THE HENRY J. KAISER FAMILY FOUNDATION

U.S. GLOBAL HEALTH POLICY

DONOR FUNDING FOR HEALTH IN LOW- & MIDDLE-INCOME COUNTRIES, 2002–2010

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Kaiser Family Foundation

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Executive Summary

While donor funding for health in low and middle-income countries rose significantly in the last decade, the era of rapid growth has come to an end. Health increased as a share of Official Development Assistance (ODA) during the early part of the past decade, largely spurred on by the creation of several new funding initiatives and mechanisms such as The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)[1] and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR).[2] However, this share has remained essentially flat in recent years, with year-to-year increases in donor funding for health peaking in 2007, and declining each year since.

Trends between 2002 and 2010 provide an indication of donor priorities and important shifts. For instance, the U.S. remained the largest donor to health in each year over the period and provided the greatest share of its ODA for health. Additionally, the donor mix has shifted over time, in part due to the entrance of new donors, particularly the Global Fund, which was created in 2002 and has been the second largest donor since 2006. The U.S. and the Global Fund combined accounted for more than half of total donor funding for health in 2010. Regionally, a growing share of funding over the period was directed to sub-Saharan Africa, which accounted for nearly half of total health funding in 2010. Finally, while funding for all health sub-sectors grew, funding for HIV/AIDS, malaria, and TB increased at faster rates, and in 2010, HIV/AIDS accounted for more than 40% of total health funding.

These trends are based on analysis of ODA disbursements for the Health sector provided by bilateral and multilateral donors between 2002 and 2010, and are part of a multi-year effort of the Kaiser Family Foundation to analyze and track trends in donor funding for health.[3,4,5]

Introduction

Donor funding, from governments and multilateral organizations, constitutes a major component of the global financial response for health in low and middle-income countries. As such, tracking these resources is an important element for assessing progress on global health, including toward meeting internationally agreed-upon health targets, such as the Millennium Development Goals (MDGs), and fulfillment of donor commitments, such as pledges to the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund).[6,7] This report provides an analysis of Official Development Assistance (ODA) disbursements for the Health sector provided by donors between 2002 and 2010, as reported to the Organisation for Economic Co-operation and Development (OECD) by Development Assistance Committee (DAC) member governments and multilateral organizations,[8,9,10] and serves to complement efforts by others in the field.[11]

Analyses of donor funding take on additional relevance in the current climate, due to continued financial uncertainty in the wake of the global economic crisis.[12,13] While 2010 is the most recent year for which standardized donor data, disaggregated by sector, are available, several other analyses provide an indicator of how it may fare in 2011 and beyond. For example, the OECD recently reported that overall ODA in 2011 declined and is expected to remain stagnant for the foreseeable future.[i,14] Additionally, a recent analysis by the Kaiser Family Foundation and UNAIDS found that donor funding for HIV/AIDS in low- and middle-income countries remained roughly flat between 2008 and 2011. Whether or not the Health sector as a whole demonstrates similar trends or experiences any downward effects beyond 2010 remains an open question.

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.

[i] The OECD announced that total donor government assistance in 2011, which includes both bilateral funding and contributions to multilateral organizations, declined in real terms for the first time in more than a decade (ODA increased slightly when represented in nominal terms). For the purposes of this analysis, data is provided in nominal terms and represent both bilateral and multilateral disbursements for health (donor government contributions to multilateral organizations are not provided). See methodology for more information.

Detailed Findings

Total ODA

- ODA rose considerably in the past decade, with disbursements more than doubling between 2002 and 2010, from nominal US$54.8 billion to US$147.4 billion, a 169.0% increase (Table 1 and Figure 2). Increases were relatively stable, except in 2005 and 2006, when scheduled, and significant, debt relief transactions were made thereby increasing ODA in those two years (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.[15,16,17] Aid to Iraq, Afghanistan, and Pakistan, for example, accounted for about 11.2% of ODA disbursements between 2002 and 2010. Debt Relief accounted for approximately 16.1% of ODA disbursements during the same period. After adjusting for these combined factors, the increase over the period in real terms was $62.1 billion, an increase of 97.1%.

Table 1: Total ODA by Major Sector, 2002, 2009, 2010

Gross US$ Disbursements in Billions

	2002	2009	2010	2009-2010	2002-2010
				+/- $ (%)	+/- $ (%)
Health*	4.4	17.0	18.4	+1.4 (8.2%)	+14.0 (316.5%)
Water	1.4	5.6	6.2	+0.6 (10.5%)	+4.8 (334.5%)
Education	3.3	12.0	12.4	+0.4 (3.3%)	+9.1 (275.5%)
Government/Civil Society	4.8	17.2	16.9	-0.3 (-1.6%)	+12.2 (255.5%)
Economic Infrastructure	5.6	19.5	21.6	+2.1 (10.9%)	+16.0 (284.9%)
Production	3.9	9.2	10.9	+1.7 (18.9%)	+7.0 (177.5%)
Commodity Aid	4.9	10.0	8.1	-1.9 (-18.8%)	+3.2 (64.0%)
Debt Relief	6.5	6.4	9.4	3.0 (46.6%)	3.0 (46.0%)
Emergency Assistance	3.0	10.9	11.6	0.7 (6.3%)	+8.6 (291.0%)
Multisector/Other**	7.0	25.8	30.3	+4.5 (17.3%)	+23.3 (334.5%)
Unspecified	10.0	2.7	1.7	-1.1 (-39.5%)	-8.4 (-83.5%)
TOTAL	**$54.8**	**$136.3**	**$147.4**	**+$11.1 (8.2%)**	**+$92.6 (169.0%)**

* 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 increased more than four-fold over the period, rising from $4.4 billion to $18.4 billion, an increase in real terms even after adjusting for inflation and currency revaluation (Figure 1 and Annex 2) and grew at a much faster pace (316.5%) than overall ODA (169.0%). Health also grew as a share of overall ODA, rising from 8.1% in 2002 to 12.5% in 2009, and remained at this level in 2010 (Figure 4).

- The Health sector demonstrated the third largest increase ($14.0 billion) in ODA over the decade, behind projects that supported Multisectoral or other general efforts ($23.3 billion)[18] and Economic Infrastructure ($16.0 billion). Health also accounted for the fifth largest share of the increase in the 2009-2010 period ($1.4 billion), behind projects that supported Multisectoral or other general efforts ($4.2 billion), Debt Relief ($3.0 billion), Economic Infrastructure ($2.1 billion), and Production ($1.7 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 2002 and 2006, for example, health grew by 147.8%, compared to a 68.1% increase in the 2006 to 2010 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). Year-to-year increases, peaked in 2007 ($2.5 billion increase) and have declined in each subsequent year. Additionally, as the base of donor funding for health has grown, the annual rate of increase has slowed with 2010 demonstrating the smallest year-to-year percent change (8.2%) over the entire period (Figure 5).

Health ODA by Donor

- Forty-three donors provided health ODA in 2010 (26 bilateral donors and 17 multilateral donors) an increase from 26 donors (21 bilateral and 5 multilateral) in 2002. This increase reflects the creation of new multilateral donors such as The Global Fund and GAVI as well as the entry of new Non-DAC bilateral donors such as Saudi Arabia and Kuwait (Box 2).

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, as well as private sector donors such as The Bill & Melinda Gates Foundation. All of these donors 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. For example, 21 Non-DAC countries report their ODA to the OCED and 23 Non-DAC countries have made contributions to the Global Fund.[25,26] However, obtaining funding data for new donors is challenging as the DAC is self-reporting and there is currently no other centralized source that contains data for all these.

- Most health ODA over the decade was provided bilaterally by donor governments, who collectively accounted for nearly two thirds of disbursements (65.8%) in 2010, with multilateral organizations providing the rest (34.2%) (See Annex 2).[19] However, funding from multilateral organizations accounted for nearly three quarters of the $1.4 billion increase in health ODA between 2009 and 2010.

- The U.S. government was the single largest donor to health over the entire period, including in 2010 ($6.4 billion), when it accounted for over a third of all health ODA (34.6%) (Figure 6). This is up somewhat from 31.7% in 2002; by comparison, the U.S. share of total ODA declined over the period (from 23.5% in 2002 to 18.6% in 2010). The Global Fund, which was created in 2002, has been the second largest donor to health since 2006 and in 2010 ($3.0 billion) accounted for nearly half of total multilateral funding ($6.3 billion).

- After the United States, the United Kingdom was the second largest bilateral donor in 2010 ($1.2 billion) followed by the European Commission ($0.5 billion), Germany ($0.5 billion), and Canada ($0.5 billion). After the Global Fund, the World Bank was the second largest multilateral ($0.9 billion) in 2010 followed by GAVI ($0.7 billion), and the World Health Organization (WHO) ($0.4 billion).

- There have been some notable shifts in the donor mix, in part due to the entrance of new donors, particularly the Global Fund and to a lesser extent, GAVI, which are now among the top five donors to global health (Figure 6).

- The U.S. allocated the largest share of its total ODA to health among donor governments (23.3%) followed by Luxembourg (19.2%), Ireland (18.6%), South Korea (15.1%), and the United Kingdom (14.5%) (Figure 7). 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 Denmark, the U.K., Ireland, and Norway (Figure 8). The U.S. was seventh by this measure.

Health ODA by Region

- Sub-Saharan Africa received the largest share of health funding of any region in each year between 2002 (31.9%) and 2010 (47.4%) (Figure 9), and accounted for a majority of the growth over the period (52.3%). Funding for the region grew as a share of health ODA between 2002 and 2008, rising from 31.9% to 47.6%, but has since remained at 2008 levels (Table 2 and Annex 2).

- Funding for South/Central Asia accounted for the second largest share in 2010 (13.3%). While the region was the second largest driver of growth (10.2%) over the 2002-2010 period, its share of health ODA has declined since 2002 (22.8%).

- The next largest region, by share of funding in 2010, was Far East Asia (7.0%). All other regions individually accounted for less than 3.0% of total health funding, and funding for three regions (North Africa, South America, and Oceania) declined between 2009 and 2010. Donors allocated a significant portion of health funding (20.1%) without specifying a region.

Table 2: Total Health ODA by Region, 2002, 2009, 2010

Gross US$ Disbursements in Billions

	2002	2009	2010	2009-2010	2002-2010
				+/- $ (%)	+/- $ (%)
North Africa	0.1	0.2	0.2	-0.01 (-5.4%)	+0.09 (115.8%)
Sub-Saharan Africa	1.4	8.1	8.7	+0.62 (7.6%)	+7.31 (519.4%)
North/Central America	0.2	0.5	0.5	+0.02 (4.3%)	+0.34 (203.0%)
South America	0.1	0.3	0.3	-0.01 (-3.5%)	+0.21 (200.5%)
Far East Asia	0.3	1.1	1.3	+0.19 (16.9%)	+0.99 (327.3%)
South/Central Asia	1.0	2.2	2.4	+0.22 (9.7%)	+1.43 (141.9%)
Middle East	0.1	0.3	0.4	+0.06 (16.9%)	+0.32 (390.9%)
Europe	0.1	0.2	0.3	+0.03 (15.2%)	+0.19 (275.0%)
Oceania	0.1	0.2	0.2	-0.01 (-4.9%)	+0.14 (175.5%)
Regional	0.1	0.3	0.4	+0.06 (19.0%)	+0.32 (422.0%)
Unspecified	1.0	3.5	3.7	+0.23 (6.6%)	+2.65 (252.6%)
TOTAL	**$4.4**	**$17.0**	**$18.4**	**+$1.39 (8.2%)**	**+$13.98 (316.5%)**

Health ODA by Sub-Sector

- Looking at specific activities within the Health sector, the greatest share of funding in 2010 went to HIV/AIDS & STDs (40.2%) (Table 3 and Figure 10).[21] Basic Health & Medical Care accounted for the next largest share (14.8%) followed by Management/Workforce (13.2%), Family Planning & Reproductive Health (11.0%) and Malaria (8.7%). HIV also experienced the largest increase between 2009 and 2010 ($0.6 billion, 8.7%) followed

by Basic Health & Medical Care ($0.4 billion, 18.2%), and Tuberculosis ($0.3 billion, 60%). Two areas within health declined between 2009 and 2010: Nutrition (-$30.5 million, -7.7%) and Other Infectious Diseases (-$172.7 million, -14.0%) (Figure 11).

- HIV/AIDS drove most of the growth in health ODA over the 2002 to 2010 period accounting for $6.5 billion (46.8%) of the $14.0 billion increase in health ODA. Basic Health & Medical Care accounted for the second largest share ($1.9 billion, 13.4%) of the increase, followed by Malaria ($1.6 billion, 11.3%), Management/Workforce ($1.3 billion, 9.0%), and Family Planning & Reproductive Health ($1.2 billion, 8.4%) (Figure 12 and Annex 2).

- While funding for all sectors grew over the 2002 to 2010 period, funding for HIV/AIDS, Malaria, and TB increased at faster rates than other sectors, each rising as a share of total health ODA. All other sectors fluctuated as a share of health ODA over the period. For example, Family Planning and Reproductive Health declined as a share of total ODA between 2002 and 2007, but has risen in subsequent years.

Box 3: ODA for Water[28]

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. 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 13, and Annex 2).

- Water ODA more than quadrupled from $1.4 billion in 2002 to $6.2 billion in 2010; while not the largest dollar increase, water demonstrated the largest percentage increase among all sectors (334.5%).
- In 2010, as with the Health sector, Sub-Saharan Africa accounted for the largest share (29.6%) of Water ODA. South & Central Asia accounted for the second largest share (17.2%) followed by Far East Asia (15.4%).
- The constellation of donors who fund water projects is different from the Health sector. In 2010, Japan was the largest donor to water ODA ($1.6 billion), accounting for more than a quarter of water funding (26.6%). The second largest donor was the World Bank ($0.7 billion, 11.6%), followed by Germany ($0.6 billion, 9.6%) the European Commission ($0.5 billion, 8.1%), the U.S. ($0.4 billion, 6.4%), and Spain ($0.3 billion, 5.4%).

Table 3: Total Health ODA by Sub-Sector, 2002, 2009, 2010

Gross US$ Disbursements in Billions

	2002	2009	2010	2009-2010	2002-2010
				+/- $ (%)	+/- $ (%)
Management/Workforce	1.2	2.3	2.4	+0.01 (3.4%)	+1.3 (108.0%)
Basic Health & Medical Care	0.9	2.3	2.7	0.42 (18.2%)	+1.9 (220.5%)
Nutrition	0.1	0.4	0.4	-0.03 (-7.7%)	+0.3 (242.0%)
Other Infectious Diseases	0.6	1.2	1.1	-$0.17 (-14.0%)	+0.51 (91.8%)
Malaria	0.0	1.5	1.6	+0.13 (8.6%)	+1.6 (NA)
Tuberculosis	0.0	0.5	0.8	+0.30 (60.0%)	+0.8 (NA)
Family Planning & Reproductive Health	0.9	1.9	2.0	+0.08 (4.3%)	+1.2 (137.5%)
HIV/AIDS	0.8	6.8	7.4	+0.59 (8.7%)	+6.5 (776.2%)
TOTAL	**$4.4**	**$17.0**	**$18.4**	**+$1.4 (8.2%)**	**+$14.0 (316.5%)**

Conclusion

Tracking donor 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 each year over the 2002 to 2010 period. While health grew as a share of overall ODA between 2002 and 2010, reflecting its priority among donors, year-to-year increases peaked in 2007 and have declined in each subsequent year. Combined with the OECD's announcement that ODA in 2011 declined in real terms after more than a decade of steady increases and preliminary estimates that ODA is not expected to increase significantly in the coming years,[16] caution about future donor assistance for health may be warranted. 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.

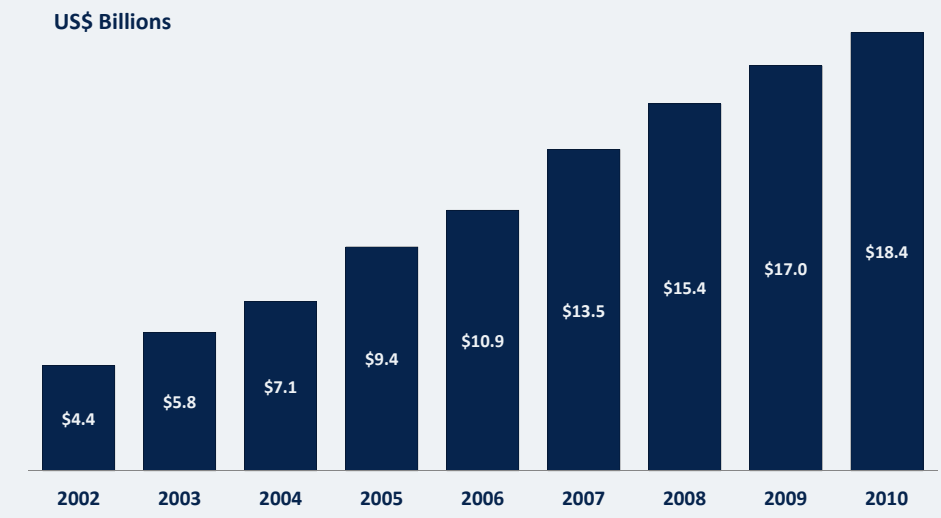
Acknowledgements

The authors would like to acknowledge input provided by Eric Lief of the Stimson Center on this year's report.

Annex 1: Figures

Figure 1:

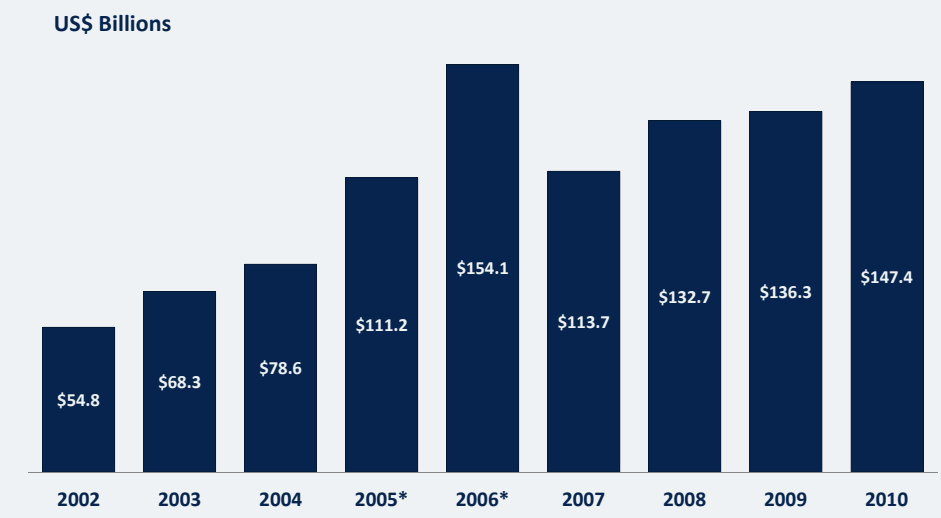
ODA Disbursements for Health, 2002-2010



Note: Amounts in gross US$ disbursements. Health ODA combines data from three OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), November 7, 2012.

Figure 2:

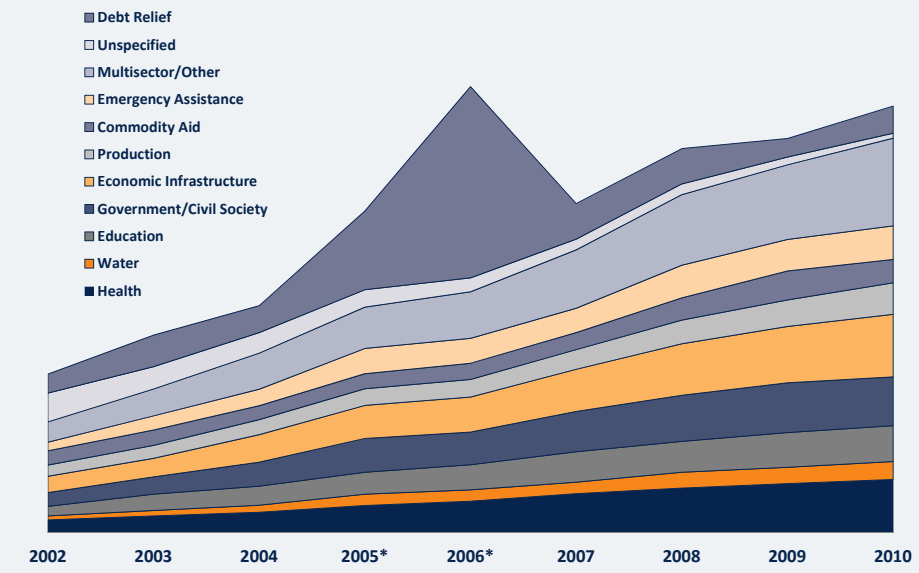
Total ODA Disbursements, 2002-2010



* ODA in 2005 and 2006 was higher than previous and subsequent years due to scheduled and significant additional debt relief transactions.
Note: Amounts in gross US$ disbursements. Health ODA combines data from three OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), November 7, 2012.

Figure 3:

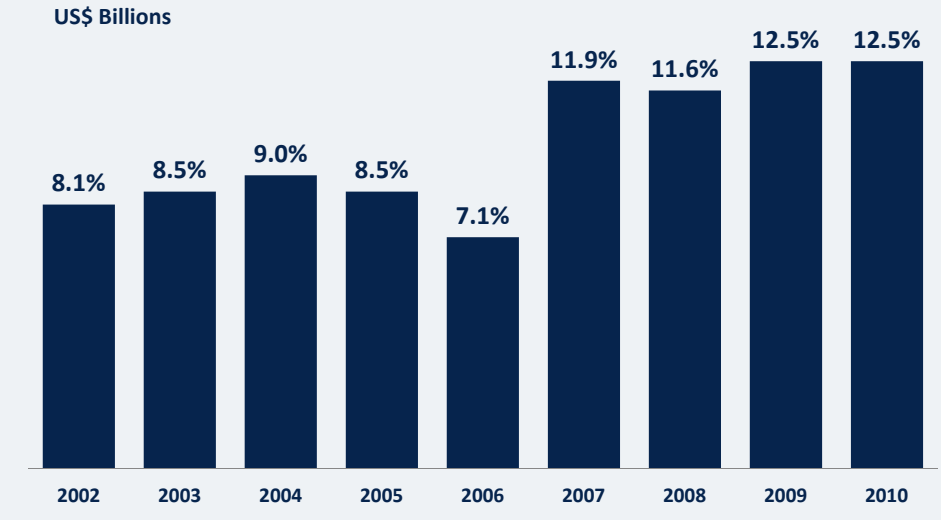
Total ODA Disbursements by Sector, 2002-2010



* Debt relief ODA in 2005 and 2006 was higher than previous and subsequent years due to scheduled and significant additional debt relief transactions.
Note: Amounts in gross US$ disbursements. Health ODA combines data from three OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), November 7, 2012.

Figure 4:

ODA Disbursements for Health as a Percentage of Total ODA, 2002-2010



Note: Amounts in gross US$ disbursements. Health ODA combines data from three OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), November 7, 2012.

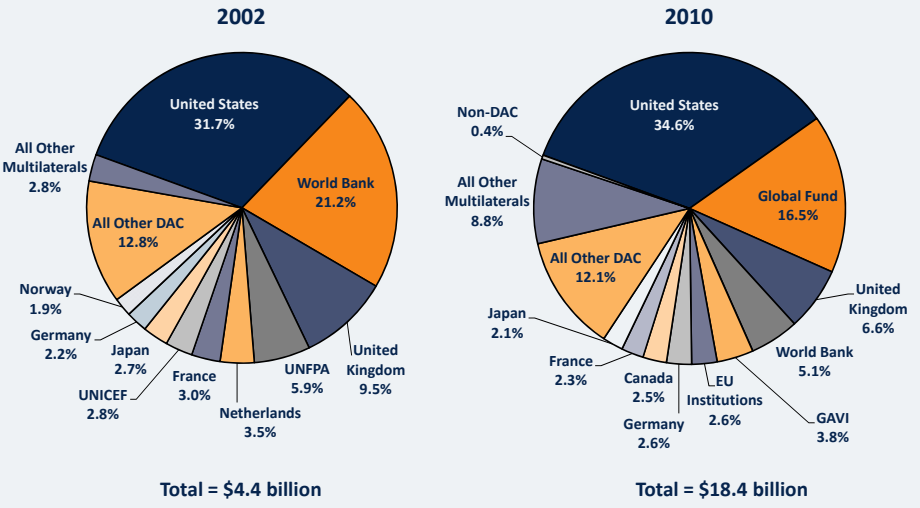
Figure 5:

Annual ODA Disbursements for Health & Year-to-Year Percent Change, 2002-2010

Note: Amounts in gross US$ disbursements. Health ODA combines data from three OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), November 7, 2012.

Figure 6:

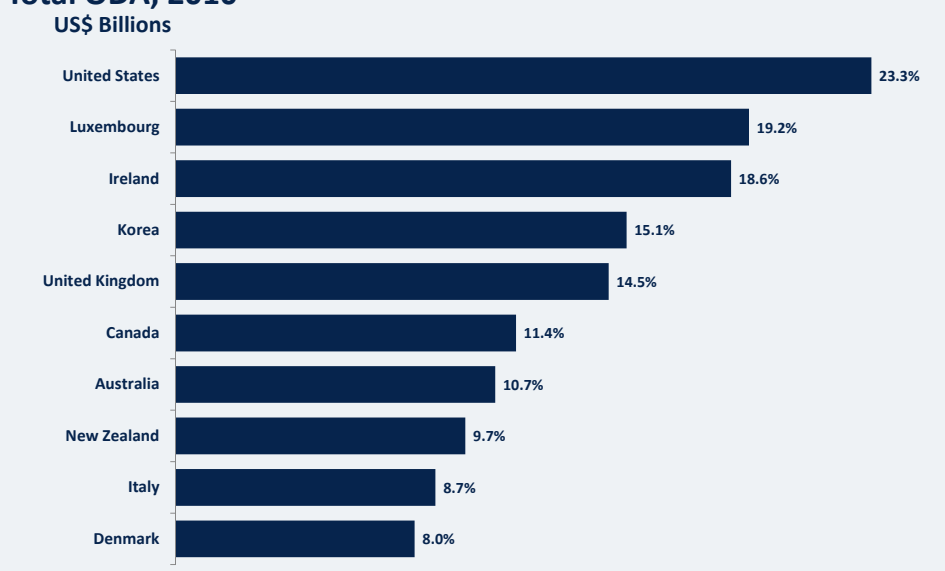
Top 10 Donors for Health ODA, 2002 & 2010



Note: Amounts in gross US$ disbursements. Health ODA combines data from three OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), November 7, 2012.

Figure 7:

Top 10 Donor Governments by Health ODA as a Percentage of Total ODA, 2010



Note: Amounts in gross US$ disbursements. Health ODA combines data from three OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), November 7, 2012.

Figure 8:

Top 10 Donor Governments by Health ODA per US$1 Million GDP, 2010

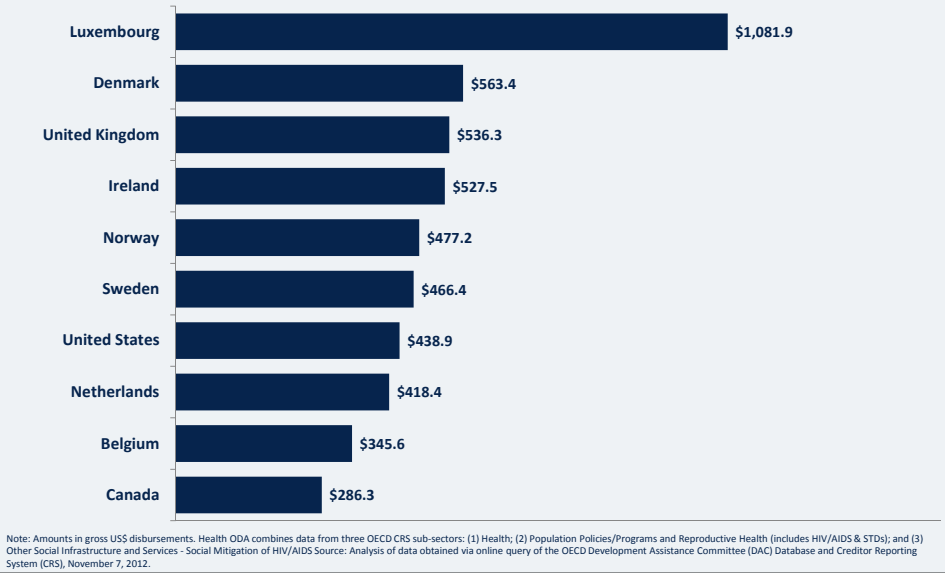


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Figure 9:

Health ODA Disbursements by Region, 2002-2010

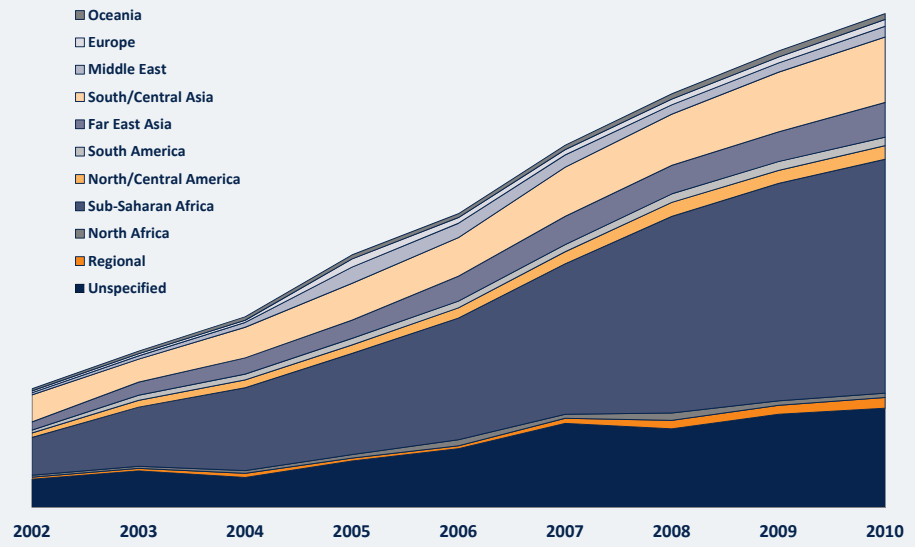

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Figure 10:

Major Sub-Sector Share of Health ODA, 2002 & 2010

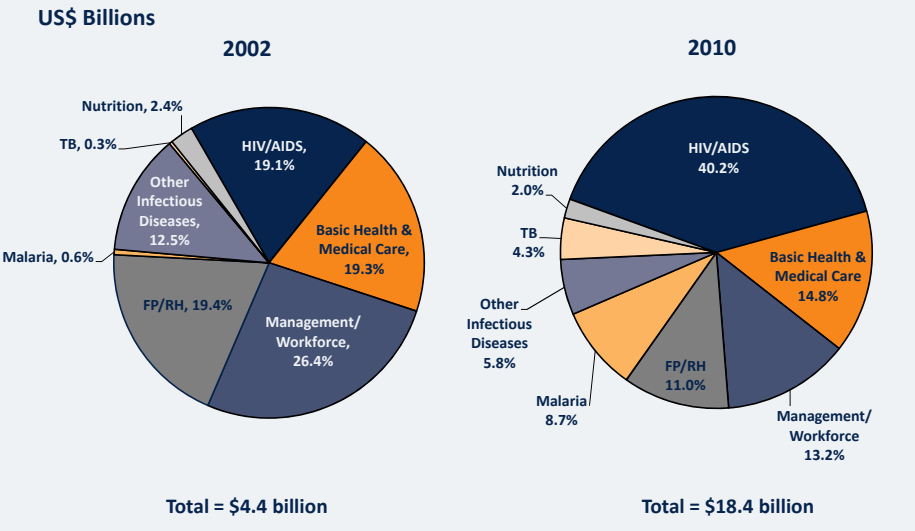

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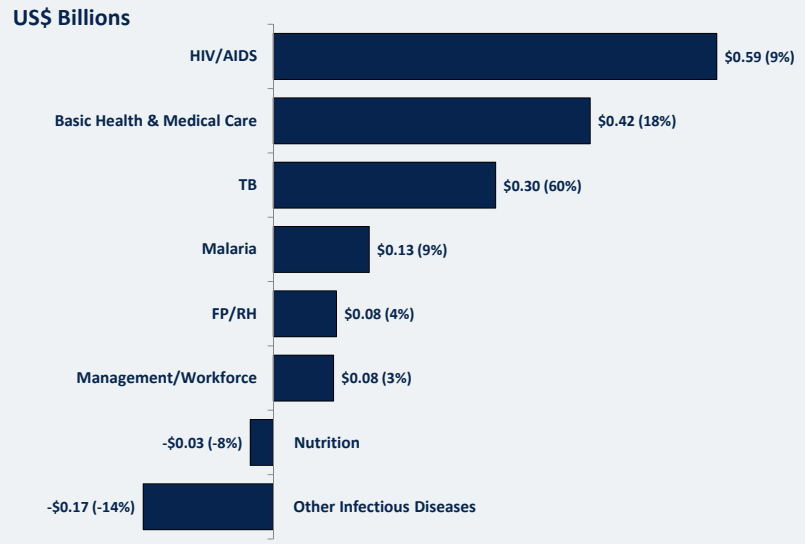
Figure 11:

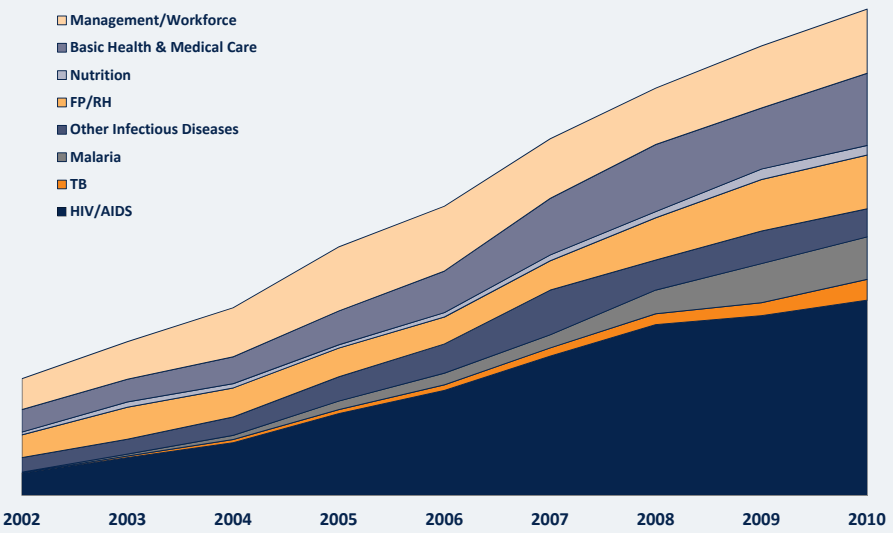
Change in Health ODA Disbursements by Major Sub-Sector, 2009-2010



Note: Amounts in gross US$ disbursements. Health ODA combines data from three OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), November 7, 2012.

Figure 12:

Health ODA Disbursements by Major Sub-Sector, 2002-2010



Note: Amounts in gross US$ disbursements. Health ODA combines data from three OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), November 7, 2012.

Figure 13:

ODA Disbursements for Water, 2002-2010

Note: Amounts in gross US$ disbursements. Health ODA combines data from three OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), November 7, 2012.

Annex 2: Data Tables

Total ODA by Major Sector, 2002-2009									
Gross US$ Disbursements in Billions									
	2002	2003	2004	2005	2006	2007	2008	2009	2010
Health	4.4	5.8	7.1	9.4	10.9	13.5	15.4	17.0	18.4
Water	1.4	1.9	2.4	3.9	3.9	4.0	5.5	5.6	6.2
Education	3.3	5.6	6.6	7.6	8.7	10.5	10.7	12.0	12.4
Government & Civil Society	4.8	6.0	8.3	11.7	11.3	13.9	15.9	17.2	16.9
Economic Infrastructure	5.6	6.4	9.5	11.4	12.1	14.6	17.8	19.5	21.6
Production	3.9	4.5	5.2	5.8	6.1	6.8	8.2	9.2	10.9
Commodity Aid	4.9	5.3	4.8	5.2	5.6	5.9	7.7	10.0	8.1
Debt Relief	6.5	10.9	9.3	27.2	66.1	12.3	12.2	6.4	9.4
Emergency Assistance	3.0	4.9	5.7	8.7	8.6	8.4	11.3	10.9	11.6
Multisector/Other	7.0	9.3	12.5	14.3	16.1	20.2	24.4	25.8	30.3
Unspecified	10.0	7.7	7.1	6.0	4.8	3.7	3.7	2.7	1.7
TOTAL	**54.8**	**68.3**	**78.6**	**111.2**	**154.1**	**113.7**	**132.7**	**136.3**	**147.4**

Total Health ODA by Region, 2002-2009									
Gross US$ Disbursements in Billions									
	2002	2003	2004	2005	2006	2007	2008	2009	2010
North Africa	0.1	0.1	0.1	0.1	0.2	0.2	0.3	0.2	0.2
Sub-Saharan	1.4	2.2	3.1	3.8	4.5	5.6	7.3	8.1	8.7
North & Central America	0.2	0.3	0.3	0.3	0.4	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	0.3
Far East Asia	0.3	0.5	0.6	0.7	0.9	1.1	1.1	1.1	1.3
South & Central Asia	1.0	0.9	1.1	1.4	1.4	1.8	1.9	2.2	2.4
Middle East	0.1	0.1	0.2	0.6	0.5	0.5	0.3	0.3	0.4
Europe	0.1	0.1	0.1	0.3	0.2	0.2	0.2	0.2	0.3
Oceania	0.1	0.1	0.1	0.2	0.1	0.2	0.2	0.2	0.2
Regional	0.1	0.1	0.2	0.1	0.1	0.2	0.3	0.3	0.4
Developing countries unspecifie	1.0	1.4	1.1	1.7	2.2	3.1	2.9	3.5	3.7
TOTAL	**4.4**	**5.8**	**7.1**	**9.4**	**10.9**	**13.5**	**15.4**	**17.0**	**18.4**

Total Health ODA by Sub-Sector, 2002-2009									
Gross US$ Disbursements in Billions									
	2002	2003	2004	2005	2006	2007	2008	2009	2010
Management/Workforce	1.2	1.4	1.9	2.4	2.5	2.3	2.1	2.3	2.4
Basic Health & Medical Care	0.9	0.9	1.0	1.3	1.6	2.1	2.5	2.3	2.7
Nutrition	0.1	0.2	0.2	0.1	0.2	0.2	0.2	0.4	0.4
Other Infectious Diseases	0.6	0.6	0.7	0.9	1.1	1.7	1.1	1.2	1.1
Malaria	0.0	0.1	0.2	0.3	0.4	0.5	0.9	1.5	1.6
TB	0.0	0.1	0.1	0.2	0.2	0.3	0.4	0.5	0.8
FP/RH	0.9	1.2	1.1	1.1	1.0	1.1	1.6	1.9	2.0
HIV/AIDS	0.8	1.4	2.0	3.1	4.0	5.3	6.5	6.8	7.4
TOTAL	**4.4**	**5.8**	**7.1**	**9.4**	**10.9**	**13.5**	**15.4**	**17.0**	**18.4**

Total Health ODA by Donor, 2002-2010									
Gross US$ Disbursements in Billions									
	2002	2003	2004	2005	2006	2007	2008	2009	2010
Australia	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.3
Austria	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Belgium	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2
Canada	0.1	0.1	0.2	0.3	0.2	0.4	0.4	0.4	0.5
Denmark	-	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.2
EU Institutions	0.1	0.1	0.2	0.4	0.6	0.7	0.7	0.6	0.5
Finland	0.0	0.0	-	-	0.0	0.0	0.0	0.0	0.0
France	0.1	0.2	0.2	0.3	0.3	0.1	0.4	0.3	0.4
Germany	0.1	0.2	0.2	0.2	0.2	0.4	0.4	0.4	0.5
Greece	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Ireland	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.1	0.1
Italy	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Japan	0.1	0.3	0.3	0.3	0.4	0.4	0.3	0.4	0.4
Korea	-	-	-	-	0.0	0.1	0.1	0.1	0.1
Luxembourg	-	-	0.0	0.0	0.0	0.1	0.1	0.0	0.1
Netherlands	0.2	0.2	0.2	0.2	0.3	0.3	0.4	0.4	0.3
New Zealand	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Norway	0.1	0.1	0.1	0.2	0.2	0.2	0.3	0.3	0.2
Portugal	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Spain	0.1	0.1	0.1	0.1	0.1	0.2	0.4	0.3	0.3
Sweden	0.1	0.1	0.2	0.2	0.3	0.3	0.3	0.2	0.2
Switzerland	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1
United Kingdom	0.4	0.4	0.5	0.6	0.9	1.1	1.0	1.1	1.2
United States	1.4	2.0	2.1	3.1	3.6	4.2	5.3	6.1	6.4
Total - DAC*	**3.0**	**4.1**	**4.8**	**6.6**	**8.0**	**9.3**	**11.0**	**11.6**	**12.0**
AfDF	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Arab Fund (AFESD)	-	-	-	-	-	-	0.0	0.0	0.0
AsDB Special Funds	-	-	-	-	-	-	-	-	0.2
GAVI	-	-	-	-	-	0.9	0.7	0.4	0.7
GEF	-	-	-	-	-	-	0.0	-	-
Global Fund	-	0.2	0.6	1.0	1.3	1.6	2.2	2.3	3.0
IDA	0.9	0.8	1.2	1.2	1.0	0.9	0.8	1.0	0.9
IDB Sp.Fund	-	-	-	-	-	-	-	0.0	0.0
OFID	-	-	-	-	-	-	-	0.0	0.0
UNAIDS	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2
UNDP	-	-	0.0	0.0	0.0	0.0	0.0	0.0	0.0
UNECE	-	-	-	-	-	-	0.0	0.0	0.0
UNFPA	0.3	0.4	0.2	0.2	0.2	0.2	0.3	0.3	0.3
UNICEF	0.1	0.1	0.1	0.2	0.1	0.2	0.1	0.2	0.2
UNPBF	-	-	-	-	-	-	-	0.0	0.0
UNRWA	-	-	-	0.1	0.1	0.1	0.1	0.1	0.1
WFP	-	-	-	-	-	-	-	0.0	0.0
WHO	-	-	-	-	-	-	-	0.4	0.4
Total - Multilateral*	**1.4**	**1.7**	**2.3**	**2.8**	**3.0**	**4.2**	**4.5**	**5.3**	**6.3**
Kuwait	-	-	-	-	-	-	-	-	0.0
United Arab Emirates	-	-	-	-	-	-	-	0.1	0.0
Total - Non-DAC	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**0.1**	**0.1**
Total - All Donors	**4.4**	**5.8**	**7.1**	**9.4**	**10.9**	**13.5**	**15.4**	**17.0**	**18.4**

*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 than a multilateral organization.

Annex 3: Country Membership/Affiliation

COUNTRY MEMBERSHIP/AFFILIATION				
Country	**DAC**	**G8**	**G20**	**BRICS**
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

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; promotion of improved personal hygiene practices, including use of sanitation facilities and handwashing with soap.
	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.

Annex 5: CRS Water Sector and Sub-Sectors Used in This Analysis

Source: OECD, The CRS List of Purpose Codes

DAC 5 CODE	CRS CODE	DESCRIPTION	Clarifications / Additional notes on coverage
140		**WATER AND SANITATION**	
	14010	Water sector policy and administrative management	Water sector policy and governance, including legislation, regulation, planning and management as well as transboundary management of water; institutional capacity development; activities supporting the Integrated Water Resource Management approach (IWRM: see box below).
	14015	Water resources conservation (including data collection)	Collection and usage of quantitative and qualitative data on water resources; creation and sharing of water knowledge; conservation and rehabilitation of inland surface waters (rivers, lakes etc.), ground water and coastal waters; prevention of water contamination.
	14020	Water supply and sanitation - large systems	Programmes where components according to 14021 and 14022 cannot be identified. When components are known, they should individually be reported under their respective purpose codes: water supply [14021], sanitation [14022], and hygiene [12261].
	14021	Water supply - large systems	Potable water treatment plants; intake works; storage; water supply pumping stations; large scale transmission / conveyance and distribution systems.
	14022	Sanitation - large systems	Large scale sewerage including trunk sewers and sewage pumping stations; domestic and industrial waste water treatment plants.
	14030	Basic drinking water supply and basic sanitation	Programmes where components according to 14031 and 14032 cannot be identified. When components are known, they should individually be reported under their respective purpose codes: water supply [14031], sanitation [14032], and hygiene [12261].
	14031	Basic drinking water supply	Rural water supply schemes using handpumps, spring catchments, gravity-fed systems, rainwater collection and fog harvesting, storage tanks, small distribution systems typically with shared connections/points of use. Urban schemes using handpumps and local neighbourhood networks including those with shared connections.
	14032	Basic sanitation	Latrines, on-site disposal and alternative sanitation systems, including the promotion of household and community investments in the construction of these facilities. (Use code 12261 for activities promoting improved personal hygiene practices.)
	14040	River basins' development	Infrastructure focused integrated river basin projects and related institutional activities; 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	Education and training for sector professionals and service providers.

Annex 6: Methodology

Data for this analysis were obtained on November 7, 2012 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.[23] 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 2002-2010. 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 than 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] See the Global Fund, www.theglobalfund.org/.
[2] See PEPFAR, www.pepfar.gov/.
[3] Data in this report are not directly comparable to prior year reports. First, prior to 2011, 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. Starting with the 2011 report, the water sector has been considered as a separate sector.
[4] "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).
[5] See www.kff.org/hivaids/internationalfinancing.cfm.
[6] United Nations, www.un.org/millenniumgoals/.
[7] United Nations. *The MDG GAP Task Force Report 2012: The Global Partnership for Development: Making Rhetoric a Reality*. September 2012.
[8] Author analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), November 7, 2012 (www.oecd.org/dataoecd/50/17/5037721.htm).
[9] 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.
[10] 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.
[11] See, for example: Grepin KA, Leach-Kemon K, Schneider M, Sridar D. "How to do (or not to do) . . . Tracking data on development assistance for health", Health Policy and Planning; 27: 527-534; 2012; 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.
[12] International Monetary Fund. *World Economic Outlook: Growth Resuming*, Dangers Remain. April 2012.
[13] United Nations. *World Economic Situation and Prospects 2012: Global Economic Outlook*. June 2012.
[14] See OECD. "Development: Aid to developing countries falls because of global recession." http://www.oecd.org/dac/aidstatistics/developmentaidtodevelopingcountriesfallsbecauseofglobalrecession.htm.
[15] 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).
[16] 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.)
[17] 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.
[18] "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).
[19] See OECD, "Non-DAC Countries reporting their development assistance to the DAC," http://www.oecd.org/dac/aidstatistics/non-daccountriesreportingtheirdevelopmentassistancetothedac.htm
[20] See Global Fund Donors and Contributions, http://www.theglobalfund.org/en/about/donors/public/.
[21] 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.
[22] 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/).
[23] 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.

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