Annex 2

Methodology

The Muskoka Methodology relies on data from the OECD's Creditor Reporting System (CRS). It applies percentages to funding reported to the OECD under certain purpose codes or to selected multilateral organisations. The percentages applied vary depending on the intended target group of the respective donor activity. Activities targeting entirely or mostly women of reproductive age and/or children under five are assigned 100%; activities targeting the general population are counted at 40%. Disease-specific interventions are attributed at 18.5% for tuberculosis, 46.1% for HIV & AIDS and 88.5% for malaria. Basic drinking water supply and sanitation is counted at 15%.[1] Originally developed in order to track the G8 Muskoka pledges to MNCH, it is still a widely credible tracking methodology, used by the PMNCH in its Accountability Reports.[2] Efforts to update it, in order to better track the 'Adolescent' component of the RMNCAH concept, are still ongoing.

Furthermore, in this Euromapping, donors' commitments and disbursements to FP were analysed using a revised version of the Muskoka Methodology, developed during London Family Planning Summit in 2012. This revised version uses part of the original Muskoka OECD CRS codes and multilateral organisations and assigns different percentages to them.

Since Euromapping 2017, both commitments and disbursements are assessed in order to give as precise as possible a representation of donors' ODA outflows. They represent two different measurements: the legally binding promise to provide defined assistance to a recipient; and the actual payment of the promised funds, or the provision of goods or services, to a recipient. It is important to note that commitments can be remitted according to different modalities or across varied time frames. Disbursements cannot be construed as representing the payments of funds fully committed by donors at a specific point in time.

Table: percentages for donor contribution to RMNCH under the Muskoka methodology and to FP under the FP metholodogy

	BILATERAL DAC purpose codes	*RMNCH*	*FP %*
12110	Health policy & administrative management	40%	5%
12181	Medical education/training	40%	5%
12191	Medical services	40%	5%
12220	Basic health care	40%	5%
12230	Basic health infrastructure	40%	5%
12240	Basic nutrition	100%	0%
12250	Infectious disease control	40%	0%
12261	Health education	40%	5%
12262	Malaria control	88.5%	0%
12263	Tuberculosis control	18.5%	0%
12281	Health personnel development	40%	5%
13010	Population policy & administrative management	40%	5%
13020	Reproductive health care	100%	20%
13030	Family planning	100%	100%
13040	STD control including HIV/AIDS[1]	46.1%	3%
13081	Personnel development for population & reproductive health	100%	5%
14030	Basic drinking water supply and basic sanitation	15%	0%
14031	Basic drinking water supply	15%	0%
14032	Basic sanitation	15%	0%
51010	Budget support	4%	0.5%
	MULTILATERAL agency/initiative	*RMNCH*	*FP %*
	GAVI	100%	0%
	Global Fund to Fight AIDS, TB and Malaria	46%	5%
	AfDF	3%	0%
	AsDF	2%	0%
	IDB Special Fund	1%	0%
	UNFPA	67%	20%
	UNICEF	55%	0%
	World Bank	5%	1%
	World Food Programme	15%	0%
	World Health Organization	22%	5%
	GPEI		0%

[1] See http://www.who.int/pmnch/activities/accountability/reports/en/

[2] For further information on the Muskoka methodology, please go to http://www.g8.utoronto.ca/summit/2010muskoka/methodology.html