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## U.S. GLOBAL HEALTH POLICY

DONOR FUNDING FOR HEALTH  
IN LOW- & MIDDLE- INCOME COUNTRIES,  
2001 – 2007

July 2009





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## SUMMARY & HIGHLIGHTS

Official Development Assistance (ODA) from OECD-member countries, including the United States, accounts directly or indirectly for most external funding channeled to health in the developing world, and as such constitutes a major component of the global health response. This paper provides an analysis of ODA funding commitments for health between 2001 and 2007, as part of an annual update prepared by the Kaiser Family Foundation.<sup>1,2,3</sup> In addition to updating prior reports, it complements recent efforts to track health funding<sup>4</sup> and expands upon them by broadening the definition of health to include clean water and sanitation activities.\*

A major limitation to all these efforts, however, is the significant lag time in the availability of data. The most recent data available reflect budgeting decisions put in place before the onset of the current global economic crisis and therefore cannot capture its impact, especially on the health and development prospects of low- and middle- income countries.<sup>5</sup> While ODA funding for health has risen significantly over time, reaching its highest level yet in 2007, it began to slow even before the economic crisis set in and, between 2006 and 2007, increased at its slowest rate in recent years. After adjusting for inflation and currency devaluation, this single-year increase in real terms was modest at best. Still, the recent U.S. announcement of a new multi-year global health initiative<sup>6</sup> and the Group of Eight's (G-8) reiteration of its health-related commitments at its just concluded annual summit<sup>7</sup> signal an intention of donor nations to sustain focus and commitment on global health. Going forward, it will be critical to monitor the potential impact of the economic crisis on the fulfillment of these commitments, and on the level of need of developing countries. Key highlights from this year's report are as follows:

- **Overall ODA:** Between 2001 and 2007, official development assistance more than doubled in nominal terms, in part due to debt relief. In the most recent period, however, ODA decreased in real value and debt relief fell, as expected.
  - Between 2001 and 2007, gross ODA<sup>8</sup> rose from US\$55.5 billion to US\$125.2 (\$69.7 billion or 126%). However, after factoring out inflation and currency revaluation, debt relief, and aid to Iraq and Afghanistan, the increase in real terms was less than half the nominal increase (\$22.7 billion, an increase of 45%).
  - In the most recent period, 2006 to 2007, gross ODA increased only marginally in nominal value (from \$122.5 billion to \$125.2 billion, or 2%), and therefore decreased in real value. Debt relief fell substantially (by more than half), as was expected after significant earlier increases due to the timing of planned transactions.<sup>9</sup>
- **Health ODA:** Funding for health tripled over the period reaching its highest level yet in 2007, although recent increases have slowed considerably.
  - Health funding rose from \$7.2 billion in 2001 to \$22.1 billion in 2007 (208%), an increase in real terms even after adjusting for inflation and currency revaluation. It grew as a share of ODA as well, rising from 13% to 18%, and was the second largest sector in 2007.
  - Between 2006 and 2007, however, funding for health increased at its slowest rate in recent years, and represented only a modest increase in real terms.
- **Health ODA by Donor & Region:** The U.S. was the single largest donor to health, accounting for more than a quarter (27%) of commitments in 2007. European nations, together, accounted for about the same share as the U.S. (28%) and the European Commission adds another 5%. Multilateral institutions represented 26%. Most health funding was channeled to sub-Saharan Africa (42%), followed by South/Central Asia (20%).
- **Health ODA by Sub-Sector:** Funding for population/reproductive health, which includes HIV/AIDS & STDs, accounted for the largest share of health funding in 2007 (42%), with the remainder split between general/basic health (29%) and water/sanitation (29%). Looking within these categories, funding for HIV/AIDS & STDs drove most of the growth over the period and accounted for the greatest share of funding in 2007 (33%), followed by large-system water supply/sanitation<sup>10</sup> (18%). All other sub-sectors within health received 6% or less of funding in 2007.

\*Health funding in this analysis combines data from four OECD CRS sub-sectors: (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 two 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](http://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/](http://www.who.int/water_sanitation_health/en/); USAID, [www.usaid.gov/our\\_work/environment/water/wrm\\_health.html](http://www.usaid.gov/our_work/environment/water/wrm_health.html); State Department, [www.state.gov/g/oes/water/](http://www.state.gov/g/oes/water/)).

### Gross ODA

- Between 2001 and 2007, gross ODA more than doubled, rising from nominal US\$55.5 billion to US\$125.2 billion, a 126% increase (see 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 Figures 3 & 4).<sup>11</sup> Aid to Iraq and Afghanistan, for example, accounted for about 10.8% of ODA commitments in 2007, and drove 18.5% of ODA growth between 2001 and 2007. After adjusting for these combined factors, the increase over the period in real terms was less than half the nominal increase (\$22.7 billion, an increase of 45%).
- Government/civil society was the fastest growing sector over the period (increasing 260%, from \$4.3 billion in 2001 to \$15.5 billion in 2007), followed by health (208%), education (179%), emergency assistance (164%) and debt relief (117%). There was a significant amount of debt relief in 2005 and 2006 due to the expected timing of specific, large, debt relief transactions; debt relief then fell as planned by more than half between 2006 and 2007. 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.
- Three sectors drove most ODA growth between 2001 and 2007: multisector/cross cutting projects drove 22% of growth, health drove 21%, and government/civil society drove 16%.
- Between 2006 and 2007, total ODA increased slightly in nominal value (from \$122.5 billion to \$125.2 billion), and therefore decreased in real value. While debt relief commitments decreased, all other sectors experienced nominal-dollar increases, with government/civil society rising the most (28%) followed by economic infrastructure (20%) and education (17%).

### Health ODA

- Funding for health tripled over the period, rising from \$7.2 billion to \$22.1 billion (see Figure 2), an increase in real terms even after adjusting for inflation and currency revaluation.
- Funding for health grew at a much faster pace (208%) than overall ODA between 2001 and 2007 and, other than government/civil society programming, which grew by 260%, was the fastest growing sector over the period.
- As a percentage of total ODA, health increased from 13% in 2001 to 18% in 2007 (see Figure 3). In 2007, health received the second largest share of ODA commitments, after multisector/cross cutting project funding.
- Other than a significant jump in health commitments between 2002 and 2003 (an increase of \$3.6 billion or 49%), largely reflecting the start-up of new global health initiatives, the rate of increase has begun to slow. In the most recent period, 2006 to 2007, health funding rose by 13% (\$19.5 billion in 2006 to \$22.1 billion in 2007), its slowest rate since 2003 and, after adjusting for inflation and currency devaluation, the real single-year increase was modest at best.

### Health ODA by Donor

- The U.S. was the single largest funder of health ODA in 2007 (\$6 billion), accounting for more than a quarter of all commitments (27.3%), and more than its 2001 share (23.4%) (see Figure 5). U.S. funding nearly quadrupled between 2001 and 2007 (a 259% 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 U.S. total also includes commitments for the President's Malaria Initiative (PMI).

- European nations, collectively, provided 28.4% of health ODA commitments in 2007 (\$6.3 billion), nearly tripling their 2001 commitment (a 201% increase over the period). The European Commission accounted for an additional \$1.0 billion, or 4.7% of the 2007 total.
- Other multilateral organizations accounted for a quarter of health commitments in 2007 at \$5.7 billion (25.6%).

## Health ODA by Region

- Sub-Saharan Africa received the largest share of health funding of any region in 2007 (42.3%) (see Figure 6). Funding for the region drove most of the growth between 2001 and 2007 (48%).
- Funding for South/Central Asia accounted for the second largest share of health funding in 2007 (19.8%) and was the second largest driver of growth by region between 2001 and 2007 (23%).
- The next largest region, by share of funding in 2007, was Far East Asia (8.2%). All other regions accounted for less than 5% of total health funding each.
- A significant portion of health funding in 2007 (16%) was allocated globally rather than to a specific recipient.

## Health ODA by Sub-Sector

- Of the \$22.1 billion provided in 2007, population/reproductive health, which includes HIV/AIDS & STDs, received the largest share of funding (\$9.3 billion or 42%). The remainder was split between general/basic health (which includes infectious disease control other than for HIV) and water/sanitation, each of which received \$6.4 billion or 29% (see Figure 7). Funding for population/reproductive health increased the fastest over the period (almost a five-fold increase) and drove half of the growth of health funding. Funding for water increased three-fold and funding for general/basic health doubled.
- Looking at specific health sub-sectors within these categories, the greatest share of funding in 2007 went to HIV/AIDS & STD programs (33.5%). Large-system water supply sanitation funding<sup>10</sup> accounted for the next greatest share in 2007 (17.7%), followed by health policy/management (6.4%) and infectious disease control (6%). Funding for malaria and TB efforts together accounted for 5.7% of funding, and funding for basic drinking water supply & basic sanitation received 4.2% (see Figure 8).
- HIV/AIDS & STDs drove the most growth over the period (42.9%), followed by large-system water supply/sanitation (14.6%), reproductive health care (6.4%), infectious disease control (5.7%), and health policy/management (5.3%) (see Figure 9). The significant increases in funding for HIV/AIDS reflect the global community's growing awareness of and response to the epidemic, but also point to the need to monitor funding for other health areas.
- Some sub-sectors that serve as building blocks for health continue to receive only small amounts of funding in 2007, such as basic health infrastructure (1.0%) and health training (<1%), raising questions about the underlying development and sustainability of health systems.<sup>12,13</sup>
- The only sub-sectors that experienced decreased funding over the period were water resources protection and water education/training, which also accounted for small shares of health funding.

## ANNEX 1: FIGURES

**FIGURE 1:**  
Total ODA Commitments, All Sectors, 2001 – 2007

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), May 31, 2009.

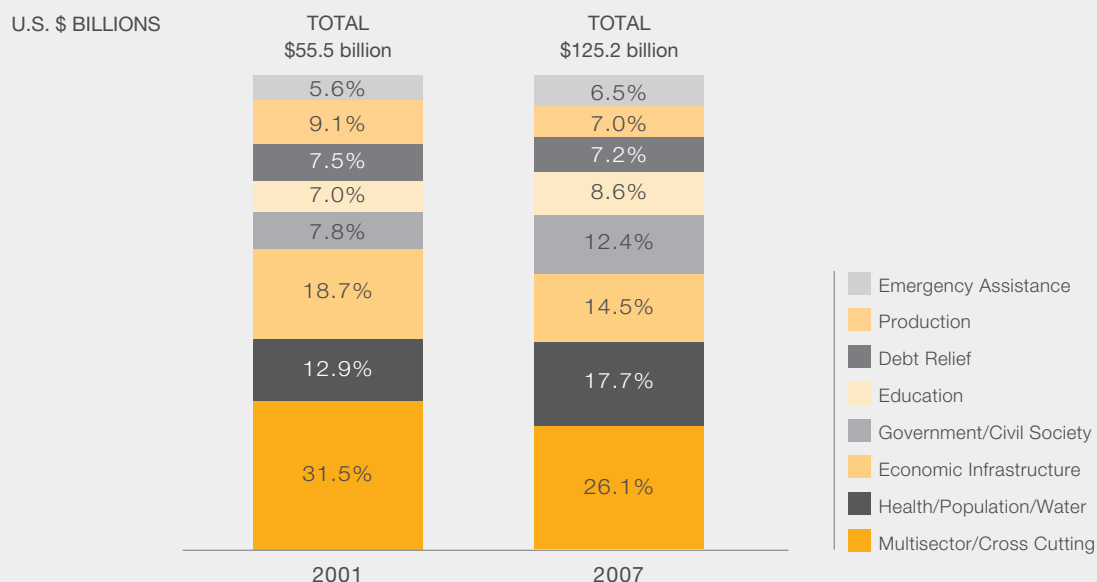
**FIGURE 2:**  
Total Health ODA Commitments, 2001 – 2007

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.  
SOURCE: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), May 31, 2009.

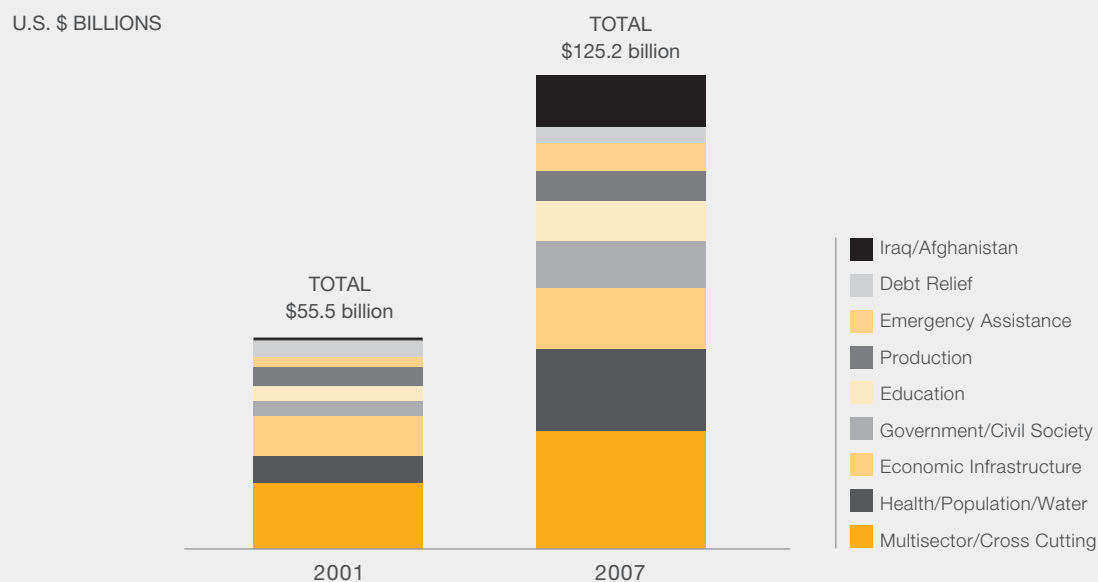
**FIGURE 3:**  
Share of ODA Commitments by Major Sector, 2001 and 2007



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), May 31, 2009.

**FIGURE 4:**  
ODA Commitments by Major Sector with Iraq/Afghanistan Disaggregated, 2001 and 2007

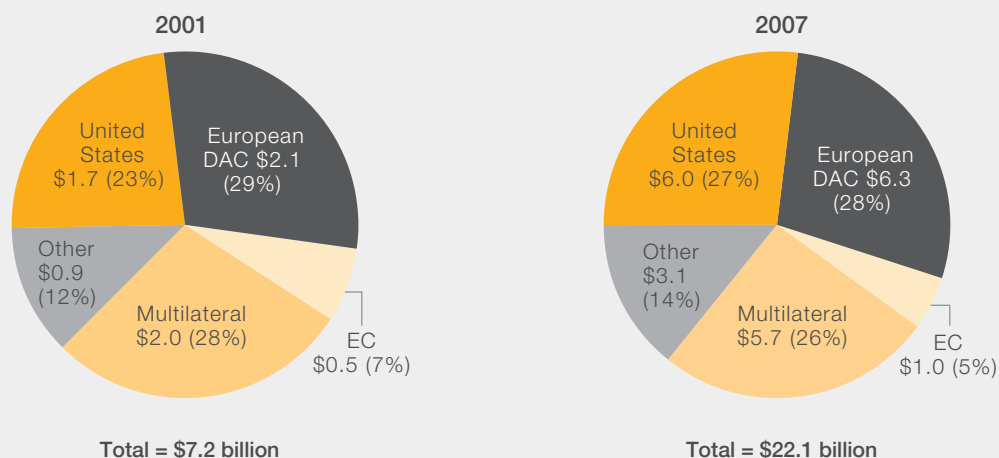


NOTES: Amounts in gross US\$ commitments. Health ODA combines data from four OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); (3) Water Supply/Sanitation; and (4) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS.

SOURCE: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), May 31, 2009.

**FIGURE 5:**  
Health ODA Commitments by Donor, 2001 and 2007

U.S. \$ BILLIONS

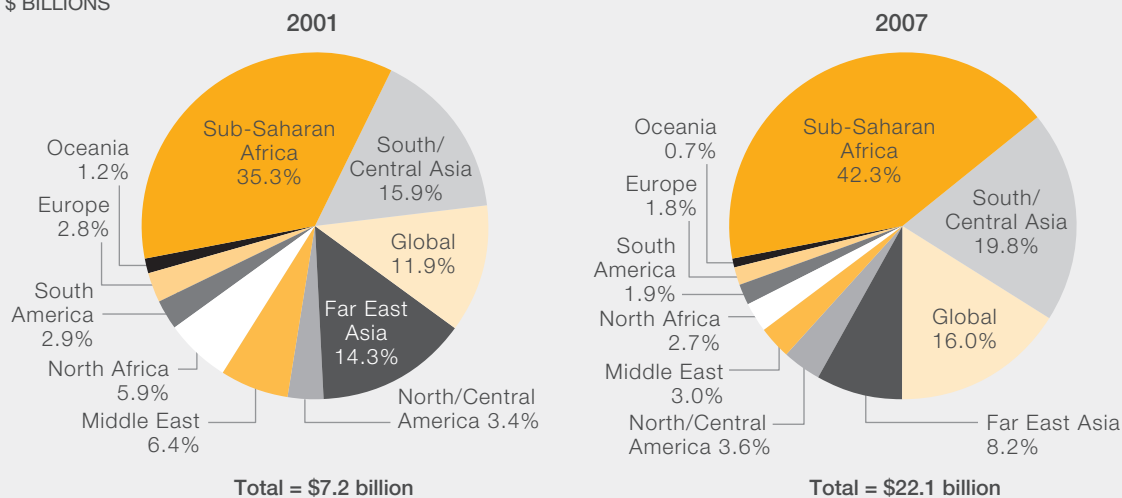


NOTES: Amounts in gross US\$ commitments. Health ODA combines data from four OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); (3) Water Supply/Sanitation; and (4) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS.

SOURCE: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), May 31, 2009.

**FIGURE 6:**  
Health ODA Commitments by Region, 2001 and 2007

U.S. \$ BILLIONS

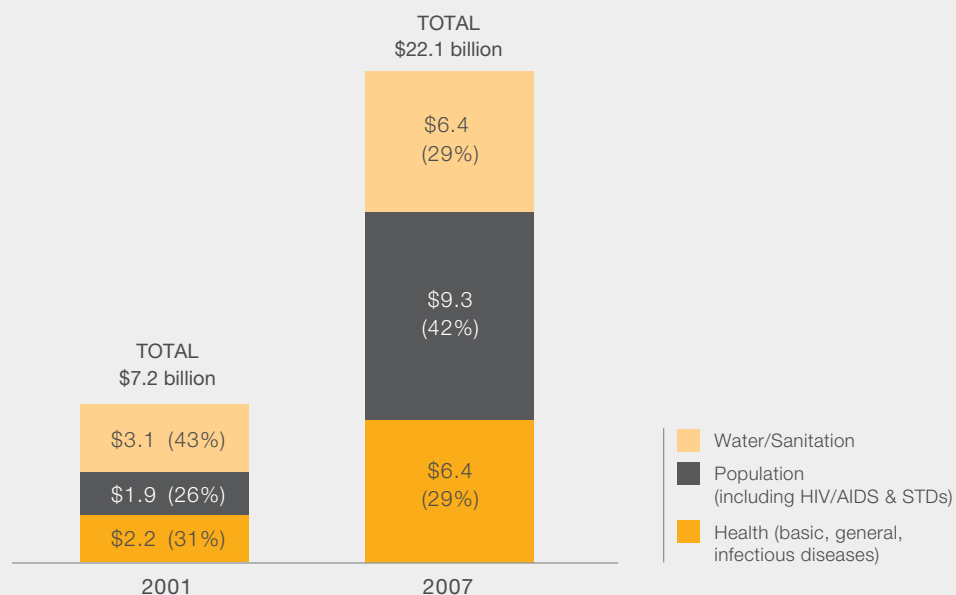


NOTES: Amounts in gross US\$ commitments. Health ODA combines data from four OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); (3) Water Supply/Sanitation; and (4) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS.

SOURCE: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), May 31, 2009.

FIGURE 7:  
Health ODA Commitments by Major Component: Health, Population, and Water, 2001 and 2007

U.S. \$ BILLIONS



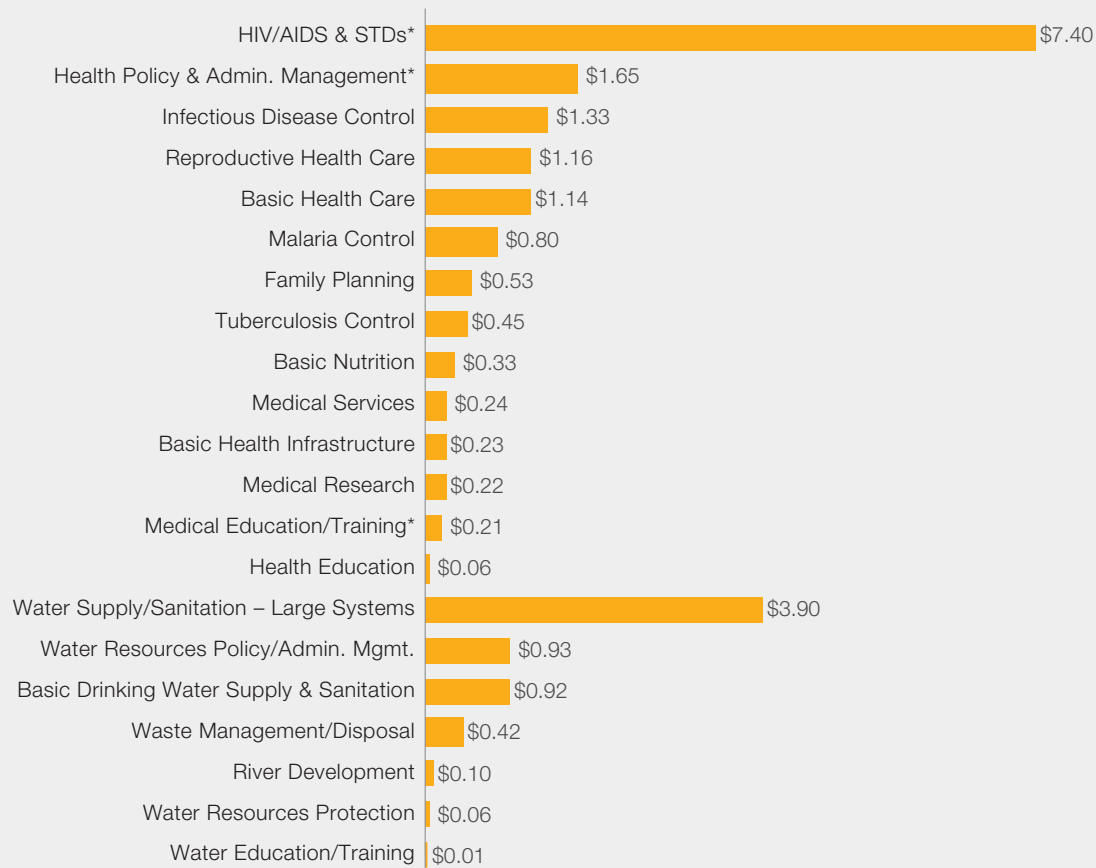
NOTES: Amounts in gross US\$ commitments. Health ODA combines data from four OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); (3) Water Supply/Sanitation; and (4) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS.

SOURCE: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), May 31, 2009.

FIGURE 8:  
Health ODA Commitments by Sub-Sector, 2007

U.S. \$ BILLIONS

Total Health ODA: \$22.1 billion



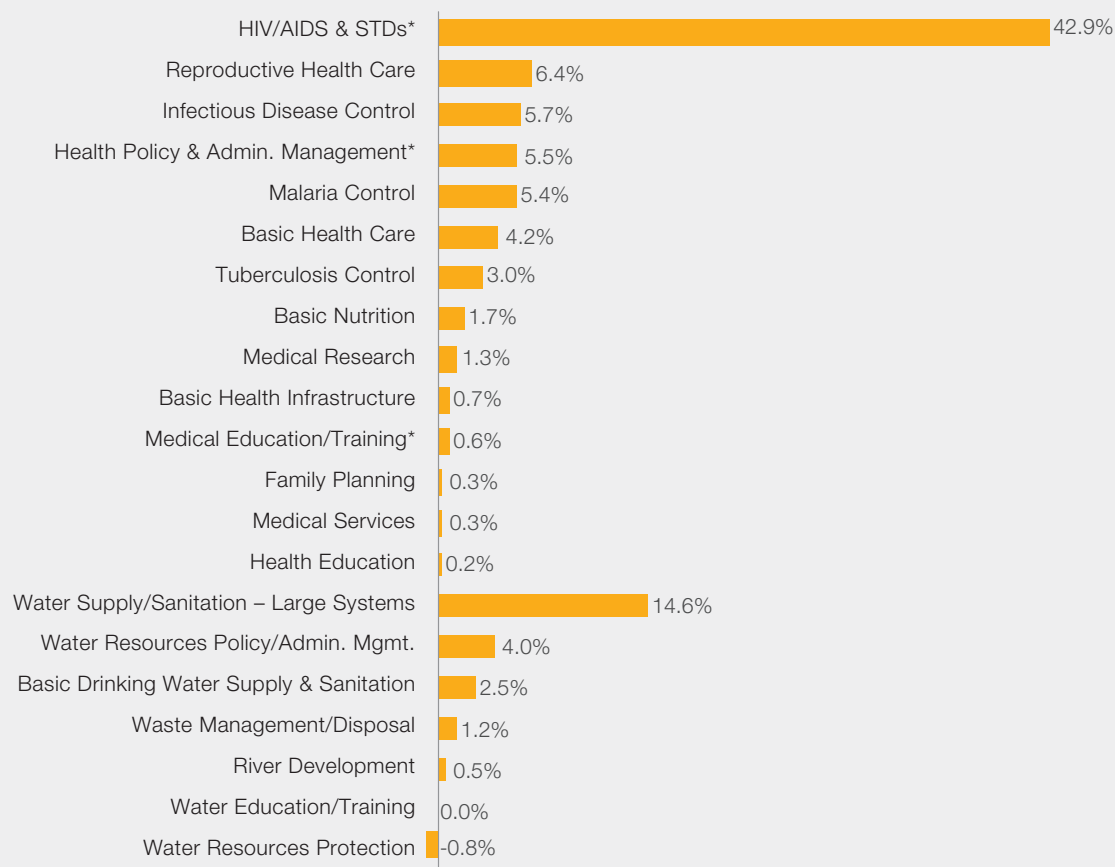
NOTES: Amounts in gross US\$ commitments. Health ODA combines data from four OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); (3) Water Supply/Sanitation; and (4) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS. \*Combines two or more sub-sectors.

SOURCE: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), May 31, 2009.

FIGURE 9:  
Contribution to Health ODA Growth by Major Sub-Sector, 2001 – 2007

U.S. \$ BILLIONS

Total Growth in Health ODA: \$14.9 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. \*Combines two or more sub-sectors.

SOURCE: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), May 31, 2009.

## ANNEX 2: TABLES

**Table 1: Total ODA Commitments by Major Sector, 2001, 2006 and 2007\***

GROSS U.S.\$ COMMITMENTS IN BILLIONS

	2001	2006	2007	2001 – 2007 +/- \$ (%)
Multisector/Other	17.5	29.0	32.6	+15.1 (86%)
Government/Civil Society	4.3	12.1	15.5	+11.2 (260%)
Economic Infrastructure	10.4	15.2	18.2	+7.8 (76%)
Health/Population/Water	7.2	19.5	22.1	+14.9 (208%)
Education	3.9	9.2	10.8	+6.9 (179%)
Production	5.0	8.1	8.7	+3.7 (73%)
Emergency Assistance	3.1	8.2	8.2	+5.1 (164%)
Debt Relief	4.2	21.2	9.0	+4.9 (117%)
<b>TOTAL</b>	<b>\$55.5</b>	<b>\$122.5</b>	<b>\$125.2</b>	<b>+\$69.7 (126%)</b>

\*Represents combined data from four OECD CRS sub-sectors (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 2: Total ODA and Health ODA Commitments by Donor, 2001-2007\***

GROSS U.S.\$ COMMITMENTS IN BILLIONS

	2001		2002		2003		2004		2005		2006		2007		2001– 2007	+/- \$ (%)
	Total	Health	Total	Health	Total	Health	Total	Health	Total	Health	Total	Health	Total	Health	Total	Health
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	+15.1 (156%)	+4.4 (259%)
European Countries	19.0	2.1	24.1	2.7	30.2	3.1	33.0	3.5	48.4	4.4	52.1	5.9	47.6	6.3	+28.6 (150%)	+4.2 (201%)
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	+7.9 (144%)	+0.5 (100%)
Multilaterals	11.0	2.0	11.7	1.9	14.6	3.3	17.8	3.8	15.5	3.8	15.7	5.2	21.6	5.7	+10.7 (97%)	+3.7 (185%)
Other	10.4	0.9	8.9	0.7	17.2	1.8	15.9	1.7	20.8	2.9	17.9	2.1	17.8	3.1	+7.5 (72%)	+2.2 (243%)
<b>TOTAL</b>	<b>\$55.5</b>	<b>\$7.2</b>	<b>\$63.3</b>	<b>\$7.4</b>	<b>\$91.0</b>	<b>\$11.1</b>	<b>\$99.4</b>	<b>\$13.5</b>	<b>\$123.8</b>	<b>\$17.0</b>	<b>\$122.5</b>	<b>\$19.5</b>	<b>\$125.2</b>	<b>\$22.1</b>	<b>+\$69.7 (126%)</b>	<b>+\$14.9 (208%)</b>

\*Represents combined data from four OECD CRS sub-sectors (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 Commitments by Sub-Sector, 2001 and 2007\*

GROSS U.S.\$ COMMITMENTS IN BILLIONS

Sub-Sector	2001 \$	2007 \$	2001 – 2007 +/- \$ (%)
<b>HEALTH/POPULATION</b>			
HIV/AIDS & STDs*	1.0	7.4	+6.4 (641%)
Health Policy & Admin. Management*	0.8	1.6	+0.8 (101%)
Infectious Disease Control	0.5	1.3	+0.8 (174%)
Reproductive Health Care	0.2	1.2	+1 (467%)
Basic Health Care	0.5	1.1	+0.6 (121%)
Malaria Control	--	0.8	--
Family Planning	0.5	0.5	+0 (9%)
Tuberculosis Control	--	0.4	--
Basic Nutrition	0.1	0.3	+0.3 (314%)
Medical Services	0.2	0.2	+0 (25%)
Basic Health Infrastructure	0.1	0.2	+0.1 (78%)
Medical Research	0.0	0.2	+0.2 (780%)
Medical Education/Training*	0.1	0.2	+0.1 (90%)
Health Education	0.0	0.1	+0 (77%)
<i>Health/Population Subtotal</i>	<b>\$4.1</b>	<b>\$15.7</b>	<b>+11.7 (286%)</b>
<b>WATER SUPPLY/SANITATION</b>			
Water Supply/Sanitation - Large Systems	1.7	3.9	+2.2 (127%)
Water Resources Policy/Admin. Management	0.3	0.9	+0.6 (179%)
Basic Drinking Water Supply & Sanitation	0.6	0.9	+0.4 (68%)
Waste Management/Disposal	0.2	0.4	+0.2 (70%)
River Development	0.0	0.1	+0.1 (250%)
Water Resources Protection	0.2	0.1	+0.1 (-65%)
Water Education/Training	0.0	0.0	+0 (-19%)
<i>Water Subtotal</i>	<b>\$3.1</b>	<b>\$6.4</b>	<b>+\$3.3 (106%)</b>
<b>TOTAL HEALTH ODA</b>	<b>\$7.2</b>	<b>\$22.1</b>	<b>+14.9 (208%)</b>

\*Represents combined data from four OECD CRS sub-sectors (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 2007, within the health/population and water supply/sanitation sub-sectors, respectively.

## ANNEX 3: CRS SECTORS & SUB-SECTORS

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

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.

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

## ANNEX 4: METHODOLOGY

Data for this analysis were obtained 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](http://www.oecd.org/dataoecd/50/17/5037721.htm)). The publication date for these files was May 31, 2009. 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 (G-8), the European Union (EU), or have a firm date for EU admission.<sup>14</sup> 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 2001-2007, with the exception of the Netherlands for which disbursement data were used 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).<sup>15</sup> 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.

This analysis combines data deriving from four OECD CRS sub-sectors 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 sub-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

- <sup>1</sup> Author analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), publication date May 31, 2009 ([www.oecd.org/dataoecd/50/17/5037721.htm](http://www.oecd.org/dataoecd/50/17/5037721.htm)).
- <sup>2</sup> The 22 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 and the United States. The European Commission is also a member of the DAC.
- <sup>3</sup> 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.
- <sup>4</sup> 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", *The Lancet*, Vol. 373, No. 9681, June 20, 2009; Schieber GJ, Gottret P, Fleisher LK, Lene AA, "Financing Global Health: Mission Unaccomplished", *Health Affairs*, Vol. 26, No. 4, July/August 2007.
- <sup>5</sup> See: World Bank, *Averting a Human Crisis During the Global Downturn: Policy Options from the World Bank's Human Development Network*, April 2009; World Bank/UNAIDS, *The Global Economic Crisis and HIV Prevention and Treatment Programmes: Vulnerabilities and Impact*, June 2009.
- <sup>6</sup> The White House, Office of the Press Secretary, "Statement by the President on the Global Health Initiative", [www.whitehouse.gov/the\\_press\\_office/Statement-by-the-President-on-Global-Health-Initiative/](http://www.whitehouse.gov/the_press_office/Statement-by-the-President-on-Global-Health-Initiative/); May 5, 2009.
- <sup>7</sup> G8 Leaders Declaration: Responsible Leadership for a Sustainable Future; July 8, 2009 ([www.g8italia2009.it/static/G8\\_Allegato/G8\\_Declaration\\_08\\_07\\_09\\_final.1.pdf](http://www.g8italia2009.it/static/G8_Allegato/G8_Declaration_08_07_09_final.1.pdf))
- <sup>8</sup> The OECD reports ODA as net ODA, which reflects loan repayments. In 2007, net ODA totaled \$104 billion. See: [www.oecd.org/document/35/0,3343,en\\_2649\\_34447\\_42458595\\_1\\_1\\_1\\_1,00.html](http://www.oecd.org/document/35/0,3343,en_2649_34447_42458595_1_1_1_1,00.html).
- <sup>9</sup> 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](http://www.oecd.org/document/8/0,3343,en_2649_33721_40381960_1_1_1_1,00.html).)
- <sup>10</sup> 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.
- <sup>11</sup> See also: OECD, Development Aid from OECD Countries Fell 5.1% in 2006, April 3, 2007.
- <sup>12</sup> WHO. *The World Health Report 2006 Working Together for Health*; April 7, 2006 ([www.who.int/whr/2006/en](http://www.who.int/whr/2006/en)).
- <sup>13</sup> 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.
- <sup>14</sup> 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](http://www.oecd.org/document/55/0,3343,en_2649_34447_35832055_1_1_1_1,00.html)).
- <sup>15</sup> DAC Glossary ([www.oecd.org/glossary/0,3414,en\\_2649\\_33721\\_1965693\\_1\\_1\\_1\\_1,00.html](http://www.oecd.org/glossary/0,3414,en_2649_33721_1965693_1_1_1_1,00.html)).







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