



U.S. GLOBAL HEALTH POLICY

DONOR FUNDING FOR HEALTH
IN LOW- & MIDDLE-INCOME COUNTRIES,
2002–2009

November 2011



U.S. GLOBAL HEALTH POLICY

DONOR FUNDING FOR HEALTH
IN LOW- & MIDDLE-INCOME COUNTRIES,
2002–2009

November 2011

AUTHORS:

Jen Kates
Adam Wexler
Allison Valentine
THE KAISER FAMILY FOUNDATION

TABLE OF CONTENTS

SUMMARY & HIGHLIGHTS	1
DETAILED FINDINGS	4
CONCLUSION	8
ANNEX 1: FIGURES	9
ANNEX 2: DATA TABLES	15
ANNEX 3: COUNTRY MEMBERSHIP/AFFILIATION	17
ANNEX 4: CRS SECTORS AND SUB-SECTORS USED IN THIS ANALYSIS	18
ANNEX 5: CRS WATER SECTOR AND SUB-SECTORS USED IN THIS ANALYSIS	19
ANNEX 6: METHODOLOGY	20
ENDNOTES	22

Donor funding for health, from governments and multilateral organizations, accounts for most external health aid channeled to the developing world, and as such constitutes a major component of the global health response. This report provides an analysis of Official Development Assistance (ODA) disbursements for the health sector provided by donors between 2002 and 2009, as reported to the Organisation for Economic Co-operation and Development (OECD) by Development Assistance Committee (DAC) member governments and multilateral organizations.^{1,2,3} It is part of a multi-year effort of the Kaiser Family Foundation to analyze and track trends in donor funding for health,^{4,5,6} and also serves to complement efforts by others in the field.⁷ Collectively, these resource tracking analyses are central to assessing progress on global health, including toward meeting internationally agreed-upon health targets, such as the Millennium Development Goals (MDGs).⁸

With data from 2002 to 2009, this report is able to provide an overall picture of health aid for much of the prior decade, one widely regarded as a period in which funding for health rose considerably, spurred on by the creation of several new global health funding initiatives and mechanisms, most notably The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund),⁹ the President's Emergency Plan for AIDS Relief (PEPFAR),¹⁰ the President's Malaria Initiative (PMI),¹¹ and the GAVI Alliance (GAVI),¹² but also one that ended as the severity of the global economic crisis began to set in. Indeed, this report finds that funding for health rose significantly over the period, even after adjusting for inflation and exchange rate fluctuations, although its rate of growth was much steeper in the first half of the decade. It also rose as a share of overall ODA, indicating that the health sector was an increasing priority for donors. While health ODA continued to increase between 2008 and 2009, its increase was smaller than in the years just before the global economic crisis. Whether or not the health sector will experience any downward effects due to the global economic crisis, however, remains an open question - the data in this report are through 2009, and represent disbursements rather than commitments,¹³ reflecting budgetary decisions made before the global economic crisis. While it may be too early to know what the effects of the financial crisis will be on health ODA disbursements, commitments continued to rise in 2009.

Box 1: Definition of Health

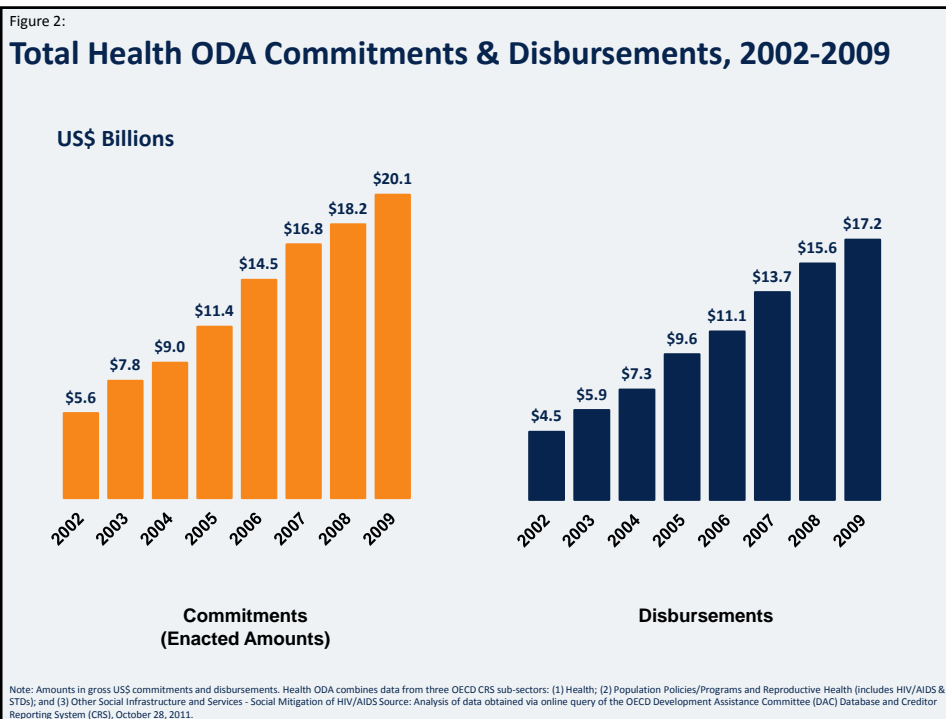
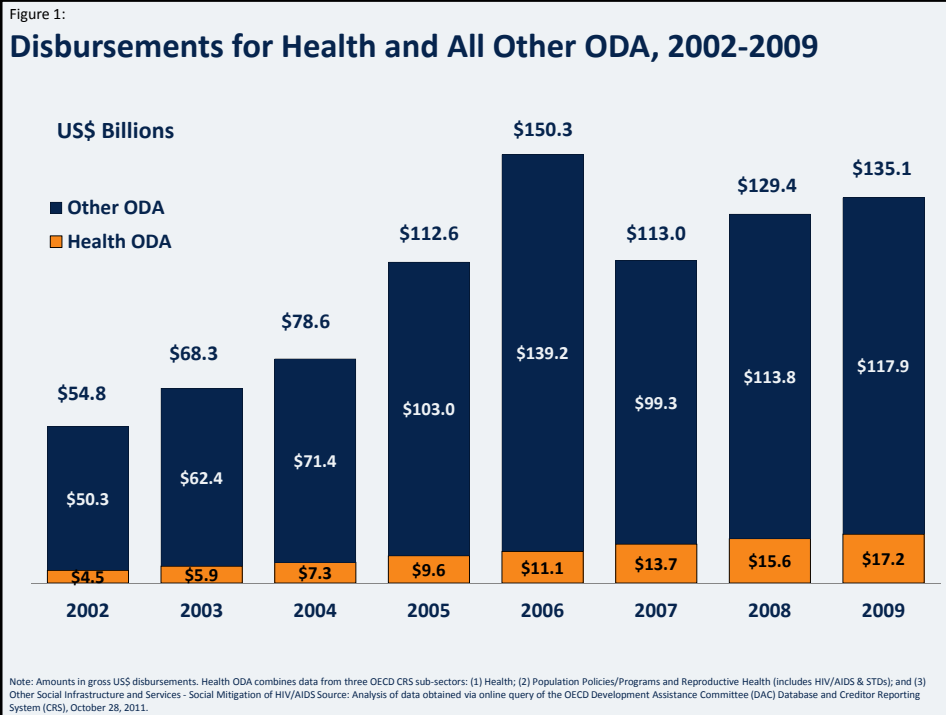
ODA is categorized by the OECD into sectors and subsectors based on the specific area being targeted. In order to capture total ODA funding for "health," this report combines the "Health" and "Population Policies/Programs and Reproductive Health" sectors, which represent the OECD DAC statistical definition of "aid to health," and the "Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS" subsector, a relatively new category in the OECD CRS database.

See the Methodology and Annex 4 below for more information.

Key highlights and notable trends from this year's report include:

- **Overall ODA:** Between 2002 and 2009, gross ODA disbursements^{14,15} more than doubled in nominal terms, with increases in nearly every sector, rising from \$54.8 billion to \$135.1 billion (a 146.5% increase). After adjusting for inflation, currency revaluation, debt relief, and aid to Iraq and Afghanistan, the \$80.3 billion increase in real terms was \$54.5 billion, an increase of 86.0%.

- Health ODA:** Funding for health nearly quadrupled between 2002 and 2009, rising from \$4.5 billion to \$17.2 billion (282.3%) an increase in real terms even after adjusting for inflation and currency revaluation. Health grew as a share of overall ODA as well, rising from 8.2% to 12.7%, making it the third largest sector in 2009. The health sector was also the third largest driver of increases over the period. While health funding increased each year over the period, the largest percentage increases occurred in the early part of the decade reflecting the start-up of new global health initiatives (as the base of donor funding for health has grown, the rate of increase has slowed).
- Health ODA by Donor:** The U.S. was the single largest bilateral donor¹⁶ to health in 2009 (\$6.1 billion) and was the largest donor in each year, from 2002 to 2009, accounting for almost a third of health funding (32.7%) over the entire period. The U.S. also channeled almost a quarter of its ODA to health (23.4%) a greater share than any other government donor, and allocated a growing share of its ODA to health over time. When standardized by the relative size of each nation's economy, however, Luxembourg, Norway, Ireland, and Sweden rise to the top, with the U.S. ranking eighth. Of note, the Global Fund, which was not created until 2002, was the second largest donor overall in 2009 (\$2.3 billion).¹⁷
- Health ODA by Region.** Sub-Saharan Africa received the largest share of health ODA of any region in 2009 (47.7%), and accounted for a growing share of health ODA over the period, up from 32.4% in 2002. South & Central Asia (13.3%) accounted for the second largest share in 2009 followed by Far East Asia (6.7%).
- Health ODA by Sub-Sector:** In 2009, HIV/AIDS accounted for the largest share (39.5%) of funding within the health sector, followed by Management & Workforce (15.2%), Basic Health & Medical Care (12.5%), and Family Planning & Reproductive Health (11.6%). Over the decade, HIV/AIDS experienced the largest increase, rising from \$0.8 billion in 2002 to \$6.8 billion in 2009, although other subsectors have grown faster in recent years. For example, between 2008 and 2009, funding for Malaria grew the most (\$0.52 billion or 56.3%) followed by Family Planning & Reproductive Health (\$0.37 billion or 22.7%) and HIV/AIDS (\$0.36 billion or 5.6%).



DETAILED FINDINGS

Total ODA

- ODA rose considerably in the past decade, with disbursements more than doubling between 2002 and 2009, from nominal US\$54.8 billion to US\$135.1 billion, a 146.5% increase (Table 1 and Figure 1). Increases were relatively stable, except in 2005 and 2006, when scheduled, and significant, debt relief transactions were made (Figure 3 and Annex 2).
- Some of the increase was offset by inflation and exchange rate changes while a considerable portion was for debt relief and aid to Iraq, Afghanistan, and Pakistan.^{18,19,20} Aid to Iraq, Afghanistan, and Pakistan, for example, accounted for about 11.6% of ODA disbursements between 2002 and 2009. Debt Relief accounted for approximately 17.2% of ODA disbursements during the same period, but has decreased as share of ODA since 2006, falling by 90.5% since then. After adjusting for these combined factors, the increase over the period in real terms was \$54.5 billion, an increase of 86.0%.

Gross US\$ Disbursements in Billions					
	2002	2008	2009	2008-2009 +/- \$ (%)	2002-2009 +/- \$ (%)
Health*	4.5	15.6	17.2	+1.6 (10.1%)	+12.7 (282.3%)
Water	1.4	5.4	5.6	+0.2 (4.6%)	+4.3 (299.7%)
Education	3.2	10.5	12.0	+1.4 (13.6%)	+8.8 (272.6%)
Government/Civil Society	4.3	15.5	16.6	+1.1 (6.9%)	+12.3 (283.3%)
Economic Infrastructure	5.9	17.6	19.3	+1.8 (10.2%)	+13.5 (229.3%)
Production	3.9	8.2	9.4	+1.2 (14.8%)	+5.5 (141.9%)
Commodity Aid	4.9	7.7	9.9	+2.3 (29.6%)	+5.0 (100.7%)
Debt Relief	6.5	10.4	5.9	-4.5 (-43.1%)	-0.6 (-9.2%)
Emergency Assistance	3.0	11.1	10.8	-0.4 (-3.4%)	+7.8 (263.6%)
Multisector/Other**	7.7	25.3	26.3	+1.0 (4.1%)	+18.6 (241.0%)
Unspecified	9.4	2.1	2.0	-0.1 (-4.0%)	-7.4 (-78.9%)
TOTAL	\$54.8	\$129.4	\$135.1	+\$5.7 (4.4%)	+\$80.3 (146.5%)

* Represents combined data from three OECD CRS subsectors (1) Health; (2) Population Policies/Programs and Reproductive Health (which includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS.

** Represents combined data from five OECD CRS sectors and sub-sectors: (1) Multisector/Cross-cutting; (2) Administrative Costs of Donors; (3) Support of NGO's; (4) Refugees in Donor Countries; (5) Other Social Infrastructure & Services (excluding Social Mitigation of HIV/AIDS).

Health ODA

- Funding for health nearly quadrupled over the period, rising from \$4.5 billion to \$17.2 billion, an increase in real terms even after adjusting for inflation and currency revaluation (Figure 2 and Annex 2). As a share of total ODA, Health increased from 8.2% in 2002 to 12.7% in 2009 (Figure 4).
- The Health sector demonstrated the third largest increase (\$12.7 billion) in ODA over the decade, behind projects that supported Multisectoral²¹ or other general efforts (\$18.6 billion) and Economic Infrastructure (\$13.5 billion) and grew at a much faster pace (282.3%) than overall ODA (146.5%). Health also accounted for the third largest share of the increase in the 2008-2009 period (\$1.6 billion), behind Commodity Aid (\$2.3 billion) and Economic Infrastructure (\$1.8 billion).

- While health funding increased each year over the period, the largest percentage increases occurred in the early part of the decade reflecting the start-up of new global health initiatives such as the Global Fund and PEPFAR; between 2003 and 2006, for example, Health grew by 87.6%, compared to a 54.4% increase in the 2006 to 2009 period. As the base of donor funding for health has grown due in large part to these new initiatives, the annual rate of increase has slowed.

Health ODA by Donor

- Most health ODA over the decade was provided bilaterally by donor governments, who collectively accounted for more than two thirds of disbursements (68.5%) in 2009, with multilateral organizations providing the rest (31.5%) (See Annex 2).¹⁶
- The U.S. government was the single largest bilateral donor to health over the entire period, including in 2009 (\$6.1 billion), when it accounted for over a third of all health ODA (35.4%) (Figure 5). The U.S. share of health ODA also increased somewhat over time, up from 31.2% in 2002, compared to a decline in its share of total ODA (from 23.5% in 2002 to 19.2% in 2009). The United Kingdom was the second largest bilateral donor to health in 2009 (\$1.1 billion) followed by the European Commission (\$0.6 billion), Canada (\$0.4 billion), and Germany (\$0.4 billion).
- Among all donor governments in 2009, the U.S. allocated the largest share of its total ODA to health (23.4%) followed by Ireland (19.9%), Luxembourg (17.7%), South Korea (16.3%), and the United Kingdom (14.1%) (Figure 6). The U.S. also allocated a growing share of its ODA to health over the period (10.8% in 2002 to 23.4% in 2009). When looking at health ODA as a share of GDP (standardized by GDP per US\$1 million, to account for differences in the sizes of government economies), Luxembourg provided the highest amount of resources for health, followed by Norway, Ireland, Sweden, and the U.K. (Figure 7). The U.S. was eighth by this measure.
- Of the \$5.4 billion in Health ODA provided by multilateral organizations in 2009, the Global Fund, first created in 2002, was the largest multilateral donor, and second largest donor to Health overall (\$2.3 billion). The World Bank was the second largest multilateral donor (\$1.2 billion) in 2009 followed by GAVI (\$0.5 billion), and the World Health Organization (WHO) (\$0.4 billion).

Box 2: Beyond the DAC

While the DAC, established in 1961 and with a current membership of 24, is considered to be the world's main donor group, other donor groups and new donors have emerged over time, with overlapping membership in some cases (see Annex 3). These include the Group of Eight (G8), first formed in 1975 and, more recently, the Group of Twenty (G20), established in 1999. There is also the newer configuration of the BRICS, a group of five of the leading emerging economies. All of these donor groups play a role in funding and defining the global health agenda, and the emerging donors are increasingly seen as critical to helping fill the global health financing gap, as well as bolstering their own domestic responses to global health. For example, China, India, Korea, Russia, Saudi Arabia, and South Africa have all made contributions to the Global Fund.²² Brazil, India, and South Africa have provided funding for health to several African countries.^{23,24} However, obtaining funding data for non-DAC nations is challenging as there is currently no centralized source that contains data for all these.

Health ODA by Region

- Sub-Saharan Africa received the largest share of health funding of any region in 2009 (47.7%) (Figure 8), and accounted for a growing share of health ODA over the period, up from 32.4% in 2002 (Table 2 and Annex 2). Funding for the region drove most of the growth over the 2002-2009 period (53.2%).
- Funding for South/Central Asia accounted for the second largest share in 2009 (13.3%). While the region was the second largest driver of growth (10.0%) over the 2002-2009 period, its share of health ODA has declined since 2002 (22.8%).
- The next largest region, by share of funding in 2009, was Far East Asia (6.7%). All other regions individually accounted for less than 3.0% of total health funding, and funding for three regions (North Africa, Middle East, and North/Central America) declined between 2008 and 2009. Donors allocated a significant portion of health funding (20.4%) without specifying a specific region.

Gross US\$ Disbursements in Billions					
	2002	2008	2009	2008-2009 +/- \$ (%)	2002-2009 +/- \$ (%)
North Africa	0.1	0.3	0.2	-0.10 (-38%)	+0.09 (127%)
Sub-Saharan Africa	1.5	7.5	8.2	+0.66 (9%)	+6.73 (463%)
North/Central America	0.2	0.5	0.5	-0.03 (-6%)	+0.33 (195%)
South America	0.1	0.3	0.3	+0.01 (4%)	+0.22 (208%)
Far East Asia	0.3	1.1	1.1	+0.08 (7%)	+0.84 (277%)
South/Central Asia	1.0	1.9	2.3	+0.35 (18%)	+1.26 (124%)
Middle East	0.1	0.3	0.3	-0.01 (-2%)	+0.18 (215%)
Europe	0.1	0.2	0.2	+0.01 (4%)	+0.15 (203%)
Oceania	0.1	0.2	0.2	+0.03 (16%)	+0.15 (192%)
Regional	0.1	0.3	0.3	+0.02 (8%)	+0.26 (347%)
Unspecified	1.0	3.0	3.5	+0.55 (19%)	+2.45 (233%)
TOTAL	\$4.5	\$15.6	\$17.2	+\$1.57 (10%)	+\$12.67 (282%)

Health ODA by Sub-Sector

- Looking at specific activities within the health sector, the greatest share of funding in 2009 went to HIV/AIDS & STDs (39.5%) (Table 3 and Figure 9).²⁵ Management/Workforce accounted for the next largest share (15.2%) followed by Basic Health & Medical Care (12.5%), Family Planning & Reproductive Health (11.6%) and Malaria (8.4%).
- HIV/AIDS also drove most of the growth in Health ODA over the 2002 to 2009 period; HIV/AIDS accounted for \$5.9 billion (46.8%) of the \$12.7 billion increase in health ODA; Malaria accounted for the second largest share (\$1.4 billion, 11.1%) of the increase, followed by Management/Workforce (\$1.4 billion, 10.9%), Basic Health & Medical Care (\$1.2 billion, 9.6%), and Family Planning & Reproductive Health (\$1.1 billion, 8.9%) (Figure 10 and Annex 2).

- While funding for all sectors grew over the 2002 to 2009 period, funding for HIV/AIDS, Malaria, and TB increased at faster rates than other sectors, each rising as a share of total health ODA. Funding for Management & Workforce, Basic Health & Medical Care, Other Infectious Diseases, and Family Planning & Reproductive Health declined as a share of health ODA.
- While funding for HIV/AIDS experienced the largest increase over the period, other subsectors have grown faster in recent years (Figure 11). For example, between 2008 and 2009, funding for Malaria grew the most (\$0.52 billion or 56.3%) followed by Family Planning & Reproductive Health (\$0.37 billion or 22.7%) and HIV/AIDS (\$0.36 billion or 5.6%). Basic Health & Medical Care was the only sector that declined (-\$0.28 billion or -11.4%) in 2009.

Box 3: ODA for Water²⁶

While the DAC does not include funding for the Water Sector as part of its definition of “Health,” in prior Kaiser reports, funding for Water was included in overall Health ODA totals, due its relevance to health.ⁱ In this year’s report, Water is kept as a separate sector, as defined by the DAC (see Appendix 5), and data specific to funding for Water are provided in tables and charts throughout the report (Table 1, Figure 12, and Annex 2).

- Water ODA quadrupled from \$1.4 billion in 2002 to \$5.4 billion in 2009; while not the largest dollar increase, water demonstrated the largest percentage increase among all sectors (299.7%).
- In 2009, as with the health sector, Sub-Saharan Africa accounted for the largest share (30.5%) of Water ODA. Far East Asia accounted for the second largest share (18.0%) followed by South & Central Asia (12.2%).
- The constellation of donors who fund water projects is different from the health sector. In 2009, Japan was the largest donor to water ODA (\$1.5 billion), accounting for more than a quarter of water funding (25.8%). The second largest donor was the World Bank (\$0.7 billion, 13.3%), followed by Germany (\$0.6 billion, 10.1%) the European Commission (\$0.5 billion, 9.4%), Spain (\$0.5 billion, 9.3%), and the U.S. (\$0.3 billion, 5.0%).

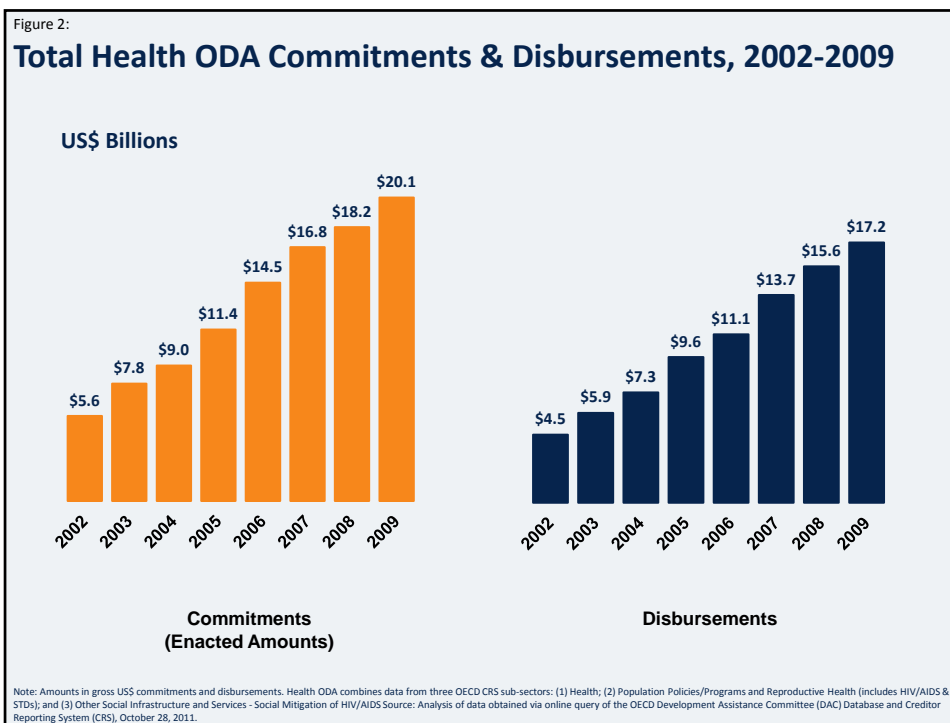
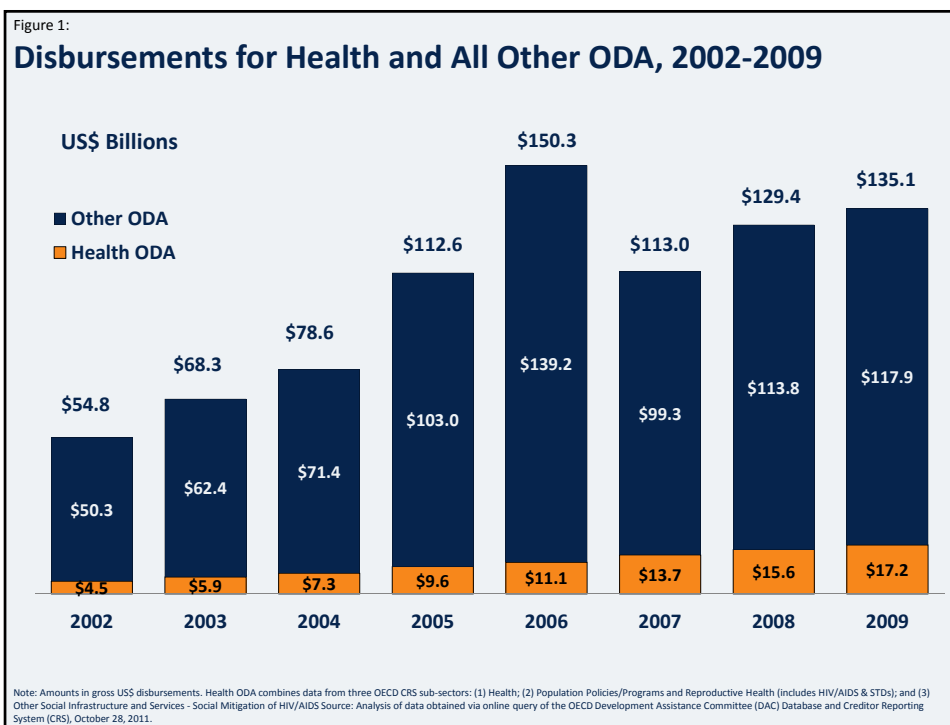
Gross US\$ Disbursements in Billions					
	2002	2008	2009	2008-2009	2002-2009
				+/- \$ (%)	+/- \$ (%)
Management/Workforce	1.2	2.4	2.6	+0.20 (8.3%)	+1.4 (112.4%)
Basic Health & Medical Care	0.9	2.4	2.2	-0.28 (-11.4%)	+1.2 (129.2%)
Nutrition	0.1	0.3	0.4	+0.14 (48.5%)	+0.6 (308.9%)
Other Infectious Diseases	0.5	1.1	1.3	+\$0.18 (16.4%)	+0.8 (166.0%)
Malaria	0.0	0.9	1.4	+0.52 (56.3%)	+1.4 (NA)
Tuberculosis	0.0	0.4	0.5	+0.08 (19.2%)	+0.5 (NA)
Family Planning & Reproductive Health	0.9	1.6	2.0	+0.37 (22.7%)	+1.1 (131.5%)
HIV/AIDS	0.8	6.4	6.8	+0.36 (5.6%)	+5.9 (706.2%)
TOTAL	\$4.5	\$15.6	\$17.2	+\$1.6 (10.1%)	+\$12.7 (282.3%)

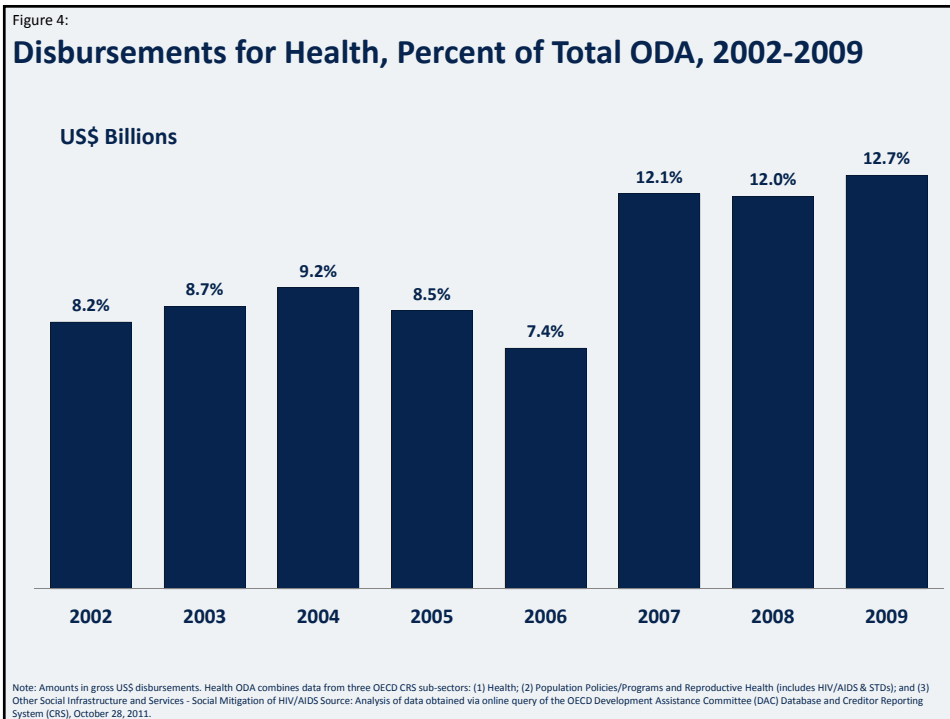
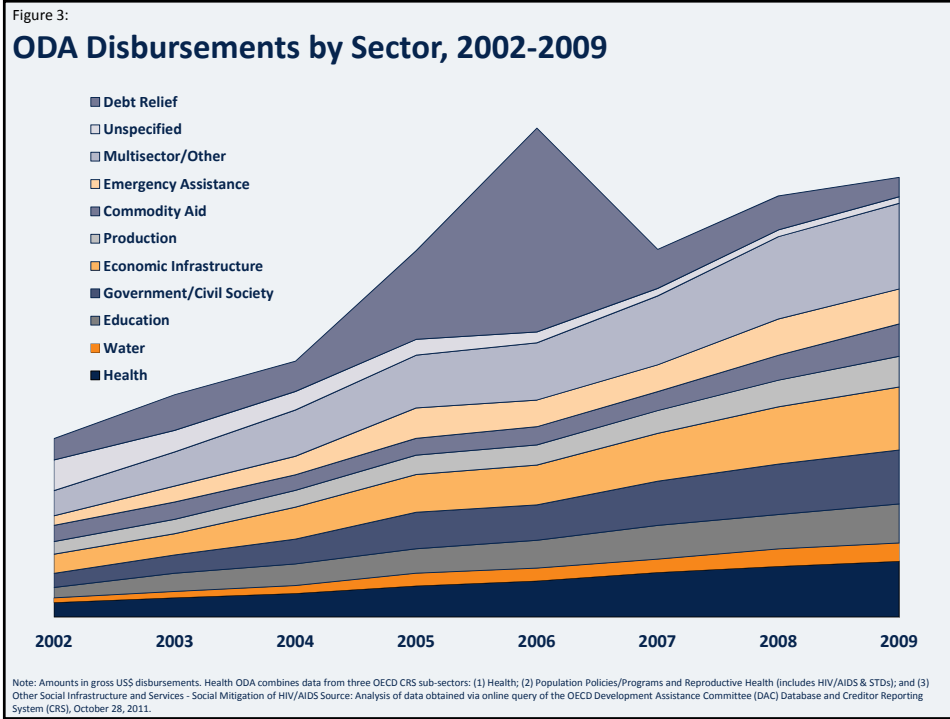
CONCLUSION

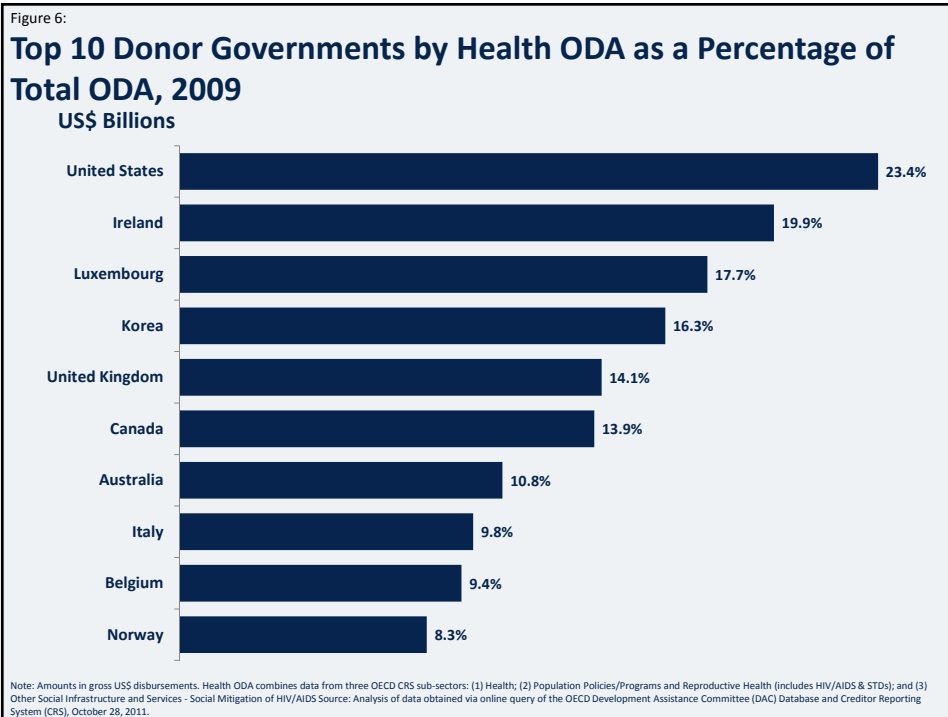
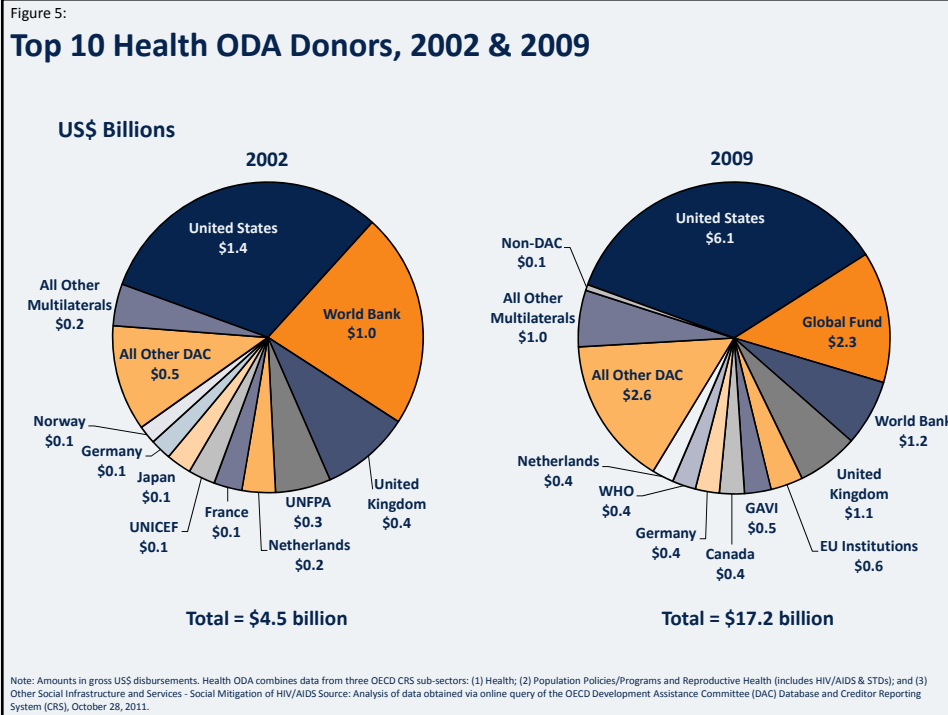
Tracking donor government funding is one important component of monitoring global progress to improve health in low- and middle-income countries and this analysis indicates that donors increased their health ODA over the 2002 to 2009 period. Moreover, health grew as a share of overall ODA, reflecting its priority among donors. At the same time, caution about future donor assistance for health may be warranted – the data in this report, although the most recent available on health ODA, reflect decisions made prior to the global economic crisis that struck in the second half of 2008. The data also indicate a slowing in the rate of growth of health ODA. Preliminary estimates from the OECD, however, predict that, despite the economic crisis, overall ODA for 2009–2010 increased, but with mixed prospects among donors.²⁷ How health, which has been an important sector for donors, fares in this uncertain context will be important to assess, both among the traditional donors of the DAC, as well as emerging donors who may enter into the mix.

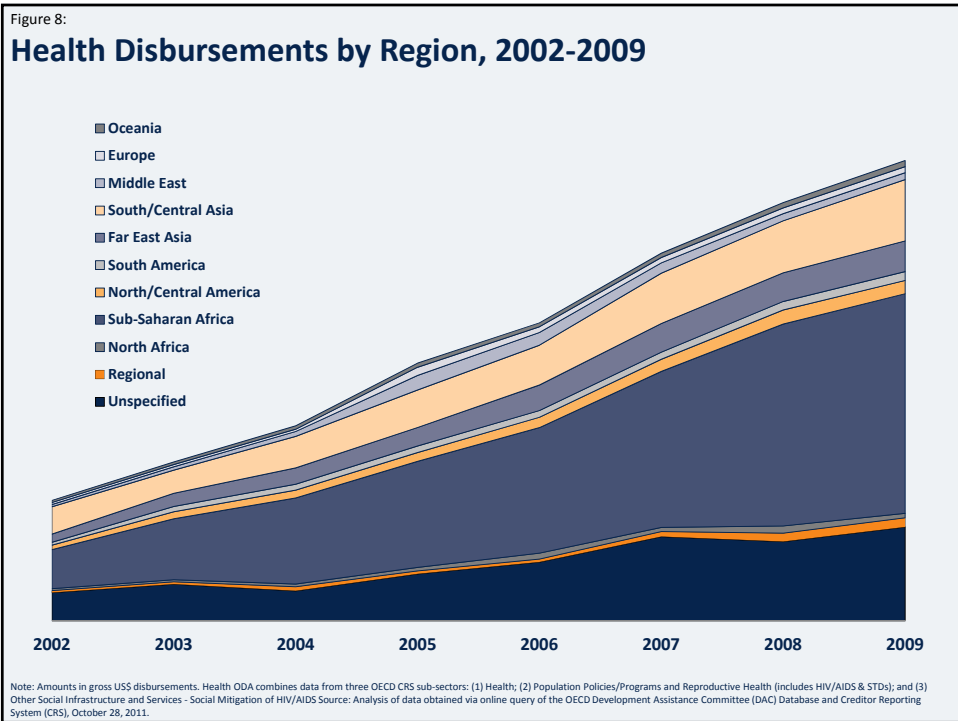
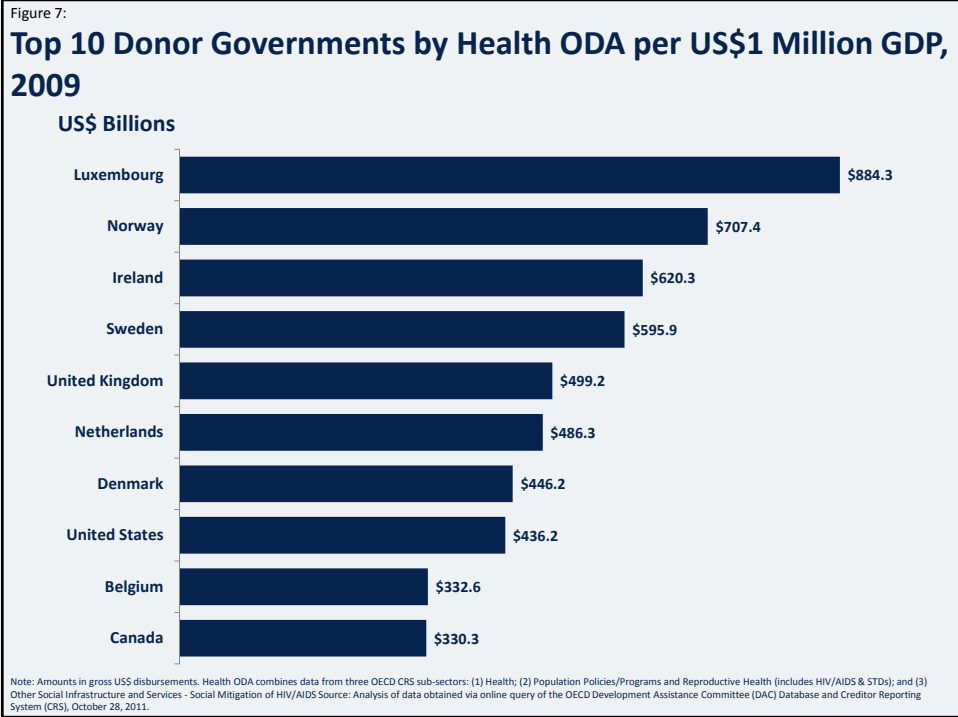
ACKNOWLEDGEMENTS

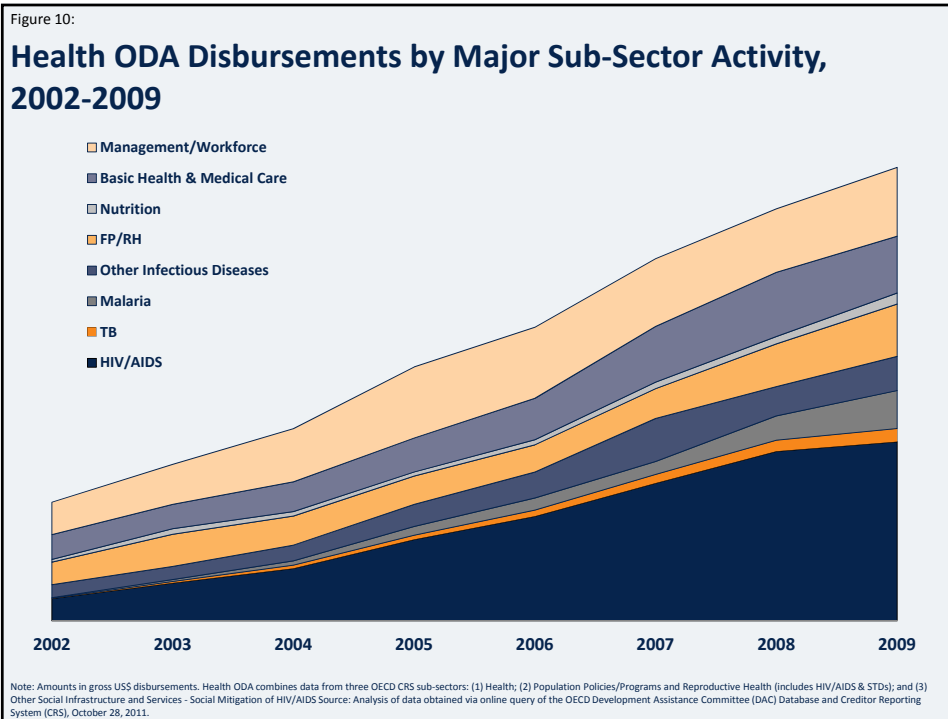
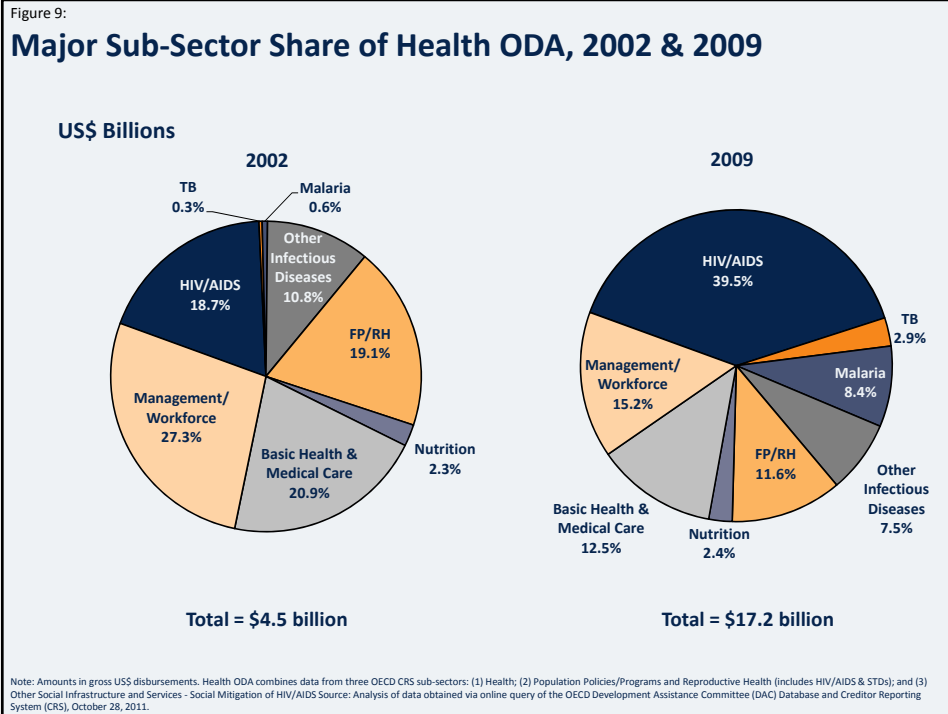
The authors would like to acknowledge input provided by Eric Lief of the Stimson Center on this year's report, as well as his co-authorship of prior year reports.

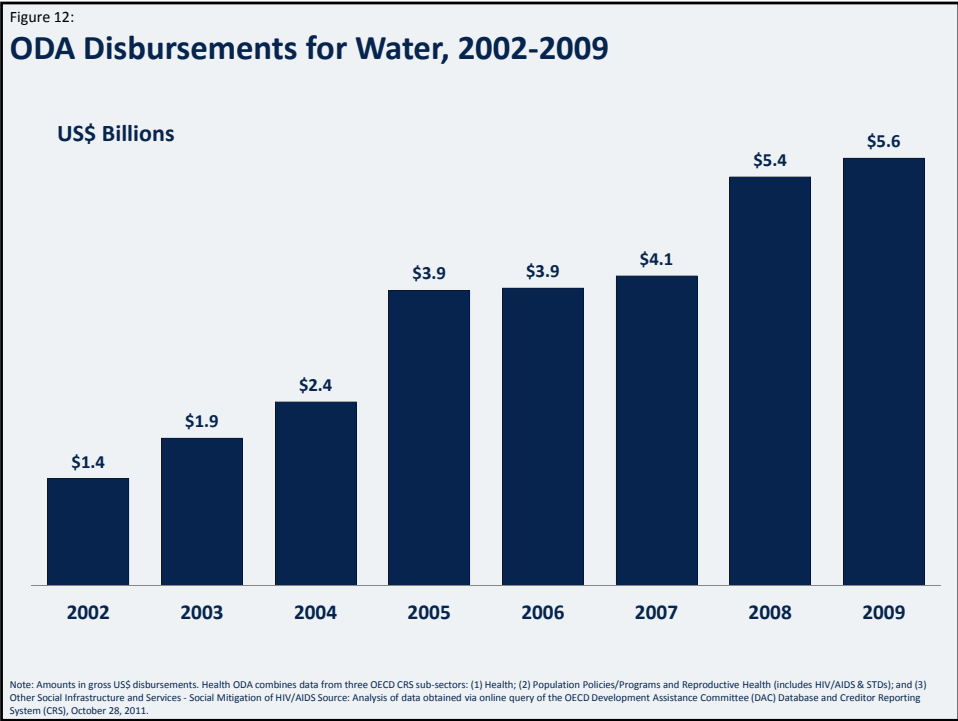
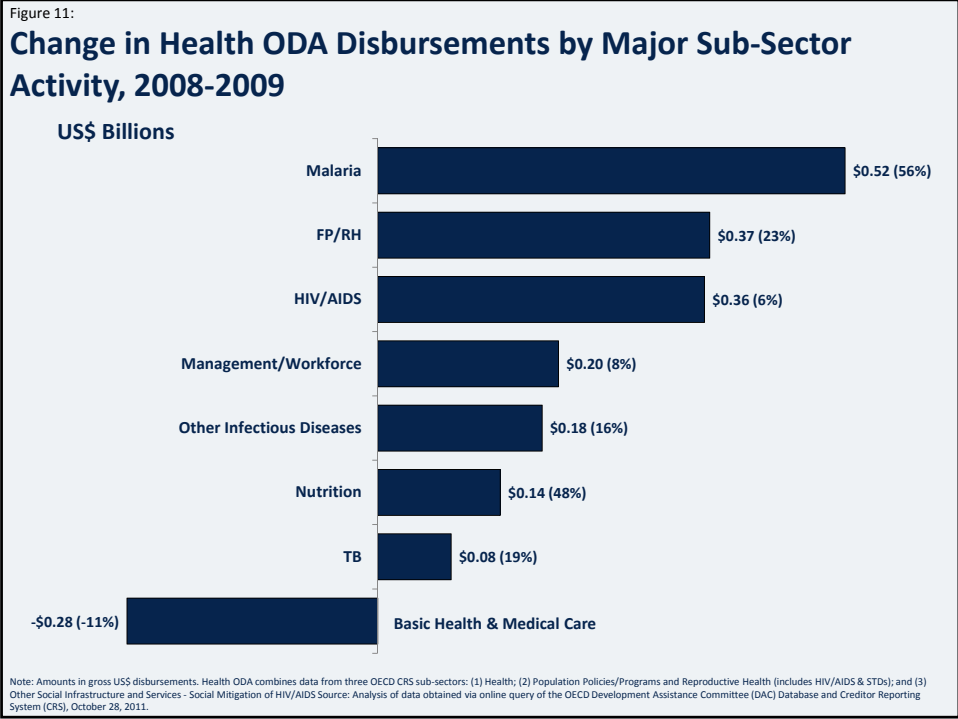












ANNEX 2: DATA TABLES

Total ODA by Major Sector, 2002-2009								
Gross US\$ Disbursements in Billions								
	2002	2003	2004	2005	2006	2007	2008	2009
Health	4.5	5.9	7.3	9.6	11.1	13.7	15.6	17.2
Water	1.4	1.9	2.4	3.9	3.9	4.1	5.4	5.6
Education	3.2	5.6	6.7	7.5	8.6	10.4	10.5	12.0
Government & Civil Society	4.3	5.6	7.6	11.2	10.9	13.6	15.5	16.6
Economic Infrastructure	5.9	6.5	9.8	11.6	12.3	14.7	17.6	19.3
Production	3.9	4.4	5.2	5.9	6.2	7.0	8.2	9.4
Commodity Aid	4.9	5.3	4.8	5.2	5.6	5.8	7.7	9.9
Debt Relief	6.5	10.9	9.3	27.2	62.7	12.0	10.4	5.9
Emergency Assistance	3.0	4.9	5.7	9.3	8.2	8.2	11.1	10.8
Multisector/Other	7.7	10.5	14.2	16.2	17.6	21.2	25.3	26.3
Unspecified	9.4	6.7	5.7	4.9	3.3	2.3	2.1	2.0
TOTAL	54.8	68.3	78.6	112.6	150.3	113.0	129.4	135.1

Total Health ODA by Region, 2002-2009								
Gross US\$ Disbursements in Billions								
	2002	2003	2004	2005	2006	2007	2008	2009
North Africa	0.1	0.1	0.1	0.1	0.2	0.2	0.3	0.2
Sub-Saharan	1.5	2.3	3.2	4.0	4.7	5.8	7.5	8.2
North & Central America	0.2	0.3	0.3	0.3	0.4	0.5	0.5	0.5
South America	0.1	0.2	0.2	0.2	0.3	0.3	0.3	0.3
Far East Asia	0.3	0.5	0.6	0.7	0.9	1.1	1.1	1.1
South & Central Asia	1.0	0.9	1.2	1.4	1.5	1.9	1.9	2.3
Middle East	0.1	0.1	0.2	0.5	0.5	0.4	0.3	0.3
Europe	0.1	0.1	0.1	0.3	0.2	0.2	0.2	0.2
Oceania	0.1	0.1	0.1	0.2	0.1	0.2	0.2	0.2
Regional	0.1	0.1	0.2	0.1	0.1	0.2	0.3	0.3
Unspecified	1.0	1.4	1.1	1.7	2.2	3.1	2.9	3.5
TOTAL	4.5	5.9	7.3	9.6	11.1	13.7	15.6	17.2

Total Health ODA by Sub-Sector, 2002-2009								
Gross US\$ Disbursements in Billions								
	2002	2003	2004	2005	2006	2007	2008	2009
Management/Workforce	1.2	1.5	2.0	2.7	2.7	2.6	2.4	2.6
Basic Health & Medical Care	0.9	0.9	1.1	1.3	1.6	2.1	2.4	2.2
Nutrition	0.1	0.2	0.2	0.2	0.2	0.2	0.3	0.4
Other Infectious Diseases	0.5	0.5	0.6	0.8	1.0	1.6	1.1	1.3
Malaria	0.0	0.1	0.2	0.3	0.5	0.5	0.9	1.4
TB	0.0	0.1	0.1	0.2	0.2	0.3	0.4	0.5
FP/RH	0.9	1.2	1.1	1.1	1.0	1.1	1.6	2.0
HIV/AIDS	0.8	1.4	2.0	3.1	4.0	5.2	6.4	6.8
TOTAL	4.5	5.9	7.3	9.6	11.1	13.7	15.6	17.2

Total Health ODA by Donor, 2002-2009								
Gross US\$ Disbursements in Billions								
	2002	2003	2004	2005	2006	2007	2008	2009
Australia	0.08	0.10	0.11	0.12	0.18	0.21	0.23	0.25
Austria	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01
Belgium	0.07	0.09	0.08	0.10	0.12	0.15	0.15	0.16
Canada	0.07	0.10	0.17	0.30	0.21	0.41	0.41	0.44
Denmark	-	0.05	0.06	0.08	0.07	0.08	0.10	0.14
EU Institutions	0.07	0.09	0.20	0.42	0.61	0.67	0.73	0.58
Finland	0.02	0.02	-	-	0.04	0.04	0.05	0.04
France	0.13	0.18	0.24	0.31	0.28	0.10	0.35	0.34
Germany	0.10	0.18	0.23	0.21	0.25	0.35	0.41	0.43
Greece	0.00	0.01	0.02	0.03	0.03	0.03	0.01	0.02
Ireland	0.06	0.09	0.10	0.11	0.18	0.19	0.17	0.14
Italy	0.01	0.04	0.05	0.07	0.07	0.11	0.12	0.10
Japan	0.12	0.28	0.26	0.26	0.35	0.40	0.35	0.36
Korea	-	-	-	-	0.04	0.05	0.06	0.10
Luxembourg	-	-	0.03	0.04	0.04	0.05	0.06	0.05
Netherlands	0.16	0.22	0.24	0.23	0.28	0.34	0.40	0.39
New Zealand	0.00	0.01	0.01	0.02	0.02	0.01	0.02	0.02
Norway	0.09	0.08	0.12	0.20	0.24	0.22	0.26	0.26
Portugal	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01
Spain	0.06	0.09	0.12	0.15	0.15	0.24	0.40	0.34
Sweden	0.07	0.10	0.15	0.20	0.26	0.31	0.27	0.24
Switzerland	0.03	0.04	0.04	0.05	0.04	0.04	0.06	0.07
United Kingdom	0.42	0.38	0.45	0.65	0.88	1.10	1.00	1.09
United States	1.40	1.99	2.06	3.09	3.58	4.22	5.32	6.08
Total DAC	2.97	4.15	4.76	6.64	7.95	9.35	10.96	11.64
AfDF	0.06	0.03	0.07	0.06	0.08	0.08	0.11	0.10
GAVI	-	-	-	-	-	0.92	0.73	0.47
GEF	-	-	-	-	-	-	0.00	-
Global Fund	-	0.22	0.58	1.01	1.25	1.63	2.17	2.34
IDA	1.01	0.90	1.36	1.38	1.27	1.15	0.98	1.18
IDB Sp.Fund	-	-	-	-	-	-	-	0.02
OFID	-	-	-	-	-	-	-	0.02
UNAIDS	0.06	0.13	0.14	0.12	0.18	0.19	0.21	0.24
UNDP	-	-	0.02	0.02	0.02	0.02	0.02	0.03
UNECE	-	-	-	-	-	-	0.00	0.00
UNFPA	0.26	0.36	0.20	0.20	0.21	0.22	0.27	0.35
UNICEF	0.13	0.13	0.14	0.18	0.14	0.15	0.14	0.19
WFP	-	-	-	-	-	-	-	0.05
WHO	-	-	-	-	-	-	-	0.42
Total Multilaterals	1.51	1.77	2.51	2.96	3.15	4.36	4.63	5.41
Total Non-DAC (United Arab Emirates)	-	-	-	-	-	-	-	0.10
TOTAL	4.49	5.92	7.27	9.60	11.11	13.70	15.59	17.16

ANNEX 3: COUNTRY MEMBERSHIP/AFFILIATION

COUNTRY MEMBERSHIP/AFFILIATION				
Country	DAC	G8	G20	BRIC
Argentina			X	
Australia	X		X	
Austria	X			
Belgium	X			
Brazil			X	X
Canada	X	X	X	
China			X	X
Denmark	X			
Finland	X			
France	X	X	X	
Germany	X	X	X	
Greece	X			
India			X	X
Indonesia			X	
Ireland	X			
Italy	X	X	X	
Japan	X	X	X	
Luxembourg	X			
Mexico			X	
Netherlands	X			
New Zealand	X			
Norway	X			
Portugal	X			
Russia		X	X	X
Saudi Arabia			X	
South Africa			X	X
South Korea	X		X	
Spain	X			
Sweden	X			
Switzerland	X			
Turkey			X	
United Kingdom	X	X	X	
United States	X	X	X	
EU	X	X	X	

ANNEX 4: CRS SECTORS AND SUB-SECTORS USED IN THIS ANALYSIS

Source: OECD, The CRS List of Purpose Codes, Annex 5. DCD/DAC(2007)39

DAC 5 CODE	CRS CODE	DESCRIPTION	Clarifications / Additional notes on coverage
120		HEALTH	
121		Health, general	
	12110	Health policy and administrative management	Health sector policy, planning and programmes; aid to health ministries, public health administration; institution capacity building and advice; medical insurance programmes; unspecified health activities.
	12181	Medical education/training	Medical education and training for tertiary level services.
	12182	Medical research	General medical research (excluding basic health research).
	12191	Medical services	Laboratories, specialised clinics and hospitals (including equipment and supplies); ambulances; dental services; mental health care; medical rehabilitation; control of non-infectious diseases; drug and substance abuse control [excluding narcotics traffic control (16063)].
122		Basic health	
	12220	Basic health care	Basic and primary health care programmes; paramedical and nursing care programmes; supply of drugs, medicines and vaccines related to basic health care.
	12230	Basic health infrastructure	District-level hospitals, clinics and dispensaries and related medical equipment; excluding specialised hospitals and clinics (12191).
	12240	Basic nutrition	Direct feeding programmes (maternal feeding, breastfeeding and weaning foods, child feeding, school feeding); determination of micro-nutrient deficiencies; provision of vitamin A, iodine, iron etc.; monitoring of nutritional status; nutrition and food hygiene education; household food security.
	12250	Infectious disease control	Immunisation; prevention and control of infectious and parasite diseases, except malaria (12262), tuberculosis (12263), HIV/AIDS and other STDs (13040). It includes diarrheal diseases, vector-borne diseases (e.g. river blindness and guinea worm), viral diseases, mycosis, helminthiasis, zoonosis, diseases by other bacteria and viruses, pediculosis, etc.
	12261	Health education	Information, education and training of the population for improving health knowledge and practices; public health and awareness campaigns.
	12262	Malaria control	Prevention and control of malaria.
	12263	Tuberculosis control	Immunisation, prevention and control of tuberculosis.
	12281	Health personnel development	Training of health staff for basic health care services.
130		POPULATION POLICIES/ PROGRAMMES AND REPRODUCTIVE HEALTH	
	13010	Population policy and administrative management	Population/development policies; census work, vital registration; migration data; demographic research/analysis; reproductive health research; unspecified population activities.
	13020	Reproductive health care	Promotion of reproductive health; prenatal and postnatal care including delivery; prevention and treatment of infertility; prevention and management of consequences of abortion; safe motherhood activities.
	13030	Family planning	Family planning services including counselling; information, education and communication (IEC) activities; delivery of contraceptives; capacity building and training.
	13040	STD control including HIV/AIDS	All activities related to sexually transmitted diseases and HIV/AIDS control e.g. information, education and communication; testing; prevention; treatment, care.
	13081	Personnel development for population and reproductive health	Education and training of health staff for population and reproductive health care services.
160		OTHER SOCIAL INFRASTRUCTURE AND SERVICES	
	16064	Social Mitigation of HIV/AIDS	Special programmes to address the consequences of HIV/AIDS, e.g. social, legal and economic assistance to people living with HIV/AIDS including food security and employment; support to vulnerable groups and children orphaned by HIV/AIDS; human rights of HIV/AIDS affected people.

ANNEX 5: CRS WATER SECTOR AND SUB-SECTORS USED IN THIS ANALYSIS

Source: OECD, The CRS List of Purpose Codes, Annex 5. DCD/DAC(2007)39

DAC 5 CODE	CRS CODE	DESCRIPTION	Clarifications / Additional notes on coverage
140		WATER SUPPLY AND SANITATION	
	14010	Water resources policy and administrative management	Water sector policy, planning and programmes; water legislation and management; institution capacity building and advice; water supply assessments and studies; groundwater, water quality and watershed studies; hydrogeology; excluding agricultural water resources (31140).
	14015	Water resources protection	Inland surface waters (rivers, lakes, etc.); conservation and rehabilitation of ground water; prevention of water contamination from agro-chemicals, industrial effluents.
	14020	Water supply and sanitation - large systems	Water desalination plants; intakes, storage, treatment, pumping stations, conveyance and distribution systems; sewerage; domestic and industrial waste water treatment plants.
	14030	Basic drinking water supply and basic sanitation	Water supply and sanitation through low-cost technologies such as handpumps, spring catchment, gravity-fed systems, rain water collection, storage tanks, small distribution systems; latrines, small-bore sewers, on-site disposal (septic tanks).
	14040	River development	Integrated river basin projects; river flow control; dams and reservoirs [excluding dams primarily for irrigation (31140) and hydropower (23065) and activities related to river transport (21040)].
	14050	Waste management/disposal	Municipal and industrial solid waste management, including hazardous and toxic waste; collection, disposal and treatment; landfill areas; composting and reuse.
	14081	Education and training in water supply and sanitation	

ANNEX 6: METHODOLOGY

Data for this analysis were obtained on October 28, 2011 using the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS) (available at: www.oecd.org/dataoecd/50/17/5037721.htm). Data represent “official development assistance” (ODA), defined by the OECD as funding provided to low- and middle-income countries as determined by per capita Gross National Income (GNI), excluding any funding to countries that are members of the Group of Eight (G8) or the European Union (EU), including those with a firm date for EU admission.²⁸ It is important to note that the OECD no longer collects data on “official aid” (OA), funding provided to countries and territories in transition, such as some of those in Central and Eastern Europe and the former Soviet States, although some do receive significant donor support for health.

Data are in nominal dollars, not adjusted for inflation or exchange rate fluctuations (unless otherwise noted) and represent gross annual new grant, concessional loan and/or equity investment disbursements in US\$, from 2002-2009. Commitments, or obligations, represent decisions to provide funding, regardless of the time at which actual outlays occur (multi-year commitments are counted in the year in which they are committed).²⁹ Disbursements, which often lag commitments, represent the actual expenditure of funds. ODA totals used in this paper have not been adjusted to reflect offsets corresponding to prior-loan repayments, which are neither identifiable with sub-sector financing nor universally available to lenders for re-obligation.

To adjust figures for inflation and exchange rate changes, published DAC deflators were used. They are available at http://www.oecd.org/document/6/0,3343,en_2649_34447_41007110_1_1_1_1,00.html

This analysis combines data deriving from two OECD CRS sectors and one subsector to capture funding for “health”: (1) Health sector; (2) Population Policies/Programs and Reproductive Health sector (includes HIV/AIDS & STDs); and (3) Social Mitigation of HIV/AIDS, a subsector of the Other Social Infrastructure and Services sector. The first two of these represent the OECD DAC statistical definition of “aid to health”. The Social Mitigation of HIV/AIDS is a relatively new category in the OECD CRS. The term “health” used in this paper, therefore, is an aggregate of all three sectors/subsectors unless otherwise noted.

The sub-sectors used in this analysis are derived from the OECD CRS “Health”, “Population Policies/Programs and Reproductive Health” and “Other Social Infrastructure and Services – Social Mitigation of HIV/AIDS” sub-sectors as follows:

Sub-Sector	OECD Sub-sector Codes
Management/Workforce	12110 - Health policy and administrative management 12181 - Medical education/training 12182 - Medical research 12230 - Basic health infrastructure 12281 - Health personnel development
Basic Health & Medical Care	12191 - Medical services 12220 - Basic health care 12261 - Health education
Nutrition	12240 - Nutrition
Other Infectious Diseases	12250 - Infectious disease control
Malaria	12262 - Malaria control
TB	12263 - Tuberculosis control
FP/RH	13010 - Population policy and administrative management 13020 - Reproductive health care 13030 - Family planning 13081 - Personnel development for population and reproductive health
HIV/AIDS	13040 - STD control including HIV/AIDS 16064 - Social Mitigation of HIV/AIDS

Data for the European Commission (EC) represent funds from the European Union's budget, as distinct from funding from member state budgets. The OECD DAC and CRS databases include EC funding as part of the multilateral sector; for the purposes of this paper, the EC is considered a donor government rather a multilateral organization.

Data on disbursements for the donor governments include their bilateral disbursements only. Disbursements entered into by multilateral institutions are attributed to those institutions, not donor governments, in the CRS database (where donors do specify such contributions for health and account for them as part of their bilateral budgets, they are included in their bilateral assistance totals). General contributions to multilateral organizations are not identified in CRS with contributors.

ENDNOTES

¹ Author analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), October 28, 2011 (www.oecd.org/dataoecd/50/17/5037721.htm).

² The 24 DAC member governments are: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Japan, Luxembourg, Netherlands, New Zealand, Norway, Portugal, South Korea, Spain, Sweden, Switzerland, United Kingdom, United States, and European Commission.

³ Multilaterals include: The Global Fund to Fight AIDS, Tuberculosis and Malaria; The World Bank; African Development Fund (AfDF); Asian Development Fund (AsDF); Regional Development Banks; UNAIDS; UNDP; UNECE; UNFPA; UNICEF; WFP; and WHO. Data are not available for some UN Agencies. The OECD estimates that 85% of multilateral ODA for health is captured. See OECD, *Recent Trends in Official Development Assistance to Health*; 2006.

⁴ Data in this report are not directly comparable to prior year reports. First, prior reports analyzed commitments, not disbursements, as reported here. Second, donors may change data in the DAC database over time and this report reflects the most current data for the period, as of the data extraction date. Finally, prior Kaiser reports analyzed donor contributions to health as defined by the OECD DAC, but expanded this definition to include the water sector. In this report, the water sector is considered as a separate sector.

⁵ “Health” funding in this analysis combines data from three OECD CRS subsectors: (1) Health; (2) Population Policies/Programs & Reproductive Health (which includes HIV/AIDS & STDs); & (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS. The first 2 constitute the OECD’s statistical definition of health (see, OECD, *Recent Trends in Official Development Assistance to Health*, 2006: www.oecd.org/dataoecd/1/11/37461859.pdf).

⁶ See www.kff.org/hivaids/internationalfinancing.cfm.

⁷ See, for example: Murray CJL, Anderson B, Burstein R, Leach-Kemon K, Schneider M, Tardiff A, Zhang R. “Development Assistance for Health: Trends and Prospects”, *Lancet*; 378: 8-10; July 2011; Ravishankar N, Gubbins P, Cooley RJ, Leach-Kemon K, Michaud CM, Jamison DT, Murray CJL. “Financing of global health: tracking development assistance for health from 1990 to 2007”, *Lancet*; 373: 2113–24; June 20, 2009; Schieber GJ et al. “Financing Global Health: Mission Unaccomplished,” *Health Affairs*, Vol. 26, No. 4, July/August 2007.

⁸ United Nations, www.un.org/millenniumgoals/.

⁹ See the Global Fund, www.theglobalfund.org/.

¹⁰ See PEPFAR, www.pepfar.gov/.

¹¹ See PMI, www.pmi.gov/.

¹² See the GAVI Alliance, www.gavialliance.org/.

¹³ A disbursement is the actual release of funds to a recipient and may include funds committed in prior years. Commitments, or enacted amounts, represent the actual budgetary decisions that funding will be provided, regardless of the time at which actual disbursements occur. Therefore, it is possible that disbursements in 2009 were the result of commitments made in years prior to the start of the economic crisis.

¹⁴ Unless otherwise noted, all amounts represent gross ODA disbursements in nominal value.

¹⁵ Unlike net ODA, gross ODA, does not include loan repayments. In 2009, net ODA totaled \$119.6 billion. See: http://www.oecd.org/document/0,3746,en_2649_34447_44981579_1_1_1_1,00.html.

¹⁶ The DAC CRS database includes DAC Members’ bilateral ODA but excludes their contributions to multilateral institutions. Rather, funding provided by multilateral institutions is attributed to these institutions. For example, donor government contributions to the Global Fund, which account for the bulk of its financing, are not attributed to donor governments in the CRS database. Instead, funding provided by the Global Fund to country recipients is counted as multilateral aid and attributed to the Global Fund.

¹⁷ The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) is an independent, multilateral, financing entity designed to raise resources to combat HIV/AIDS, tuberculosis (TB), and malaria in low- and middle-income countries. The Global Fund raises and pools resources from public and private donors and in turn finances programs developed and implemented by recipient countries.

¹⁸ See also: OECD, “Development Aid from OECD Countries Fell 5.1% in 2006,” April 3, 2007 (http://www.oecd.org/document/17/0,2340,en_2649_201185_38341265_1_1_1_1,00.html).

¹⁹ Also see OECD DAC, “Debt Relief is down: Other ODA rises slightly”, April 2008 (www.oecd.org/document/8/0,3343,en_2649_33721_40381960_1_1_1_1,00.html).

²⁰ It is important to note that debt relief, although reported to the DAC at full face value, often costs creditors significantly less, such as in cases where forgiven or rescheduled loans are already unserviceable or in arrears.

²¹ “Multisector/Other” represents combined data from five OECD CRS sectors and sub-sectors: (1) Multisector/Cross-cutting; (2) Administrative Costs of Donors; (3) Support of NGO’s; (4) Refugees in Donor Countries; (5) Other Social Infrastructure & Services (excluding Social Mitigation of HIV/AIDS).

²² See, Global Fund Donors and Contributions, <http://www.theglobalfund.org/en/about/donors/public/>.

²³ See, www.aiddata.org/.

²⁴ See, CRS. *China’s Foreign Aid Activities in Africa, Latin America, and Southeast Asia*; February 25, 2009.

²⁵ It is possible that these sub-sectors receive funding reported in other sub-sectors (e.g., training categorized as HIV/AIDS/STDs). For example, the U.S. Office of the Global AIDS Coordinator reported to Congress that in FY 2008, PEPFAR provided an estimated \$310 million to support training activities and supported close to 130,000 health care workers (see: US State Department Office of the Global AIDS Coordinator, *Celebrating Life: The U.S. President’s Emergency Plan for AIDS Relief 2009 Annual Report to Congress*). Such disaggregation, however, is not possible through the DAC or CRS databases.

²⁶ Funding for clean water and sanitation activities was included here given its importance to health (see, for example, WHO, www.who.int/water_sanitation_health/en/; USAID, www.usaid.gov/our_work/environment/water/wrm_health.html; State Department, www.state.gov/g/oes/water/).

²⁷ OECD. “Development aid reaches an historic high in 2010.” http://www.oecd.org/document/35/0,3746,en_2649_34447_47515235_1_1_1_1,00.html.

²⁸ OECD, “History of DAC Lists of Aid Recipient Countries,” www.oecd.org/document/55/0,3343,en_2649_34447_35832055_1_1_1_1,00.html.

²⁹ OECD, DAC Glossary, http://www.oecd.org/document/32/0,3343,en_2649_33721_42632800_1_1_1_1,00.html.



THE HENRY J. KAISER FAMILY FOUNDATION

Headquarters
2400 Sand Hill Road
Menlo Park, CA 94025
Phone 650-854-9400 Fax 650-854-4800

Washington Offices and
Barbara Jordan Conference Center
1330 G Street, NW
Washington, DC 20005
Phone 202-347-5270 Fax 202-347-5274

www.kff.org

This report (#7679-05) is available on the Kaiser Family Foundation's website at www.kff.org.

The Kaiser Family Foundation, a leader in health policy analysis, health journalism and communication, is dedicated to filling the need for trusted, independent information on the major health issues facing our nation and its people. The Foundation is a non-profit private operating foundation, based in Menlo Park, California.