broadly defined, and allocates an additional $14.6 million to HIV/AIDS programs.

MULTILATERAL FUNDING: Australia is a minor donor to most multilateral organizations in the population field. During the 1990s, Australia allocated an average of 50 percent of total population assistance to multilateral organizations. This assistance is spread broadly among various UN and other international health agencies; Australia does not rank as a major donor to either UNFPA or the World Health Organization (WHO).

Australian contributions to UNFPA's core budget peaked in 1996 at only $2.2 million. The Australian contribution declined to $1.6 million in 1997—ranking Australia 13th among the Fund's donors. Over the last few years, Australia has also contributed additional funds to UNFPA for specific multi-bilateral programs—over $2 million in 1995 and 1996 but only $226,000 in 1997. Australia also contributes to UNAIDS, the WHO human reproduction research program, and other WHO activities relating to maternal health, safe motherhood and HIV/AIDS.

BILATERAL FUNDING:

Bilateral population funding rose rapidly during the 1990s. Between 1986 and 1993, Australian bilateral funding for population programs fluctuated at a low level—between $1 million and $3 million annually. Following the inception of the Population Initiative and the introduction of an expanded definition of population assistance, reported levels of bilateral assistance increased sharply to $17.5 million in 1995 and then dropped to about $8.5 million in 1996.

FUNDING FOR NGOS:

Australia funds several major international NGOs, again at relatively low levels. Since 1995, it has contributed approximately $1.2 million a year to IPPF, although its 1997 contribution fell slightly, to about $1 million. Australia also made small contributions to the International Union for the Scientific Study of Population and the Population Council in 1995 and 1996, but has since discontinued this assistance.

4 PROGRAM PRIORITIES

GEOGRAPHIC PRIORITIES:

Australia's aid program focuses almost exclusively on Asia and the South Pacific. This geographic emphasis is also reflected in its population and health assistance. Australia has identified HIV/AIDS prevention in South and Southeast Asia as a priority area for assistance given rising HIV infection rates, and also seeks to reduce infant and maternal mortality in the region.

Country-specific initiatives include a $17.7 million AIDS/STD prevention program in Indonesia, funded since 1995, which aims to develop HIV/AIDS policy at the local and national level, train staff in STD management, and support STD education and communication activities implemented by NGOs. Other reproductive health initiatives in the region include projects in the area of maternal and child health care in Laos and the Philippines; training in women's health research in Vietnam; family planning and child health activities in China; and the expansion of family planning services in the South Pacific. Australia also provides support to the national family planning association in Thailand.

AREAS OF PROGRAM EMPHASIS:

Australian population assistance has a strong emphasis on reproductive health service delivery. Australian assistance has sought to reduce infant and maternal mortality by expanding and improving family planning services, training health workers and supporting information, education and communication programs. In the South Pacific region, where population growth rates remain especially high, Australia's bilateral program has focused on population policy development and population education, in addition to training of health workers.

Since the Population Initiative concluded in June 1997, AusAID has been reformulating its health and population strategy. The new policy is expected to focus on primary health care, disease prevention including HIV/AIDS prevention and care, and capacity building for local health institutions. Program strategies will emphasize simple, low-cost health interventions, local participation and targeting of those in greatest need. Australian aid officials anticipate the policy will be launched in 1998.

5 TECHNICAL CAPACITY

STAFFING:

AusAID's population and reproductive health programs are managed by the Health Group, which is staffed by five policy officers and three public health advisors. These eight staff members provide policy advice and technical assistance on a range of health issues including reproductive health and population.

TECHNICAL EXPERTISE OF COLLABORATING INSTITUTIONS:

The Australian IPPF affiliate is the major NGO involved in the population assistance program. Eight independent state-level family planning associations have also formed Family Planning Australia, Inc., an umbrella NGO which provides expertise to the overseas aid program.

There is active opposition to family planning aid from some Australian parliamentarians.

AUSTRIA

Austria is currently a minor donor in the population field, but awareness of reproductive health issues is growing slowly among aid officials.

GRADE

AUSTRIA

POPULATION AND REPRODUCTIVE HEALTH ASSISTANCE

OVERALL ASSESSMENT

Austria is currently a minor donor in the population field, but awareness of reproductive health issues is growing slowly among aid officials. To date, the bilateral aid program has done little to address population and reproductive health concerns. Although Austrian development cooperation policy has emphasized the role of women in development, the aid program has not yet recognized the linkages between the status of women and their reproductive rights and health.

The greatest potential to expand Austria's support to population programs is through its role in multilateral organizations. The Austrian government has the potential to increase its small contribution to UNFPA. Austria will also have some influence over the priority given to ICPD goals by the European Commission (EC) aid program, when it assumes the rotating European Union (EU) presidency in late 1998. In addition, Austria's recent EU membership has led to a number of positive developments that appear likely to improve the coherence of its bilateral aid program.

1 DEVELOPMENT ASSISTANCE: POLICY AND FUNDING

Austria is one of the smaller European donors, ranking 16th out of the 21 major donor countries in 1997 in total aid volume. Austria's development assistance in that year represented only 0.26 percent of GNP—significantly lower than the donor country average of 0.4 percent.

Development aid in Austria is fragmented both in its administration at home and its geographic and sectoral allocation overseas. Overall responsibility for development assistance lies with the Federal Ministry for Foreign Affairs, which also oversees most bilateral assistance and almost all UN activities. However, the Ministry of Finance is responsible for relations with the International Monetary Fund and the World Bank. To facilitate coordination between these different entities, the government has established two consultative councils within the Ministry of Foreign Affairs, which include government, political and NGO representatives.

AUSTRIA

VITAL STATISTICS

1996 population size:	8.1 million
Total Official Development Assistance (ODA), 1996:	$557 million
ODA as a percentage of GNP, 1996:	0.24%
Total population assistance, 1996:	$861,000
Population assistance as percentage of ODA, 1996:	0.15%
Population assistance per $US million GNP, 1996:	$4

Population Action International's Country Grade

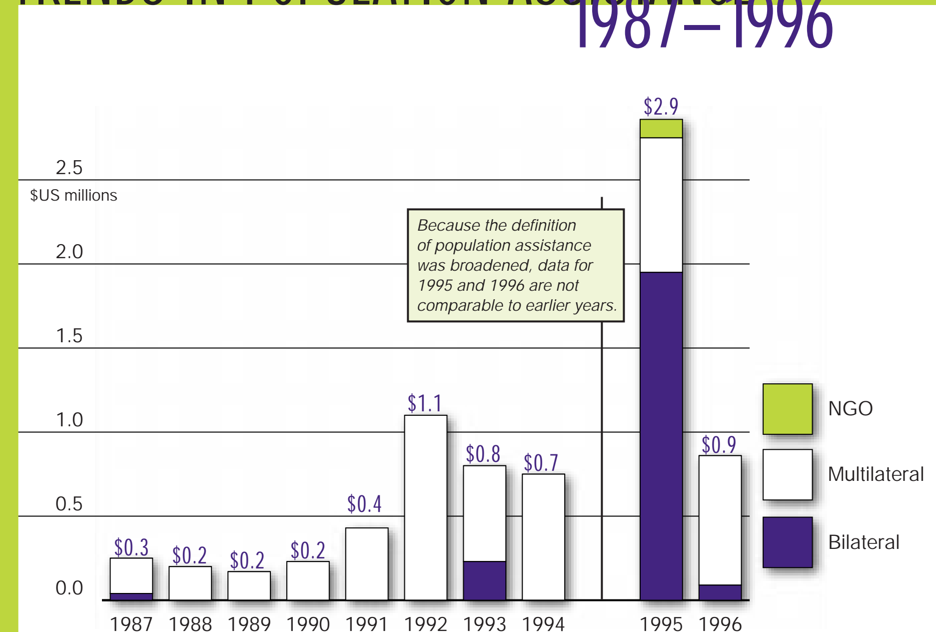
Despite these efforts, Austrian development assistance has historically lacked a clear strategy in terms of both external policy and internal coordination among government agencies. Austrian development aid levels are also difficult to assess since they traditionally include domestic expenditures on refugees, scholarships for students from developing countries and export credits. Moreover, actual aid allocations to developing countries are distributed across many countries and sectors.

Austria concentrates its development aid on poverty alleviation, based on the rationale that ameliorating poverty has a positive impact on many other areas, including population, health, education, environment, gender equity, governance, and internal and external political stability. Austria dropped health as a priority sector several years ago, perceiving it has no special expertise to offer in this sector.

Priority countries for Austrian development assistance currently include Bhutan, Burkina Faso, Cape Verde, Ethiopia, Mozambique, Nicaragua, Rwanda and Uganda. Development cooperation activities are also undertaken with Costa Rica, El Salvador, Guatemala, Kenya, Namibia, Nepal, Pakistan, Senegal, Tanzania and Zimbabwe.

Recent changes in the Austrian aid program include restructuring of aid management and adoption of new sectoral priorities. Austria's entry into the EU in 1995 prompted the government to reexamine many issues related to the development cooperation program. The bilateral aid budget has declined, in part owing to new financial obligations resulting from Austria's EU membership. As an EU member, Austria also has obligations in the policy arena, including coordination of development assistance. Other changes include the concentration of aid in fewer recipient countries, and the development of a strategic approach to country programming for the first time.

TRENDS IN POPULATION ASSISTANCE 1987–1996



Sources: Population assistance: UNFPA. Vital statistics: UNFPA, UN Population Division, OECD.

AUSTRIA

Austrian development assistance has historically lacked a clear strategy in terms of both external policy and internal coordination.

2 THE POLICY ENVIRONMENT FOR INTERNATIONAL POPULATION ASSISTANCE

Austria does not have an explicit policy on population assistance. Neither family planning nor reproductive health are official priorities, although in some cases Austrian support to women in development activities may deal peripherally with women's health. NGOs in Austria report that the ICPD has resulted in increased interest in reproductive health within the aid bureaucracy, but this has not translated into changes in funding under the development cooperation program to date.

The main reproductive health NGO in Austria is Osterreich gesellschaft fur familienplanung (OGF)—the IPPF-affiliated national family planning association. OGF has conducted education and advocacy activities related to the ICPD with Austrian parliamentarians.

3 TRENDS IN FUNDING FOR POPULATION ASSISTANCE

OVERALL FUNDING LEVELS:

Austria is one of the smallest donors to population programs. Austrian funding for population programs has risen slowly since 1990, when the government allocated only $225,000 to these programs. In 1996, Austria reported $861,000 in population assistance through bilateral and multilateral channels. Austrian population assistance is low not only in absolute volume, but also in terms of the percentage of overall aid allocated to population assistance. In 1996, Austria gave only $4 per million dollars of GNP in population assistance, compared to $242 per million contributed by Sweden, which has a similar sized economy.

MULTILATERAL FUNDING:

Until 1992, Austria allocated all its population assistance through multilateral channels. Since 1993, Austria's reported contributions to bilateral and multilateral programs have been highly variable from year to year, suggesting inconsistencies in reporting and data quality. In 1994, Austria gave $1 million to UNFPA, but since then its contribution has fallen to approximately $545,000 in 1997. Austria also contributes to UNICEF, UNDP, the World Bank and the regional development banks, although these funds are not specifically earmarked for reproductive health.

BILATERAL FUNDING:

Data gaps and inconsistencies in reporting make trends in Austria's bilateral population assistance difficult to assess. Austria reported a large increase in bilateral assistance in 1995. In 1996, however, Austrian bilateral expenditures totaled only $90,000. Since Austria's aid portfolio does not appear to include any explicit support for population or health-oriented projects, it seems likely that these funds reflect a very broad definition of population assistance and are spent primarily on projects to improve the status of women. Moreover, Austria has only reported bilateral population spending in 4 of the last 10 years.

FUNDING FOR NGOS:

There is little or no NGO involvement in the implementation of Austrian population assistance. Austria conducts its broader aid program with significant NGO collaboration. However, Austria does not contribute to IPPF or to other major international NGOs involved in reproductive health.

BELGIUM

The emphasis on family planning and reproductive health in Belgium's new health strategy is a positive response to the Cairo conference.

BELGIUM

POPULATION AND REPRODUCTIVE HEALTH ASSISTANCE

OVERALL ASSESSMENT

Although Belgium is likely to remain a minor donor in the population field, recent policy developments have improved the chances that the Belgian aid program will more directly address reproductive health needs. The emphasis on family planning and reproductive health in Belgium's new health strategy shows a late but nonetheless positive response to the Cairo conference. Historically, most of Belgium's small contribution for population programs has been channeled multilaterally, but Belgium is expanding its bilateral and NGO assistance in this area. The Belgian aid program has yet to demonstrate, however, that it can back up its new policy with increased funding and effective implementation of reproductive health initiatives.

VITAL STATISTICS

1996 population size:	10.2 million
Total Official Development Assistance (ODA), 1996:	$913 million
ODA as a percentage of GNP, 1996:	0.34%
Total population assistance, 1996:	$5.5 million
Population assistance as percentage of ODA, 1996:	0.60%
Population assistance per $US million GNP, 1996:	$21

Population Action International's Country Grade

GRADE

1 DEVELOPMENT ASSISTANCE: POLICY AND FUNDING

Belgium appears poised to fundamentally restructure its development assistance program and formulate new policy priorities, including greater emphasis on population and reproductive health assistance. Belgian development policy historically has tied development assistance to business interests, resulting recently in a series of corruption-related scandals in the foreign aid system.

In response to these events, the Belgian government has reorganized the Administration for Development Cooperation (AGCD), the main agency in charge of administering development assistance. It has also proposed the establishment of an independent agency to implement technical cooperation activities under the oversight of the AGCD. To coordinate Belgian aid efforts in developing countries, the State Secretary for Development Cooperation within AGCD chairs an interministerial working group

including the Ministries of Finance, Foreign Affairs, Foreign Trade, Agriculture, Economic Affairs, Science Policy and Defense.

The AGCD continues to grapple with obstacles to its effectiveness, in particular, constraints to the disbursement of foreign aid funds. Only 78 percent of funds committed in 1996 were disbursed in that year, owing to a lack of adequate staff to develop new programs. The recent reorganization plans to address this problem by delegating more authority to directors and unit heads within AGCD to accelerate the pace of decision making and disbursements.

It is still unclear whether ongoing changes in the administration of development programs will ultimately lead to increased levels of foreign aid. Public support for development assistance remains limited as Belgians in general are more concerned about domestic economic and political problems than about international economic cooperation. Belgium's overall aid levels peaked in the early 1980s and fell to about $764 million in 1997—about 0.31 percent of GNP. Belgium ranked 15th out of 21 donor countries in volume of aid given in 1997. The proportion of development assistance flowing through the bilateral channel has fluctuated between 60 and 70 percent in recent years.

2 THE POLICY ENVIRONMENT FOR INTERNATIONAL POPULATION ASSISTANCE

In late 1997, the Belgian government released a new policy for development cooperation which strongly emphasizes family planning and reproductive health as priorities for Belgian assistance in the health sector. The policy statement endorses the ICPD definition of reproductive health and advocates the integration of reproductive health services into the health system in order to increase women's access to care. The appointment of a physician as Secretary of State for Development Cooperation was an important influence in the development of this new policy. The State Secretary, Dr. Reginald Moreels, is also the former head of the Belgian chapter of the international NGO, Doctors Without Borders.

The political environment for population assistance in Belgium is complex. While the Cairo and Beijing conferences have been an important influence on development policy, increased discussion of population and women's health issues has been largely within the governmental sphere rather than among the population at large. A predominantly Catholic country, Belgium is home to a vocal minority of religious and right wing parties in Parliament who are active in opposing family planning both at home and abroad.

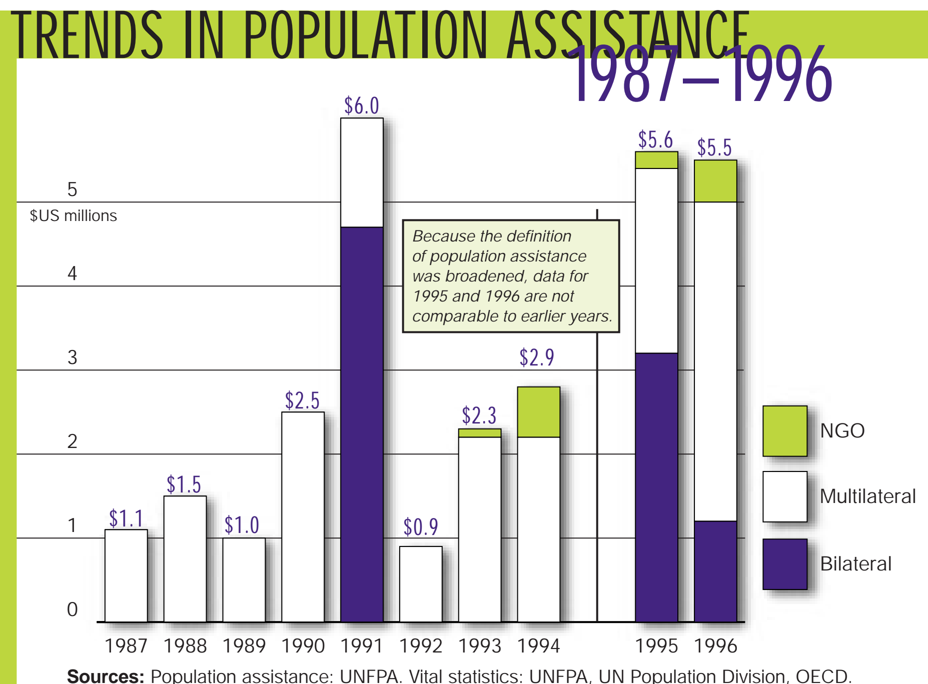
The government anticipates vigorous parliamentary debate regarding the new development policy, especially the focus on family planning. Despite this anticipated debate, both the development cooperation law and its strong emphasis on reproductive health and family planning are expected to be approved and implemented as planned.

3 TRENDS IN FUNDING FOR POPULATION ASSISTANCE

OVERALL FUNDING LEVELS:
Belgium's contributions to population assistance have gradually increased from about $1 million in 1987 to $5.5 million in 1996. This low level of funding ranked Belgium 16th among the top 20 donors to reproductive health programs in 1996.

MULTILATERAL FUNDING:
Historically, Belgium has allocated the vast majority of these funds to multilateral channels. Belgium makes voluntary contributions to a number of international organizations involved in population and reproductive health. These include UNICEF, the International Union for the Scientific Study of Population, the UN Women's Fund (UNIFEM), UNAIDS and UNFPA.

Belgium's core contribution to UNFPA fell from $2.3 million in 1996 to $1.7 million in 1997, partly



Sources: Population assistance: UNFPA. Vital statistics: UNFPA, UN Population Division, OECD.

reflecting the falling value of the Belgian franc relative to the U.S. dollar. Contributions for multi-bilateral activities—where Belgium contributes to a specific UNFPA program—peaked in 1995 at $1.1 million and then dropped to approximately half a million dollars a year in 1996 and 1997.

BILATERAL FUNDING:

Belgium is a very small bilateral donor to population programs. In 1995, Belgium began allocating bilateral funds to population assistance and reported approximately $3.2 million of $5.6 million in total population assistance as bilateral expenditures. In 1996, a smaller amount flowed through the bilateral channel—just $1.2 million of total population funding of $5.5 million.

FUNDING FOR NGOS:

Recently, the Belgian government has begun allocating funds to NGOs for reproductive health programs. Since 1995, Belgium has provided IPPF with 5 million francs a year, an amount which has declined in U.S. dollar terms owing to exchange rate changes and which represented about $140,000 in 1997. Belgium also co-finances the activities of some Belgian NGOs which are collaborating with developing country NGOs in the areas of AIDS prevention and sexual health education. The shift towards funding NGO reproductive health activities in 1995, even at a low level, is a sign of a positive but still tentative Belgian response to the ICPD.

4 PROGRAM PRIORITIES

GEOGRAPHIC PRIORITIES:

Consistent with the government's overall allocation of development aid, most ongoing bilateral population projects are in sub-Saharan Africa. North Africa, Southeast Asia and the Andean region of South America are lesser priorities. To date, Belgium's largest reproductive health programs have been in Niger, Morocco, Rwanda, and with the Palestinian Authority. In Bangladesh, Belgium has decided to terminate its bilateral cooperation activities but plans to continue support to NGO programs. The new health strategy proposes to concentrate aid resources in 25 priority countries, mostly in sub-Saharan Africa.

AREAS OF PROGRAM EMPHASIS:

The newly proposed development cooperation strategy shifts the emphasis within the overall health sector toward family planning and reproductive health. While still emphasizing the importance of primary health care, the policy statement strongly endorses the ICPD platform and highlights the importance of family planning as a key priority for future health sector activities.

A separate health strategy document seeks to integrate reproductive health within a primary health framework. The policy calls for integrated family planning, HIV/AIDS prevention, maternal and child health and information, education and communication components within primary health projects. Over the past decade, Belgian assistance has also supported reproductive health projects in Kenya and Rwanda, as well as STD/AIDS prevention programs in six other African countries.

Belgian aid officials indicate that other bilateral and multi-bilateral initiatives under consideration include several reproductive health projects in West Africa, a project related to trafficking in women in the Philippines implemented jointly by the University of Manila, the University of Ghent and AGCD, and a project in Laos relating to development of a social health system that will include family planning. There are also plans to develop more integrated programs through other sectors, for example, sexual health education programs through initiatives in the education sector.

5 TECHNICAL CAPACITY

STAFFING:

Belgium does not have a strong cadre of health sector specialists within the AGCD. This is not surprising considering the low level of funding for health programs to date. A 1997 paper on health sector activities reports that 41 Belgian experts work on health sector projects worldwide; no data are available on staff working specifically in population or reproductive health. The majority of health sector staff are assigned to African countries, including 12 in Rwanda and 8 in Niger.

TECHNICAL EXPERTISE OF COLLABORATING INSTITUTIONS:

There are currently no Belgian institutions with the capacity to support the AGCD in implementing international reproductive health assistance programs. Some religiously affiliated NGOs work with local NGOs in developing countries on health-related initiatives, which may include some reproductive health activities. However, these activities are funded out of a separate budget line for NGO collaboration and little information on them is available. A new proposal to support five year programs with such NGOs, rather than fund individual projects, has the potential to strengthen technical collaboration between NGOs and the AGCD in all sectors, including reproductive health.

Belgium has yet to back up its new policy with increased funding for reproductive health initiatives.

CANADA

After declining steeply in the early 1990s,
Canadian population assistance levels have stabilized,
but not recovered.

GRADE

CANADA

POPULATION AND REPRODUCTIVE HEALTH ASSISTANCE

OVERALL ASSESSMENT

After declining steeply in the early 1990s, Canadian population assistance levels have stabilized, but not recovered. Current levels of population assistance are only about a quarter of the level needed for Canada to contribute its fair share of the ICPD year 2000 goals for donor assistance. Given continuing deep cuts in overall development aid, it is unclear whether recently initiated advocacy efforts can help restore—let alone increase—funding for population and reproductive health.

At the policy level, Canada appears to be giving increased priority to reproductive health. A new health strategy adopted by the Canadian aid agency includes a strong emphasis on women's and reproductive health. However, work on a population and reproductive health strategy expected to clarify program priorities and future directions has been suspended. Unless levels of population assistance increase, Canada will likely be a donor of declining importance in the international population field.

Canada channels over half of its population assistance bilaterally. Despite its limited technical expertise, Canada is an effective donor in population and reproductive health, largely because it allocates a significant proportion of bilateral funds to cofinancing of multilateral projects.

1 DEVELOPMENT ASSISTANCE: POLICY AND FUNDING

Canada's development assistance has been declining since 1991. Early in the decade, a lack of high-level political support led to cuts in the foreign aid budget. More recently, economic problems have made it difficult to reverse this trend. While still low historically, 1997 Canadian development assistance increased to $2.1 billion, up from $1.8 billion in 1996. In 1997, Canada ranked 9th out of 21 major donor countries in terms of total aid volume. Canadian aid represented 0.36 percent of GNP, slightly less than the average for the donor community.

Despite recent negative trends, Canada's role as a donor nation remains an important part of its international identity. There is strong public support for humanitarian and emergency aid, although support for long-term development aid may be weaker in the current economic context. Canada also holds a unique position within the donor community as a member of the following intergovernmental groups: the British Commonwealth, La Francophonie, and the Group of Seven major economic powers.

CANADA

VITAL STATISTICS

1996 population size:	29.7 million
Total Official Development Assistance (ODA), 1996:	$1,795 million
ODA as a percentage of GNP, 1996:	0.32%
Total population assistance, 1996:	$36.5 million
Population assistance as percentage of ODA, 1996:	2.03%
Population assistance per $US million GNP, 1996:	$64

Population Action International's Country Grade

Official Canadian development policy identifies basic human needs (including family planning) and women in development as priority program areas. Other priorities include infrastructure services, human rights, democracy and good governance, private sector development and the environment.

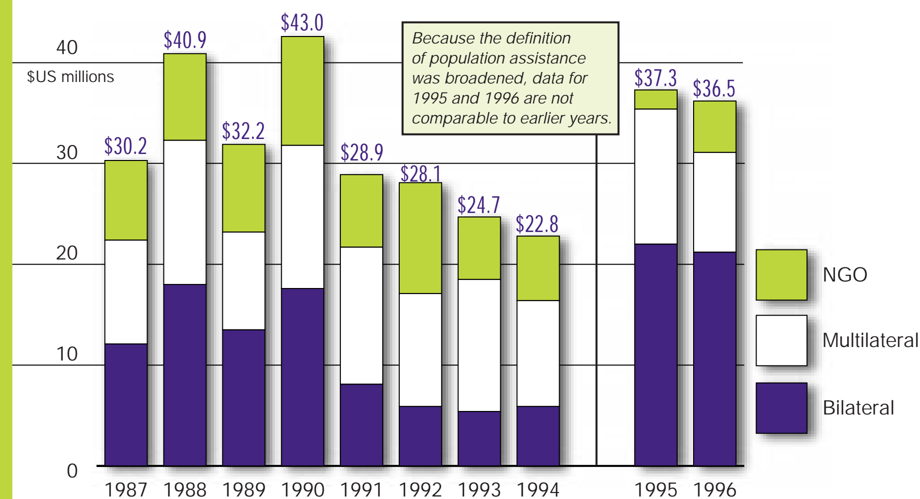
Canadian development assistance is managed by the Canadian International Development Agency (CIDA), which administers 75 to 80 percent of bilateral and multilateral development assistance funds. The Department of Finance, which handles contributions to the World Bank and International Monetary Fund, and the Department of Foreign Affairs and Trade manage smaller portions of the aid budget. As part of a decentralization initiative, CIDA has also delegated limited authority to approve projects to Canadian embassies overseas. Following a series of management reviews and reorganizations during the 1990s, CIDA has recently taken a more "results-based" approach. In response to cuts in the development assistance budget, it has also concentrated its activities in fewer countries.

2 THE POLICY ENVIRONMENT FOR INTERNATIONAL POPULATION ASSISTANCE

In 1996, CIDA released a policy document entitled *Strategy for Health* which assigns high priority to women's health and reproductive health programs. The health policy aims to address problems of poverty and population growth through health projects focusing on women, and also supports access to health services as a human right. The strategy frames the problem of rapid population growth as an impediment to economic growth in developing countries, and also sees reduction of high unmet need for family planning as a prerequisite to arresting the spread of HIV/AIDS and other sexually transmitted diseases (STDs).

Other than these broad policy statements, there is no detailed population strategy to guide CIDA programming in this area. Recognizing this gap, CIDA embarked on an internal consulta-

TRENDS IN POPULATION ASSISTANCE 1987–1996



Sources: Population assistance: UNFPA. Vital statistics: UNFPA, UN Population Division, OECD.

Despite recent negative trends, Canada's role as a donor nation remains an important part of its international identity.

tion process to develop a population, reproductive health and sustainable development strategy. As of mid-1998, however, work on this strategy had been suspended.

On the policy front, the establishment of Action Canada for Population and Development has given advocacy for population assistance a boost. This new NGO, set up in 1997 with the assistance of the Planned Parenthood Association of Canada, aims to promote Canadian fulfillment of its ICPD commitments. The Conservation Council in Ontario is another NGO with a history of involvement in advocacy for Canadian population assistance.

3 TRENDS IN FUNDING FOR POPULATION ASSISTANCE

OVERALL FUNDING LEVELS:

Canadian population assistance declined along with development assistance levels during the 1990s. Funding fell to a low in 1994 of $22.8 million a year, down from a high of $43 million in 1990. CIDA population staff and external advocates have worked hard to maintain core population and family planning assistance in the $20 to $25 million range in recent years, even as CIDA's overall aid budget has continued to shrink.

Following the Cairo conference, Canada reported spending about $37 million annually in 1995 and 1996 on population assistance defined more broadly to include maternal health and AIDS activities. Canada would have to increase its allocations almost four-fold to reach its fair share of the year 2000 goal for donor assistance to population programs, based on Canada's proportional share of total donor country GNP.

MULTILATERAL FUNDING:

Canada's annual contribution to UNFPA peaked in 1994 at $10.1 million, and has since fallen, amounting in 1997 to $6.5 million. Canada provides additional multi-bilateral funding to UNFPA to finance the costs of Canadian junior professional staff on loan to UNFPA, as well as the purchase of Canadian contraceptives. In 1996, Canada also funded UNAIDS at $3 million, including both a core contribution and cofinancing of a multi-bilateral breastfeeding and AIDS project in Zimbabwe. The WHO human reproduction research program receives a modest annual contribution from Canada, amounting in 1996 to about $300,000.

BILATERAL FUNDING:

Canada increased the bilateral share of its population assistance from one-fifth of the total in 1992 to over half in 1996. Bilateral funds are concentrated in Asia and Africa, which in 1996 received the bulk of overall reproductive health funding.

FUNDING FOR NGOS:

Canada supports numerous NGOs working in the international family planning and reproductive health arena. In 1996, CIDA disbursed about $4.4 million through its "partnership branch" to international NGOs such as IPPF, the Population Council, the International Council on Management of Population Programs, the Planned Parenthood Federation of Canada and various other health and development NGOs. In 1996, support to family planning NGOs amounted to about $3.7 million; funding for NGOs working in other areas of reproductive health, including HIV/AIDS, totaled about $684,000.

The health strategy adopted by the Canadian aid agency includes a strong emphasis on women's and reproductive health.

The Canadian government cut support to IPPF by almost 50 percent between 1988 and 1997. Contributions to IPPF, historically the major recipient of Canada's population assistance through the NGO channel, fell from over $6 million in 1994 to $368,000 in 1995. These funding cuts resulted from a new policy announced in 1994 by the Ministry of Foreign Affairs and Trade, limiting eligibility for Canadian support to international NGOs based in Canada. At the time, CIDA proposed to partly offset these cuts by increasing direct support to national family planning associations affiliated with IPPF, particularly in the Africa region. Despite protests by advocacy groups, CIDA has only partially restored its core support to IPPF, to about $3.3 million in 1996.

4 PROGRAM PRIORITIES

GEOGRAPHIC PRIORITIES AND AREAS OF PROGRAM EMPHASIS:

The Canadian bilateral population program is concentrated in Asia; its most substantial activity—in terms of both funding and length of involvement—is cofinancing of the World Bank's Bangladesh Health and Population Project (BHPP). The project is implemented by the Bangladesh government and local NGOs with the support of a consortium of donors under the World Bank's leadership. Canada has been a large donor to this project since its inception in the early 1970s. CIDA resources currently support the purchase of oral contraceptives, the strengthening of management information systems, formulation of a master plan for human resources development in the health sector, and services provided by local NGOs.

Canada also supports smaller projects focusing on other aspects of reproductive health in China (maternal and child health) and Indonesia (safe motherhood). In Africa, Canada has recently supported regional family planning projects in Southern African, West Africa and the Sahel, as well as country-specific projects in Egypt, Eritrea, Malawi, Tanzania and Zimbabwe. In Latin America, Canada cofinances a small multi-bilateral project with UNFPA in Haiti, and other reproductive health programs emphasizing safe motherhood and STD/HIV prevention in Peru and Bolivia, as well as on a region-wide basis.

5 TECHNICAL CAPACITY

STAFFING:

Critics of Canadian population assistance cite the dearth of expertise in CIDA as a major constraint to effective bilateral programming in the sector. In 1997, CIDA hired a new reproductive health expert, increasing total senior technical staff in this area to three. Five other staff within CIDA work on broader health issues, which may include some aspects of reproductive health.

TECHNICAL EXPERTISE OF COLLABORATING INSTITUTIONS:

Although Canada is home to numerous NGOs involved in international development, few of these NGOs focus specifically on population and reproductive health issues. The International Development Research Center, a government-affiliated think tank previously active in this area, has reduced its involvement in population research activities during the 1990s, leaving the population research niche largely unfilled in Canada. CIDA meets the technical needs of its bilateral program from in-house sources or through individual consultants, supplemented in some cases by experts from Canadian universities.

The dearth of reproductive health expertise at CIDA constrains effective programming in the population sector.

DENMARK

Denmark gives the most population assistance of any donor country on a per capita basis and relative to the size of its economy.

GRADE

DENMARK

POPULATION AND REPRODUCTIVE HEALTH ASSISTANCE

OVERALL ASSESSMENT

Denmark's unique policy of "active multilateralism" and high levels of aid make it an influential donor in the international population field. The Danish government has doubled its contribution to population programs following the ICPD, and gives the most population assistance of any donor country on a per capita basis and relative to the size of its economy. The government has chosen not to develop a bilateral program or domestic technical capacity in the area of international reproductive health, and channels most of its assistance in this area through UNFPA and IPPF. Denmark is an activist donor, seeking to influence these organizations on both policy and programmatic issues, including their geographic allocation of funds.

At the policy level, Denmark has truly embraced the Cairo population and reproductive health agenda. Official Danish documents state that "population is now an interdisciplinary, thematic priority area which should…always be taken into consideration, both in bilateral and multilateral Danish development cooperation." At international meetings, Denmark is at the forefront of the donor community in advocacy for ICPD goals.

1 DEVELOPMENT ASSISTANCE: POLICY AND FUNDING

The Danish government is more generous than virtually all other donor nations in the overall aid it provides relative to the size of its economy. While on average, donor countries provide 0.4 percent of GNP in development assistance, Denmark gave a full 1 percent of GNP in aid in 1996 and 1997. Denmark has consistently exceeded the UN goal that donor countries provide 0.7 percent of GNP in development assistance, a noteworthy achievement since many other donor countries that have endorsed this goal are still struggling to reach it. Moreover, this level of aid appears politically sustainable, since the majority of the Danish people strongly support foreign aid. According to a 1995 survey, 75 percent of Danes endorse maintaining development assistance at the level of 1 percent of GNP.

An emphasis on poverty reduction guides the geographic allocation of Danish bilateral aid resources. In 1994, the Danish government released its development aid strategy, titled *A Developing World—Strategy for Danish Development Policy Towards the Year 2000.* According to this document, poverty reduc-

DENMARK

VITAL STATISTICS

1996 population size:	5.2 million
Total Official Development Assistance (ODA), 1996:	$1,772 million
ODA as a percentage of GNP, 1996:	1.04%
Total population assistance, 1996:	$63.0 million
Population assistance as percentage of ODA, 1996:	3.56%
Population assistance per $US million GNP, 1996:	$371

Population Action International's Country Grade

tion is the central goal of Danish development policy. Despite consensus on this goal, there continues to be considerable debate among policy makers on which strategies Denmark should employ to achieve it. The aid strategy calls for Denmark to concentrate its bilateral efforts in 20 priority countries with an emphasis on the poorest nations of sub-Saharan Africa. In 1997, Africa received 50 percent of Danish development aid, while Asian nations received 22 percent and Latin American countries 8 percent.

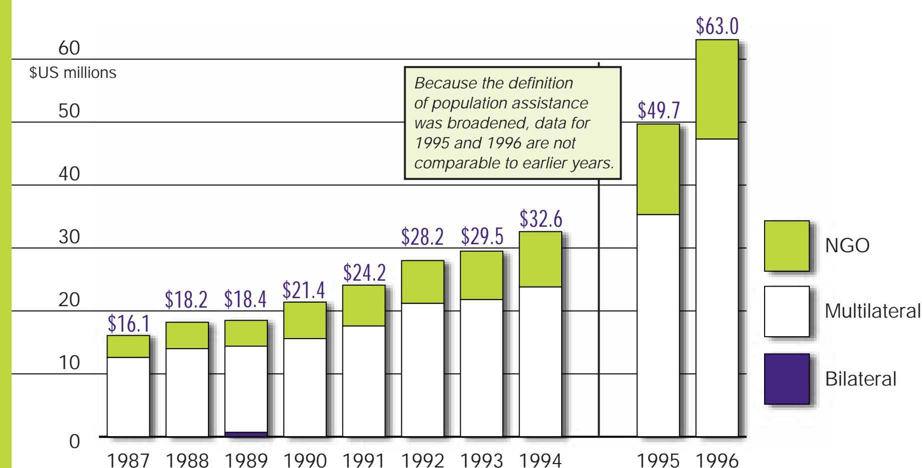
Aid administration in Denmark is effectively coordinated by a single Ministry which handles both bilateral and multilateral aid portfolios. Danish aid is administered through the Ministry of Foreign Affairs (MFA). Within the Ministry, the "South Group" sets aid, trade and foreign policy, and a separate Minister for Development Cooperation is responsible for the implementation of bilateral and multilateral assistance programs. This arrangement is seen as optimal since a single Ministry houses both policy and implementation relating to foreign aid, reducing the need for formal coordination. Denmark has traditionally divided its overall development assistance equally between bilateral and multilateral channels.

2 THE POLICY ENVIRONMENT FOR INTERNATIONAL POPULATION ASSISTANCE

Along with trade and debt relief, population is one of three priority themes for Danish development assistance. As part of the 1994 aid strategy development process, Denmark also reformulated its approach to population assistance, which it has traditionally supported solely through multilateral channels.

Denmark's sexual and reproductive health and rights approach is highly consistent with the ICPD *Programme of Action.* The Danish strategy incorporates family planning and maternal and child health within a larger concept of "Sexual and Reproductive Health and Rights." This broader definition includes the needs of previously neglected groups such as adolescents and men, and emphasizes the linkages between issues such as infertility, sexually transmitted diseases, environmental effects

TRENDS IN POPULATION ASSISTANCE 1987–1996



Sources: Population assistance: UNFPA. Vital statistics: UNFPA, UN Population Division, OECD.

Denmark provides significant financial resources as well as policy guidance to UNFPA, its most important multilateral partner in the population field.

of population growth, declining fertility and economic growth, women's and girls' education, and sexual and reproductive health services.

Danish development policy embraces a strategy of "active multilateralism." This term refers to Denmark's preference for relying extensively on the UN system and other international organizations to channel development aid, while also vigorously seeking to influence the policies and programs of these organizations. In keeping with this policy, Denmark provides significant financial resources as well as policy guidance to UNFPA, its most important multilateral partner in the population field. Denmark has, for example, recommended that UNFPA expand its activities in Africa, and in 1995 made a special supplementary contribution of about $6 million in funds to UNFPA earmarked to advance the ICPD agenda within the region. Denmark has also suggested that UNFPA increase the use of NGOs in program implementation, and decentralize and retrain its staff to enhance their capacity to implement the Cairo agenda in the field.

3 TRENDS IN FUNDING FOR POPULATION ASSISTANCE

OVERALL FUNDING LEVELS:

Denmark has steeply increased its population assistance levels, particularly since 1994. Between 1993 and 1996, Denmark more than doubled its allocations to population from $29 million to $63 million. In 1996, Denmark was the sixth highest donor in the population field, providing almost 5 percent of total donor resources for population programs. Historically these high funding levels have been allocated between multilateral and NGO channels; Denmark has no bilateral population program.

MULTILATERAL FUNDING:

Denmark's core contributions to UNFPA account for a large proportion of the overall increase in Danish population funding since 1994. Denmark rose from the fifth highest ranking donor to UNFPA in 1993 to third place in 1997, when contributions amounted to $33.8 million. The Danish contribution to UNFPA actually peaked in 1996 with a contribution of $47 million, when it also provided a small amount of additional funding for multi-bilateral projects. That year Denmark ranked as the second largest donor to UNFPA, behind Japan.

In 1998, Denmark pledged approximately $33.5 million in core funds to UNFPA. Support for 1999 is expected to be maintained at roughly this level, with additional funds earmarked for the ICPD mid-decade conference.

FUNDING FOR NGOS:

Denmark has an explicit policy of supporting NGO involvement in reproductive health program implementation. The International Planned Parenthood Federation (IPPF), the most prominent international NGO in the reproductive health field, attracts significant Danish assistance. Danish core contributions to IPPF have increased steadily over the past decade, rising especially sharply, by over 20 percent annually, between 1993 and 1995. In 1997, Denmark contributed $12.8 million to IPPF and was the second largest donor to the Federation behind Japan. In 1996, Denmark contributed additional restricted funds to IPPF to advance the Cairo agenda in Africa ($1.7 million) and for IPPF's Vision 2000 strategic plan implementation ($1.7 million). The 1998 Danish contribution to IPPF of approximately $11.4 million is expected to increase slightly in 1999.

Bureaucratic obstacles and a slow disbursement rate have limited the great potential of the European Commission's population program.

EUROPEAN UNION

POPULATION AND REPRODUCTIVE HEALTH ASSISTANCE

OVERALL ASSESSMENT

The European Commission (EC) faces many constraints to realizing its enormous potential as a donor in the population and reproductive health field. To date, the bureaucracy of the Commission, which administers the European Union's development cooperation program, has undermined the impact of its financial support to population programs. The Commission has disbursed only a tiny percentage of the funds committed to population activities. Although formal mechanisms exist for consultation among the different units involved in population activities, effective coordination on policy and implementation has been problematic. This situation is gradually improving as a result of a reorganization in mid-1998, as well as increased informal communication among population program staff.

However, the greatest obstacle to the Commission's effectiveness in population and reproductive health assistance is the inadequacy of its expertise in this area. Expert staff available to the Commission are limited and often in place only on a short-term basis. Until these problems affecting the quality and efficiency of aid in the population sector are resolved, the Commission will continue to perform below its full potential as a population donor. Moreover, while the Commission claims it has already reached its own year 2000 goal of 300 million ECU (about $347 million) in annual *commitments* to population programs, annual *spending* lags far behind and is unlikely to reach that level within the next two years.

NOTE: The European Union is not graded because most of the indicators used to score individual donor countries do not apply.

1 DEVELOPMENT ASSISTANCE: POLICY AND FUNDING

During the 1990s, the European Commission emerged as the world's fifth largest source of development assistance. The member states of the European Union (EU) allocate a proportion of their development assistance budgets to the European Commission (EC), the executive body of the EU, for programming and disbursement. In 1996, EU member countries collectively contributed 17 percent of their total aid through the Commission. Over three decades, the level of development aid provided by the Commission has risen steadily, reaching $7.1 billion in 1995 before declining to $5.3 billion in 1997.

Development assistance provided through the Commission is thus complementary to contributions provided directly by member states. In comparing the development assistance contributions of EU member states with those of other large donors, such as the United States or Japan, both their

VITAL STATISTICS

1996 population size of all EU member states:	372.6 million
Total Official Development Assistance (ODA), 1996:	$5,455 million*
ODA as a percentage of GNP, 1996:	NA
Total population assistance, 1996:	$14.0 million
Population assistance as percentage of ODA, 1996:	0.26%
Population assistance per $US million GNP, 1996:	NA

direct aid programs and their contributions through the Commission need to be taken into consideration.

The Commission has a complex structure and process for managing development assistance. Historically, aid provided by the EC has its roots in the 1957 treaty which established the European Economic Community and assigned a special status to its relationship with former European colonies. The EU was formalized in 1992 under the Maastricht Treaty, which created a common market for trade within Europe, but also addresses development cooperation. Within the Commission, four directorates are responsible for external relations. These directorates deal with development cooperation in different regions through various funding instruments.

The Lomé Convention: After gaining independence from the former colonial powers, the Africa, Caribbean and Pacific (ACP) countries negotiated a separate agreement on development assistance with the Commission, formalized as the Lomé Convention in 1975. The convention established the European Development Fund (EDF), which provides aid funds to the 71 ACP signers of the Lomé agreement. The EC establishes separate EDFs for five-year periods with contributions from member states. The current convention—Lomé IV—expires in February 2000 and is currently being renegotiated.

EC aid to ACP countries is based on agreements with each recipient country for a package of technical and financial assistance and trade concessions. Aid to these countries is administered through Directorate-General VIII. Each country negotiates a National Indicative Program of priorities with the Commission and specifies the sectoral focus of EC cooperation. Traditionally, the EC has emphasized infrastructure and economic development rather than the social sectors.

The Lomé Convention also provides for Regional Indicative Programs which cover multiple countries and involve more complex negotiations. These regional initiatives have encountered frequent implementation problems due to the complexity of projects, weak commitment by recipient governments to regional cooperation, and the number of partners involved.

General Budget: The general Commission budget finances development assistance to the Asia and Latin America (ALA) and Southern and Eastern Mediterranean (MEDA) regions, as well as to Central and Eastern Europe and the former Soviet Union, drawing on funds available under special geographic and categorical budget lines. Directorate-General IB administers aid to the MEDA/ALA regions; Directorate-General IA administers aid to Central and Eastern Europe and the former Soviet Union. In 1997, 28 percent of EC aid funds were allocated to Central and Eastern Europe and the former Soviet Union, reflecting a desire to devote a large share of aid to the European region.

EUROPEAN COMMISSION AID BY REGION, 1997

Regional Program	Estimated Appropriations Millions of ECU (millions of $US)	Percent of Total
Lomé/ACP countries	1,810 (2,052)	30
Central & Eastern Europe and the former Soviet Union	1,685 (1,910)	28
Asia & Latin America	477 (540)	8
MEDA	628 (712)	10
Others	1,463 (1,659)	24
TOTAL	**6,063 (6,875)**	**100**

NOTE: 1 ECU = $US 1.134

* 1996 ODA refers only to contributions made by EU member countries through the EC.

SPECIAL BUDGET LINES OF THE EUROPEAN COMMISSION PROVIDING ANNUAL SUPPORT TO POPULATION PROJECTS AND 1998 BUDGET ESTIMATES

Budget Line	Title	Notes/Allocation
B7-6000	Cofinancing of Development Projects with NGOs (for general development projects, including population)	Exclusively for European NGOs. 1998 allocation: 200 million ECUs ($US 218 million)
B7-631	Aid for Population and Reproductive Health Policies and Programs in Developing Countries	Created in 1990. 1998 allocation: 8 million ECUs ($US 8.7 million)
B7-6211	The Fight Against AIDS in Developing Countries	1998 allocation: 14.8 million ECUs ($US 16.2 million)

In the Mediterranean region, between 1990 and 1995 the bulk of aid funds were allocated to humanitarian assistance and food aid. Aid to Asia and Latin America has focused more on the social sectors, including education, women in development and humanitarian aid in Asia, and food aid, rural development and support to NGOs in Latin America. In Central and Eastern Europe and the former Soviet Union, EC programs have emphasized humanitarian assistance, democratization projects and food aid.

Special Budget Lines: Outside of the national and regional programs, the Commission has several special budget lines which can be accessed for support to population and reproductive health activities in all regions. These budget lines are shown above.

Some European NGOs have also successfully accessed additional funds for reproductive health activities through country-specific or sectoral budget lines that do not have a particular health focus. For example, Marie Stopes International (MSI), a British NGO, has obtained funding for reproductive health activities in Cambodia and the West Bank through other budget lines.

2 THE POLICY ENVIRONMENT FOR INTERNATIONAL POPULATION ASSISTANCE

Within its overall aid program, the Commission has given greater emphasis in recent years to health policy, health sector reform and drug policy. As a result, the share of aid resources allocated to the health and population sectors has increased between 1986 and 1995 from one percent to almost three percent.

The Commission has also issued several policy statements on population and reproductive health:

- A 1992 communication on population and family planning made recommendations for policy goals and funding targets. The "Communication on Demography, Family Planning and Cooperation with Developing Countries" proposed to double population aid by 1995 and triple aid levels by the year 2000; improve human resources in the population sector within the Commission; and increase coordination of policies and programs among member states, the Commission and recipient countries. The formal resolution resulting from this communication by the Council of the European Union—one of the EC's legislative bodies—does not reflect these financial targets, but refers to the need for increased resources and improved coordination in the population field.

- **In 1994, the Commission announced its intention to increase funding for population programs "more than tenfold" by the year 2000, to $347 million.** This target was announced by the Commission's leadership prior to the ICPD.

- A 1994 resolution summarizes the Commission's policy on AIDS. The resolution called for 69 million ECU ($US 82 million) in contributions to AIDS programs from 1994 to 1998, under the budget line for AIDS in developing countries. Financial support for AIDS programs has focused on prevention (including improved STD treatment), related health sector support, research and training, technical assistance, and the socioeconomic impacts of the epidemic.

Levels of funding by the EC for population and reproductive health are difficult to assess precisely.

- A further influence on the EC's policy on population assistance is an all-party Working Group within the European Parliament. The Working Group on Population, Sustainable Development and Reproductive Health, established in 1991, aims to raise awareness regarding the need for integrated approaches in the areas of population, reproductive health, sustainable development, gender equality and the environment, and to provide a forum for ongoing dialogue on these issues. It also seeks to monitor and increase EU resources for programs to address problems related to population, sustainable development and reproductive health.

- In 1998, the Working Group engaged in an intense and ultimately successful advocacy effort to restore proposed cuts in the budget line, "Aid for Population Policies and Programmes in Developing Countries." In the future, it plans to focus on raising awareness within the European Parliament regarding needs in the areas of safe motherhood, refugee reproductive health, and gender-based violence and female genital mutilation. Despite general support for population and reproductive health within the parliament, some conservative members are reportedly uncomfortable with more controversial issues such as sexual and reproductive rights or unsafe abortion.

- As of mid-1998, preparation of a new policy paper on reproductive health assistance was underway. The proposed "Communication on Aid for Reproductive Health in Developing Countries" will focus on family planning, safe motherhood, HIV/AIDS and STDs, adolescents and violence against women. The paper, likely to be issued as a formal Commission "communication," is expected to be finalized in 1999.

3 TRENDS IN FUNDING FOR POPULATION ASSISTANCE

OVERALL FUNDING LEVELS:

Levels of funding provided by the EC for population and reproductive health are difficult to assess precisely. The Commission only began reporting population-related spending to UNFPA in 1996; partial data for 1994 and 1995 are available from other sources. The EC reported spending $14 million in 1996 on population-related projects—a figure considered to be an underestimate of actual spending but currently the only available estimate. Figures for the two prior years reflect only funds allocated through NGOs, at $3.7 million in 1994 and $3.6 million in 1995.

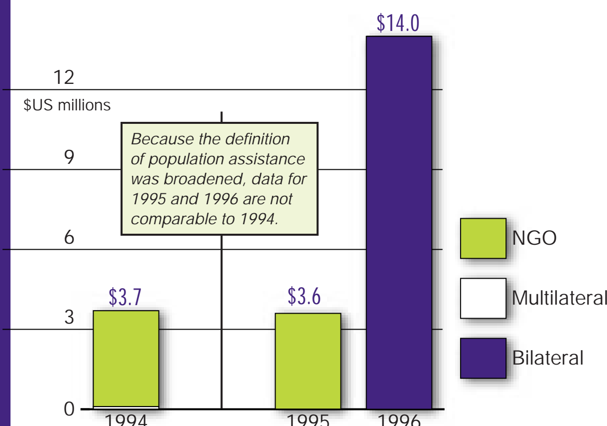
MULTILATERAL FUNDING:

The Commission does not contribute core support to multilateral organizations in population or other sectors. However, it is collaborating with UNFPA on a special NGO reproductive health initiative in Asia (see below), and is supporting costs incurred by UNFPA for coordination of this activity.

BILATERAL FUNDING:

Commission funds for country-level programs are potentially the largest source of EC funding for population activities, but are difficult to track. These funds flow through the European Development Fund (for Lomé Convention countries) and from the general Commission budget. The Commission reports an increase in population funding disbursed through the EDF from $7.3 million in 1994 to $10.7 million in 1996. No consolidated data are currently available on funding under the general budget for population programs in other regions. Under the special budget line, "Aid for Population Policies and Programs in Developing Countries," the Commission disbursed about $4.5 million in 1996.

TRENDS IN POPULATION ASSISTANCE 1994–1996



Sources: Population assistance: UNFPA.
Vital statistics: UNFPA, UN Population Division, OECD.

NOTE: According to UNFPA, data on expenditures for population assistance in 1994 and 1995 came from sources other than the EC. 1995 figures represent multi-year assistance and 1996 figures do not include NGO co-financed projects.

FUNDING FOR NGOS:
As noted above, NGOs can access Commission funds through several different budget mechanisms. In 1994 and 1995, the Commission reported funding for NGO population programs at $3.7 and $3.5 million. Given the complexity of the Commission budget and lack of systematic reporting of disbursements, expenditures on NGO programs in 1996 and beyond remain difficult to estimate. However, Commission staff currently compiling data on reproductive health expenditures report a steady upward trend between 1994 and 1997. The Commission has also initiated a major new reproductive health program in Asia involving NGOs.

Another recent development relating to NGOs is the establishment in 1997 of the Cofinancing Support Program, which aims to assist NGOs in improving the quality of their funding proposals. The program is represented in each member state and maintains a central liaison office in Brussels. It provides assistance to NGOs in preparing proposals and reports relating to funds available under the main NGO budget line for cofinancing of development projects, B7-6000.

4 PROGRAM PRIORITIES

GEOGRAPHIC PRIORITIES:
Commission resources for population activities are concentrated primarily in Asia, which in 1996 accounted for 46 percent of population spending. In the same year, the Commission supported population projects in Bangladesh, India, Indonesia, Nepal, Pakistan, the Philippines, Thailand and Vietnam, in addition to several regional Asian initiatives. Western Asia and North Africa received the next largest proportion of funding at 20 percent of the total, including projects in Egypt, Jordan, Morocco, Palestine, Tunisia, Turkey and Yemen. The Commission allocated a smaller share of total population expenditures to sub-Saharan Africa, Latin America and to global or interregional projects.

AREAS OF PROGRAM EMPHASIS:
In 1996, EC population and reproductive health spending had a strong focus on STD/HIV activities. Of the $14 million the Commission reported to UNFPA in population assistance, over $11 million (80 percent) went to STD/HIV projects. In addition, 12 percent went to family planning activities and 7 percent to other reproductive health initiatives.

Staff in Directorate-General VIII are working to integrate reproductive health into larger health sector projects and the policy dialogue on health sector reform. The directorate provides aid under the terms of the Lomé Convention, which mandates a key partnership role in priority-setting for signatory countries in the Africa, Caribbean and Pacific regions. Commission staff observe that most of these countries do not identify population as a priority sector for cooperation with the Commission, preferring to request assistance in this sector from donors more closely identified with technical expertise in this area. Partner countries also more frequently request assistance for HIV projects than for other reproductive health activities.

Moreover, a substantial proportion of health sector assistance provided under the Lomé Convention goes to direct support to health sector budgets in signatory countries. Directorate staff see a role for the Commission in raising population and reproductive health concerns in policy discussions with governments in these countries relating to this budget support. For example, efforts are underway to strengthen the focus on reproductive health in health financing and policy reform, and to include contraceptive supplies in essential drug programs. The directorate has appointed a consultant to recommend strategies for strengthening the focus on reproductive health in health sector policy dialogue, a sign it is taking this responsibility seriously.

Recent projects initiated by Directorate-General IB provide an indication of approaches the Commission is using in other regions.

- In 1996, the Commission committed 200 million ECUs ($253 million) in support of an initiative in India to improve the national family welfare program. The EC's assistance complements efforts by the World Bank and other donors to shift the emphasis of the family welfare program from the delivery of family planning services to more comprehensive reproductive health services. This major sector reform program includes support for managerial and financial decentralization, community participation, client-oriented approaches and efforts to improve quality of care, access to services and program evaluation.
- The Reproductive Health Initiative in Asia is a new program funded by the Commission in collaboration with UNFPA. The 25 million ECU ($28 million) initiative was formalized in 1997 with the objective of addressing family planning and sexual health issues in partnership with non-governmental organizations. It will support projects in seven countries implemented by European NGOs in partnership with local NGOs in these countries over a three-year period.

A new reorganization is designed to increase the Commission's efficiency.

The program aims to support ICPD goals by emphasizing improved access to services, special attention to gender issues and reproductive rights, strengthening of NGO capacity and South-South NGO cooperation. The initiative recently completed its first year planning phase, which has identified adolescent reproductive health needs as a program priority. NGO partners in Europe and participating Asian countries have submitted proposals, and the initiative will begin funding project activities in early to mid-1998. The program also has a "regional dimension" involving data collection, research and evaluation.

Although these two highly visible initiatives in Asia take an integrated approach to reproductive health assistance, data for 1996 indicate that over 90 percent of reproductive health-related expenditures in Asia supported more focused HIV/STD programs.

5 TECHNICAL CAPACITY

STAFFING:
Despite the rapid expansion of Commission staff in the early 1990s, expertise in the social sectors is still limited. Both directorates with primary responsibility for development work have a mix of permanent and contract staff at headquarters; in addition, significant numbers of staff are assigned to EU "delegations" or country offices. However, in both directorates, only a handful of technical staff work on population and reproductive health-related programs.

A budget ceiling imposed by the European Council of Ministers has prevented recruitment in population and reproductive health as well as other areas for several years. Recruitment of more external technical consultants is under discussion, but this will not address the need to develop long-term technical capacity within the Commission.

TECHNICAL EXPERTISE OF COLLABORATING INSTITUTIONS:
The Commission has access to a broad range of expertise through collaborating institutions throughout Europe. Many European NGOs with expertise in reproductive health have accessed EC funding for projects or are in the process of negotiating agreements to do so, either through the NGO cofinancing budget line or the Asia Reproductive Health Initiative. The Asia initiative in particular has developed a new model of "coordinated" NGO programming that encourages collaboration and information exchange among NGOs working in a particular country. European NGOs involved in this project include Marie Stopes International, CARE, the International Planned Parenthood Federation, the German Population Foundation (DSW), Save the Children Fund (UK), the Dutch World Population Foundation and many others.

The availability of NGO expertise is less of a constraint to the Commission's effectiveness than the difficulties these NGOs experience working with the EC. European NGOs have found the bureaucracy of the directorate structure difficult to navigate, and have experienced long delays in approval of proposals and even payment for work completed. For European NGOs working in partnership with developing country NGOs, these delays present serious obstacles. Local partners lose patience with a system that can take years to process a proposal.

In other instances, local circumstances are dynamic and needs change significantly between development and approval of a particular project. Commission staff are working to overcome these problems and improve the administration of NGO project proposals. As European NGOs gain experience working with the EC, they have also become more familiar with its procedures and the pace of approval for funding for reproductive health and HIV/AIDS projects is reportedly improving.

Plans to establish a new administrative and financial service cutting across directorates represent a further effort to increase the Commission's efficiency. A major reorganization in mid-1998 created a new department, called the Common Service Unit (SCR). This department consolidated technical support and legal, contractual and financial management functions previously handled separately by the directorates involved in development cooperation. This new division, with about 650 staff, is one of the biggest in the Commission. A reform of the current budgeting system is expected to accompany these organizational changes, with funding likely to be provided on a program basis, rather than by applications to specific budget lines.

FINLAND

Finland devotes a relatively high percentage of development assistance to population activities.

FINLAND

POPULATION AND REPRODUCTIVE HEALTH ASSISTANCE

OVERALL ASSESSMENT

Drastic cuts in Finland's foreign aid program in recent years have also reduced funds available to population programs. Even in an environment of shrinking resources, however, Finland allocates a higher share of its development cooperation budget to population assistance than many other donors. Still, current levels of population assistance remain significantly below levels achieved in the early 1990s. While Finland reports a recent increase in population assistance, this likely reflects the broader definition of population programs used to report expenditures since 1994.

Finland allocates the bulk of its population assistance through international organizations, primarily UNFPA. Finland's small bilateral population program is thinly dispersed across twenty recipient countries, undermining its impact. Bilateral programs also favor broad reproductive health programs over more focused family planning activities. Given shrinking staff in the bilateral aid program, the greatest potential for increasing Finnish population assistance is through the multilateral channel.

VITAL STATISTICS

1996 population size:	5.1 million
Total Official Development Assistance (ODA), 1996:	$408 million
ODA as a percentage of GNP, 1996:	0.34%
Total population assistance, 1996:	$19.8 million
Population assistance as percentage of ODA, 1996:	4.86%
Population assistance per $US million GNP, 1996:	$167

Population Action International's Country Grade

B–
GRADE

1 DEVELOPMENT ASSISTANCE: POLICY AND FUNDING

Finland's economic woes have led to drastic cuts in foreign aid in recent years. In 1995, the newly elected government responded to a 20 percent unemployment rate by instituting stringent controls on public spending. This included freezing expenditures on development assistance at $388 million—the level achieved in 1995 after years of budget cuts.

In 1996, when economic conditions improved, the government issued a policy statement "unfreezing" development assistance levels and confirming Finland's commitment to achieving the UN target of 0.7 percent of GNP for development aid. This policy shift coincided with Finland's membership in the European Union and a government initiative to review development assistance programs and policies. Aid levels rose in 1996 to $408 million or 0.34 percent of GNP. In 1997, however, Finnish development assistance fell again to $379 million or 0.33 percent of GNP.

FINLAND

Finland traditionally allocates the bulk of its population assistance to multilateral organizations.

The Department for International Development Cooperation (formerly FINNIDA) within the Ministry of Foreign Affairs administers the Finnish aid program. The aid program has been shrinking in staff resources even as its responsibilities have expanded to include cooperation and coordination with the European Commission. In 1996, 43 percent of Finnish development assistance was allocated through multilateral channels, including $42 million through the European Commission and other funds channeled through UN agencies and international financial institutions.

Finland's aid is geographically concentrated in Africa, which receives half of all project aid. Priority countries in Africa include Egypt, Ethiopia, Kenya, Mozambique, Tanzania and Zambia. Finland also programs bilateral development funds in Bangladesh, Nepal, Nicaragua and Vietnam. Program emphases include poverty, the environment and human rights and democracy.

2 THE POLICY ENVIRONMENT FOR INTERNATIONAL POPULATION ASSISTANCE

Finland, while not among the largest donors to population programs, devotes a relatively high percentage of development assistance to population activities. Since 1989, Finland has devoted over two percent of development assistance to population, with this ratio peaking in 1995 at close to six percent. Finland includes the development of human resources—including investments in reproductive health, family planning and primary health care—as a priority activity related to the goal of poverty alleviation.

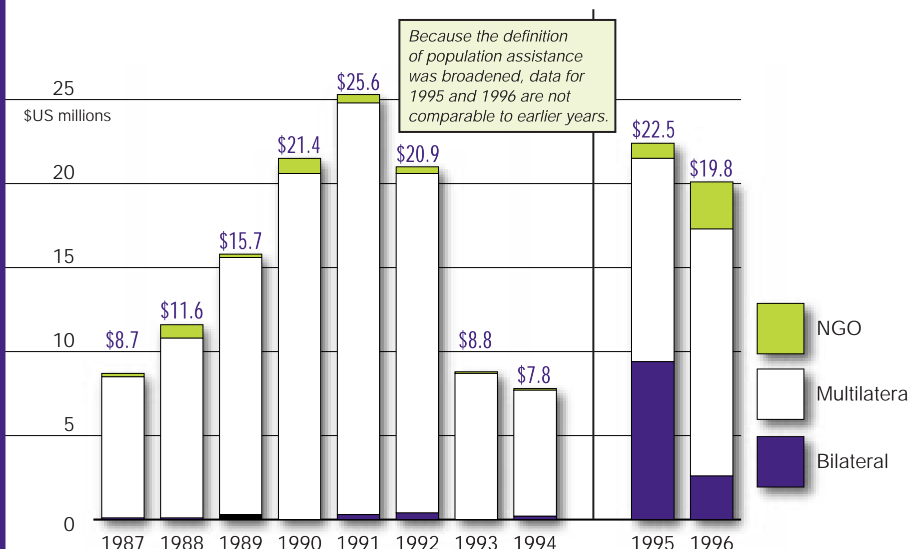
A recent public opinion survey on development assistance found that 99 percent of a sample of 1,000 Finns generally support development assistance, and 69 percent favor giving priority to expenditures on health.

3 TRENDS IN FUNDING FOR POPULATION ASSISTANCE

OVERALL FUNDING LEVELS:
Finland contributed $19.8 million in population assistance in 1996, ranking 11th among donor countries in the aid it provides to this sector. This represents a significant increase from 1994, when Finnish population assistance dropped to its lowest point at just $7 million. Despite this positive recent trend, population assistance levels remain below the peak $25 million level achieved in 1991 prior to budget cuts. Moreover, expenditures reported since 1995 reflect a broader range of reproductive health activities than in 1994 and earlier years.

MULTILATERAL FUNDING:
Finland traditionally allocates the bulk of its population assistance to multilateral organizations. Finland's contributions to UNFPA peaked in 1991 at $24 million, and then fell to a low of $4.2 million in 1993. Finland has only partially restored its funding for UNFPA; its contribution of

TRENDS IN POPULATION ASSISTANCE 1987–1996



Sources: Population assistance: UNFPA. Vital statistics: UNFPA, UN Population Division, OECD.

$14.5 million in 1997 ranks Finland ninth among the major donors to UNFPA. Finland also supports multi-bilateral projects in collaboration with UNFPA, including a youth reproductive health program and some census activities. In addition, Finland has co-financed a population project in Kenya with the World Bank, and contributes to reproductive health research carried out by the Population Council and the WHO human reproduction research program.

BILATERAL FUNDING:

Recently, Finland has reported an increased share of expenditures through the bilateral channel. Previously, Finland reported channeling only about 1 to 2 percent of population expenditures through bilateral programs. This percentage increased to 42 percent in 1995 and to 13 percent in 1996, following introduction of the broader definition of population assistance.

FUNDING FOR NGOS:

Since 1990, Finland has allocated between one and four percent of its population assistance to projects implemented by NGOs. This proportion rose significantly in 1996, when Finland allocated 14 percent of population aid through international and national NGOs. Finland's contribution to IPPF has fluctuated during the past decade; it made no contribution in 1992, and then slowly restored funding to about $344,000 in 1997. The net outcome of these erratic contributions has been an increase of about 40 percent between 1988 and 1997 in funding for IPPF.

4 PROGRAM PRIORITIES

GEOGRAPHIC PRIORITIES:

Most of Finland's bilateral population assistance is concentrated in North and sub-Saharan Africa. The largest projects in financial terms are in Egypt, Ethiopia, Ghana, Mozambique and Uganda. Of these, the Manica Health Project in Mozambique is the only family planning and reproductive health project; other large Finnish initiatives in Africa focus on AIDS prevention and control and primary health care (including reproductive health services).

Finland also funds bilateral programs in Asia and Latin America, including an activity in Pakistan's Northwest Frontier Province that provides reproductive health services through the primary health care system. In Latin America, Finland supported small initiatives in Ecuador, Paraguay and Peru in 1996; in 1997, it initiated a reproductive health and women's empowerment program in Nicaragua.

AREAS OF PROGRAM EMPHASIS:

Roughly half of resources allocated in 1996 for bilateral and NGO population programs went to broad reproductive health activities. These include primary health care or community development projects with reproductive health components. Family planning activities made up about a third of bilateral population assistance expenditures, and STD control approximately 20 percent. In terms of its stated policies, the Finnish aid program emphasizes sustainability, participatory program planning, voluntary contraception, cost recovery and an emphasis on quality of care.

5 TECHNICAL CAPACITY

STAFFING:

Traditionally, Finland's bilateral aid program has had very limited technical staff in population and reproductive health. Currently, one health and population advisor within the Ministry is directly involved in population-related programming.

TECHNICAL EXPERTISE OF COLLABORATING INSTITUTIONS:

The Finnish aid program uses the technical expertise of a number of public and private collaborating institutions in the population field. Within the government, the Finnish health and social welfare administration provides advisory services to the Department for International Development Cooperation. In addition, Vaestolitto, the national IPPF affiliate, has participated with the government in both planning and implementation of international population projects. The Finnish Red Cross provides expertise to the aid program in HIV/AIDS-related programs. Various private consulting organizations have also had a long-standing involvement with general health and development projects in priority countries such as Kenya, Egypt and Mozambique over the past 10 years.

B–
GRADE

A recent survey found that 99 percent of Finns support development assistance.

FRANCE

Population and reproductive health have never been development aid priorities for France.

GRADE

FRANCE

POPULATION AND REPRODUCTIVE HEALTH ASSISTANCE

OVERALL ASSESSMENT

Population and reproductive health have not been development aid priorities for France—either before or after the ICPD. Of the $7.4 billion France provided in development aid in 1996, the allocation of $16.5 million to population assistance programs—an infinitesimal fraction—reveals the level of neglect of the sector by French development policy makers. The absence of a budget line item for population assistance and the lack of real understanding of population and reproductive health among policy makers remain barriers to improving France's record on resource allocation and its effectiveness as a population donor.

Despite this poor record, there are some recent indications of a more favorable environment for population policy and programming. Two parliamentary groups and a French NGO are currently actively seeking to influence the policy dialogue on population issues and to move French population assistance policy forward. Early signs of change include reports that the French development administration is preparing a new population project.

1 DEVELOPMENT ASSISTANCE: POLICY AND FUNDING

France remains a large development aid donor, though its aid has been declining in recent years both in absolute volume and as a percentage of GNP. French development aid levels began to fall steeply in 1995, after stagnating during the early 1990s and then rising briefly in 1993-94. Between 1994 and 1996, development assistance fell from 0.64 percent to 0.48 percent of GNP—a significant movement away from the United Nations target of 0.7 percent. In 1997, total development assistance fell again to 0.45 percent of GNP. Despite these negative trends, France remains a large donor in terms of total aid volume, ranking second out of 21 major donors and allocating over $6 billion to foreign assistance in 1997.

A fundamental reorganization of the administration of French aid is scheduled to take place in 1999. French development assistance has historically been administered by the French Development Fund—an extension of the Ministry of Finance—and the Ministry of Cooperation, an independent but non-Cabinet level ministry. In early 1998, the French

VITAL STATISTICS

1996 population size:	58.3 million
Total Official Development Assistance (ODA), 1996:	$7,451 million
ODA as a percentage of GNP, 1996:	0.48%
Total population assistance, 1996:	$16.5 million
Population assistance as percentage of ODA, 1996:	0.22%
Population assistance per $US million GNP, 1996:	$11

Population Action International's Country Grade

cabinet voted to reform the Ministry of Cooperation by essentially abolishing it as an independent ministry and subsuming it under the Ministry of Foreign Affairs. Under this new arrangement, the Ministry of Cooperation will be administratively merged with Foreign Affairs, but the Minister will be elevated to cabinet status. This change is expected to take effect in 1999, and the impact on overall aid administration remains to be seen.

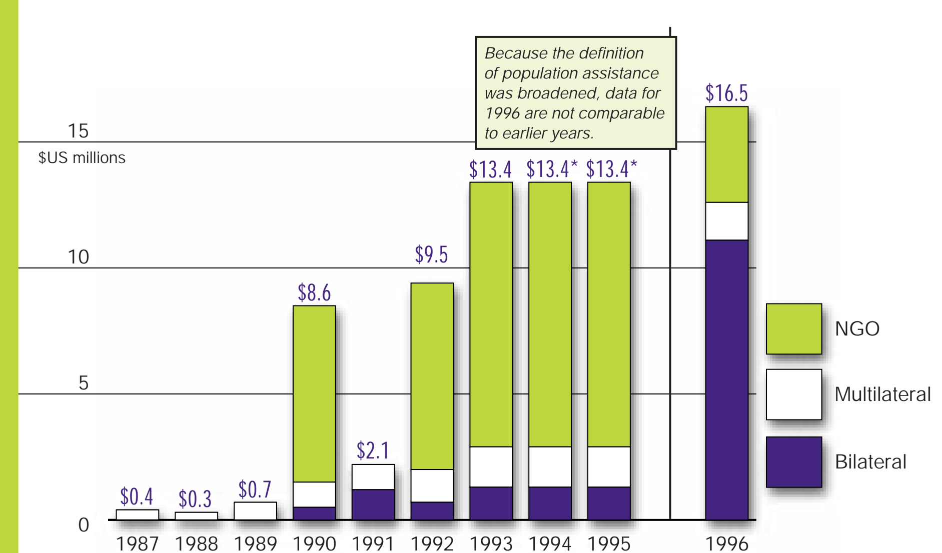
French aid policy has traditionally emphasized sub-Saharan Africa, a region where France has long-standing cultural and historical ties. This geographic emphasis is reflected in both bilateral initiatives and French policy with respect to multilateral organizations. In recent years, France has diverted funding from UN organizations to the European Commission (EC), where it has greater influence on policy and serves as a strong advocate for Africa. In 1995, French contributions to UN agencies fell to just 5.5 percent of total development aid, down from 14 percent in 1993. In contrast, France is now the largest contributor to the EC's European Development Fund, through which it channels approximately 10 to 12 percent of total French development assistance.

2 THE POLICY ENVIRONMENT FOR INTERNATIONAL POPULATION ASSISTANCE

Official endorsement of the Cairo conference priorities by the French government has not resulted in any discernible changes in reproductive health policy or programming. France officially endorses the ICPD *Programme of Action* and goals relating to infant mortality, maternal mortality and access to family planning services. In practice, however, France has been slow to respond to the ICPD and reticent in implementing reproductive health related programs in the sub-Saharan African countries where it is most active as a donor.

A recent external review of the French aid program observes that France does not see overpopulation as a problem in sub-Saharan Africa, and is reluctant to advocate family planning in cultures that place a high value on fertility. Reflecting this point of view, the Ministry of Cooperation has focused its activities in areas that

TRENDS IN POPULATION ASSISTANCE 1987–1996



Sources: Population assistance: UNFPA. Vital statistics: UNFPA, UN Population Division, OECD.
*As 1994 and 1995 expenditures were not reported to UNFPA, they are estimated at the 1993 level.

Although French aid policy emphasizes sub-Saharan Africa, France does not see overpopulation as a problem in that region.

are related to but do not directly support use of family planning. These include maternal and child health—very broadly defined, women's rights and education, and population and reproductive health training for African researchers.

Three advocacy groups are actively engaged in efforts to influence French population assistance policy. The first, Populations, is made up of 56 members of parliament in the National Assembly and was founded in 1996; Demography and World Population includes 23 senators and was established in 1997. Both of these parliamentary groups aim to make population policy recommendations to the government and assess French efforts in the areas of population and demography. The third group involved in the discourse on population in France is Equilibres et Populations, a NGO founded by doctors and journalists in 1993.

There are some small signs that France may be ready to change its long-standing reluctance to be more active in population assistance. Officials within the Ministry of Cooperation report that a population project is currently under preparation for approval by the government, but is still in the early stages of development. Moreover, for the first time since 1993, France has reported on its 1996 financial support to population programs, in response to UNFPA's effort to collect data on global resource flows for population activities.

3 TRENDS IN FUNDING FOR POPULATION ASSISTANCE

OVERALL FUNDING LEVELS:
Information regarding overall French funding for population assistance is limited. Between 1990 and 1993, total funding appears to have increased from $8.6 million to $13.4 million—a dramatic change from the 1980s when total assistance was reported at less than $1 million annually. Knowledgeable sources indicate the 1990-93 data reported by France largely reflect support for demographic research by French institutions that are not strictly part of the foreign aid program. In 1996, France reported $16.5 million in population assistance, primarily channeled through its bilateral aid program.

MULTILATERAL FUNDING:
France has traditionally been a very small donor to UNFPA, but there are some signs that it may increase support to UNFPA in the future. After contributing less than $2 million in 1993-94, France reduced its already tiny contribution to UNFPA and contributed only between $650,000 and $785,000 annually during the period 1995-97. At this level of participation, France is outranked as a donor to UNFPA by Belgium, Australia and Italy—all countries with significantly smaller overall development assistance programs. The 1995 contribution to UNFPA by France represented only 0.03 percent of total French multilateral contributions and 0.5 percent of contributions to UN organizations.

However, top UNFPA officials view as a positive development the slight increase in France's contributions to UNFPA ($904,000 in 1997 and $1 million in 1998), as well as recent multi-bilateral funding of $2.3 million provided by France for programs in Madagascar and Côte d'Ivoire.

The European Commission could eventually emerge as a more important—although indirect—channel for French support to multilateral population assistance programs. The Commission received 48 percent of total multilateral funds contributed by France in 1995. However, member states do not earmark their aid contributions for specific sectors, making it impossible to directly attribute a share of population assistance provided by the EC to France or any other member state.

BILATERAL FUNDING:
French reporting of bilateral population assistance has been erratic and funding trends are therefore difficult to determine. France began reporting bilateral expenditures on population assistance for the first time in 1990, at a nominal level of $0.5 million. Prior to that time, the French government reported its entire contribution for population assistance as channeled through multilateral organizations.

Since 1990, the reported proportion of bilateral population spending has fluctuated greatly, from 6 percent of total assistance to 67 percent in 1996, suggesting variability in reporting and data quality. In 1996, France reported its bilateral population assistance to UNFPA (following a 3-year hiatus in reporting) at $11 million— a steep increase from the last reported level of $1.3 million in bilateral funding in 1993.

FUNDING FOR NGOS:
France does not contribute to IPPF, the major international NGO in the population field. Other contributions to domestic NGOs are largely for demographic research, rather than for the delivery of reproductive health or family planning services.

4 PROGRAM PRIORITIES

GEOGRAPHIC PRIORITIES:
The limited French bilateral population assistance effort reflects the regional focus of the larger foreign aid program. The vast majority of funds are disbursed in French-speaking African nations, with the largest single programs in Congo, Cameroon and Togo. France also provides some limited assistance in Asia—India, Vietnam and the Pacific—for small demographic research projects on such topics as urban population density and migration.

AREAS OF PROGRAM EMPHASIS:
Among the priorities identified during the ICPD, France emphasizes STD/HIV prevention and control and girls' education programs, rather than family planning or safe motherhood. In the past, France has argued that many of the social sector programs it finances reflect the goals of the ICPD *Programme of Action,* and should be included in any accounting of French population assistance. Girls' education projects are one example frequently cited by French aid officials. Among the activities in the "costed package" identified in the *Programme of Action,* France allocates over half of all bilateral and NGO funds to AIDS prevention and control projects in Africa, and slightly over one-third to basic population research. About 10 percent of bilateral and NGO funds are allocated to general reproductive health care, and less than 1 percent specifically to family planning.

5 TECHNICAL CAPACITY

STAFFING AND TECHNICAL EXPERTISE OF COLLABORATING INSTITUTIONS:
The Ministry of Cooperation is staffed by just one senior specialist in the health sector with responsibility for population-related programming. France's nongovernmental technical resources are also limited in the population and reproductive health sector, with the major organizations concentrated in demographic disciplines. The Center for Population and Development and the National Institute for Demographic Studies are two such institutions.

UNFPA officials view the slight increase in France's contributions as a positive sign for the future.

GERMANY

Following Cairo, Germany increased funding for population programs despite economic difficulties.

GRADE

GERMANY

POPULATION AND REPRODUCTIVE HEALTH ASSISTANCE

OVERALL ASSESSMENT

Germany has demonstrated significant advances in its population assistance program. In the years following the Cairo conference, Germany has increased funding for population programs during difficult budgetary and economic times, and shifted resources in favor of an integrated and effective bilateral reproductive health program.

These positive developments notwithstanding, Germany faces a number of challenges. Compared with most other large donors, current levels of population assistance are low relative to the size of the German economy. Anticipated cuts in the bilateral aid budget could also negatively affect reproductive health programs. Moreover, German aid officials perceive low demand from developing countries for aid in the population and reproductive health sector to be a constraint to increasing levels of funding.

1 DEVELOPMENT ASSISTANCE: POLICY AND FUNDING

The German government strongly supports development assistance, but the public is more concerned about economic problems closer to home. Public support for foreign assistance in Germany has eroded in recent years owing to concerns about the flagging economy, the high financial costs of German reunification and the fiscal strain of large monetary transfers to Eastern Europe and the former Soviet states. Nonetheless, the present government remains strongly committed to development aid and plans to maintain support for foreign assistance at a high level.

Despite the government's commitment to foreign assistance, domestic economic problems appear likely to affect the administration of German aid, primarily through cuts in civil service staff at the Ministry for Economic Cooperation and Development (BMZ). However, political pressure is unlikely to result in significant cuts in the aid budget in the near future. Although the German parliament has authority over the foreign assistance budget, the majority parties generally prefer to leave foreign aid allocations to government policy

GERMANY

VITAL STATISTICS

1996 population size:	81.9 million
Total Official Development Assistance (ODA), 1996:	$7,601
ODA as a percentage of GNP, 1996:	0.33%
Total population assistance, 1996:	$96 million
Population assistance as percentage of ODA, 1996:	1.26%
Population assistance per $US million GNP, 1996:	$41

Population Action International's Country Grade

makers. In some circumstances, however, parliamentarians try to influence aid policy through parliamentary debate and formal inquiries to the BMZ.

German development assistance has increased in absolute terms but more slowly than economic growth, resulting in a declining ratio of aid to GNP. With a development assistance program of $5.9 billion in 1997, Germany is the fourth largest donor nation in total aid volume. Germany accepts the UN goal that donor countries should give 0.7 percent of GNP in development assistance. However, it has moved away from this goal as the aid to GNP ratio has slipped from a high of 0.45 percent in 1986 to 0.28 percent in 1997.

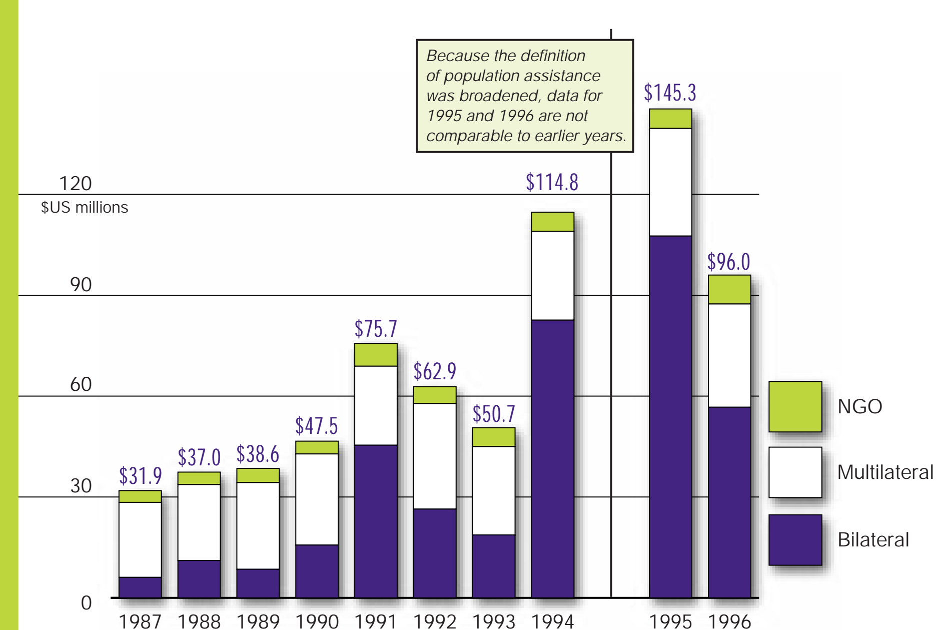
Germany's policy response to another international target—the compact to spend 20 percent of development assistance on the social sectors—has also been weak. To date, allocations to basic education and health remain well below 20 percent of the aid budget, although the population sector has benefited from a modest increase, from 0.75 percent of development assistance commitments in 1990 to 1.28 percent in 1996.

Three different entities are involved in management and implementation of the German aid program. BMZ, the Ministry for Economic Cooperation and Development, has overall responsibility for initiating specific programs in collaboration with recipient governments, and for coordinating and managing development assistance. BMZ staff issue contracts as needed to the German agencies for technical cooperation (GTZ) and financial cooperation (KfW) respectively, to design and implement these programs.

2 THE POLICY ENVIRONMENT FOR INTERNATIONAL POPULATION ASSISTANCE

To date, population is not among the top priorities for the German aid program. Germany's development policy designates poverty, the environment and education as first level

TRENDS IN POPULATION ASSISTANCE 1987–1996



Sources: Population assistance: UNFPA. Vital statistics: UNFPA, UN Population Division, OECD.

development assistance priorities. Advocacy groups are pushing for population to be elevated to a first level priority, anticipating that a higher policy profile would result in increased financial allocations. German development aid officials, however, believe a higher profile for population and reproductive health could be counterproductive in the present political environment, as more visibility could increase the vulnerability of these programs to budget cuts.

A 1991 policy statement on population and family planning still represents official German policy on population assistance. German aid officials view this policy statement as current and congruent with the ICPD agenda, although it does not explicitly use the term reproductive health. The policy statement ties population and family planning to larger economic and social development goals and protection of the environment, and asserts that the ability to control the number and spacing of births is a human right.

There is considerable interest in population issues within the German parliament. In 1998, several parliamentarians introduced a resolution on the need for German development policy to actively emphasize population assistance. The resolution highlights the predicted impact of future population growth on the environment and employment, and endorses the ICPD action plan. The resolution was still under discussion as of mid-1998. The German Foundation for World Population (DSW), the leading German population NGO, has worked to build support for population assistance among parliamentarians and the public.

3 TRENDS IN FUNDING FOR POPULATION ASSISTANCE

Recent trends in population assistance reported by the German government are difficult to interpret. The BMZ reports its population activities in two categories, which differ from the standard definitions used by UNFPA:

- ***reproductive health,*** including maternal health, infant care, information, education and communications, and other projects involving reproductive functions; and
- ***population-related issues,*** which include HIV/AIDS, basic health, basic education and women's empowerment. (Beginning in 1997, HIV/AIDS is considered part of reproductive health.)

According to aid officials, population assistance levels reported to UNFPA understate the true level of German support for reproductive health. While most German aid projects integrate reproductive health within primary health activities, the German government only reports those with an explicit reproductive health focus. In addition, the BMZ provides financial information based on commitments, while UNFPA compiles expenditure data. BMZ officials believe that commitments are a better reflection of long-term policy intentions than expenditure data, which are highly variable from year to year.

German officials also perceive a lack of demand from recipient countries for assistance in the population sector to be a major constraint to maintaining funding levels and developing new programs. Generating such demand is vital to ensure that financial commitments made by BMZ are translated into actual programs.

OVERALL FUNDING LEVELS:

German population assistance levels almost tripled from 1990 to 1995, but declined sharply in 1996. German population assistance levels rose steadily from $47.5 million in 1990 to $145 million in 1995, when Germany ranked second among all donor countries in its contributions to population programs. In 1996, Germany slipped to fourth place with a contribution of $96 million. Moreover, the German contribution to population activities in 1996 represented only 1.26 percent of total development aid, compared with the average allocation for donor countries of 2.0 percent. Germany also lags behind other donors in the volume of population assistance it provides relative to the size of its economy. In 1996, Germany provided $41 in population assistance per million dollars of GNP—down from $60 in 1995, and a fraction of the $371 contribution made by Denmark, the most generous donor.

MULTILATERAL FUNDING:

Both the volume and share of German population assistance channeled through multilateral organizations declined in the 1990s. During the 1980s, Germany consistently allocated more than half of total population assistance to multilateral organizations. Since 1990, this trend has changed; by 1996, only about a third of German assistance to population programs passed through multilateral channels, reflecting an across-the-board cap on contributions to UN organizations imposed by the budget committee in the parliament.

Germany contributed approximately $32.5 million to UNFPA in 1995; although the government maintained the level of funding in German currency in 1996, the dollar value of these resources was considerably diminished by exchange rate losses. In 1997, BMZ reduced German contributions to UN agencies owing to overall budget cuts; as a result, UNFPA received only $24.3 mil-

lion—a reduction of 28 percent from the previous year. In 1998, the contribution to UNFPA appears likely to remain stable in German currency, but to decline even further in dollar terms.

BILATERAL FUNDING:

German resources for population assistance are increasingly being channeled through the bilateral aid program. In 1990, only 33 percent of German population assistance was administered bilaterally. As the share of multilateral assistance has declined, the share of German population assistance flowing through the bilateral aid program has risen, reaching 74 percent in 1995. The German government has a strong preference for managing its own development aid resources; the former minister of development cooperation had stated publicly that German bilateral assistance is more "efficient" than other channels, including the European Commission with its problems with project planning and disbursement of funds. This trend towards increasing bilateral funding and reducing multilateral allocations could change, however, as a result of the 1998 elections.

FUNDING FOR NGOS:

The level of German contributions to national and international NGOs is also low. In 1996, Germany channeled only 9 percent of its population funding through NGOs. The International Planned Parenthood Federation (IPPF) has been the main recipient of German contributions to NGO population programs. Germany's contribution to IPPF increased throughout the early 1990s, but declined from $5.8 million to $4.6 million in 1996 and 1997; it will likely remain at this level in 1998.

4 PROGRAM PRIORITIES

GEOGRAPHIC PRIORITIES:

German population assistance is concentrated in sub-Saharan Africa. The German technical cooperation agency—GTZ—is implementing reproductive health initiatives in Africa involving family planning service provision, adolescent sexual health education, and reproductive health services delivered through integrated family health or district/rural health programs. In addition, Germany makes some large financial commitments in the poorer Asian countries, namely Bangladesh, Nepal and India, and in El Salvador and Paraguay in Latin America.

AREAS OF PROGRAM EMPHASIS:

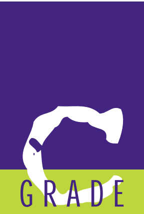
The German aid program favors integrated programs with strong reproductive health components. German aid officials do not see reproductive health as defined at the Cairo conference as a discrete program focus. Moreover, they view integrated programs that include reproductive health as more likely to succeed than programs focusing solely on family planning or other reproductive health needs. German technical cooperation in the area of health systems development and reform also includes an emphasis on family planning and reproductive health. Germany does not fund abortion services in any of the projects it supports.

In Africa, projects implemented by GTZ in Kenya, Malawi and Zimbabwe focus more narrowly on community-based contraceptive education and distribution, and are exceptions to Germany's general approach of integrating reproductive health within larger health sector initiatives. The German aid program also funds more focused social marketing programs, which aid officials view as an effective intervention in both family planning and AIDS prevention. Germany has supported contraceptive social marketing activities in Indonesia, Pakistan, the Philippines, Rwanda and India, through KfW, the German financial cooperation agency.

5 TECHNICAL CAPACITY

STAFFING:

Government-wide staff reductions have affected the Ministry of Economic Cooperation and Development. Currently, only 3 staff persons in the BMZ are responsible for support to all health, reproductive health and education projects. As the technical cooperation agency, GTZ has fared better, with 5 technical staff in Germany and 38 in the field who work exclusively on population-related issues.



TECHNICAL EXPERTISE OF COLLABORATING INSTITUTIONS:

The private and NGO sectors in Germany have very limited capacity to provide technical support to population activities. The BMZ currently implements projects overseas primarily through its quasi-governmental affiliates, KfW and GTZ. In several instances, KfW has contracted with a U.S. NGO, Population Services International, for technical assistance related to the social marketing of contraceptives, a field where no significant European technical capacity yet exists. From the Ministry's perspective, there is a need to strengthen the expertise of German and European organizations in population and reproductive health.

However, the German government has made no real effort to build technical capacity among existing German NGOs, or to create mechanisms to access external technical consultants as the British aid machinery has done. Significantly, the German Foundation for World Population (DSW), which has initiated some reproductive health projects in developing countries in addition to its advocacy work, supports these activities with funds from corporate and international sources rather than from the German government.

IRELAND

Ireland is a newcomer to population and reproductive health assistance, and its effort remains small.

GRADE

IRELAND

POPULATION AND REPRODUCTIVE HEALTH ASSISTANCE

OVERALL ASSESSMENT

The Irish foreign aid program concentrates its efforts on poverty alleviation in the world's least developed countries. Ireland is a relatively generous donor when compared with other developed countries, with contributions of $3,086 per million dollars GNP in 1996.

Ireland is a newcomer to international population and reproductive health assistance, and as such, the Irish population assistance effort remains small. Within the first few years, aid in this area has been limited in size, program focus and geographic scope. Contributions to the sector fall well below the donor average as a percentage of overall development aid, ranking Ireland 17th out of 21 donor countries. Recent population assistance initiatives have included maternal and reproductive health and HIV/STD prevention activities in a handful of countries in sub-Saharan Africa and Central America, and in India.

1 DEVELOPMENT ASSISTANCE: POLICY AND FUNDING

Ireland has one of the smallest, yet fastest growing, development aid programs. Total aid grew from $57 million in 1990 to $179 million in 1996. Over the last five years, the proportion of development aid relative to the size of the Irish economy increased steadily, and in 1997 stood at 0.31 percent of GNP. Ireland has expressed its intention of meeting the United Nations goal of allocating 0.7 percent of GNP to development assistance.

Irish development assistance—provided solely as grants—is administered through the Development Cooperation Division of the Department of Foreign Affairs in Dublin, as well as through overseas development cooperation offices and embassies. Health, education, rural development and safe water supply are priority sectors for Irish assistance.

Ireland's bilateral program is expanding, and in 1996 received 64 percent of the development assistance budget. Ireland's official development agency, Irish Aid, concentrates its efforts in sub-Saharan Africa. Ethiopia, Lesotho, Mozambique,

VITAL STATISTICS

1996 population size:	3.6 million
Total Official Development Assistance (ODA), 1996:	$179 million
ODA as a percentage of GNP, 1996:	0.31%
Total population assistance, 1996:	$728,000
Population assistance as percentage of ODA, 1996:	0.41%
Population assistance per $US million GNP, 1996:	$13

Population Action International's Country Grade

GRADE

Tanzania, Uganda and Zambia received nearly 40 percent of the bilateral development assistance budget in 1996, and are considered Irish Aid's six priority countries. Sudan is also considered a priority country for Irish Aid, but has received limited assistance in recent years because of internal conflicts.

The surge in allocations to the aid program has followed the adoption in 1993 of a four-year strategic plan for development assistance. The Irish government strengthened this commitment in 1996 with the release of a "White Paper on Foreign Policy" expressing the aim of increasing aid and improving the quality of assistance, particularly through the bilateral channel. This paper—the first of its kind to be presented to the Irish Parliament—describes the country's development assistance program as part of a foreign policy designed to promote "peace and justice in the world."

The White Paper also refers to the 1993 strategic plan's call for continued growth in aid; an increase from four to six in the number of priority countries for Irish aid; and expanded cooperation with other countries in Africa, Asia and Latin America. The strategic plan also calls for greater NGO participation in the Irish aid program, and for the creation of an independent committee to advise the Irish Government on development assistance issues. As development assistance levels have increased, Irish Aid has expanded staff resources both at home and in the field, putting special emphasis on hiring local development experts in priority countries.

2 THE POLICY ENVIRONMENT FOR INTERNATIONAL POPULATION ASSISTANCE

Historically, domestic controversies over reproductive health and family planning, combined with the strength of the Catholic Church, have kept the Irish government from active involvement in international population assistance. However, Ireland has gradually shown support for population assistance through its recent contributions to UNFPA and assistance to development activities in maternal and reproductive health.

The country's aid program enjoys continued popular and cross-party political support, despite a change in government in 1997. A recent UNFPA survey also shows popular support among the Irish public for development assistance in the area of reproductive health.

3 TRENDS IN FUNDING FOR POPULATION ASSISTANCE

OVERALL AND MULTILATERAL FUNDING LEVELS:

Ireland began participating in international population assistance in 1993, through a $74,000 contribution to UNFPA. Subsequent contributions to UNFPA increased rapidly, reaching nearly $409,000 in 1995. Ireland's contributions in national currency to UNFPA increased in both 1996 and 1997, despite reported decreases in U.S. dollar terms. Ireland's total population assistance rose to $2.9 million in 1995, but then declined in 1996 to $728,000, or just 0.41 percent of total ODA.

Controversies over reproductive health have inhibited Irish assistance to population over the years, but a new commitment is emerging.

Ireland has gradually shown support for population assistance through its contributions to UNFPA.

BILATERAL FUNDING AND PROGRAM PRIORITIES:
The Irish government does not consider itself as having a bilateral population assistance program. Irish Aid, however, supports reproductive health and maternal care, and even a small community-based contraceptive distribution project through its health sector programs.

Despite plans to strengthen and expand bilateral efforts in reproductive health, both the volume and share of reproductive health assistance allocated to bilateral activities declined from 1995 to 1996. In 1995, Ireland spent 62 percent of total reproductive health funds or $1.8 million on bilateral activities; in 1996 bilateral expenditures amounted to only 45 percent of total assistance in this area, or just over $325,000.

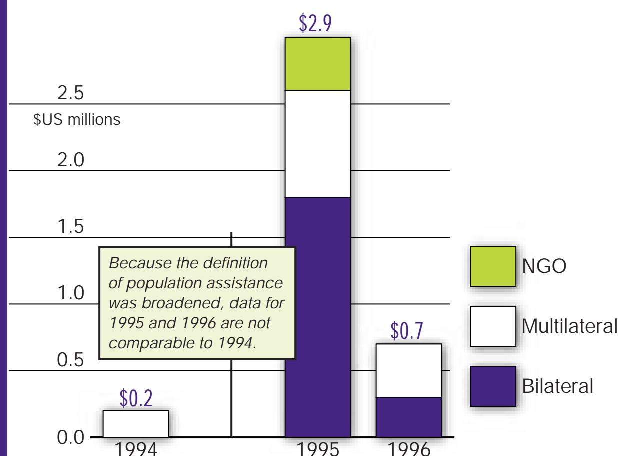
All of Irish Aid's bilateral reproductive health activities in 1996 were in eastern and southern Africa. One-third of bilateral funds assisted HIV/AIDS programs while the other two-thirds supported other reproductive health activities in the region. Bilateral funds have only recently supported contraceptive initiatives through a pilot community-based distribution program in Ethiopia.

FUNDING FOR NGOS:
Irish Aid directly awards grants to international and local NGOs through its newly revised NGO cofinancing scheme. In 1996, Ireland provided support to a variety of health initiatives including mother and child care, pre- and post-natal care, and HIV/AIDS prevention and treatment. The new NGO scheme decreases the number of funding mechanisms available to NGOs, but increases the number of block grants awarded each year—giving NGOs more financial stability and alleviating administrative burdens on the government. Ireland does not contribute to IPPF, the largest international NGO in the reproductive health field.

5 TECHNICAL CAPACITY

The Development Cooperation Division is currently recruiting additional staff as the overall aid program expands. Staff capacity in reproductive health has improved with the recent addition of a physician at Irish Aid's home office and local health specialists in priority countries.

TRENDS IN POPULATION ASSISTANCE 1994–1996



Sources: Population assistance: UNFPA.
Vital statistics: UNFPA, UN Population Division, OECD.

I T A L Y

Italy gave less than one percent of aid in 1996 to population assistance.

ITALY

POPULATION AND REPRODUCTIVE HEALTH ASSISTANCE

OVERALL ASSESSMENT

Italy is an important overall donor to developing countries, but an extremely low contributor to population and reproductive health programs. In 1996, Italy gave less than one percent of overall development aid to population assistance programs.

The greatest potential for increasing funding for effective population programs lies in Italian contributions to multilateral organizations. However, Italy's contribution to UNFPA is negligible, and actually fell between 1996 and 1997. The dearth of reproductive health staff in the Ministry of Foreign Affairs represents a major constraint to increasing Italy's bilateral population assistance.

Advocacy groups in Italy face a formidable task in lobbying for changes in governmental policy on international population assistance. The relatively new collaboration of Italian NGOs to promote reproductive health issues and pressure their government to allocate additional resources in this area is a positive development. However, it will be a challenge to shift long-standing sectoral priorities in the Italian aid program, which has neglected family planning and reproductive health.

VITAL STATISTICS

1996 population size:	57.2 million
Total Official Development Assistance (ODA), 1996:	$2,416 million
ODA as a percentage of GNP, 1996:	0.20%
Total population assistance, 1996:	$3.6 million
Population assistance as percentage of ODA, 1996:	0.15%
Population assistance per $US million GNP, 1996:	$3

Population Action International's Country Grade

GRADE

1 DEVELOPMENT ASSISTANCE: POLICY AND FUNDING

Italy emerged as a bilateral donor in the 1980s, and since then has had a variable record on overseas development assistance volume and policy. Ranked last among the OECD Development Assistance Committee (DAC) countries in the late 1970s, Italy increased its aid levels to reach and surpass the DAC average of 0.4 percent of GNP for development assistance by 1986. Unfortunately, Italy has reversed this trend; in 1997, Italy's aid cuts resulted in an aid to GNP ratio of just 0.11 percent—down from 0.2 percent the previous year.

Italian NGOs concerned about the development cooperation program attribute the drop in foreign assistance levels to the government's efforts to meet the entry criteria for the European monetary union. These organizations have been advocates for Italy's role as a donor nation and have launched a campaign to support foreign aid. In mid-1998, their activities coincided with the development of a

Population assistance has never been a political or programmatic priority.

draft law on development cooperation—the result both of government initiatives and proposals from various political parties.

In 1996, just over 50 percent of Italian development aid flowed through multilateral institutions—more if Italian multi-bilateral agreements with several institutions, such as the United Nations Development Program, are included. Italy is also a supporter of European Commission aid activities, particularly through the European Development Fund.

Italy's bilateral aid program is targeted at relief, rehabilitation and peacekeeping activities, and concentrated among its former colonies in the Horn of Africa. The top two recipients of Italian bilateral aid in 1995-96 were Mozambique and Ethiopia, which together accounted for over $200 million of Italy's approximately $811 million bilateral aid program.

A much needed 1997 reorganization of the aid program has sought to rationalize development assistance through more emphasis on project planning and country strategy development. More recently, the government has proposed to establish a new agency to administer foreign aid. The Ministry of Foreign Affairs, which currently implements Italian development assistance, would continue to define the political goals of the aid program. However, the new agency would likely have autonomy in implementing foreign aid programs, with parliamentary oversight.

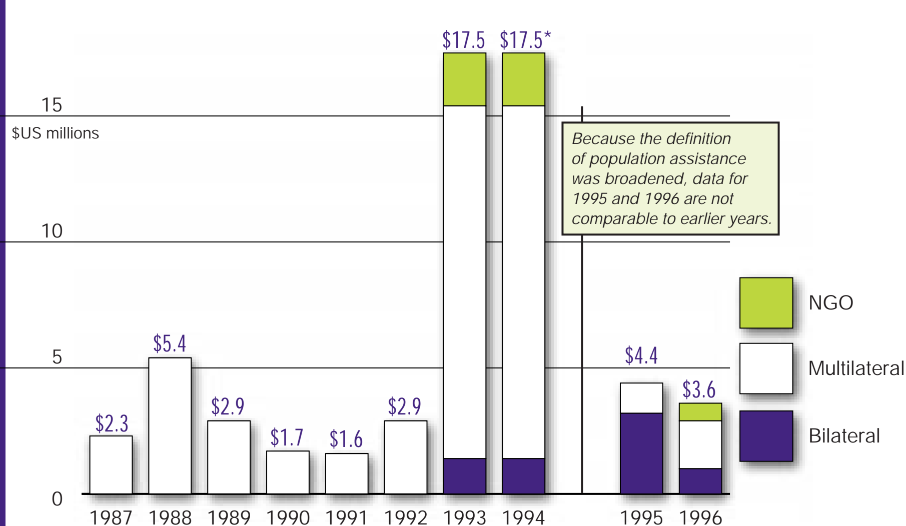
2 THE POLICY ENVIRONMENT FOR INTERNATIONAL POPULATION ASSISTANCE

The Italian government has embraced the very broadest definition of population programs emerging from the ICPD. According to a spokesperson from the Ministry of Foreign Affairs, Italy includes in "population" a broad range of sectors which impact on population growth, encompassing education, training, women's empowerment, general health and reproductive health.

Whatever the definition, population assistance has not been a political or programmatic priority. Moreover, in the recent environment of shrinking development assistance resources, there has been little impetus for increases in Italian population assistance. Many Italian NGOs see population assistance as only one component of a larger approach to development, rather than a cross-cutting constraint to overall development.

However, a few NGOs are engaged in advocacy for population and reproductive health assistance. These include AIDOS (the Italian Association for Women in Development) and the Italian Family Planning Association (UICEMP), which have recently organized an All-Party Parliamentary Group on Reproductive Health, Population and Development. These groups are also attempting to influence upcoming legislation on development assistance to include a reference to family planning and reproductive health.

TRENDS IN POPULATION ASSISTANCE 1987–1996



Sources: Population assistance: UNFPA. Vital statistics: UNFPA, UN Population Division, OECD.
*As 1994 expenditures were not reported to UNFPA, they are estimated at the 1993 level.

3 TRENDS IN FUNDING FOR POPULATION ASSISTANCE

OVERALL FUNDING LEVELS:

Overall population assistance has risen slowly, from just over $2 million in 1987 to $3.6 million in 1996. In 1993, Italy reported an anomalous $17 million in population expenditures, which included a small percentage allocated to the bilateral channel. Previously, the totality of Italy's modest population assistance expenditures had been channeled through multilateral organizations.

The small size of Italy's population assistance allocation is particularly noteworthy given its large volume of overall development assistance and the size of its economy. In 1996, Italy was among a handful of donors that allocated less than one-quarter of a percent of overall development aid to population assistance. Another indicator of its capacity to increase aid levels is the ratio of population aid to GNP. In 1996, Italy ranked second from last on this indicator, giving just $3 for each million dollars of GNP. Only Portugal, which has a very small aid program and the lowest GNP per capita in Europe, gave less than Italy relative to GNP.

MULTILATERAL AND NGO FUNDING:

Italy is not a major supporter of the international organizations working in the population field. In 1997, Italy ranked last out of the fourteen major donors to UNFPA. Since 1993, Italy has contributed between $1.2 and $1.9 million annually to this major multilateral organization involved in population activities. In 1996, this represented one-tenth of one percent of the total $1.6 billion Italy contributed to multilateral organizations. In 1997, Italy also contributed $1.7 million to UNFPA for a multi-bilateral project serving women in Honduras and El Salvador. To date, the Italian government has not provided any funding to IPPF.

BILATERAL FUNDING AND GEOGRAPHIC PRIORITIES:

Italian bilateral population assistance is limited and concentrated in sub-Saharan Africa. In 1996, Italy spent less than $2 million through bilateral and NGO channels on reproductive health more narrowly defined, focusing on reproductive health and basic research in Africa. Italy's limited initiatives in reproductive health were implemented in Djibouti, Ethiopia and Niger.

The Italian development administration appears to have difficulty reporting annual population-related expenditures. One reason for this difficulty is that actual disbursements for projects lag far behind allocations. Furthermore, since most of Italy's population-related expenditures are integrated into maternal and child health projects, emergency/relief programs and NGO activities, it is difficult to disaggregate funding for population activities.

4 PROGRAM PRIORITIES

AREAS OF PROGRAM EMPHASIS:

Since the Italian government defines population very broadly, it views a wide range of bilateral projects as population-related. Based on its broad definition, which includes education, micro-credit and general health activities, Italy reports funding population projects in Central America, Latin America, Africa and the Palestinian Authority. An Italian consulting organization, SOTECNO, has recently completed implementation of a reproductive health project in Colombia with adolescents and women heads of household as beneficiaries.

5 TECHNICAL CAPACITY

STAFFING AND TECHNICAL EXPERTISE OF COLLABORATING INSTITUTIONS:

External observers perceive little technical depth in reproductive health and population within the Ministry of Foreign Affairs. Government officials, however, report that Ministry staff include physicians, demographers and gender specialists with the capacity to provide technical assistance in this area.

Outside the Ministry, there are several NGOs working in the domestic reproductive health field, but these groups do not generally collaborate with the Ministry on development cooperation projects. These include the Associazione Italiana Contraccettivie Sessualitá, (AIECS), Associazione Italiana Educazione Demografica (AIED), UICEMP—the IPPF associate in Italy, and several other NGOs.

Development NGOs are another category of Italian organizations that could potentially become involved in population and reproductive health programs. The few NGOs working in this area tend to employ medical personnel (gynecologists, midwives, nurses) on their projects on a consulting basis. However, AIDOS is working collaboratively with UICEMP and AIED on advocacy and other activities in population and reproductive health.

Italy's contributions to UNFPA represent a tiny fraction of its total multilateral aid.

JAPAN

Japan's high contributions to UNFPA and IPPF support important reproductive health initiatives worldwide.

GRADE

JAPAN

POPULATION AND REPRODUCTIVE HEALTH ASSISTANCE
OVERALL ASSESSMENT

Japan's standing as the number one donor to UNFPA and IPPF is the most important aspect of its role as a population donor. Japan's consistently high core contributions to these two major international population organizations support important reproductive health initiatives worldwide. However, Japan lags behind some other major donors in the overall level of population assistance it provides.

Japan has been striving to increase both its importance and effectiveness as a bilateral population donor. However, the limited reproductive health expertise in Japan's bilateral aid program represents a major constraint to success in this area. Recent closer collaboration between Japan's bilateral aid agency and the largest Japanese NGO involved in international population programs is a positive step toward addressing this shortcoming. Japan is also engaged in joint initiatives with the U.S. bilateral population program; however, Japan and the United States have very different styles of development assistance, and these efforts have received mixed reviews. Japanese bilateral "population" projects generally do not emphasize family planning services, and at least in some cases appear indistinguishable from more general health sector projects.

Overall, Japan's contributions fall far short of the increases required to meet its fair share of the ICPD year 2000 goal for population assistance, given the large size of its economy. However, the advocacy efforts of Japanese NGOs have succeeded in establishing a high profile for global population issues. Despite anticipated cuts in future foreign aid levels, there is still scope within the very large Japanese aid program to expand the tiny share allocated to international population assistance.

1 DEVELOPMENT ASSISTANCE: POLICY AND FUNDING

Despite its standing as the world's largest donor, Japan's development assistance represented only 0.22 percent of GNP in 1997, well below the average for the donor countries. Moreover, Japan's preeminence as a donor is currently in jeopardy as domestic economic problems have caused a downturn in Japanese overseas aid allocations.

In 1993, Japan overtook the United States as the largest development assistance donor, providing a total of $11.3 billion in aid. However, in 1996, total aid levels fell 35 percent to $9.4 billion, down from $14.5 billion the previous year. Most of this decrease reflects large loan repayments to Japan and declining Japanese contributions to multilateral institutions; bilateral commitments actually increased 17 percent. The Japanese government is planning deeper cuts in the aid program over the period 1998 to 2000, as a result of a government-wide effort to cut all public spending by 10 percent annually.

JAPAN

VITAL STATISTICS

1996 population size:	125.4 million
Total Official Development Assistance (ODA), 1996:	$9,439 million
ODA as a percentage of GNP, 1996:	0.20%
Total population assistance, 1996:	$93.8 million*
Population assistance as percentage of ODA, 1996:	0.99%
Population assistance per $US million GNP, 1996:	$20

Population Action International's Country Grade

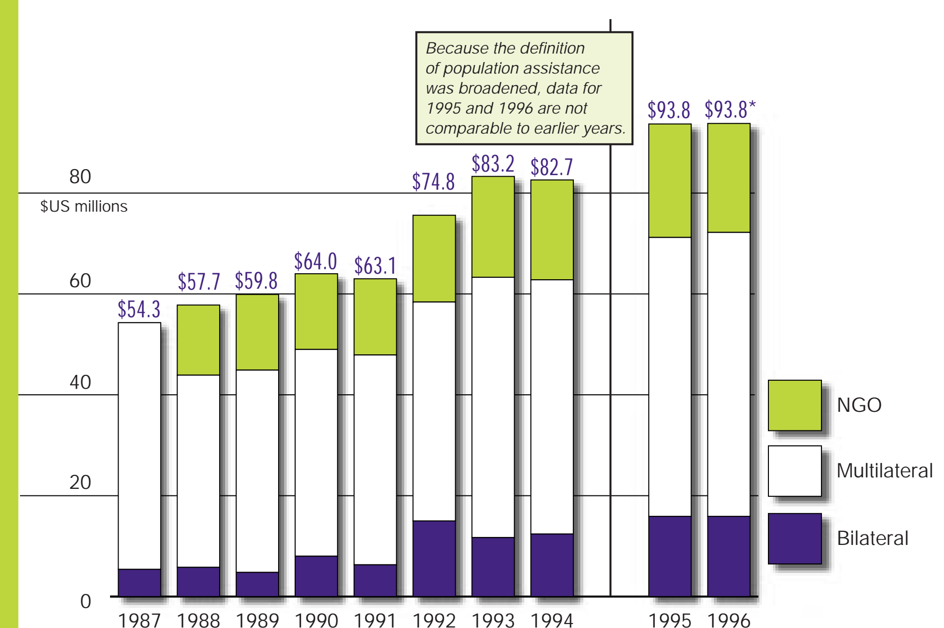
Japan's aid program is administered through a "four-Ministry system." This system involves the Ministry of Foreign Affairs, the Ministry of Finance, the Ministry of International Trade and Industry, and the Economic Planning Agency. Implementing institutions include the Japan International Cooperation Agency (JICA), the major technical cooperation agency, and the Overseas Economic Cooperation Fund, the bilateral loan agency. Technical and financial cooperation activities are supervised by the Ministry of Foreign Affairs and the Ministry of Finance respectively. The Ministry of Foreign Affairs also acts as the primary coordinating ministry for all Japanese development aid.

During the 1990s the Japanese government has sought to increase the effectiveness of its aid program. Japanese development assistance has historically emphasized large infrastructure projects, loans rather than grants and a geographic focus on Asia. Japan's Official Development Assistance Charter of 1992 responds to criticism of these aspects of Japanese aid by setting out a reform policy aimed at improving the effectiveness and allocation of development assistance. The 1992 Charter remains the official aid policy document to date.

Japan has achieved the goal of devoting at least 20 percent of aid resources to the social sectors, as recommended at the 1995 World Summit on Social Development. Indeed, Japan's spending on social and administrative infrastructure in developing countries has increased very significantly, from 3 percent of total aid in 1975-76 to 24 percent in 1995-96. Still, a lack of technical expertise within the aid bureaucracy has constrained Japan's ability to more effectively program funding for social sector projects.

Japan has been less successful in addressing the criticism that it favors Asian nations in the allocation of its development assistance resources. Critics argue that this practice allocates aid

TRENDS IN POPULATION ASSISTANCE 1987–1996



Sources: Population assistance: UNFPA. Vital statistics: UNFPA, UN Population Division, OECD.
*As 1996 expenditures were not reported to UNFPA, they are estimated at the 1995 level.

Japan has been striving to increase both its importance and effectiveness as a bilateral population donor.

resources to higher-income developing countries rather than those in greatest need. In 1996, Mexico was the only country outside Asia among the top 10 recipients of Japanese aid.

The Japanese public has generally been supportive of foreign aid, but current economic problems may be eroding this support. A survey conducted in 1996 found that 47 percent of the public favored maintaining aid at the current level, while 33 percent favored increasing aid levels. By 1997, another poll found that while 41 percent of the public supported development assistance, 47 percent felt domestic concerns should take precedence over needs overseas.

2 THE POLICY ENVIRONMENT FOR INTERNATIONAL POPULATION ASSISTANCE

The policy environment in Japan has encouraged increased Japanese support for international population assistance. The increased focus on the social sectors and an emphasis on closer coordination with the United States have also helped to increase attention to population assistance. In 1993, the Japanese and U.S. governments initiated the U.S.-Japan Common Agenda for Cooperation in Global Perspective as a mechanism for cooperating on technical and foreign assistance issues under the U.S.-Japan Framework for a New Economic Partnership.

Under the Common Agenda, Japan pledged to give $3 billion through a Global Issues Initiative for Population and AIDS over a seven-year period, 1993-2000. At a recent meeting marking the fifth anniversary of the Common Agenda, the health working group reiterated the importance of a focus on population and recommended that reproductive health issues be addressed more directly and systematically under Common Agenda programs.

The Global Issues Initiative includes both "direct" and "indirect" population aid. The Japanese aid program defines direct population aid as support for family planning, and maternal and child health services, related information, education and communication (IEC) programs, and demographic and policy analysis. Indirect population aid includes primary health care, basic education, women's empowerment and HIV/AIDS prevention and monitoring. Japan's women in development initiative, announced at the 1995 Beijing international conference on women, and its recent commitment to increasing NGO involvement in project implementation are additional policies that are supportive of programming in population and reproductive health.

More recently, Japan's economic troubles have made population assistance more vulnerable. In 1997-98, in response to a directive from the Japanese parliament requiring all government ministries to cut public spending by 10 percent, the Ministry of Foreign Affairs proposed deep cuts in its voluntary contributions to UN organizations, including UNFPA, causing concern among advocates of population assistance. However, the Ministry of Foreign Affairs ultimately chose to maintain, in Japanese yen, its assessed contributions to UN agencies, its voluntary contributions to UNFPA, UNICEF and the UN High Commissioner for Refugees (UNHCR), as well as the bilateral aid budget.

This policy reversal followed strong appeals to the Japanese government from the heads of the various UN special funds and programs, and domestic pressure from population NGOs such as the Japanese Organization for International Cooperation in Family Planning (JOICFP) and a newly established NGO, 2050, involved in population advocacy. Advocates for maintaining support to UNFPA argued that Japan's leadership as a population donor was important to its standing in the world community, and that cuts in population aid would have a severe negative impact on maternal and child health in developing countries.

3 TRENDS IN FUNDING FOR POPULATION ASSISTANCE

OVERALL FUNDING LEVELS:

Population assistance from Japan has increased over the past decade, but Japan still lags behind the other major economic powers in the aid it allocates for population programs. Population assistance provided by Japan increased over 70 percent between 1987 and 1995. (Data on Japanese population assistance for 1996 were not available at the time of writing, and the discussion of funding is therefore limited to data for 1995.) In 1987, Japan provided $54 million in total resources for population programs; by 1995 the Japanese contribution had grown to $93.7 million, or seven percent of total global population assistance. Despite this large increase, Japan still gives considerably less in total population aid than other major economic powers such as the United States and Germany, which gave $667 million and $145 million respectively in 1995.

Japan also performs poorly on indicators of the extent to which it bears its fair share of the burden for population assistance relative to other donor countries. In 1995, Japan gave less than 0.65 percent of general development aid to population assistance, compared with 9 percent from the United States and 1.9 percent from Germany. Japan also falls short in its contributions to population programs relative to its large economy, giving $18 per million dollars of GNP in 1995—a level lower than some of the smallest donors. In comparison, the United States gave $92 in population assistance per million dollars of GNP in 1995, and Germany gave $60.

MULTILATERAL FUNDING:

Japan's strength in supporting population programs has always been through the multilateral channel. Despite its poor comparative performance in population assistance in terms of total volume and burden sharing, Japan has consistently been a top donor to UNFPA. Since 1995, Japan's contribution to UNFPA's core budget has topped $50 million a year. In 1997, the Japanese contribution amounted to $54.4 million—19 percent of UNFPA's total income from the major donor countries. While Japan maintained its 1998 pledge in yen at the 1997 level, the value of its contribution will drop significantly in dollars due to the lower value of the yen in relation to the U.S. dollar.

BILATERAL FUNDING:

The volume of bilateral population aid from Japan has almost doubled during the 1990s. In 1990, Japan gave $7.7 million bilaterally; by 1995 it was allocating close to $16 million through this channel. A greater proportion of funds can be expected to flow through the bilateral channel in the future as Japan improves its capacity for project development and technical support.

FUNDING FOR NGOS:

Japan is a major donor to IPPF and has recently also begun funding population-related programs implemented by Japanese NGOs in developing countries. Japanese funding for NGO population programs has increased from about $15 million in 1990 to $22.5 million in 1995. This funding primarily reflects Japan's contributions to IPPF over this period. The Japanese contribution accounted for 22 percent of IPPF's total budget in 1997, making Japan the single largest donor to the organization. Japan has only recently begun directly funding Japanese and developing country NGOs to implement reproductive health projects in aid recipient countries. A number of such initiatives are in the pipeline and will receive funding in the 1997-98 fiscal year.

Japan also provides funding through its embassies for local NGO projects in the areas of population, AIDS, women in development and the environment. This decentralized program disburses grants to a maximum of $100,000 based on applications from local organizations. In 1995, grants disbursed through this program worldwide amounted to about $1.1 million.

4 PROGRAM PRIORITIES

GEOGRAPHIC PRIORITIES:

The largest projects supported by Japanese assistance are in Asia. Japan's Global Issues Initiative, launched in 1994, identifies 12 priority countries for development assistance, grant aid and technical cooperation in the areas of population and AIDS. These include 6 nations in Asia (Bangladesh, India, Indonesia, Pakistan, the Philippines and Thailand), 5 in Africa (Egypt, Ghana, Kenya, Senegal and Tanzania), and 1 in Latin America (Mexico). Japanese aid officials recently claimed that Japan has initiated population and reproductive health projects in all priority countries and provided about $2 billion in assistance between 1994 and 1998. However, some critics assert this figure includes non-population related activities and significantly overstates real levels of population assistance.

Despite a 10 percent cut in public spending in 1997-98, Japan maintained its commitments to population assistance.

Japanese-funded initiatives generally integrate family planning and reproductive health services into maternal and child health programs.

In 1996, Japan supported bilateral family planning and reproductive health initiatives in 10 nations: Argentina, Cambodia, Kenya, Mexico, Nepal, the Philippines, Tanzania, Thailand, Tunisia and Turkey. More recently, JICA has initiated two technical cooperation projects in Bangladesh and Vietnam in collaboration with JOICFP.

AREAS OF PROGRAM EMPHASIS:
Japanese-funded initiatives generally integrate family planning and reproductive health services into maternal and child health programs. Given restricted domestic family planning options (no hormonal methods are approved for use in Japan and condoms are the most readily available and widely used contraceptive method), policy makers reportedly prefer to combine overseas family planning efforts with broader maternal and child health services, an approach that has strong support within Japan. Traditionally, Japan has been reluctant to directly fund service delivery projects, perhaps due to lack of technical expertise in the bilateral aid program, and has relied on its funding to UNFPA and IPPF to support family planning services.

5 TECHNICAL CAPACITY

STAFFING:
Japan's bilateral development assistance agencies are generally known for having very limited expert staff across a broad range of development disciplines, including population and reproductive health. JICA's main approach to staffing population project teams is to convene a committee of national experts from the government and private sector. Teams for population projects are often lead by senior physicians rather than public health or population experts. As a result of this reliance on outside experts, staff within JICA have not built up experience in population project implementation. JICA has only recently begun to address this shortcoming in the population field by relying more heavily on technical resources available through JOICFP.

TECHNICAL EXPERTISE OF COLLABORATING INSTITUTIONS:
Japan has begun to use domestic NGOs to supplement the slim technical assistance resources at JICA in the population field. The primary Japanese NGO involved in project implementation is JOICFP. The organization's community-based approach has allowed JICA to diversify its traditional medical orientation and give greater emphasis to public health concerns and local capacity building.

JOICFP has a thirty-year record of project implementation in developing countries. Since 1968, the organization has played a dual role as an advocate for population issues and funding and as an executing agency for international projects. JOICFP's technical expertise initially reflected a narrow focus on the integration of family planning and parasite control efforts. However, over the years the organization's breadth of expertise in reproductive health and family planning has grown. JOICFP's staff of about 22 now acts as a technical resource to JICA in the areas of community-based reproductive health, adolescent health, HIV/AIDS prevention and women's income generation activities.

JOICFP is currently involved in numerous population-related activities in collaboration with JICA. It is conducting a mid-term review of the Global Issues Initiative in 1997-98, and has been selected by JICA to lead a team to Vietnam to implement a new reproductive health project. JICA is also funding two developing country NGOs with longstanding ties to JOICFP, the Family Planning Association of Bangladesh (FPAB) and the Mexican Foundation for Family Planning (MEXFAM).

THE NETHERLANDS

The Dutch government more than doubled funding for population and reproductive health between 1994 and 1996.

THE NETHERLANDS

POPULATION AND REPRODUCTIVE HEALTH ASSISTANCE

OVERALL ASSESSMENT

The Netherlands' financial response to the ICPD is one of the strongest among the donor nations. The Dutch government more than doubled funding for population and reproductive health programs between 1994 and 1996. The Netherlands continues to support the delivery of family planning and reproductive health services by channeling a large share of its population assistance to core funding for UNFPA and IPPF. The Dutch government is also expanding support for broader reproductive health initiatives through its bilateral aid program. The political environment in the Netherlands is highly supportive of reproductive health assistance, as evidenced by the government's willingness to work in controversial areas such as unsafe abortion and adolescent reproductive health services that other donors are often reluctant to fund.

Despite this very positive record, recent changes in the Dutch development aid program warrant some concern. The ongoing transition to a more decentralized aid management system could potentially hinder the development and implementation of new bilateral reproductive health programs. In particular, the effectiveness of new mechanisms for coordination between the Ministry of Foreign Affairs and health program staff in Dutch embassies remains to be seen.

Some policy changes are likely in store for the Dutch foreign assistance program. The Ministry of Foreign Affairs has new leadership following elections in mid-1998. Recent debates have focused on the role of Dutch business in development assistance, and the potential for a shift in geographic emphasis from Africa to Eastern Europe and the former Soviet states. The Ministry's new leadership has also indicated interest in concentrating Dutch aid in fewer countries and program areas.

Population Action International's Country Grade

GRADE

1 DEVELOPMENT ASSISTANCE: POLICY AND FUNDING

The volume of assistance provided by the Netherlands is especially significant given the small size of its economy and its population of just under 16 million. In 1997, the Netherlands was the sixth largest source of development aid worldwide, giving over $2.9 billion in foreign assistance. Dutch aid has also long been known for its emphasis on poverty alleviation, economic self-sufficiency and concern for aid effectiveness. The Netherlands is one of very few donor nations to meet and exceed the UN target of allocating 0.7 percent of GNP to development aid. In 1996 and 1997, the Dutch government gave over 0.8 percent of GNP in foreign aid, and is reportedly committed to increasing this percentage to even higher levels.

New directions in the administration of Dutch aid include reorganization of the Ministry of Foreign Affairs, decentralization of authority to embassies and the adoption of financial

VITAL STATISTICS

1996 population size:	15.6 million
Total Official Development Assistance (ODA), 1996:	$3,246 million
ODA as a percentage of GNP, 1996:	0.81%
Total population assistance, 1996:	$111.7 million
Population assistance as percentage of ODA, 1996:	3.44%
Population assistance per $US million GNP, 1996:	$280

targets in the development budget. The Dutch coalition government—in power since 1994—has sought to improve coordination among the various ministries involved in foreign affairs, development cooperation and economic affairs. Simultaneously, the government embarked on a decentralization policy which designated Dutch embassies overseas as the main partners for governments and NGOs receiving Dutch development assistance. These changes were designed to enable the Netherlands to better achieve its five main financial targets for the development program:

- allocation of 20 percent of the development aid budget to basic social services;
- allocation of 4 percent of the development aid budget to reproductive health care (as part of the 20 percent goal for basic social services);
- expenditure of 0.1 percent of GNP annually on international nature conservation and environment programs;
- annual expenditure of 50 million Dutch guilders (approximately U.S. $25 million) to preserve tropical rainforests; and
- a minimum of 0.25 percent of GNP to be spent on aid to the least developed countries.

To date, the Dutch government has been successful in meeting many of these financial targets. However, the decentralization process was only initiated in 1996, and it is too soon to assess its effectiveness in programming aid funds. In 1997, the Dutch aid program reportedly experienced some bottlenecks in disbursement of funds due to the unfamiliarity of embassy staff with their new responsibilities. In response, the government reduced the number of thematic budget lines and centralized authority for project approval in the Ministry of Foreign Affairs.

2 THE POLICY ENVIRONMENT FOR INTERNATIONAL POPULATION ASSISTANCE

Dutch policy initiatives to increase population assistance predate the 1994 Cairo conference. In 1992, the Foreign Minister, Jan Pronk, initiated an internal dialogue regarding the need to strengthen Dutch population policy, which culminated in a published strategy on family planning and reproductive health in development cooperation. However, this policy change did not lead to increases in funding in the short-term. Following the ICPD, the Netherlands initiated further policy reforms to increase actual financial support to reproductive health activities.

In 1995, the Dutch parliament passed a resolution requiring the allocation of four percent of development assistance to reproductive health. Some controversy has ensued regarding how to count resources allocated to HIV/AIDS activities and primary health programs with reproductive health components. Despite these ambiguities, the government reported that it met the four percent goal in 1996. This legislative requirement provides both a strong policy mandate for programming funds in population and reproductive health, and an administrative responsibility to report back to the parliament on these expenditures. The Netherlands thus has one of the most supportive policy environments for population assistance within the donor community.

3 TRENDS IN FUNDING FOR POPULATION ASSISTANCE

OVERALL FUNDING LEVELS:
Dutch funding for population and reproductive health has increased steadily over the past decade. The Netherlands does especially well when its contributions are considered relative to its population size and wealth. In 1995, the Netherlands was the fifth largest donor in terms of total volume of population assistance; in 1996, it became the second largest donor, contributing $111 million. It also ranks third among donor countries in the allocation of funds for population assistance relative to GNP, spending $280 per million dollars of GNP compared with the average for donor nations of $93 in 1996. In that year, UNFPA reports that the Netherlands devoted 3.4 percent of total development aid to population activities, compared with an average of two percent for the donor community.

MULTILATERAL FUNDING:
The Netherlands has traditionally channeled a high proportion of its population assistance through multilateral institutions. In 1996, 78 percent of

Dutch population funding went to multilateral organizations. UNFPA has reported a steady increase in Dutch contributions between 1993 ($28.3 million) and 1997 ($44.4 million), when the Netherlands became the second largest contributor to the Fund. The Dutch are also contributors to other multilateral organizations that implement health and population programs, such as WHO, UNICEF, the World Bank, the EC and UNAIDS.

BILATERAL FUNDING:

It is difficult to assess trends in Dutch bilateral population assistance. According to UNFPA, Dutch bilateral population assistance increased to $21.7 million in 1995 (25 percent of total population assistance), up from $2.2 million in 1994. This dramatic increase can be largely attributed to the broadened definition of population assistance introduced by UNFPA in 1995. However, in 1996, UNFPA reported that the Dutch bilateral share of assistance dropped to 11 percent (approximately $12 million), although overall population assistance increased to over $111 million. It is unclear whether this decline in the share of bilateral assistance is real or simply a reflection of inconsistencies in reporting. Changes in the administration of Dutch bilateral development aid—in particular, the new policy of decentralization—may also have affected the efficiency of disbursements for population as well as other activities.

FUNDING FOR NGOS:

Dutch contributions to IPPF consistently increased during the 1990s. However, in 1997, the dollar value of the Dutch contribution declined owing to the falling value of the guilder relative to the U.S. dollar. In 1998, IPPF expects to receive $3.9 million from the Netherlands in core funding (maintaining the 1997 level), and an additional $900,000 for capacity building and training activities with its national affiliates.

4 PROGRAM PRIORITIES

GEOGRAPHIC PRIORITIES:

The concentration of Dutch population aid funds in sub-Saharan Africa reflects the larger emphasis of the aid program on poverty alleviation and the targeting of aid to the poorest nations. In 1995, Africa received the largest share of resources (49 percent) allocated to population and reproductive health programs. Much smaller shares of population aid went to Asia (17 percent), Latin America (15 percent), and Europe and the Middle East (which together received less than 5 percent.)

AREAS OF PROGRAM EMPHASIS:

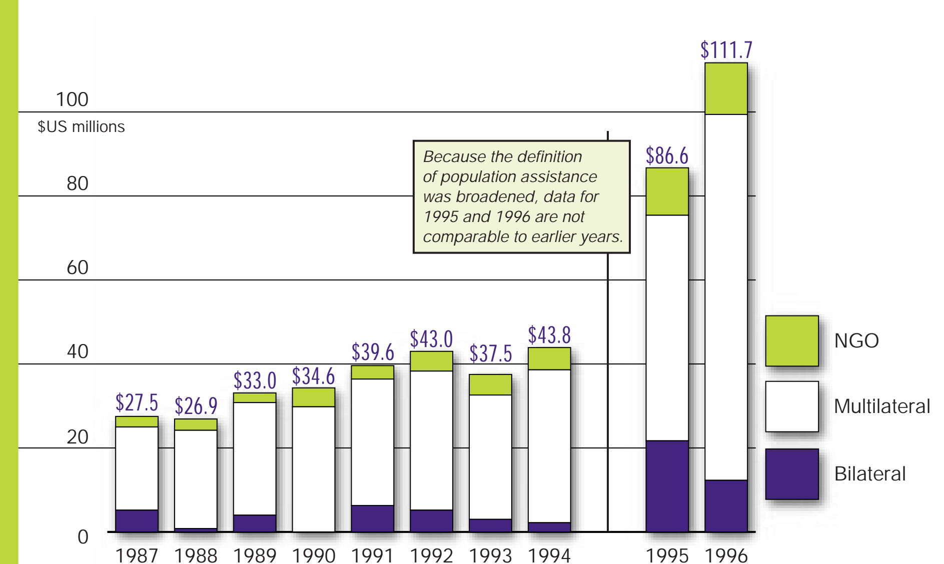
The Dutch government recently identified the following priority areas within reproductive health: safe motherhood, adolescent sexual health, unsafe abortion, refugee reproductive health, and AIDS and other STDs. Recent policy statements also indicate a shift in focus to addressing the broader problems of health systems rather than providing direct support for health services. This policy change is likely to benefit safe motherhood programs, since it shifts the emphasis from village level services to the capacity of health systems, including facilities available at the district level for emergency obstetric care.

5 TECHNICAL CAPACITY

STAFFING:

The recent reorganization and decentralization of the aid program have resulted in significant changes in technical staffing. Several Dutch embassies have appointed health specialists to assist with programming aid funds at the country or regional level; in early 1998, there were 8 such specialists worldwide. In the remaining embassies, women in develop-

TRENDS IN POPULATION ASSISTANCE 1987–1996



Sources: Population assistance: UNFPA. Vital statistics: UNFPA, UN Population Division, OECD.

The volume of assistance provided by the Netherlands is especially significant given the small size of its economy.

ment specialists handle reproductive health programming. At the Ministry of Foreign Affairs in The Hague, a single technical expert in reproductive health is assigned to the social and institutional development section. In addition, the Ministry has a full-time staff person monitoring its substantial reproductive health assistance to multilateral organizations. Mechanisms for formal coordination between these ministry experts and health specialists in the field are evolving slowly following the reorganization.

The new decentralization scheme gives embassies the flexibility to access technical assistance in reproductive health through either the Ministry or outside consultants. However, the newly hired health experts are working on a contract basis rather than as part of the permanent civil service structure. As such, they are less likely to provide continuity in technical assistance or to contribute to the development of long-term institutional capacity within the Dutch foreign aid system. This arrangement is under review and, according to Ministry officials, likely to change in the near future.

TECHNICAL EXPERTISE OF COLLABORATING INSTITUTIONS: To date, the Ministry of Foreign Affairs has not allocated a significant share of population resources through the bilateral channel, or utilized Dutch institutions extensively to support its reproductive health programming. Still, several Dutch institutions have the potential to play a more significant role in bilateral cooperation activities:

- ***The World Population Foundation*** (WPF) is well known as an advocate for Dutch population and reproductive health assistance. WPF is also involved in population and reproductive health projects. It supports local organizations in developing countries by helping design and manage projects, and mobilizes funding for such projects by working closely with donors—especially UNFPA, the World Bank and the European Commission.

- ***The Royal Tropical Institute*** (KIT), a well known medical research institution, currently works with core support from the Dutch government in the field of international health. KIT currently has partnerships with reproductive health research institutes in Benin, Egypt and Burkina Faso.

- ***The Rutgers Foundation,*** the Dutch IPPF affiliate, has recently established an international branch and is beginning to utilize its expertise in adolescent sexual health in new program initiatives in Eastern Europe.

- ***The Netherlands Interdisciplinary Demographic Institute*** (NIDI) has a contract with UNFPA to track global resource flows for population programs. While it receives some government contracts in the area of demographic research, NIDI has little expertise in reproductive health service delivery.

In the future, it is possible that Dutch NGOs could play a more substantial role in implementation of bilateral reproductive health programs. However, the increasing decentralisation of the Dutch aid system and the requirement that programs be initiated in the field are major obstacles to the greater involvement of Dutch NGOs, given their limited overseas presence. Meanwhile, other development NGOs in the Netherlands have demonstrated only limited interest in reproductive health activities.

NEW ZEALAND

New Zealand has tripled funding for population programs, but remains one of the smallest donors.

NEW ZEALAND

POPULATION AND REPRODUCTIVE HEALTH ASSISTANCE

OVERALL ASSESSMENT

Support for population assistance in New Zealand has risen since the ICPD, as reflected in significantly higher contributions to UNFPA and IPPF. Given the limited capacity of the bilateral aid program to administer funds for reproductive health programs, this appears to be a wise use of aid resources.

New Zealand's geographic focus on the Pacific Islands could spur additional bilateral initiatives in reproductive health in the future. In 1997, the New Zealand government funded small research initiatives through IPPF in the Pacific region. It has indicated interest in funding other similar programs bilaterally and will be encouraging NGOs involved in general development work in the Pacific to submit proposals for population-related activities. For the foreseeable future, however, New Zealand is likely to remain a minor donor, and new bilateral initiatives are also likely to remain modest in financial terms.

VITAL STATISTICS

1996 population size:	3.6 million
Total Official Development Assistance (ODA), 1996:	$122 million
ODA as a percentage of GNP, 1996:	0.21%
Total population assistance, 1996:	$1.2 million
Population assistance as percentage of ODA, 1996:	1.00%
Population assistance per $US million GNP, 1996:	$21

Population Action International's Country Grade

D–

GRADE

1 DEVELOPMENT ASSISTANCE: POLICY AND FUNDING

A new framework for New Zealand's small foreign aid program places a priority on poverty alleviation and concentrates its efforts on the South Pacific. The government has formulated a new framework for development assistance which emphasizes poverty alleviation, capacity building and equitable economic development. Aid from New Zealand is closely aligned with its foreign policy objectives and concentrated in the neighboring South Pacific region and Southeast Asia.

New Zealand was one of the smallest donors in terms of its total aid volume in 1997. Although New Zealand has signed on to the UN target of allocating 0.7 percent of GNP for development aid, its assistance levels peaked at 0.52 percent in 1975 and dropped to 0.25 percent by 1997. Since 1990, aid levels have increased slowly in absolute terms, and New Zealand has expanded its bilateral pro-

gram. Over 40 percent of the aid budget is spent on health, education, water and sanitation. Critics argue that this figure is distorted by the inclusion of significant expenditures on education and training in New Zealand itself for Asian/Pacific beneficiaries.

2 THE POLICY ENVIRONMENT FOR INTERNATIONAL POPULATION ASSISTANCE

Recently, New Zealand has demonstrated interest in expanding initiatives in the area of reproductive health and women's development. In 1996, an independent review of the integration of women in development concerns into the development aid program recommended that New Zealand increase efforts to meet the goals developed at the ICPD, World Summit on Social Development and Fourth World Conference on Women. The review, in particular, recommended expanding initiatives in the areas of women's reproductive health, basic education and women's rights.

Currently, support for reproductive health and family planning appears strong in New Zealand, and is demonstrated primarily through multilateral channels.

3 TRENDS IN FUNDING FOR POPULATION ASSISTANCE

OVERALL FUNDING LEVELS:

Overall funding for population has increased steadily since 1991, although remaining at relatively low levels. Despite almost tripling population assistance levels between 1990 and 1996, New Zealand remains one of the smallest donors to international population programs. In 1996, New Zealand gave $1.2 million in population assistance, ranking 18th out of 21 donors, just behind Italy which has a much larger population and overall foreign aid program. With its population of 3.6 million, New Zealand is a small donor country, yet its allocations to population are higher than some other wealthier and more populous donor nations.

MULTILATERAL FUNDING:

New Zealand allocates most of its modest funding for population through multilateral or NGO channels. About half of all population assistance flowed through the multilateral channel between 1990-95, primarily via UNFPA. New Zealand's commitment to population assistance is seen most clearly through its small but rising national currency contributions to UNFPA. In 1996 New Zealand contributed $672,000 to UNFPA, a significant increase from 1995 when it gave only $375,000. The contribution for 1997 rose to $821,000, and remained stable in 1998.

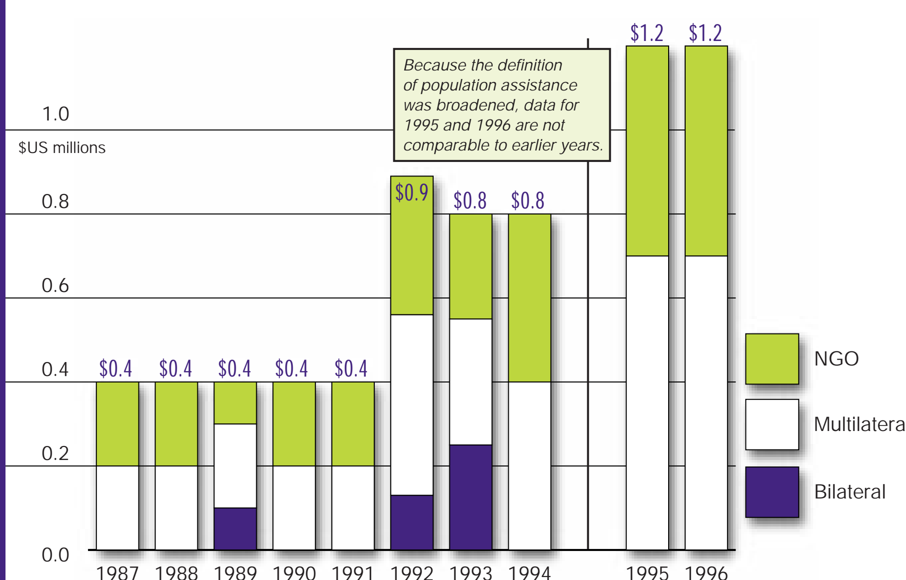
BILATERAL FUNDING:

New Zealand officially has no reproductive health or population program, but has recently funded a small number of bilateral reproductive health activities. For example, regional health programs may include a component related to sexual and reproductive health.

FUNDING FOR NGOS:

New Zealand has increased its support to IPPF in recent years, together with its rising contributions to UNFPA. Between 1988 and 1997, New Zealand's contribution to IPPF increased over two and a half times to $582,000, ranking it twelfth out of fourteen major donors. New Zealand's pledge to IPPF for 1998 is approximately $650,000, a slight increase from the previous year. In 1997, New Zealand also funded two research projects in the South Pacific through IPPF, one on male attitudes toward contraception and another on adolescent attitudes toward family planning, sexual health and teenage pregnancy. In 1997, for the first time, New Zealand made a contribution to the Population Council, an international NGO. This funding continued at the same level in 1998.

TRENDS IN POPULATION ASSISTANCE 1987–1996



Sources: Population assistance: UNFPA. Vital statistics: UNFPA, UN Population Division, OECD.

NORWAY

Norway is a leading donor to population programs, but its contributions have declined since the early 1990s.

Population Action International's Country Grade

GRADE

NORWAY

POPULATION AND REPRODUCTIVE HEALTH ASSISTANCE

OVERALL ASSESSMENT

Norway's importance as a donor to population programs lies primarily in the consistent support it provides to UNFPA and IPPF, the major international population organizations. Despite a slight decline in the total volume of funding during the 1990s, Norway is still a leading donor to population programs in its contribution relative to GNP, and consistently ranks among the top donors to UNFPA and IPPF. Norway has largely phased out its bilateral population assistance program, but supports selected population and reproductive health initiatives implemented by other agencies, including the World Bank and WHO.

Still, Norway is not fulfilling its potential as a source of funding for population programs. Both the proportion of Norwegian development aid allocated to population programs and the ratio of population assistance relative to GNP declined between 1990 and 1996. Given its strong economy, Norway could do more to support reproductive health and family planning, especially by increasing contributions to international organizations and NGOs working in the population field.

VITAL STATISTICS

1996 population size:	4.3 million
Total Official Development Assistance (ODA), 1996:	$1,311 million
ODA a a percentage of GNP, 1996:	0.85%
Total population assistance, 1996:	$46.1 million
Population assistance as percentage of ODA, 1996:	3.52%
Population assistance per $US million GNP, 1996:	$298

1 DEVELOPMENT ASSISTANCE: POLICY AND FUNDING

Norway has been a long-standing and generous donor to developing countries. This commitment to development cooperation began in 1952, when Norway initiated its bilateral development aid program. The Norwegian public has consistently expressed strong support for their government's contribution to efforts to reduce poverty in developing countries. This support is reflected in the fact that Norway is one of only a few donor nations that have allocated more than 1 percent of GNP to development aid in most recent years, although this level fell in 1997 to 0.86 percent.

The Norwegian aid program is evolving away from its roots—assisting the poorest countries with basic needs. The Norwegian aid program has historically had a strong focus on poverty alleviation and concentrated its resources in the poorest countries of sub-Saharan Africa and South Asia. Recently, however, the focus of

The Norwegian government sees population as closely linked to other key development issues, such as the environment.

Norwegian aid has begun to change. The government is now giving more attention to issues such as the environment, human rights, relief and conflict resolution, and the potential for aid recipients to become emerging trade partners. The Ministry of Foreign Affairs reports that it continues to give priority to environmental and gender concerns in development.

Another new aspect of Norwegian aid is a shift toward an expanded role for developing countries in their cooperation with Norway. Concern about aid effectiveness has led Norway to adopt a policy of "recipient responsibility." Recipient countries are encouraged to develop sector plans, including all development assistance as well as domestic budgetary resources. The Norwegian government expects this approach to strengthen local ownership of projects, develop in-country technical know-how and improve prospects for sustainability.

Although Norway remains a major donor, particularly given the size of its economy, in recent years aid levels have not kept pace with economic growth. The absolute volume of Norwegian aid continued to rise during the 1990s. In 1997, Norway gave $1.3 billion in development assistance—almost double the level of aid compared to a decade earlier. However, the aid to GNP ratio fell by 12 percent in 1995, partly due to a revised method of calculating GNP. Emerging trends in 1997 include an increase in funds for social development, the environment and women's development programs; in addition, Norway has allocated 50 percent of all bilateral aid funds to Africa.

Norway's development administration responsibilities are divided between the Ministry of Foreign Affairs (MFA) and the Norwegian Agency for Development Cooperation (NORAD). The Ministry is responsible for developing Norwegian aid programs, while NORAD has responsibility for implementing bilateral and NGO development cooperation projects. The Minister of International Development and Human Rights within the MFA has oversight of both NORAD (under the bilateral department of the Ministry) and a separate multilateral department. In recent years, the Ministry has integrated NORAD offices in priority countries into Norwegian embassies as part of a decentralization process, with the aim of more effectively using available aid resources.

2 THE POLICY ENVIRONMENT FOR INTERNATIONAL POPULATION ASSISTANCE

The policy environment in Norway has long been extremely supportive of population assistance. Prior to the ICPD, Norway stood out as the only donor nation allocating four percent of development assistance to population-related activities. The Norwegian government has always seen population as closely linked to other development issues such as the environment and economic development.

Norwegian population policy takes a multi-faceted approach to population programming. Although Norway provides direct support for family planning, its aid policy affirms the role of multiple influences on the adoption of the small family norm and fertility decline. Thus, Norway's policy has been to emphasize the importance of maternal and child health services, child survival, the status of women and education, along with expanded access to family planning services, as the way to achieve a more rapid reduction in fertility.

Norway's former Prime Minister Gro Brundtland, who became the Director-General of WHO in July 1998, has been an outspoken international advocate for reproductive health and rights. Dr. Brundtland, who led the Norwegian delegation to the 1994 ICPD, generated controversy at the conference with a widely-publicized speech calling on all countries to decriminalize abortion.

3 TRENDS IN FUNDING FOR POPULATION ASSISTANCE

OVERALL FUNDING LEVELS: Although Norwegian population assistance levels have declined in recent years, Norway still performs well as a donor to population programs. Norway ranks high relative to other donor countries both in volume of aid and in its contribution relative to GNP. Norwegian population assistance reached a high level in the early 1990s, peaking in 1991 at $53 million. Since then the level of aid for population programs has fallen, to $46 million in 1996. This decline occurred despite the broadened definition used to report population assistance beginning in 1995.

Population aid also declined over this period as a percentage of total development assistance—from 4.1 percent in 1990 to 3.5 percent in 1996. In addition, Norwegian population assistance declined relative to GNP, from $487 per million GNP in 1990 to $298 in 1996. Despite these declines, Norway still ranked as the eighth largest donor to population programs in 1996 in absolute aid volume; moreover, its contribution relative to GNP still ranks Norway among the top population donors.

MULTILATERAL FUNDING:

Norway channels the vast majority of its population assistance through multilateral organizations. In 1996, the multilateral channel accounted for 85 percent of Norway's total population assistance. Norway is a very important donor to UNFPA, ranking fourth among the Fund's donors in 1997 with a contribution of $28.3 million. Norway allocated an additional $6.9 million to UNFPA in 1997 for multi-bilateral projects. The Norwegian government also makes voluntary contributions to the WHO Women's Health and Development Programme and its human reproduction research program.

BILATERAL FUNDING:

Norway no longer has a bilateral population assistance program. In 1991, Norway began to phase out its bilateral population assistance program. Since 1994, the government has not reported any allocations for population-related projects through the bilateral channel.

FUNDING FOR NGOS:

IPPF, the largest international NGO in the population field, is the major recipient of Norwegian population assistance through the NGO channel. Norway's contribution to IPPF peaked in 1992 at $8.2 million and then fell for several years in U.S. dollar terms. Recently, the annual Norwegian kroner contribution has slowly increased—and stabilized in dollar terms at around $6.6 million—making Norway the fifth largest donor to IPPF in 1997.

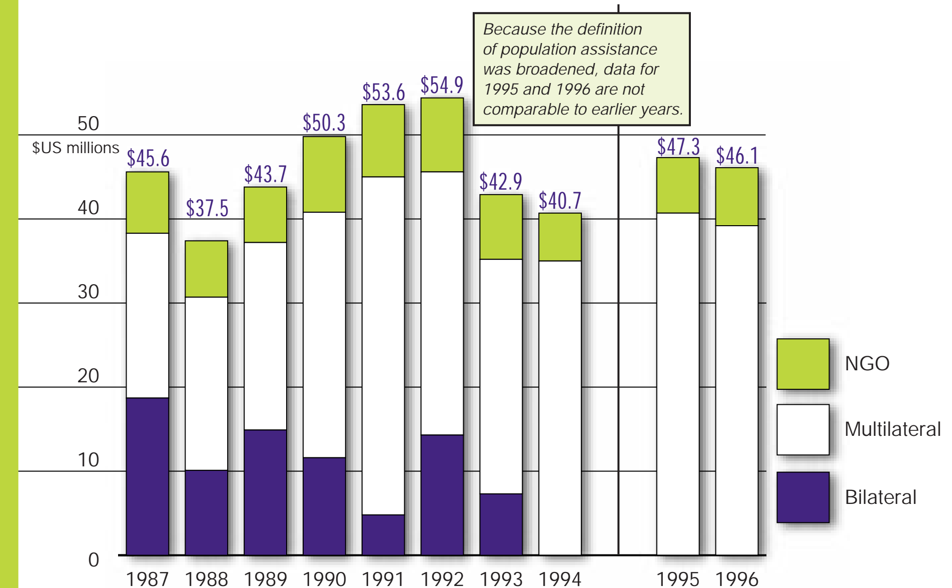
Like some other European countries, Norway is decentralizing its foreign aid program and transferring many development cooperation functions from central government departments to embassies in the field. As a result, embassies in priority countries will manage funds for NGO collaboration and become the contact points for local and international NGOs in the population field seeking Norwegian funding.

4 PROGRAM PRIORITIES

Following the phase-out of Norway's bilateral population assistance program, priority areas for Norwegian assistance are difficult to discern. However, activities supported by Norway on a multi-bilateral basis—i.e., through major international organizations—provide some indication of geographic and programmatic priorities.

Norway is part of the large donor consortium which supports the Bangladesh population and health program through the World Bank. In Africa, Norway funds AIDS and population work in Burkina Faso; reproductive health and family planning programs in Ethiopia; efforts by UNFPA to strengthen reproductive health and family planning capacity in Mozambique; and a World Bank family health program in Zimbabwe. Norway also funds regional programs in sub-Saharan Africa through IPPF and UNFPA to strengthen reproductive health services and enhance adolescent health. In Latin America, Norway funds multi-bilateral activities in Nicaragua in the areas of reproductive health and family planning.

TRENDS IN POPULATION ASSISTANCE 1987–1996



Sources: Population assistance: UNFPA. Vital statistics: UNFPA, UN Population Division, OECD.

PORTUGAL

Even as one of the least wealthy donor countries, Portugal could afford to increase its very low levels of population assistance.

GRADE

PORTUGAL

POPULATION AND REPRODUCTIVE HEALTH ASSISTANCE

OVERALL ASSESSMENT

Portugal is not fulfilling its potential as a donor to international population programs, as evidenced by its low and static contributions to UNFPA throughout the 1990s. Even as one of the least wealthy donor countries, Portugal could afford to increase its contributions to UNFPA and to make a small contribution to IPPF. Portuguese observers report no specific obstacles to increased contributions for population programs, but point to the need for expanded advocacy efforts to change the government's development policy and financial allocations. A recent NGO initiative to raise awareness of international reproductive health issues among parliamentarians is a positive step towards increasing attention to needs in this area.

1 DEVELOPMENT ASSISTANCE: POLICY AND FUNDING

Portugal is a small and relatively new donor whose development assistance program focuses on Portuguese-speaking nations in Africa. Portugal has one of the smallest economies and the lowest GNP per capita among the donor countries. Its small development assistance program is highly concentrated in its former colonies in Africa, where it has strong historical and cultural ties. In recent years, the government has extended its aid program to other countries, but the bulk of funds are still channeled to Angola, Cape Verde, Guinea Bissau, Mozambique, and Sao Tome and Principe.

Portugal's aid program allocations remain far short of the UN goal of 0.7 percent of GNP. In 1997, Portugal's total development assistance amounted to $251 million, which represented 0.25 percent of GNP. Portugal's aid to GNP ratio has dropped in recent years, after peaking in 1992 at 0.35 percent. Portuguese officials cite 0.36 percent of GNP as a goal, but it is unclear whether this level is achievable given recent downward trends.

VITAL STATISTICS

1996 population size:	9.8 million
Total Official Development Assistance (ODA), 1996:	$218 million
ODA as a percentage of GNP, 1996:	0.21%
Total population assistance, 1996:	$249,000
Population assistance as percentage of ODA, 1996:	0.11%
Population assistance per $US million GNP, 1996:	$2

Population Action International's Country Grade

The aid program is administered through several different governmental departments and ministries, including the departments of education and health. Priority sectors for the aid program include economic policy reform and debt restructuring. Historically Portugal has devoted a very high percentage of total development assistance to debt relief in Portuguese-speaking Africa.

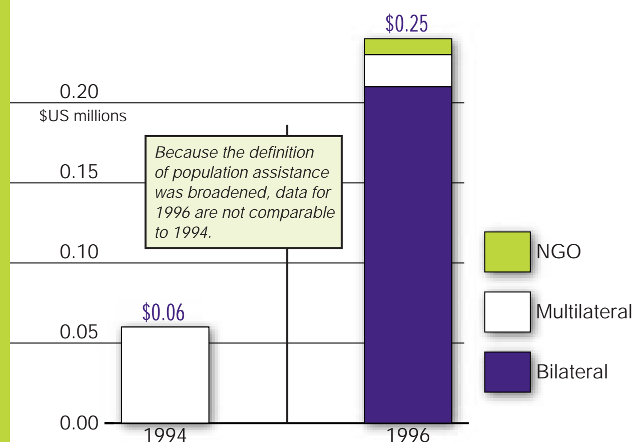
Technical projects focus on the areas of environmental management and hospital-based health services. Portugal also funds the training of students and professionals from Africa through university-level education programs. Staffing of the development assistance program is generally considered adequate, although there is a lack of expertise in specific technical areas like poverty and gender.

2 THE POLICY ENVIRONMENT FOR INTERNATIONAL POPULATION ASSISTANCE

The Portuguese government has not responded in clearly identifiable ways to the Cairo conference on population and development. Although the Ministry of Health has expanded its working definition of reproductive health to include maternal and child health and AIDS in addition to family planning, these changes have not translated into increases in funding levels or new programs.

The political environment does not appear to be an obstacle to increasing population assistance levels. Public opinion surveys on support for overall development aid are very positive, with over 90 percent of the public supporting foreign assistance. Portugal's Family Planning Association (FPA) has recently initiated advocacy activities to strengthen political support for the ICPD agenda in Portugal. These activities include a 1998 conference called Cairo Plus Three to raise awareness of reproductive health needs among parliamentarians and government officials. The FPA has received additional funding from UNFPA to conduct public education activities relating to reproductive health.

TRENDS IN POPULATION ASSISTANCE 1994 & 1996



Sources: Population assistance: UNFPA.
Vital statistics: UNFPA, UN Population Division, OECD.

The Portugese aid program has done little to respond to the ICPD.

3 TRENDS IN FUNDING FOR POPULATION ASSISTANCE

OVERALL AND MULTILATERAL FUNDING LEVELS:

Portugal's reporting on population assistance has been erratic, so trends are difficult to assess. Portugal reported population assistance expenditures to UNFPA for the first time in 1994, when it provided $59,000, and again in 1996 when it reported $249,000. This latter figure includes a $25,000 core contribution to UNFPA in 1996. In 1997 and 1998 Portugal doubled its contribution to UNFPA to $50,000—still a tiny percentage of the roughly $7 million Portugal contributes in total to the UN system, and of its total aid program of over $250 million.

BILATERAL FUNDING AND PROGRAM PRIORITIES:

Portugal's small bilateral population program emphasizes training, AIDS prevention and medical services. In 1996, Portugal reported spending approximately $212,000 bilaterally in population-related programs. Since the late 1980s, Portugal has conducted a training of trainers program for family planning workers from Portuguese-speaking African countries. These programs were expanded in recent years to include AIDS prevention. Some Portuguese medical assistance programs also address reproductive health needs. For example, in Mozambique, Portugal has provided medical personnel to staff six rural health centers providing maternity care and to train local staff.

FUNDING FOR NGOS:

Portugal does not contribute to IPPF, the major international NGO in the reproductive health field. Government funding of projects initiated by national NGOs is in its infancy, as NGOs are still exploring how to successfully access development assistance funds for reproductive health projects.

Portuguese NGOs are raising awareness of international health needs among policy makers.

4 TECHNICAL CAPACITY

Owing to the current low level of programming in reproductive health, Portuguese aid officials do not perceive a need for additional specialized staff in this area. At the present time, Portugal's limited bilateral reproductive health program is administered through two divisions of the Ministry of Health: the Division of Maternal and Infant Care and Adolescence and the National Committee Against AIDS. Overseas field personnel funded through the bilateral program are mostly medical professionals who provide clinical services in recipient countries.

Collaboration between the government and NGOs in the reproductive health field is in a nascent phase and has thus far been limited to advocacy activities. The Portuguese FPA is expanding its role in international cooperation and advocacy, and has proposed visits by parliamentarians to Portuguese-speaking African countries to explore reproductive health needs. There is clearly potential for further collaboration in population policy and program development between the government and the FPA.

SPAIN

Spain was actively engaged in the Cairo process, however, new policies to increase funding have yet to materialize.

SPAIN

POPULATION AND REPRODUCTIVE HEALTH ASSISTANCE

OVERALL ASSESSMENT

Although Spain remains a minor contributor to international population and reproductive health efforts, the policy environment for increased aid to this sector appears to be improving. In 1996, Spain allocated 0.59 percent of total development assistance to population activities—well below the average for donor countries of 2.0 percent. Although funding levels continue to lag, the establishment of a coalition of Spanish NGOs concerned about population and reproductive health, together with the passage of a parliamentary resolution in support of UNFPA, are signs of a changing policy environment. It remains to be seen whether these developments will lead to increased financial support for population programs, either through multilateral organizations or through Spain's bilateral development agency.

VITAL STATISTICS

1996 population size:	39.7 million
Total Official Development Assistance (ODA), 1996:	$1,251 million
ODA as a percentage of GNP, 1996	0.22%
Total population assistance, 1996:	$7.4 million
Population assistance as percentage of ODA, 1996:	0.59%
Population assistance per $US million GNP, 1996:	$13

Population Action International's Country Grade

GRADE

1 DEVELOPMENT ASSISTANCE: POLICY AND FUNDING

Spain is a relatively new member of the international donor community, with an official aid program that only began in 1985. Overall development aid did not reach significant levels (0.2 percent of GNP or greater) until 1990. In 1997, Spain gave $1.2 billion in development aid or 0.23 percent of GNP. Currently, Spanish aid strongly emphasizes commercial opportunities overseas for domestic business interests through the Development Aid Fund (FAD), a program of concessional credits for businesses. Spanish aid is administered through several government departments within two major ministries: the Ministry of the Economy and Finance, and the Ministry of Foreign Affairs, which houses the Spanish Agency for International Cooperation (AECI).

Historically, Spanish development aid has been closely linked to the Latin America region, where Spain has cultural and historical ties, and to countries where it has a strong

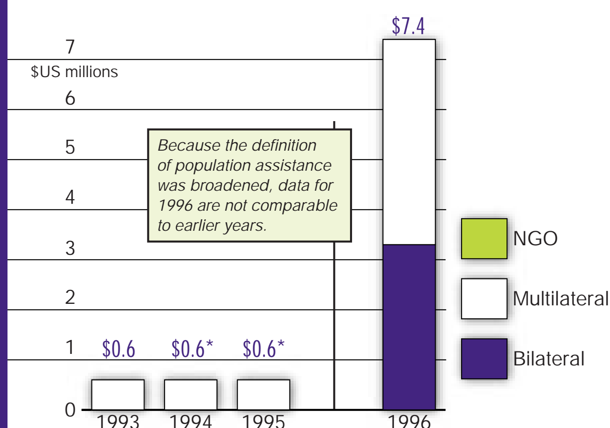
Spain is the only European country with a strong, organized political advocacy movement focused on foreign aid.

commercial interest. Argentina, Bolivia, Colombia, Ecuador and Nicaragua are among the top 10 recipients of Spanish assistance. The geographic allocation of Spanish assistance differs greatly for commercial credits versus bilateral grant aid for projects, reflecting the different criteria for commercial and development assistance. In the early 1990s, China was a leading recipient of Spanish commercial credits, while Equatorial Guinea received the largest proportion of grant aid.

The Spanish government has reiterated support for the allocation of 20 percent of development aid to social sector spending. Most social sector programs funded by Spain are implemented through NGOs. Some Spanish NGOs have questioned the government's method of estimating social sector allocations; Spain has historically counted all projects in health, education and sanitation as social sector programs, even if these projects are financed through commercial credits.

Spain is the only European country with a strong, organized political advocacy movement focused specifically on the issue of foreign aid. The "0.7 percent movement" has staged demonstrations and conducted public education activities since 1995 to make the case for increased levels of bilateral aid. Observers in Spain credit the group with increasing public awareness about foreign aid issues and creating a favorable environment for future increases in aid levels. At the present time, however, Spain is just emerging from several years of domestic economic difficulties, and the new conservative government—elected in 1996—has yet to clearly articulate changes in policy on foreign aid.

TRENDS IN POPULATION ASSISTANCE 1993–1996



Sources: Population assistance: UNFPA. Vital statistics: UNFPA, UN Population Division, OECD.
*As 1994 and 1995 expenditures were not reported to UNFPA, they are estimated at the 1993 level.

2 THE POLICY ENVIRONMENT FOR INTERNATIONAL POPULATION ASSISTANCE

The Cairo conference recommendations are not yet reflected in the thinking of government officials involved in development assistance. Spain was actively engaged in the ICPD process, primarily through the participation of the former Minister for Social Affairs, Christina Alberti. Unfortunately, new policies reflecting the Cairo agenda and increased funding levels for reproductive health programs have yet to materialize.

Advocates for population assistance in Spain cite confusion among government officials regarding the definition of population assistance as an obstacle to effective programming of existing resources. Spanish government sources tend to report all social sector programs as being population-related, making it difficult to distinguish policies and disaggregate expenditures relating more narrowly to reproductive health.

Among NGOs and parliamentarians, awareness of the importance of reproductive health needs in the developing world appears to be rising, resulting in a number of positive developments since the ICPD. Among these was the establishment of the Spanish Interest Group on Population, Reproductive Health and Development (SIG) in 1996. The SIG—an umbrella organization made up of academics, medical and development NGOs, women's organizations, parliamentarians and the national family planning association—conducts diverse advocacy activities in support of population and reproductive health assistance. Through its work with parliamentarians, the SIG initiated an all-party motion in support of UNFPA, which passed in 1998, and has published a report on Spain's response to the ICPD.

3 TRENDS IN FUNDING FOR POPULATION ASSISTANCE

OVERALL FUNDING LEVELS:

Trends in population assistance provided by Spain are difficult to assess since limited data are available. The Spanish government has only reported on its contributions for two years since Spain became a population assistance donor in 1993. In 1993, Spain reported spending $578,000 on population through the multilateral channel, primarily reflecting its contribution to UNFPA. In 1996, Spain reported spending $7.4 million on population assistance—$3.3 million bilaterally and approximately $4.1 million through multilateral channels.

MULTILATERAL FUNDING:

The basis for Spain's reported contributions to multilateral organizations involved in population activities is unclear. Spain maintained its contribution to UNFPA between 1995 and 1997 in local currency terms; in 1996, the Spanish contribution was the U.S. dollar equivalent of $475,000. This represents only about 12 percent of the total the Spanish government reports spending on population activities through multilateral channels. In 1997, Spain's contribution to UNFPA had fallen in U.S. dollar terms to $408,000.

Spain also supports some reproductive health-related initiatives through other UN organizations. For example, in 1996-97, it supported maternal and child health projects in Algeria and Morocco through UNICEF, and HIV/AIDS prevention activities in Latin America through UNAIDS.

BILATERAL FUNDING:

Spain reported no bilateral funding for population programs in 1993, and $3.3 million in 1996. No information was reported to UNFPA on population assistance for 1994 or 1995. Based on this incomplete data, trends are difficult to evaluate. However, the 1996 figure appears to be a substantial overestimate of actual spending on reproductive health, reflecting the tendency by the Spanish government to include health, education, human rights and sanitation projects as part of population spending. In addition, the increase between 1993 and 1996 likely reflects the broader definition of population assistance introduced in 1995 by UNFPA.

4 PROGRAM PRIORITIES

GEOGRAPHIC PRIORITIES AND AREAS OF PROGRAM EMPHASIS:

Spain is currently cofinancing UNFPA multi-bilateral projects in the Philippines, Algeria and Mauritania. The Philippines project is a two-year $1 million effort implemented through UNFPA. The project supports an information and education campaign to increase awareness of reproductive health and to improve services in 14 provinces, with the aim of assisting the Philippines in achieving the ICPD goal of reducing maternal mortality rates by 50 percent by the year 2000.

Spain allocated less than one percent of development assistance to population in 1996, well below the average for donor countries.

SWEDEN

Sweden continues to play a pioneering role **in addressing the more controversial aspects of sexual and reproductive health and rights.**

SWEDEN

POPULATION AND REPRODUCTIVE HEALTH ASSISTANCE

OVERALL ASSESSMENT

Sweden is a pioneer in the population field—one of the first countries to provide bilateral family planning assistance and a major supporter of multilateral population and reproductive health initiatives. As other major donors have taken on more responsibility for family planning assistance, Sweden has shifted its emphasis into neglected areas such as safe delivery, safe abortion, adolescent health, sexual health education and violence against women. Sweden's current formulation of "sexual and reproductive health and rights" is in many respects even broader than the definition of reproductive health agreed on at the Cairo conference. Today, Sweden's approach to population and development highlights human rights and gender concerns, and is broadly inclusive of the social and economic elements which impact population and reproductive health.

Sweden's financial allocations to population programs are difficult to assess. Reasons for this difficulty include the government's broad definition of sexual and reproductive health and rights; the devaluation of the Swedish currency relative to the dollar; and a shift in aid mechanisms from more focused projects to sector-wide approaches. Government officials report that Sweden has maintained or increased its financial support in national currency for population-related programs following the ICPD, but the dollar value of Swedish contributions has declined owing to exchange rate changes. Even in national currency, Sweden's contribution to UNFPA fell between 1994 and 1997, but in 1998 this trend was reversed. As the seventh largest contributor to population programs in 1996, Sweden remains an important donor in reproductive health and continues to play a pioneering role in addressing the more controversial aspects of sexual and reproductive health and rights.

1 DEVELOPMENT ASSISTANCE: POLICY AND FUNDING

Sweden is one of the few donor nations that allocates at least 0.7 percent of GNP to development cooperation annually. Since 1996, the Swedish development assistance budget has been directly linked to GNP and, therefore, has increased in absolute terms; this trend is expected to continue to the year 2000 and beyond. Unfortunately, due to the falling value of the Swedish currency relative to the U.S. dollar, Swedish allocations have fallen in dollar terms.

Sweden has been a pioneer both in the volume of aid it has given and in the implementation of aid programs. The Swedish aid program has a reputation for being on the leading edge in adopting new development assistance program directions and innovations. For example, Sweden was among the first donors to adopt multi-year funding commitments and a recipient-oriented approach to designing projects. Sweden was also one of the first donors to fund programs in the areas of NGO cooperation, women in development, the environment, democracy and human rights.

VITAL STATISTICS

1996 population size:	8.8 million
Total Official Development Assistance (ODA), 1996:	$1,999 million
ODA as a percentage of GNP, 1996:	0.84%
Total population assistance, 1996:	$57.9 million
Population assistance as percentage of ODA, 1996:	2.90%
Population assistance per $US million GNP, 1996:	$242

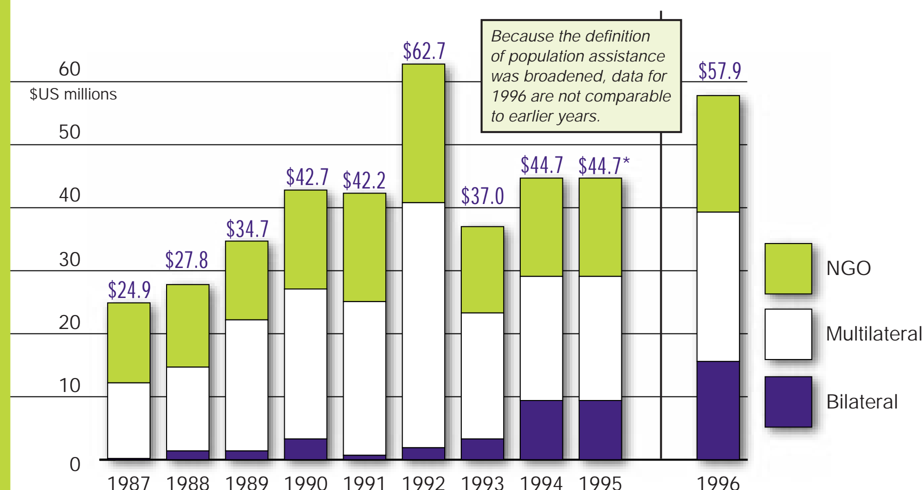
Population Action International's Country Grade

In recent years, aid management has been increasingly streamlined. In the past, the administration of Sweden's aid program involved many actors. The Swedish Parliament has always played an important function in setting overall policy for development cooperation and approving annual budget allocations. The Ministry of Foreign Affairs, through its Department for International Development Cooperation, has responsibility for policy development, multilateral organizations, and development programs in Eastern Europe and the former Soviet Union. Prior to 1995, the remainder of the aid program was administered through various agencies, of which the largest was the Swedish International Development Agency (SIDA). Traditionally, SIDA disbursed half of all Swedish development assistance funds and three-quarters of all bilateral aid.

Concerns with the efficiency of aid administration led in 1995 to the creation of a new entity called "Sida." This new entity merged the old SIDA and four other agencies involved in the Swedish development program, with the aim of improving the efficiency of aid administration and eliminating the overlapping responsibilities these agencies had in many of the same cooperating countries. Sweden's 1995 membership in the European Union (EU) also provided an impetus for reorganizing and improving the efficiency of its aid bureaucracy.

After declining since 1992, Sweden's aid budget appears to have stabilized at about 0.7 percent of GNP. During the early 1990s, Sweden experienced economic difficulties including high unemployment, and, for the first time, saw some decline in public support for foreign aid. Although budget cuts in domestic programs played a major role in these changes in attitudes, the Swedish public had also become concerned with the lack of clear successes resulting from their foreign aid program. Public debates focused on aid effectiveness and the problem of aid dependency among recipient countries. As a result, Sweden's official development assistance declined from a high of almost $2.5 billion in 1992 to $1.7 billion in 1997. However, cuts to the foreign aid budget were smaller than those in other areas, and Swedish development assistance continues to meet or

TRENDS IN POPULATION ASSISTANCE 1987–1996



Sources: Population assistance: UNFPA. Vital statistics: UNFPA, UN Population Division, OECD.
*As 1995 expenditures were not reported to UNFPA, they are estimated at the 1994 level.

Sweden's concept of sexual and reproductive health and rights is even broader than the ICPD's.

exceed the 0.7 percent goal which most other donor nations have failed to reach.

2 THE POLICY ENVIRONMENT FOR INTERNATIONAL POPULATION ASSISTANCE

The Swedish government was one of the first bilateral donors to provide population assistance, initiating funding for contraceptive commodities and services in the 1950s and 1960s. In the 1970s, the Swedish government became concerned about the ethics of funding family planning programs in countries which reportedly used coercive approaches. Swedish women's groups were also critical of the government's support for international family planning programs following reports of sterilization abuses in countries such as Bangladesh and India. As a result, Swedish population assistance fell to a low of $17 million in 1985, before slowly recovering and rising to a high of $62 million in 1992.

Sweden is one of only a few donor nations with official policy statements on both population and reproductive health. In 1997, Sida published two position papers, *Population, Development and Cooperation* and a *Strategy for Sexual and Reproductive Health and Rights.* In these documents, Sweden rejects the premise that population problems can be solved solely by contraceptive programs and describes four priority areas it perceives as linked to population and the ICPD recommendations: poverty alleviation; peace, democracy and human rights; gender equality; and sustainable development.

Sweden's conceptualization of sexual and reproductive health and rights is even broader than the vision adopted by the ICPD *Programme of Action.* For example, while other donors have family planning programs, Sida refers to the broader concept of "fertility regulation," which includes both delaying or preventing childbearing through contraception as well as the safe termination of unwanted pregnancies.

Parliamentarians and high-ranking policy makers appear supportive of Sida's broad conceptualization of population and reproductive health, and the casting of reproductive rights as an issue of human rights and gender equality. In 1996, the parliament passed a formal resolution endorsing the promotion of equality between women and men in partner countries as a new goal for development cooperation.

3 TRENDS IN FUNDING FOR POPULATION ASSISTANCE

OVERALL FUNDING LEVELS:

Trends in Swedish funding for population programs are difficult to assess, both because of Sweden's very broad definition of population activities, as well as the falling value of the Swedish currency against the dollar. Swedish officials report that contributions to sexual and reproductive health and rights and HIV/AIDS programs rose between 1994 and 1997 in national currency. However, UNFPA data indicate that Swedish contributions have declined in dollar terms. In addition, Sweden did not provide data on its population assistance levels to UNFPA for 1995. In 1996, Sida reported about $114 million in population assistance, using a very broad definition of reproductive health. UNFPA's estimate of Swedish expenditures that year is approximately $58 million, based on its standard and narrower definition of population assistance.

Definitional issues notwithstanding, Sweden remains an important donor to population programs. Sweden ranked seventh in 1996 among donor nations in the level of population funding it provided. Sweden's population assistance increased 36 percent between 1990 and 1996, with the caveat that the 1996 level reflects a broader range of reproductive health activities. Sweden's population assistance also rose from 2.1 percent to 2.9 percent as a share of the declining total development aid budget over this period. In addition, Swedish population assistance appears to have increased relative to GNP, rising from $192 per million GNP in 1990 to $242 per million GNP in 1996.

MULTILATERAL FUNDING:

Over the past decade, Sweden has consistently channeled 40 to 60 percent of its population aid through multilateral organizations. Organizations supported by Sweden include UNFPA, UNAIDS, and the WHO human reproduction research program. However, Sweden's U.S. dollar contribution to UNFPA fell from $18.4 million in 1993 to $15.1 million in 1997. The Swedish contribution also declined in national currency terms from 1994 and 1997, but then rose slightly in 1998. This small increase, however, is likely to be lost in exchange rate conversion.

BILATERAL FUNDING:

Bilateral funding for population programs has increased from one percent of total population assistance in 1987 to 27 percent in 1996. The proportion of funds going to the multilateral and NGO channels has accordingly decreased during this period.

In 1996, Sweden allocated about $15.6 million to population-related activities on a bilateral basis.

FUNDING FOR NGOS:
Swedish allocations to NGOs for population activities, including those to IPPF, have fallen during the past decade. In 1987 Sweden channeled fully half of its total population assistance through NGOs; by 1996 it channeled only 32 percent through this channel.

Of the $18.5 million Sweden contributed to NGOs in 1996, $11.4 million went to core support of IPPF, the largest NGO in the population field. The Swedish contribution to IPPF has also declined, amounting to only $7.7 million in 1997—a 32 percent decrease from the previous year. Even in national currency terms, Sweden's kroner contribution to IPPF has fallen 20 percent between 1988 and 1997. Sida recently completed the first phase of an evaluation of IPPF which acknowledges the strong congruence between the goals of IPPF's Vision 2000 strategic plan and Sida's sexual and reproductive health strategy. The evaluation recommends that Sweden continue support to IPPF, and that the Federation develop systems for cost recovery at many different levels of the organization.

In 1995 and 1996, Sida also supported the International Council on Management of Population Programs, the International Women's Health Coalition, the Population Council, the Swedish Association for Sexual Education and various other Swedish non-governmental institutions working in the sexual and reproductive health and rights field.

4 PROGRAM PRIORITIES

GEOGRAPHIC PRIORITIES:
Sub-Saharan African countries receive the majority of Swedish bilateral aid in the sexual and reproductive health sector. In 1995-96, Sweden funded bilateral programs in Angola, Ethiopia, Kenya, Uganda, Zambia and Zimbabwe. In Asia, Bangladesh is the largest single recipient of Swedish reproductive health aid. Sweden also funds smaller initiatives in Nicaragua and region-wide activities in Central America.

AREAS OF PROGRAM EMPHASIS:
Swedish aid officials describe their health sector policy as "standing on two legs": health sector support and reform, and reproductive health and rights. Program priorities in the latter area include human rights and gender equality, maternal health and newborn care, fertility regulation, abortion, HIV/AIDS, adolescent health, female genital mutilation, discrimination, violence and abuse. Sweden is notable among donors in its commitment to expanding the availability of medically safe termination of pregnancy (including menstrual regulation), improving access to quality post-abortion care and supporting the liberalization of abortion laws.

Sweden has also made adolescent reproductive health a high priority. Sida's adolescent programming focuses on sexual and reproductive health education for in-school and out-of-school youth; counseling and provision of contraceptives and STD services through youth clinics; sexual health education through peer counseling and youth clubs; and advocacy with policy makers on adolescents' rights to information and reproductive health care.

This broad formulation of sexual and reproductive health and rights makes it difficult for Sweden to report on its population programming according to the definitions developed by UNFPA. According to Sida, sexual and reproductive health and rights components are integrated in broad health support projects in some recipient countries, such as Zambia, Vietnam and Uganda. Moreover, the new sector-wide approach to program implementation—where Swedish support is pooled with funds from other donors and from national governments—makes it virtually impossible to account for financial allocations specifically for population-related activities.

5 TECHNICAL CAPACITY

STAFFING:
A small cadre of technical staff manage multilateral and bilateral population programming efforts within the Swedish aid administration. One staff-person in the Ministry of Foreign Affairs is responsible for Swedish relations with UNFPA and other multilateral organizations. Within Sida, 10 professional staff have sexual and reproductive health programs within their country portfolios; of these, 4 have special responsibility for policy development and support for sexual and reproductive health and rights and HIV/AIDS.

TECHNICAL EXPERTISE OF COLLABORATING INSTITUTIONS:
Sida collaborates with many Swedish institutions in its bilateral sexual and reproductive health and rights programs. The Karolinska Institute—a world-famous medical research institution—and population centers at the Lund and Uppsala universities are often partners in bilateral program implementation. The Swedish IPPF affiliate (RFSU) and several private development consulting firms and individual experts also assist in the planning, monitoring and evaluation of bilateral and multilateral sexual and reproductive health and rights programs, including those relating to HIV/AIDS.

Sweden is unique among donors in its commitment to safe abortion.

SWITZERLAND

Switzerland has recently made modest increases in its contributions to population programs.

GRADE

SWITZERLAND

POPULATION AND REPRODUCTIVE HEALTH ASSISTANCE

OVERALL ASSESSMENT

Although reproductive health is not a priority for the Swiss development aid program, Switzerland has recently made modest increases in its contributions to population programs. Swiss population assistance is largely limited to contributions to UNFPA, UNAIDS, IPPF and other international organizations; these contributions have shown a slow upward trend since the ICPD. The Swiss government appears likely to continue this emphasis on multilateral population assistance, and to focus bilateral efforts on areas such as agriculture, environment and gender where the Swiss aid program has greater expertise. Aid officials also perceive these areas as having a long-term impact on economic development as well as population growth.

1 DEVELOPMENT ASSISTANCE: POLICY AND FUNDING

Switzerland has a long-standing and unique tradition of independence in its foreign policy, as well as in development cooperation. Switzerland is not a member of the United Nations or European Union, and has charted its own course rather than sign on to international agreements regarding development assistance. The Swiss people have voted against membership in the United Nations and the European Economic Area (EEA). Switzerland has not signed on to the UN development aid target of 0.7 percent of gross national product (GNP). In 1992, the Swiss government established its own target of 0.4 percent of GNP, but has yet to reach this goal.

The Swiss development aid budget is low—particularly compared to the wealth of the country as reflected in GNP levels—and likely to continue declining. The volume of Swiss development aid peaked in 1992 at $1.1 billion; annual aid levels have since fluctuated between $700 million and $1 billion. In 1997, the Swiss government provided $839 million in official development assistance, or 0.32

SWITZERLAND

VITAL STATISTICS

1996 population size:	7.2 million
Total Official Development Assistance (ODA), 1996:	$1,026 million
ODA as a percentage of GNP, 1996:	0.34%
Total population assistance, 1996:	$16.2 million
Population assistance as percentage of ODA, 1996:	1.58%
Population assistance per $US million GNP, 1996:	$53

Population Action International's Country Grade

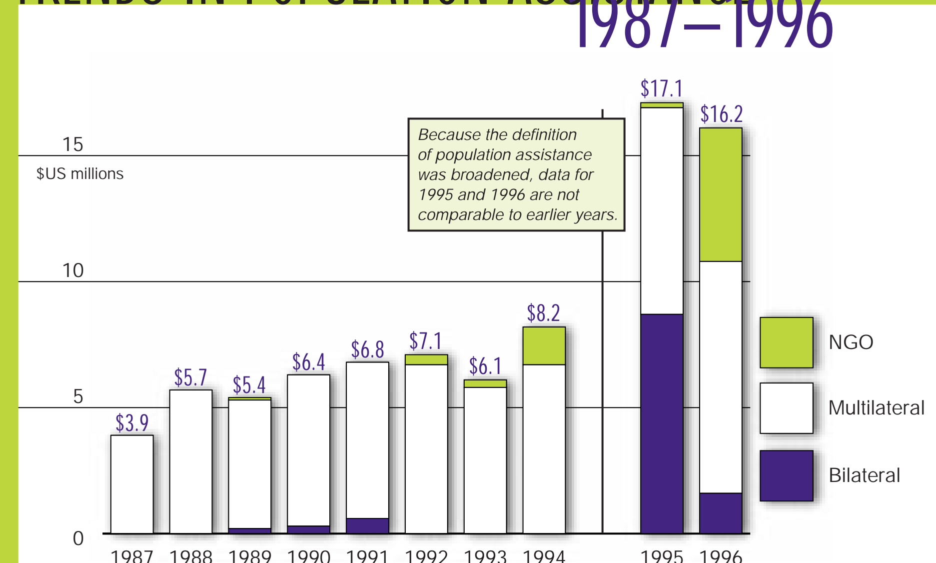
percent of GNP. In that year, Switzerland ranked 14th among 21 donor countries in total volume of development assistance, and ninth in terms of aid as a percentage of GNP. The Swiss government predicts a continuing downward trend in aid levels, resulting in a development assistance to GNP ratio of 0.29 percent by the year 2000.

Coordination of the different agencies involved in Swiss development assistance remains a problem. Swiss development assistance is implemented through two different agencies: the Swiss Agency for Development and Cooperation (SDC), housed in the Federal Department of Foreign Affairs, and the Federal Office for External Economic Affairs (FOEEA), which is part of the Federal Department of Public Economy. The SDC administers technical and financial cooperation and humanitarian aid, and handles approximately 80 percent of total aid disbursements. The FOEEA is the designated agency for economic aid and administers approximately 10 percent of aid disbursements. Coordination between the two agencies remains a continuing issue, as both handle initiatives in the same geographic regions and collaborate with multilateral organizations.

2 THE POLICY ENVIRONMENT FOR INTERNATIONAL POPULATION ASSISTANCE

The long-standing neglect of population issues in Swiss aid policy appears unlikely to change given declining aid budgets. Traditionally, population assistance has not been a priority for Swiss overseas development cooperation, primarily because the Swiss government perceives population growth as an outcome of underdevelopment. The SDC has taken the position that support for activities to fight poverty, address basic needs and create a better environment will in turn contribute to declines in population growth rates. Swiss policy also emphasizes that programs related to demographic growth and contraception must respect the "autonomy and cultural values of developing countries." Moreover, since the current economic environment in Switzerland has required a near freeze of the federal budget, large increases in reproductive health spending appear unlikely.

TRENDS IN POPULATION ASSISTANCE 1987–1996



Sources: Population assistance: UNFPA. Vital statistics: UNFPA, UN Population Division, OECD.

The slow upward trend in multilateral population assistance appears likely to continue.

Despite a lack of emphasis on population issues in their bilateral aid policy, the Swiss support the ICPD *Programme of Action* and contribute to both UNFPA and IPPF. Switzerland officially supports the broad formulation of "reproductive health" agreed on at the International Conference on Population and Development (ICPD) in 1994, in particular the linkages between wider access to education and health services, including family planning, and improved reproductive health care for women. Currently, Switzerland's support for direct family planning service provision occurs primarily through the funds it provides to UNFPA and IPPF. Over the long-term, Swiss development cooperation policy is reportedly moving towards increased support for the social sectors, including an eventual increase in allocations for reproductive health through the Swiss bilateral aid program.

The SDC has launched an initiative to increase domestic awareness of international population issues through Swiss NGOs. The main NGO in the family planning field is the Swiss IPPF affiliate, l'Association suisse pour de planning familial et d'éducation sexuelle (ASPFES), founded in 1993. ASPFES has been active in advocacy for international reproductive health assistance with both the public and parliamentarians.

3 TRENDS IN FUNDING FOR POPULATION ASSISTANCE

OVERALL FUNDING LEVELS:

Switzerland has reported significant increases in funding for population programs with the broadening of the definition of population assistance after the ICPD. Swiss funding for population activities increased slightly between 1990 and 1994 from $6.4 to $8.2 million. In 1996, Switzerland reported $16 million in reproductive health-related funding, representing more than a doubling in population assistance since 1994. This increase appears to reflect the change in the definition of population activities to include basic reproductive health and STD/HIV prevention. The SDC reports $13 million in reproductive health-related funding in 1997, of which roughly $10 million was allocated to core population and family planning activities, including contributions to UNFPA and IPPF.

Switzerland is unlikely to reach its fair share of the ICPD year 2000 goal for donor contributions to population programs. Although Switzerland signed on to the ICPD *Programme of Action,* even with modest increases in funding it is unlikely to achieve its $78 million share of the ICPD goal for donor contributions (estimated by calculating Switzerland's proportional share of GNP). Achieving this goal would require an almost five-fold increase in budget allocations between 1996 and 2000.

MULTILATERAL FUNDING:

Most Swiss population assistance is channeled through multilateral organizations, but these funds represent a tiny share of the overall aid budget. Switzerland has repeatedly stated that its main contribution to ICPD goals is through funding of multilateral agencies like UNFPA, UNAIDS, the WHO human reproduction research program and the World Bank, all of which provide broad support to reproductive health programs. In 1997, contributions to these institutions amounted to just 1.5 percent of total Swiss development assistance. Switzerland's U.S. dollar contributions to UNFPA have fluctuated around $7 million from 1994 to 1997, an increase from $5.8 million in 1993.

BILATERAL FUNDING:

A very small share of bilateral health spending goes to reproductive health. According to SDC officials, only two percent of bilateral health expenditures in 1997—about $700,000—were allocated to basic health services and health programs relating to reproductive health, family planning and HIV/AIDS control and prevention.

FUNDING FOR NGOS:

In recent years, the Swiss contribution to IPPF has been stable or increasing in Swiss francs, but has declined in U.S. dollar terms. Switzerland's support to IPPF—the main international NGO in the population field—declined in U.S. dollar terms from approximately $819,000 in 1995 and 1996 to $670,000 in 1997. The national currency contribution remained stable at a million Swiss Francs annually during this period, though, reflecting a change in exchange rates rather than a deliberate reduction in funding.

4 PROGRAM PRIORITIES

GEOGRAPHIC PRIORITIES:

The SDC concentrates its development assistance activities in fewer than 20 countries worldwide. Only about half these countries have health as a priority sector for intervention: Benin, Chad, Mali, Madagascar, Mozambique, Nepal and Tanzania, as well as the entire Sahel region. In addition, in Bangladesh, the Swiss support health activities, although health is not formally considered a priority sector. In Latin America and Asian countries other than Bangladesh and Nepal, the Swiss do not work directly in the health sector but are involved in collaborative initiatives such as cofinancing of UNFPA activities in Vietnam. Swiss aid officials report that "most health projects develop reproductive health activities," but currently there is no formal inventory of reproductive health activities funded by the Swiss aid program.

AREAS OF PROGRAM EMPHASIS:

Switzerland has no tradition of bilateral assistance in the population and reproductive health sector. Its bilateral aid program has focused instead on areas which the Swiss see as closely related to population issues—poverty alleviation, environmental conservation, income generation and institutional and social development. As part of plans for a gradual increase in social sector spending, SDC is considering allocating more funds for reproductive health, safe motherhood, adolescent health, basic education and "gender balanced development."

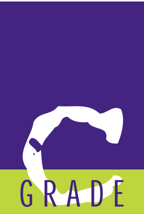
5 TECHNICAL CAPACITY

STAFFING:

Staff resources at the SDC in the health sector are very thin. Currently, fewer than two full-time technical staff have specialized training in public health. Most operational responsibility is delegated to local offices in the field. These offices may employ local health specialists, especially where health is a priority sector for the Swiss aid program, as in Mozambique.

TECHNICAL EXPERTISE OF COLLABORATING INSTITUTIONS:

Thus far, there is little involvement of Swiss NGOs in population and reproductive health assistance. Most large development NGOs in Switzerland have expertise in maternal and child health or basic health services, rather than family planning and reproductive health. These NGOs for the most part do not collaborate with the Swiss aid program on reproductive health related initiatives. ASPFES, the Swiss family planning association, has the potential to expand its advocacy role and become involved in the future as a technical assistance or implementing agency for Swiss bilateral reproductive health activities. However, the formal development of such a relationship has yet to occur.



Since the current economic environment has required a near freeze of the federal budget, large increases in reproductive health spending appear unlikely.

UNITED KINGDOM

Britain's effectiveness as a population donor has grown substantially during the past decade.

B–
GRADE

UNITED KINGDOM

POPULATION AND REPRODUCTIVE HEALTH ASSISTANCE

OVERALL ASSESSMENT

Britain's technical capacity, innovation and effectiveness as a population donor have grown substantially during the past decade. Increasing numbers of health and population staff in the field, a commitment to innovative programs and effective technical cooperation with collaborating institutions have resulted in a population program that is widely considered to be well managed and results oriented. Britain is one of only a few donors funding projects in such leading edge areas as post-abortion care, sexual violence, vesico-vaginal fistula prevention as well as core family planning, safe motherhood and adolescent reproductive health services. The British aid program also supports a mix of projects emphasizing public, private and NGO involvement in reproductive health.

Despite strong political support, significant increases in funding for reproductive health assistance appear unlikely. The current government has maintained the strong support for reproductive health assistance shown by the previous government. Yet although the government has pledged to increase its assistance in this area, it is committed to maintaining overall budget levels established by the previous government for at least two years. Moderate increases in funds for population and reproductive health programs may still be possible through reallocation of existing aid resources. However, much larger increases will be needed if Britain is to reach its "fair share" of the year 2000 ICPD goal for donor assistance, based on its proportional share of donor country GNP.

1 DEVELOPMENT ASSISTANCE: POLICY AND FUNDING

Britain has entered a new era with the election in 1997 of a Labour government committed to strengthening aid to developing countries. Over the course of a decade, British development aid levels had steadily eroded. In 1995, British development assistance, adjusted for inflation, was at the lowest level since 1987. While the British government has endorsed the United Nations' target of allocating 0.7 percent of GNP to overseas development assistance, the British ratio had been moving in the opposite direction—falling from 0.45 percent in 1985 to 0.26 percent in 1997.

The new government plans to reverse these trends. The elevation of the former British Overseas Development Administration (ODA) to Cabinet level status as the Department for International Development (DFID) was among the first policy changes made by the government. Under the leadership of Clare Short, the new Secretary for International Development, DFID issued a White Paper on international development in November 1997 entitled "Eliminating World

VITAL STATISTICS

1996 population size:	58.1 million
Total Official Development Assistance (ODA), 1996:	$3,199 million
ODA as a percentage of GNP, 1996:	0.27%
Total population assistance, 1996:	$106.4 million
Population assistance as percentage of ODA, 1996:	3.33%
Population assistance per $US million GNP, 1996:	$91

Population Action International's Country Grade

GRADE

Poverty: A Challenge for the 21st Century." The White Paper—the first such policy document issued in over twenty years—emphasizes poverty elimination as the central goal of the British aid program. It also abolishes the Aid and Trade Provision (ATP), a controversial mixed aid and credit facility which combined development objectives with commercial opportunities for British businesses.

2 THE POLICY ENVIRONMENT FOR INTERNATIONAL POPULATION ASSISTANCE

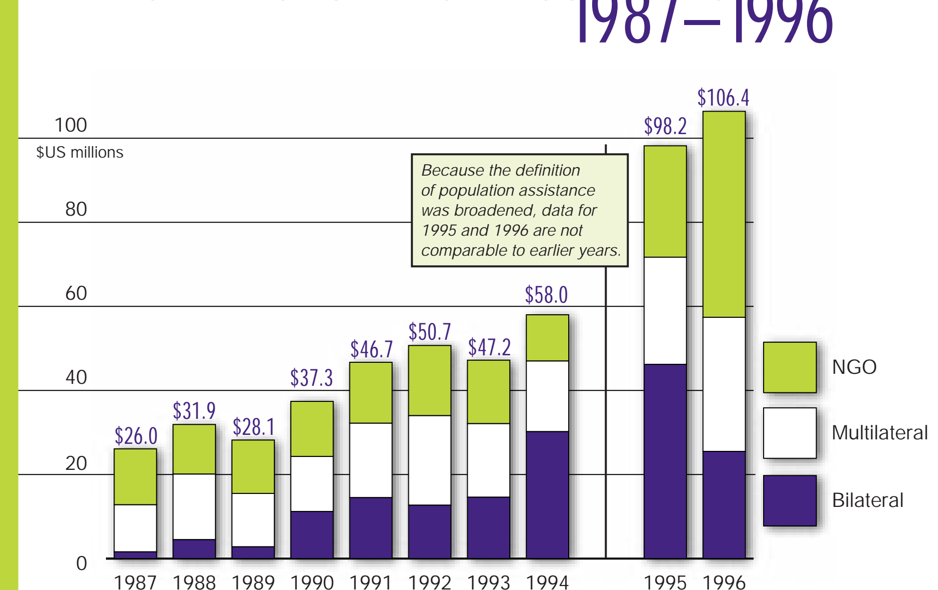
The Labour government's strong commitment to reproductive health assistance builds on the previous government's policy. Using the slogan "Children by Choice not Chance," the previous government emphasized improved access to reproductive health services, particularly for the poor in developing countries. The emphasis on reproductive health by the current government thus represents an evolution of earlier policy rather than a departure. While the outlook for reproductive health assistance appears promising, no dramatic changes in funding or program directions have been announced to date.

Clare Short has made numerous public statements in support of reproductive and sexual health, access to family planning and safe abortion. The new aid policy paper endorses a number of international targets for the year 2015, including halving the proportion of people living in extreme poverty, halving child mortality, reducing maternal mortality by 75 percent, and ensuring universal access to reproductive health services. Some preliminary changes in program emphasis have followed the change in government, including increased attention to maternal and adolescent sexual health, and a shift from support to small projects to country-level partnerships involving a sector-wide approach.

3 TRENDS IN FUNDING FOR POPULATION ASSISTANCE

OVERALL FUNDING LEVELS: **Despite declining levels of overall development aid, reproductive health assistance has been rising since 1986.** According to UNFPA, British population assistance increased 70 percent between 1994 and 1995,

TRENDS IN POPULATION ASSISTANCE 1987–1996



Sources: Population assistance: UNFPA. Vital statistics: UNFPA, UN Population Division, OECD.

The British aid program is fostering increased technical capacity in reproductive health among NGOs.

although it is unclear how much of this increase is attributable to the broader definition of population assistance used in reporting expenditures following the ICPD.

In conjunction with the Cairo conference, the British government announced it expected to commit more than £100 million to population assistance over the two-year period 1995 to 1996. The government more than fulfilled this pledge, committing over £184 million over this period. The British government also claims that expenditures on reproductive health—including the British share of expenditures by the World Bank and European Commission—meets its goal of spending four percent of development aid on population and reproductive health.

However, if Britain's "fair share" of the ICPD year 2000 target is estimated based on its share of donor country GNP, current levels are clearly lagging. In 1996, the United Kingdom spent $106 million on population assistance; the British will need to increase this contribution three-fold to reach their share of the year 2000 goal for donor assistance.

MULTILATERAL FUNDING:
The British government has increased its contributions to population programs through key UN organizations. Contributions to UNFPA have more than doubled since 1993, when the U.K. provided $10.8 million in core funds. In 1997, the U.K. was the seventh largest contributor to the UNFPA, contributing a total of $23.1 million in core funding plus an additional $2.4 million for multi-bilateral projects. In a recent announcement, Tony Blair, the British Prime Minister, pledged a 28 percent increase in core funding for UN agencies in 1998. UNFPA expects to receive about $26 million in core funding and an additional $5.6 million in funding for multi-bilateral programs. Britain makes much smaller annual contributions to the Joint UN Program on HIV/AIDS and the WHO human reproduction research program, to which it is the largest single contributor.

Britain has also sought closer collaboration with the European Commission (EC) in the area of health and population assistance. The British government has seconded a permanent staff member to EC headquarters in Brussels to work on managing and developing mechanisms for EC support to reproductive health programs. This staff appointment has reportedly contributed to smoother processing of NGO funding applications to the EC for reproductive health projects.

BILATERAL FUNDING:
The bulk of increases in British population assistance funds has been channeled bilaterally. While the British government has increased multilateral contributions, bilateral funding levels have grown even faster, significantly increasing the share of population assistance allocated through bilateral programs. In 1987, only six percent of British population assistance was allocated to bilateral programs; in 1995, almost half of population funding was channeled through the British bilateral aid system.

FUNDING FOR NGOS:
The British aid system also supports a number of special NGO initiatives in reproductive health. The "Joint Funding Scheme" cofinances activities of British NGOs that target poor communities; a special provision under this program waives the cofinancing requirement and allows 100 percent grant support for population and reproductive health projects. Spending on reproductive health activities through this program has risen from about $650,000 in 1992 to $2.5 million in 1996.

The United Kingdom was also the third largest contributor to IPPF in 1997, although its contribution declined 18 percent from the previous year. Britain also provides restricted funding to IPPF for specific projects, such as the Vision 2000 Fund projects in India, Cameroon and Bangladesh, the development of new infrastructure and training for family planning associations (FPAs) in Europe and the former Soviet Union, and an external review of IPPF's work in China.

4 PROGRAM PRIORITIES

GEOGRAPHIC PRIORITIES:
The British aid program has traditionally given priority to low income developing countries (particularly in Africa), and countries with historical ties to Britain. Population assistance is even more concentrated in low income countries than general development assistance; in 1996, 64 percent of reproductive health assistance went to Africa, compared with 31 percent to Asia, 3 percent to Latin America and 2 percent to Europe and Central Asia. Some observers criticize the overall British aid portfolio for being too widely dispersed across countries—about 160 in 1996.

Twenty-two countries have been identified as priority partners for reproductive health programming, as shown in the table below:

PRIORITY COUNTRIES FOR BRITISH REPRODUCTIVE HEALTH ASSISTANCE

Region	Country
Africa	Angola, The Gambia, Ghana, Kenya, Malawi, Namibia, Nigeria, South Africa, Tanzania, Uganda, Zambia and Zimbabwe
Asia	Bangladesh, Cambodia, India, Nepal and Pakistan
Latin America	Peru and Bolivia
Europe and Central Asia	Russia, Kazakstan and Kyrgystan

AREAS OF PROGRAM EMPHASIS: **The British population assistance program closely reflects the broad ICPD definition of reproductive health.** The aid program has a strong focus on adolescent sexual and reproductive health, STD and HIV prevention, prevention of maternal morbidity and mortality, and addressing the unmet need for family planning services. In addition, girls' education, promotion of gender equality and reproductive rights, and prevention and care of the consequences of sexual violence, female genital mutilation and vesico-vaginal fistula are important priorities.

Britain also has a strong commitment to developing new approaches to reproductive health. This commitment is demonstrated by the Innovations Fund, earmarked for financing innovative or action-oriented research, and efforts to improve reproductive health service quality or widen available contraceptive choices. In 1996, the Innovations Fund financed seventeen such ventures for a total cost of about $500,000. These projects include social marketing efforts, initiatives to introduce emergency contraception, and support for private sector provision of reproductive health services.

Britain is among the few donors who provide substantial support for contraceptive commodities. In 1996, the British aid program spent close to $10 million on contraceptive commodities of all kinds. In response to individual government requests, DFID regional offices handle most commodity-related programs, including procurement and shipping of contraceptives at bulk prices. The British government also supports special programs to introduce new contraceptives, such as the female condom, into diverse settings. In 1997, DFID arranged two large shipments of female condoms to Zambia and Zimbabwe.

5 TECHNICAL CAPACITY

STAFFING: **British staff expertise in health and population is concentrated in the field, while a small core of technical staff provide support and direction from London.** The allocation of field staff is heavily weighted toward Africa, which has as many health and population experts as Asia and Central Europe combined. Field staff bear primary responsibility for coordination at the country level with other donors working in reproductive health. Efforts at donor coordination vary significantly by country, depending on the extent of population-related donor activity.

TECHNICAL EXPERTISE OF COLLABORATING INSTITUTIONS: The network of reproductive health institutions collaborating with the British aid program has evolved and matured over the past decade. The British aid program has undertaken special initiatives to foster the development of technical capacity among NGOs and academic institutions, including phasing out the long-standing practice of providing general support to cooperating organizations. The new approach to building "consultancy organizations" closely mirrors the U.S. model of providing restricted or project-specific funding to collaborating agencies, usually on a competitive basis.

Recently established "resource centers" in collaborating institutions provide a mechanism to access technical expertise in reproductive health. In 1996, DFID provided $9.5 million to specific reproductive health resource centers, to "access, develop and expand expertise of UK professionals, build NGO capacity and conduct public information activities." Options, a subsidiary of Marie Stopes International (MSI), currently administers the Resource Center for Reproductive Health, while International Family Health, another NGO, manages the HIV/AIDS and STD resource center. DFID indicates plans to eventually combine these two centers.

DFID has also funded training through the resource centers for prospective consultants in areas such as social marketing of contraceptives, where British technical know-how is still limited. This trend towards building the capacity of the technical institutions which support the British reproductive health program is expected to continue—with an increasing focus on development of expertise in developing countries. Available technical resources are thus likely to grow both in number and in depth of expertise.

B–
GRADE

UNITED STATES

Despite its low per capita development assistance, the United States provides more funding for population than any other nation.

B GRADE

UNITED STATES

POPULATION AND REPRODUCTIVE HEALTH ASSISTANCE
OVERALL ASSESSMENT

The U.S. foreign aid program has faced many challenges in recent years. Funding for overall foreign aid has declined, and the United States now ranks last among donor countries in the proportion of national wealth devoted to development aid. The U.S. bilateral aid agency (USAID) has undergone major restructuring, including reductions in staff and the number of overseas field missions.

The U.S. population assistance effort still leads the way among donor nations. The United States provides the largest population assistance contribution of any donor nation, and also devotes the largest share of its development aid budget to population assistance. U.S. population assistance funds flow primarily through the bilateral and NGO channels; U.S. contributions to multilateral organizations remain relatively small. While the U.S. population assistance program continues to maintain a strong focus on family planning, it is moving towards a more integrated approach to reproductive health programming. With over 30 years of experience in the field, USAID also has the greatest population program expertise of any donor, supplementing a substantial staff of in-house specialists with an extensive network of private and public cooperating agencies.

However, recent political attacks have undermined the U.S. population assistance program and its contribution to achievement of the Cairo conference goals. Severe cuts in population assistance funds and restrictions on their disbursement have constrained the U.S. population assistance effort. Moreover, the 1996 level of U.S. population assistance is only one-third of its "fair share" (relative to the size of its economy) of the year 2000 financial target agreed on at the ICPD. No other donor nation has further to go in absolute terms to bridge this gap.

1 DEVELOPMENT ASSISTANCE: POLICY AND FUNDING

The United States has ranked last among donor countries in recent years in overall aid relative to national wealth (annual GNP). In 1997, it gave only $765 in foreign aid for every million dollars of GNP. In terms of total aid volume, the United States ranks third after Japan and France as a donor nation, providing $6.2 billion in development assistance in 1997 compared with $9.4 billion for Japan and $6.3 billion for France. This level of aid is almost half what the United States gave in 1992, when foreign assistance levels peaked at $11.7 billion, and $3.2 billion less than in 1996. Part of the decline in aid in 1997 reflects that Israel is no longer classified as a developing country; aid in 1996 included $2.2 billion for Israel.

The declining U.S. aid budget largely reflects efforts to reduce government spending and taxes, refocus on domestic issues, and promote international trade as an alternative to development aid. Diminishing aid is also an outcome related to the growing power of conservative Republicans in the U.S. Congress.

VITAL STATISTICS

1996 population size:	269.4 million
Total Official Development Assistance (ODA), 1996:	$9,377 million
ODA as a percentage of GNP, 1996:	0.12%
Total population assistance, 1996:	$637.7 million
Population assistance as percentage of ODA, 1996:	6.80%
Population assistance per $US million GNP, 1996:	$84

Population Action International's Country Grade

Polls suggest Americans are generally supportive of U.S. global involvement and foreign aid despite the low priority attached to foreign aid by their elected representatives. Public knowledge of U.S. development assistance efforts remains limited, however. Many Americans believe foreign aid constitutes a much larger share of the federal budget than the less than one percent it currently receives.

The U.S. foreign aid budget includes development assistance as well as funds for key political allies. The Middle East (26.4 percent), sub-Saharan Africa (21.6 percent) and North and Central America (15.1 percent) received the largest share of development assistance in 1996. The United States allocates approximately half of all development assistance funds to lower income countries. Education, health and population, emergency relief, and food aid programs receive the largest shares of aid resources.

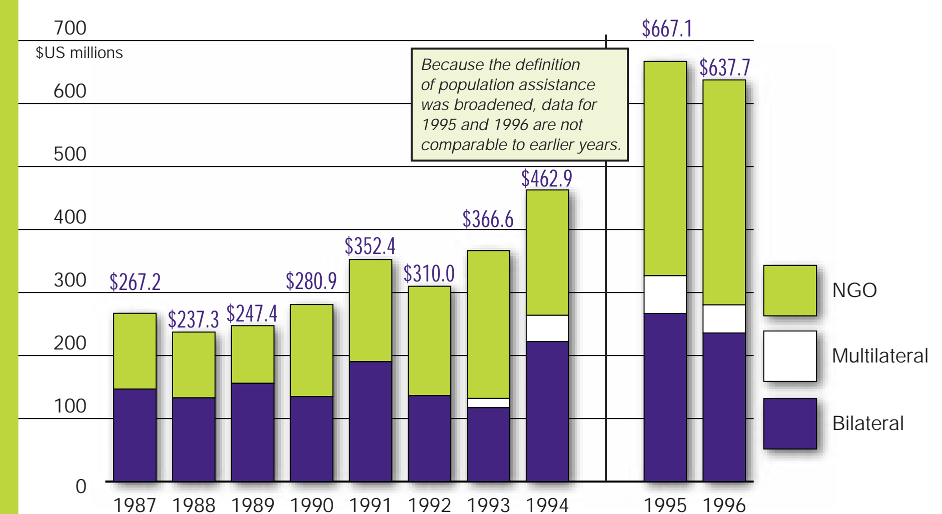
The U.S. Agency for International Development (USAID), the official bilateral aid agency, disburses three-quarters of U.S. foreign assistance. The Department of State administers most U.S. contributions to multilateral institutions, which have accounted for about one-quarter of total official development assistance in recent years.

USAID has undergone a major restructuring effort over the last few years, accompanied by a decrease in staff and the closing of several overseas offices. In addition, legislation passed in late 1998 gives the State Department closer oversight of USAID. The full implications for the U.S. foreign aid program are still unclear.

2 THE POLICY ENVIRONMENT FOR INTERNATIONAL POPULATION ASSISTANCE

The United States has historically been one of the strongest supporters of international population assistance. The U.S. government established one of the first international population assistance programs in 1965 and helped to create UNFPA a few years later. For much of its history, the program enjoyed strong bi-partisan support in Congress and the executive branch, reflect-

TRENDS IN POPULATION ASSISTANCE 1987–1996



Sources: Population assistance: UNFPA. Vital statistics: UNFPA, UN Population Division, OECD.

The U.S. must triple its current population spending to reach its "fair share" of the ICPD year 2000 goal.

ing a consensus that rapid population growth was a serious global problem eroding economic and social progress in developing countries. This climate changed in the 1980s during the Reagan and Bush administrations, when anti-abortion groups sought to link international family planning efforts to the domestic politics of abortion. (In fact, a law in effect since 1973 prohibits the use of U.S. population assistance funds for abortion services.) Despite these political attacks, congressional support remained strong and population assistance funding increased during this period.

In recent years, a small but politically powerful social conservative movement has systematically sought to undermine U.S. government funding for both domestic and international family planning programs. These groups, which have in common a desire to end abortion both in the United States and overseas, have succeeded in imposing funding cuts on U.S. population assistance. Yet polls suggest the vast majority of Americans support public funding for these programs. A broad coalition of NGOs working in reproductive health, development, and the environment are strong advocates for population assistance, and have lobbied the Congress to prevent deeper cuts in funds.

The current administration and Congress have repeatedly been at odds over U.S. reproductive health policy and funding. The Clinton administration is extremely supportive of international population assistance, and took a leadership role at the Cairo conference. Since then, the president has strongly resisted efforts by the Congress to impose new policy restrictions on population assistance funds. Within the Congress, the Senate remains narrowly supportive of international family planning assistance. On the other hand, the House of Representatives has repeatedly voted to deny U.S. family planning funds to foreign organizations if they use other, non-U.S. funds to provide legal abortion services or participate in policy debates over abortion in their own countries. This policy, however, has not been enacted into law. Despite these controversies, the United States remains the largest contributor to international population programs, and still provides almost half of all donor contributions.

3 TRENDS IN FUNDING FOR POPULATION ASSISTANCE

OVERALL FUNDING LEVELS: **Funding cuts and restrictions imposed by the Congress beginning in 1996 have effectively reduced USAID's budget for population assistance.** Between 1993 and 1995, high-level political support together with the momentum from the Cairo conference led to dramatic increases in population assistance budgets. Funds approved by Congress for international population assistance peaked at more than $583 million for U.S. fiscal year 1995. However, in 1996, the Congress drastically reduced funding to $379 million; funding increased slightly above this level to $410 million in 1997, then fell slightly to $405 million in 1998.

USAID reported spending $440 million in 1996 and $455 million in 1997 on population and family planning activities, excluding HIV/AIDS and safe motherhood programs. These actual expenditures are higher than recent budgets approved by Congress because they largely reflect funds approved in prior years. If HIV/AIDS and maternal health activities are included, USAID spent $667 million in 1995 and $638 million in 1996 on population and reproductive health more broadly defined. Despite these impressive figures, the U.S. still falls short of its fair share of donor resources committed to at Cairo, based on its relative wealth among donors. Given its huge economy, the United States would need to increase overall population assistance to over $1.9 billion to reach its fair share of donor contributions in the year 2000.

Despite recent cuts in family planning funds, the United States contributes a larger share of its development aid budget to population and reproductive health assistance than any other donor nation. In 1996, nearly seven percent of official development assistance went to population assistance, broadly defined.

MULTILATERAL FUNDING: **Unlike other large donors, the United States contributes a small proportion of its population assistance through multilateral channels.** In 1996, U.S. multilateral contributions amounted to $45 million, or just seven percent of total population assistance. In contrast, the Netherlands channeled 78 percent or $87 million through multilateral organizations.

In 1993, President Clinton restored the U.S. contribution to UNFPA, which had been withheld since 1986 owing to controversies relating to UNFPA's assistance to China. However, the United States ranked as only the sixth largest donor to UNFPA in 1996, with a contribution of $23 million. U.S. foreign aid legislation for 1999 once again eliminates the U.S. contribution to UNFPA because UNFPA has initiated a new program in China. The withholding of U.S. funds undermines the potential for the United States to play a leadership role on UNFPA's Executive Board, and also reduces the availability of funds to other developing countries in need of UNFPA assistance.

The United States is a global leader in the fight against HIV/AIDS. Contributions to UNAIDS reached $17.6 million in both 1996 and 1997, nearly one-quarter of its budget. In addition, the United States provided $4 million in 1997 to the WHO human reproduction research program, an international leader in contraceptive research and development.

BILATERAL FUNDING:

Despite recent budget cuts, the United States remains the largest bilateral donor in the population field. Currently, nearly 70 countries receive USAID population and reproductive health assistance. USAID administers direct bilateral population assistance to priority developing countries primarily through its four regional bureaus and its overseas field missions. Thirty-seven percent of total population assistance, approximately $236 million, flowed through the bilateral channel in 1996. The proportion of population aid channeled bilaterally has fluctuated between 54 percent in 1991 and 32 percent in 1993.

FUNDING FOR NGOS:

NGOs represent an important channel for U.S. population assistance. The Office of Population at USAID headquarters in Washington, D.C., administers U.S. financial support to a vast network of NGOs known as USAID cooperating agencies. In 1997, USAID channeled $229 million, or 50 percent of all population expenditures, through the Office of Population.

U.S. support to IPPF, the major international NGO in the reproductive health field, was terminated in 1985 by the Reagan administration. The U.S. contribution was restored in 1993 by President Clinton, but has remained at a relatively low and declining level. The United States provided $5.0 million annually in unrestricted funding to IPPF in 1996 and 1997, a 45 percent decrease from 1995 levels. In addition, the United States contributes to IPPF through contraceptive commodity donations and direct funding agreements between USAID field missions, cooperating agencies and local family planning associations.

4 PROGRAM PRIORITIES

GEOGRAPHIC PRIORITIES:

Although USAID supports population activities in 69 countries, about 15 countries receive the bulk of program funds. These countries generally have the greatest need for assistance, or have a long-standing cooperative relationship with USAID. The Asia/Near East region received $155 million or just over a third of all population funds in 1997, while Africa received $126 million or 28 percent of the total. Bangladesh, the Philippines, Kenya and India were the largest recipients of U.S. population assistance from 1993 through 1997.

AREAS OF PROGRAM EMPHASIS:

Family planning remains the cornerstone of USAID's efforts in reproductive health. Early in the Clinton administration and prior to the Cairo conference, USAID announced a new population, health and nutrition strategy that aims to stabilize global population and improve human health. The new strategy emphasizes the reproductive health needs of women and adolescents and reinforces the lead role of family planning within the population, health and nutrition sector.

Because of its long history in family planning assistance, USAID holds a comparative advantage over other donors in this area. USAID support for family planning initiatives encompasses service delivery, the supply of contraceptive commodities, contraceptive social marketing and other strategies for expanding private sector involvement in family planning. Delivery of family planning and reproductive health services, which includes technical assistance and training, received the largest share of USAID population expenditures in 1997. In addition, USAID provided nearly $39 million in contraceptive commodities to nearly 80 developing countries.

USAID also supports a range of population and reproductive health related research activities, including biomedical studies, development of new contraceptive technologies, demographic surveys, social science research into gender issues and service-

Recently, a small but powerful conservative movement has worked to undermine U.S. government commitment to family planning.

The technical capacity of the U.S. international population assistance program is unmatched by any other donor.

delivery research. The Demographic and Health Surveys supported by USAID are nationally representative sample surveys that have been especially important in documenting unmet need for family planning and tracking trends in contraceptive use, child health and fertility in developing countries. In the last five years, these surveys have expanded to include indicators relating to male use of family planning, maternal mortality and HIV/AIDS.

Over the last few years, USAID began to reshape its population and health assistance to support the broad reproductive health approach advocated at the 1994 ICPD. USAID has placed particular emphasis on strengthening programmatic links between family planning and other reproductive health activities. The Cairo conference has also helped spur new initiatives in adolescent health, post-abortion care and integration of family planning services with efforts to prevent AIDS and other sexually transmitted diseases. In addition, USAID has increasingly worked in technical and financial partnership with other donor agencies working in the population and reproductive health field. For example, it has sought to collaborate more closely on population and AIDS activities with Japan through the U.S.-Japan Common Agenda.

In an effort to reduce HIV transmission and the impact of HIV/AIDS in developing countries, USAID has supported various prevention and treatment initiatives. Recent undertakings include a rapidly expanding social marketing program focusing on male and female condoms, products for the diagnosis and treatment of sexually transmitted infections, as well as public health messages. USAID also continues its active support of maternal health and nutrition initiatives designed to improve pregnancy outcomes and child health. Within its broader goal of increasing the social, economic and health status of women, USAID has recently embarked on initiatives in the areas of micro-enterprise, legal and political rights, and education, including a five-year project to increase girls' educational opportunities in twelve countries.

5 TECHNICAL CAPACITY

STAFFING:

The technical capacity of the U.S. international population assistance program is unmatched by any other donor. With technical staff based both at headquarters and overseas, USAID has a wide base of knowledge and experience in the international population field. At USAID headquarters in Washington, D.C., a critical core of over 80 experts has experience in population programs.

Within USAID, there is an increasing trend towards integrated management of population and health activities. The Center for Population, Health and Nutrition (PHN), within the Bureau for Global Programs, Field Support and Research at USAID headquarters, was created in 1994. The Center brings together the Office of Population, Office of Health and Nutrition, and Office of Field and Program Support under unified management. Staff from all three offices increasingly work together on jointly-funded projects.

USAID's field presence is also a unique strength of its population assistance effort. The agency has nearly 100 expatriate and local population and health staff in nearly 50 of its 85 country offices. USAID's ability to provide technical and managerial oversight for its assistance through a professional corps of field-based population officers has contributed to effective implementation of bilateral population projects, as well as to the success of country programs.

Due to the overall decline of agency resources, USAID has seen a substantial reduction in the number of permanent population and health staff. Meanwhile, management burdens on technical staff are increasing; expert population and health staff manage roughly double the volume of funds compared to a decade ago. The agency is now moving to recruit new staff in the population and health fields.

TECHNICAL EXPERTISE OF COLLABORATING INSTITUTIONS:

Adding strength to USAID staff is the established network of U.S.-based cooperating agencies which implement USAID-funded projects. These cooperating agencies include over 30 universities, private companies, research and educational organizations, other U.S. government agencies, international organizations, and nonprofit organizations with the expertise and staff to fulfill broad contractual mandates. The Office of Population enters into agreements with these institutions to provide technical assistance to national governments and NGOs in developing countries. Many of these agencies have expertise in specialized areas such as population policy development, family planning service delivery, communications, training or evaluation, helping to broaden USAID's technical capacity.