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# DONOR FUNDING FOR HEALTH IN LOW- & MIDDLE-INCOME COUNTRIES, 2001–2008

July 2010

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# DONOR FUNDING FOR HEALTH IN LOW- & MIDDLE-INCOME COUNTRIES, 2001–2008

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## Summary & Highlights

Donor government funding, directly and indirectly through contributions to multilateral organizations, accounts for most external health aid channeled to the developing world, and as such constitutes a major component of the global health response. This paper provides an analysis of Official Development Assistance (ODA) commitments for health provided by donors between 2001 and 2008, as reported to the Organisation for Economic Co-operation and Development (OECD) by Development Assistance Committee (DAC) member countries and multilateral organizations.[1,2,3] In addition to updating prior reports prepared by the Kaiser Family Foundation,[4,5] it is intended to complement efforts by others to track health funding[6] and to expand upon them by broadening the definition of health to include water and sanitation activities.[7] Collectively, these resource tracking analyses are central to assessing progress on global health, including toward meeting internationally agreed-upon health targets, such as the Millennium Development Goals (MDGs).[8]

The current analysis finds that ODA for health rose significantly between 2001 and 2008, after adjusting for inflation and exchange rate fluctuations. Donors have continued to focus international attention on global health through such efforts as the U.S. government's Global Health Initiative,[9] the Group of Eight's new signature initiative on maternal, newborn, and child health,[10] and the upcoming United Nations Summit of world leaders designed to accelerate progress towards the MDGs.[11]

Despite these past increases and new initiatives, the future of donor funding for global health remains uncertain, given that the onset of the global economic crisis began after donor governments made their budgeting decisions for 2008, the most recent period for which standardized ODA health data are available. This significant lag in the availability of data hampers efforts to monitor, and potentially address, real-time changes in donor funding for health. Going forward, then, the effects of the economic downturn on health ODA flows and the needs of countries in the developing world, will need to be assessed.

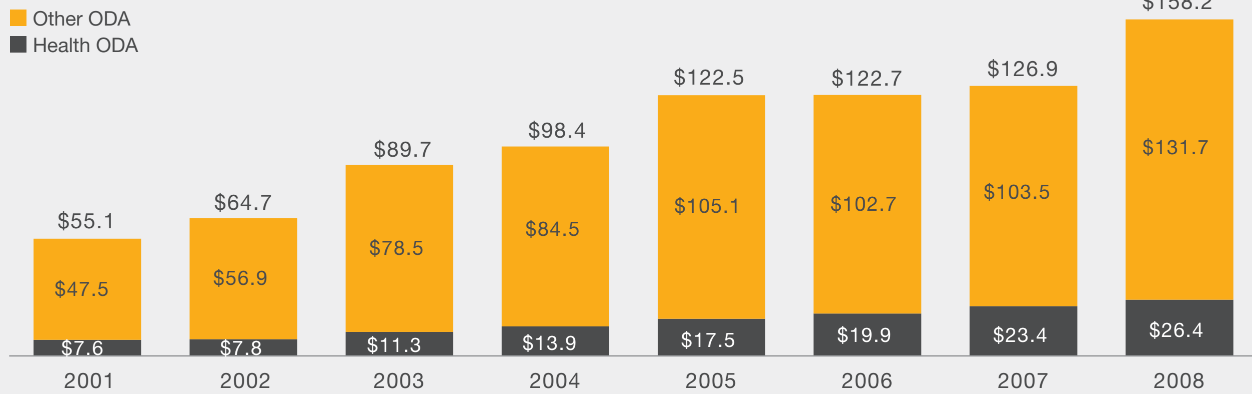
Key highlights from this year's report include:

- **Overall ODA:** Between 2001 and 2008, gross ODA[12,13] nearly tripled in nominal terms, with increases in nearly every sector, rising from US$55.1 billion to US$158.2 (a 187.1% increase). After adjusting for inflation, currency revaluation, debt relief, and aid to Iraq and Afghanistan, the $103.1 billion increase in real terms was $58.3 billion, an increase of 74.8%. A particularly steep increase was reported between 2007 and 2008 (an increase of more than $31 billion, or almost 25%), largely driven by economic infrastructure projects. In recent years, an increasing share of ODA has been provided in the form of "ODA loans," which require some level of repayment, as compared to "ODA grants," and loans have been a significant driver of recent increases in overall ODA.
- **Health ODA:** Funding for health more than tripled between 2001 and 2008, rising from $7.6 billion to $26.4 billion (248.7%), an increase in real terms even after adjusting for inflation and currency revaluation. Health grew as a share of overall ODA as well, rising from 13.8% to 16.7%. As the base of donor funding for health has grown, largely due to the start-up of big, new global health initiatives earlier in the decade (including the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the U.S. President's Emergency Plan for AIDS Relief, or PEPFAR), the rate of increase has slowed, although the overall amount of funding has continued to rise.
- **Health ODA by Donor & Region:** The U.S. was the single largest ODA donor to health, accounting for nearly a third (31.1%) of financing in 2008, and its share has grown over time. European nations, together, accounted for more than a quarter (28.1%) and the European Commission adds another 3.1%. Multilateral institutions represented 24.2%. Most health funding was channeled to Sub-Saharan Africa (43.5%), followed by South/Central Asia (13.3%).
- **Health ODA by Sub-Sector:** Within the health sector, which is comprised of the three broad areas of population/reproductive health (which includes HIV/AIDS & STDs), general and basic health, and water and sanitation, funding for population/reproductive health accounted for the largest share of health funding in 2008 (39.4%), as it has in prior years, with the remainder split between general/basic health (31.4%), water/sanitation (29.1%). Looking within these broader categories, funding for HIV/AIDS & STDs accounted for the largest share of health funding (30.0%) in 2008, followed by large-system water supply/sanitation[14] (18.5%) and basic health care (9.3%). All other subsectors within health received 5.9% or less of funding in 2008.

FIGURE 1:

Total ODA Commitments for Health and All Other ODA, 2001–2008

U.S. $ BILLIONS




Note: Amounts in gross US$ commitments. Health ODA combines data from four OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); (3) Water Supply/Sanitation; and (4) Other Social Infrastructure and Services – Social Mitigation of HIV/AIDS Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), June 22, 2010.

## Total ODA

- Between 2001 and 2008, gross ODA nearly tripled in nominal terms, rising from US$55.1 billion to US$158.2 billion, a 187.1% increase (see Table 1 and Figure 1).
- Some of the increase was offset by inflation and exchange rate changes; a considerable portion was for debt relief and aid to Iraq and Afghanistan (see Table 1, Figure 5).[15] Aid to Iraq and Afghanistan, for example, accounted for about 11.7% of ODA commitments in 2008, and drove 17.5% of ODA growth between 2001 and 2008. After adjusting for these combined factors, the increase over the period in real terms was $58.3 billion, an increase or 74.8%.
- Over the same period, government/civil society funding grew the most in percentage terms (increasing 296.7%, from $4.8 billion in 2001 to $19.0 billion in 2008, followed by health (248.7%), emergency assistance (248.2%) education (185.6%) and Multisector/Other (162.9%) (see Table 1).[16]
- One of the steepest annual increases in ODA over the eight year period was reported to have occurred between 2007 and 2008, a $31.3 billion (or 24.7%) increase. Between 2007–2008, funding for commodity aid rose the most (91.0%, see Figure 2), followed by economic infrastructure (49.7%), and production (26.9%). Health increased by 13.2%. Looking at the main drivers of the $31.3 billion increase (see Figure 3), economic infrastructure projects drove almost a third (31.3%) of the growth, followed by multisector projects (16.5%), commodity aid (16.0%), and health funding (9.9%); all other sectors drove 8.0% or less of the growth.
- Economic infrastructure and multisector projects have consistently represented the largest shares of ODA over time. In 2001, economic infrastructure accounted for almost 20%, as did multisector funding; in 2008, they accounted for 18.6% and 18.2% respectively. Funding for health increased somewhat as a share of ODA, rising from 13.8% in 2001 to 16.7% in 2008. Debt relief, as expected, accounted for a decreasing share of ODA, due to the timing of specific, large, debt relief transactions in 2005 and 2006; debt relief then fell as planned by more than half between 2006 and 2007, and rose slightly in 2008.[17,18] (see Figure 5).
- ODA is provided in the form of both loans and grants. ODA loans, which require some level of repayment, are less “concessional” than ODA grants, and therefore cost more to the recipient country.[19] The amount of ODA provided in loans vs. grants has fluctuated over time (see Figure 6). In 2001, more than a third of ODA was provided in the form of loans; by 2006, it had dropped to 16.4%. More recently, ODA loans have been on the rise and represented 22.0% of ODA in 2008; ODA loans drove almost a third of the increase in ODA between 2007–2008.

**TABLE 1: TOTAL ODA BY MAJOR SECTOR, 2001, 2007, 2008**
**Gross US$ Commitments in Billions**

| | | | | 2007–2008 | 2001–2008 |
|---|---|---|---|---|---|
| | 2001 | 2007 | 2008 | +/- $ (%) | +/- $ (%) |
| Multisector/Other* | 11.0 | 23.6 | 28.8 | +5.2 (21.8%) | +17.8 (162.9%) |
| Commodity Aid | 4.3 | 5.5 | 10.5 | +5.0 (91.0%) | +6.2 (143.4%) |
| Government/Civil Society | 4.8 | 16.5 | 19.0 | +2.5 (14.9%) | +14.2 (296.7%) |
| Economic Infrastructure | 10.8 | 19.7 | 29.5 | +9.8 (49.7%) | +18.6 (171.8%) |
| Health** | 7.6 | 23.4 | 26.4 | +3.1 (13.2%) | +18.9 (248.7%) |
| Education | 4.1 | 11.1 | 11.6 | +0.5 (4.0%) | +7.5 (185.6%) |
| Production | 5.3 | 9.3 | 11.8 | +2.5 (26.9%) | +6.5 (121.6%) |
| Emergency Assistance | 3.1 | 8.7 | 10.7 | +2.0 (22.8%) | +7.6 (248.2%) |
| Debt Relief | 4.2 | 9.1 | 9.9 | +0.9 (9.6%) | +5.7 (137.0%) |
| **TOTAL** | **$55.1** | **$126.9** | **$158.2** | **+$31.3 (24.7%)** | **+$103.1 (187.1%)** |

* Represents combined data from six OECD CRS sectors and sub-sectors: (1) Multisector/Cross-cutting; (2) Administrative Costs of Donors; (3) Support of NGO's; (4) Refugees in Donor Countries; (5) Unallocated/Unspecified; and (6) Other Social Infrastructure & Services (excluding Social Mitigation of HIV/AIDS).

** Represents combined data from four OECD CRS subsectors (1) Health; (2) Population Policies/Programs and Reproductive Health (which includes HIV/AIDS & STDs); (3) Water Supply/Sanitation; and (4) Other Social Infrastructure and Services — Social Mitigation of HIV/AIDS.

## Health ODA

- Funding for health tripled over the period, rising from $7.6 billion to $26.4 billion (see Table 1 and Figure 1), an increase in real terms even after adjusting for inflation and currency revaluation.
- As a percentage of total ODA, health increased from 13.8% in 2001 to 16.7% in 2008 (see Figure 5); it consistently represented the third largest sector between 2001 and 2008, with the exception of 2003 (4th) and 2007 (2nd).
- Funding for health grew at a much faster pace (248.7%) than overall ODA between 2001 and 2008 and was the second fastest growing sector, after government/civil society (which grew at 296.7%).
- The most significant rates of increase in health commitments occurred in the early part of the 2001–2008 period, largely reflecting the start-up of new global health initiatives, particularly the Global Fund and PEPFAR. As the base of donor funding for health has grown due in large part to these new initiatives, the rate of increase has slowed; between 2007 and 2008, the annual rate of increase in health ODA was less than overall ODA (13.2% compared to 24.7%).
- As with overall ODA, health ODA is also provided in the form of loans and grants, although over time, a decreasing share of health ODA has been provided in the form of loans, dropping from 34.1% of health ODA in 2001, to 22.8% in 2004 and 19.9% in 2008.

## Health ODA by Donor

- The U.S. was the single largest donor to health ODA in 2008 ($8.2 billion), accounting for nearly a third of health funding (31.1%) and an increasing share over time (the U.S. accounted for 22.2% of health ODA in 2001) See Table 2 and Figure 7. The U.S. accounts for a larger share of health ODA than overall ODA (31.1% compared to 20.0%, respectively, in 2008) and, between 2001–2008, its share of health ODA increased at a faster rate than its share of overall ODA.
- U.S. funding nearly quadrupled between 2001 and 2008 (a 389.6% increase). Much of this was due to commitments for PEPFAR, the President's Emergency Plan for AIDS Relief. PEPFAR was initially authorized by the U.S. Congress for $15 billion over five-years, starting in FY 2004; actual funding commitments for PEPFAR over the five-year period totaled almost $19 billion, though not all of this was reportable as ODA. The total also includes commitments for the PMI, the President's Malaria Initiative. (The program has since been reauthorized by Congress at a level of US$ 48 billion dollars for the period 2009 to 2013.)
- European nations, collectively, accounted for 28.1% of health ODA commitments in 2008 ($7.4 billion), more than tripling their 2001 funding level (a 247.7% increase over the period). The European Commission accounted for an additional $823 million, or 3.1% of the 2008 total.
- Other multilateral organizations accounted for a quarter of health commitments in 2008 at $6.4. billion (24.2%), down from their share in 2001 (31.0%).

## Health ODA by Region

- Sub-Saharan Africa received the largest share of health funding of any region in 2008 (43.5%), and accounted for a growing share of health ODA (see Figure 8). Funding for the region drove most of the growth over the 2001–2008 (46.0%).
- Funding for South/Central Asia accounted for the second largest share in 2008 (13.3%) and was the second largest driver of growth by region, between 2001 and 2008 (12.3%).
- The next largest region, by share of funding in 2008, was East Asia (8.7%). All other regions accounted for less than 7% of total health funding each.
- A significant portion of health funding (17.9%) was allocated globally rather than to a specific country recipient.

## Health ODA by Sub-Sector

- Within the health sector, which is comprised of the three broad areas of population/reproductive health (which includes HIV/AIDS & STDs), general and basic health, and water and sanitation, funding for population/reproductive health accounted for the largest share of health funding in 2008 (39.4%), as it has in prior years, with the remainder split between general/basic health (31.4%), water/sanitation (29.1%). See Table 3 and Figure 9.
- Funding for population/reproductive health increased the fastest over the period (almost a five-fold increase) and drove half of the growth. Funding for water and sanitation more than doubled and funding for general/basic health increased by 225.9%.

## Health ODA, Activities by Sub-Sectors

- Looking at specific health activities within these broader categories, the greatest share of funding in 2008 went to HIV/AIDS & STDS related programs (30.0%). Large-system water supply sanitation[15] accounted for the next largest share (18.5%) followed by basic health care (9.3%), Reproductive Health Care (5.9%) and health policy/management (5.6%). Malaria and TB efforts together accounted for 6.5% of 2008 funding while basic drinking water supply & sanitation received 4.4%. Family planning accounted for just over 2 percent (see Table 3 and Figure 10).
- Most of the growth over the 2001 to 2008 period was driven by funding for HIV/AIDS & STDs (37.8%), followed by large-system water supply/sanitation (15.7%) reproductive health care (7.0%), basic health care (10.0%) and malaria control (6.6%) (see Figure 11).
- Some sub-sectors that serve as “building blocks” for health continue to receive only small amounts of funding in 2007, such as medical education and training (0.1%) and health education (0.1%), raising questions about the underlying development and sustainability of health systems.[20,21]
- The only sub-sector that experienced decreased funding over the period was water resources protection, which also accounted for a small share of health funding.

## Conclusion

Tracking donor government funding is one important component of monitoring global progress to improve health in low- and middle-income countries and this analysis indicates that donors increased their health ODA over the 2001–2008 period. Moreover, health grew as a share of overall ODA, reflecting its priority among donors. At the same time, caution about future donor assistance for health may be warranted – the data in this report, although the most recent available on health ODA, reflect decisions made prior to the global economic crisis that struck in the second half of 2008. The data also indicate a slowing in the rate of growth of health ODA. Still, donor attention to global health has been evident in the post-economic crisis era, with new initiatives being launched, such as the U.S. government’s GHI and the G8’s recent launching of a new maternal and child health initiative. Preliminary estimates from the OECD predict limited overall ODA growth for 2009–2010,[22] with mixed prospects among donors. How health fares within this will be important to assess.

**TABLE 2: TOTAL ODA AND HEALTH* ODA BY DONORS, 2001–2008**
Gross US$ Commitments in Billions

| | 2001 | | 2002 | | 2003 | | 2004 | | 2005 | | 2006 | | 2007 | | 2008 | | 2001–2008 Total ODA | | 2001–2008 Health | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total | Health | Total | Health | Total | Health | Total | Health | Total | Health | Total | Health | Total | Health | Total | Health | Value +/- | %+/- | Value +/- | %+/- |
| United States | 9.6 | 1.7 | 12.0 | 1.8 | 20.9 | 2.3 | 23.5 | 3.6 | 27.7 | 4.5 | 24.3 | 5.0 | 24.7 | 6.0 | 31.7 | 8.2 | 22.0 | 229% | 6.6 | 390% |
| European Countries | 18.7 | 2.1 | 25.6 | 2.9 | 29.6 | 3.0 | 32.5 | 3.6 | 48.0 | 4.6 | 51.7 | 5.9 | 47.0 | 6.3 | 59.1 | 7.4 | 40.5 | 217% | 5.3 | 248% |
| European Commission | 5.5 | 0.5 | 6.6 | 0.3 | 8.0 | 0.6 | 9.1 | 0.9 | 11.4 | 1.4 | 12.5 | 1.3 | 13.4 | 1.0 | 19.5 | 0.8 | 14.0 | 256% | 0.3 | 57% |
| Multilaterals | 11.0 | 2.3 | 11.7 | 2.1 | 14.0 | 3.6 | 17.4 | 4.1 | 14.6 | 4.1 | 15.5 | 5.5 | 22.9 | 6.7 | 20.8 | 6.4 | 9.8 | 90% | 4.1 | 173% |
| Other | 10.4 | 0.9 | 8.9 | 0.7 | 17.2 | 1.8 | 15.9 | 1.7 | 20.8 | 2.9 | 18.6 | 2.3 | 18.9 | 3.3 | 27.1 | 3.6 | 16.7 | 162% | 2.7 | 298% |
| **Grand Total** | **55.1** | **7.6** | **64.7** | **7.8** | **89.7** | **11.3** | **98.4** | **13.9** | **122.5** | **17.5** | **122.7** | **19.9** | **126.9** | **23.4** | **158.2** | **26.4** | **103.1** | **187%** | **18.9** | **249%** |

* Represents combined data from four OECD CRS subsectors (1) Health; (2) Population Policies/Programs and Reproductive Health (which includes HIV/AIDS & STDs); (3) Water Supply/Sanitation; and (4) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS.

| TABLE 3: HEALTH* ODA BY SUB-SECTOR, 2001 & 2008 Gross US$ Commitments in Billions | | | | | |
|---|---|---|---|---|---|
| | | 2001 | 2008 | 2001–2008 | |
| | Sub-Sector | $ | $ | $ +/- | % +/- |
| **Health/Population** | HIV/AIDS, STDs** | 0.81 | 7.94 | 7.12 | 875% |
| | Basic Health Care | 0.58 | 2.47 | 1.89 | 329% |
| | Health Policy & Admin. Management | 0.25 | 1.57 | 1.32 | 525% |
| | Reproductive Health Care | 0.92 | 1.47 | 0.55 | 60% |
| | Malaria Control | 0.01 | 1.26 | 1.25 | – |
| | Infectious Disease Control | 0.47 | 1.03 | 0.57 | 120% |
| | Family Planning | 0.48 | 0.59 | 0.11 | 23% |
| | Basic Health Infrastructure | 0.13 | 0.56 | 0.44 | 336% |
| | Tuberculosis Control | 0.01 | 0.47 | 0.46 | – |
| | Medical Services | 0.18 | 0.38 | 0.20 | 113% |
| | Population Policy And Admin. Management | 0.21 | 0.30 | 0.09 | 44% |
| | Basic Nutrition | 0.08 | 0.25 | 0.17 | 224% |
| | Medical Research | 0.03 | 0.17 | 0.14 | 512% |
| | Health Personnel Development*** | 0.03 | 0.11 | 0.08 | 274% |
| | Medical Education/Training | 0.08 | 0.09 | 0.01 | 15% |
| | Health Education | 0.04 | 0.06 | 0.02 | 55% |
| **Health/Population Total** | | **4.31** | **18.74** | **14.43** | **335%** |
| **Water** | Water Supply & Sanitation – Large Systems | 1.94 | 4.90 | 2.96 | 153% |
| | Basic Drinking Water Supply And Basic Sanitation | 0.72 | 1.16 | 0.44 | 61% |
| | Water Resources Policy/Admin. Management | 0.30 | 0.95 | 0.65 | 218% |
| | River Development | 0.03 | 0.24 | 0.21 | 847% |
| | Water Resources Protection | 0.02 | 0.21 | 0.20 | 1308% |
| | Waste Management/Disposal | 0.25 | 0.18 | -0.07 | -29% |
| | Water Education and Training | 0.03 | 0.06 | 0.03 | 107% |
| **Water Total** | | **$3.28** | **$7.71** | **$4.43** | **135%** |
| **Total Health ODA** | | **$7.59** | **$26.45** | **$18.86** | **249%** |

* Represents combined data from four OECD CRS subsectors: (1) health; (2) population policies/programs and reproductive health (which includes HIV/AIDS & STDs); (3) water supply/sanitation; and (4) other social infrastructure and services - social mitigation of HIV/AIDS. Sub-sectors are ranked above by amount of funding in 2008, within the health/population and water supply/sanitation subsectors, respectively.

** Represents combined data from two OECD CRS purpose codes: (1) STD control including HIV/AIDS; and (2) Social mitigation of HIV/AIDS.

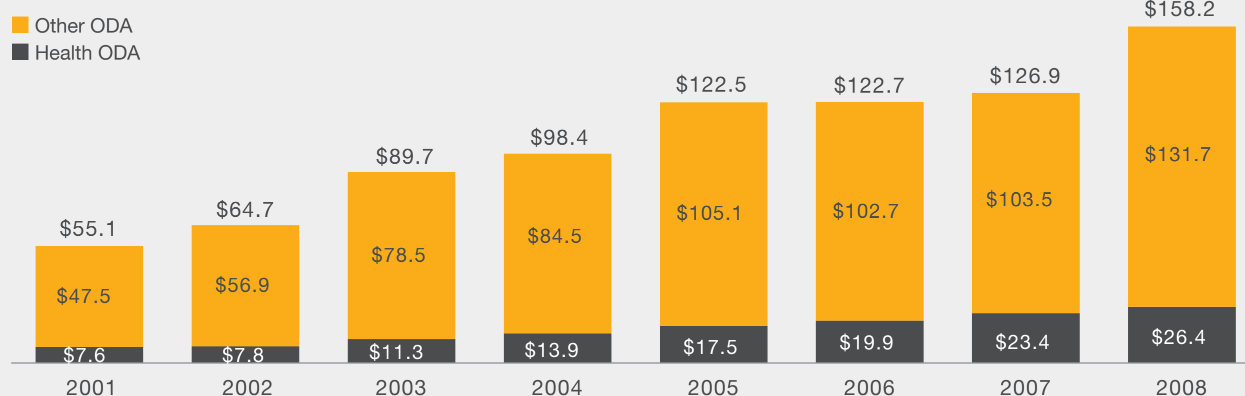
*** Represents combined data from two OECD CRS purpose codes: (1) Health personnel development; and (2) Personnel development: population and reproductive health.

# ANNEX 1: FIGURES

FIGURE 1:

Total ODA Commitments for Health and All Other ODA, 2001–2008

U.S. $ BILLIONS

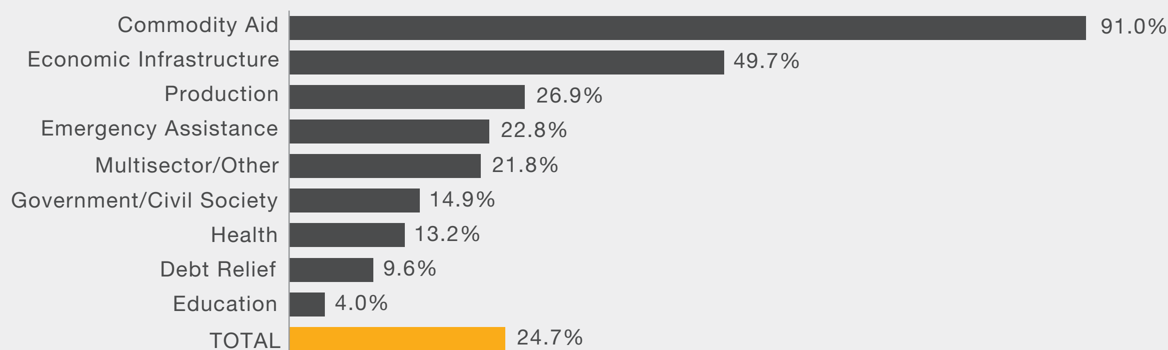



Note: Amounts in gross US$ commitments. Health ODA combines data from four OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); (3) Water Supply/Sanitation; and (4) Other Social Infrastructure and Services – Social Mitigation of HIV/AIDS Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), June 22, 2010.

FIGURE 2:

The 2007–2008 ODA Increase: Percent Change by Sector

U.S. $ BILLIONS

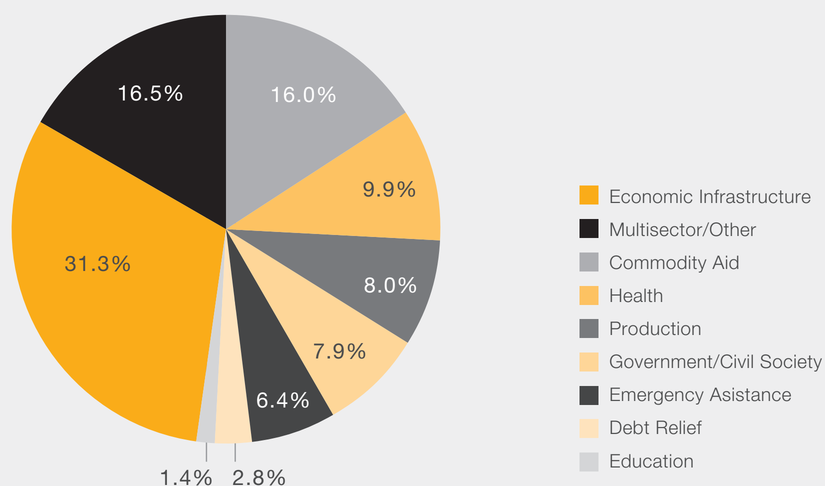



Notes: Amounts in gross US$ commitments. Health ODA combines data from four OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); (3) Water Supply/Sanitation; and (4) Other Social Infrastructure and Services – Social Mitigation of HIV/AIDS. Multisector/Other ODA combines data from six OECD CRS sectors and sub-sectors: (1) Multisector/Cross-cutting; (2) Administrative Costs of Donors; (3) Support of NGO's; (4) Refugees in Donor Countries; (5) Unallocated/Unspecified; and (6) Other Social Infrastructure & Services (excluding Social Mitigation of HIV/AIDS). Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), June 22, 2010.

FIGURE 3:

## The 2007–2008 ODA Increase: Drivers of Growth by Sector

ODA Growth, 2007–2008: $31.3 billion

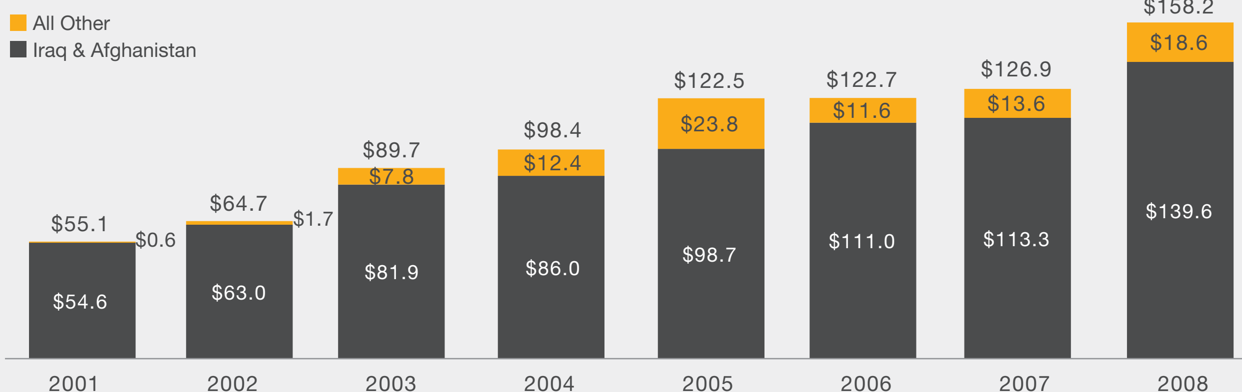



Notes: Amounts in gross US$ commitments. Health ODA combines data from four OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); (3) Water Supply/Sanitation; and (4) Other Social Infrastructure and Services – Social Mitigation of HIV/AIDS. Multisector/Other ODA combines data from six OECD CRS sectors and sub-sectors: (1) Multisector/Cross-cutting; (2) Administrative Costs of Donors; (3) Support of NGO's; (4) Refugees in Donor Countries; (5) Unallocated/Unspecified; and (6) Other Social Infrastructure & Services (excluding Social Mitigation of HIV/AIDS). Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), June 22, 2010.

FIGURE 4:

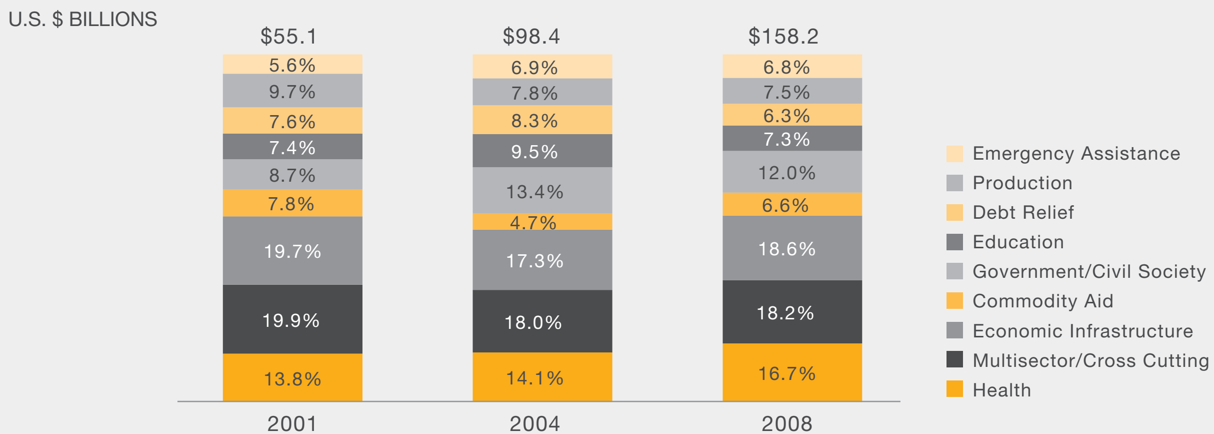
## ODA Commitments with Iraq/Afghanistan Disaggregated, 2001–2008

U.S. $ BILLIONS



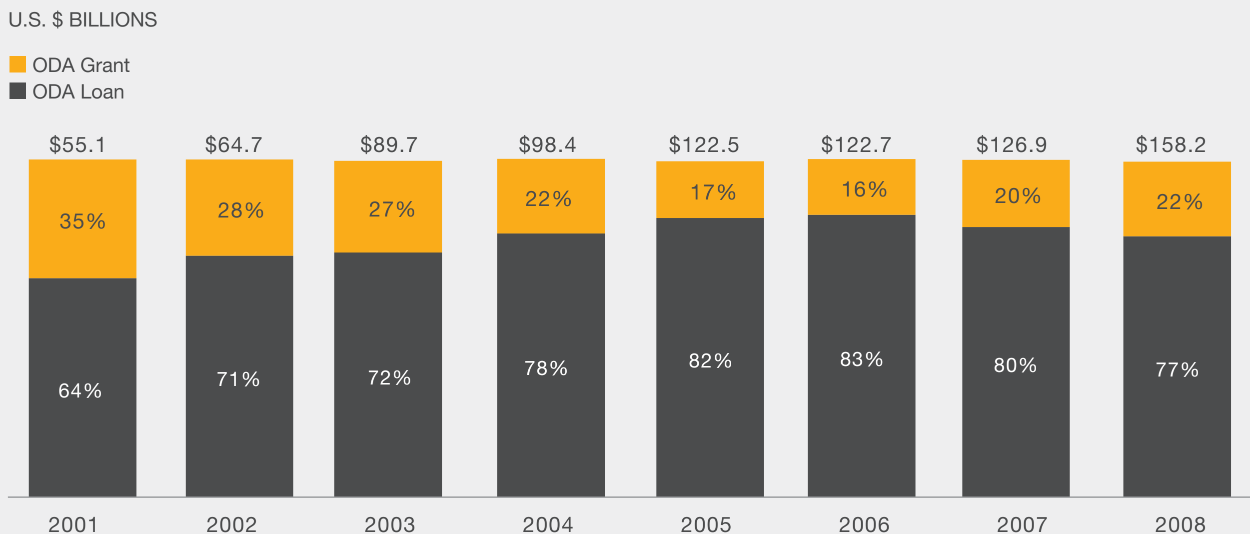

Note: Amounts in gross US$ commitments. Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), June 22, 2010.

FIGURE 5:
Share of ODA Commitments by Major Sector, 2001, 2004, 2008




Notes: Amounts in gross US$ commitments. Health ODA combines data from four OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); (3) Water Supply/Sanitation; and (4) Other Social Infrastructure and Services – Social Mitigation of HIV/AIDS. Multisector/Other ODA combines data from six OECD CRS sectors and sub-sectors: (1) Multisector/Cross-cutting; (2) Administrative Costs of Donors; (3) Support of NGO's; (4) Refugees in Donor Countries; (5) Unallocated/Unspecified; and (6) Other Social Infrastructure & Services (excluding Social Mitigation of HIV/AIDS). Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), June 22, 2010.

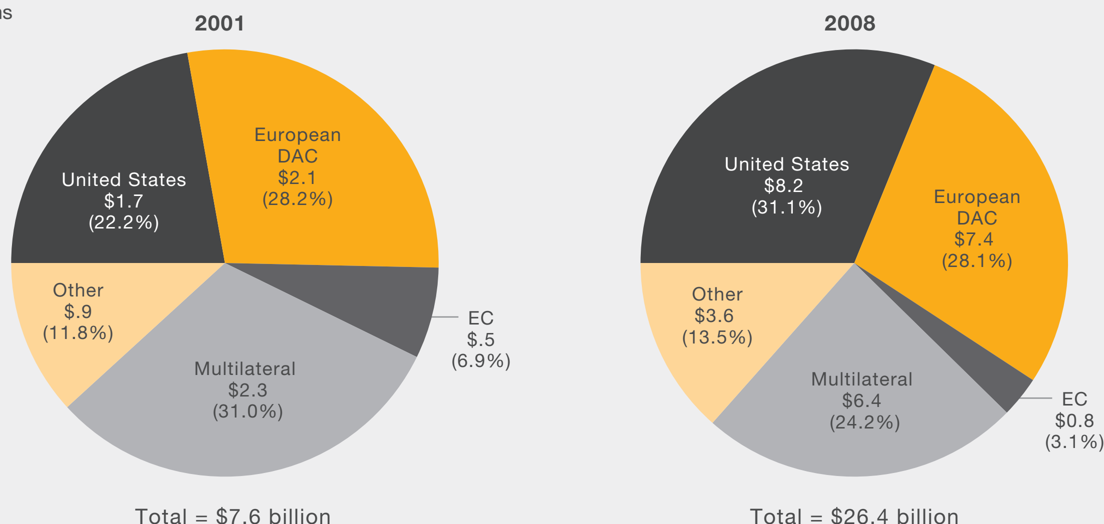
FIGURE 6:
Total ODA Commitments, Grants & Loans, 2001–2008




Notes: Amounts in gross US$ commitments. Equity Investment and Grant-Like ODA are included in the calculation of total ODA commitments, but are not represented graphically due to their relatively small contributions to total ODA commitments. Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), June 22, 2010.

FIGURE 7:

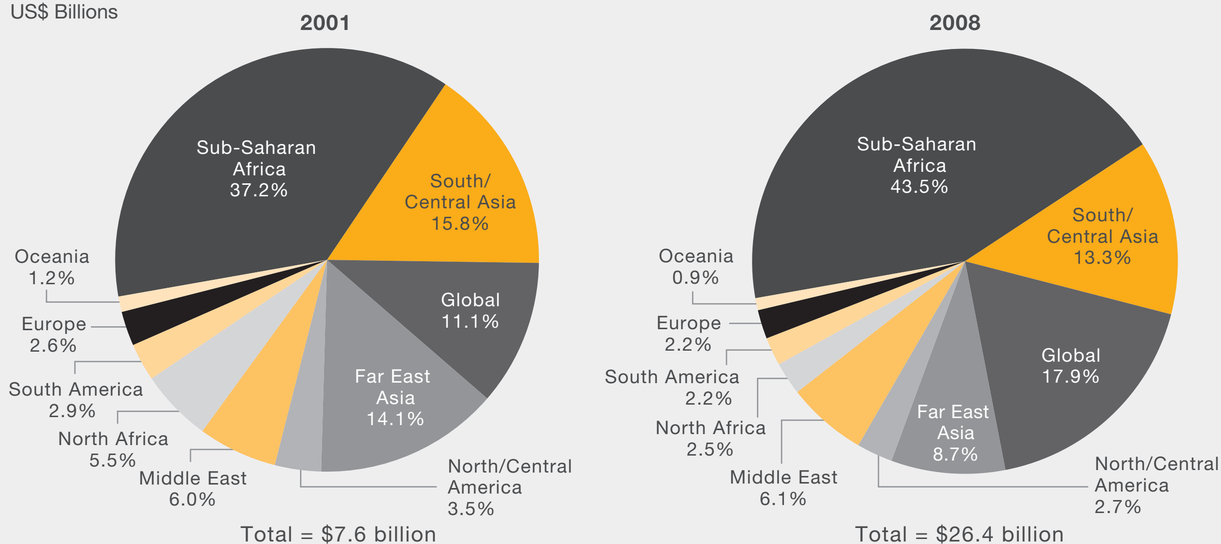
Health ODA Commitments by Donor, 2001 & 2008




Notes: Amounts in gross US$ commitments. Health ODA combines data from four OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); (3) Water Supply/Sanitation; and (4) Other Social Infrastructure and Services – Social Mitigation of HIV/AIDS. Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), June 22, 2010.

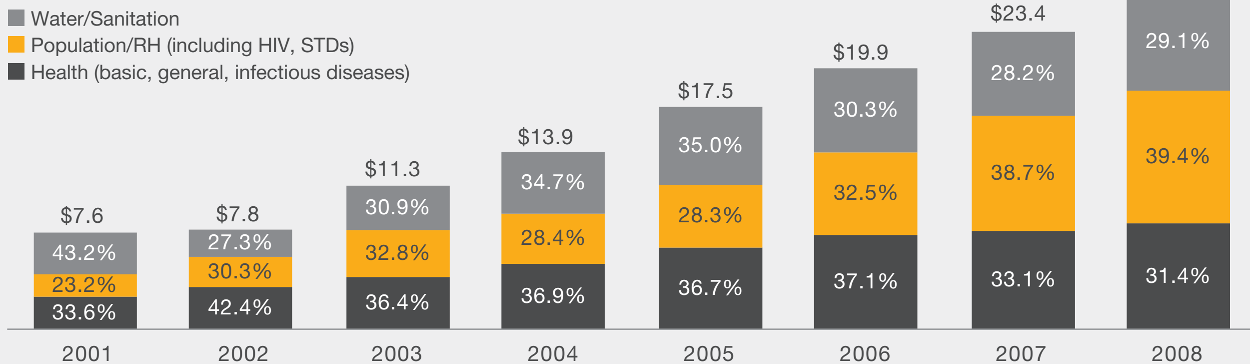
FIGURE 8:

Health ODA Commitments by Region, 2001 & 2008



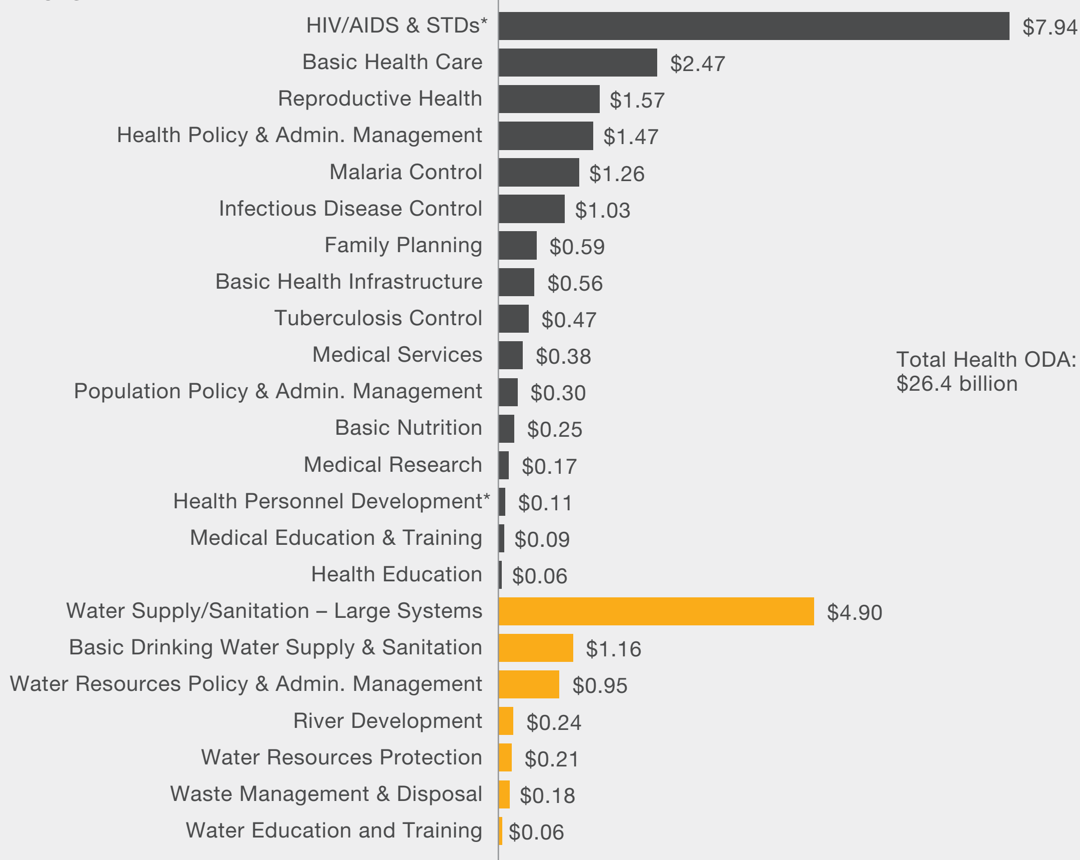

Notes: Amounts in gross US$ commitments. Health ODA combines data from four OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); (3) Water Supply/Sanitation; and (4) Other Social Infrastructure and Services – Social Mitigation of HIV/AIDS. Global totals include ODA for unspecified recipients and regional programs. Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), June 22, 2010.

FIGURE 9:
Health ODA Commitments: Health, Population, Water Components, 2001–2008




Note: Amounts in gross US$ commitments. Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), June 22, 2010.

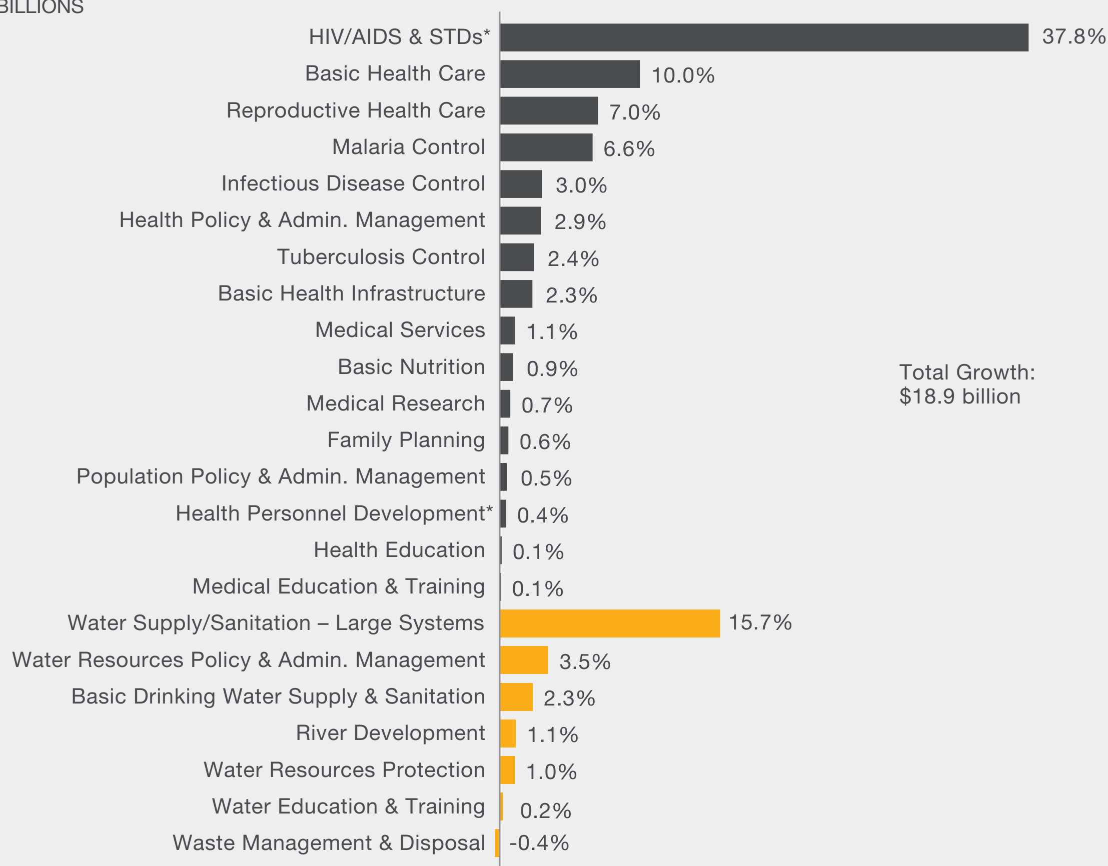
FIGURE 10:
Health ODA Commitments by Major Sub-Sector Activity, 2008




Notes: Amounts in gross US$ commitments. "HIV/AIDS & STDs" represents combined data from two OECD CRS purpose codes: (1) STD control including HIV/AIDS; and (2) Social mitigation of HIV/AIDS. "Health Personnel Development" represents combined data from two OECD CRS purpose codes: (1) Health personnel development; and (2) Personnel development: population and reproductive health. Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), June 22, 2010.

FIGURE 11:

Drivers of Health ODA Growth by Major Sub-Sector Activity, 2001–2008




Notes: Amounts in gross US$ commitments. "HIV/AIDS & STDs" represents combined data from two OECD CRS purpose codes: (1) STD control including HIV/AIDS; and (2) Social mitigation of HIV/AIDS. "Health Personnel Development" represents combined data from two OECD CRS purpose codes: (1) Health personnel development; and (2) Personnel development: population and reproductive health. Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), June 22, 2010.

## Annex 2: CRS Sectors and Sub-sectors Used in This Analysis

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

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

| DAC 5 CODE | CRS CODE | DESCRIPTION | CLARIFICATIONS / ADDITIONAL NOTES ON COVERAGE |
|---|---|---|---|
| 140 | | WATER SUPPLY AND SANITATION | |
| | 14010 | Water resources policy and administrative management | Water sector policy, planning and programmes; water legislation and management; institution capacity building and advice; water supply assessments and studies; groundwater, water quality and watershed studies; hydrogeology; excluding agricultural water resources (31140). |
| | 14015 | Water resources protection | Inland surface waters (rivers, lakes, etc.); conservation and rehabilitation of ground water; prevention of water contamination from agro-chemicals, industrial effluents. |
| | 14020 | Water supply and sanitation – large systems | Water desalination plants; intakes, storage, treatment, pumping stations, conveyance and distribution systems; sewerage; domestic and industrial waste water treatment plants. |
| | 14030 | Basic drinking water supply and basic sanitation | Water supply and sanitation through low-cost technologies such as handpumps, spring catchment, gravity-fed systems, rain water collection, storage tanks, small distribution systems; latrines, small-bore sewers, on-site disposal (septic tanks). |
| | 14040 | River development | Integrated river basin projects; river flow control; dams and reservoirs [excluding dams primarily for irrigation (31140) and hydropower (23065) and activities related to river transport (21040)]. |
| | 14050 | Waste management/disposal | Municipal and industrial solid waste management, including hazardous and toxic waste; collection, disposal and treatment; landfill areas; composting and reuse. |
| | 14081 | Education and training in water supply and sanitation | |
| 160 | | OTHER SOCIAL INFRASTRUCTURE AND SERVICES | |
| | 16064 | Social Mitigation of HIV/AIDS | Special programmes to address the consequences of HIV/AIDS, e.g. social, legal and economic assistance to people living with HIV/AIDS including food security and employment; support to vulnerable groups and children orphaned by HIV/AIDS; human rights of HIV/AIDS affected people. |

## Annex 3: Methodology

Data for this analysis were obtained on June 22, 2010 using the Ready-made Files feature of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS) (available at: www.oecd.org/dataoecd/50/17/5037721.htm). Data represent "official development assistance" (ODA), defined by the OECD as funding provided to low- and middle-income countries as determined by per capita Gross National Income (GNI), excluding any funding to countries that are members of the Group of Eight (G8) or the European Union (EU), including those with a firm date for EU admission.[23] It is important to note that the OECD no longer collects data on "official aid" (OA), funding provided to countries and territories in transition, such as some of those in Central and Eastern Europe and the former Soviet States, although some do receive significant donor support for health.

Data are in nominal dollars, not adjusted for inflation or exchange rate fluctuations (unless otherwise noted) and represent gross annual new grant, concessional loan and/or equity investment commitments in US$, from 2001–2008, with the exception of the Netherlands, for which disbursement data were used for 2006, in place of commitments, to compensate for what appeared to be excessive single-year trendline aberrations. Commitments, or obligations, represent decisions to provide funding, regardless of the time at which actual outlays occur (multi-year commitments are counted in the year in which they are committed).[24] Disbursements, which often lag commitments, represent the actual expenditure of funds. ODA totals used in this paper have not been adjusted to reflect offsets corresponding to prior-loan repayments, which are neither identifiable with sub-sector financing nor universally available to lenders for re-obligation.

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

This analysis combines data deriving from four OECD CRS subsectors to capture funding for "health": (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); (3) Water Supply/Sanitation; and (4) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS. The first two of these represent the OECD DAC statistical definition of "aid to health". The water supply and sanitation sector was included given its importance to health. The Social Mitigation of HIV/AIDS is a relatively new category in the OECD CRS. The term "health" used in this paper, therefore, is an aggregate of all four sectors/subsectors unless otherwise noted.

For comparisons between the U.S. and Europe, the European donor nations who are members of the OECD DAC were included: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, United Kingdom (two European donors – Iceland and Liechtenstein – are not part of the DAC and are not included). Data for the European Commission represent funds from the European Union's budget, as distinct from funding from member state budgets. The OECD DAC and CRS databases include EC funding as part of the multilateral sector; in this paper, they were disaggregated and counted on their own for purposes of analysis.

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

## Endnotes

[1] Author analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), June 22, 2010 (www.oecd.org/dataoecd/50/17/5037721.htm).

[2] The 23 DAC member governments are: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Japan, Luxembourg, Netherlands, New Zealand, Norway, Portugal, South Korea Spain, Sweden, Switzerland, United Kingdom, United States, and European Commission.

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

[4] See www.kff.org/hivaids/internationalfinancing.cfm.

[5] Data in this report for the period between 2001-2007 may differ from that presented in prior reports due to updated data on donor commitments.

[6] See, for example: Ravishankar N, Gubbins P, Cooley RJ, Leach-Kemon K, Michaud CM, Jamison DT, Murray CJL. "Financing of global health: tracking development assistance for health from 1990 to 2007", Lancet; 373: 2113–24; June 20, 2009; Schieber GJ et al. "Financing Global Health: Mission Unaccomplished," Health Affairs, Vol. 26, No. 4, July/August 2007.

[7] "Health" funding in this analysis combines data from 4 OECD CRS subsectors: (1) Health; (2) Population Policies/Programs & Reproductive Health (which includes HIV/AIDS & STDs); (3) Water Supply/Sanitation; & (4) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS. The first 2 constitute the OECD's statistical definition of health (see, OECD. Recent Trends in Official Development Assistance to Health, 2006: www.oecd.org/ dataoecd/1/11/37461859.pdf). Funding for clean water and sanitation activities was included here given its importance to health (see, for example, WHO, www.who.int/water_sanitation_health/en/; USAID, www.usaid.gov/our_work/environment/water/wrm_health.html; State Department, www.state.gov/g/oes/water/).

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

[9] White House, "Statement by the President on Global Health Initiative," May 5, 2010, www.whitehouse.gov/the_press_office/Statement-by-the-President-on-Global-Health-Initiative/.

[10] G8 Muskoka Declaration Recovery and New Beginnings, Muskoka, Canada, 25-26 June 2010, http://g8.gc.ca/g8-summit/summit-documents/g8-muskoka-declaration-recovery-and-new-beginnings/.

[11] United Nations, www.un.org/en/mdg/summit2010/.

[12] Unless otherwise noted, all amounts represent gross ODA commitments in nominal value.

[13] Unlike net ODA, gross ODA, does not include loan repayments. In 2006, net ODA totaled $104.4 billion. See: www.oecd.org/document/8/0,3343,en_2649_34447_40381960_1_1_1_1,00.html.

[14] The OECD defines large water systems as those that provide water and sanitation to communities through networks of households, as distinguished from basic systems that generally are shared between several households. Large systems also have much higher per capita costs. See: OECD, The CRS List of Purpose Codes, Annex 5. DCD/DAC(2007)39.

[15] See also: OECD, "Development Aid from OECD Countries Fell 5.1% in 2006," April 3, 2007.

[16] "Multisector/Other" represents combined data from six OECD CRS sectors and sub-sectors: (1) Multisector/Cross-cutting; (2) Administrative Costs of Donors; (3) Support of NGO's; (4) Refugees in Donor Countries; (5) Unallocated/Unspecified; and (6) Other Social Infrastructure & Services (excluding Social Mitigation of HIV/AIDS).

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

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

[19] Concessionality is a measure of the "softness" of the credit, and reflective of the cost to the borrower/recipient country compared to a loan at market rate – e.g., the higher the concessionality, the less cost to the borrower/recipient country.

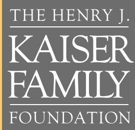
[20] WHO, The World Health Report 2006—Working Together for Health, April 7, 2006, www.who.int/whr/2006/en.

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

[22] OECD, "Development aid rose in 2009 and most donors will meet 2010 aid targets," April 14, 2010, www.oecd.org/document/11/0,3343,en_21571361_44315115_44981579_1_1_1_1,00.html.

[23] OECD, "History of DAC Lists of Aid Recipient Countries," www.oecd.org/document/55/0,3343,en_2649_34447_35832055_1_1_1_1,00.html.

[24] OECD, DAC Glossary, www.oecd.org/glossary/0,3414,en_2649_33721_1965693_1_1_1_1,00.html.

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