

Resource Flows for International Population Assistance and UNFPA

Background paper prepared for the
***Center for Global Development Working Group on UNFPA's
Leadership Transition***

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* The content of this paper is the responsibility of the author and may not represent the views of the Center for Global Development.

Foreword

In August 2010—three months before a new executive director of the United Nations Population Fund (UNFPA) was announced—CGD formed a Working Group to examine UNFPA’s evolving role in sexual and reproductive health, reproductive rights, and the integration of population dynamics into development. The recommendations from the Working Group on UNFPA’s Leadership Transition were based on consultative meetings, one-on-one interviews, expert-panel deliberation, and literature reviews. As the Working Group deliberated and considered “what’s next” for UNFPA, we invited a few scholars to provide background information to help inform our recommendations. In this paper, Lori Ashford provides information on the funding landscape for overall population assistance; offers data on UNFPA’s income and expenditures; and shows us where and how UNFPA spends its money. Lastly, she highlights opportunities and constraints in UNFPA’s funding going forward.

This paper is part of the larger Demographics and Development Initiative at CGD and a contribution to CGD’s Working Group Report on UNFPA’s Leadership Transition. The work is generously supported by a grant from the William and Flora Hewlett Foundation.

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Introduction

As a major player in the development of international population policy, the United Nations Population Fund (UNFPA) both influences and is influenced by resource flows for population activities. Part 1 of this paper describes the funding landscape for population assistance, using data collected by the Netherlands Interdisciplinary Demographic Institute (NIDI) and published by UNFPA. It describes trends in donor assistance as well as developing-country spending for population and reproductive health activities.

Part 2 presents information on UNFPA's income and expenditures since 2000, with a focus on the most recent country and program allocations (2009). All of the data presented is from published sources, including reports and websites, as cited. The interpretation throughout the paper is the author's own and includes observations made during Working Group discussions and interviews with key informants. UNFPA staff have not reviewed this paper.

Part 1: The Funding Landscape

The funding landscape for population activities shapes the work of UNFPA and all other agencies addressing population issues, whether globally or in developing countries. In keeping with its mandate to promote implementation of the 1994 International Conference on Population and Development (ICPD), UNFPA monitors and reports on resource allocations for population activities worldwide.

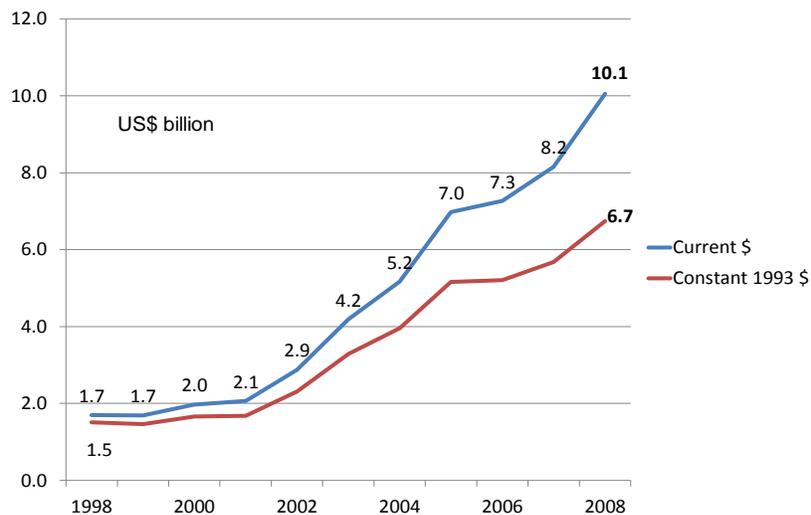
International Donor Assistance for Population

According to UNFPA's report, *Financial Resource Flows for Population Activities in 2008* (published in 2010), international donor assistance for population activities grew steadily in the last decade and surpassed \$10 billion for the first time in 2008.¹ For reporting purposes, UNFPA defines "population assistance" as donor funding for those activities in the "costed population package"—that is, resource targets agreed upon in the ICPD *Programme of Action*.

The ICPD costed package includes funds for family planning services, maternal health care, prevention and treatment of sexually transmitted infections (STIs) and HIV/AIDS, other reproductive health services (such as diagnosis and treatment of reproductive tract infections and information and counseling services), education and communication programs, training, and data collection, research, and policy analysis.²

In current dollars, international population assistance grew from \$1.7 billion in 1998 to \$10.1 billion in 2008 (Figure 1), representing 19 percent annual growth on average and almost a six-fold increase over 10 years. Even after adjusting for inflation, average growth over the decade 1998 to 2008 was 15 percent annually, representing a four-fold increase in constant dollars.³

Figure 1: International population assistance, 1998 – 2008



Note: Includes *grants* from country donors, the UN system, foundations, NGOs and development banks. If *loans* from development banks were added, the totals would range from \$2.1 billion in 1998 to \$10.4 billion in 2008.

Source: UNFPA, Financial Resource Flows for Population Activities in 2008 (2010).

In 2008, population assistance accounted for about 7.5 percent of official development assistance (ODA) grants, which also reached a high-water mark that year at \$120 billion.⁴ (Note: this total excludes loans; ODA with loans was estimated at \$158 billion in 2008.) Population, reproductive health, and HIV/AIDS together accounted for 39 percent of the \$26 billion in ODA for health in 2008.⁵

Methods: How population assistance is measured

Since 1997, UNFPA has contracted with NIDI, a research organization in the Netherlands, to collect data annually on international and domestic resource flows in developing countries. (Domestic spending in developing countries is discussed later in Part 1.) To collect data on donor assistance, NIDI sends detailed questionnaires to developed-country governments and nongovernmental organizations, and also obtains data from the Development Assistance Committee of the Organization for Economic Cooperation and Development (OECD).⁶

Beginning with the 1999 round of questionnaires, data collection has included HIV/AIDS treatment and care, not just HIV prevention as called for in the 1994 *Programme of Action*. It became clear by the late 1990s that HIV/AIDS prevention could not be tracked separately from AIDS treatment in donor budgets and programs; thus, UNFPA has included AIDS treatment as part of population assistance since that time.⁷ Reports on global population assistance before and after 1999 are therefore not comparable. UNFPA is a co-sponsor of UNAIDS and collaborates in tracking HIV/AIDS expenditures.

Who Provides Population Assistance?

Population assistance shown in Figure 1 is provided mainly by governments in wealthy countries. That is, they are the original, or primary, sources of funds. UNFPA/NIDI does not include intermediate organizations such as UN agencies and NGOs in this total to avoid double-counting the funds flowing to developing countries. Only a small percentage of population funding originates in multilateral organizations, and less than one-tenth comes from private foundations and NGOs (6 percent in 2008).

Of the \$10.1 billion provided in population assistance in 2008, about \$1.2 billion *passed through* multilateral agencies--mainly UN agencies because development banks are excluded from this analysis. **Among the multilateral agencies working in population, UNFPA is the largest. In 2008, when donors provided \$10.1 billion in population assistance, \$845 million passed through UNFPA – about 8 percent of total population assistance.** (UNFPA's income and expenditures are discussed in Part 2.)

Although the World Bank is a larger player in development, its loans are usually not categorized as population or reproductive health, per se. Rather, the loans are usually designed to support entire development sectors such as health, education, or the social sector. In these cases, the reproductive

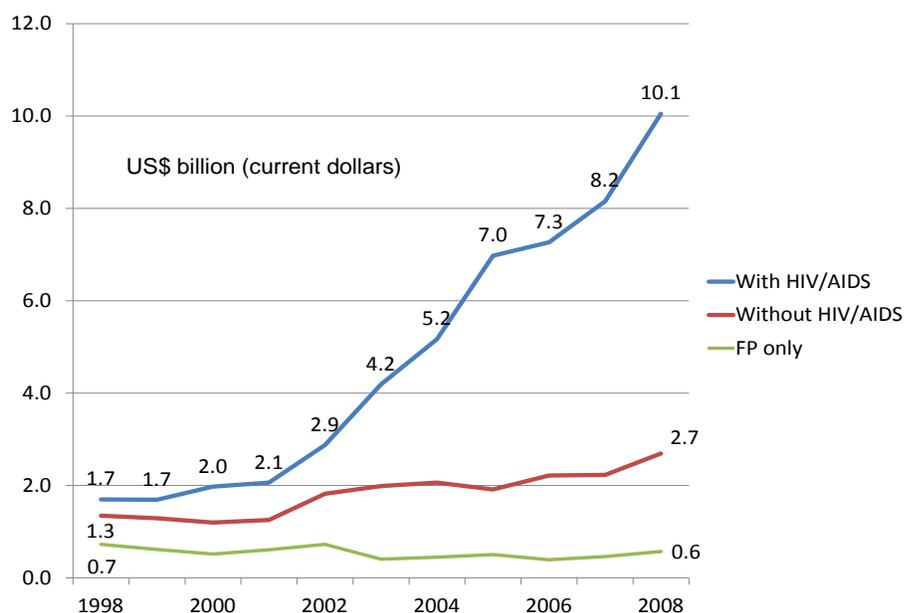
health component cannot be easily disaggregated, making it difficult to compare how much the Bank contributes to population and reproductive health relative to UNFPA and other donor agencies. UNFPA estimated that the World Bank (IDA + IBRD) provided \$354 million for population and reproductive health in 2008. If these loans were included in Figure 1, the population assistance total would be \$10.4 billion.

How much of the growth in population assistance is due to HIV/AIDS?

Most of the growth in international population assistance since 2000 has been due to increases in funding for HIV/AIDS programs, including prevention, treatment, and care. *AIDS treatment* – though not reported separately from prevention activities – is likely to account for the largest portion of the increase due to the high cost of antiretroviral drugs.

Figure 2 show trends in resource flows for population assistance with and without HIV/AIDS. Assistance for family planning, basic reproductive health, and research, data and policy activities has remained relatively flat over the last decade.⁸

Figure 2: Population assistance with and without HIV/AIDS, 1998 – 2008



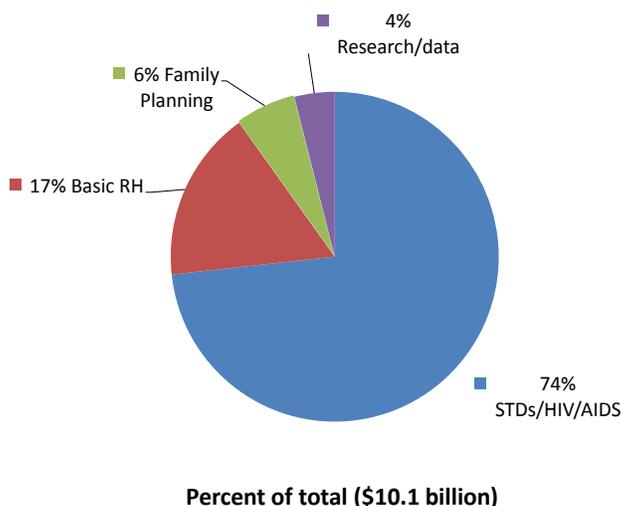
Source: UNFPA, Financial Resource Flows for Population Activities in 2008 (2010).

The third and lowest line in Figure 2 shows the family planning component of population assistance; it declined from \$723 million in 1998 to \$572 million in 2008.⁹

There have been dramatic shifts in the proportions of population assistance devoted to family planning and HIV/AIDS since the ICPD. In 1995, immediately post-ICPD, funding for STIs and HIV/AIDS made up

only 9 percent of international population assistance, but by 2008 it represented 74 percent of the total (Figure 3). The proportion of funding devoted to other components of population assistance correspondingly decreased. **Family planning decreased from 55 percent of international population assistance in 1995 to 6 percent in 2008.** Basic reproductive health services (including maternal health care) stayed relatively steady at 18 percent and 17 percent, respectively; while the data, research, and policy component declined from 18 percent in 1995 to 4 percent in 2008.

Figure 3: International population assistance by program category, 2008



Source: UNFPA, Financial Resource Flows for Population Activities in 2008 (2010).

A recent analysis by the Kaiser Family Foundation shows that HIV/AIDS has been a major driver of growth in health-related ODA since 2000. HIV/AIDS (including control of sexually transmitted diseases-STDs) accounted for \$8 billion, or almost one-third, of the \$26 billion in health ODA in 2008.¹⁰ HIV/AIDS programs also accounted for 38 percent of the total growth in health ODA from 2001-2008, while assistance for other reproductive health care accounted for 7 percent of the increase during that period.¹¹

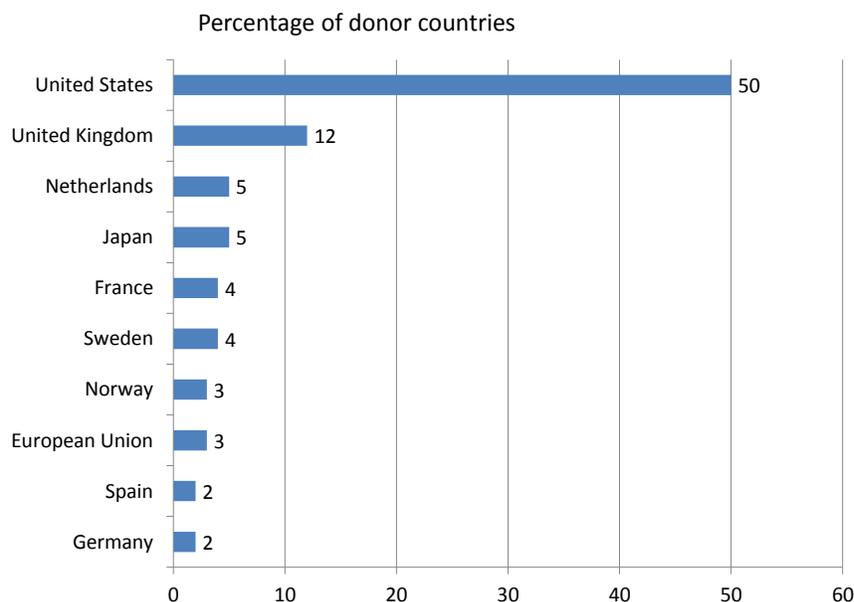
In another research article published in 2008, Jeremy Shiffman pointed out that donor prioritization of HIV/AIDS appears to have crowded out nearly all other areas of health care, including reproductive health.¹² **However, while the shift in relative shares has been dramatic, the size of the population—assistance pie grew tremendously—from \$1.7 billion in 1998 to \$10.1 billion in 2008, as shown in Figure 1. It is not possible to know whether the other areas of population and reproductive health, such as family planning, would have received greater funding in the last decade in the absence of HIV/AIDS.**¹³

Top Donor Countries Providing Population Assistance

Figure 4 shows the top donor countries providing population assistance, accounting for more than 90 percent (\$9.3 billion) of the funds provided for population-related activities in 2008. The U.S. accounts for half of all assistance provided by donor countries (50 percent of the \$9.3 billion). European donors provide most of the remaining assistance, with Japan at 5 percent. The U.S. is also the largest donor in all areas of development, accounting for about one-third of ODA in 2008.

Private donors and multilateral funds (self-generated, not from donor countries) make up the remainder of assistance—less than 10 percent of total grant assistance for population. The largest *private donor* is the Bill & Melinda Gates Foundation, which provided about \$445 million in 2008 – more than the small country donors shown in the figure.

Figure 4: Donor countries provided 90% of population assistance in 2008



Source: UNFPA, Financial Resource Flows for Population Activities in 2008 (2010).

Developing Country Spending for Population

Domestic spending in developing countries accounts for the largest portion of funds devoted to population and reproductive health. In 2008, developing-country spending was estimated at \$23 billion; thus donor assistance and developing-country spending *combined* totaled \$33 billion in 2008.¹⁴ However, the \$23 billion represents an extremely rough estimate and is far more likely to be *underestimated* than donor spending. (See next section, “Data Challenges.”)

Table 1 shows domestic spending for population-related activities by region in 2008. Huge variations in spending reflect differences in resource availability and capacity in these regions. The totals in Column 1

include consumers, governments and NGOs. Column 2 shows the percentage of domestic spending devoted to HIV/AIDS. The latter varies also greatly by region, with the highest in Eastern and Southern Europe and Sub-Saharan Africa, and the lowest in Asia and the Pacific.

Table 1: Domestic spending on population activities, by region, 2008

	Spending in US\$ billions	% spent on STD/HIV/AIDS
Asia and the Pacific	15.8	15%
Sub-Saharan Africa	3.0	79%
Latin America and Caribbean	2.5	80%
Western Asia and North Africa	1.0	22%
Eastern and Southern Europe	0.8	83%
Total	23.2	33%

Source: UNFPA, Financial Resource Flows for Population Activities in 2008 (2010).

Note: Figures shown are rough estimates. See discussion on “Data Challenges.”

Data Challenges: Measuring Developing Country Spending

Developing country estimates presented in the annual “Resource Flows” reports are derived from surveys that NIDI sends to in-country informants. These must be understood as crude estimates because national accounts do not usually separate reproductive health from the rest of health care. Many areas of health care typically share the same health personnel, facilities, management, etc., especially when health care is integrated.

In fact, many in-country informants have complained in response to the UNFPA/NIDI surveys that much of their spending on “population” activities is not captured because so many health programs are integrated. Because individual services cannot easily be disaggregated, spending on family planning and reproductive health often goes unrecorded. Thus, **the developing country data reported here should be considered an underestimate.**¹⁵ It is likely that far more than \$23 billion is spent on reproductive health in developing countries, but how much is unknown. There are no other organizations investigating resource allocations *worldwide* for reproductive health. Specific country estimates could be used to make generalizations about global spending, but precise numbers could not easily be generated given the diversity of countries and health care systems.

In spite of concerns about data quality and accuracy, NIDI compiles funding data from the survey responses it receives and develops estimates for developing country spending by region (shown in Table 1.) The \$23 billion estimate includes \$14 billion from consumers, \$8.6 billion from governments, and \$0.4 billion from NGOs. These breakdowns are assumptions based on what is known about health care spending overall in developing countries.

In its 2008 *Financial Resource Flows* report, UNFPA explains that: “Country case studies were conducted as part of the Resource Flows project to supplement the mail survey. **Despite intensive follow-up, it was becoming increasingly difficult to track progress of developing countries towards achieving the ICPD**

financial targets.”¹⁶ Reasons include: funding, staffing and time constraints in developing country governments; weak health information systems; inability to disaggregate funding that is pooled in integrated social and health projects and sector-wide approaches; and difficulty obtaining sub-national data in decentralized accounting systems. Thus, the developing country survey now focuses only on a core group of countries, which are selected based on population size and regional representation.

Spending Relative to Need for Population and Reproductive Health

UNFPA estimates the “need” for population and reproductive health funding based on a model that uses Demographic and Health Survey data on reproductive health status (such as fertility and maternal mortality) and the use of reproductive health services (contraceptive, prenatal, delivery, postnatal, and other reproductive health services). Estimated resource needs are close to \$70 billion annually in 2015, and **\$65 billion in 2010 – or about double the level of spending in 2008 from international and domestic sources.**^{17,18,19}

Thus, if all unmet need for family planning and reproductive health services were met, including HIV/AIDS, international donor assistance would have to more than double to make up one-third of resources, as called for in the ICPD *Programme of Action*.

Should UNFPA continue to track financial resource flows for population?

Data collection and analysis on resource flows for population activities—particularly domestic spending and resource needs in developing countries—is usually accompanied by lengthy disclaimers about data availability and data quality. Aside from challenges related to weak reporting systems in developing countries, in an era of sector-wide approaches in health, it is increasingly difficult to separate population and health from all other areas of health spending. (Donor spending, on the other hand, is more easily accounted for: it originates in organizations with stronger reporting systems and is collected and analyzed by a number of independent groups that monitor official development assistance.)

Persistent problems with data collection and analysis, along with the “aging” of the ICPD agenda, call into question whether UNFPA and NIDI should continue devoting the time and expense to gather data and report on the ICPD resource targets. On the positive side, UNFPA is making a major contribution to the population field because no other entity is tracking activity worldwide related to reproductive health. Moreover, because the Millennium Development Goals do not focus on either population or reproductive health, UNFPA makes a unique contribution within the UN system: It “keeps the reproductive health agenda alive” by highlighting resources flows for reproductive health and population. Donor agencies and NGOs working in reproductive health depend a great deal on UNFPA’s reports on financial resource flows and funding targets to raise awareness and garner funds from their constituents. On the negative side, audiences receiving and using this data are—and should be—skeptical about the quality of the data.

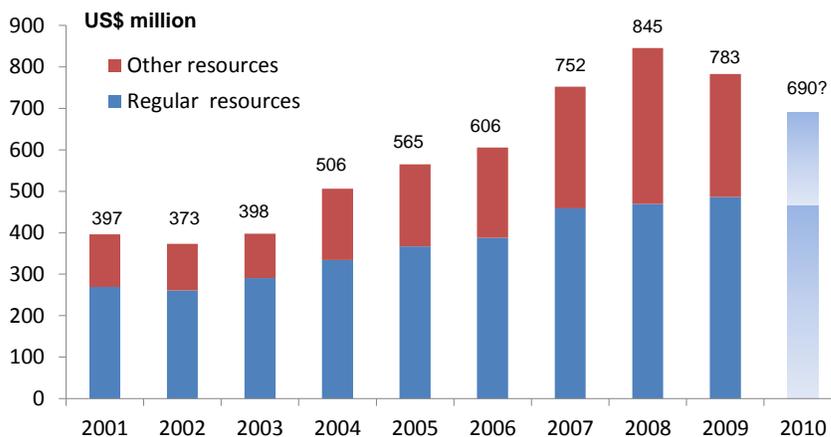
Part 2: UNFPA’s Income and Expenditures

UNFPA’s annual reports and reports to its Executive Board are available on the website and provide detailed information about the organization’s sources of funds (amounts contributed, by donor) and expenditures by region and country. In addition, the annual reports and website provide much descriptive information about UNFPA’s programs. However, individual project expenditures are harder to extract, and expenditures by line item, such as salaries, travel, commodities and supplies, do not appear to be publicly available. The data presented here have been gathered from UNFPA’s public documents.

UNFPA’s Income

UNFPA’s income reached the highest point in the organization’s history in 2008, at \$845 million (regular and other resources combined—see Figure 5). Funding dipped in 2009 to \$783 million due to the economic recession, and it is not clear when contributions will return to the higher levels. Until 2009, UNFPA’s income had risen steadily during the 2000s, especially because of increased contributions from European donors. UNFPA’s “other” contributions, in particular, which are earmarked for specific initiatives, increased substantially from 2003 to 2008.

Figure 5: UNFPA Income, 2001-2010



Regular resources = Unrestricted ; Other = earmarked, co-financed projects
 Source: UNFPA annual reports

Notes: Regular resources, also called core resources, comprise mostly government contributions and provide flexible support for UNFPA programs. They are also used for program administration and management. Income from other resources is earmarked for specific activities and encompasses trust funds, cost-sharing program arrangements and other restricted funds. 2010 data are provisional. Figures are in current US dollars.

In terms of the number of countries contributing to UNFPA, 2007 was a high point, with 182 donor countries and 100 percent of African countries pledging funds to UNFPA—before the financial crisis hit. Many of these pledges were small dollar amounts, but they represented widespread, symbolic support. For example, Morocco, Viet Nam, and Afghanistan pledged (and paid) US \$10,000, \$4,000 and \$500, respectively, in 2007.²⁰

Many of the interviews conducted for the Working Group revealed that the cutoff in U.S. funding, which was a political decision related to the Chinese government’s support for abortion, had the unintended consequence of helping UNFPA raise funds from other donors. European donors rallied around UNFPA during the Bush administration, from 2001 to 2008, and nearly all developing countries pledged funds to UNFPA. Although UNFPA’s total income dropped from 2008 to 2009, regular income increased slightly in 2009, in part because the U.S. restored funding with a \$46 million contribution during the first year of the Obama administration.

For 2010, Thoraya Obaid reported estimated income of \$690 million to the Executive Board (the actual will not be available until early 2011). Her report stated that that the forecast included drops in funding from six donors in the range of 6 percent to 20 percent.²¹ Based on her comments and the budget deficits that many donor countries are experiencing, it is not likely that UNFPA’s income in 2011 will rebound. The increases seen during the 2000s possibly cannot be sustained because European donors are cutting budgets or identifying other priorities. The United States could also drop out again as a donor because of political changes following the 2010 elections.

UNFPA’s Major Donors

In 2009, 85 percent of UNFPA’s *regular* resource income came from the top 10 donors (see Table 2); 39 percent of those resources came from the top three donors. About 70 percent of *other* resource income came from the top 10 donors. Donors to “other” resources – the restricted resources - include governments as well as institutions, such as UNDP, Humanitarian Affairs Office of the UN, UNICEF, UNAIDS, and WHO, that are funding projects through UNFPA. UNFPA stands out as having possibly more donors than any UN agency. However, it reported in 2009 that only 19 donors committed more than \$1 million.²²

**Table 2: Top donors to UNFPA’s regular and other resources, 2009
(in \$ millions)**

Regular (Core) Contributions		Other (Earmarked) Contributions	
Netherlands	80.9	Netherlands	54.0
Sweden	59.0	UNDP	43.3
Norway	48.0	Spain	29.6
USA	46.1	UK	23.7
Denmark	39.5	OCHA	9.8
UK	34.5	Sweden	9.6
Japan	30.1	Australia	9.4
Finland	27.9	EC	8.9
Germany	25.3	Norway	8.9
Spain	20.7	Luxembourg	7.0

Notes:

- Other contributions: payments received for trust funds and co-financed projects
- UNDP: includes funds received through multi-donor trust funds and join programs
- OCHA: includes funds received through the Central Emergency Response Fund
- Contributions varied in US\$ at the time they were received

Source: UNFPA, *Annual Report 2008 (2009)*.

UNFPA as an Intermediary Organization

UNFPA is a relatively small UN agency that depends on donors, international partners, and implementing organizations in the field to carry out its objectives. It is neither a primary donor nor an end-recipient of population funds; rather, it is an intermediary organization that facilitates a wide range of activities worldwide in collaboration with numerous partners. Like many UN agencies, both its donors and recipients are predominantly government agencies.

On the donor side, UNFPA does not have assessed contributions; it receives voluntary contributions that vary from year to year, although there are some multi-year commitments. UNFPA receives at least 90 percent of its income from more than 100 national governments, a small amount from other international organizations, and less than 10 percent from private foundations. **UNFPA’s Executive Director has wide fundraising latitude but little control over the amount of funds that will be received in a given year.**

At the international level, UNFPA collaborates with a large number of organizations working in the population field and in health and development more broadly. Collaborating agencies in the population field include the International Planned Parenthood Federation (its largest NGO counterpart), other international NGOs such as Pathfinder and Ipas, as well as a large number of UN agencies —UNDP, UNICEF, WHO, UNPD, UNAIDS, UNIFEM, the UN Secretariat’s Humanitarian Affairs office, and the World Bank—depending on the policy issue or project. This is only a partial list of partners: UNFPA reported carrying out **221 joint programs** with other UN organizations in 2009.²³

On the receiving end, **about 90 percent UNFPA’s funds were channeled to government entities in 2009**; about 10 percent were provided to NGOs as implementing agencies.²⁴ The in-country partners vary a great deal in terms of capacity, creating myriad management and evaluation challenges.

Accountability—both for financial resources and program results—has been a major concern.

Problems related to accountability can be traced to many factors, including the complexity of reporting requirements and weak capacity in UNFPA’s field offices and among its implementing partners.

UNFPA is committed to having countries determine their priorities in population and reproductive health. As Thoraya Obaid noted in her final report to the Executive Board on August 30, 2010, “UNFPA is a relatively small organization and has depended on its national partners, governmental and non-governmental, to deliver its programs. UNFPA recognized early on the criticality of national ownership and adopted national execution as its preferred implementation modality. We are aware that this approach has its own challenges, especially in terms of the capacity of our partners and its impact on accountability.”²⁵

UNFPA Personnel

Relatively little public information is available about UNFPA’s personnel. UNFPA reported that in 2009, the number of budget posts totaled 1,119, about half of which were professional and half general service (support) staff. The total includes 286 positions at headquarters (25 percent); three positions in Geneva; and 830 positions in the field (close to 75 percent).²⁶

The percentage of women among professional staff worldwide was 45 percent in 2009, reportedly one of the highest percentages among UN agencies. Moreover, in 2009, 10 of the 20 members of the Executive Committee were women.²⁷

The number of staff positions worldwide appears to have changed little over the years. In 2000, UNFPA reported it had 1,018 posts, 76 percent of which were located in the field.²⁸ It is not clear why the number of posts would remain constant over the decade 2000-2009 while income rose substantially. More information would be needed about these positions and other categories of employees to determine how the staff are deployed according to country and program priorities.

Recipients of UNFPA Funds in 2009

UNFPA country allocations are based on an index related to country progress. The highest priority countries (“A” countries) are those that have made the *least* progress in achieving ICPD goals, namely reducing unmet need for family planning, lowering fertility, and reducing maternal and infant mortality. These countries are mainly in sub-Saharan Africa and South Asia. In 2009, UNFPA worked in 155 countries and territories—almost one-third of which were in sub-Saharan Africa. The top ten countries receiving UNFPA assistance were all in Sub-Saharan Africa, except for India, which was the sixth largest that year (see Table 3).

**Table 3. Top 10 recipients of UNFPA funds, 2009
(in \$ millions)**

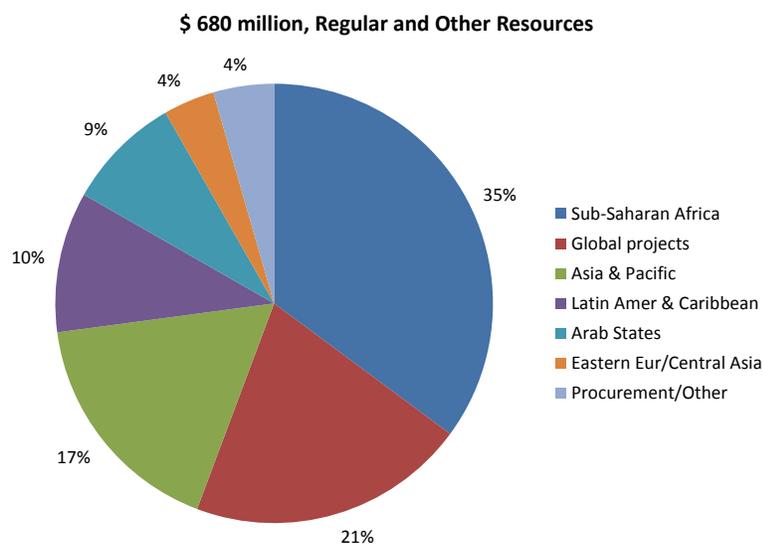
Sudan	19.9
Ethiopia	16.4
DR Congo	16.3
Mozambique	13.2
Zimbabwe	12.7
India	12.3
Uganda	12.0
Nigeria	10.5
Chad	10.2
Cote d'Ivoire	9.5

Source: UNFPA Annual Report 2009 (2010).

UNFPA Expenditures by Region

According to its annual report, UNFPA project expenditures were \$680 million in 2009, from both regular and other resources. The region receiving the largest share of funds was sub-Saharan Africa (35 percent of project expenditures), followed by Asia and the Pacific, Latin America and the Caribbean, Arab States, and Eastern Europe/Central Asia (see Figure 6). In addition, 21 percent of expenditures were for global projects and 4 percent for procurement and other programs at the global level, such as fellowships.

Figure 6: UNFPA spending by region, 2009



Source: UNFPA Annual Report 2009

UNFPA's Strategic Plan: Guiding Document for Expenditures

UNFPA's strategic plan 2008-2011 (recently extended to 2013) establishes a development results framework that is intended to guide the organization's programs, management, and evaluation. The strategic plan identifies three goals and 13 outcomes within these goals.²⁹ The three goals, or focus areas, that are core to the agency's mission are stated in the plan as follows:

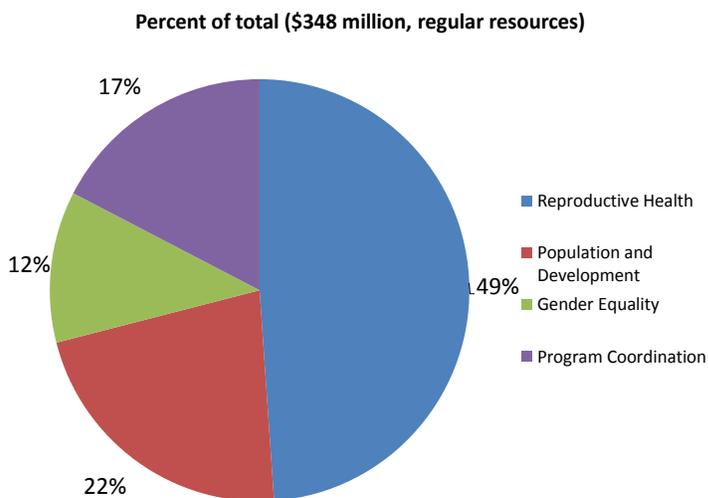
- **Population and Development:** Systematic use of population dynamics analyses to guide increased investments in gender equality, youth development, reproductive health and HIV/AIDS for improved quality of life and sustainable development and poverty reduction.
- **Reproductive Health and Rights:** Universal access to reproductive health by 2015 and universal access to comprehensive HIV prevention by 2010 for improved quality of life.
- **Gender equality:** Gender equality advanced and women and adolescent girls empowered to exercise their human rights, particularly their reproductive rights, and live free of discrimination and violence.

UNFPA's strategic plan does not mention access to abortion services. The plan is consistent with the ICPD Program of Action in that it promotes family planning and maternal health services in the context of preventing recourse to unsafe abortion.

UNFPA Spending by Program Area

UNFPA's 2009 program expenditures (Figure 7) reflect the three areas defined in its 2008-2011 strategic plan. Expenditures of regular resources also include "program coordination," which is assumed to be program management and administration.

Figure 7: UNFPA spending by program area, 2009



Source: UNFPA, Report of the Executive Director, Statistical and Financial Review, 2009

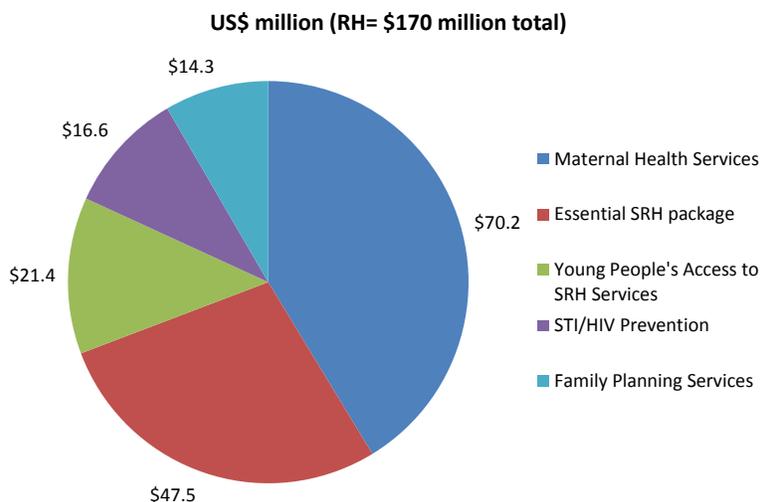
Program expenditures are also available, but not shown here, for other resources—trust funds and co-financed projects. In 2009, 75 percent of other resources were categorized as reproductive health; the remainder was for the other two program categories.³⁰ There is no separate program coordination (management and administrative support) category in “other resources,” presumably because these are funds earmarked for specific programs. Within the program categories, UNFPA reports spending by strategic plan outcome – consistent with its results framework – rather than by project type.

UNFPA Spending by Strategic Plan Outcome

Reproductive health expenditures shown in Figure 7 can be broken down further by UNFPA’s strategic plan outcomes (see Figure 8). The largest category of reproductive health—and largest subcategory of all regular resources—is maternal health services, followed by integrated sexual and reproductive health (SRH) services; young people’s access to SRH services, STI/HIV services, and family planning services.³¹

In viewing these data it is important to note that UNFPA does not *provide* reproductive health, maternal health, or family planning services *per se*. Rather, its role is to *facilitate access* to improved services through advocacy and policy work, framework setting and related activities, procurement of supplies, training of health professionals, and other types of support.

Figure 8: Reproductive health spending at UNFPA by strategic plan outcome, 2009



Note: Reproductive health spending accounts for 49% of regular resources (\$348 million).

Source: UNFPA, Report of the Executive Director, Statistical and Financial Review, 2009

UNFPA’s financial and statistical review for 2009 categorized reproductive health expenditures as follows (also shown in Figure 8):³²

- Increased access to and use of maternal health services: \$70.2 million (20 percent of regular resources);
- Promoting an essential package of sexual and reproductive health (SRH) services and integrating into development policies: \$47.5 million (13 percent of regular resources);
- Improving young people’s access to SRH services, including HIV and gender-based violence (GBV) prevention \$21.4 million (6 percent of regular resources);
- Increased demand, access and use of HIV and STI prevention services: \$16.6 million (4.8 percent of regular resources); and
- Increased access to and use of voluntary family planning services: \$14.3 million (4.1 percent of regular resources).³³

Why Is so Little Spent on Family Planning?

UNFPA’s reports often stress the need for reinvigorating family planning programs (especially in sub-Saharan Africa, where unmet need for contraception is high) to fully achieve ICPD goals. Yet few program resources appear to be devoted to family planning. The Fund’s annual reports, financial reports to the Executive Board, and Resource Flows reports do not explain why this is so.

Several related factors may explain why family planning accounts for such a small slice of the population and reproductive health pie, in spite of the fact that it was central to the UNFPA’s original mission:

- In promoting the ICPD agenda, UNFPA has encouraged countries to include family planning as part of broader reproductive health services, which now receive the bulk of its support.
- Health services are more integrated now following decades of health sector reforms and sector-wide approaches by the World Bank (supported by bilateral donor agencies).
- Fewer donors and developing country governments support vertical family planning programs with separate facilities and personnel. Stand-alone family planning services are now relatively rare in developing countries.
- Family planning services may still be offered at the same level but are missing from reports because they are not accounted for separately. Contraceptive commodities, especially condoms, may be reported as “sexual and reproductive health” expenditures.

Also, family planning is cheap, especially when compared with services like maternal health, which requires well equipped health facilities for emergency deliveries and medically trained birth attendants. Family planning is often referred to as a “best buy”—it is one of the most inexpensive *and* cost-effective of all health interventions.

Many of these issues are related to *tracking* and *costs*, not policy decisions or program emphasis. The data do not reveal the degree to which family planning is promoted in health services, or whether health providers are trained to counsel women on family planning when providing other SRH services.

However, policy and program emphasis is a major concern among Working Group members and informants interviewed for this project. There is a strong perception that family planning has been

deemphasized in the years following the ICPD; that HIV/AIDS has eclipsed family planning as a major health concern, especially in sub-Saharan Africa; and that family planning services have suffered as a result. UNFPA's expenditure data reinforce these concerns, but should be viewed with the caveats above.

UNFPA Trust Funds

UNFPA's strategic plan 2008-2011 called for the formation of several major thematic funds to advance the ICPD agenda. (Trust funds had existed previously—the “thematic funds” appear in UNFPA's more recent reports.) UNFPA reported in 2009 that its trust funds make up most of its “other resources” – earmarked resources. However, these funds are not itemized as budget line items in the annual reports or financial reports to the Executive Board. Without additional data, it is difficult to rank the trust funds by size or funding level.

Four major trust funds are prominent in UNFPA's reports and press releases:

- The **Maternal Health Thematic Fund** was established in 2008 and is carried out in collaboration with the World Health Organization, Columbia University, UNICEF, and the International College of Midwives. Its goal is to accelerate action on reducing maternal mortality in 60 countries. The project began in about a dozen countries and is still growing.
- The **Campaign to End Fistula** is managed in collaboration with UNICEF. The trust fund quadrupled in size from 2003 to 2008 and is now providing assistance in 45 countries to raise awareness about obstetric fistula and build the capacity of facilities and health providers to address the condition.
- The trust fund on **Female Genital Mutilation/Cutting** works in 12 countries in collaboration with UNICEF. The trust fund's latest report is titled “The End is in Sight.”
- The **Reproductive Health Commodity Trust Fund** is part of a global initiative to enhance commodity security in developing countries. It includes technical assistance, an international working group (Reproductive Health Supplies Coalition), and a revolving fund for procuring contraceptive commodities (including male and female condoms for HIV prevention). It also includes reproductive health kits for emergency situations (clean delivery kits). The revolving fund is also known as the Contraceptive Commodity Program.

Other Recent Initiatives

As part of global efforts to advance MDG 5- to reduce maternal mortality – UNFPA works with the so-called “**Health Four Group**” (**H4**), consisting of WHO, UNICEF, UNFPA and the World Bank. These organizations have concentrated their resources in the countries with the highest maternal mortality rates to strengthen their health systems to provide a full range of maternal health services, from family planning to emergency obstetric care.³⁴

UNFPA's **Census Initiative** aims to build the capacities of national statistical offices to carry out the 2010 round of national population and housing censuses. The initiative provided funds support to 77 countries in 2009. UNFPA is unique in supporting such countries as Sudan and North Korea in conducting censuses.

UNFPA is taking part in the UN's "**Delivering as One**" Initiative, now being piloted in a handful of countries. (Thoraya Obaid has actively supported this initiative.) If fully implemented, UN One would consolidate all UN country programs under one roof, with one budget, management plan, and country leader. Its aim is to increase the coherence of UN assistance and reduce the transactions costs associated with a large number of agencies working with local counterparts. Though still at an early stage, the initiative has major implications for how UNFPA country offices will collaborate with other agencies and allocate funds in the future. It particularly raises questions about how outcomes in recipient countries will be measured and attributed to UNFPA.

UNFPA's Resources: Opportunities and Constraints

UNFPA's financial resources and program allocations present a picture of both opportunities and constraints for the new executive director. The trends reviewed in this paper point to several unique opportunities that the new director can seize:

1. UNFPA has seen **remarkable growth in its income** in the last decade, which has enabled it to expand its programs in all three of its core areas –population, reproductive health, and gender. UNFPA is now managing the highest level of resources and greatest diversity of projects in the organization's history.
2. Its regular, **discretionary resources make up about 60 percent** of the organization's funds. These funds give management a great deal of flexibility in deciding program priorities and allocating resources.
3. **UNFPA's donors do not micromanage** its policies and operations. Decision documents and financial statements submitted to and approved by the board appear to move forward without a great deal of in-depth discussion. Donors that are not represented on the board have even less detailed information at their disposal to oversee UNFPA's programs and results. (The Working Group has commissioned a separate paper about influences on UNFPA's decision-making process.)

Thus, UNFPA's director has relatively wide latitude to determine the organization's directions and allocate resources. On the other hand, the Thoraya Obaid's last statement to the Executive Board (in August 2010) presented a frank assessment of challenges and constraints that her predecessor must address.³⁵

1. **As funding has grown, the organization's commitments have grown.** The director reported that it cannot meet all of the demands in the field for the many types of assistance it offers. Moreover, if contributions in 2011-2012 are well below 2008 levels, the organization will be hard pressed to meet these demands. Some tough decisions will have to be made about priorities.

2. **Most donor commitments are single-year and unpredictable**, creating a barrier to future planning. It is quite possible that with the global recession and political changes in the U.S., some European donors may reduce their contributions and others, such as the U.S. and many smaller countries, could drop out entirely as donors.
3. **Financial management is weak in the country offices and among implementing partners.** The UN Board of Auditors issued a qualification with respect to national expenditure in UNFPA's 2008-2009 financial statement, which must be addressed in the next year. The qualification was related to weak financial controls and reporting in the field offices. As the ED noted in her statement, "This qualified audit is a reflection of the need to further develop the capacity of both our offices and our national partners to achieve the required accountability results." The implementing and oversight agencies in the field are usually government ministries. In the poorest countries where UNFPA commits most of its resources (such as Sudan, DR Congo, and Ethiopia), government accounting systems are extremely weak.
4. UNFPA has **high transaction costs** associated with its activities. Many complex reporting processes have been created entirely by UNFPA (in connection with its results framework); other challenges stem from parallel reporting requirements of the UN and bilateral donors. UNFPA is managing hundreds of projects in more than 150 countries, each with its own reporting requirements. In turn, the recipient organizations must report not only to UNFPA but to all of its other funders, both bilateral and multilateral. The parallel reporting and evaluation requirements have become burdensome for everyone involved in UNFPA projects.

Several informants and Working Group members discussed the problem of attribution in evaluating results. This is not a funding problem per se, but the increased pooling of resources and coordination of assistance – which is viewed as positive -- will make it extremely hard to justify future funding requests to donors that are looking for results.

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