THE HENRY J. KAISER FAMILY FOUNDATION

Donor Funding for Health in Low- & Middle- Income Countries, 2001-2005

AUGUST 2007

JENNIFER KATES
Kaiser Family Foundation

ERIC LIEF
Center for Strategic and International Studies

CSIS

DONOR FUNDING FOR HEALTH IN LOW- & MIDDLE- INCOME COUNTRIES, 2001-2005

Prepared by Jennifer Kates, Kaiser Family Foundation, and Eric Lief, CSIS

SUMMARY & HIGHLIGHTS

Donor governments, including the United States and European nations, provide almost all external health funding to low- and middle- income countries, through both bilateral and multilateral channels. Despite increases in donor funding for health, however, a significant funding gap remains, much of which will need to be filled by donors.[1,2,3,4] Therefore, tracking donor funding for health is important for assessing their priorities and the availability of funding over time. This paper provides an analysis of donor funding commitments for health between 2001 and 2005. Data were obtained from the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) Database and the Creditor Reporting System (CRS), which include official development assistance (ODA) provided by the 23 DAC member governments and by multilateral institutions.[5,6,7] "Health" used here represents the aggregate of three sectors[8]: health and population (the OECD's statistical definition of health[9]) and the water supply/sanitation sector[10], given the latter's importance to health.[11] Highlighted findings are below, followed by more detailed analysis, tables, charts and methodology:

- Between 2001 and 2005, total ODA more than doubled in nominal value, rising from US$55.4 billion to US$121.7 (120%). Some of the increase was offset by inflation and exchange rate changes[12]; a considerable portion was for debt relief and aid to Iraq and Afghanistan.[13] Aid to Iraq and Afghanistan, for example, accounted for about one-fifth of ODA commitments in 2005, and drove one-third of ODA growth between 2001 and 2005.
- ODA for health rose from $7.2 billion to $15.7 billion (117%). Of the $15.7 billion in 2005, $9.7 billion (62%) was for health/population; $6 billion (38%) was for water.
- Health funding, however, did not rise as quickly as some other sectors (e.g., emergency assistance/reconstruction and government/civil society), and it represented the same share of ODA in 2005 as in 2001 (13%). Other than a significant jump in health funding between 2002 and 2003, marking the start-up of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), annual rates of increase have been fairly steady.
- The United States is the single largest donor to health, accounting for almost a quarter (23%) of commitments in 2005. European nations, collectively, account for an even larger share (29%), and the European Commission adds another 9%. Multilateral institutions account for about a fifth (21%). Donors channel most of their health funding to Sub-Saharan Africa, followed by South and Central Asia.
- Looking at specific sub-sectors within health, the greatest share of funding in 2005 went to large-system water supply/sanitation[14] (19%), followed by HIV/AIDS/STDs (16%), health policy/management (11%) and infectious disease control (10%). Some sub-sectors that serve as "building blocks" for health, such as basic health infrastructure and health training, received small amounts of funding, raising questions about the underlying development and sustainability of health systems.[15,16] In addition, some sub-sectors, including health training and family planning, saw reduced funding over the period.
- Despite increases in health ODA, funding falls far short of needs estimates made by the Commission on Macroeconomics and Health (CMH)[2] and even short of estimated needs for AIDS alone.[17,18] Therefore, any shifting of funding between health sub-sectors (e.g., more to basic health infrastructure or training but less to infectious disease control) will not address the overall gap. It is unclear what the future will bring: in 2005, as expected, total ODA was high due to the timing of specific, large, debt relief transactions. To the extent that this is not repeated, donors might be able to devote increased resources to other aid areas including health; however, since the cost of debt relief to creditors is often significantly less than its corresponding face value, it is unlikely that any "liberated" funding would approach the amount of debt relief in 2005. Given past trends, one development that could boost health funding to higher levels would be the introduction of new donor initiatives for health, including additional innovative financing mechanisms, although it remains to be seen if such initiatives will emerge.

DETAILED FINDINGS

Total ODA

- Between 2001 and 2005, total ODA gross commitments more than doubled, rising from nominal US$55.4 billion to US$121.7, a 120% increase.
- Some of the increase was offset by inflation and exchange rate changes. A considerable portion of the increase was for debt relief and for aid to Iraq and Afghanistan.
  - Nominal debt relief was the fastest growing sector over the period (increasing more than 6-fold, from $4.3 billion in 2001 to $27.4 billion in 2005), contributing the most to overall ODA growth (35%), and accounting for the largest share of ODA in 2005 (23%). 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. The significant amount of debt relief in 2005 was due to the expected timing of specific, large, debt relief transactions.
  - Aid to Iraq and Afghanistan accounted for about one-fifth (19%) of ODA commitments in 2005, and drove one-third (34%) of ODA growth between 2001 and 2005.
  - Without aid to Iraq and Afghanistan, overall ODA rose by 80% over the period; further, without emergency assistance and debt relief, overall ODA rose by 33% over the period, most of which was offset by currency revaluation and inflation.

Health ODA

- ODA for health also more than doubled over the period, rising from $7.2 billion to $15.7 billion. Within the $15.7 billion in 2005, $9.7 billion (62%) was for health/population and $6.0 billion (38%) was for water/sanitation.
- Health accounted for the same share of total ODA in both 2001 and 2005 (13%). In 2005, health received the third largest share of ODA commitments, after debt relief and multisector funding. Other than a significant jump in health commitments between 2002 and 2003 (increase of $3.6 billion or 47%), largely reflecting the start-up of the Global Fund and of PEPFAR, annual rates of increase have been fairly steady.
- Funding for health grew at a slightly slower pace than unadjusted overall ODA (117% compared to 120%), and rose more slowly than funding for debt relief, emergency assistance/reconstruction, and government/civil society. A significantly smaller share of the increase in health funding was due to aid to Iraq and Afghanistan (13%) compared to overall ODA. Without this funding, health comprised 15% of ODA in 2005.

Health ODA by Donor

- The United States provided the largest ODA commitment for health of any single donor ($3.6 billion in 2005), accounting for almost a quarter of health funding (23%), the same as its 2001 share. The U.S. commitment more than doubled between 2001 and 2005.
- European nations, collectively, committed $4.6 billion, or 29%, of health ODA in 2005, more than doubling their 2001 commitment. The European Commission accounted for an additional $1.4 billion, or 9% of the 2005 total.
- Multilaterals accounted for about a fifth of health commitments in 2005 at $3.4 billion (21%).

Health ODA by Region

- Sub-Saharan Africa received a third of health funding in 2005 (33%), the largest share of any region. Funding for the region drove most of the growth over the period.
- South and Central Asia accounted for the second largest share of health funding in 2005 (18%) and was the second largest driver of growth by region.
- The next largest regions, by share of funding in 2005, were Far East Asia (15%) and the Middle East (10%). All other regions accounted for less than 5% of total health funding.
- Funding increased for all regions over the period, except for North Africa.

Health ODA by Sub-Sector

- Looking at specific sub-sectors in 2005, the greatest share of funding went to large-system water supply/sanitation[14] (19%). HIV/AIDS/STDs accounted for the next greatest share in 2005 (16%) followed by policy/management (11%), infectious disease control (10%), and basic health care (9%).

- HIV/AIDS/STDs drove the most growth over the period (18%), followed by large-system water supply/sanitation (14%) and infectious disease control (14%).
- Some sub-sectors that serve as "building blocks" for health received only small amounts of funding in 2005, such as basic health infrastructure (3%) and health training (<1%), raising questions about the underlying development and sustainability of health systems.[15,16]
- Sub-sectors that experienced decreased funding over the period were health training, family planning, water resources protection, and water waste management/disposal; each of these sub-sectors also accounted for small shares of health funding in 2005.

Table 1: Total ODA and Health* ODA by Donor, 2001-2005
Gross US$ Commitments in Billions

	2001		2002		2003		2004		2005		2001-2005 +/- $ (%)	
	Total	Health	Total	Health	Total	Health	Total	Health	Total	Health	Total	Health
United States	9.9	1.7	12.0	1.8	20.9	2.3	23.5	3.5	26.9	3.6	+17.0 (172%)	+1.9 (115%)
European Countries	18.7	2.1	25.6	2.9	29.6	3.0	32.5	3.6	48.5	4.6	+29.8 (160%)	+2.5 (116%)
European Commission	5.5	0.5	6.6	0.3	8.0	0.6	9.1	0.9	11.4	1.4	+5.9 (107%)	+0.9 (162%)
Multilaterals	11.0	2.0	11.7	1.9	14.8	3.5	17.3	3.6	14.4	3.4	+3.4 (31%)	+1.4 (70%)
Other	10.4	0.9	8.9	0.7	17.2	1.8	16.0	1.7	20.6	2.7	+10.3 (99%)	+1.8 (201%)
TOTAL	**$55.4**	**$7.2**	**$64.8**	**$7.6**	**$90.6**	**$11.2**	**$98.3**	**$13.3**	**$121.7**	**$15.7**	**+$66.4 (120%)**	**+$8.4 (117%)**

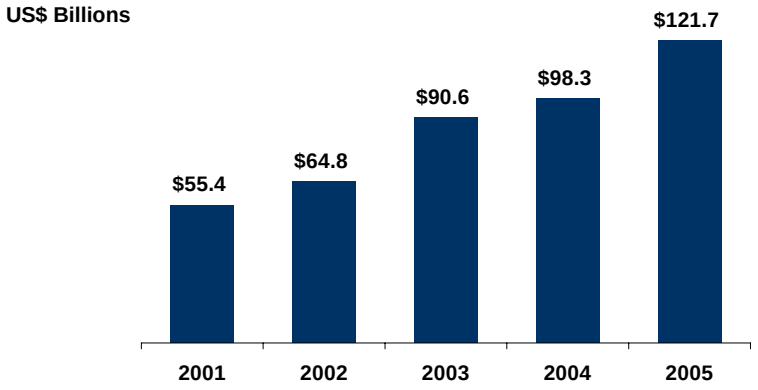
*Health ODA aggregates three CRS sectors: (1) Health; (2) Population Policies/Programmes & Reproductive Health; and (3) Water Supply/Sanitation.

Table 2: Health* ODA by Sub-Sector, 2001 & 2005 Gross US$ Commitments in Billions			
Sub-Sector	**2001 $**	**2005 $**	**2001-2005 +/- $ (%)**
Health/Population			
STD & HIV/AIDS Control	1.0	2.6	+1.6 (155%)
Health Policy/Management	0.8	1.7	+0.9 (107%)
Infectious Disease Control	0.5	1.6	+1.2 (235%)
Basic Health Care	0.6	1.4	+0.8 (152%)
Basic Health Infrastructure	0.1	0.5	+0.4 (323%)
Reproductive Health Care	0.2	0.5	+0.2 (119%)
Basic Nutrition	0.1	0.4	+0.3 (414%)
Medical Services	0.2	0.3	+0.2 (95%)
Family Planning	0.5	0.3	-0.2 (-41%)
Medical Research	.03	0.3	+0.2 (874%)
Health Training/Personnel Development	0.2	0.1	-0.1 (-36%)
Health Education	.04	.04	+0.01 (21%)
Subtotal	*4.1*	*9.7*	*+5.6 (137%)*
Water Supply/Sanitation			
Water supply/sanitation-large systems	1.7	2.9	+1.2 (70%)
Water Policy/Management	0.4	1.0	0.7 (173%)
River development	.02	0.9	+0.9 (3566%)
Basic drinking water supply & sanitation	0.6	0.9	+0.3 (57%)
Waste management/disposal	0.2	0.1	-0.1 (-60%)
Water resources protection	0.2	0.1	-0.1 (-47%)
Water Education/Training	.03	.05	+0.02 (62%)
Subtotal	*3.1*	*6.0*	*+2.8 (91%)*
TOTAL HEALTH ODA	**$7.2**	**$15.7**	**+$8.4 (117%)**

*Health ODA aggregates three CRS sectors: (1) Health; (2) Population Policies/Programmes & Reproductive Health; and (3) Water Supply/Sanitation. The first two represent the OECD's statistical definition of "health".
Sub-sectors are ranked above by amount of funding in 2005, within health/population and water supply/sanitation, respectively.

Figure 1

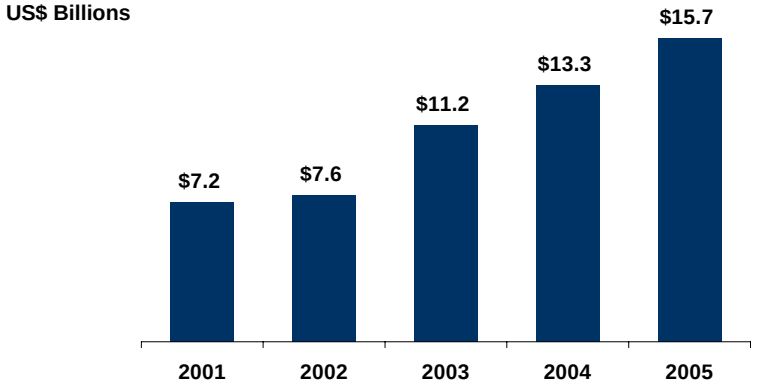
Total ODA Commitments, All Sectors, 2001-2005



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) during the period June 24-29, 2007.

Figure 2

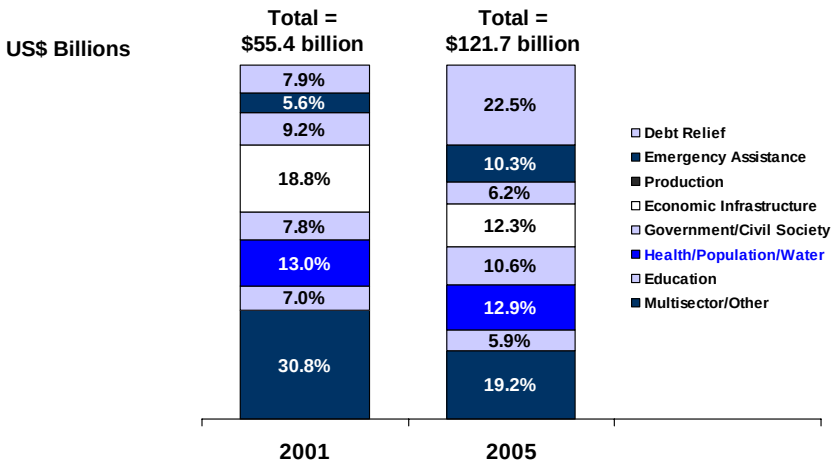
Total Health ODA Commitments, 2001-2005



Note: Amounts in gross US$ commitments. Health ODA aggregates three CRS sectors: (1) Health (2) Population Policies/Programmes & Reproductive Health (3) Water Supply/Sanitation.
Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS) during the period June 24-29, 2007.

Figure 3

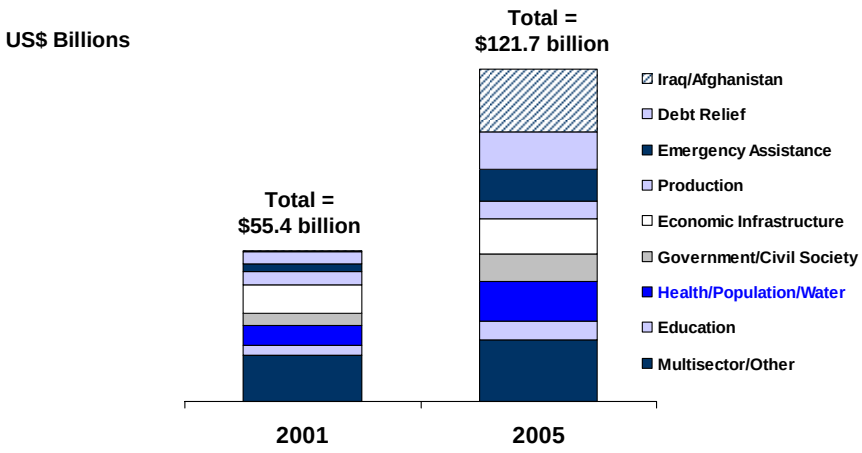
Share of ODA Commitments by Major Sector, 2001 & 2005



Note: Percentages may not add to 100% due to rounding. Amounts in gross US$ commitments. Health ODA aggregates three CRS sectors: (1) Health (2) Population Policies/Programmes & Reproductive Health (3) Water Supply/Sanitation.
Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS) during the period June 24-29, 2007.

Figure 4

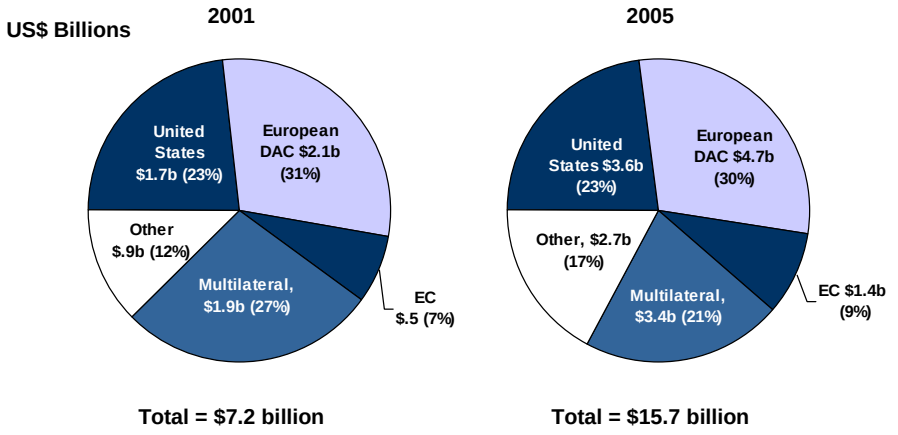
ODA Commitments by Major Sector with Iraq/Afghanistan Disaggregated, 2001 & 2005



Note: Amounts in gross US$ commitments. Health ODA aggregates three CRS sectors: (1) Health (2) Population Policies/Programmes & Reproductive Health (3) Water Supply/Sanitation.
Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS) during the period June 24-29, 2007.

Figure 5

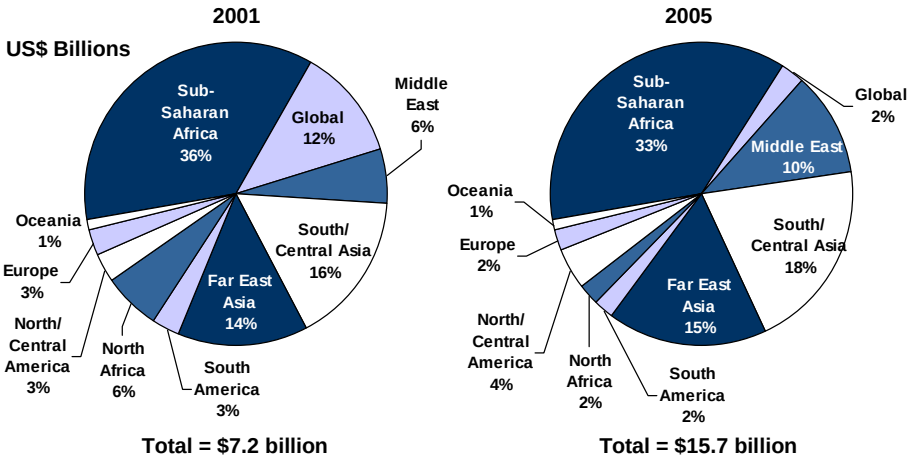
Health ODA Commitments by Donor, 2001 & 2005



Note: Percentages may not add to 100% due to rounding. Amounts in gross US$ commitments.
Health ODA aggregates three CRS sectors: (1) Health (2) Population Policies/Programmes & Reproductive Health (3) Water Supply/Sanitation.
Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS) during the period June 24-29, 2007.

Figure 6

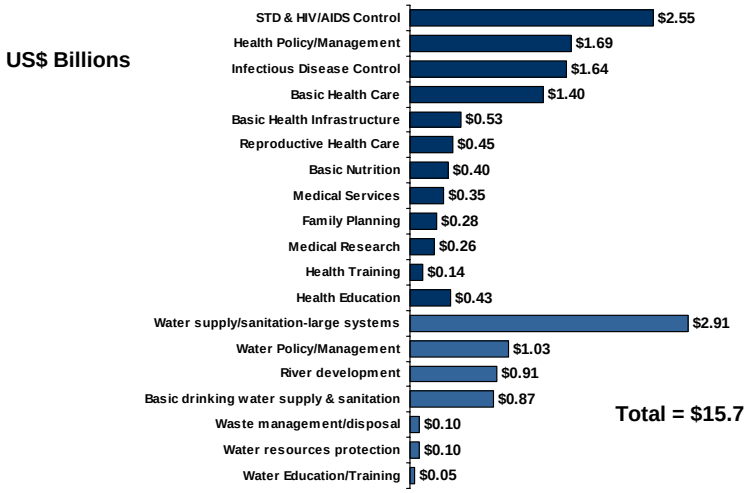
Health ODA Commitments by Region, 2001 & 2005



Note: Percentages may not add to 100% due to rounding. Amounts in gross US$ commitments.
Health ODA aggregates three CRS sectors: (1) Health (2) Population Policies/Programmes & Reproductive Health (3) Water Supply/Sanitation.
Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS) during the period June 24-29, 2007.

Figure 7

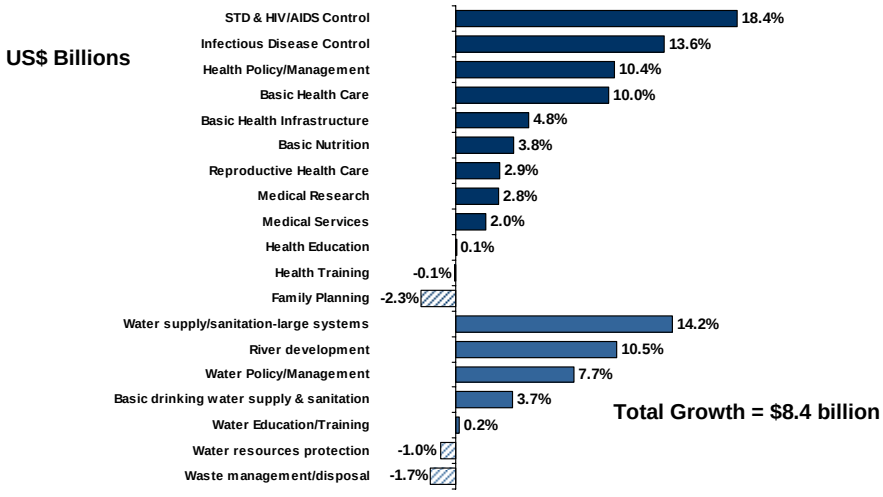
Health ODA Commitments by Major Sub-Sector, 2005



Note: Amounts in gross US$ commitments. Health ODA aggregates three CRS sectors:
(1) Health (2) Population Policies/Programmes & Reproductive Health (3) Water Supply/Sanitation.
Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS) during the period June 24-29, 2007.

Figure 8

Contribution to Health ODA Growth by Major Sub-Sector, 2001-2005



Note: Amounts in gross US$ commitments. Health ODA aggregates three CRS sectors:
(1) Health (2) Population Policies/Programmes & Reproductive Health (3) Water Supply/Sanitation.
Source: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS) during the period June 24-29, 2007.

ANNEX 1: CRS SECTORS AND SUB-SECTORS USED IN THIS ANALYSIS

Source: OECD, The CRS List of Purpose Codes, 2006

DAC 5 CODE	CRS CODE	DESCRIPTION	Clarifications / Additional notes on coverage
120		HEALTH	
121		Health, general	
	12110	Health policy and administrative management	Health sector policy, planning and programmes; aid to health ministries, public health administration; institution capacity building and advice; medical insurance programmes; unspecified health activities.
	12181	Medical education/training	Medical education and training for tertiary level services.
	12182	Medical research	General medical research (excluding basic health research).
	12191	Medical services	Laboratories, specialised clinics and hospitals (including equipment and supplies); ambulances; dental services; mental health care; medical rehabilitation; control of non-infectious diseases; drug and substance abuse control [excluding narcotics traffic control (16063)].
122		Basic health	
	12220	Basic health care	Basic and primary health care programmes; paramedical and nursing care programmes; supply of drugs, medicines and vaccines related to basic health care.
	12230	Basic health infrastructure	District-level hospitals, clinics and dispensaries and related medical equipment; excluding specialised hospitals and clinics (12191).
	12240	Basic nutrition	Direct feeding programmes (maternal feeding, breastfeeding and weaning foods, child feeding, school feeding); determination of micro-nutrient deficiencies; provision of vitamin A, iodine, iron etc.; monitoring of nutritional status; nutrition and food hygiene education; household food security.
	12250	Infectious disease control	Immunisation; prevention and control of malaria, tuberculosis, diarrheal diseases, vector-borne diseases (e.g. river blindness and guinea worm), etc.
	12261	Health education	Information, education and training of the population for improving health knowledge and practices; public health and awareness campaigns.
	12281	Health personnel development	Training of health staff for basic health care services.

DAC 5 CODE	CRS CODE	DESCRIPTION	Clarifications / Additional notes on coverage
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	

ANNEX 2: METHODOLOGY

Data for this analysis were obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS) during the period June 24-29, 2007 (available at: http://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 countries that are members of the Group of Eight (G8) or the European Union (EU), including those with a firm date for EU admission.[19] 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, and represent gross annual new commitments in US$, from 2001-2005. New commitments are new grant and concessional loan commitments. Commitments, not disbursements, were used because disbursement data by sector are not available from the CRS database pre-2002. Commitments, or obligations, are firm decisions that funding will be provided, regardless of the time at which actual outlays occur (multi-year commitments are counted in the year in which they are committed).[20] Disbursements, which often lag commitments, are the actual expenditure of obligated funds. ODA totals used in this paper have not been adjusted to reflect offsetting from prior-loan repayments, which are neither identifiable with sub-sector financing nor universally available to lenders for re-obligation.

This analysis combines three OECD CRS sectors[8] to capture funding for "health": (1) Health; (2) Population Policies/Programmes and Reproductive Health (includes HIV/AIDS & STDs); and (3) Water Supply and Sanitation[10]. The first two of these sectors represent the OECD DAC statistical definition of "aid to health".[9] The water supply and sanitation sector was included given its importance to health. The term "health" used in this paper, therefore, is an aggregate of all three sectors 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.

REFERENCES

[1] WHO, Commission on Macroeconomics and Health. *Investing in Health: A Summary of the Findings of the Commission on Macroeconomics and Health*; 2003 (www.who.int/macrohealth/infocentre/advocacy/en/investinginhealth02052003.pdf).
[2] UN Millennium Project, *Investing in Development A Practical Plan to Achieve the Millennium Development Goals*; 2005.
[3] Schieber GJ et al. "Financing Global Health: Mission Unaccomplished." *Health Affairs*, Vol. 26, No. 4; July/August 2007
[4] Lane C, Glassman L. "Bigger And Better? Scaling Up And Innovation In Health Aid." *Health Affairs.* Vol. 26, No. 4; July/August 2007.
[5] Author analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS) during the period June 24-29, 2007 (http://www.oecd.org/dataoecd/50/17/5037721.htm).
[6] DAC member governments are: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Japan, Luxembourg, Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, United Kingdom, United States, European Commission.
[7] Multilaterals include: The Global Fund to Fight AIDS, Tuberculosis and Malaria; The World Bank; Regional Developments Banks; International Fund for Agricultural Development (IFAD); UNAIDS; UNFPA; UNICEF. 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.
[8] OECD. "The CRS List of Purpose Codes"; 2006.
[9] OECD. *Recent Trends in Official Development Assistance to Health*; 2006. (www.oecd.org/dataoecd/1/11/37461859.pdf).
[10] Exclusive of funding for non-health related water uses which are coded separately in the CRS, such as agricultural water resources (categorized under the agricultural sector), flood prevention/control (categorized under the multi-sector/cross cutting sector), and hydro power (categorized under the energy generation and supply).
[11] See, for example: WHO, "Water, Sanitation and Hygiene Links to Health: Facts and Figures"; November 2004 (www.who.int/water_sanitation_health/publications/facts2004/en/index.html).
[12] e.g., the real value of assistance in some recipient countries is offset by losses in dollar purchasing power, just as their real cost in some Euro-zone donor countries is similarly offset.
[13] See also: OECD, "Development Aid from OECD Countries Fell 5.1% in 2006," April 3, 2007; Schieber GJ et al. "Financing Global Health: Mission Unaccomplished," *Health Affairs*, Vol. 26, No. 4, July/August 2007.
[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, 2006.
[15] WHO. *The World Health Report 2006—Working Together for Health*; April 7, 2006 (http://www.who.int/whr/2006/en).
[16] 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 US Office of the Global AIDS Coordinator reported to Congress that in FY 2006, PEPFAR provided approximately $350 million to "partnerships for workforce and health-system development" (see: US State Department Office of the Global AIDS Coordinator, *The Power of Partnerships: Third Annual Report to Congress on PEPFAR*; 2007). Such disaggregation, however, is not possible through the DAC or CRS databases.
[17] UNAIDS, "Press Note: UNAIDS Welcomes G8 Reaffirmation of Commitment to Universal Access AIDS Goals"; June 8, 2007 (http://data.unaids.org/pub/PressStatement/2007/070608_g8announcement_en.pdf).
[18] UNAIDS. *Resource needs for an expanded response to AIDS in low- and middle-income countries*. Geneva: UNAIDS; 2005.
[19] 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).
[20] DAC Glossary (www.oecd.org/glossary/0,3414,en_2649_33721_1965693_1_1_1_1,00.html).

Additional copies of this publication (#7679) are available on the Kaiser Family Foundation's website at www.kff.org.

The Kaiser Family Foundation is a non-profit, private operating foundation dedicated to providing information and analysis on health care issues to policymakers, the media, the health care community and the general public. The Foundation is not associated with Kaiser Permanente or Kaiser Industries.

The Henry J. Kaiser Family Foundation
Headquarters:
2400 Sand Hill Road, Menlo Park, CA 94025 USA Phone: 650.854.9400 Fax: 650.854.4800

Washington Offices and Barbara Jordan Conference Center:
1330 G Street N.W., Washington, DC 20005 USA Phone: 202.347.5270 Fax: 202.347.5274

www.kff.org