Why is Funding for Population Activities Declining?

Only by putting women and their reproductive freedom at the centre of development will we see true progress in alleviating the plight of poverty and win back donor support.

By Steven W. Sinding*

The sexual and reproductive health community heralded the International Conference on Population and Development (ICPD) held in 1994 at Cairo as a new dawn in reproductive rights. ICPD saw a seismic shift in the way we look at reproductive health, away from the narrow confines of family planning and demographic targets to the broader areas of women's empowerment and young people's reproductive health needs. Most importantly, ICPD strengthened the concepts of "rights" and "choice" as the backbone of reproductive health. But many of the declarations hailed at the time remain just that – declarations. Many of

* Director-General, International Planned Parenthood Federation (IPPF), e-mail: info@ippf.org.

the positive changes mooted at the Conference have not been implemented. No doubt this is partly owing to a lack of political resolve – particularly around sensitive issues of young people's sexual rights and abortion – but also, crucially, a lack of financial will.

It seems that population and development issues are losing ground against new and competing priorities. Why is this happening and how can we in the development community convince donors of the value of the ICPD agenda and help win back their support?

Are donors delivering?

Popular support affects the monies allocated to any policy area and, as purses have been tightened across the globe and budgets tailored to political ends, so the Cairo goals have begun to slip from the global agenda.

Let us begin with the positive news; in 2002 the world's wealthiest countries made more progress towards their ICPD goals than in the previous two years. Nordic countries are consistent voices in the battle for better reproductive health, as are Canada, the Netherlands and the United Kingdom of Great Britain and Northern Ireland. The European Commission is an increasingly important channel for development aid from European Union member States, not only in terms of funding but also political leadership.

But this progress is not consistent − some failed to deliver even a tiny fraction of their share. A number of donors have made commitments to make development aid proportional to their economies. Five countries, Belgium, France, Ireland, Spain and the United Kingdom, have pledged to provide 0.7 per cent of gross national income before 2015. But Japan and the United States of America, the world's two largest economies, remain far from the 0.7 per cent goal.

In short, donor countries would have had to triple their population assistance to meet the funding goal for 2005 agreed at ICPD.

Moreover, the target of allocating 4 per cent of official development assistance (ODA) to population programmes has not yet been achieved, with the current share resting at 2.46 per cent of ODA. Add to this the fact that ODA itself has remained stagnant for more than a decade and there is reason for real concern about fulfilling the ICPD agenda.

While the average of GNP given in official aid is 0.39 per cent across all 22 Organisation for Economic Cooperation and Development (OECD) donors, there

are differences between countries. The average for EU countries is 0.33 per cent, while for six of the Group of Seven countries (Canada, France, Germany, Italy, the United Kingdom, Japan and the United States of America) it is 0.19 per cent. Germany gives 0.27 per cent. Only four countries, Denmark, the Netherlands, Norway and Sweden, have consistently met or exceeded the goal of 0.7 per cent of GNP allocated to ODA.

Competition for Funds

We find ourselves competing for funds from dwindling reserves of development aid. Competition comes from three main areas.

1. Sector-wide approaches and health sector reform

Despite the fact that high fertility, in particular, unwanted fertility, is known to contribute to high morbidity and mortality rates among infants, women and children, many Governments downplay the priority of preventative health services and look instead to secondary and tertiary health services in high-cost facilities. Preventative and promotive services, such as those at the centre of the sexual and reproductive health agenda, often end up with little or no funding at all.

2. HIV/AIDS

An analysis of the breakdown of spending within the health sector confirms that family planning is losing ground to HIV/AIDS when it comes to funding. During the last 10 years, spending on HIV/AIDS has increased by 300 per cent, while the proportion spent on family planning has actually decreased in the last couple of years.

3. Millennium Development Goals

In 2000, the United Nations Millennium Summit gathered 189 Member States to adopt a Declaration and an ambitious set of eight goals, the Millennium Development Goals (MDGs). The overarching goal is to halve the level of poverty by 2015. While the MDGs represent a step forward in highlighting the plight of the poor, unfortunately they are silent on a number of goals and objectives of ICPD, in particular, its core goal of universal access to reproductive health services by 2015.

The MDGs are now providing the framework both for donors to allocate resources and Governments to determine their priorities at the national level. This makes it of paramount importance that the reproductive health and rights community *demonstrates* the impact of our work on poverty alleviation and also

shows how our efforts are succeeding in reducing maternal mortality, infant mortality and new cases of HIV/AIDS. I firmly believe that fulfilment of the Cairo goals is fundamental to the MDGs, and without reproductive freedom, a significant reduction of poverty is not possible.

The donor community's increasing attachment to MDGs can be problematic. In theory the goals related to maternal heath, HIV and gender equality should reinforce donor support for reproductive health care: but do they?

Some aid agencies and charities think not; they feel frustrated at the omission of reproductive health and rights from the plans for halving poverty. Since the adoption of the Millennium Development Goals, we have been working actively to demonstrate that without the active promotion of reproductive health and rights, poverty will continue to grow. But more needs to be done. This is why we will call for the adoption of a *universal access* indicator that can be used to hold Governments accountable for their progress, or lack of progress, on sexual and reproductive health and rights.

Our advocacy has already had some success, as seen in the inclusion of much of what we seek in the new Millennium Project report, *Investing in Development: a Practical Plan to Achieve the Millennium Development Goals*. This report, which will form the basis for the deliberations at the MDG Summit in September 2005, includes strong statements on sexual and reproductive health and rights, including both targets and indicators. We welcome this step forward and are prepared to strongly defend the robust language on sexual and reproductive health from attacks that we anticipate from various Member States, the Holy See and conservative non-governmental organizations.

Only by putting women and their reproductive freedom at the centre of development will we see true progress in alleviating the plight of poverty and win back donor support.

Ideology and its influences on donor support

A shortfall in funding is not the only threat to reproductive health care; ideological constraints pose a more insidious risk and influence donors' attitudes. As George W. Bush begins his second term as President of the United States of America, we are going to have to fight hard for sexual and reproductive health care which is firmly grounded in science, not ideology.

The Government of the United States made its intentions clear from the outset. One of the Government's first acts in January 2001 was to reimpose the

Mexico City Policy, more commonly known as the "Global Gag Rule". Under the Rule, no United States family planning assistance can be provided to foreign NGOs that use funding from any source to perform abortions, provide counselling or referral for abortion, or to lobby to make abortion legal or more available in their country.

When an NGO refuses to accept the Gag Rule it loses much more than funding: contraceptive supplies, technical support, partnerships and valuable contacts are also forfeit. The International Planned Parenthood Federation (IPPF) has witnessed the effects at first hand-closed clinics, community outreach programmes slashed, family planning scaled back and, inevitably, many more unsafe abortions.

HIV/AIDS assistance from the United States is subject to similarly punitive controls. So restrictive in fact, that they sever the obvious links between HIV activities and basic reproductive health services. The irony is that HIV is predominantly spread through sex: thus an essential tool to contain the virus remains basic contraceptive and family planning programmes.

To date, most United States support for HIV/AIDS has focused on prevention, most of which must conform to the ABC model, but with the emphasis firmly on A (Abstinence) and B (Be faithful), and C (Condoms) only deemed appropriate for certain designated "high-risk" groups. It also favours faith-based organizations promoting the kind of abstinence-only programmes that frustrates the more effective comprehensive prevention strategies.

A recent Human Rights Watch report provides an example of how abstinence- only programming can jeopardize an otherwise successful fight against HIV/AIDS. In Uganda, the report documents how United States-funded abstinence-only programmes are denying young people information about any method of HIV prevention other than sexual abstinence until marriage. Now Uganda is removing condoms from its HIV/AIDS strategy and Human Rights Watch fears that this triumph of ideology over fact-based public health strategy could be fatal. Of course, delaying sexual debut is a healthy choice for young people but they have the right to know that there are other effective means of prevention. We believe that abstinence messages should complement other HIV prevention strategies and not undermine them.

My hope is that donor countries resist efforts to impose a particular morality on individuals. Forty years of experience in family planning and reproductive

health have shown us that empowering individuals to make informed choices is the only approach that really works.

Conclusion

In the face of competing demands for funding and ideological threats to reproductive health, what should be our response? Since the 1970s we have seen great progress in the history of family planning – it is one of the great success stories of development history – and enormous strides in girls' education and women's reproductive rights. I believe that if the sexual and reproductive health community pulls together, if reproductive health and AIDS organizations integrate their work, if we work together to prove the critical link between ICPD goals and fighting poverty, then and only then will we see donors re-committing to funding reproductive health. If not, we risk losing those hard-won gains.

References

Progress and Promises. Trends in International Assistance for Reproductive Health and Population. PAI, 2004.

Dailard (2003). *CHANGE*, 2004.

"The Less They Know, the Better: Abstinence-Only HIV/AIDS Programs in Uganda". *Human Rights Watch*, 30 March 2005.