



**ACTION FOR
GLOBAL HEALTH**

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An Unhealthy Prognosis?

The EC's development funding for health

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About...

Action for Global Health

Action for Global Health is a new advocacy network calling for Europe to do more to enable developing countries to achieve the health Millennium Development Goals by 2015. Coordinated by ActionAid International, the Brussels partners at the start of this work are: Stop AIDS Alliance, Marie Stopes International (MSI) and European Public Health Alliance (EPHA). We want to see donors meet their commitments for health ODA, health systems to be prioritised and equitable access to services.

Visit www.actionforglobalhealth.eu to learn more or to register to receive news from us.

DSW

Deutsche Stiftung Weltbevölkerung (DSW) sees as its mission to help young people in Africa and Asia to escape poverty by providing sexual and reproductive health information, services and supplies. It raises awareness about the close links between sustainable development, poverty, health, environmental protection and demographic trends.

See also: www.dsw-hannover.de

Eurostep

Eurostep is a network of 17 European non-confessional development organisations and implements advocacy for a responsible social Europe in the world, in the framework of the Millennium Development Goals. Eurostep is actively engaging with the EU programming process of country programmes, and especially looks at the implementation of the social development goals, which are seen as essential for the worldwide eradication of poverty. Eurostep's website includes a portal which collects all information on EU country programmes.

See also: www.eurostep.org or www.csp-programming.eu

EEPA

Europe External Policy Advisors (EEPA) is a group of consultants on EU external policies with special expertise on development policy. EEPA facilitates advocacy, develops campaign strategies, undertakes research and produces publications, organises events and monitors EU aid.

See also: www.eepa.be



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The EC's development funding for health

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This overview has been commissioned by a range of organisations to provide a clear survey of the European Commission's (EC) official development assistance (ODA) for the health sector. We felt that assumptions about the amount allocated or actually disbursed by the Commission needed to be investigated to give us a true picture of past, current and future funding in this area.

The picture that has emerged is concerning. Although the Commission's ODA allocations for the health sector have increased over recent years, they have not kept pace with the increase of ODA overall. The proportion of ODA being allocated to health is now less than it was in 1996.

This is despite many high-profile political and binding commitments made by the European Union (EU) to increase its contributions in this area. In addition, the EU has committed itself to international action for poverty eradication, most importantly to the achievement of the Millennium Development Goals (MDGs) by 2015. Their achievement will depend on adequate funding for the social sectors.

Even more worryingly, there are indications that future spending could drop significantly unless the Commission acts quickly. Early analysis of evidence from the country strategy papers (CSPs) being written to guide the spending of regional budgets such as the European Development Fund (EDF), show little or no prioritisation of the health sector. As these budgets will increasingly determine the EC's spending of ODA, it suggests we are about to see a massive fall in the proportional spending of ODA for health. Some suggest that, far from moving towards the target of 20% of ODA to fund basic health and basic education, the figure may fall to an all-time low. The EC may argue that it supports country ownership and this fall would reflect a lack of interest in health from developing country governments. We would argue that, if this potential reduction proves to be true, it would show a lack of commitment on the part of the EC and the EU Member States to make these new instruments work for the benefit of poor people in developing countries.

Moreover, if the EC and the EU Member States would like to argue that the programmes are the result of priorities of the partner countries, they will need to substantiate this with facts regarding those priorities as expressed by the countries, and provide information as to who was consulted in the partner countries and which ministries were asked to contribute to the exercise of priority-setting. If health ministries are systematically left out of the consultations, it is not surprising that health is not emerging as a focal sector. We are especially concerned by some evidence emerging that partner countries indeed expressed the wish of funding health to the EC, but the latter expressed its disinterest.

The EC further suggests that general budget support (GBS) is piloted given its potential beneficial effects for social development. The analysis presented in this report points to several questions to be raised, especially in relation to the allocations in ACP countries, including:

- Why is GBS mainly used in ACP countries and much less in Latin America or Asia?
- Why are sectors such as transport, which receive massive contributions from the EC, excluded from GBS and specially targeted?
- Why is transport favoured over health in ACP countries?
- Can the positive effects of GBS on health be proven? Is there a track record demonstrating the contribution of GBS to health?
- Why does the governance instrument, which is linked to GBS, not include strong indicators related to the MDGs, including to health?

There is still time to rescue this situation and we are calling for urgent action on the part of the EC, in conjunction with the European Parliament and the ACP-EU Joint Parliamentary Assembly. Improvements for global health are vital to the achievement of development and poverty reduction targets, which is why health was highlighted so strongly in the MDGs.

The EU has a very important role to play. If it fails to honour its commitments, developing countries will fail to meet the MDGs.

Simon Wright
Project Manager
Action for Global Health

It is firstly worth collating the many commitments that the EU has made to support health in its international co-operation, and the binding targets that it has adopted. These give some indications of benchmarks against which the EC's spending on health can be judged, before we go on to consider the reality of its allocations and spending.

On the international level, all of the 27 EU Member States are signatories to the 1966 International Covenant on Economic, Social and Cultural Rights and to the 2000 UN Millennium Declaration. At the EU level, the main legal instruments governing the EU's relations with developing countries in all of the different regions across the globe – the Cotonou Agreement and the Development Co-operation Instrument (DCI) – include clear obligations to support health in development co-operation.

The Cotonou Agreement (ACP-EU Partnership Agreement)

The ACP-EU Partnership Agreement, also known as the Cotonou Agreement, governs the EU's relations with almost 80 developing countries in Africa, the Caribbean and Pacific regions. Signed in the Beninese capital, Cotonou, on 23 June 2000, this 20 year partnership agreement commits the EU to support ACP countries' efforts to improve the quality of and access to basic social services for their populations. The Cotonou Agreement includes specific commitments for improving health systems, basic healthcare, reproductive healthcare and family planning, preventing female genital mutilation and fighting HIV/AIDS.

Under a separate article on regional co-operation, the Cotonou Agreement also provides for general support to 'health education and training'.⁽¹⁾

The financial instrument for the Cotonou Agreement is the EDF, which is not part of the EU budget.

The Development Co-operation Instrument (DCI)⁽²⁾

This EC regulation provides the overall legal framework for Community policies in the field of development co-operation. Adopted in December 2006, this legal instrument incorporated a raft of both thematic and geographic regulations, including several which dealt explicitly with the EC's support to the health sector.

Article 5 sets out the EC's approach to geographic programmes. It obliges the EC to focus on increasing access to and provision of health services, with a central focus on the health-related MDGs.

Article 12 sets out the thematic strategy *Investing in*

People. One of the four pillars of this programme is 'good health for all'.⁽³⁾ This covers, inter alia, the fight against poverty diseases and actions to support sexual and reproductive health and rights.

Furthermore, in a declaration on the occasion of the agreement of the DCI, the Commission committed itself to ensure that by 2009, 20% of funds under the geographic programmes covered by the DCI would be allocated to basic health and basic and secondary education.

The European Consensus on Development

The *European Consensus*, which was adopted in December 2005, replaced the November 2000 *Joint Statement on the European Community's Development Policy*. The *European Consensus* sets out the pursuit of the MDGs as the overarching objective of EU development co-operation. It includes very clear commitments to promote sexual and reproductive health and rights, tackle HIV/AIDS, tuberculosis and malaria, address the exceptional human resource crisis of health providers, address fair financing for health and strengthening health systems, and make medicines more affordable for the poor.

In addition to these specific commitments on health, the *European Consensus* also provides that the EC will mainstream the fight against HIV/AIDS in all of its activities.

EU Obligations to Health in International Co-operation

Millennium Declaration

19. We resolve further:

By [2015], to have reduced maternal mortality by three quarters, and under-five child mortality by two thirds, of their current rates.

To have, by then, halted, and begun to reverse, the spread of HIV/AIDS, the scourge of malaria and other major diseases that afflict humanity.

European Consensus

Paragraph 5

The primary and overarching objective of EU development co-operation is the eradication of poverty in the context of sustainable development, including pursuit of the Millennium Development Goals (MDGs).

MDGs

Goal 4: Reduce child mortality

Target 5: Reduce by two thirds the mortality rate among children under five.

Goal 5: Improve maternal health

Target 6: Reduce by three quarters the maternal mortality ratio

Goal 6: Combat HIV/AIDS, malaria and other diseases

Target 7: Halt and begin to reverse the spread of HIV/AIDS

Target 8: Halt and begin to reverse the incidence of malaria and other major diseases

Cotonou Agreement

Article 25

1. (...) In this context, co-operation shall aim at:

(b) improving health systems and nutrition, eliminating hunger and malnutrition, ensuring adequate food supply and security;

(c) integrating population issues into development strategies in order to improve reproductive health, primary health care, family planning; and prevention of female genital mutilation;

(d) promoting the fight against HIV/AIDS.

DCI

Article 5

(i) increasing access to and provision of health services for lower income population groups and marginalized groups [...] with a central focus on the related MDGs;

Article 12

2. (a) Good health for all

International Covenant on Economic, Social and Cultural Rights

Part III - Article 12

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

EU Budget

Since 2001, the annual EU budget has included benchmarks for the allocation of EC ODA. In 2003, the European Parliament and the Commission agreed to the inclusion of a benchmark of 35% of expenditure on health and education. In 2004, the budget lines for EC relations with developing countries in Latin America, Asia and the Mediterranean and Middle East regions included the remark that 35% of annual commitments would be allocated to 'social infrastructure, mainly education and health but also including macroeconomic assistance with social sector conditionality'.⁽⁴⁾ These budget lines also included the remark that a minimum of 20% of total annual commitments would be allocated to 'activities in the sectors of basic health and basic education, including sectoral budget support to health and education ministries where it is to serve basic health and basic education'.⁽⁵⁾

The 20% and 35% benchmarks were maintained in the 2005 and 2006 budgets. Furthermore, since 2005, the European Commission has been obliged to report on how its work has 'contributed to the 35% target for social infrastructure and in achieving the MDGs'.⁽⁶⁾

The 2007 budget maintained the allocation benchmarks but amended them in line with the Commission's declaration about the DCI (see above). As a consequence, the 20% benchmark for basic health and basic education became 20% for 'basic and secondary education and basic health'⁽⁷⁾ and the EC's reporting commitment was amended to include reporting on the new 20% benchmark.

Regional Policy Strategies

In 2005, the heads of state and government of the then 25 EU Member States, meeting as the European Council, adopted the EU-Africa Strategy. It committed the EU inter alia to providing predictable, multi-year financing for health systems in Africa and increasing its support for the fight against infectious diseases.

The 2001 Commission communication on EU-Asia relations provides for sector programmes in health and education and specific support for health and education in South Asia.

Although the 2005 Commission communication on EU-Latin American relations does not include any explicit commitments on health, it does cite the achievement of the MDGs as the overarching objective of EC aid to the region. It also lists health as one of eight sectors in which the EC has been particularly active in Latin America in the past.

The 2006 Commission communication on EU-Caribbean relations sets out support for the fight against HIV/AIDS and other endemic health problems in the region as a priority. In addition, it commits the EC to support the regionalisation of co-operation in health services.

Thematic Policy Strategies

The thematic strategy paper on human and social development *Investing in People* sets out the EC's priorities in this area for the period 2007 – 2013. It identifies four separate areas for EC action: health, education, gender equality and other aspects of human and social development.

Investing in People provides that the distribution of funds under this thematic programme should be based on the importance of each of the four priority areas for the achievement of the MDGs. In this respect, *Investing in People* provides that 'at least 50 per cent of the overall budget will be allocated to Good Health for All'.⁽⁸⁾

In terms of the EC's support to health under this thematic strategy, Article 12 of the DCI identifies four health priorities to be addressed: tackling major poverty-related diseases, actions in support of sexual and reproductive health and rights, addressing the human resources crisis in healthcare and ensuring a balanced approach between prevention, treatment and care.

Petersberg Communiqué on European Development Policy launched by EU Development Ministers on the occasion of the fiftieth anniversary of the European Union, 13 March 2007

Based on the *European Consensus on Development* (2005), the primary and overarching objective of EU development co-operation is the eradication of poverty in the context of sustainable development, including pursuit of the Millennium Development Goals (MDGs).

Reducing child mortality is therefore one of European development policy's foremost responsibilities. Basic health care and protection against preventable diseases such as HIV/AIDS are other key tasks.

Conclusions

These impressive commitments show that the EU has repeatedly acknowledged health as vital to development and a key element of its focus. It has committed to the benchmark of 20% of EC funding to be allocated to basic health and education. The next section will consider whether the reality of allocations and disbursements to this sector lives up to these multiple commitments.

The EU has been praised for its increase in allocations to official development assistance in recent years. In 2005, the EC (excluding the EU Member States) made ODA commitments to the value of US\$ 11.154 billion.⁽¹⁾

Did the increase in spending contribute to an increase in allocations to health? Having seen multiple political commitments to health in EU and international declarations, this section identifies whether the spending has been in line with these commitments and whether the EC is moving towards the 20% target.

In 1996, the EC's ODA commitments to health were US\$ 290 million⁽²⁾, and this had increased to US\$ 603 million in 2005.⁽³⁾ However, allocations to health as a proportion of all EC ODA have decreased since 1996. In 2005, ODA allocations to health only accounted for 5% of total EC ODA commitments, while in 1996 this was 7%. Moreover, only one third of these commitments for health were actually disbursed during the period 1996 – 2005.⁽⁴⁾

The EC's allocations to reproductive health have remained very low. The EC did not report any ODA commitments to the sub-sector 'Reproductive health care' in 1996. In 2000 the allocation amounted to 0.99%, however in 2005 it decreased to only 0.32% of EC ODA.⁽⁵⁾

Percentage-wise, EC ODA commitments to 'Basic health' were at their highest level in 1996: 5.5% of total EC ODA. This decreased to 1.5% in 2000 and was 4% in 2005.

The EU Budget

Analysis of the EC's own budget shows that until 2007 a significant proportion of the EC's spending on health was allocated under a number of separate budget lines, including those for poverty-related diseases (HIV/AIDS, malaria and tuberculosis), and for population and reproductive healthcare.

The EC Regulation on aid to fight poverty diseases (HIV/AIDS, malaria and tuberculosis) in developing countries included a financial envelope of € 351 million for the period 2003 - 2006.⁽⁶⁾ The EC Regulation on aid for policies and actions on reproductive and sexual health and rights in developing countries included a financial envelope of € 73.95 million for the period 2003 - 2006.⁽⁷⁾ The EC Regulation on promoting gender equality in development cooperation included € 9 million for the period 2004 - 2006.⁽⁸⁾ Collectively, the budget lines combined contributed approximately around a € 110 million a year to health.

In addition, the EC made funding available through the sixth and seventh European Research Framework Programmes for the development of new medicines and vaccinations against poverty-related diseases.

Intra-ACP Funding

In addition to these budget lines, under the ninth EDF (EDF 9) for ACP countries, the health sector was supported from the intra-ACP funding. Out of a total of € 2.7 billion under this envelope, € 356 million was allocated to health and an additional € 5 million was forecasted to be allocated by the end of 2007. Of the € 356m which has been committed to date, € 170 million went to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

OECD/DAC Definitions

Health:

This covers assistance to hospitals, clinics, other medical and dental services, public health administration and medical insurance programmes.

Basic Health:

This covers basic health care, basic health infrastructure, basic nutrition, infectious disease control, health education and health personnel development.

Population Policies / Programmes and Reproductive Health:

This covers all activities in the field of reproductive health, family planning and research into population problems.

Reproductive health care:

This covers promotion of reproductive health, prenatal and postnatal care including delivery, prevention and treatment of infertility, prevention and management of consequences of abortion, and safe motherhood activities.

Source:

OECD DAC Creditor Reporting System 2007

Country Strategy Programmes

Finally, support from geographic funding to health was included in CSPs from 2000 – 2006. In Asia, seven out of the 19 available CSPs included health as a focal sector.⁽⁹⁾ Some support for health was also included in four other CSPs.

Health was included as a focal sector in only four out of the 45 available CSPs for African countries.⁽¹⁰⁾ Support for health was included as an objective under other priority sectors, including 'access to social services' and 'rehabilitation of priority infrastructure', in two other CSPs. Support for health

EC Allocations to Health: 1996 - 2005

was either included as a non-focal sector or under 'other programmes' in a further nine CSPs.

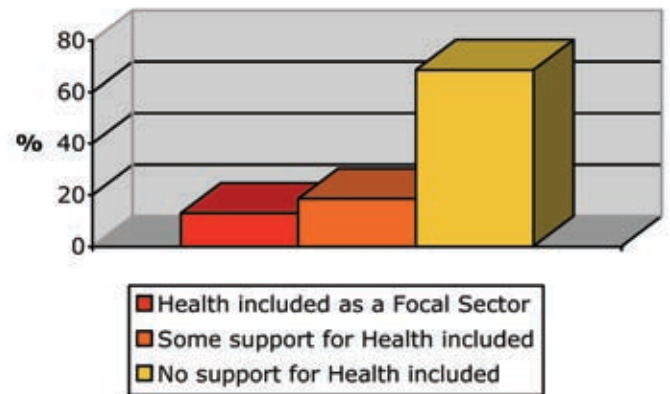
Health was included as a focal sector in two out of the 14 available CSPs for Caribbean countries.⁽¹¹⁾ Some support for health was also included in one other CSP in this region.

Support for health was included as a focal sector in three out of the 15 CSPs for countries in the Pacific region.⁽¹²⁾

However, 'health' was not incorporated as a priority sector in any of the 17 CSPs for Latin American countries.⁽¹³⁾ Some support to health was included under various priority sectors such as 'social development', 'reducing social imbalances' and the 'fight against social exclusion', in four Latin American CSPs.

Similarly, in the regions which currently fall under the scope of the European Neighbourhood and Partnership Instrument (ENPI), support for health was not included as a priority sector in any of the 14 available CSPs.⁽¹⁴⁾ Some support for health was included under various priority sectors, including 'support for institutional, legal and administrative reform', and 'support in addressing the social consequences of transition', in three CSPs.

EC support for Health in All CSPs



All Country Strategy Programmes

Out of the total of 124 CSPs (2000 – 2006) which were analysed, only nine included support to health as a focal sector. 12 others included some support for health. The remaining 85 CSPs did not include any direct support for health.

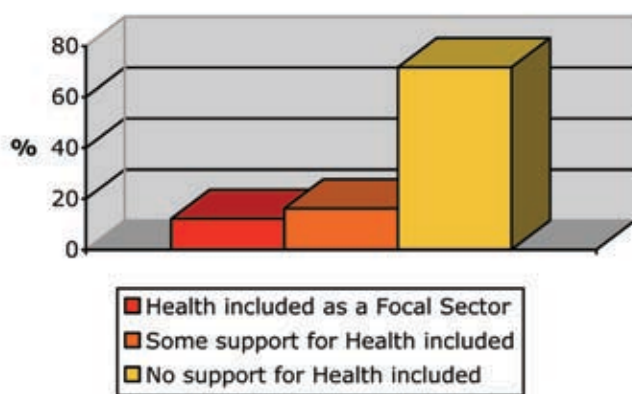
Commitments and Disbursements

Year after year, disbursements are far behind commitments and the disparity is alarming.

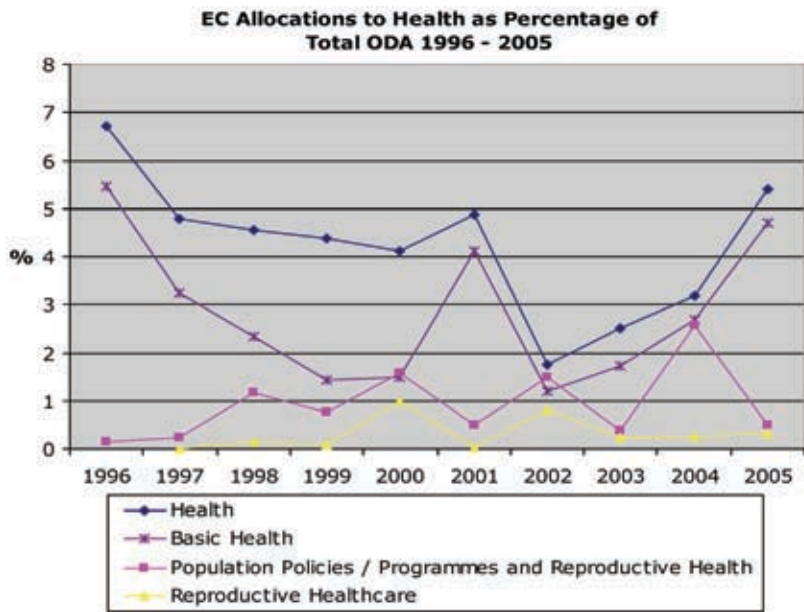
Conclusions

The period 1996 – 2005 shows a repeated failure to provide adequate resources to invest in health systems. It is especially worrying that the proportion of ODA allocated to health declined during the period, despite the EU's commitments to health.

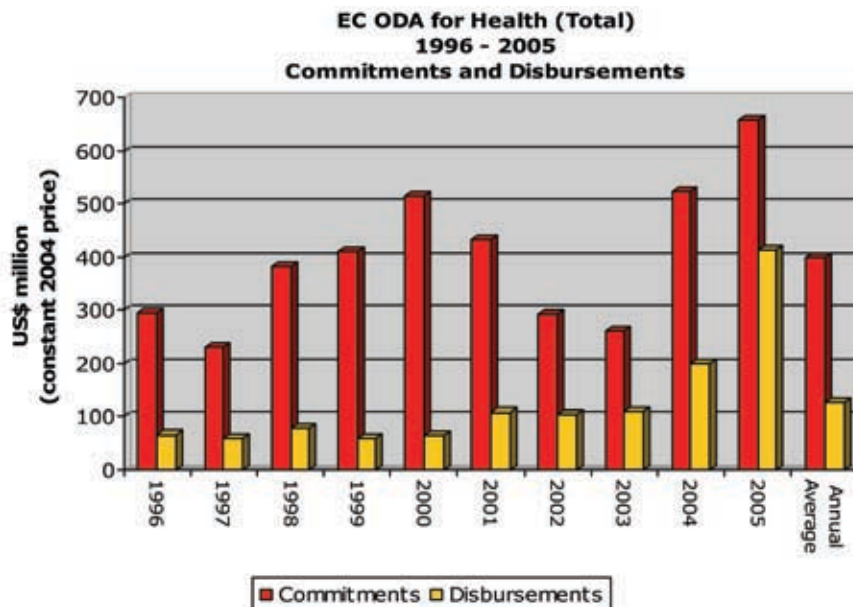
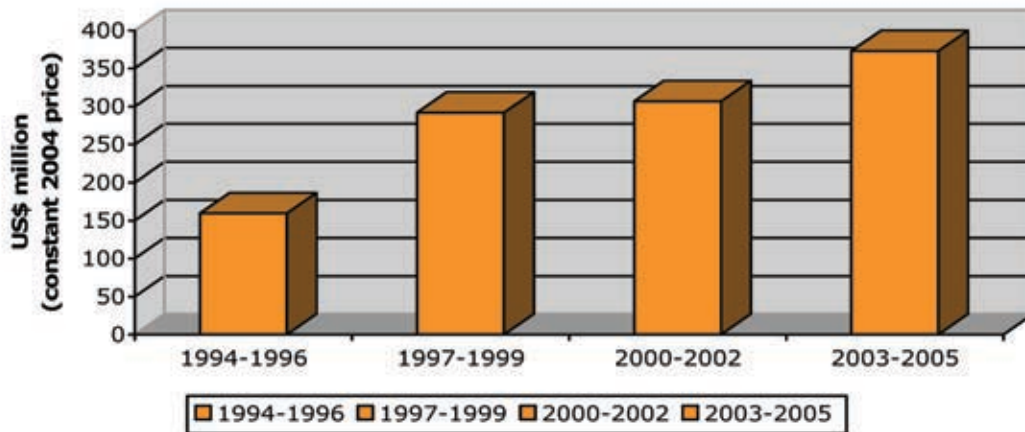
EC support to Health in ACP CSPs



EC Allocations to Health: 1996 - 2005



EC Allocations to DAC Sector 'Health' 1994 -2006 (3-year averages)



Trends in EC Funding for Health

Given that it is the first year of the implementation of the new financial perspective (2007 - 2013) and EDF 10, 2007 is an important transition year.

Firstly, as part of the new legislation underpinning the financial perspective (2007 - 2013), previous budget lines boosting specific EC allocations to the health sector have been merged into one general instrument for development co-operation (the *Investing in People* programme), causing an already noticeable reduction in health spending in certain areas from that source.

In addition, a new EDF (EDF 10) is expected to be ratified for the country programmes for ACP countries, and early indications are not reassuring that this mechanism will drive an increase in ODA for health.

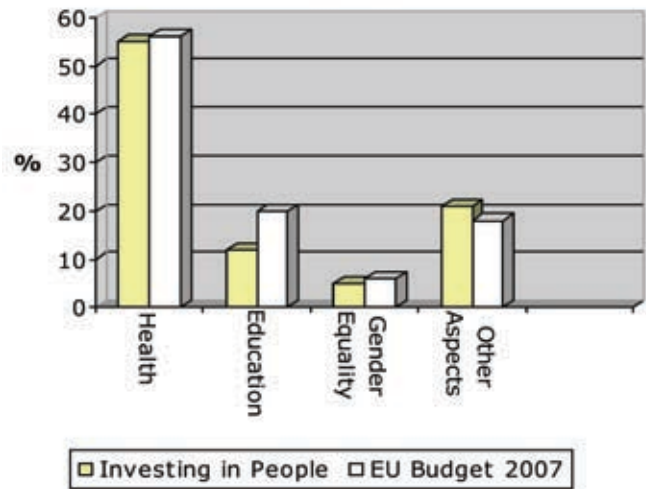
Thematic Strategy: Investing in People

Thematic strategies are replacing the sectoral budget lines, which were previously included in the EU budget. Under the previous financial perspective (2000 - 2006), the EC's funding for health was divided into separate budget lines (see Section 2) amounting to approximately € 110 million per year. These have now all been amalgamated under the thematic strategy *Investing in People*, which has a smaller overall budget and covers many more issues than health, including education, gender equality, culture and employment.

The thematic strategy *Investing in People* (IiP) will account for € 1.060 billion (6.28%) of the total € 16.897 billion available under the Development Co-operation Instrument for the next seven years. It provides that at least 55% of the IiP budget should be allocated to health. Nonetheless, at best this structure of spending will see a fall to approximately € 84 million per annum from the € 110 million per annum during the period 2004 - 2006.

The 2007 annual EU budget, which was adopted in December 2006, divided the overall human and social development budget into four separate lines corresponding to the four pillars of the thematic strategy *Investing in People*: health, education, gender equality and other aspects of human and social development. The total budget for human and social development of € 110.445 million was divided among the four areas as follows: health (€ 62 million), education (€ 22 million), gender equality (€ 6.6 million) and other aspects of human and social development (€ 19.845 million). However, as these allocations are not ringfenced the annual budget might allocate the amounts differently each year.

Breakdown of EC Allocations under thematic strategy Investing in People 2007 - 2013 and EU Budget 2007



Intra-ACP funding

At the time of writing, the programming exercise for EDF 10 was still in its early stages with the ACP countries. Of a total EDF of € 22.682 billion, € 2.7 billion (12.3% of operational funds) has been earmarked for intra-ACP co-operation. However, it was unclear exactly how this envelope would be allocated apart from the € 300 million for the Africa Peace Facility during the period 2008 - 2010, and the € 330 million for the joint ACP-EU institutions.

Given that the overall amount of funding available in the intra-ACP envelope under EDF 10 has remained at the same level as under the EDF 9, it would require concerted action to see any increase in the amount which is allocated in support of health under this instrument. 2007 is the year when CSPs for all developing countries should be adopted providing the framework for EC aid for the period 2007 - 2013. If there was to be any increase in ODA spending on health, we would expect to see the health sector prioritised much more under EDF 10 than under EDF 9, and that this would be reinforced by financial support from the intra-ACP envelope.

Country Strategy Programmes

The following analysis attempts to identify trends in support for health for each of the three geographic development instruments: (i) the CSPs for Latin America and Asia (approved under the Development Co-operation Instrument), (ii) the CSPs approved for the EU's neighbour countries (approved under the European Neighbourhood and Partnership Instrument) and (iii) the CSPs approved under the ACP-EU Partnership Agreement (EDF 10).

Country Strategy Programmes for Asia and Latin America under the Development Co-operation Instrument (DCI)⁽¹⁾

At the time of writing, the draft CSPs for Asia and Latin America were awaiting approval by the Member States Committee (DCI Committee) and final adoption by the Commission.

None of the 16 draft CSPs for Latin American countries which have been analysed, included health as a focal sector. Some support to health was included in five of the draft CSPs for this region.

Five of the 15 draft CSPs for Asian countries included health as a focal sector. Some support for health was included in one other CSP for this region.

Country Strategy Programmes for the EU's neighbour countries under the ENPI⁽²⁾

At the time of writing, the draft CSPs for the EU's neighbour countries were also awaiting approval.

Of the 12 draft CSPs for ENPI countries which were analysed, only one explicitly provided for EC support to the health sector.

Five others included non-specific support for health under a number of separate but related focal sectors, including 'support for social and economic development' and 'support for social and economic reform'.

Country Strategy Programmes for countries in Africa and the Caribbean and Pacific regions

At the time of writing, the CSPs for ACP countries were still at the drafting stage. Therefore, the analysis for this sub-section was based on information received from both EC delegations in ACP countries and ACP embassies or ministries.

Information was provided about the CSPs for 14 African countries. Health will only be included as a focal sector in two CSPs. Health will be included as a non-focal sector in two other countries. No direct support to health is foreseen in the remaining ten African countries about whose CSPs information was provided. However, it has been indicated that the EC would support health in five of those countries through GBS, but this does not ensure any direct allocations to health – as clarified by Commission staff.

In cases where health is included as a focal sector, this does not necessarily imply that the level of financial support remains at a similar level as previously, given that focal sectors might be continued with reduced funding.

Health will not be included as a focal sector in the one country in the Pacific region about whose CSP information was provided.

EC support for human and social development through GBS was foreseen in the one country in the Caribbean region about whose CSP information was provided.

It is worth noting that there is evidence that a huge amount of funding in ACP countries could be specifically allocated to transport, and that this sector would not be included in GBS. The reason for this is unclear, but suggests a de-prioritisation of health in favour of transport by the EC.

Country Strategy Programmes

From a total 59 CSPs which were either analysed or about which information was provided, only nine included or foresaw support to health as a focal sector. 13 others either included or foresaw some support for health. The remaining 37 CSPs neither included nor foresaw any direct support for health.

As is noted above, in several cases, draft CSPs which include health as a focal sector foresee a lower financial allocation to that focal sector than they did under the previous financial perspective.

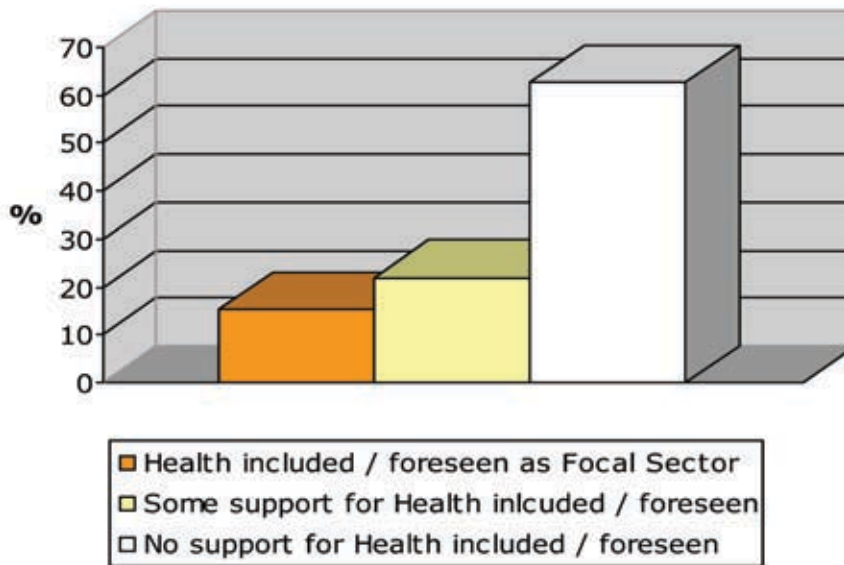
The OECD/DAC lists 152 countries and territories as recipients of ODA. Based on the above analysis, the EC could hypothetically include some support for health in 57 country programmes, but with no certainty that levels of funding would remain the same.

Although the draft CSPs provide an overview of the partner countries' own policy agenda, they do not include any specific information about the adequacy of the EC's response to weaknesses in the health sector in a particular partner country or about the adequacy of the international community to respond to the financial gap for health in that country. It therefore does not identify whether the decision of the EC to not invest in health, where this is the case, is justified or not.

Based on current predictions, the trends suggest that there is a massive disparity between allocations and actual disbursements. In previous years, money allocated but not disbursed remained available to the health sector and could be disbursed in future years. The flexibility introduced in the new financial perspective (2007 - 2013) will allow money to be shifted to other sectors.

Trends in EC Funding for Health

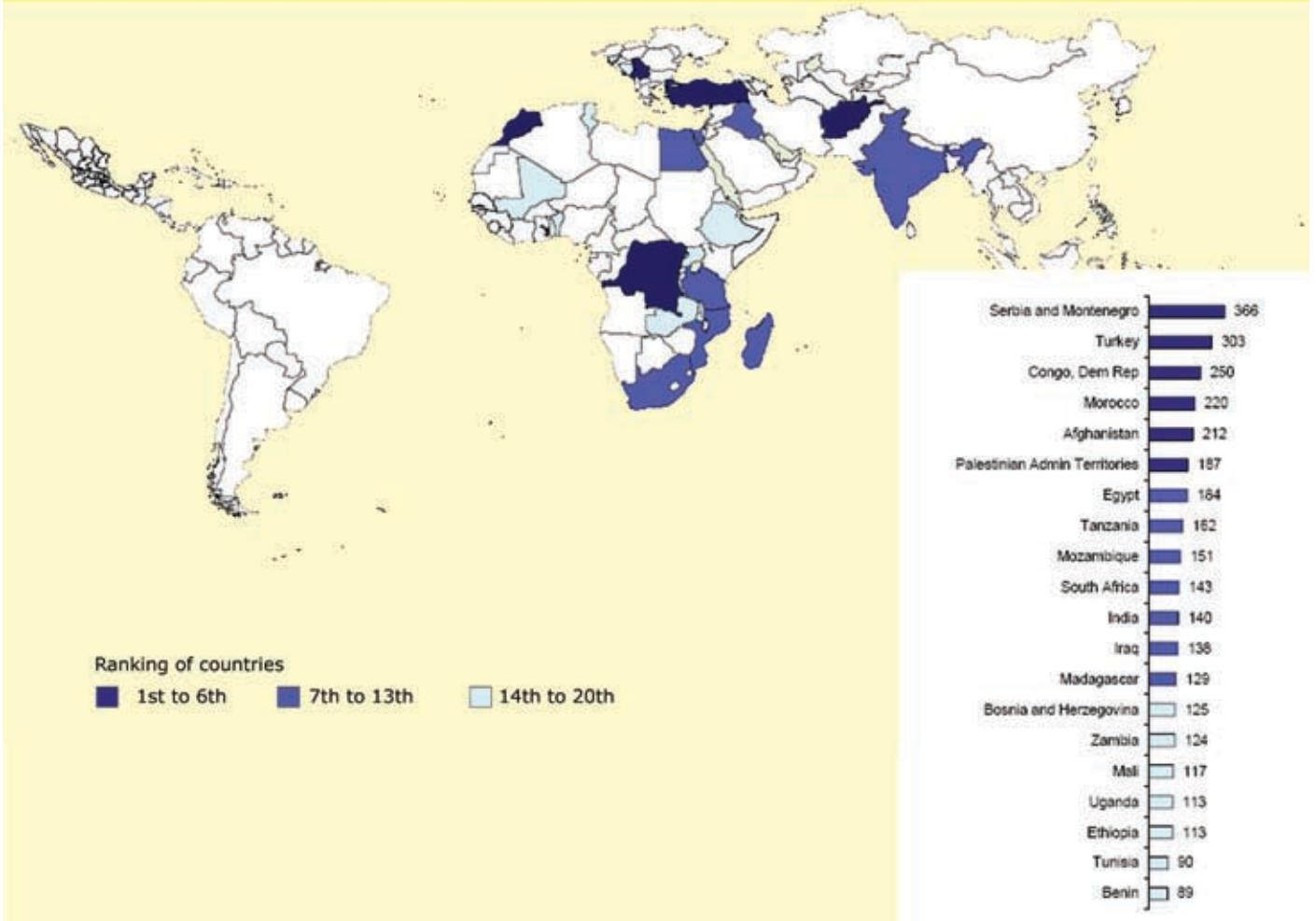
EC support for Health in all CSPs 2007 - 2013



■ Health included / foreseen as Focal Sector
■ Some support for Health included / foreseen
■ No support for Health included / foreseen

Top 20 Recipients of EC Aid

EC bilateral ODA, net disbursements, Millions US\$, 2004



Ranking of countries

■ 1st to 6th
 ■ 7th to 13th
 ■ 14th to 20th

It is important for context to look at the EU Member States' ODA commitments in support of health, and also to consider how the principle of subsidiarity should be driving ODA spending for this sector. In 2005, EU Member States made ODA commitments in support of health to the value of US\$ 2.804 billion. Together with the EC contribution, the EU's combined contribution to health in 2005 totaled US\$ 3.461 billion.

From the EC and EU Member States, the United Kingdom (UK) was the single largest contributor to the health sector, with average annual ODA commitments during the period 1996 – 2005 of US\$ 637 million. Luxembourg was the best performer in terms of proportion – during the period 2001 – 2005, an average 21.76% of its ODA went to support health. During the period 2000 – 2005, Ireland allocated an average 21.23% in support of health.⁽¹⁾ Ireland and Luxembourg were also the best performers in terms of the proportion of their ODA which they allocated to the sub-sector 'Basic health' – Ireland allocated an average 8.83% (2000 – 2005), Luxembourg allocated an average 8.41% (2001-2005).

Ireland and the Netherlands gave the highest proportion among EU Member States 'in support of HIV/AIDS control', averaging 4% in 2000 – 2005.

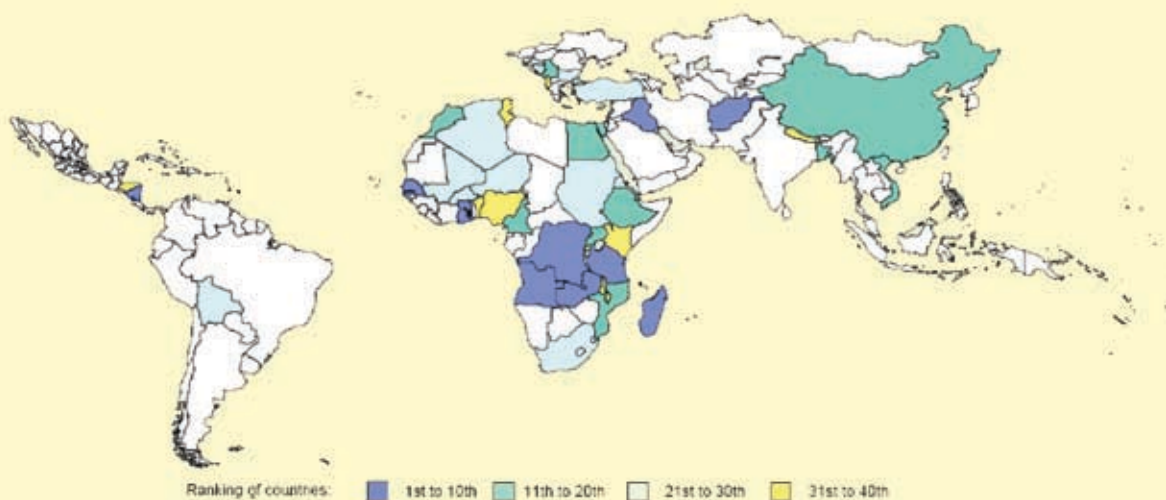
Aid orphans

The geographical distribution of ODA by the EC and EU Member States is also a cause for concern. In 2005, Iraq heads the list of ODA recipients for many EU Member States. There is a reasonably high degree of convergence between the EC and the EU Member States' lists of top ODA recipients. At the same time, it is possible to identify several countries which receive little if any aid. These are often countries with serious problems in terms of poverty and health.

The EC CSPs do not identify the funding gap for health in the partner country. They also neglect to identify whether other donors are helping to close the funding gap and the extent to which this gap remains. Furthermore, the CSPs do not address what is the EC's responsibility in addition to that of the EU Member States.

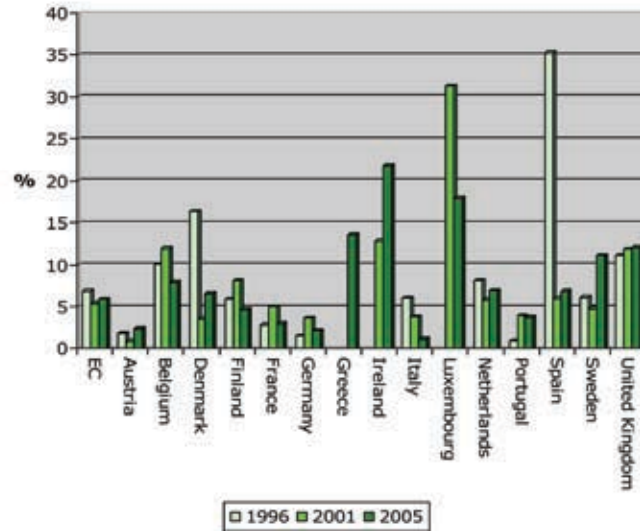
While the EC identifies budget support as a key mechanism for improving health, there is no plan or policy for ensuring that basic health is properly addressed in those countries which do not qualify for budget support. These are often the countries which are most in need of support to ensure that basic health facilities are in place. The EC and EU Member States do not appear to be adequately working together to address this issue, as illustrated by the map below.

Top recipients of EU bilateral Aid (MS and EC), Millions US\$, 2004

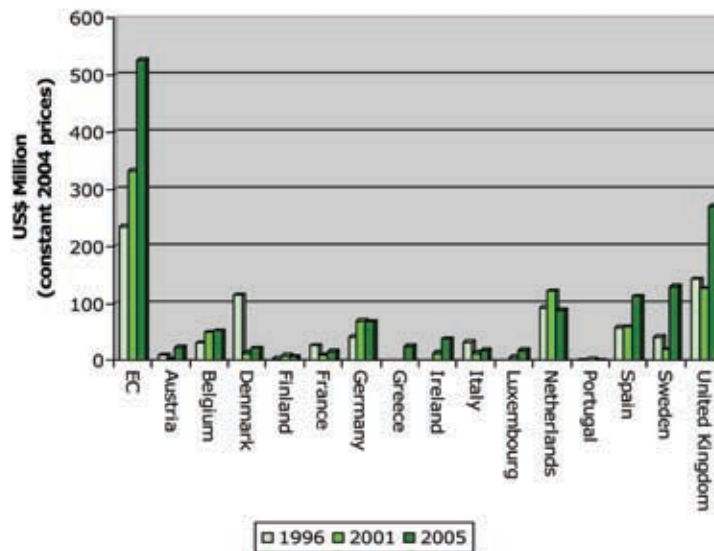


EU Member States' Allocations to Health: 1996 - 2005

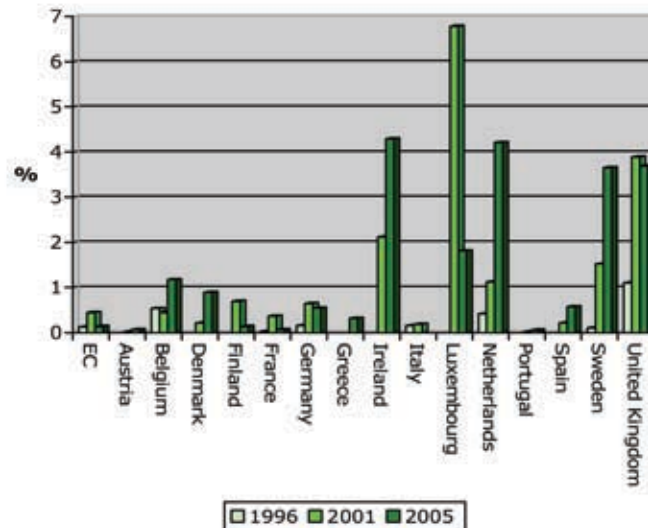
EC and EU Member States' Allocations to Health (Total) 1996 - 2005 as Percentage of Total ODA



EC and EU Member States' Allocations to Basic Health 1996 - 2005



EC and EU Member States' ODA in support of HIV/AIDS Control 1996 - 2005 as Percentage of Total ODA



Various studies have revealed that there is a major gap between the volume of ODA resources required to ensure even the most basic level of health provision in developing countries and the current levels of ODA in support of health.

WHO Commission on Macroeconomics and Health

In 2001, the WHO Commission on Macroeconomics and Health (CMH) estimated that the total annual required health expenditure in all countries in 2002 would amount to US\$ 106.1 billion (US\$ 26 per capita) and that this figure would rise to US\$ 162.8 billion (US\$ 38 per capita) by 2007 and to US\$ 200.3 billion (US\$ 42 per capita) by 2015. The CMH also estimated that in 2007, there would be an annual net health financing gap for all countries of US\$ 22.1 billion (US\$ 5 per capita) and that this would increase to US\$ 30.7 billion (US\$ 5 per capita) by 2015.⁽¹⁾

Furthermore, the CMH urged donor countries to close the health financing gap by increasing their ODA for health from an approximate level of US\$ 6 billion in 2002 to US\$ 27 billion in 2007 and to US\$ 38 billion by 2015. Although this represents a major increase in funding for health, the CMH calculated that it would only be equivalent to an overall increase of 0.1% of donor GNP.

In 2005, the EC and EU Member States made ODA commitments to the value of US\$ 55.693 billion. Of this total, US\$ 3.461 billion (6.22%) was allocated in support of health. The combined EC and EU Member States' ODA commitments to health in 2005 accounted for 50% of the total US\$ 6.902 billion in ODA commitments to health reported by the 22 DAC members in that year. If the EC and EU Member States are to follow the CMH's recommendation and support the achievement of the health MDGs by 2015, their combined ODA for health would have had to double to US\$ 13.541 billion by 2007 and to increase to US\$ 19.058 billion by 2015.⁽²⁾

The EC should therefore increase its commitments and disbursements to health significantly to a level of at least US\$ 1.3 billion annually in 2007 and US\$ 1.9 billion in 2015.

Abuja pledges

In April 2001, the heads of state and government of the Organisation of African Unity (OAU) held a special summit to address the challenges of HIV/AIDS, tuberculosis and other related infectious diseases in Abuja, Nigeria. They pledged to set a target of allocating 15% of their national budgets to the improvement of the health sector.

In addition, they also called upon donor countries to complement their efforts to tackle HIV/AIDS, tuberculosis and other related infectious diseases, including by fulfilling their commitment to meet the 1970 UN target of allocating 0.7% of their countries' GNP to ODA.

In spite of the 2001 appeal from the OAU heads of state and government, to date, only four out of the 27 EU Member States have achieved the 0.7% ODA target. Furthermore, the current EC CSPs do not take into account whether adequate budgetary resources for health are being allocated by partner governments.

In 2003, the heads of state and government of the African Union (AU) devoted a special session of their second ordinary assembly to reviewing and debating the current status of HIV/AIDS, tuberculosis, malaria and other related infectious diseases in Africa. They reaffirmed the pledges that they had made in Abuja in 2000 and 2001, and reiterated their commitment to intensify and consolidate efforts for their implementation.

Furthermore, the AU heads of state and government urged the international community to honour its pledges by disbursing the funds required to fully execute programmes in the fields of HIV/AIDS, tuberculosis, malaria and other related infectious diseases, including through the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank, the Africa Multi-country AIDS Programme and other initiatives.

The European Programme for Action to Confront HIV/AIDS, Malaria and Tuberculosis through External Action 2007 - 2011

In 2005, the Commission published a communication on an action plan to confront HIV/AIDS, malaria and tuberculosis in its external actions under the next financial perspective. In its assessment of the policy context and the scope of the proposed programme for action, the Commission recognised the major shortfall in funding for addressing the challenges of HIV/AIDS, malaria and tuberculosis. It stated that the projected annual external resource gap for tackling these diseases would continue to grow and that it was estimated to reach US\$ 14.9 billion by 2007, including US\$ 11.5 billion for HIV/AIDS, US\$ 2.6 billion for malaria, and US\$ 0.8 billion for tuberculosis.⁽³⁾

The Commission's plan also proposed that the EU should 'aim for a contribution that helps to fill the financing gap for the three diseases and meet the Millennium Development Goal (MDG) 6 and that reflects Europe's weight and importance as an international partner in development'.

In 2005, the EC and EU Member States made

Funding Gap

combined ODA commitments of US\$ 777.434 million 'in support of HIV/AIDS control'. During the period 2001 – 2005, the EC and EU Member States' combined pledges to the Global Fund to Fight AIDS, Malaria and Tuberculosis were US\$ 1.993 billion⁽⁴⁾, falling far short of the US\$14.9 billion required by 2007.

The CSPs do not address the question of whether the funding gap for HIV/AIDS, malaria and tuberculosis in partner countries is resolved and whether an EC contribution is required to do so.

WHO Commission on Macroeconomics and Health

Although the required assistance is large relative to current donor assistance in health, it would be only around 0.1 percent of donor GNP, and would leave ample room for significant increases in other areas of donor assistance as needed.

Abuja Declaration

Paragraph 26

(...) In addition, we pledge to set a target of allocating at least 15% of our annual budget to the improvement of the health sector.

Paragraph 28

We call upon donor countries to complement our resources mobilization efforts to fight the scourge of HIV/AIDS, Tuberculosis and Other Related Infectious Diseases.

UN Millennium Project

The MDG financing gap for all low-income countries will amount to US\$ 73 billion in 2006 and rise to US\$ 135 billion by 2015.

We project that the cost of meeting the Goals in all countries will amount to US\$ 121 billion in 2006 and US\$ 189 billion in 2015. This compares with 2002 official development assistance of roughly US\$ 28 billion in support of the Goals (out of US\$ 65 billion in total ODA).

The European Programme for Action to Confront HIV/AIDS, Malaria and Tuberculosis through External Action 2007 - 2011

The projected annual external resource gap will continue to grow and is estimated to reach US\$ 14.9 billion by 2007 – US\$ 11.5 billion for HIV/AIDS, US\$ 2.6 billion for malaria, and US\$ 0.8 billion for TB.

Ensuring the availability of sufficient funding to achieve MDGs 4, 5 and 6, on reducing child mortality, improving maternal health and combating HIV/AIDS, malaria and other diseases is one of the most important roles that the EU can play.

This report has looked at the trends in EU ODA funding for health at a crucial point in time. Not only is it the mid-point to the MDGs target date, it is also the year when the EC moves to new mechanisms for the delivery of ODA. As this report shows, the effect of this change on ODA spending for health remains uncertain and many indications suggest it could lead to a drastic reduction in the amount allocated and actually disbursed for health. While the EU has made strong commitments to supporting health services for poverty eradication in developing countries, these commitments have not been matched with increasing resources and in the future, funding for health may fall unless urgent action is taken.

This overview shows that the proportion of the overall EC ODA budget allocated to health has actually *decreased* between 1996 and 2005. This has occurred despite the binding targets included in the EC budget that 20% of EC ODA be targeted to basic health and basic education. These binding targets have been included in the EC budget since 2001.

EC ODA has increased over the same period but allocations to health have not kept pace – measured in real commitments and disbursements. Moreover, the discrepancy between the commitments and actual disbursements is very large. On average, actual disbursements made to health in developing countries during the period 1996 – 2005 are less than one third of the ODA commitments.⁽¹⁾ Under the new mechanisms, undisbursed funds, whether for health or other issues, will no longer be ringfenced and may therefore be used in other areas, thereby further reducing the health spending.

Actual allocations have oscillated strongly during the period, depending on spending pressures arising in different years. The allocations show low long-term predictability in EC funding for health.

The report finds differences in resource trends for sub-sectors of the EC's support to health in developing countries. Especially noteworthy is that the EC's ODA allocations 'in support of HIV/AIDS control', which peaked at US\$ 67.365 million in 2004, fell to US\$ 14.84 million in 2005.⁽²⁾ These figures contrast sharply with the Commission's own 2005 estimation that the annual external resource gap for tackling HIV/AIDS would reach

US\$ 11.5 billion by 2007. The low levels of EC support in this area is all the more surprising given the public support the EC has offered to the fight against HIV/AIDS and MDG 6 overall, a commitment which has been made at the highest level of the European Commission.

The EC's ODA allocations relevant to MDG 4 and 5 on child mortality and maternal care have increased during the period 1996 – 2005⁽³⁾, but they remain low. As the separate budget lines for resources have been integrated into the thematic strategy *Investing in People*, there is no longer designated funding for this area.

Under the new Development Co-operation Instrument, the budget line *Investing in People* has combined various former health-related budget lines to a single budget line, also intended to cover a wide variety of non-health spending. The decision to take the EC's 2007 pledge to the Global Fund to Fight AIDS, Malaria and Tuberculosis from the IiP budget line has serious implications for the EC's ability to fund other activities in support of health, and it would appear that this could reduce the regular annual contribution in support of MDGs 4 and 5. The fault is that this budget is insufficient to allow EC investment in a range of interventions.

With regard to the future trend of financial resources implemented by the Commission, an important question is therefore, whether the new regime for the financial perspective for the period 2007 – 2013 will increase EC funding for health. The new arrangements for this period, including EDF 10 for ACP countries, include a drastic simplification of the budget lines for development co-operation. Separate budget lines specifically focusing on supporting the health sector, have now merged under the new legislation and need to be covered by the Development Co-operation Instrument (DCI), European Neighbourhood Policy Instrument (ENPI) and the (existing) ACP-EU Partnership Agreement (Cotonou Agreement).

Moreover, our analysis of the future trends in EC development co-operation, specifically the CSPs and thematic programmes which will cover the period 2007 – 2013, indicates that overall allocations to health seem certain to decrease, rather to deliver the increase that is needed.

In addition to the budgetary targets, the Commission has signed a declaration committing itself to allocating 20% of its resources for geographic programmes under the DCI to basic health and basic and secondary education by 2009. Despite this re-affirmation of the Commission's commitment to supporting social sectors, the lack of focus on health in the 31 draft CSPs for DCI countries, which were analysed for this report, is striking. This is especially the case for Latin American countries.

Conclusions & Recommendations

It was found that less than 20% of the draft CSPs for countries falling under the scope of the DCI include health as a focal sector. Only one ENPI country, out of a sample of 12 draft CSPs analysed, includes a focus on health.

The information received from 14 EC delegations about probable or expected focal sectors in the forthcoming CSPs for ACP countries suggests that health will feature only rarely. Only two EC delegations reported that health might be included as a focal sector. This is worrying as the MDGs related to child mortality, maternal health and the fight against HIV/AIDS, tuberculosis and malaria are especially relevant for the ACP countries. Almost half of the EC delegations which responded, indicated that the European Commission might rely on GBS as an instrument to target the health sector and that it had introduced a new instrument called 'HIV/AIDS mainstreaming'.

In addition to the CSPs, out of the intra-ACP funding which was disbursed under EDF 9, 13.19% was allocated to health. For the next period, a total of € 2.7 billion will again be available for intra-ACP funding under EDF 10. There is not yet any definitive information about the allocation of intra-ACP funds under EDF 10, but while firm commitments have been made to the Africa peace facility and support to the ACP-EU institutions, no such commitments are known to have been made to health, especially to the Global Fund to Fight AIDS, Malaria and Tuberculosis.

With regard to the EU Member States, the UK is the single largest contributor to the health sector. During the period 1996 - 2005, the UK committed an average US\$ 636.473 million per year to the health sector. On average, the EU Member States together allocated US\$ 1.863 billion per year to health.

The EC is increasing the amount of aid which it channels through budget support. EU Member States employ different methodologies to account for their general and sectoral budget support to social sectors, thus creating uncertainty as to how to interpret the data.

Recommendation 1

The EC must take urgent action to close the funding gap for health

All the evidence seems to show that despite recent efforts and commitments, ODA for health is not increasing as fast as it should and may actually fall under the new DCI. The EC must act immediately to give much higher priority to health funding and double its spending to the health sector in the coming years to US\$ 1.3 billion annually and to US\$ 1.9 billion in 2015. Increased reliance on aid through GBS means that increases in ODA must ensure significant increases in allocations to health

budgets in partner countries. The EC needs to urgently review its funding mechanisms to ensure it is supporting the 2001 OAU target for spending 15% of national budgets on health. It should act urgently to step up its spending towards the 20% target for basic health and education. This report should serve as a warning that unless drastic steps are taken, the EC's ODA allocations in support of health are likely to fall.

Recommendation 2

European Union flagship report on health policy

The EC and the EU Member States are major contributors to global health policies – essential for the achievement of the MDGs on child mortality, maternal health and the fight against HIV/AIDS and other diseases. It would be particularly useful if the EU's contribution to health policy and financing were to receive greater visibility in an annual EU flagship report. This report, which would detail the EU's collective efforts to close the funding gap for health, would help to ensure that the worrying trends which have been identified in this report are reversed.

Recommendation 3

Increase the focus on health in CSPs

The EC must ensure that its forthcoming CSPs address health in a much more targeted way, identifying the funding gap for health in each partner country and taking into account what other donors are doing (or not) to close the funding gap for health. Furthermore, the annual reviews of the CSPs must pay special attention to health as this sector appears to be inadequately addressed in their draft versions. In this respect, the EC must immediately redouble its efforts to ensure that it fulfils its commitment to allocate 20% of ODA under its geographic programmes to basic health and education by 2009.

Recommendation 4

Investing in People

The thematic strategy *Investing in People* incorporates specific commitments to health, including to reproductive health and rights but it only has limited funding. One of the main purposes of the strategy is to ensure sufficient funding for health, which is itself essential for the achievement of the MDGs. This is particularly important if the health sector is not sufficiently funded through the CSPs. It also has particular relevance for sexual and reproductive health care to ensure the promotion of maternal and children's health and gender equality in the broader context of health. The IiP budget must be sufficient to fund a meaningful range of health interventions. Its strategy should ensure that a comprehensive approach to health issues is encouraged, which

Conclusions & Recommendations

incorporates a comprehensive set of actors and stakeholders from the health sector.

Recommendation 5

Maintain strong support for the Global Fund to Fight AIDS, Malaria and Tuberculosis

The EU has a good record as a major contributor to the Global Fund to Fight AIDS, Malaria and Tuberculosis. The EC and its ACP partners must maintain its significant contribution to the Fund through intra-ACP funding, and ensure that the limited resources in the IiP budget line are sufficient to also finance different programmes in other health sub-sectors.

Recommendation 6

European Parliament to identify benchmarks on health for discharge procedure

The annual discharge of the EU budget provides an important opportunity for the European Parliament to identify whether the EC is implementing the budget in accordance with set targets and commitments. The European Parliament should set clear benchmarks for 2007 and 2008 to measure the EC's progress towards achieving the 20% target for basic health and education by 2009.

Recommendation 7

EU Court of Auditors to report on achievement of targets and commitments

The binding targets related to health, which have been included in the EU budget since 2001, and the declaration adopted with the DCI on the realisation of the 20% target to basic health and education by 2009 provide a good opportunity for the European Court of Auditors to investigate in 2008 whether the EC is in compliance. In addition, the Court of Auditors should identify whether the EC's strategy on general and sectoral budget support is consistent with the targets it has set.

Recommendation 8

Ensure health does not lose out in times of increased GBS

In 2005, the EC and the EU Member States committed themselves to the *Paris Declaration on Aid Effectiveness*. In order to increase the effectiveness of its ODA spending, the EC intends to distribute 50% of its aid for 2007 - 2013 through general or sectoral budget support. The EC is also setting up incentive tranches for countries which perform well on current budget support.

- To ensure funding for health is reflected in the concept of budget support, the EC needs to include realistic, adequate and meaningful

indicators on human and social development, and particularly health, in its monitoring system, including in the governance instrument.

- Transport should be included in GBS.
- The EC must also demonstrate that health ministries in partner countries are consulted in the process of identification of priority areas for co-operation.
- The EC and EU Member States must further ensure that the statistical accounting methodologies on the purpose of aid remain credible and that conformity in donor reporting of statistical allocations in budget support is maintained.
- Budget support which is not allocated with a specific purpose cannot and should not be reported as a statistical allocation to the health sector.

Abbreviations

ACP	African, Caribbean and the Pacific Countries
AIDS	Acquired Immunodeficiency Syndrome
AU	African Union
CMH	Commission on Macroeconomics and Health
CRS	Creditor Reporting System
CSP	Country Strategy Paper / Programme
DAC	Development Assistance Committee
DCI	Development Co-operation Instrument
EC	European Commission / European Community
EDF	European Development Fund
ENPI	European Neighbourhood and Partnership Instrument
EPHA	European Public Health Alliance
EU	European Union
GBS	General Budget Support
GNP	Gross National Product
HIV	Human Immunodeficiency Virus
IiP	Investing in People
MDG	Millennium Development Goals
MSI	Marie Stopes International
OAU	Organisation of African Unity
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
TB	Tuberculosis
UK	United Kingdom
UN	United Nations
US	United States
WHO	World Health Organisation

Section 1

1. Article 30, ACP-EU Partnership Agreement (2000).
2. Regulation (EC) No. 1905/2006 of the European Parliament and of the Council of 18 December 2006 establishing a financing instrument for development co-operation
3. Article 12, Regulation (EC) No 1905/2006 of the European Parliament and of the Council of 18 December 2006 establishing a financing instrument for development co-operation.
4. EU Budget 2004.
5. Ibid.
6. EU Budget 2005.
7. EU Budget 2007.
8. Investing in People: Strategy Paper for the Thematic Programme 2007 – 2013.

Section 2

1. The commitments and disbursements to health by the EC can be analysed using the statistical data provided by the OECD/DAC. The analysis below is based on their statistical reports from 1996 – 2005. The following countries were the top ten recipients of gross EC ODA/OA (2004/2005 average): (1) Turkey; (2) Serbia and Montenegro; (3) Morocco; (4) Afghanistan; (5) Democratic Republic of Congo; (6) Egypt; (7) Palestinian Administered Areas; (8) India; (9) Mozambique; (10) Tanzania.
2. OECD/DAC figures (commitments) 1996 – 2005.
3. The rise in EC ODA to 'Health' in 2005 might be due to the fact that the ends of both the financial perspective and of EDF 9 were drawing near and there was increased pressure to commit ODA within the allotted timeframe.
4. Source: OECD/DAC Creditor Reporting System Database 2007.
5. Total ODA commitments to the DAC sector 'Population Policies / Programmes and Reproductive Health' have also remained low. In 1996, the EC allocated 0.15% to these combined sectors and EC ODA allocations to this sector remained at less than US\$ 150 million per year until 2004. In 2005, this figure decreased to 0.49%.
6. Regulation (EC) No. 1568/2003 of the European Parliament and of the Council of 15 July 2003.
7. Regulation (EC) No. 1567/2003 of the European Parliament and of the Council of 15 July 2003
8. Regulation (EC) No. 806/2004 of the European Parliament and of the Council of 21 April 2004.
9. Afghanistan, Bangladesh, Bhutan, Cambodia, East Timor, India, Indonesia, Laos, Malaysia, Maldives, Mongolia, Nepal, North Korea, Pakistan, Philippines, Sri Lanka, Thailand, Vietnam and Yemen.
10. Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo (Brazzaville), Democratic Republic of Congo, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Ivory Coast, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Somalia, South Africa, Sudan, Swaziland, Tanzania, Uganda and Zambia.
11. Antigua and Barbuda, Bahamas, Barbados, Belize, Dominica, Dominican Republic, Grenada, Guyana, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent, Suriname and Trinidad and Tobago.
12. Cook Islands, Fiji, Kiribati, Marshall Islands, Micronesia, Nauru, Nieu, Palau, Papua New Guinea, Samoa, Solomon Islands, Timor Leste, Tonga, Tuvalu, Vanuatu
13. Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay and Venezuela.
14. Algeria, Armenia, Azerbaijan, Belarus, Egypt, Georgia, Lebanon, Moldova, Morocco, Syria, Tunisia and Ukraine.

Section 3

1. The following draft DCI CSPs were analysed for this sub-section: Afghanistan, Argentina, Bangladesh, Brazil, Burma/Myanmar, Bhutan, Cambodia, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, India, Indonesia, Laos, Malaysia, Mexico, Mongolia, Nicaragua, Pakistan, Panama, Paraguay, Peru, The Philippines, Thailand, Uruguay, Venezuela, Vietnam and Yemen.
2. The following draft ENPI CSPs were analysed for this sub-section: Algeria, Armenia, Azerbaijan, Belarus, Georgia, Israel, Jordan, Lebanon, Moldova, Syria, Ukraine and Tunisia.

Section 4

1. Luxembourg did not report on any of its ODA commitments during the period 1996 – 2000. Ireland did not report on any of its ODA commitments during the period 1996 – 1999.

Section 5

1. US\$ at 2002 prices.
2. This calculation does not take into account the fact that the CMH estimation is based on US\$ at 2002 prices whereas the figures from the OECD/DAC Creditor Reporting System are in US\$ at 2004 prices.
3. The Global Fund, (2005), Addressing HIV/AIDS, Malaria and Tuberculosis: The Resource Needs of the Global Fund 2005 – 2007.
4. Includes pledges from the following Member States which joined the EU in 2004: Hungary, Slovenia and Poland.

Section 6

1. Source: OECD/DAC Creditor Reporting System Database 2007
2. Source: OECD/DAC CRS Aid activities in support of HIV/AIDS Database
3. These allocations are recorded in the DAC Sector 'Population Policies / Programmes and Reproductive Health'

