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## HealthAffairs

**Trends In Alignment and Harmonization Of Reproductive, Maternal, Newborn, And Child Health Funding, 2008–13**

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Manuscript ID	2017-0364.R3
Manuscript Type:	Original Article
Keywords:	aid effectiveness, ODA, RMNCH, ALIGNMENT, HARMONISATION
Note: The following files were submitted by the author for peer review, but cannot be converted to PDF. You must view these files (e.g. movies) online.	
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## 4 **Trends In Harmonization Of**

### 5 **Financing For Reproductive,**

### 6 **Maternal, Newborn, And**

### 7 **Child Health, 2008–13**

#### 8 **Abstract**

9 Donor financing to low- and middle-income countries for reproductive, maternal,  
10 newborn, and child health increased substantially from 2008 to 2013. However,  
11 increased spending by donors might not improve outcomes, if funds are delivered in  
12 ways that undermine countries' public financial management systems and incur high  
13 transaction costs for project implementation. We combined quantitative and  
14 qualitative methods to examine the quality of funding for reproductive, maternal,  
15 newborn, and child health globally and in Tanzania, based on two principles of aid  
16 effectiveness: the alignment of donor financing with the recipient country's public  
17 health financial management systems, and donor harmonization for coordinated,  
18 transparent, and collectively effective actions. We found that alignment of donor  
19 financing deteriorated throughout the period, with the proportion of funds channeled  
20 through governments decreasing from 47 percent to 39 percent. Tanzania-based  
21 donors attributed the change to pressure donors were under to achieve and show  
22 results. Donor harmonization was low overall and remained relatively constant,  
23 although it increased in sub-Saharan Africa and decreased in South Asia. Bilateral  
24 funding agencies were the most harmonized donors. We recommend that future  
25 assessments of Sustainable Development Goals financing include measures of  
26 harmonization and alignment of funding.  
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Official development assistance for health from wealthy countries to low- and middle-income countries quadrupled from \$5 billion in 1990 to over \$21 billion in 2013.<sup>1</sup> The increase was accompanied by an expansion of actors and initiatives in the health sector, including global health initiatives. Simultaneously, interest in the effectiveness of official development assistance has grown, a topic addressed in a series of high-level forums and international conferences—in Monterrey, Mexico (2002); Rome, Italy (2003); Paris, France (2005); Accra, Ghana (2008); Busan, South Korea (2011); Mexico City (2014); and Addis Ababa, Ethiopia (2015)—each of which issued declarations. The Paris declaration articulated five principles of aid effectiveness: country ownership of national strategies; alignment of aid with country strategies; harmonization, or coordination, of donor aid; results for funding; and accountability between donors and aid recipients.<sup>2</sup> These principles encourage providers of official development assistance to align their funding with a recipient country's development strategies and systems, so that donors' activities are harmonized, and recipients and donors focus on achieving results for which they are mutually accountable.<sup>2</sup> These principles form the core of declarations and conferences above, and have been collectively defined as the "global aid effectiveness agenda."<sup>3</sup>

Most of the literature to date on official development assistance for health has focused on tracking its distribution from donors to countries and its targeting to countries' needs.<sup>4-8</sup> Less attention has been paid to its effectiveness in relation to the Paris principles, although there is evidence that funding fragmentation,<sup>9</sup> volatility,<sup>10</sup> and high transaction costs for recipient governments<sup>11</sup> limit both the impact of official development assistance on health and the sustainability of progress already achieved. A 2014 report found progress in the use of country-results

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4 frameworks and joint assessments of national strategies, but it reported reduced use  
5 of national financial management procedures and less predictable funding for 2015–  
6 17.<sup>12</sup> There have been further concerns that the focus on achieving global goals  
7 (including the Millennium Development Goals of the United Nations) and targets  
8 based on national averages have incentivized programs to focus on easily attained  
9 targets, thereby widening inequities<sup>13</sup> and favoring specific health conditions and  
10 population groups.<sup>14,15</sup> In addition, little attention has been paid to the adherence to  
11 aid effectiveness principles of health donors that target specific populations or  
12 diseases—despite recognition of the fact that providing assistance in the form of  
13 vertical projects (that is funds that are designated for specific diseases or population  
14 groups contribute to the proliferation of programs, fragmentation of programming,  
15 and transaction costs for national health ministries and hinders donor  
16 harmonization.<sup>16,17</sup>

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33 We used a mixed-methods approach to assess whether there were  
34 improvements in the alignment and harmonization of donor funding for reproductive,  
35 maternal, newborn, and child health between 2008 and 2013, both at the global level  
36 for donors and recipients and at the country level, using Tanzania as a case study.  
37 We focused on this funding because of the large increase in donor funding in recent  
38 years to low- and middle-income countries related to Millennium Development Goals  
39 4 and 5 (to improve child survival and maternal health, respectively).<sup>18</sup> We used a  
40 case study to highlight how global trends affect national ministries and country-based  
41 donors. We selected Tanzania as our case study because it is a low-income  
42 recipient country that has a high degree of dependency on official development  
43 assistance and that experienced a substantial increase in external reproductive,  
44 maternal, newborn, and child health funding between 2008 and 2013.<sup>18</sup> It is also a  
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4 country in which we have extensive experience working and living, and we are  
5 therefore familiar with its health systems and relevant stakeholders.  
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## 8 **Study Data And Methods**

### 9 *Data Sources*

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13 Quantitative data for both global and country-level analyses were extracted for  
14 the years 2008-13 from the Countdown ODA+ data set, which tracks flows of official  
15 development assistance (ODA) and private funds from the Bill and Melinda Gates  
16 Foundation (collectively referred to hereafter as ODA+ to reproductive, maternal,  
17 newborn, and child health.<sup>18,19</sup> The data set includes information about sixty-four  
18 donors and 147 recipient countries and is based on the Organization for Economic  
19 Cooperation and Development's (OECD's) Creditor Reporting System (CRS)  
20 database, to which it applies the Countdown project classification for reproductive,  
21 maternal, newborn, and child health (RMNCH).<sup>18</sup> All records in the CRS are  
22 individually classified as RMNCH following the Countdown ODA+ framework<sup>18</sup>—in  
23 which both the full value of vertical projects (such as family planning, providing  
24 emergency obstetric care, and vaccinating children) and a proportion of the value of  
25 funding for primary health care, HIV prevention and treatment, health-sector budget  
26 support, general budget support, and so on are considered to promote reproductive,  
27 maternal, newborn, and child health.<sup>18</sup>  
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46 For the qualitative component of the study, Melisa Martinez-Alvarez  
47 conducted semistructured interviews with members of the headquarters staff of four  
48 of the top ten donors to reproductive, maternal, newborn, and child health ( $n = 4$ ),  
49 representatives of donors in Tanzania ( $n = 7$ ), and representatives of governmental  
50 and nongovernmental organizations working in the Tanzanian health sector ( $n = 15$ ).  
51 The interviews explored whether and how principles of aid effectiveness are  
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4 considered in resource allocation and the perceptions of trends in resource allocation  
5 patterns over time and their consequences. A semistructured interview tool was used  
6 to guide the interviews (see the interview guide in the online Appendix).<sup>20</sup>

### 11 *Analytical Framework*

12 We developed an analytical framework to assess progress toward alignment  
13 and harmonization of official and Gates assistance to reproductive, maternal,  
14 newborn, and child health, based on the definitions in the Paris Declaration on Aid  
15 Effectiveness<sup>2</sup> that could be feasibly measured with our data (Appendix Table 1).<sup>20</sup>

16 According to the Paris Declaration, *alignment* refers to the degree to which  
17 donors base their support on recipient countries' national development strategies,  
18 institutions, and procedures.<sup>2</sup> The Paris indicators to assess the alignment of donor  
19 funding focus on the proportion of official development assistance that uses national  
20 financial systems, is reported on national budgets, and is predictable and untied (can  
21 be used to purchase goods and services from any country), as well as the quality of  
22 country systems.<sup>2,21</sup> The Countdown ODA+ data did not allow us to assess the  
23 proportion of funds reported on national budgets or the degree of tying official and  
24 Gates assistance to reproductive, maternal, newborn, and child health. Instead, we  
25 assessed the proportion of funds disbursed through government systems; the  
26 proportion of funds that were pooled to assess the use of national financial systems;  
27 and the volatility of funds from the top ten donors of ODA+ for reproductive,  
28 maternal, newborn, and child health at the country level in Tanzania as a proxy for  
29 predictability.

30 Tanzania received ODA+ for this area of health from twenty-eight to thirty-two  
31 donors during the study period. The top ten donors accounted for 88.2 percent of the  
32 funds (and therefore would have had the most impact on the volatility of funding); we

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4 discuss only these funders in our analysis of volatility. We therefore measured  
5 alignment by the share of ODA+ delivered through government channels by donor  
6 and by recipient country; the share of ODA+ delivered through the government that  
7 used pooled modalities rather than project funding; and volatility in total ODA+ to  
8 reproductive, maternal, newborn, and child health disbursed by donors to  
9 Tanzania.<sup>22</sup>

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18 *Harmonization* is defined in the Paris Declaration as the degree to which  
19 donors' actions are coordinated, transparent, and collectively effective.<sup>2</sup> The  
20 indicators used to evaluate harmonization according to that definition are the use of  
21 common arrangements and procedures and shared analysis.<sup>2,21</sup> Our data did not  
22 allow us to systematically compare donors and recipient countries using these  
23 indicators. Furthermore, we did not consider them to be suitable ways to assess the  
24 impact of donor activities on recipient countries. Instead, we assessed the  
25 fragmentation and proliferation of funding for reproductive, maternal, newborn, and  
26 child health, which donors committed to reduce in the Paris<sup>2</sup> and Accra Declarations.  
27 We did this at the global level through indices of dispersion by assessing donor  
28 proliferation and recipient-country fragmentation of funding. A donor is a high  
29 proliferator if it distributes its budget among many recipients and a low proliferator if it  
30 concentrates its budget among a small number of countries.<sup>11</sup> *Fragmentation* refers  
31 to the number of donors in a given recipient country relative to the total official and  
32 Gates assistance for reproductive, maternal, newborn, and child health. A country is  
33 highly fragmented if there are many donors, each of which provides a small share of  
34 the total official and Gates assistance.<sup>11</sup>

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*Data Analysis*



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4 We classified ODA+ to reproductive, maternal, newborn, and child health as  
5 disbursed through the government if the OECD's Creditor Reporting System  
6 database classified it as such (CRS channel codes 10000–19999) or if the channel  
7 code was empty but the CRS aid type was general budget support (A01) or health-  
8 sector budget support (A02). We manually classified projects as disbursed *through*  
9 *the government* if the "channel name" field indicated a government agency, and as  
10 *outside the government* if the same field indicated a nongovernmental organization.  
11 We considered ODA+ to reproductive, maternal, newborn, and child health to have  
12 been delivered as pooled funds if the type of assistance was general budget support  
13 (CRS type A01), health-sector budget support (CRS type A02), or basket funds or  
14 pooled funding (CRS type B04) that were explicitly channeled through the  
15 government. We analyzed trends in aid type for the period 2009–13, because data  
16 for 2008 were incomplete.

### 32 *Global Analysis*

33 We examined donor proliferation and recipient-country fragmentation of  
34 funding using the Theil and Herfindahl-Hirschman Indices, respectively<sup>11</sup> (see the  
35 supplementary methods in Appendix),<sup>20</sup> based on three-year averages of ODA+ to  
36 reproductive, maternal, newborn, and child health in the period 2006<sup>11</sup> and the  
37 average in the period 2012–13 to remove yearly variation.<sup>23</sup> The Theil Index (which  
38 ranges from 0 to the natural log of the number of recipients) compares the amount  
39 disbursed by a donor to a country to the average amount disbursed by the donor per  
40 country. A smaller Theil Index indicates greater proliferation, or that there are many  
41 recipients that receive less than the average amount from a particular donor. The  
42 Herfindahl-Hirschman Index (HHI) compares the number of donors in a recipient  
43 country to the total amount of ODA+ to reproductive, maternal, newborn, and child  
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4 health that the country receives. It is estimated as a number between  $1/n$  and 1,  
5 where  $n$  is the number of donors disbursing official development assistance to a  
6 recipient country. Larger values suggest concentration of ODA+ (in other words, that  
7 a single donor or small group of donors contribute a significant share of the  
8 assistance); smaller values indicate greater fragmentation in assistance (in other  
9 words, the assistance is distributed in small amounts by many donors). Therefore,  
10 the larger the HHI, the greater the degree of harmonization of ODA+.

11 We generated measures of alignment and harmonization of funding for every  
12 donor and recipient country. We estimated averages across donor types (bilateral,  
13 multilateral, global health initiatives, and the Gates Foundation) and recipient country  
14 income groups (using the World Bank classification through 2016 per-capita gross  
15 national income of low- (<\$1,005), lower-middle(\$1,006-\$3,955), upper-middle  
16 (\$3,956-\$12,235), and high-income countries(>\$12,236) )<sup>24</sup>. We categorized the  
17 European Union (EU) as a bilateral donor since EU institutions, rather than member  
18 states, ensure coherence and control spending for official development assistance.<sup>25</sup>  
19 We distinguished between multilaterals (made up of multiple members, including UN  
20 agencies and Bretton Woods institutions) and global health initiatives (single-issue  
21 agencies, including the Global Fund to Fight AIDS, Tuberculosis, and Malaria and  
22 GAVI, the Vaccine Alliance). For 2013 we estimated ranges of values for channel,  
23 modality and fragmentation index [please provide] for each of the income groups  
24 (see Appendix Figure 1).<sup>20</sup> We analyzed fragmentation across geographic regions.

### 51 *Tanzania Case Study*

52 To explore the alignment of donor funding with government strategies in  
53 Tanzania, we also examined volatility year by year in ODA+ to reproductive,  
54 maternal, newborn, and child health disbursements for each of the top ten donors in  
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4 the period 2008–13. To measure fragmentation in Tanzania, we calculated the  
5 number of donors; the proportion of total ODA+ to reproductive, maternal, newborn,  
6 and child health that each donor represented; and the number of transactions for the  
7 period 2008–13. We assumed that each record in the CRS database represented a  
8 transaction. Although a single project can be delivered as multiple transactions, each  
9 transaction incurs costs in terms of reports and meetings.  
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17 For the qualitative analysis, interviews were recorded and transcribed. Data  
18 from the interviews were analyzed using thematic coding<sup>26</sup> that was based on the  
19 analytical framework (for details, see Appendix Table 1).<sup>20</sup> The coding framework  
20 was developed by Melisa Martinez-Alvarez and Josephine Borghi, and all coding  
21 was undertaken by Melisa Martinez-Alvarez. NVivo was used to manage the data.  
22 Qualitative analysis was undertaken after the analysis of quantitative data. The  
23 results of the analyses were integrated during the writing of this article.  
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### 33 *Limitations*

34 This study was subject to several methodological limitations. First, we  
35 assessed aid effectiveness in relation to the two principles that could be measured  
36 with our data. Other important principles of aid effectiveness (country ownership of  
37 national strategies, management for results, and mutual accountability of donors and  
38 recipients) were not addressed. These principles are difficult to assess across  
39 countries, since they require the use of qualitative methods to understand whether  
40 the mechanisms in place achieved their intended outcomes.<sup>3</sup> In addition, we did not  
41 determine what the funds were spent on, despite the implications this may have for  
42 their effectiveness. Alignment and harmonization of funding could be measured in  
43 ways other than those used in this study. For instance, a measure of alignment  
44 should consider whether donor funding is filling gaps in national plans, but there is  
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4 no consistent methodology that can be used to assess this. Similarly, harmonization  
5 should be assessed according to the degree to which donors adopt common  
6 approaches in recipient countries. This is difficult to achieve across countries. An in-  
7 depth case study in Tanzania found that despite coordination mechanisms' being in  
8 place, internal donor structures and incentives were hindering harmonization efforts.<sup>3</sup>  
9 Furthermore, our definition of *aid effectiveness* was restricted to the code of good  
10 practice outlined by the global aid effectiveness agenda, instead of being based on  
11 an evaluation of the impact of different modalities for official and Gates assistance on  
12 reproductive, maternal, newborn, and child health outcomes.  
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24 Second, there were some limitations to our data. Information in the  
25 Countdown ODA+ database was manually coded by different people in different  
26 years, and although the team performed consistency checks, some bias may have  
27 still been introduced.<sup>19</sup> In addition, we made assumptions about the proportions of  
28 funds for reproductive, maternal, newborn, and child health that were delivered as  
29 general or health-sector budget support, since donors indicated only the funding  
30 modality, not its subsequent allocation to reproductive, maternal, newborn, and child  
31 health.<sup>18</sup> In Tanzania, general budget support is disbursed through the Ministry of  
32 Finance, so including this type of financing might have resulted in an overestimation  
33 of the number of transactions that the Ministry of Health managed. However, we do  
34 not anticipate this to be substantial. Our estimates of official and Gates assistance  
35 for reproductive, maternal, newborn, and child health differ from those previously  
36 reported in Countdown ODA+ analyses<sup>18</sup> because we excluded funds reported as  
37 regional disbursements—since we were interested in aid flows to specific recipient  
38 countries. By considering only funds disbursed through the government if that was  
39 the channel recorded in the CRS database, we might have underestimated the  
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4 amount of funds delivered through a third partner but ultimately disbursed to  
5 governments (for instance, GAVI disburses 74.3 percent of its official and Gates  
6 assistance for reproductive, maternal, newborn, and child health through UNICEF).  
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8 In addition, we were not able to unpack the drivers of funding allocation. However,  
9 this is the subject of future work currently being undertaken by the authors.  
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15 Finally, only Martinez-Alvarez conducted the interviews and analyzed the  
16 qualitative data. This may have biased both the participants' responses and how  
17 they were interpreted.  
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## 22 **Study Results**

### 23 *Alignment Of Donor Funding*

24 In the period 2009–13, 40.9 percent of official and Gates assistance for  
25 reproductive, maternal, newborn, and child health was delivered through  
26 governments (Exhibit 1). On average, in the period 2008–13, global health initiatives  
27 delivered 44.3 percent of their funds through governments; the shares for bilaterals  
28 and multilaterals were 38.5 percent and 58.7 percent, respectively (Appendix Table  
29 2).<sup>20</sup> Of the top ten donors, those channeling the highest proportions of funds  
30 through governments were Germany (81.3 percent) and the Global Fund (61.7  
31 percent), and those channeling the lowest proportions were the Gates Foundation  
32 (1.4 percent) and GAVI (9.7 percent) (Appendix Table 3).<sup>20</sup> In the same period, the  
33 share of funds for reproductive, maternal, newborn, and child health disbursed  
34 through government channels declined from 46.6 percent to 38.7 percent (Exhibit 2).  
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Bilateral agencies and global health initiatives reduced their funding through  
governments, while the funding of multilaterals increased in 2009 and then stayed  
constant.

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In the period 2009–13, for those donors delivering official and Gates assistance for reproductive, maternal, newborn, and child health through government channels, only 12.9 percent of the assistance, on average, was delivered as pooled funds with other donors, with 82.0 per cent being disbursed as project funding (there was insufficient information to estimate the modality of the remainder 5.1 percent) (Appendix Table 4).<sup>20</sup> Of the top ten donors, Canada (86.0 percent), EU institutions (61.7 percent), and the United Kingdom (32.8 percent) disbursed the highest proportion of their funds through governments as pooled funds (Appendix Table 4).<sup>20</sup> Eighteen donors disbursed none of their funds to governments as pooled funding, including the Global Fund, GAVI, and the Gates Foundation. The share of government funds pooled across all donors increased from 7.5 percent in 2009 to 18.2 percent in 2011 and then decreased to 13.1 percent in 2013 (Exhibit 3).

Between 2008 and 2013, disbursements of total official and Gates assistance for reproductive, maternal, newborn, and child health through government channels increased for lower-middle- and low-income countries (from \$1,403.5 million to \$2,035.3 million and from \$1,292.7 million to \$1,785.8 million, respectively) (Exhibit 4); however, as a proportion of total ODA+ to reproductive, maternal, newborn, and child health, funds through the government decreased in both income groups (from 45.9 percent to 39.3 percent and from 47.0 percent to 36.2 percent, respectively) (Appendix Table 5)<sup>20</sup>). Of the funds channeled through the government, 9.6 percent were delivered as pooled funds with other donors in lower-middle-income countries, and 15.8 percent were delivered as pooled funds in low-income countries. Trends in alignment showed a high degree of heterogeneity (Appendix Figure 1);<sup>20</sup> although the top three recipients received about half of their funds for reproductive, maternal,

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4 newborn, and child health through their governments (Nigeria 46.6 percent, Ethiopia  
5 45.9 percent, and Kenya 41.4 percent) (data not shown).  
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9 Qualitative findings showed that donors' headquarters staff members had  
10 concerns about the use of pooled funds, given the need for control and  
11 accountability to their own governments that resources are spent in appropriate  
12 ways.  
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18 One staff member said: "For us as an agency..., the solution is not,  
19 essentially, to have all the funds in one basket and then make grants to countries;  
20 we have some specific things that we need to try to accomplish.... The degree of  
21 control and accountability that we need, therefore—it's usually not going to be  
22 satisfied by, essentially, having all of our funds in global mechanisms."  
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### 28 *Harmonization Of Donor Funding*

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31 On average, donors provided official and Gates assistance for reproductive,  
32 maternal, newborn, and child health to about forty five recipient countries between  
33 2006 and 2013. Seven donors donated to more than a hundred recipient countries,  
34 including three of the top ten donors (the United States donated to 110.6 countries,  
35 the Global Fund to 109.2, and the European Union to 110.7) (Appendix Table 7).<sup>20</sup>  
36 For most donors, the Theil Index was less than or near 1.0, which indicates high  
37 proliferation of funding—that is, disbursement of small levels of official and Gates  
38 assistance for reproductive, maternal, newborn, and child health to many countries.  
39 The Theil Index overall was relatively unchanged between 2006–08 (0.95) and  
40 2012–13 (0.99) (Appendix Figure 2).<sup>20</sup> Multilaterals had higher levels of proliferation  
41 of funding, with a Theil Index of 0.57 in 2006–08 and 0.72 in 2012–13, than bilaterals  
42 (Theil Index: 1.12 and 1.11, respectively). The Gates Foundation had the lowest  
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levels of proliferation of funding (Theil Index: 1.49 in 2009–11 and 1.91 in 2012–13) (Appendix Figure 2).<sup>20</sup>

In a given year in the period 2008–13, recipient countries received official and Gates assistance for reproductive, maternal, newborn, and child health from an average of 15.4 donors, although five countries had more than 30.0 donors (Mozambique had 32.6; Tanzania and Kenya each had 31.4; and Afghanistan and Ethiopia each had 30.2) (data not shown). There was little change in the fragmentation of funding over time (the HHI was around 0.32 for the time interval averages across the time period) (Appendix Table 9).<sup>20</sup> However, fragmentation was reduced for countries in sub-Saharan Africa (HHIs 0.23 in 2006–08 and 0.26 in 2012–13) and in Latin America and the Caribbean (HHIs: 0.39 and 0.44, respectively), whereas it increased in South Asia (HHIs: 0.19 and 0.15, respectively) (Appendix Table 8).<sup>20</sup> Official and Gates assistance for reproductive, maternal, newborn, and child health was more fragmented across low-income countries, although there was substantial variation within country income groups (Appendix Figure 1c).<sup>20</sup>

Our qualitative research findings showed that bilateral donor representatives were especially concerned about the risk of proliferation of donors in recipient countries. Other donor types acknowledged that the risk of proliferation of donors was not explicitly considered when allocating funds to countries, with allocations based on priority areas and country proposals. Most staff members in donor headquarters who participated in our interviews agreed that fragmentation increases transaction costs for recipient governments, hinders the coordination of donors with different priorities and funding models, and risks duplication of efforts. However, one



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4 headquarters staff member did not think that "having multiple partners engaged on  
5 common issues is inherently a problem."  
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### 8 *Tanzania Case Study*

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11 Tanzania received US\$2.6 billion of official and Gates assistance for  
12 reproductive, maternal, newborn, and child health in the period 2008–13. The top ten  
13 donors accounted for 86.0 percent of all funds, with just the top two (the United  
14 States and the Global Fund) making up 55.8 percent of all of the assistance.  
15 Assistance delivered through government channels decreased from 69.9 percent of  
16 the total assistance in 2008 to 52.8 percent in 2013, and the share of funds  
17 channeled through the government but pooled with funds from other donors  
18 decreased from 2011 to 2013 (Appendix Figure 3a).<sup>20</sup> There was increased reliance  
19 on project funding, from 49.0 percent of the assistance in 2008 to 90.9 percent in  
20 2013 (Appendix Figure 3a).<sup>20</sup> In the same period, the United States delivered 40.7  
21 percent of its funds through the Tanzanian government, compared to 80.1 percent  
22 for the Global Fund (data not shown). Neither donor disbursed money as pooled  
23 funds with other donors.  
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40 Official and Gates assistance for reproductive, maternal, newborn, and child  
41 health in Tanzania was highly volatile over the period 2008–13. With the exception of  
42 the United States, disbursements from the top ten donors fluctuated considerably  
43 (Appendix Figure 3c).<sup>20</sup> Fluctuations were greatest for Global Fund disbursements,  
44 which oscillated between \$61.0 million and \$124.9 during the period (Appendix  
45 Figure 3c).<sup>20</sup>  
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53 In our qualitative research, Tanzania-based respondents reported that donors  
54 had disbursed funds through the government without giving sufficient consideration  
55 to strengthening health financial management capacity. As a result, donors had been  
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4 disappointed by the results obtained, which—coupled with increased pressures to  
5 “attribute [money] to results”—meant that donors had reverted to funding projects  
6 instead of using pooled approaches with other donors.  
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10 One representative of a donor said: “Everybody thought we had found the  
11 Holy Grail, but I think now the people are a little bit more critical and realize that it's  
12 not that easy. And now we see another move—moving away from [general budget  
13 support and health-]sector budget support and back to projects, and putting the flag  
14 (meaning attributing results to their funding).”  
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22 The average number of donors disbursing official and Gates assistance for  
23 reproductive, maternal, newborn, and child health in Tanzania increased from  
24 twenty-eight in 2006–08 to thirty-five in 2012–13 (Appendix Table 9).<sup>20</sup>  
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28 Fragmentation of donor funding increased slightly between 2009–11 (HHI: 0.21) and  
29 2012–13 (HHI: 0.18). The assistance was delivered as 2,563 transactions in 2008,  
30 increasing to 4,258 transactions in 2011 (Appendix Figure 3b).<sup>20</sup> The United States  
31 and Global Fund accounted for 161 and 11 of these transactions in 2008 and 225  
32 and 9 transactions in 2013, respectively (data not shown).  
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40 Like donor headquarters staff members, most donor representatives  
41 interviewed in our qualitative research in Tanzania reported concerns about the  
42 levels of fragmentation of funding and its impact on the quality of the dialogue  
43 between the government and donors. One representative based in Tanzania said,  
44 “There are so many activities and initiatives and implementing agencies that the  
45 dialogue often remains very general, and at a higher level we are not able, because  
46 of the multitude of actors, to coordinate all activities very well.”  
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4 However, another interviewee perceived that fragmentation of donor funding  
5 resulted in "a more active dialogue in health," with "more substance in the  
6 discussions between donors and government in the health sector."  
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## 10 Discussion

11 Our study analyzed trends in the period 2008–13 in two key principles of aid  
12 effectiveness: the alignment of donor funding with country strategies and financial  
13 management systems and the harmonization of the funding with that of other donors  
14 in relation to official and Gates assistance for reproductive, maternal, newborn, and  
15 child health. We found little evidence of improvement in donors' adherence to either  
16 principle overall, although we identified both improvements and deteriorations in  
17 some metrics for certain donors and recipients. Alignment of the assistance  
18 deteriorated in the study period, with most donors moving away from pooled funding  
19 supplied by multiple donors. Harmonization of donor funding remained constant,  
20 despite increased funding for reproductive, maternal, newborn, and child health.  
21 High levels of fragmentation of funding at the country level remain a concern, as  
22 demonstrated by the case of Tanzania.  
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40 Achieving alignment of donor funding with country strategies requires that  
41 donors use a country's institutional and management arrangements, which we  
42 assessed as the proportion of funds that were pooled by multiple donors and  
43 delivered through government channels. In the study period, fewer than half of all  
44 reproductive, maternal, newborn, and child health funds from donors to recipient  
45 countries were delivered through governments, and the share of donor funding to  
46 governments decreased over time across lower-middle- and low-income countries.  
47 This is surprising, given donors' commitments to the Paris Declaration and its five  
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4 principles, which call for greater alignment of donor funding with recipient countries'  
5 priorities and systems than was typical in the past.  
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9 We found substantial variation across donor types: Multilaterals disbursed the  
10 highest proportion of funds through governments, while some of the largest bilateral  
11 donors disbursed the majority of their funds through nongovernment channels (for  
12 instance, the United States disbursed 65.4 percent of its funds this way). By pooling  
13 funds with other donors, donors could create an effective means of aid coordination,  
14 but we found that donors' enthusiasm for pooling funds has decreased in recent  
15 years, as shown by the decrease in the share of pooled funds (from 18.2 percent in  
16 2011 to 13.1 percent in 2013).  
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27 These trends are concerning because they represent a reversal of gains  
28 perceived by our country-level participants in increased donor coordination and  
29 greater government control of funds. While still aligned to government systems,  
30 project funding channeled by donors through governments increases transaction  
31 costs, since each project requires separate negotiation, management, and  
32 reporting.<sup>11</sup> Projects delivered outside the government are the least coordinated with  
33 or aligned to country strategies. Results from our qualitative research showed that  
34 donor disillusionment with progress and the desires to control funds and for greater  
35 accountability to domestic populations of donor countries—to make it possible to  
36 demonstrate the effective use of funds—are making these modalities more attractive.  
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38 Our results are similar to those of a study in Uganda.<sup>14</sup>  
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51 Funding volatility at the country level was also substantial, as seen in  
52 Tanzania. Year-by-year fluctuation of funds makes it hard for governments to plan  
53 activities and honor their commitments to their citizens.<sup>27</sup> This is particularly  
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4 worrisome, as the poorest countries have been shown to be more likely to receive  
5 unpredictable amounts of official development assistance.<sup>10</sup>  
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9 Through international agreements, donors have repeatedly committed to  
10 becoming more harmonized with other donors by increasing the concentration of  
11 funding.<sup>2,28</sup> We found that the proliferation of official and Gates assistance for  
12 reproductive, maternal, newborn, and child health remained relatively constant over  
13 time. Proliferation was lowest for bilateral donors and the Gates Foundation.  
14  
15 Multilateral donors and global health initiatives have resource-funding formulas that  
16 require them to fund all eligible countries. Therefore, we would have expected them  
17 to spread their funds more evenly, but we would have expected bilaterals to make  
18 further strides toward concentration of funding. Two studies that explored trends in  
19 overall concentration of official development assistance also reported little  
20 progress.<sup>23,29</sup>  
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33 We found little change between 2008 and 2013 in fragmentation trends for  
34 official and Gates assistance for reproductive, maternal, newborn, and child health at  
35 the country level. However, low-income countries received the most fragmented  
36 funds, with fragmentation levels falling in sub-Saharan Africa and increasing in Asia  
37 . The fact that funds became less fragmented in sub-Saharan Africa despite  
38 increases in funding and the number of donors suggests that funds were  
39 concentrated among few donors—which is encouraging. Nevertheless, some of the  
40 poorest countries still had high levels of fragmentation in funding, as seen in  
41 Tanzania. This is consistent with findings from a study of official development  
42 assistance for health.<sup>9</sup> High degrees of proliferation and fragmentation in funding  
43 decrease the effectiveness of the assistance by increasing transaction costs for the  
44 recipient government and hindering coordination with other donors,<sup>11</sup> especially  
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4 when donors are disbursing funds through their own projects outside of government  
5 channels. Arne Bigsten and Sven Tengstam attribute a lack of harmonization to  
6 donors' having differing goals, and a tendency to micromanage developmental  
7 projects and to the possibility of some donors becoming free riders when there is  
8 harmonization of funding.<sup>30</sup>

### 15 **Policy Implications**

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18 The findings from this study suggest the need for reflection on the future of  
19 official development assistance to low- and middle-income countries. There have  
20 been concerns about the stagnation of donor health-sector funding,<sup>31</sup> and indeed  
21 only one of the United Nations' seventeen Sustainable Development Goals to be  
22 achieved by 2030 directly addresses health (compared to three of the Millennium  
23 Development Goals). However, it is not enough to advocate for increased funding,  
24 particularly if funds are delivered for separate projects by myriad donors with diverse  
25 requirements. With a higher number of goals and indicators for the Sustainable  
26 Development Goals than for the Millennium Development Goals, there is potential for  
27 increasing the fragmentation and recipient countries' transaction costs of official  
28 development assistance. It may be unrealistic to expect UN agencies to concentrate  
29 this assistance, but they could reduce transaction costs by coordinating funds in a  
30 given country—for instance, through delegated cooperation mechanisms. In addition,  
31 there is no agreed-on ideal level of fragmentation of funding, and too much  
32 concentration of funding may also be harmful.<sup>11</sup> The key may be to find a balance  
33 between meeting recipients' needs and not undermining the effectiveness of official  
34 development assistance.

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4 while the indicators proposed to assess progress are narrow and imprecise and rely  
5 too heavily on quantitative data.<sup>3</sup> The indicators used in our study capitalize on  
6 publicly available data to compare countries globally. However, they do not capture  
7 some principles of aid effectiveness (notably country ownership of national  
8 strategies, management for results, or accountability), nor do they capture all  
9 aspects of alignment and harmonization (such as donors' ability to fill gaps in  
10 national strategies or coordinate in-country activities). Country ownership of national  
11 strategies, management for results and accountability are best assessed  
12 qualitatively. Therefore, there is a need for more single- or multicountry case studies,  
13 as well as better methods to assess qualitative indicators globally (for instance,  
14 surveys that assess global aid effectiveness declarations could include open-ended  
15 questions).<sup>3</sup>

### 30 **Conclusion**

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33 When donors are assessed for their support in implementing the Sustainable  
34 Development Goals, they should be held accountable not only for how much they  
35 disburse to achieve different goals or subgoal targets, but also for how aligned their  
36 funds are with national health plans, how the funds are disbursed, and the number of  
37 donors already operating in the health sector. Our study has shown that it is possible  
38 to monitor the alignment and harmonization of donor funds by using existing data  
39 sources and country case studies. The Global Financing Facility is a financing  
40 instrument launched at the Financing for Development Conference in Addis Ababa in  
41 2015 in an effort to strengthen the Paris principles by improving domestic and donor  
42 resources for reproductive, maternal, newborn, child, and adolescent health in sixty-  
43 three high-burden countries. It will be important to link this initiative with processes to  
44 monitor progress toward the Sustainable Development Goals.

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<jrn>22. **Government channels:** Government financial management systems.  
Official development assistance can be disbursed through these, private and non-  
profit organizations.

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4 **Pooled modalities:** These include general or health-sector budget support and  
5 health basket funds. Funds disbursed in this way allow recipient governments more  
6 control of how resources are used and accounted for.  
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8 **Health basket:** A mechanism of pooling donor funds, which is then allocated to  
9 recipients (usually through their government financial management systems).  
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## 4 Exhibit list

### 5 Exhibit 1 (figure)

6 **CAPTION:** Total official development assistance for reproductive, maternal,  
7 newborn, and child health, by donor, channel, and modality, 2009–13

8 **Source/Notes:** SOURCE Authors' analysis of data from the Countdown ODA+  
9 database. NOTES Channels include governments and private and nonprofit  
10 organizations. "Other bilaterals" include all bilateral funders other than the United  
11 States and the United Kingdom (such as the European Union). IDA is the  
12 International Development Agency of the World Bank. "Other multilaterals" include all  
13 multilateral funding agencies other than the World Bank (such as the United Nations  
14 and development banks). The Global Fund is the Global Fund to Fight AIDS,  
15 Tuberculosis, and Malaria. BMGF is the Bill and Melinda Gates Foundation.  
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### 20 Exhibit 2 (figure)

21 **CAPTION:** Percentages of official development assistance for reproductive,  
22 maternal, newborn, and child health delivered through government channels, by  
23 donor type, 2008–13

24 **Source/Notes:** SOURCE Authors' analysis of data from the Countdown ODA+  
25 database. NOTES BMGF is the Bill and Melinda Gates Foundation. GHI is global  
26 health initiatives (defined in the text).  
27  
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### 29 Exhibit 3 (figure)

30 **CAPTION:** Percentages of official development assistance for reproductive,  
31 maternal, newborn, and child health delivered through government channels and  
32 disbursed as pooled funds (with those of other donors), by donor type, 2008–13

33 **Source/Notes:** SOURCE Authors' analysis of data from the Countdown ODA+  
34 database. NOTES The percentages for global health initiatives (defined in the text)  
35 and the Bill and Melinda Gates Foundation were zero.  
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### 38 Exhibit 4 (figure)

39 **CAPTION:** Total disbursements of official development assistance for reproductive,  
40 maternal, newborn, and child health, by channel and modality and recipient-country  
41 income group, 2009–13

42 **Source/Notes:** SOURCE Authors' analysis of data from the Countdown ODA+  
43 database. NOTES Amounts are in constant 2013 US dollars. "Government pooled"  
44 includes donor funds disbursed through government channels and pooled with funds  
45 of other donors. "Government other" includes funds delivered through governments  
46 for which the modality could not be specified. "Nongovernment" includes all funds  
47 delivered outside of the government, whether or not the modality could be specified.  
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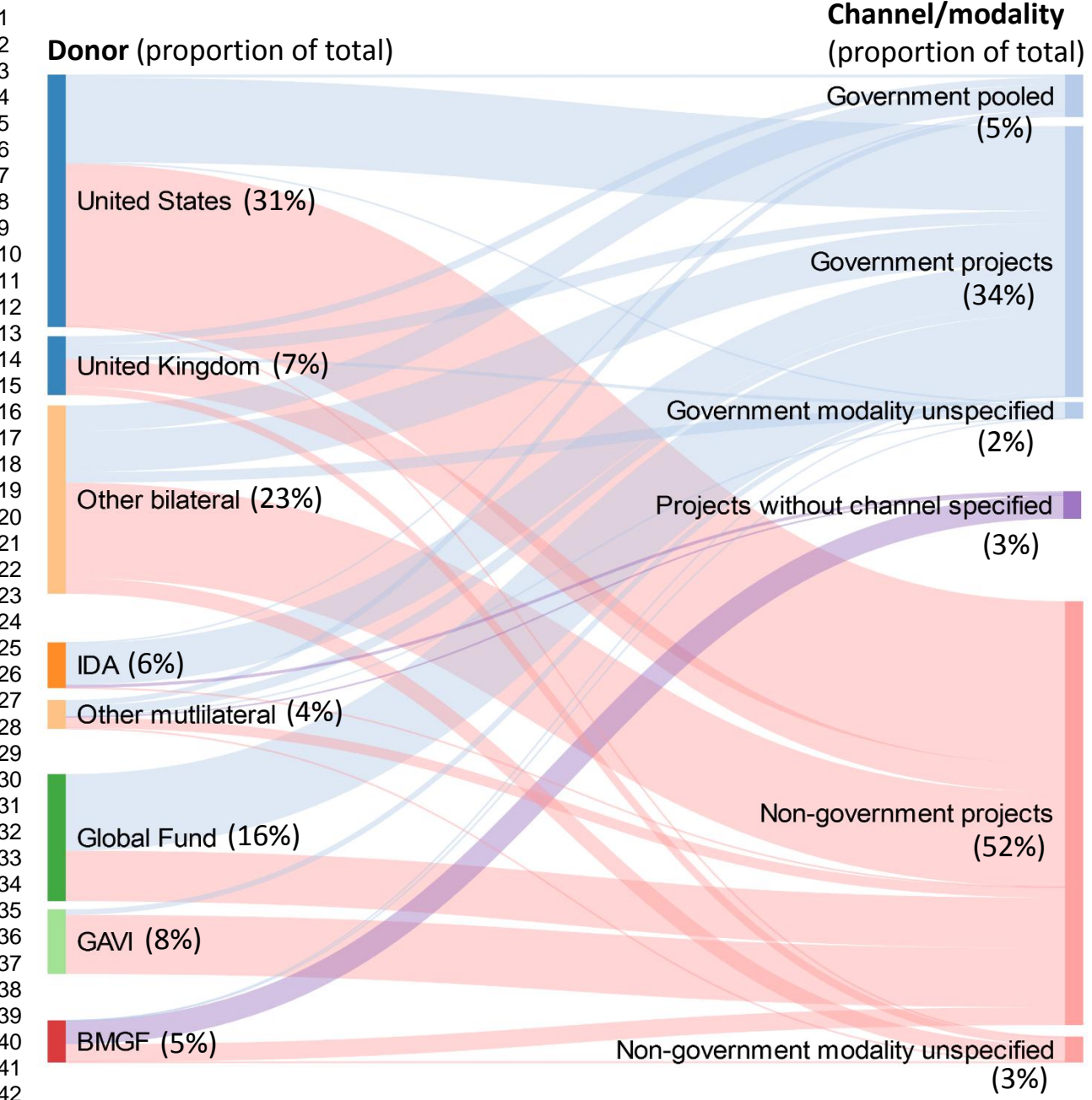
Bio 3: Leonardo Arregoces is a research degree student in the Department of Global Health and Development, London School of Hygiene and Tropical Medicine.

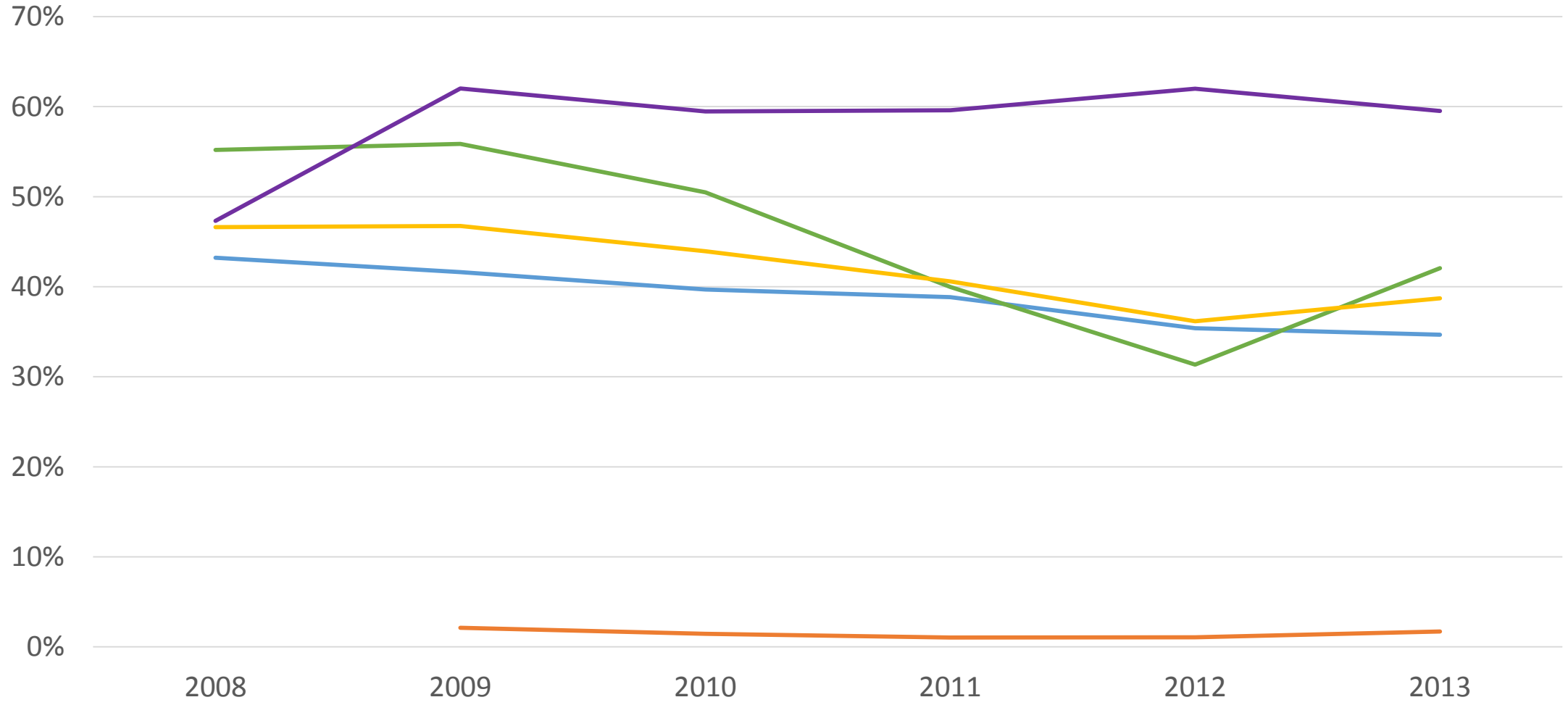
Bio 4: Lara Brearley is a senior health policy adviser at Save the Children, in London, the United Kingdom.

Bio 5: Catherine Pitt is an assistant professor of health economics in the Department of Global Health and Development, London School of Hygiene and Tropical Medicine.

Bio 6: Christopher Grollman is a research fellow in the Department of Global Health and Development, London School of Hygiene and Tropical Medicine.

Bio 7: Josephine Borghi is an associate professor in health economics and policy in the Department of Global Health and Development, London School of Hygiene and Tropical Medicine.



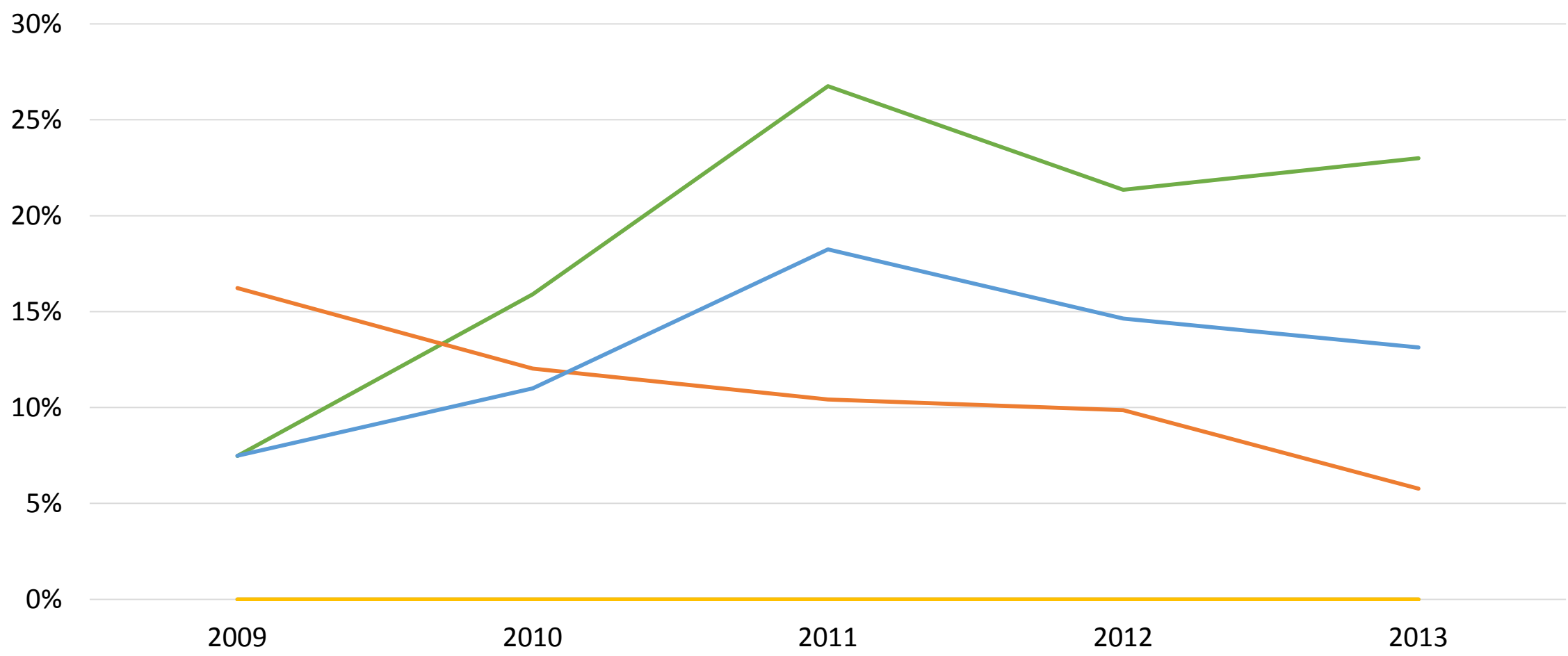


— Bilateral — BMGF — GHI — Multilateral — All donors

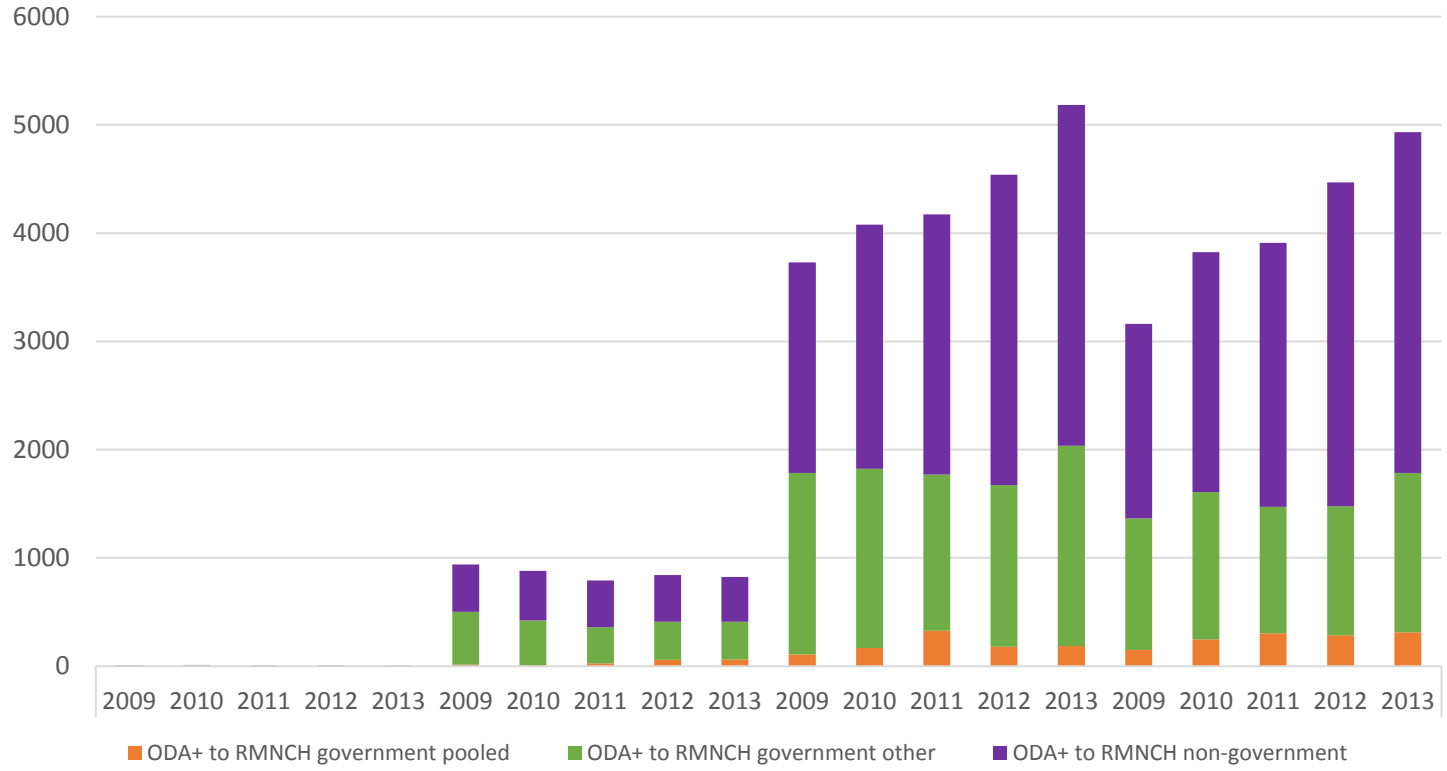
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— Bilateral — Multilateral — GHI — BMGF — All donors



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## Supplementary methods

### A. Interview guide

1. Introduction
  - a. Introduce aim and objectives of projects
  - b. Introduce aim of the interview
  - c. Ask for permission to record, explain what the results will be used for and procedures for anonymising data
  - d. Ask for permission to quote and
2. Introduce interviewees
  - a. What their job involves
  - b. How long they have worked at X agency
3. How are decisions of funding allocation made in your agency?
  - a. What is the decision-making process?
    - i. Who is involved?
    - ii. What procedures are involved?
4. How does your agency decide on how much to invest in RMNCH?
  - a. Versus total health ODA
  - b. Versus total ODA
5. How does your agency decide which countries to invest in? the size of investment?
  - a. Country-level factors – disease, need, history
  - b. Aid effectiveness
6. How does your agency decide on the size of each project?
7. Once in-country
  - a. Does your agency work with other donors?
    - i. If so how and why?
    - ii. What are the advantages and disadvantages of this?
  - b. Does your agency work with (recipient country) governments?
    - i. If so how and why?
    - ii. What are the advantages and disadvantages of this?
8. In your view, is fragmentation a problem for the effectiveness of ODA to RMNCH and your agency's projects in particular?
  - a. If so how?
  - b. How does your agency deal with this?
9. In your view, is your agency's ODA to RMNCH effective?
  - a. Why?
  - b. How could it be improved?
10. Challenges and important issues for the future

## B. Theil and Herfindahl-Hirschman Indices

We calculated the Theil index through the weighted value of a ratio of actual amount donated to a recipient and the mean value a given donor donates:  $\frac{1}{N} \sum_{i=1}^N \frac{x_i}{\mu} \ln \left( \frac{x_i}{\mu} \right)$ , where N is number of recipients,  $\ln$  expresses the natural log,  $x_i$  is the amount a recipient  $i$  receives, and  $\mu$  is the mean amount received across recipients. If a donor gave an equal amount to all recipients, then the Theil value would be 0; and if a donor heavily favours one recipient whilst also giving to more than a few recipients (say,  $N > 5$ ) then the Theil value converges to the natural log of N. There are different versions of the Theil Index, in the present context the important aspect is that the amount donated by a donor to a country is compared to the average amount donated to all countries by the donor, through the corresponding ratio:  $\ln \left( \frac{x_i}{\mu} \right)$ ; thus, many small donations in comparison to the mean will produce a small Theil number. The log term above would be negative in this case for a lot of recipients. This would be characteristic of a proliferator.<sup>1</sup> The global number of recipients is above 100, the overall donations made to the countries by a multi-lateral should result in a small Theil index due to many small recipients. However, a bilateral donor can restrict the number of recipients; there is no specific reason why it cannot concentrate in giving aid to only a few countries. Thus, a small Theil index value for bilateral should be worrisome.

The HH index is expressed as the following,  $\sum_1^n s_i^2 = HH \text{ Index}$ , where  $s_i$  represents the share of total aid donor  $i$  gives to the recipient. The smallest value would occur if all donors gave the same amount to country  $i$ , and the largest value would occur if there were only a single donor.

**Figure 1:** Variations around the income country group average in 2013 for proportion of ODA+ to RMNCH disbursed through the government, proportion of ODA+ to RMNCH pooled and the fragmentation index

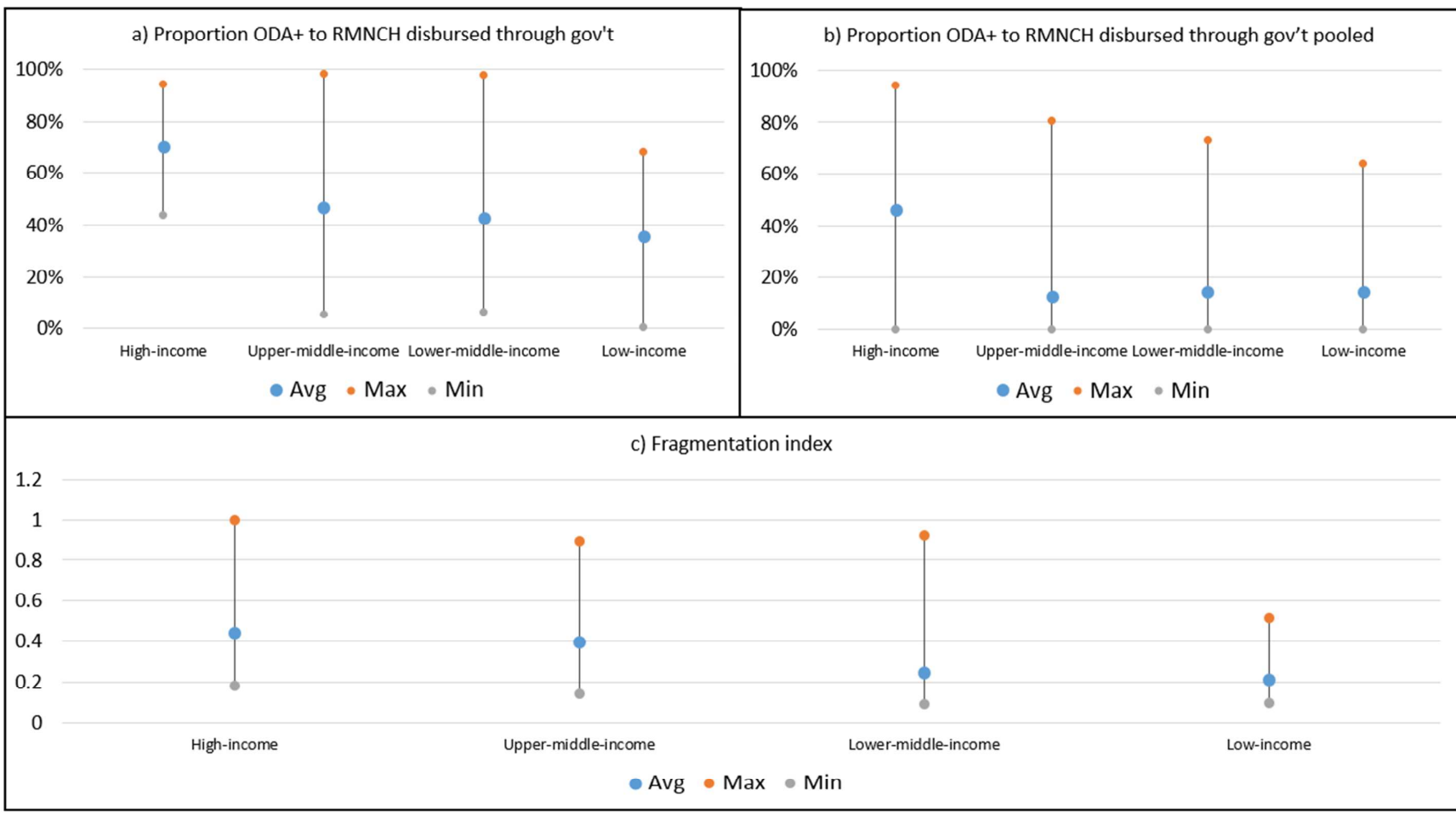
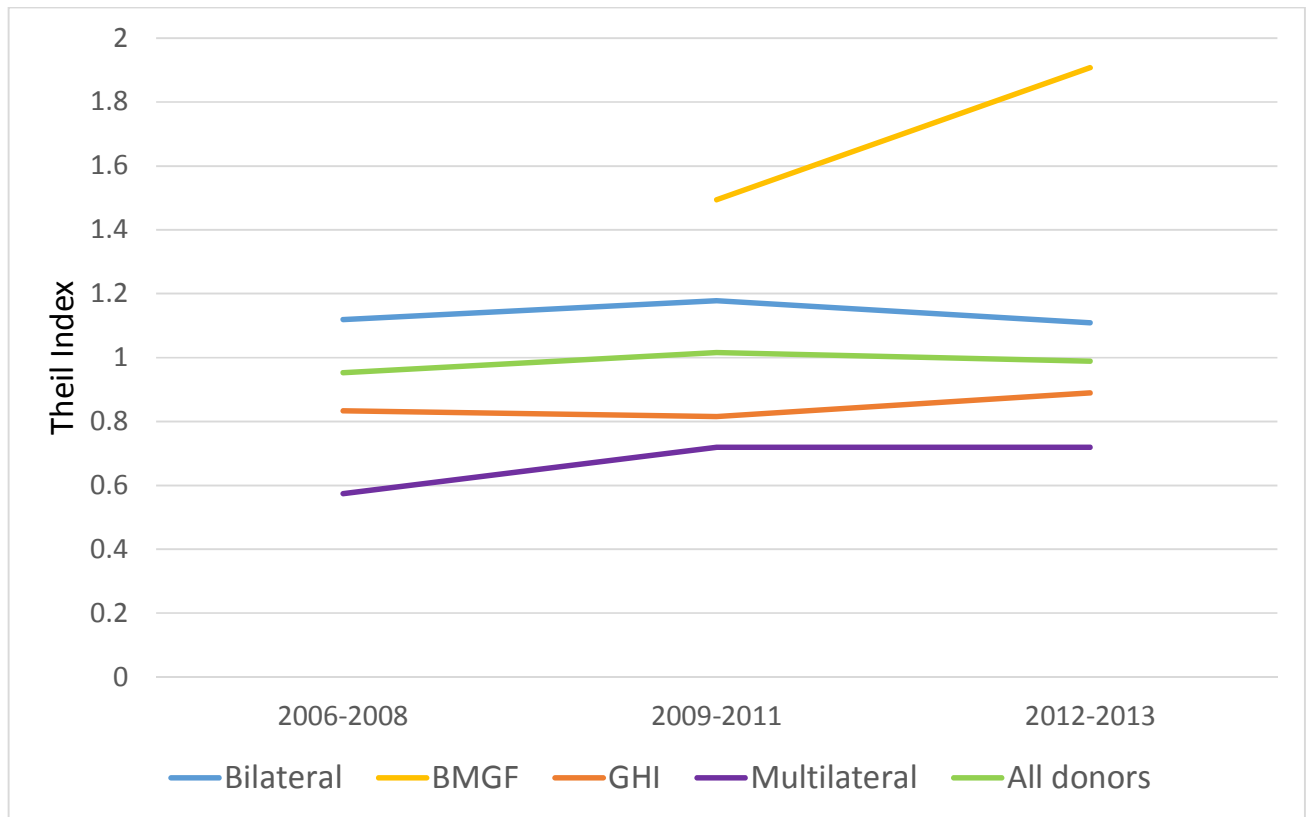


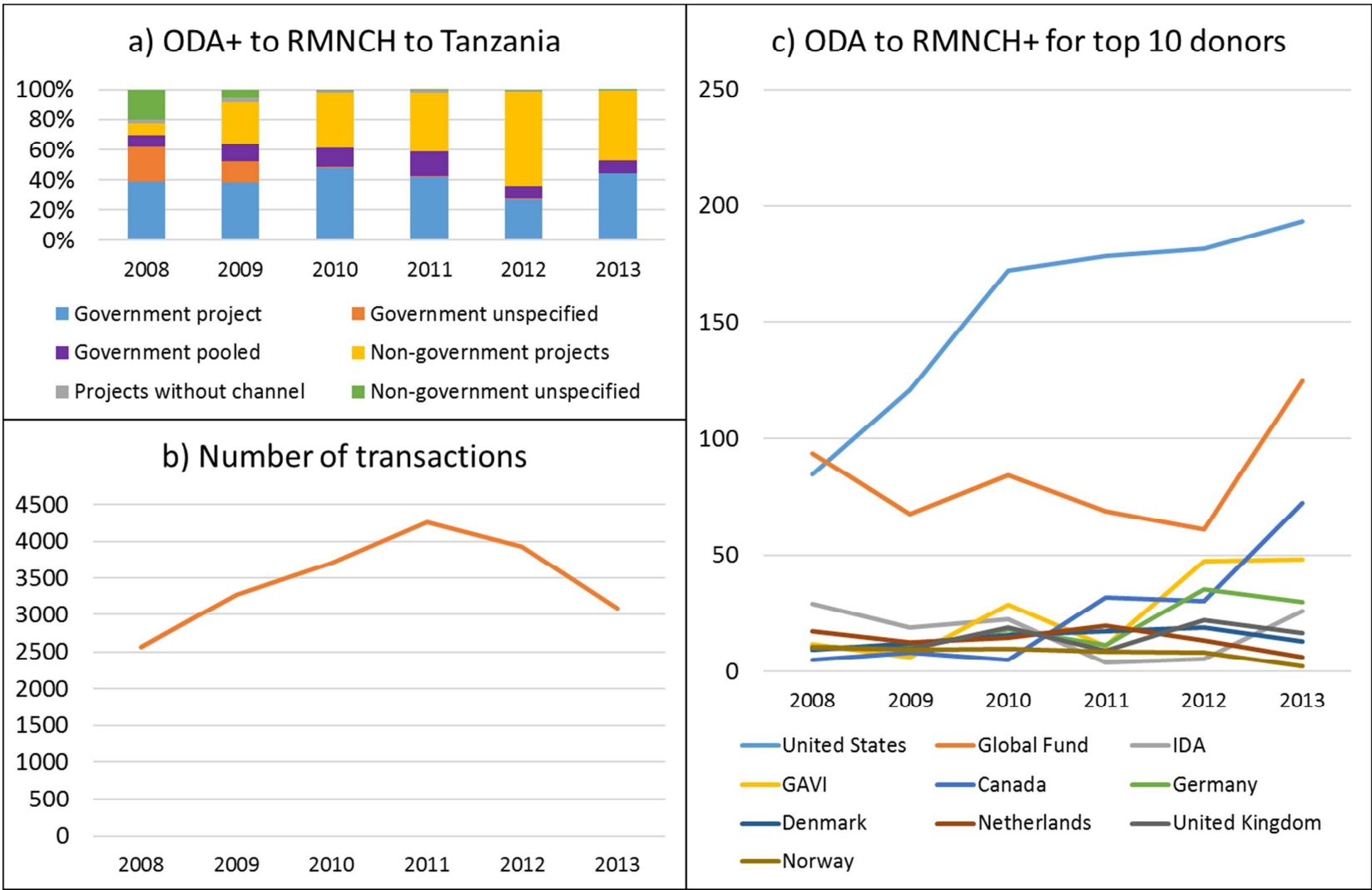
Figure 2: Theil index of donor proliferation between 2006-2008 and 2012-2013 by donor type



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Figure 3. ODA+ to RMNCH to Tanzania by a) modality, b) number of transactions and c) year-on-year variation of the top 10 donors



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**Table 1.** Definitions, indicators, and measurement strategy for assessing the alignment and harmonisation of ODA+ to RMNCH

Principle	Paris Declaration definition	Indicator	Measurement strategy
Alignment	Donors base their overall support on partner countries' national development strategies, institutions and procedures.	ODA+ to RMNCH delivered through government channels / Total ODA+ to RMNCH	Global trends by donor and recipient country (2008-2013)
		ODA+ to RMNCH to government channels that is pooled / ODA+ to RMNCH to government	Global trends by donor and recipient country (2009-2013)
		Individual donor volatility	Trends in total ODA+ to RMNCH disbursed by top 10 donors to Tanzania (2008-2013)
Harmonisation	Donors' actions are more harmonised, transparent and collectively effective.	Donor proliferation	Trends in Theil index at the global level for all donors (2008-2013)
		Recipient fragmentation	Trends in Herfindahl-Hirschman index at the global level for all recipient countries (2008-2013)
		Number of transactions	Trends in Tanzania (2008-2013)



**Table 2.** ODA+ to RMNCH by channel and modality for each donor type between 2008 and 2013 (all values presented in constant 2013 USD millions)

	2008	2009	2010	2011	2012	2013	Total
<b>Bilateral</b>							
Total ODA+ to RMNCH	4,128.7	4,935.8	5,552.2	5,634.1	6,094.5	6,486.4	32,831.6
ODA+ to RMNCH through government (% of total)	1,784.6 (43.2%)	2,054.7 (41.6%)	2,203.1 (39.7%)	2,188.4 (38.8%)	2,156.7 (35.4%)	2,249.0 (34.7%)	12,636.5 (38.5%)
ODA+ to RMNCH pooled (% ODA+ to RMNCH delivered through government)		153.5 (7.5%)	350.3 (15.8%)	585.4 (26.7%)	460.6 (21.4%)	517.3 (23.0%)	2,167.2 (17.2%)
<b>Multilateral</b>							
Total ODA+ to RMNCH	916.9	1,207.7	1,051.9	1,167.8	1,007.7	1,145.6	6,497.6
ODA+ to RMNCH through government (% of total)	433.9 (47.3%)	748.9 (62.0%)	625.6 (59.5%)	696.1 (59.6%)	624.7 (62.0%)	681.9 (59.5%)	3,811.1 (58.7%)
ODA+ to RMNCH pooled (% ODA+ to RMNCH delivered through government)		121.6 (16.2%)	75.2 (12.0%)	72.5 (10.4%)	61.6 (9.9%)	39.4 (5.8%)	443.0 (11.6%)
<b>BMGF</b>							
Total ODA+ to RMNCH		165.0	141.8	281.4	266.2	214.5	1068.9
ODA+ to RMNCH through government (% of total)		3.5 (2.1%)	2.1 (1.4%)	2.9 (1.0%)	2.9 (1.1%)	3.6 (1.7%)	15.0 (1.4%)
ODA+ to RMNCH pooled (% ODA+ to RMNCH delivered through government)		0	0	0	0	0	0
<b>GHI</b>							
Total ODA+ to RMNCH	1,557.7	1,548.4	2,052.8	1,797.7	2,495.9	3,105.1	12,557.7
ODA+ to RMNCH through government (% of total)	860.0 (52.2%)	864.9 (55.9%)	1,036.4 (50.5%)	718.6 (40.0%)	782.3 (31.3%)	1,305.7 (42.0%)	5,567.8 (44.3%)
ODA+ to RMNCH pooled (% ODA+ to RMNCH delivered through government)		0	0	0	0	0	0

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	2008	2009	2010	2011	2012	2013	Total
through government)							
<b>Total</b>	<b>6,603.3</b>	<b>7,856.8</b>	<b>8,798.7</b>	<b>8,881.0</b>	<b>9,864.3</b>	<b>10,951.5</b>	<b>52,955.7</b>

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**Table 3<sup>1</sup>:** ODA+ to RMNCH through the government by donor as a proportion of total ODA+ to RMNCH for that donor (2008-2013, constant 2013 US dollars)

Donor	Total ODA+ to RMNCH	ODA+ to RMNCH through gov't	ODA+ to RMNCH through gov't as % of total ODA+ to RMNCH
<b>Bilateral</b>			
Australia	1069.3	204.5	19.1%
Austria	34.1	10.5	30.7%
Belgium	330.3	181.5	55.0%
Canada	1624.8	253.9	15.6%
Czech Republic	5.3	0.9	16.1%
Denmark	344.8	163.3	47.4%
Estonia	0.4	0.0	3.8%
EU Institutions	2500.0	1031.3	41.3%
Finland	118.2	24.9	21.1%
France	373.7	318.6	85.3%
Germany	1402.8	1140.2	81.3%
Greece	8.9	7.3	81.2%
Iceland	4.0	2.5	60.7%
Ireland	322.7	132.2	41.0%
Italy	245.8	140.6	57.2%
Japan	1203.7	580.4	48.2%
Korea	268.6	228.6	85.1%
Luxembourg	129.0	56.4	43.7%
Netherlands	561.8	266.5	47.4%
New Zealand	59.2	21.4	36.2%
Norway	556.5	136.4	24.5%
Poland	0.6	0.4	56.1%
Portugal	27.5	18.9	68.9%
Slovak Republic	0.3		0.0%
Slovenia	1.3	0.2	15.4%
Spain	549.1	105.4	19.2%
Sweden	567.0	136.4	24.1%
Switzerland	210.3	55.1	26.2%
United Arab Emirates	162.4	94.0	57.9%
United Kingdom	3850.5	1682.5	43.7%
United States	16298.3	5641.7	34.6%
<b>BMGF</b>	<b>1068.9</b>	<b>15.0</b>	<b>1.4%</b>
<b>GHI</b>	<b>12557.7</b>	<b>5567.8</b>	<b>44.3%</b>
GAVI	4201.9	408.7	9.7%
Global Fund	8355.8	5159.2	61.7%
<b>Multilateral</b>	<b>6497.6</b>	<b>3811.1</b>	<b>58.7%</b>
AfDB	0.6	0.6	100.0%
AfDF	254.7	202.1	79.4%
Arab Fund (AFESD)	5.9		0.0%

<sup>1</sup> Donors with more than 50% of NULL Channel and empty values excluded, as well as UNAIDS that had 100% coded as other

Donor	Total ODA+ to RMNCH	ODA+ to RMNCH through gov't	ODA+ to RMNCH through gov't as % of total ODA+ to RMNCH
AsDB Special Funds	200.3	200.3	100.0%
BADEA	4.3	0.1	1.2%
GEF	0.7	0.3	38.6%
IDA	3032.0	2785.0	91.9%
IDB Sp.Fund	111.8	66.3	59.3%
IMF (Concessional Trust Funds)	316.4	316.4	100.0%
Kuwait (KFAED)	18.3	12.1	66.5%
OFID	41.7		0.0%
UNAIDS	157.3		0.0%
UNDP	50.3	14.3	28.5%
UNFPA	743.3	213.5	28.7%
UNICEF	1020.9		0.0%
UNPBF	0.8		0.0%
UNRWA	280.3		0.0%
WFP	120.2		0.0%
WHO	137.8		0.0%
<b>Grand Total</b>	<b>52955.7</b>	<b>22030.4</b>	<b>41.6%</b>

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**Table 4.** Total ODA+ to RMNCH, ODA+ to RMNCH through the government and ODA+ to RMNCH pooled by donor between 2009 and 2013 (constant 2013 US dollars)

Donor	Total ODA+ to RMNCH	ODA+ to RMNCH delivered through gov't	ODA+ to RMNCH to the government delivered as pooled funds	ODA+ to RMNCH to the government delivered as projects	ODA+ to RMNCH to the government modality unknown	% ODA+ to RMNCH through the gov't delivered as pooled funds	% ODA+ to RMNCH through the gov't delivered as projects
<b>Bilateral</b>							
Australia	958.4	181.8	94.6	48.6	38.7	52.0%	26.7%
Austria	27.3	8.5	2.5	5.9	0.0	30.0%	69.9%
Belgium	280.3	148.7	31.7	86.0	31.0	21.3%	57.8%
Canada	1441.2	239.1	205.6	17.2	16.4	86.0%	7.2%
Czech Republic	5.3	0.9		0.2	0.7	0.0%	18.8%
Denmark	293.6	136.9	47.6	79.4	9.8	34.8%	58.0%
Estonia	0.4	0.0		0.0		0.0%	100.0%
EU Institutions	2183.6	814.0	502.6	216.3	95.1	61.7%	26.6%
Finland	96.9	19.5	13.4	1.7	4.4	68.6%	8.6%
France	334.0	282.2	20.8	198.4	63.0	7.4%	70.3%
Germany	1189.8	966.8	91.9	804.1	70.9	9.5%	83.2%
Greece	5.8	4.5	2.1	0.2	2.2	46.2%	4.4%
Iceland	4.0	2.5		2.5		0.0%	100.0%
Ireland	259.5	106.4	79.4	4.7	22.3	74.6%	4.4%
Italy	188.5	101.3	0.6	69.0	31.8	0.6%	68.1%
Japan	1055.2	503.0	29.1	440.8	33.1	5.8%	87.6%
Korea	242.6	204.1		174.5	29.7	0.0%	85.5%
Luxembourg	95.8	45.5		34.6	10.8	0.0%	76.2%
Netherlands	460.9	207.8	125.6	30.2	52.1	60.4%	14.5%
New Zealand	48.7	18.0	12.8	3.4	1.8	71.0%	18.7%
Norway	455.6	106.4	71.9	7.9	26.7	67.5%	7.4%
Poland	0.6	0.4		0.3	0.0	0.0%	89.1%
Portugal	24.4	17.1	0.9	15.5	0.7	5.2%	90.5%

Donor	Total ODA+ to RMNCH	ODA+ to RMNCH delivered through gov't	ODA+ to RMNCH to the government delivered as pooled funds	ODA+ to RMNCH to the government delivered as projects	ODA+ to RMNCH to the government modality unknown	% ODA+ to RMNCH through the gov't delivered as pooled funds	% ODA+ to RMNCH through the gov't delivered as projects
Slovak Republic	0.3						
Slovenia	1.3	0.2		0.1	0.1	0.0%	35.2%
Spain	383.4	79.3	26.6	30.5	22.2	33.5%	38.5%
Sweden	476.6	95.5	55.9	16.8	22.7	58.6%	17.6%
Switzerland	179.1	41.1	20.6	12.0	8.4	50.2%	29.2%
United Arab Emirates	162.4	94.0	30.5	47.3	16.2	32.5%	50.3%
United Kingdom	3363.9	1329.0	436.1	705.4	187.5	32.8%	53.1%
United States	14483.2	5097.5	164.6	4858.5	74.4	3.2%	95.3%
<b>BMGF</b>	1068.9	15.0		14.5	0.5	0.0%	96.8%
<b>GHI</b>							
GAVI	3706.5	309.7		309.7		0.0%	100.0%
Global Fund	7293.5	4398.2		4398.2		0.0%	100.0%
<b>Multilateral</b>							
AfDB	0.6	0.6		0.3	0.3	0.0%	46.4%
AfDF	202.1	202.1	36.2	110.4	55.6	17.9%	54.6%
Arab Fund (AFESD)	4.8						
AsDB Special Funds	200.3	200.3		199.9	0.4	0.0%	99.8%
BADEA	4.3	0.1		0.1		0.0%	100.0%
GEF	0.4	0.3		0.3		0.0%	100.0%
IDA	2625.3	2440.1	63.3	2376.8		2.6%	97.4%
IDB Sp.Fund	111.8	66.3		66.3		0.0%	100.0%
IMF (Concessional Trust Funds)	270.8	270.8	270.8			100.0%	0.0%

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Donor	Total ODA+ to RMNCH	ODA+ to RMNCH delivered through gov't	ODA+ to RMNCH to the government delivered as pooled funds	ODA+ to RMNCH to the government delivered as projects	ODA+ to RMNCH to the government modality unknown	% ODA+ to RMNCH through the gov't delivered as pooled funds	% ODA+ to RMNCH through the gov't delivered as projects
Kuwait (KFAED)	18.3	12.1		12.1		0.0%	100.0%
OFID	41.7						
UNAIDS	137.0						
UNDP	42.2	14.3		13.5	0.8	0.0%	94.2%
UNFPA	601.5	170.2		134.7	35.4	0.0%	79.2%
UNICEF	821.8						
UNPBF	0.8						
UNRWA	238.7						
WFP	120.2						
WHO	137.8						
<b>Grand Total</b>	<b>46352.4</b>	<b>18951.9</b>	<b>2437.4</b>	<b>15548.7</b>	<b>965.8</b>	<b>12.9%</b>	<b>82.0%</b>

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**Table 5<sup>2</sup>.** ODA+ to RMNCH by channel and modality for each recipient country income group between 2008 and 2013 (all values presented in constant 2013 USD millions)

	2008	2009	2010	2011	2012	2013	Total
<b>High-income</b>							
Total ODA+ to RMNCH (constant 2013 USD)	6.3	4.4	9.0	1.8	3.1	2.4	27.0
ODA+ to RMNCH through government (% of total)	5.4 (86.6%)	4.4 (65.1%)	6.7 (74.8%)	0.5 (27.7%)	1.4 (44.8%)	0.9 (36.6%)	17.8 (66.0%)
ODA+ to RMNCH through gov't pooled (% of ODA+ to RMNCH through gov't)		1.7 (57.4%)	1.6 (24.4%)	0.1 (18.8%)	0.5 (33.2%)	0.0 (0.0%)	4.5 (25.5%)
ODA+ to RMNCH through gov't project (% of ODA+ to RMNCH through gov't)		0.7 (24.3%)	4.7 (69.1%)	0.3 (67.0%)	0.9 (62.7%)	0.8 (85.3%)	8.8 (49.4%)
<b>Upper-middle-income</b>							
Total ODA+ to RMNCH (constant 2013 USD)	784.7	940.2	879.6	792.4	842.3	824.7	5063.8
ODA+ to RMNCH through government (% of total)	368.9 (47.0%)	502.1 (53.4%)	420.3 (47.8%)	360.9 (45.6%)	409.9 (48.7%)	410.6 (49.8%)	2,472.7 (48.8%)
ODA+ to RMNCH through gov't pooled (% of ODA+ to RMNCH through gov't)		14.9 (3.0%)	9.0 (2.1%)	25.8 (7.1%)	57.0 (13.9%)	59.4 (14.5%)	169.3 (6.8%)
ODA+ to RMNCH through gov't project (% of ODA+ to RMNCH through gov't)		402.4 (80.1%)	393.9 (93.7)	323.7 (89.7%)	342.7 (83.6%)	340.5 (82.9%)	1,967.8 (79.6%)
<b>Lower-middle-income</b>							
Total ODA+ to RMNCH (constant 2013 USD)	3055.9	3730.9	4077.3	4173.0	4541.2	5183.8	24762.1
ODA+ to RMNCH through government (% of total)	1,403 (45.9%)	1,783.9 (47.8%)	1,823.9 (44.7%)	1,770.9 (42.4%)	1,670.8 (36.8%)	2,035.3 (39.3%)	10,488.4 (42.4%)

<sup>2</sup> Income unclassifiable includes countries not included on the World Bank classification. ODA+ to RMNCH disbursed through the government where modality was not identified not shown (hence percentage ODA+ to RMNCH through gov't pooled plus ODA+ to RMNCH gov't project does not add up to 100)



	2008	2009	2010	2011	2012	2013	Total
ODA+ to RMNCH through gov't pooled (% of ODA+ to RMNCH through gov't)	107.6 (6.0%)	166.1 (9.1%)	328.0 (18.5%)	178.2 (10.7%)	185.4 (9.1%)		1,007.2 (9.6%)
ODA+ to RMNCH through gov't project (% of ODA+ to RMNCH through gov't)	1,331.1 (75.0%)	1,625.7 (89.1%)	1,424.5 (80.4%)	1,474.6 (88.3%)	1,830.0 (89.9%)		8,475.7 (80.9%)
<b>Low-income</b>							
Total ODA+ to RMNCH (constant 2013 USD)	2748.4	3162.0	3824.0	3911.4	4469.1	4932.8	23047.7
ODA+ to RMNCH through government (constant 2013 USD)	1,292.7 (47.0%)	1,364.2 (43.1%)	1,607.7 (42.0%)	1,471.8 (37.6%)	1,476.3 (33.0%)	1,785.8 (36.2%)	8,998.5 (39.0%)
ODA+ to RMNCH through gov't pooled (% of ODA+ to RMNCH through gov't)	149.8 (11.0%)	247.7 (15.4%)	303.5 (20.6%)	285.9 (19.4%)	311.2 (17.4%)		1,423.1 (15.8%)
ODA+ to RMNCH through gov't project (% of ODA+ to RMNCH through gov't)	918.0 (67.3%)	1,327.1 (82.5%)	1,146.6 (77.9%)	1,172.8 (79.4%)	1,460.9 (81.8%)		6,712.4 (74.6%)
Income not classified							
Total ODA+ to RMNCH (constant 2013 USD)	8.0	19.3	8.9	2.6	8.5	7.9	55.2
ODA+ to RMNCH through government (constant 2013 USD)	8.0 (100.0%)	18.9 (97.9%)	8.5 (96.3%)	1.7 (68.2%)	8.1 (95.6%)	7.8 (96.8%)	53.0 (96.1%)
ODA+ to RMNCH through gov't pooled (% of ODA+ to RMNCH through gov't)	1.1 (5.8%)	1.1 (12.9%)	0.6 (32.5%)	0.6 (7.6%)	0.7 (8.8%)		6.0 (11.3%)
ODA+ to RMNCH through gov't project (% of ODA+ to RMNCH through gov't)	0.2 (1.3%)	4.9 (57.8%)	1.2 (66.6%)	7.5 (92.4%)	7.0 (91.1%)		21.1 (39.8%)

**Table 6:** Annual total ODA+ to RMNCH, ODA+ to RMNCH through the government and ODA+ to RMNCH pooled by recipient country (constant 2013 US dollars; pooled funds not shown for 2008 because of data inaccuracy)

Recipient country	2008			2009			2010			2011			2012			2013		
	Total ODA+ to RMNCH	ODA+ to RMNCH through gov't	ODA+ to RMNCH pooled	Total ODA+ to RMNCH	ODA+ to RMNCH through gov't	ODA+ to RMNCH pooled	Total ODA+ to RMNCH	ODA+ to RMNCH through gov't	ODA+ to RMNCH pooled	Total ODA+ to RMNCH	ODA+ to RMNCH through gov't	ODA+ to RMNCH pooled	Total ODA+ to RMNCH	ODA+ to RMNCH through gov't	ODA+ to RMNCH pooled	Total ODA+ to RMNCH	ODA+ to RMNCH through gov't	ODA+ to RMNCH pooled
Afghanistan	212	64	0	313	76	0	293	81	0	315	93	0	295	76	1	309	76	1
Albania	10	3	0	7	3	0	6	2	0	5	2	0	7	2	0	2	0	0
Algeria	3	2	0	3	1	0	2	1	0	4	2	0	2	1	0	4	1	0
Angola	82	13	0	55	14	0	65	13	0	49	5	0	70	12	0	78	32	0
Anguilla	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Antigua and Barbuda	0	0	0	0	0	1	1	1	0	0	0	0	0	0	0	0	0	0
Argentina	14	3	0	8	7	0	6	0	0	2	1	0	2	0	0	1	0	0
Armenia	9	2	0	11	4	1	11	5	3	11	5	4	8	4	1	6	3	1
Azerbaijan	6	3	0	7	4	0	10	4	0	11	8	0	8	5	0	10	5	0
Bangladesh	151	21	0	233	120	0	212	77	4	202	26	21	210	76	18	337	122	18
Barbados	2	1	0	0	0	0	1	1	0			0			0			0
Belarus	4	1	0	2	1	0	1	0	0	1	0	0	1	0	0	4	0	0
Belize	0	0	0	2	0	0	3	0	0	2	0	0	2	0	0	5	2	0
Benin	46	17	5	62	28	3	71	26	2	72	27	3	56	16	1	63	7	1
Bhutan	3	3	0	2	2	1	3	2	0	2	1	0	3	2	0	3	1	0
Bolivia	39	7	2	40	7	4	38	10	6	36	12	7	38	12	0	34	4	0
Bosnia and Herzegovina	11	4	0	11	8	0	14	9	0	10	5	0	11	8	0	10	3	0
Botswana	94	27	0	103	38	0	46	36	0	45	35	0	30	28	0	40	28	0
Brazil	8	3	0	11	1	0	13	4	0	10	2	0	5	2	0	4	1	0
Burkina Faso	78	48	6	92	53	16	114	72	14	64	32	14	103	38	9	107	54	9

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Recipient country	Total ODA+ to RMNC H	2008 ODA+ to RMNCH through gov't	2008 ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2009 ODA+ to RMNCH through gov't	2009 ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2010 ODA+ to RMNCH through gov't	2010 ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2011 ODA+ to RMNCH through gov't	2011 ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2012 ODA+ to RMNCH through gov't	2012 ODA+ to RMNCH pooled	Total ODA+ to RMNC H	2013 ODA+ to RMNCH through gov't	2013 ODA+ to RMNCH pooled
Burundi	46	29	2	50	25	3	65	31	2	61	18	1	53	14	1	74	33	1
Cambodia	72	38	0	90	46	3	121	55	6	113	64	0	100	25	0	102	41	0
Cameroon	34	16	4	50	30	1	38	17	0	86	53	0	58	22	1	77	41	1
Cape Verde	3	3	0	3	2	1	5	5	0	6	3	0	3	3	0	5	4	0
Central African Republic	22	5	2	15	3	0	20	6	0	21	1	1	21	3	0	30	5	0
Chad	32	13	0	33	7	0	59	5	0	41	7	0	47	7	0	83	33	0
Chile	1	0	0	0	0	0	4	3	0	1	0	0	1	0	0	1	0	0
China (People's Republic of)	106	55	0	103	79	1	84	61	0	49	29	0	52	37	0	31	20	0
Colombia	8	1	0	6	0	0	12	2	0	11	5	0	8	2	0	42	31	0
Comoros	1	0	0	2	1	0	6	2	0	4	2	0	6	4	0	7	3	0
Congo, Rep.	14	8	0	7	4	0	27	8	0	20	6	0	13	6	0	15	6	0
Cook Islands	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Costa Rica	3	0	0	3	1	0	3	1	0	2	0	0	2	0	0	1	0	0
Cote d'Ivoire	62	25	9	75	41	1	111	54	7	82	46	5	80	46	4	105	70	4
Croatia	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cuba	5	1	0	2	0	0	5	1	0	3	0	0	3	0	0	4	0	0
Democratic Republic of the Congo	7	0	0	15	0	0	17	0	0	8	0	0	15	0	0	19	0	0
Democratic Republic of Korea	226	61	18	268	70	4	310	71	6	330	80	0	376	78	1	434	77	1
Djibouti	10	6	1	10	6	0	6	3	0	7	3	2	12	6	0	8	2	0

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Recipient country	Total ODA+ to RMNC H	2008 ODA+ to RMNCH through gov't	ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2009 ODA+ to RMNCH through gov't	ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2010 ODA+ to RMNCH through gov't	ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2011 ODA+ to RMNCH through gov't	ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2012 ODA+ to RMNCH through gov't	ODA+ to RMNCH pooled	Total ODA+ to RMNC H	2013 ODA+ to RMNCH through gov't	ODA+ to RMNCH pooled
Dominica	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dominican Republic	18	10	0	19	9	1	23	11	0	22	4	2	23	9	0	23	13	0
Ecuador	14	8	0	10	3	0	8	2	0	5	1	0	4	1	0	5	2	0
Egypt	65	32	0	31	10	14	35	19	9	18	12	0	17	4	0	11	7	0
El Salvador	14	3	0	16	4	0	19	5	0	15	4	0	14	4	0	15	6	0
Equatorial Guinea	9	1	0	6	0	0	7	0	0	3	0	0	1	0	0	0	0	0
Eritrea	24	16	0	20	10	0	37	27	0	15	8	0	20	17	0	26	18	0
Ethiopia	349	174	8	378	196	27	479	265	59	561	193	71	515	174	87	687	363	87
Fiji	4	1	0	3	1	0	4	1	0	3	1	0	12	1	0	5	1	0
Former Yugoslav Republic of Macedonia	2	2	0	1	1	0	2	1	0	2	2	0	1	1	0	2	2	0
Gabon	4	1	0	6	5	0	3	2	0	3	2	0	3	2	0	4	3	0
Gambia	9	7	1	12	10	0	15	9	0	13	7	1	13	6	0	22	11	0
Georgia	16	6	5	15	8	4	16	9	2	14	4	2	15	3	0	10	1	0
Ghana	104	67	19	163	83	37	156	87	34	150	61	40	197	93	6	203	83	6
Grenada	1	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Guatemala	44	8	0	32	9	0	26	4	3	36	15	0	34	10	0	31	6	0
Guinea	25	14	0	23	6	0	35	15	0	27	12	1	40	12	1	33	10	1
Guinea-Bissau	9	3	1	10	6	1	15	11	0	10	4	0	5	1	0	21	11	0
Guyana	18	10	0	18	11	0	15	10	0	11	7	0	9	5	0	7	5	0
Haiti	90	27	3	110	38	7	183	61	1	190	53	0	139	44	0	142	45	0
Honduras	37	16	0	35	7	3	42	13	0	40	13	0	47	20	0	50	7	0

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Recipient country	Total ODA+ to RMNC H	2008 ODA+ to RMNCH through gov't	2008 ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2009 ODA+ to RMNCH through gov't	2009 ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2010 ODA+ to RMNCH through gov't	2010 ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2011 ODA+ to RMNCH through gov't	2011 ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2012 ODA+ to RMNCH through gov't	2012 ODA+ to RMNCH pooled	Total ODA+ to RMNC H	2013 ODA+ to RMNCH through gov't	2013 ODA+ to RMNCH pooled
India	414	324	4	467	361	11	458	321	45	594	371	1	486	293	99	400	234	99
Indonesia	111	64	0	102	51	0	126	71	0	96	54	1	125	59	1	135	83	1
Iran	5	0	0	1	0	0	5	0	0	7	0	0	11	0	0	6	0	0
Iraq	34	20	0	44	6	0	37	7	0	13	2	0	21	1	0	20	1	0
Jamaica	6	4	0	5	4	0	6	5	0	6	4	0	3	2	0	6	4	0
Jordan	32	2	0	53	11	0	52	7	11	66	13	14	83	21	0	57	6	0
Kazakhstan	9	6	0	11	3	0	10	5	0	5	3	0	11	9	0	7	4	0
Kenya	228	112	5	329	139	0	427	179	6	473	179	4	533	206	4	592	253	4
Kiribati	3	2	0	2	1	0	2	0	0	2	0	0	2	0	0	2	0	0
Kosovo			0	5	1	0	4	1	0	4	1	0	5	1	0	2	1	0
Kyrgyz Republic	19	12	1	16	11	2	17	12	5	18	11	2	14	7	2	14	6	2
Lao People's Democratic Republic	22	15	1	21	15	0	30	19	1	29	20	0	33	20	0	35	24	0
Lebanon	15	3	0	14	1	0	16	3	0	11	1	0	20	1	0	25	1	0
Lesotho	20	15	1	23	17	11	40	31	4	54	38	5	57	38	1	66	50	1
Liberia	63	28	1	58	14	3	62	14	5	71	18	19	77	35	18	74	34	18
Libya	13	12	0	8	8	0	0	0	0	4	1	0	3	1	0	2	0	0
Madagascar	71	30	0	57	14	0	103	26	0	61	13	0	73	7	0	113	17	0
Malawi	152	100	7	153	81	22	141	65	11	187	90	20	256	115	17	262	97	17
Malaysia	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	1	0	0
Maldives	1	1	0	1	1	0	1	0	0	2	1	0	2	0	0	1	0	0
Mali	77	31	14	89	41	8	104	24	34	134	51	4	137	18	15	157	25	15
Marshall Islands	4	4	4	4	4	0	0	0	0	0	0	7	7	7	0	0	0	0

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Recipient country	Total ODA+ to RMNC H	2008 ODA+ to RMNCH through gov't	2008 ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2009 ODA+ to RMNCH through gov't	2009 ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2010 ODA+ to RMNCH through gov't	2010 ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2011 ODA+ to RMNCH through gov't	2011 ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2012 ODA+ to RMNCH through gov't	2012 ODA+ to RMNCH pooled	Total ODA+ to RMNC H	2013 ODA+ to RMNCH through gov't	2013 ODA+ to RMNCH pooled
Mauritania	14	7	0	12	3	1	13	3	1	12	4	1	14	2	0	14	4	0
Mauritius	1	1	2	3	3	1	2	2	2	2	2	2	3	2	0	1	0	0
Mayotte	4	4	0	2	2	1	5	5	0			0			0			0
Mexico	3	1	0	3	1	0	3	0	0	4	0	0	5	0	0	4	0	0
Micronesia, Fed. States	7	7	9	9	9	0	0	0	0	0	0	11	12	12	0	0	0	0
Moldova	13	6	0	16	10	8	31	21	14	24	17	7	21	14	0	12	3	0
Mongolia	6	2	0	5	2	1	8	5	0	9	7	0	11	7	0	10	8	0
Montenegro	2	1	0	1	0	0	1	0	0	1	0	0	1	0	0	1	0	0
Montserrat	1	1	0	0	0	0			0	1		0	0		0	0	0	0
Morocco	17	14	0	30	25	1	29	22	3	20	17	5	23	14	8	37	15	8
Mozambique	219	125	17	228	117	50	287	178	57	289	161	57	311	163	63	340	169	63
Myanmar	44	3	0	36	4	0	47	1	0	40	1	0	107	2	10	125	14	10
Namibia	40	22	0	71	57	0	74	50	0	55	29	0	71	47	0	63	35	0
Nauru	1	1	0	1	0	0	0	0	0	0	0	1	1	1	0	0	0	0
Nepal	61	33	0	57	26	6	82	26	7	63	27	6	63	22	7	70	30	7
Nicaragua	47	19	3	56	15	7	48	13	4	50	23	2	41	14	0	33	6	0
Niger	70	23	0	71	19	3	89	19	7	80	19	4	70	20	1	85	20	1
Nigeria	373	192	0	649	342	14	445	216	9	556	238	4	675	235	6	954	480	6
Niue	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Oman	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pakistan	176	66	1	269	80	1	360	117	94	362	167	0	401	86	0	455	90	0
Palau	1	1	1	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Panama	1	1	0	3	1	0	3	0	0	2	0	0	3	1	0	3	1	0
Papua New Guinea	59	17	0	66	21	10	52	16	1	78	8	1	78	5	1	95	3	1

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Recipient country	Total ODA+ to RMNC H	2008 ODA+ to RMNCH through gov't	ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2009 ODA+ to RMNCH through gov't	ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2010 ODA+ to RMNCH through gov't	ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2011 ODA+ to RMNCH through gov't	ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2012 ODA+ to RMNCH through gov't	ODA+ to RMNCH pooled	Total ODA+ to RMNC H	2013 ODA+ to RMNCH through gov't	ODA+ to RMNCH pooled
Paraguay	9	4	0	12	3	0	14	4	0	6	1	0	7	2	0	5	1	0
Peru	28	5	0	70	39	0	34	4	0	22	1	24	43	28	23	36	26	23
Philippines	45	8	0	52	17	2	64	10	8	55	17	4	55	13	0	63	6	0
Rwanda	131	78	12	156	99	16	180	121	17	191	119	4	191	117	8	170	99	8
Saint Helena	1	1	1	1	1	0	3	2	0	1	1	0	7	7	0	7	7	0
Saint Kitts and Nevis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Saint Lucia	0	0	1	1	1	0	0	0	0	4	4	0	3	3	0	2	2	0
Saint Vincent and the Grenadines	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Samoa	1	1	0	2	1	2	4	3	0	1	1	3	5	4	4	5	5	4
Sao Tome and Principe	4	1	0	2	1	0	3	1	0	5	1	0	3	1	0	7	1	0
Senegal	65	19	7	76	33	2	69	23	8	83	25	8	100	39	0	95	29	0
Serbia	8	4	3	13	11	3	7	5	0	10	5	0	5	3	0	8	2	0
Seychelles	0	0	0	0	0	1	1	1	0	0	0	0	0	0	0	0	0	0
Sierra Leone	36	16	2	52	15	3	57	19	1	55	23	1	51	15	1	75	14	1
Solomon Islands	9	5	0	10	5	6	10	8	6	12	10	4	8	5	6	13	10	6
Somalia	34	3	0	52	0	0	50	0	0	48	0	0	93	0	0	75	1	0
South Africa	220	113	0	307	160	0	356	158	23	383	163	18	390	180	31	373	187	31
South Sudan			0			0			0	65	5	12	155	23	28	162	34	28
Sri Lanka	16	11	0	26	12	0	27	15	0	18	8	0	16	7	0	15	8	0
States Ex-Yugoslavia	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sudan	133	17	0	115	8	0	180	18	0	87	8	0	115	8	0	127	7	0
Suriname	3	2	2	9	8	0	4	4	0	4	4	0	1	1	0	2	2	0

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Recipient country	Total ODA+ to RMNC	2008 ODA+ to RMNCH through gov't	ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2009 ODA+ to RMNCH through gov't	ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2010 ODA+ to RMNCH through gov't	ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2011 ODA+ to RMNCH through gov't	ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2012 ODA+ to RMNCH through gov't	ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2013 ODA+ to RMNCH through gov't	ODA+ to RMNCH pooled
Swaziland	12	9	0	21	14	0	39	28	0	42	19	0	35	15	0	41	24	0
Syrian Arab Republic	12	2	0	16	7	0	12	5	0	6	1	0	18	0	0	62	3	0
Tajikistan	16	4	2	16	5	3	27	8	1	14	3	1	22	6	0	22	6	0
Tanzania	321	225	39	342	217	55	434	266	68	413	244	39	468	166	49	589	311	49
Thailand	31	20	0	21	12	0	26	17	0	38	27	0	33	10	0	43	20	0
Timor-Leste	14	1	0	11	4	0	19	10	0	14	4	0	25	5	0	16	3	0
Togo	21	7	2	27	10	3	26	12	1	32	16	0	10	6	0	36	12	0
Tokelau	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Tonga	1	1	0	1	1	0	2	1	0	4	4	1	3	2	1	1	1	1
Trinidad and Tobago	2	2	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Tunisia	10	10	1	4	3	0	3	2	0	2	1	0	6	5	0	5	3	0
Turkey	4	3	0	1	0	0	1	0	0	1	0	0	1	0	0	3	0	0
Turkmenistan	2	0	0	1	0	0	2	0	0	1	0	0	1	0	0	1	0	0
Tuvalu	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Uganda	182	78	4	234	126	14	278	122	4	286	112	7	404	212	3	356	131	3
Ukraine	28	6	0	27	4	0	26	2	0	28	2	0	18	3	0	11	5	0
Uruguay	1	0	0	1	0	0	2	1	0	1	0	0	1	1	0	1	0	0
Uzbekistan	16	5	0	19	3	0	21	5	0	16	3	0	24	10	0	19	11	0
Vanuatu	3	2	0	4	3	0	3	2	0	2	0	1	4	2	1	7	4	1
Venezuela	1	0	0	1	0	0	2	0	0	1	0	0	1	0	0	1	0	0
Vietnam	80	50	16	78	66	3	100	62	3	109	69	6	99	68	6	115	82	6
Wallis and Futuna	0	0	0	15	15	0	1	1	0	0	0	0	1	1	0	0	0	0
West Bank	67	11	3	63	6	3	195	120	26	98	30	5	98	10	0	57	4	0



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Recipient country	Total ODA+ to RMNCH	2008 ODA+ to RMNCH through gov't	2008 ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2009 ODA+ to RMNCH through gov't	2009 ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2010 ODA+ to RMNCH through gov't	2010 ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2011 ODA+ to RMNCH through gov't	2011 ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2012 ODA+ to RMNCH through gov't	2012 ODA+ to RMNCH pooled	Total ODA+ to RMNCH	2013 ODA+ to RMNCH through gov't	2013 ODA+ to RMNCH pooled
and Gaza Strip																		
Yemen	43	18	0	38	14	1	52	17	0	43	8	1	91	28	0	147	54	0
Zambia	187	87	19	194	95	11	176	74	12	250	84	15	264	103	8	331	88	8
Zimbabwe	68	19	0	106	23	0	143	10	0	121	9	14	309	28	0	215	19	0
<b>Grand Total</b>	<b>6603</b>	<b>3078</b>	<b>275</b>	<b>7857</b>	<b>3672</b>	<b>426</b>	<b>8799</b>	<b>3867</b>	<b>658</b>	<b>8881</b>	<b>3606</b>	<b>522</b>	<b>9864</b>	<b>3567</b>	<b>557</b>	<b>10952</b>	<b>4240</b>	<b>557</b>

For Review Only

**Table 7:** Number of countries supported and Theil index by donor between 2003 and 2013 (presented in two or three year averages)

Time period	2006-2008		2009-2011		2012-2013		2006-2013 average	
Donor	Avg. No. countries Supported	Theil Index	Avg. No. countries Supported	Theil Index	Avg. No. countries Supported	Theil Index	Avg. No. countries Supported	Theil Index
AfDB					2.0	0.67	0.7	0.22
AfDF	28.3	0.31	18.0	0.50	16.5	0.75	20.9	0.52
Arab Fund (AFESD)	1.7	0.76	3.7	0.82	4.5	0.66	3.3	0.75
AsDB Special Funds			27.0	1.64	10.5	0.87	12.5	0.84
Australia	36.0	1.46	59.3	1.81	54.0	1.24	49.8	1.50
Austria	52.7	1.50	40.3	1.21	62.0	1.23	51.7	1.31
BADEA			1.7	0.07	7.0	0.32	2.9	0.13
Belgium	55.0	1.20	64.3	1.49	51.0	1.19	56.8	1.29
Bill & Melinda Gates Foundation			53.0	1.49	66.5	1.91	39.8	1.13
Canada	73.0	1.20	95.0	1.59	84.0	1.48	84.0	1.42
Czech Republic			7.7	0.83	22.5	0.70	10.1	0.51
Denmark	36.0	0.93	44.0	1.20	30.0	1.34	36.7	1.16
Estonia					4.5	0.38	1.5	0.13
EU Institutions	106.3	0.89	115.7	0.96	110.0	0.92	110.7	0.92
Finland	48.0	1.18	59.3	1.00	57.5	0.86	54.9	1.01
France	48.7	1.19	68.0	1.06	62.0	1.22	59.6	1.16
GAVI	67.7	0.84	69.7	0.81	71.5	0.86	69.6	0.84
GEF	0.3	0.00	0.3		4.0	0.22	1.6	0.07

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Time period	2006-2008		2009-2011		2012-2013		2006-2013 average	
Germany	90.0	1.28	92.7	1.22	93.0	1.25	91.9	1.25
Global Fund	105.3	0.83	106.7	0.82	115.5	0.92	109.2	0.86
Greece	37.7	0.83	22.0	2.10	10.0	2.32	23.2	1.75
Iceland			1.3	0.39	5.0	1.04	2.1	0.48
IDA	69.3	0.80	64.7	1.31	53.0	1.06	62.3	1.06
IDB Sp.Fund			11.0	1.16	13.5	1.71	8.2	0.96
IMF (Concessional Trust Funds)	29.7	0.65	34.3	0.73	26.0	0.58	30.0	0.65
Ireland	62.0	1.46	50.7	1.50	40.0	1.15	50.9	1.37
Italy	81.7	1.12	82.7	0.91	74.5	0.90	79.6	0.98
Japan	126.3	1.05	126.3	1.02	126.0	1.10	126.2	1.06
Korea	60.7	0.97	64.7	1.22	60.5	0.99	61.9	1.06
Kuwait (KFAED)			4.0	0.89	3.5	0.19	2.5	0.36
Luxembourg	46.3	1.10	48.7	1.04	42.5	1.26	45.8	1.13
Netherlands	43.3	1.07	33.3	1.06	25.0	0.93	33.9	1.02
New Zealand	21.7	1.34	21.7	1.25	17.0	1.06	20.1	1.22
Norway	70.3	1.13	65.3	1.28	64.0	1.35	66.6	1.25
OFID			14.0	0.85	18.5	0.68	10.8	0.51
Poland					12.0	0.91	4.0	0.30
Portugal	7.7	0.47	7.7	0.87	6.5	0.55	7.3	0.63
Slovak Republic					4.0	0.88	1.3	0.29
Slovenia			11.0	0.51	14.0	2.20	8.3	0.90
Spain	78.3	0.76	79.3	0.86	64.0	0.97	73.9	0.86
Sweden	94.3	1.39	87.7	1.34	81.5	1.26	87.8	1.33
Switzerland	59.7	1.09	56.7	1.21	53.0	0.92	56.4	1.07

Time period	2006-2008		2009-2011		2012-2013		2006-2013 average	
UNAIDS	114.3	0.59	105.0	0.45	97.0	0.43	105.4	0.49
UNDP	66.3	1.00	69.3	1.06	62.0	1.17	65.9	1.08
UNFPA	115.0	0.52	116.3	0.46	116.5	0.43	115.9	0.47
UNICEF	116.0	0.93	116.3	1.07	114.5	1.11	115.6	1.04
United Arab Emirates			24.0	1.65	23.0	1.32	15.7	0.99
United Kingdom	55.3	1.14	52.3	1.37	52.5	1.10	53.4	1.20
United States	108.0	1.10	111.3	1.28	112.5	1.27	110.6	1.22
UNPBF			1.3	0.11	0.5		0.6	0.04
UNRWA	4.0	0.17	4.0	0.20	4.0	0.25	4.0	0.21
WFP			44.7	0.76	39.0	0.97	27.9	0.58
WHO			36.7	0.31	111.0	0.34	49.2	0.22

**Table 8:** Total ODA+ to RMNCH (2013 USD millions), average number of donors and average HHI by region

Time period	2006-2008	2009-2011	2012-2013	Change
<b>East Asia &amp; Pacific</b>				
Total ODA+ to RMNCH	587.43	680.05	808.20	220.89
Average No Donors	10.34	11.67	12.46	2.12
HHI	0.51	0.37	0.44	-0.07
<b>Europe &amp; Central Asia</b>				
Total ODA+ to RMNCH	176.27	187.57	158.82	-17.45
Average No Donors	14.42	14.22	13.86	-0.56
HHI	0.26	0.27	0.29	0.03
<b>Latin America &amp; Caribbean</b>				
Total ODA+ to RMNCH	378.54	494.62	448.85	70.31
Average No Donors	10.02	11.73	11.17	1.15
HHI	0.39	0.36	0.44	0.06
<b>Middle East &amp; North America</b>				
Total ODA+ to RMNCH	347.38	352.83	422.08	74.70
Average No Donors	13.27	16.76	20.00	6.73
HHI	0.38	0.30	0.25	-0.12
<b>South Asia</b>				
Total ODA+ to RMNCH	949.52	1454.09	1532.84	583.32
Average No Donors	20.58	24.00	23.50	2.92
HHI	0.19	0.15	0.15	-0.04
<b>Sub-Saharan Africa</b>				
Total ODA+ to RMNCH	3,343.53	5,344.22	7,030.45	3,686.91
Average No Donors	19.94	22.52	22.04	2.11
HHI	0.23	0.26	0.26	0.03

**Table 9:** Number of donors and Herfindahl-Hirschman index by recipient country between 2003 and 2013 (presented in two or three year averages)

Recipient country	2006-2008		2009-2011		2012-2013		2006-2013 average	
	Average no. of donors	HH-index	Average no. of donors	HH-index	Average no. of donors	HH-index	Average no. of donors	HH-index
Afghanistan	26.67	0.2	32	0.2	32	0.14	30.2	0.18
Albania	19.67	0.13	17.33	0.13	14.5	0.33	17.2	0.20
Algeria	12.33	0.17	14.33	0.17	13.5	0.43	13.4	0.26
Angola	24.67	0.13	23	0.25	21	0.27	22.9	0.22
Anguilla	0.33	1	0.33	1	0.5	1	0.4	1.00
Antigua and Barbuda	1.67	0.36	1.33	0.84	0.5	1	1.2	0.73
Argentina	14	0.22	14.33	0.36	12	0.19	13.4	0.26
Armenia	18.67	0.32	17.33	0.25	16	0.17	17.3	0.25
Azerbaijan	13.33	0.26	14	0.22	14	0.22	13.8	0.23
Bangladesh	24.67	0.11	28.33	0.12	28.5	0.12	27.2	0.12
Barbados	3	0.73	3	0.6	13	0.56	6.3	0.63
Belarus	14.33	0.27	14.67	0.11			9.7	0.13
Belize	4.67	0.33	7.67	0.54	8	0.24	6.8	0.37
Benin	25	0.11	25.67	0.15	25.5	0.17	25.4	0.14
Bhutan	10	0.19	11.33	0.14	12	0.19	11.1	0.17
Bolivia	20.67	0.14	24	0.16	25.5	0.14	23.4	0.15
Bosnia and Herzegovina	23	0.11	19.67	0.23	18	0.2	20.2	0.18
Botswana	12.33	0.87	16	0.85	12	0.85	13.4	0.86
Brazil	18	0.14	19	0.18	18.5	0.16	18.5	0.16
Burkina Faso	26	0.09	27.33	0.11	28.5	0.13	27.3	0.11
Burundi	24.33	0.13	28	0.12	26	0.14	26.1	0.13
Cambodia	25	0.17	30.33	0.17	30	0.13	28.4	0.16

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Recipient country	2006-2008		2009-2011		2012-2013		2006-2013 average	
	Average no. of donors	HH-index	Average no. of donors	HH-index	Average no. of donors	HH-index	Average no. of donors	HH-index
Cameroon	24.33	0.19	25.33	0.26	26.5	0.2	25.4	0.22
Cape Verde	10.33	0.22	13.67	0.21	7	0.37	10.3	0.27
Central African Republic	15	0.18	19.33	0.11	22.5	0.15	18.9	0.15
Chad	21.33	0.09	25.33	0.11	22	0.16	22.9	0.12
Chile	10.33	0.33	13.33	0.29	10	0.31	11.2	0.31
China (People's Republic of)	24.67	0.14	26	0.2	25	0.16	25.2	0.17
Colombia	16	0.17	20.33	0.22	19	0.42	18.4	0.27
Comoros	7.67	0.22	10	0.26	12.5	0.17	10.1	0.22
Congo, Rep.	15.67	0.16	19	0.21	16	0.21	16.9	0.19
Cook Islands	2.33	0.57	2	0.29	3.5	0.46	2.6	0.44
Costa Rica	9.33	0.28	10.33	0.43	7.5	0.57	9.1	0.43
Cote d'Ivoire	20.33	0.26	23.67	0.25	22.5	0.22	22.2	0.24
Croatia	7.33	0.26	5.67	0.25			4.3	0.17
Cuba	12.33	0.33	12	0.27	12.5	0.5	12.3	0.37
Democratic People's Republic of Korea	13	0.17	10	0.19	13.5	0.2	12.2	0.19
Democratic Republic of the Congo	27.33	0.1	31.67	0.1	30.5	0.13	29.8	0.11
Djibouti	12	0.18	17.33	0.09	15.5	0.09	14.9	0.12
Dominica	2.67	0.27	3.33	0.26	2.5	0.57	2.8	0.37
Dominican Republic	13.67	0.28	14	0.35	11.5	0.4	13.1	0.34
Ecuador	17	0.19	20	0.17	17.5	0.15	18.2	0.17

Recipient country	2006-2008		2009-2011		2012-2013		2006-2013 average	
	Average no. of donors	HH-index	Average no. of donors	HH-index	Average no. of donors	HH-index	Average no. of donors	HH-index
Egypt	22	0.34	23.67	0.3	21	0.28	22.2	0.31
El Salvador	15	0.22	18.33	0.2	19	0.26	17.4	0.23
Equatorial Guinea	6.33	0.42	6.67	0.46	6.5	0.27	6.5	0.38
Eritrea	17.67	0.18	18.33	0.35	14	0.52	16.7	0.35
Ethiopia	26.67	0.15	32.33	0.2	31.5	0.18	30.2	0.18
Fiji	7	0.29	5.67	0.26	9.5	0.55	7.4	0.37
Former Yugoslav Republic of Macedonia	13.67	0.2	10	0.42	9	0.45	10.9	0.36
Gabon	10.33	0.52	9.67	0.34	11.5	0.21	10.5	0.36
Gambia	15.67	0.33	17.67	0.48	15	0.34	16.1	0.38
Georgia	17.33	0.2	16.67	0.24	17	0.31	17.0	0.25
Ghana	25	0.11	30.33	0.13	30	0.16	28.4	0.13
Grenada	2.33	0.64	2.67	0.35	1	0.59	2.0	0.53
Guatemala	19	0.23	21	0.2	20	0.29	20.0	0.24
Guinea	19.67	0.13	18.67	0.18	21	0.15	19.8	0.15
Guinea-Bissau	16.33	0.12	19.33	0.24	16.5	0.39	17.4	0.25
Guyana	9	0.42	10.67	0.34	10.5	0.49	10.1	0.42
Haiti	17.33	0.39	26.67	0.27	25	0.45	23.0	0.37
Honduras	15.67	0.18	20.67	0.12	21	0.22	19.1	0.17
India	25	0.15	29	0.17	31	0.14	28.3	0.15
Indonesia	23.33	0.12	24.33	0.17	23.5	0.16	23.7	0.15
Iran	7.67	0.41	9	0.44	10.5	0.5	9.1	0.45
Iraq	18.33	0.52	21.33	0.46	22	0.37	20.6	0.45
Jamaica	9.33	0.35	9	0.46	6.5	0.36	8.3	0.39



Recipient country	2006-2008		2009-2011		2012-2013		2006-2013 average	
	Average no. of donors	HH-index	Average no. of donors	HH-index	Average no. of donors	HH-index	Average no. of donors	HH-index
Jordan	18.67	0.33	22.67	0.31	24.5	0.36	21.9	0.33
Kazakhstan	11.67	0.35	13.33	0.24	12	0.46	12.3	0.35
Kenya	28	0.24	31.67	0.32	34.5	0.36	31.4	0.31
Kiribati	4.67	0.48	5	0.32	5.5	0.41	5.1	0.40
Kosovo			13.67	0.14	13.5	0.22	9.1	0.12
Kyrgyz Republic	17	0.12	19.67	0.11	21	0.11	19.2	0.11
Lao People's Democratic Republic	21	0.17	27.33	0.1	27.5	0.1	25.3	0.12
Lebanon	23.33	0.2	22.33	0.35	24.5	0.24	23.4	0.26
Lesotho	16	0.22	20.33	0.33	17	0.48	17.8	0.34
Liberia	20.33	0.1	25.33	0.19	21	0.22	22.2	0.17
Libya	3.33	0.73	7.67	0.41	12.5	0.18	7.8	0.44
Madagascar	22.67	0.15	25.33	0.25	25	0.24	24.3	0.21
Malawi	26.67	0.14	29.67	0.15	31.5	0.17	29.3	0.15
Malaysia	8.67	0.42	10	0.27	9.5	0.24	9.4	0.31
Maldives	6	0.38	8.33	0.18	7.5	0.21	7.3	0.26
Mali	24.67	0.09	28.67	0.13	29.5	0.14	27.6	0.12
Marshall Islands	3	0.95	2.33	0.87	3.5	0.9	2.9	0.91
Mauritania	16.67	0.31	18	0.14	19.5	0.14	18.1	0.20
Mauritius	4	0.63	5.67	0.63	5.5	0.38	5.1	0.55
Mayotte	0.67	1	0.67	1			0.4	0.67
Mexico	11	0.28	15.67	0.19	15	0.31	13.9	0.26
Micronesia, Fed. States	2	0.98	3	0.91	3.5	0.93	2.8	0.94

Recipient country	2006-2008		2009-2011		2012-2013		2006-2013 average	
	Average no. of donors	HH-index	Average no. of donors	HH-index	Average no. of donors	HH-index	Average no. of donors	HH-index
Moldova	17.33	0.18	19	0.25	20	0.15	18.8	0.19
Mongolia	17.33	0.13	20	0.11	23	0.16	20.1	0.13
Montenegro	7.67	0.27	8.33	0.36	7	0.49	7.7	0.37
Montserrat	0.67	1	1	0.91	1	1	0.9	0.97
Morocco	16.67	0.18	17.33	0.22	19.5	0.26	17.8	0.22
Mozambique	29.33	0.11	33	0.23	35.5	0.23	32.6	0.19
Myanmar	18.67	0.09	20.67	0.1	24.5	0.14	21.3	0.11
Namibia	18.33	0.4	16.67	0.52	16	0.51	17.0	0.48
Nauru	2.33	0.97	1.67	0.52	2	0.95	2.0	0.81
Nepal	25.33	0.16	29	0.13	29.5	0.14	27.9	0.14
Nicaragua	26	0.09	27	0.08	24	0.1	25.7	0.09
Niger	24	0.1	26.33	0.13	25.5	0.1	25.3	0.11
Nigeria	23	0.21	26.33	0.2	22	0.16	23.8	0.19
Niue	2.33	0.95	1.67	0.82	2.5	0.9	2.2	0.89
Oman	1.33	0.52	1.33	0.5			0.9	0.34
Pakistan	21.33	0.18	27	0.14	23.5	0.19	23.9	0.17
Palau	2.67	0.81	4.67	0.61	5	0.44	4.1	0.62
Panama	7.33	0.23	9	0.46	7.5	0.27	7.9	0.32
Papua New Guinea	15.67	0.55	16	0.29	16.5	0.42	16.1	0.42
Paraguay	11.33	0.23	14.67	0.2	12	0.21	12.7	0.21
Peru	21.33	0.22	22	0.25	20	0.4	21.1	0.29
Philippines	21	0.28	20.67	0.18	22.5	0.22	21.4	0.23
Rwanda	27	0.22	29.33	0.3	27.5	0.31	27.9	0.28
Saint Helena	1	1	1.33	0.99	2	0.99	1.4	0.99
Saint Kitts and	1	0.94	1	0.65	1.5	0.87	1.2	0.82

Recipient country	2006-2008		2009-2011		2012-2013		2006-2013 average	
	Average no. of donors	HH-index	Average no. of donors	HH-index	Average no. of donors	HH-index	Average no. of donors	HH-index
Nevis								
Saint Lucia	3	0.66	5	0.55	2.5	0.75	3.5	0.65
Saint Vincent and the Grenadines	2.67	0.89	3.67	0.31	2.5	0.86	2.9	0.69
Samoa	5.67	0.27	5.67	0.25	5.5	0.31	5.6	0.28
Sao Tome and Principe	10.67	0.24	11.67	0.21	12	0.22	11.4	0.22
Saudi Arabia	1	0.98					0.3	0.33
Senegal	24	0.14	27.67	0.16	29.5	0.2	27.1	0.17
Serbia	18.67	0.14	16	0.49	15	0.57	16.6	0.40
Seychelles	3	0.42	5.33	0.24	5.5	0.33	4.6	0.33
Sierra Leone	20	0.11	23.33	0.17	25.5	0.17	22.9	0.15
Solomon Islands	4.33	0.83	7	0.31	8.5	0.7	6.6	0.61
Somalia	19	0.11	24.67	0.13	26.5	0.16	23.4	0.13
South Africa	23.67	0.45	24	0.68	24	0.51	23.9	0.55
South Sudan					26.5	0.12	8.8	0.04
Sri Lanka	25.67	0.18	27	0.11	24	0.11	25.6	0.13
States Ex-Yugoslavia	4.33	0.34	1.33	0.74	2	0.53	2.6	0.54
Sudan	23	0.11	28.67	0.16	26.5	0.24	26.1	0.17
Suriname	5.33	0.51	5	0.42	5	0.42	5.1	0.45
Swaziland	13.33	0.42	16	0.34	16.5	0.4	15.3	0.39
Syrian Arab Republic	11.67	0.22	13.33	0.23	26.5	0.11	17.2	0.19
Tajikistan	19	0.12	23	0.11	21.5	0.13	21.2	0.12
Tanzania	28.33	0.15	31.33	0.21	34.5	0.18	31.4	0.18
Thailand	16.33	0.42	19	0.41	18.5	0.36	17.9	0.40

Recipient country	2006-2008		2009-2011		2012-2013		2006-2013 average	
	Average no. of donors	HH-index	Average no. of donors	HH-index	Average no. of donors	HH-index	Average no. of donors	HH-index
Timor-Leste	15.67	0.16	17.33	0.19	19	0.2	17.3	0.18
Togo	18	0.25	22.67	0.25	21	0.31	20.6	0.27
Tokelau	1	1	1.67	0.85	2.5	0.95	1.7	0.93
Tonga	6	0.42	4.33	0.38	4	0.41	4.8	0.40
Trinidad and Tobago	4	0.49	3.33	0.32			2.4	0.27
Tunisia	9	0.59	12.33	0.22	16.5	0.17	12.6	0.33
Turkey	10.67	0.85	9.33	0.21	9	0.25	9.7	0.44
Turkmenistan	5.67	0.4	8.67	0.24	6	0.28	6.8	0.31
Turks and Caicos Islands	0.33	1					0.1	0.33
Tuvalu	2.33	0.7	2.67	0.22	4	0.35	3.0	0.42
Uganda	27.67	0.25	29.67	0.36	32	0.3	29.8	0.30
Ukraine	19	0.32	20.67	0.38	18	0.27	19.2	0.32
Uruguay	7.67	0.24	9.67	0.16	9.5	0.24	8.9	0.21
Uzbekistan	15.67	0.13	16	0.19	16	0.15	15.9	0.16
Vanuatu	4.67	0.62	5.67	0.27	5	0.42	5.1	0.44
Venezuela	8	0.24	9.67	0.16	6.5	0.34	8.1	0.25
Vietnam	28	0.08	31	0.1	30.5	0.12	29.8	0.10
Wallis and Futuna	1	1	1	1	1	1	1.0	1.00
West Bank and Gaza Strip	23.67	0.16	30.67	0.3	29.5	0.16	27.9	0.21
Yemen	18	0.15	21.33	0.16	24	0.15	21.1	0.15
Zambia	27.67	0.19	28.33	0.3	25.5	0.29	27.2	0.26
Zimbabwe	26	0.16	27.67	0.15	24	0.22	25.9	0.18
<b>All recipients</b>							15.4	0.32

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Recipient country	Average no. of donors	HH-index	Average no. of donors	HH-index	Average no. of donors	HH-index	Average no. of donors	HH-index

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