THE HENRY J. KAISER FAMILY FOUNDATION

REPORT

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Donor Funding for Health in Low- & Middle-Income Countries, 2002-2013

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Executive Summary

As 2015 marks the end of the Millennium Development Goals (MDGs) and a transition to the new Sustainable Development Goals (SDGs), the global community is taking stock of progress made as well as the unmet needs looking forward. A key component in the effort to address global health challenges has been donor funding from governments and multilateral organizations. Indeed, while domestic funding has increased, and in some areas now constitutes a greater share of total available resources, donor funding will continue to play a significant role in achieving the SDGs.[1] This analysis presents trends in donor funding for health in low- and middle-income countries between 2002 and 2013. Funding during the period increased more than five-fold, rising from $4.4 billion to $22.8 billion (see Figure 1), an increase even after adjusting for inflation and exchange rates. In 2013, donor funding for health increased by $2.7 billion compared to 2012, the largest percentage increase (13.5%) since the early part of the previous decade when increases were largely spurred on by the creation of several new funding initiatives and mechanisms such as The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)[2] and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR).[3] These increases occurred despite the financial uncertainty that resulted from the global economic crisis and its aftermath.

Donors have placed a priority on health, relative to some other sectors, with funding for health increasing as a share of total Official Development Assistance (ODA) for the third year in a row. The health sector saw the third largest increase, after multisectoral and economic infrastructure projects. Additionally, 2013 marked the first year since 2003 where every health sub-sector (e.g. HIV, TB, Malaria, etc.) increased. HIV/AIDS accounted for the largest share of health assistance (35.3%), although it has declined from prior year levels. The next largest sub-sector was Basic Health & Infrastructure followed by Family Planning & Reproductive Health (FP/RH).

Fifty donors provided Health ODA in 2013 (32 bilateral donors and 18 multilateral donors), an increase from 26 donors (21 bilateral and 5 multilateral) in 2002. While the number of donors has increased over time, the majority of the increase between 2002 and 2013 is largely attributable to the original 26 donors (63%), of which the U.S. accounted for nearly half of the increase. Two new donor entrants accounted for nearly one third of the increase: the Global Fund (22%), which first disbursed funding in 2003, and GAVI (8%), which first disbursed funding in 2007.

Nearly two-thirds (64.5%) of Health ODA was provided bilaterally in 2013 with one-third (35.5%) provided by multilateral institutions. While the U.S. has consistently been the largest donor to health and provided the greatest share of its ODA for health, the donor mix has shifted over time. This is in part due to the entrance of new donors, particularly the Global Fund, and to a lesser extent, GAVI, which are now among the top five donors to global health. The U.S. and the Global Fund combined have accounted for more than half of total donor funding for health since 2010. Regionally, a growing share of funding over the period was directed to Sub-Saharan Africa. In addition, donors have provided an increasing share of Health ODA to Least Developed Countries (LDCs), rising from 27.0% in 2002 to 41.2% in 2013.

These trends are based on analysis of ODA disbursements for the health sector provided by bilateral and multilateral donors between 2002 and 2013, and are part of a multi-year effort of the Kaiser Family Foundation to analyze and track trends in donor funding for health.[4,5,6]

Introduction

As 2015 marks the end of the Millennium Development Goals (MDGs) and a transition to the new Sustainable Development Goals (SDGs), the global community is taking stock of progress made in addressing global development issues as well as unmet needs looking forward. A key component in the effort to address global health challenges and fulfill the MDGs has been donor funding from governments and multilateral organizations. While domestic funding has increased, and in some areas now constitutes a greater share of the total available resources, donor funding will continue to play a significant role over the foreseeable future. As such, tracking donor funding for health in low- and middle-income countries is an important element for assessing progress and planning towards fulfillment of future goals. These analyses take on additional relevance following the Third International Conference on Financing for Development in Addis Ababa, Ethiopia in July 2015, where the international community worked towards the implementation of the post-2015 development agenda.

This report provides an analysis of Official Development Assistance (ODA) disbursements for the health sector provided by donors between 2002 and 2013, as reported to the Organisation for Economic Co-operation and Development (OECD) by Development Assistance Committee (DAC) member governments and multilateral organizations,[7,8,9] and serves to complement efforts by others in the field.[10] While 2013 is the most recent year for which standardized donor data, disaggregated by sector, are available, several other analyses provide an indicator of how it may fare in 2014 and beyond. For example, the OECD recently reported that overall ODA in 2014 remained essentially flat compared to 2013.[11] In addition, a recent analysis by the Kaiser Family Foundation and UNAIDS found that donor funding for HIV/AIDS in low- and middle-income countries remained roughly flat between 2008 and 2013, while other Kaiser analyses show increases in donor funding for family planning and malaria. Whether or not the health sector as a whole demonstrates similar trends or experiences any downward effects beyond 2013 remains an open question.

Box 1: Definition of Health

ODA is categorized by the OECD into sectors and subsectors based on the specific area being targeted. In order to capture total ODA funding for "health," this report combines the "Health" and "Population Policies/Programs and Reproductive Health" sectors, which represent the OECD DAC statistical definition of "aid to health," and the "Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS" subsector, a relatively new category in the OECD CRS database.

See the Methodology and Annex 2 below for more information.

Detailed Findings

Total ODA

- ODA rose considerably in the past decade, with disbursements more than tripling between 2002 and 2013, from nominal US$54.8 billion to US$167.0 billion, a 204.7% increase (Table 1). Increases were relatively stable, except in 2005 and 2006, when scheduled, and significant, debt relief transactions were made thereby increasing ODA in those two years (Figure 2 and Annex 1).
- Some of the increase was offset by inflation and exchange rate changes while a considerable portion was for debt relief and aid to Iraq, Afghanistan, and Pakistan.[12,13,14] Aid to Iraq, Afghanistan, and Pakistan, for example, accounted for about 2.1% of ODA disbursements between 2002 and 2013. Debt Relief accounted for approximately 12.3% of ODA disbursements during the same period. After adjusting for these combined factors, the increase over the period in real terms was $84.1 billion, an increase of 126.8%.

Table 1: Total ODA by Major Sector, 2002, 2012, 2013

Gross US$ Disbursements in Billions

	2002	2012	2013	2012-2013	2002-2013
				+/- $ (%)	+/- $ (%)
Health*	4.4	20.1	22.8	+2.7 (13.5%)	+18.4 (416.3%)
Water	1.4	6.4	6.4	-0.1 (-1.4%)	+5.0 (350.5%)
Education	3.3	11.7	11.7	+0.0 (0.2%)	+8.4 (254.5%)
Government/Civil Society	4.8	18.1	18.1	+0.8 (4.6%)	+13.3 (279.7%)
Economic Infrastructure	5.6	28.5	28.5	+1.3 (5.0%)	+22.9 (407.7%)
Production	3.9	12.8	12.8	+1.4 (12.5%)	+8.9 (226.9%)
Commodity Aid	4.9	10.8	10.8	+4.0 (58.0%)	+5.9 (119.1%)
Debt Relief	6.5	7.0	7.0	+0.2 (2.3%)	+0.5 (7.7%)
Emergency Assistance	3.0	11.2	13.8	+2.5(22.5%)	+10.8 (365.1%)
Multisector/Other**	7.0	30.2	32.6	+2.4 (7.9%)	+25.6 (367.8%)
Unspecified	10.0	2.3	2.5	0.2 (7.9%)	-7.5 (-75.0%)
TOTAL	**$54.8**	**$151.5**	**$167.0**	**$15.5 (10.2%)**	**+$112.2 (204.7%)**

* Represents combined data from three OECD CRS subsectors (1) Health; (2) Population Policies/Programs and Reproductive Health (which includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS.
** Represents combined data from five OECD CRS sectors and sub-sectors: (1) Multisector/Cross-cutting; (2) Administrative Costs of Donors; (3) Support of NGO's; (4) Refugees in Donor Countries; (5) Other Social Infrastructure & Services (excluding Social Mitigation of HIV/AIDS).

Health ODA

- Funding for health increased more than five-fold over the period, rising from $4.4 billion to $22.8 billion, an increase even after adjusting for inflation and currency revaluation (Figure 1 and Annex 1) and grew at a much faster pace (416.3%) than overall ODA (204.7%). Health also grew as a share of overall ODA, rising from 8.1% in 2002 to 13.7% in 2013 (Figure 3).
- The Health sector demonstrated the third largest increase ($18.4 billion) in ODA over the decade, behind projects that supported Multisectoral or other general efforts ($25.6 billion)[15] and Economic Infrastructure ($22.9 billion). Health also accounted for the second largest share of the increase in the 2012-2013 period (17.6% or $2.7 billion), behind Commodity Aid (25.7% or $3.7 billion).

- While health funding increased each year over the period, the largest increases occurred in the early part of the decade reflecting the start-up of new global health initiatives such as the Global Fund and PEPFAR; between 2003 and 2008, for example, Health grew by $11.0 billion (248.8%), compared to $7.4 billion (48.0%) in the 2008 to 2013 period. After five years of declining year-to-year increases, donor funding for Health increased by $2.7 billion in 2013, representing the largest increase over the study period, and demonstrated the largest year-to-year percent change (13.5%) since 2008 (Figure 4).

Health ODA by Sub-Sector

- Looking at specific activities within the health sector, the greatest share of funding in 2013 went to HIV/AIDS (35.3%) (Table 2 and Figure 5).[16] Basic Health & Infrastructure accounted for the next largest share (19.2%) followed by Family Planning & Reproductive Health (12.6%),[17] Malaria (8.6%), and Health Management & Workforce (8.0%). For the first time since 2003, funding for every sector increased from the previous year (Figure 6). Donor funding for Basic Health & Infrastructure experienced the largest increase between 2012 and 2013 ($905.4 million, 26.0%) followed by Nutrition ($371.7 million, 65.5%), Other Infectious Diseases ($369.7 million, 38.1%), TB ($312.4 million, 40.4%), and HIV/AIDS ($289.8, 3.7%).
- HIV/AIDS drove most of the growth in Health ODA over the 2002 to 2013 period accounting for $7.2 billion (39.2%) of the $18.4 billion increase in health ODA (Figure 7). Basic Health & Infrastructure accounted for the second largest share ($3.4 billion, 18.6%) of the increase, followed by Family Planning & Reproductive Health ($2.0 billion, 10.9%),[17] Malaria ($1.9 billion, 10.6%), and TB ($1.1 billion, 5.8%) (Annex 1).

Box 2: ODA for Water

While the DAC does not include funding for the Water Sector as part of its definition of "Health," in prior Kaiser reports, funding for Water was included in overall Health ODA totals, due its relevance to health. In this year's report, Water is kept as a separate sector, as defined by the DAC (see Appendix 4), and data specific to funding for Water are provided in tables and charts throughout the report (Table 1, Figure 8, and Annex 3).

- Water ODA more than quadrupled from $1.4 billion in 2002 to $6.4 billion in 2013; an increase of 350.5% across the period.
- In 2013, as with the health sector, Sub-Saharan Africa accounted for the largest share (36.8%) of Water ODA. Far East Asia accounted for the second largest share (16.8%) followed by South & Central Asia (16.5%).
- The constellation of donors who fund water projects is different from the health sector. In 2013, Japan was the largest donor to water ODA ($1.3 billion), accounting for nearly one-fifth of water funding (19.9%). The second largest donor was the World Bank ($0.9 billion, 13.9%), followed by Germany ($0.7 billion, 10.1%), the European Commission ($0.6 billion, 8.8%), and the U.S. ($0.4 billion, 6.9%).

Table 2: Total Health ODA by Sub-Sector, 2002, 2012, 2013					
Gross US$ Disbursements in Billions					
	2002	2012	2013	2012-2013	2002-2013
				+/- $ (%)	+/- $ (%)
Basic Health & Infrastructure	1.0	3.5	4.4	+0.91 (26.0%)	+3.43 (357.5%)
Health Management & Workforce	1.0	1.8	1.8	+0.06 (3.5%)	+0.78 (75.2%)
Research	0.0	0.3	0.3	+17 (5.1%)	+0.83 (779.9%)
Nutrition	0.1	0.6	0.9	+0.37 (65.5%)	+0.83 (779.9%)
Other Infectious Diseases	0.6	1.0	1.3	+0.37 (38.1%)	+0.79 (142.2%)
Malaria	0.0	1.8	2.0	+0.20 (11.3%)	+1.95 (NA)
Tuberculosis	0.0	0.8	1.1	+0.31 (40.4%)	+1.07 (NA)
Family Planning & Reproductive Health[17]	0.9	2.7	2.9	+0.19 (6.9%)	+2.01 (235.1%)
HIV/AIDS	0.8	7.8	8.1	+0.29 (3.7%)	+7.22 (855.8%)
TOTAL	**$4.4**	**$20.1**	**$22.8**	**+$2.71 (13.5%)**	**+$18.39 (416.3%)**

Health ODA by Donor

- Fifty donors provided Health ODA in 2013 (32 bilateral donors and 18 multilateral donors) an increase from 26 donors (21 bilateral and 5 multilateral) in 2002. This increase reflects the creation of new multilateral donors such as The Global Fund and GAVI as well as the entry of new Non-DAC bilateral donors such as Estonia, Kuwait, and the United Arab Emirates (Box 3).

Box 3: Measuring Health ODA and Looking Beyond the DAC

The DAC, established in 1961 and with a current membership of 29, is considered to be the world's main donor group and the primary source for data on development assistance. The DAC collects two sets of development assistance data: one that is high-level data on funding from donor governments (both bilateral and multilateral). This data is referred to as the DAC dataset. Another dataset provides project-level funding data from both donor governments and multilateral organizations (this data is referred to as the CRS dataset). Many non-DAC donor governments (e.g. Turkey, Hungary, etc.) and private donors (e.g. The Bill and Melinda Gates Foundation) provide only high-level data on their development assistance, and not project-level data.

While all donors play a role in funding and defining the global health agenda, emerging, non-DAC donors are increasingly seen as critical to helping fill the global health financing gap. For instance, The Bill & Melinda Gates Foundation disbursed $2.8 billion for global health activities in 2013, which is included in the high-level DAC dataset, but is not available in the project level CRS dataset. Since this analysis utilizes only the project level data (CRS database) it is likely a low-bound estimate of total donor assistance for health.

- While the number of donors has increased over time, the majority of the increase between 2002 and 2013 is largely attributable to the original 26 donors (63%), of which the U.S. accounted for nearly half of the increase. Two new donor entrants accounted for nearly one third of the increase: the Global Fund (22%), which first disbursed funding in 2003, and GAVI (8%), which first disbursed funding in 2007.
- Most health ODA over the decade was provided bilaterally by donor governments, who collectively accounted for nearly two thirds of disbursements (64.5%) in 2013, with multilateral organizations providing the rest

(35.5%) (See Annex 1).[19] Bilateral donors provided the greatest share of disbursements in 2013, however, bilateral and multilateral donors accounted for an equal share of the increase in health ODA. While bilateral donors increased their health ODA by 10%, multilateral donors increased health disbursements at a faster rate, providing 20% more than the previous year.[18,19]

- The U.S. government was the single largest donor to health over the entire period, including in 2013 ($7.6 billion), when it accounted for over a third of all health ODA (33.5%) (Figure 8). This is up somewhat from 31.7% in 2002; by comparison, the U.S. share of total ODA declined over the period (from 23.5% in 2002 to 16.4% in 2013). The Global Fund, which was created in 2002, has been the second largest donor to Health since 2006 and in 2013 ($4.0 billion) accounted for nearly half of total multilateral funding ($8.1 billion).
- After the United States, the United Kingdom was the second largest bilateral donor in 2013 ($2.0 billion) followed by the Canada ($0.8 billion), European Commission ($0.6 billion), and Germany ($0.5 billion). After the Global Fund, GAVI was the second largest multilateral donor ($1.4 billion) in 2013 followed by the World Bank ($1.1 billion), and the World Health Organization (WHO) ($0.5 billion).
- There have been some notable shifts in the donor mix, in part due to the entrance of new donors, particularly the Global Fund and to a lesser extent, GAVI, which are now among the top five donors to global health (Figure 9).
- The U.S. allocated the largest share of its total ODA to health (28.0%) among donor governments followed by Canada (21.8%), Ireland (19.4%), the United Kingdom (18.6%), and Luxembourg (16.7%) (Figure 10). When looking at health ODA as a share of gross domestic product (GDP) (standardized by GDP per US$1 million, to account for differences in the sizes of government economies), the U.K. provided the highest amount of resources for health, followed by Luxembourg, the United Arab Emirates, Norway, and Ireland (Figure 11).

Health ODA by Region

- Sub-Saharan Africa received the largest share of health funding of any region in each year between 2002 and 2013 (46.6%) (Figure 12), and accounted for a majority of the growth over the period (57.5%). Funding for the region grew as a share of health ODA between 2002 and 2013, rising from 31.9% to

Box 4: ODA for Least Developed Countries

There are a number of ways to categorize recipient countries including by region, income-level, development status, etc. With the development of the new Sustainable Development Goals (SDGs), increased attention has been placed on the 48 Least Developed Countries (LDCs), which account for 12% of the world's population, but just 2% of the world's GDP. LDCs are designated by the United Nations (UN) as countries that have "severe structural impediments to sustainable development." The UN uses three criteria for designating LDCs: gross national income (GNI) per capita, the human asset index (HAI), and the economic vulnerability index (EVI).

- Total ODA (excluding debt relief) for LDCs has increased from $11.7 billion in 2002 to $48.3 billion in 2013. In addition, 2013 marked the largest increase ($4.6 billion or 10%) in total ODA for LDCs since 2008.
- Health ODA for LDCs increased each year over the period, rising from 1.2 billion in 2002 to $9.4 billion in $2013. In 2013, Health ODA provided to LDCs increased by $1.5 billion (or 19.2%).
- While the share of total ODA directed to LDCs has remained essentially flat (approximately 30% over the last seven years), donors have provided an increasing share of Health ODA to LDCs, rising from 27.0% in 2002 to 41.2% in 2013 (Figure 13).

52.% (Table 3 and Annex 1).

- Funding for South/Central Asia accounted for the second largest share in 2013 (13.5%). While the region was the second largest driver of growth (11.3%) over the 2002-2013 period, its share of health ODA has declined since 2002 (22.8%).
- The next largest region, by share of funding in 2013, was Far East Asia (5.6%). All other regions individually accounted for less than 3.0% of total health funding, and funding for three regions (Far East Asia, Europe, and Oceania) declined between 2012 and 2013. Donors allocated a significant portion of health funding (17.8%) without specifying a region.

Table 3: Total Health ODA by Region, 2002, 2012, 2013

Gross US$ Disbursements in Billions

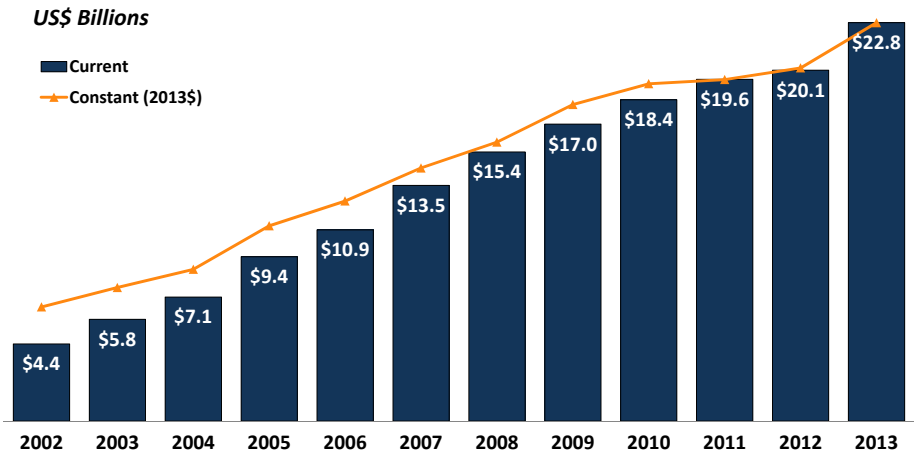
	2002	2012	2013	2012-2013	2002-2013
				+/- $ (%)	+/- $ (%)
North Africa	0.1	0.1	0.2	+0.06 (60.1%)	+0.08 (109.3%)
Sub-Saharan Africa	1.4	10.4	12.0	+1.56 (15.0%)	+10.58 (751.6%)
North/Central America	0.2	0.6	0.6	+0.03 (5.3%)	+0.44 (265.3%)
South America	0.1	0.2	0.3	+0.11 (49.4%)	+0.21 (206.9%)
Far East Asia	0.3	1.3	1.3	-0.02 (-1.8%)	+0.98 (322.5%)
South/Central Asia	1.0	2.5	3.1	+0.56 (22.1%)	+2.07 (205.7%)
Middle East	0.1	0.4	0.4	+0.04 (10.7%)	+0.36 (433.0%)
Europe	0.1	0.3	0.2	-0.02 (-8.9%)	+0.17 (250.6%)
Oceania	0.1	0.3	0.3	-0.02 (-5.1%)	+0.22 (280.1%)
Regional	0.1	0.4	0.3	-0.01 (-2.8%)	+0.27 (350.6%)
Unspecified	1.0	3.6	4.1	+0.43 (11.9%)	+3.00 (286.4%)
TOTAL	**$4.4**	**$20.1**	**$22.8**	**+$2.71 (13.5%)**	**+$18.39 (416.3%)**

Conclusion

In the wake of the Sustainable Development Summit and adoption of the SDGs by the global community, this analysis provides updated trends in donor funding for low- and middle-income countries. It shows that while donors have increased total ODA over the period between 2002 and 2013 period, health has grown as a share of total ODA, reflecting its priority among donors. In addition, 2013 marked the greatest increase in donor funding for health over the entire period. Given the OECD's announcement that total ODA in 2014 remained essentially flat,[16] and the development of new health targets as part of the SDGs, how health, which has been an important sector for donors, fares in the future years will be important to assess.

Annex 1: Figures

Figure 1: ODA Disbursements for Health, 2002-2013



NOTES: Amounts in gross US$ disbursements. Health ODA combines data from three OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS.
SOURCE: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS); September 14, 2015.

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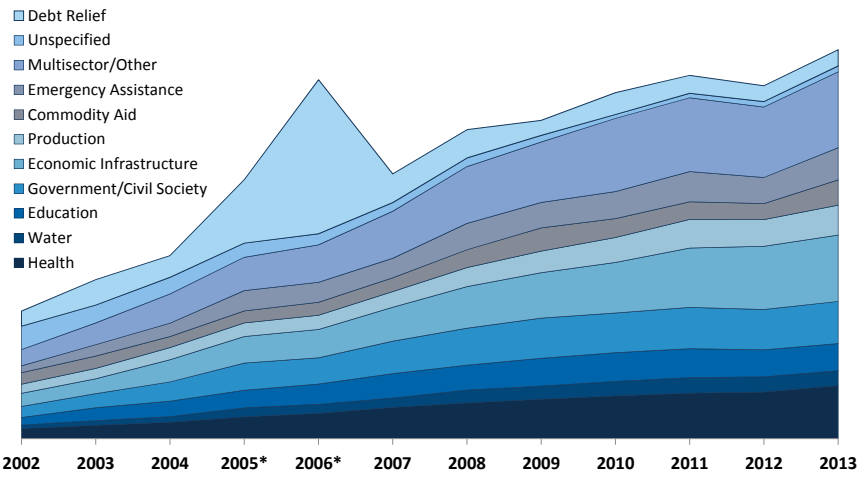
Figure 2: Total ODA Disbursements by Sector, 2002-2013



NOTES: Amounts in gross US$ disbursements. Health ODA combines data from three OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS. ODA in 2005 and 2006 was higher than previous and subsequent years due to scheduled and significant additional debt relief transactions.
SOURCE: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS); September 14, 2015.

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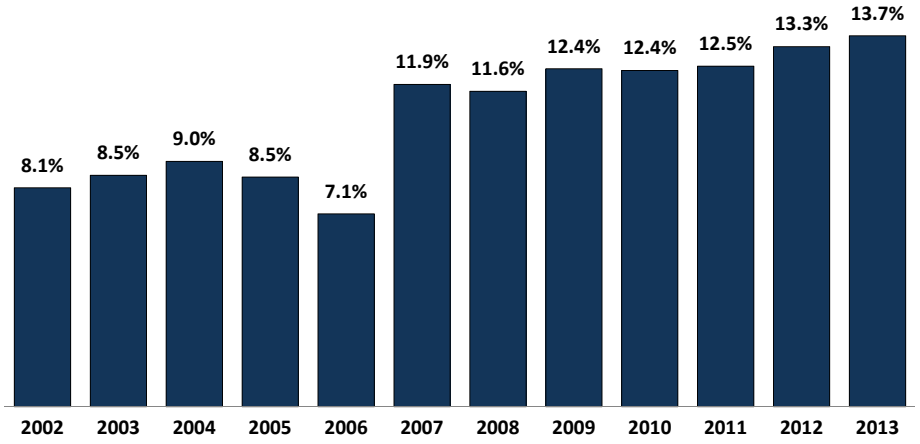
Figure 3: ODA Disbursements for Health as a Percentage of Total ODA, 2002-2013



NOTES: Amounts in gross US$ disbursements. Health ODA combines data from three OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS.
SOURCE: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS); September 14, 2015.

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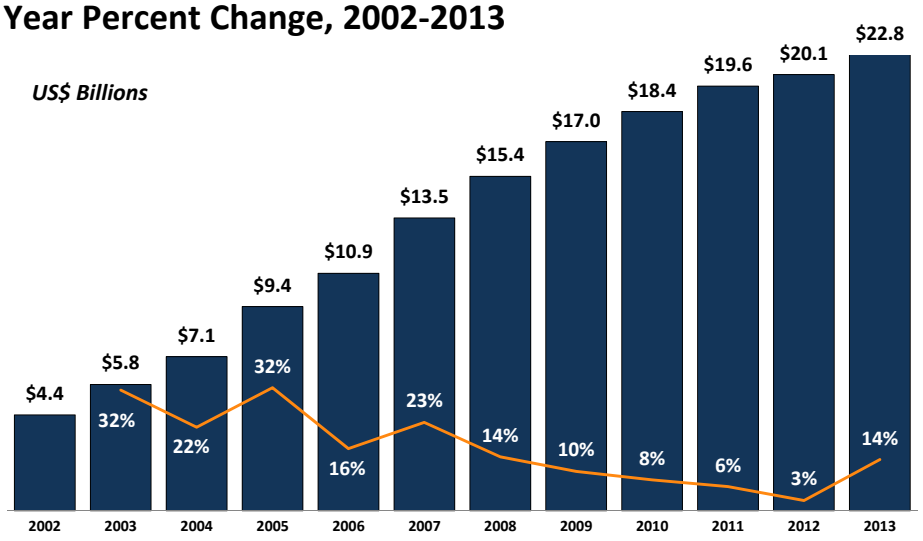
Figure 4: Annual ODA Disbursements for Health & Year-to-Year Percent Change, 2002-2013



NOTES: Amounts in gross US$ disbursements. Health ODA combines data from three OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS.
SOURCE: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS); September 14, 2015.

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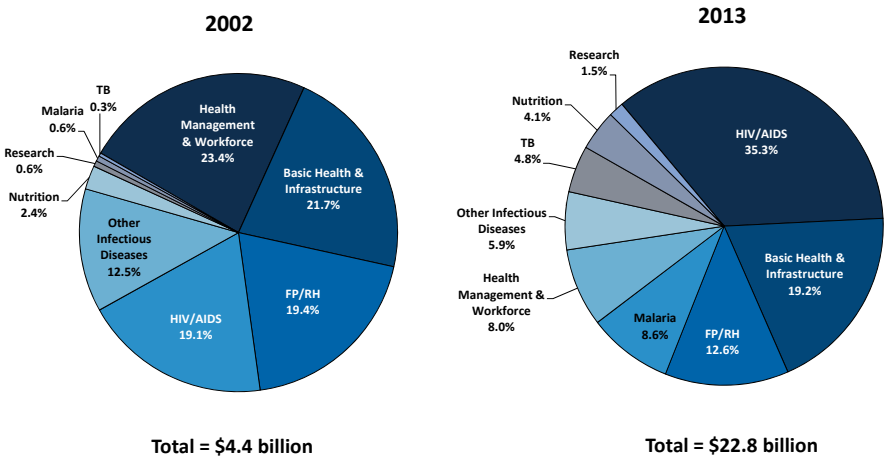
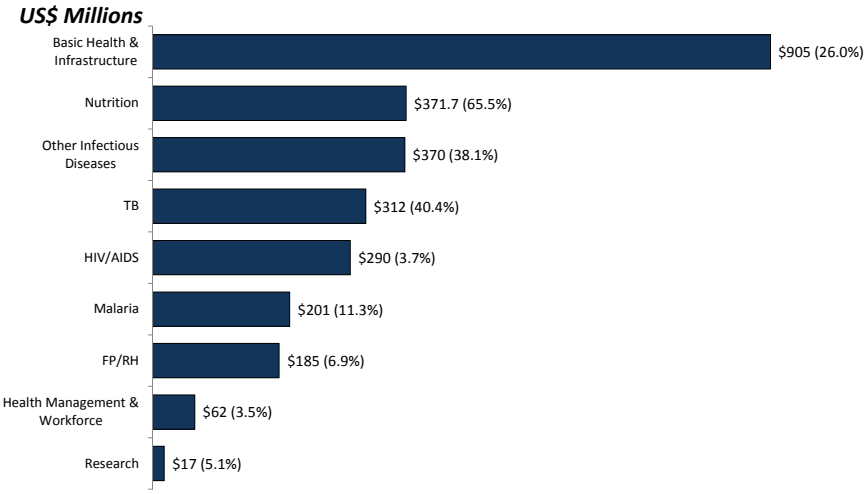
Figure 5: Major Sub-Sector Share of Health ODA, 2002 & 2013



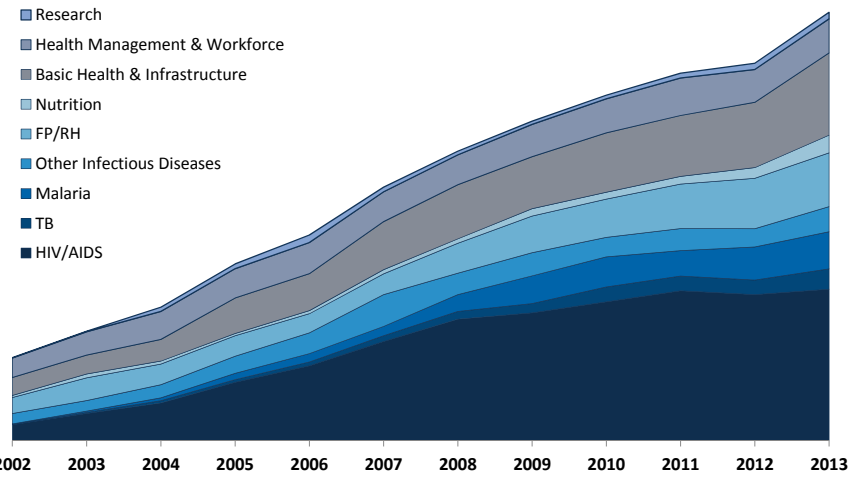
NOTES: Amounts in gross US$ disbursements. Health ODA combines data from three OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS.
SOURCE: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS); September 14, 2015.

Figure 6: Change in Health ODA Disbursements by Major Sub-Sector, 2012-2013



NOTE: Amounts in gross US$ disbursements. Health ODA combines data from three OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS.
SOURCE: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS); September 14, 2015.

Figure 7: Health ODA Disbursements by Major Sub-Sector, 2002-2013



NOTES: Amounts in gross US$ disbursements. Health ODA combines data from three OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS.
SOURCE: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS); September 14, 2015.

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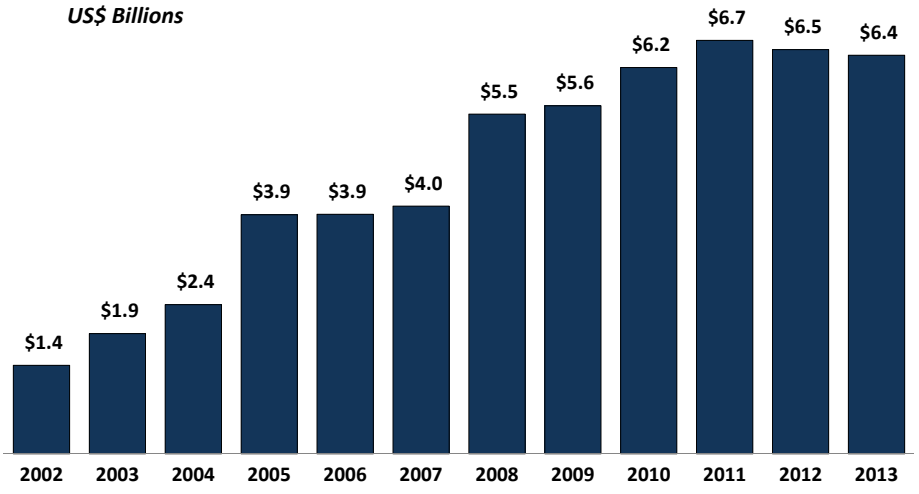
Figure 8: ODA Disbursements for Water, 2002-2013



NOTES: Amounts in gross US$ disbursements. Health ODA combines data from three OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS.
SOURCE: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS); September 14, 2015.

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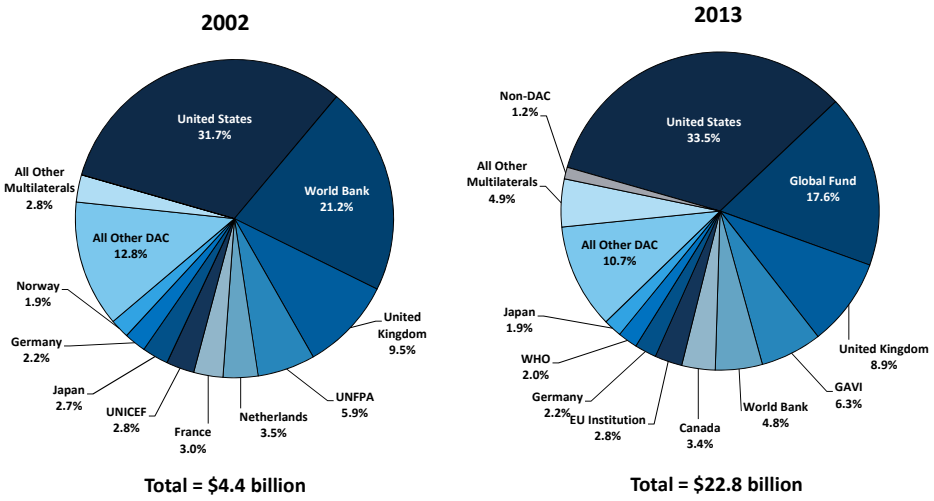
Figure 9: Top 10 Donors for Health ODA, 2002 & 2013



NOTES: Amounts in gross US$ disbursements. Health ODA combines data from three OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS.
SOURCE: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS); September 14, 2015.

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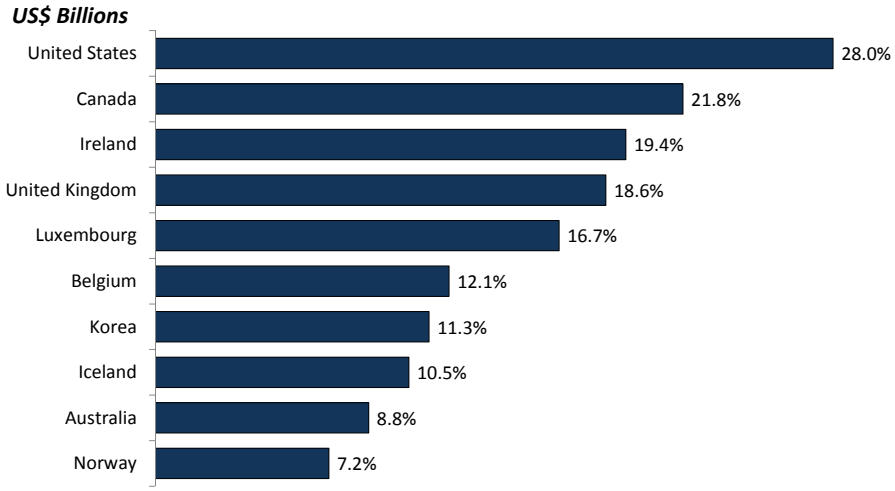
Figure 10: Top 10 Donor Governments by Health ODA as a Percentage of Total ODA, 2013



NOTES: Amounts in gross US$ disbursements. Health ODA combines data from three OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS.
SOURCE: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS); September 14, 2015.

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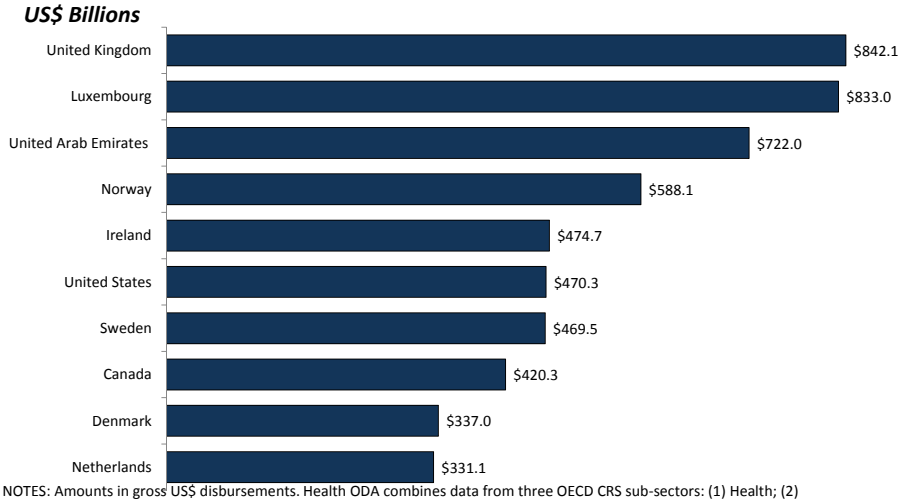
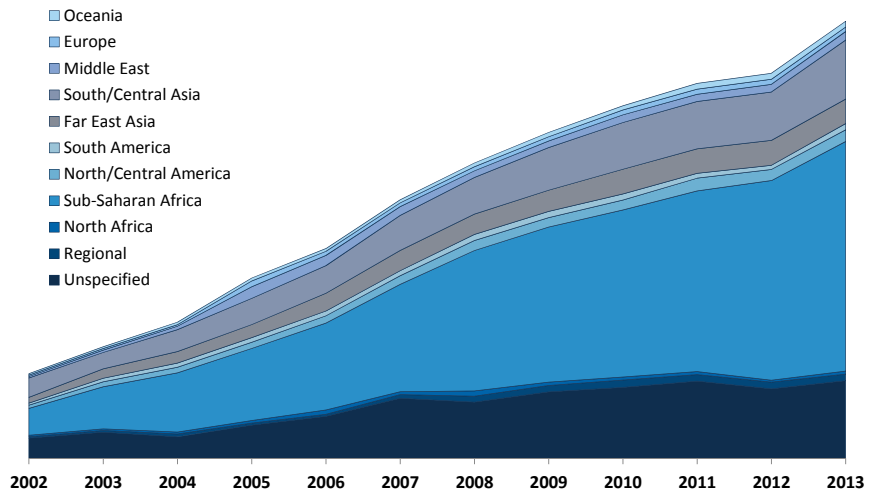
Figure 11: Top 10 Donor Governments by Health ODA per US$1 Million GDP, 2013



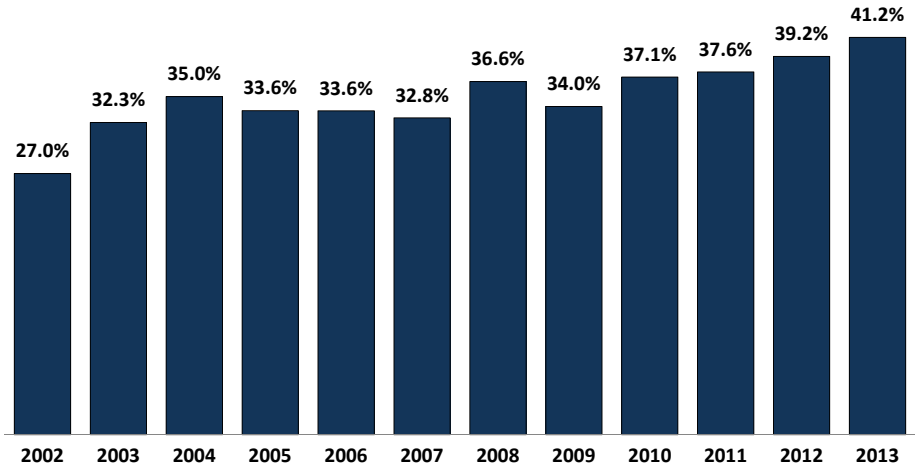
NOTES: Amounts in gross US$ disbursements. Health ODA combines data from three OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS.
SOURCE: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS) on September 14, 2015, and International Monetary Fund World Economic Outlook Database on September 15, 2015.

Figure 12: Health ODA Disbursements by Region, 2002-2013



NOTES: Amounts in gross US$ disbursements. Health ODA combines data from three OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS.
SOURCE: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS); September 14, 2015.

Figure 13: Health ODA Disbursements for LDCs as a Percentage of Total Health ODA, 2002-2013



NOTES: Amounts in gross US$ disbursements. Health ODA combines data from three OECD CRS sub-sectors: (1) Health; (2) Population Policies/Programs and Reproductive Health (includes HIV/AIDS & STDs); and (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS. Debt relief transactions are not included in this figure.
SOURCE: Analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS); September 14, 2015.

Annex 2: Data Tables

Total ODA by Major Sector, 2002-2013 Gross US$ Disbursements in Billions												
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Health	4.4	5.8	7.1	9.4	10.9	13.5	15.4	17.0	18.4	19.6	20.1	22.8
Water	1.4	1.9	2.4	3.9	3.9	4.0	5.5	5.6	6.2	6.7	6.5	6.4
Education	3.3	5.6	6.6	7.6	8.7	10.5	10.7	12.0	12.4	12.5	11.6	11.7
Government & Civil Society	4.8	6.0	8.3	11.7	11.3	13.9	15.9	17.2	17.0	17.7	17.3	18.1
Economic Infrastructure	5.6	6.4	9.5	11.4	12.1	14.6	17.8	19.5	21.7	25.5	27.1	28.5
Production	3.9	4.5	5.2	5.8	6.1	6.8	8.2	9.2	10.7	12.3	11.4	12.8
Commodity Aid	4.9	5.3	4.8	5.2	5.6	5.9	7.7	10.0	8.1	7.5	6.9	10.8
Debt Relief	6.5	10.9	9.3	27.2	66.1	12.3	12.2	6.5	9.4	7.7	6.8	7.0
Emergency Assistance	3.0	4.9	5.7	8.7	8.6	8.4	11.3	10.9	11.6	13.0	11.2	13.8
Multisector/Other	7.0	9.3	12.5	14.3	16.1	20.2	24.4	26.0	31.4	31.7	30.2	32.6
Unspecified	10.0	7.7	7.1	6.0	4.8	3.7	3.7	2.8	1.7	1.9	2.3	2.5
Total	**54.8**	**68.3**	**78.6**	**111.2**	**154.1**	**113.7**	**132.7**	**136.7**	**148.5**	**156.0**	**151.5**	**167.0**

Total Health ODA by Sub-Sector, 2002-2013 Gross US$ Disbursements in Billions												
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Basic Health & Infrastructure	1.0	1.0	1.2	1.9	2.0	2.6	2.9	2.8	3.2	3.2	3.5	4.4
Health Management & Work Force	1.0	1.2	1.5	1.6	1.7	1.6	1.6	1.7	1.8	2.0	1.8	1.8
Research	0.0	0.0	0.2	0.3	0.4	0.2	0.2	0.2	0.2	0.3	0.3	0.3
Nutrition	0.1	0.2	0.2	0.1	0.2	0.2	0.2	0.4	0.4	0.4	0.6	0.9
Other Infectious Diseases	0.6	0.6	0.7	0.9	1.1	1.7	1.1	1.2	1.0	1.2	1.0	1.3
Malaria	0.0	0.1	0.2	0.3	0.4	0.5	0.9	1.5	1.6	1.4	1.8	2.0
Tuberculosis	0.0	0.1	0.1	0.2	0.2	0.3	0.4	0.5	0.8	0.8	0.8	1.1
FP/RH	0.9	1.2	1.1	1.1	1.0	1.1	1.6	1.9	2.0	2.4	2.7	2.9
HIV/AIDS	0.8	1.4	2.0	3.1	4.0	5.3	6.5	6.8	7.4	8.0	7.8	8.1
Total	**4.4**	**5.8**	**7.1**	**9.4**	**10.9**	**13.5**	**15.4**	**17.0**	**18.4**	**19.6**	**20.1**	**22.8**

Total Health ODA by Region, 2002-2009 Gross US$ Disbursements in Billions												
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Europe	0.1	0.1	0.1	0.3	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.2
North Africa	0.1	0.1	0.1	0.1	0.2	0.2	0.3	0.2	0.2	0.2	0.1	0.2
Sub-Saharan Africa	1.4	2.2	3.1	3.8	4.5	5.6	7.3	8.1	8.7	9.4	10.4	12.0
North & Central America	0.2	0.3	0.3	0.3	0.4	0.4	0.5	0.5	0.5	0.7	0.6	0.6
South America	0.1	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.2	0.3
Far East Asia	0.3	0.5	0.6	0.7	0.9	1.1	1.1	1.1	1.3	1.3	1.3	1.3
South & Central Asia	1.0	0.9	1.1	1.4	1.4	1.8	1.9	2.2	2.4	2.5	2.5	3.1
Middle East	0.1	0.1	0.2	0.6	0.5	0.5	0.3	0.3	0.4	0.4	0.4	0.4
Oceania, Total	0.1	0.1	0.1	0.2	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3
Regional	0.1	0.1	0.2	0.1	0.1	0.2	0.3	0.3	0.4	0.3	0.4	0.3
Developing Countries unspecified	1.0	1.4	1.1	1.7	2.2	3.1	2.9	3.5	3.7	4.0	3.6	4.1
Total	**4.4**	**5.8**	**7.1**	**9.4**	**10.9**	**13.5**	**15.4**	**17.0**	**18.4**	**19.6**	**20.1**	**22.8**

Health ODA by Donor 2002-2003 Gross US$ Disbursements in Billions												
Donors	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
Australia	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.3	0.5	0.5	0.4
Austria	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Belgium	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2
Canada	0.1	0.1	0.2	0.3	0.2	0.4	0.4	0.4	0.4	0.7	0.7	0.8
Czech Republic	-	-	-	-	-	-	-	-	-	0.0	0.0	0.0
Denmark	-	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.1	0.1
EU Institutions	0.1	0.1	0.2	0.4	0.6	0.7	0.7	0.6	0.5	0.7	0.5	0.6
Finland	0.0	0.0	-	-	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
France	0.1	0.2	0.2	0.3	0.3	0.1	0.4	0.3	0.4	0.2	0.2	0.3
Germany	0.1	0.2	0.2	0.2	0.2	0.4	0.4	0.4	0.5	0.4	0.4	0.5
Greece	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Iceland	-	-	-	-	-	-	-	-	-	0.0	0.0	0.0
Ireland	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.1
Italy	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.1
Japan	0.1	0.3	0.3	0.3	0.4	0.4	0.3	0.4	0.4	0.4	0.5	0.4
Korea	-	-	-	-	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.2
Luxembourg	-	-	0.0	0.0	0.0	0.1	0.1	0.0	0.1	0.0	0.0	0.1
Netherlands	0.2	0.2	0.2	0.2	0.3	0.3	0.4	0.4	0.3	0.3	0.3	0.3
New Zealand	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Norway	0.1	0.1	0.1	0.2	0.2	0.2	0.3	0.3	0.2	0.2	0.2	0.3
Poland	-	-	-	-	-	-	-	-	-	-	-	0.0
Portugal	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Slovak Republic	-	-	-	-	-	-	-	-	-	-	-	0.0
Slovenia	-	-	-	-	-	-	-	-	0.0	0.0	0.0	0.0
Spain	0.1	0.1	0.1	0.1	0.1	0.2	0.4	0.3	0.3	0.2	0.1	0.1
Sweden	0.1	0.1	0.2	0.2	0.3	0.3	0.3	0.2	0.2	0.2	0.3	0.3
Switzerland	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1
United Kingdom	0.4	0.4	0.5	0.6	0.9	1.1	1.0	1.1	1.2	1.5	1.7	2.0
United States	1.4	2.0	2.1	3.1	3.6	4.2	5.3	6.1	6.4	7.2	7.0	7.6
Total - DAC*	**3.0**	**4.1**	**4.8**	**6.6**	**8.0**	**9.3**	**11.0**	**11.6**	**12.0**	**13.3**	**13.2**	**14.4**
AfDB (African Dev. Bank)	-	-	-	-	-	-	-	-	-	0.0	0.0	0.0
AfDF (African Dev.Fund)	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0
Arab Fund (AFESD)	-	-	-	-	-	-	0.0	0.0	0.0	0.0	0.0	0.0
AsDB Special Funds	-	-	-	-	-	-	-	-	0.2	0.1	0.1	0.1
BADEA	-	-	-	-	-	-	-	-	-	0.0	0.0	0.0
GAVI	-	-	-	-	-	0.9	0.7	0.4	0.7	0.7	1.0	1.4
GEF	-	-	-	-	-	-	0.0	-	-	-	-	-
Global Fund	-	0.2	0.6	1.0	1.3	1.6	2.2	2.3	3.0	2.6	3.4	4.0
IDA	0.9	0.8	1.2	1.2	1.0	0.9	0.8	1.0	0.9	1.1	0.9	1.1
IDB Sp.Fund	-	-	-	-	-	-	-	0.0	0.0	0.1	0.0	0.0
OFID	-	-	-	-	-	-	-	0.0	0.0	0.0	0.0	0.0
UNAIDS	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.3	0.2	0.2
UNDP	-	-	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
UNECE	-	-	-	-	-	-	0.0	0.0	0.0	0.0	0.0	0.0
UNFPA	0.3	0.4	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.4
UNICEF	0.1	0.1	0.1	0.2	0.1	0.2	0.1	0.2	0.2	0.2	0.2	0.2
UNPBF	-	-	-	-	-	-	-	0.0	0.0	-	0.0	-
UNRWA	-	-	-	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
WFP	-	-	-	-	-	-	-	0.0	0.0	0.0	0.0	0.0
WHO	-	-	-	-	-	-	-	0.4	0.4	0.4	0.4	0.5
Total - Multilateral*	**1.4**	**1.7**	**2.3**	**2.8**	**3.0**	**4.2**	**4.5**	**5.3**	**6.3**	**6.2**	**6.8**	**8.1**
Estonia	-	-	-	-	-	-	-	-	-	-	-	0.0
Kuwait (KFAED)	-	-	-	-	-	-	-	-	0.0	0.0	0.0	0.0
United Arab Emirates	-	-	-	-	-	-	-	0.1	0.0	0.1	0.2	0.3
Total - Non-DAC	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**0.1**	**0.1**	**0.1**	**0.2**	**0.3**
Total - All Donors	**4.4**	**5.8**	**7.1**	**9.4**	**10.9**	**13.5**	**15.4**	**17.0**	**18.4**	**19.6**	**20.1**	**22.8**

*The OECD DAC and CRS databases include EC funding as part of the multilateral sector; for the purposes of this report, the EC is considered a donor government rather than a multilateral organization

Annex 3: CRS Sectors and Sub-sectors Used in This Analysis

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

DAC 5 CODE	CRS CODE	DESCRIPTION	Clarifications / Additional notes on coverage
140		**WATER AND SANITATION**	
	14010	Water sector policy and administrative management	Water sector policy and governance, including legislation, regulation, planning and management as well as transboundary management of water; institutional capacity development; activities supporting the Integrated Water Resource Management approach (IWRM: see box below).
	14015	Water resources conservation (including data collection)	Collection and usage of quantitative and qualitative data on water resources; creation and sharing of water knowledge; conservation and rehabilitation of inland surface waters (rivers, lakes etc.), ground water and coastal waters; prevention of water contamination.
	14020	Water supply and sanitation - large systems	Programmes where components according to 14021 and 14022 cannot be identified. When components are known, they should individually be reported under their respective purpose codes: water supply [14021], sanitation [14022], and hygiene [12261].
	14021	Water supply - large systems	Potable water treatment plants; intake works; storage; water supply pumping stations; large scale transmission / conveyance and distribution systems.
	14022	Sanitation - large systems	Large scale sewerage including trunk sewers and sewage pumping stations; domestic and industrial waste water treatment plants.
	14030	Basic drinking water supply and basic sanitation	Programmes where components according to 14031 and 14032 cannot be identified. When components are known, they should individually be reported under their respective purpose codes: water supply [14031], sanitation [14032], and hygiene [12261].
	14031	Basic drinking water supply	Rural water supply schemes using handpumps, spring catchments, gravity-fed systems, rainwater collection and fog harvesting, storage tanks, small distribution systems typically with shared connections/points of use. Urban schemes using handpumps and local neighbourhood networks including those with shared connections.
	14032	Basic sanitation	Latrines, on-site disposal and alternative sanitation systems, including the promotion of household and community investments in the construction of these facilities. (Use code 12261 for activities promoting improved personal hygiene practices.)
	14040	River basins' development	Infrastructure focused integrated river basin projects and related institutional activities; river flow control; dams and reservoirs [excluding dams primarily for irrigation (31140) and hydropower (23065) and activities related to river transport (21040)].
	14050	Waste management / disposal	Municipal and industrial solid waste management, including hazardous and toxic waste; collection, disposal and treatment; landfill areas; composting and reuse.
	14081	Education and training in water supply and sanitation	Education and training for sector professionals and service providers.

Source: OECD, The CRS List of Purpose Codes

Methodology

Data for this analysis were obtained on September 14, 2015 using the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS) (available at: www.oecd.org/dataoecd/50/17/5037721.htm). Data represent "official development assistance" (ODA), defined by the OECD as funding provided to low- and middle-income countries as determined by per capita Gross National Income (GNI), excluding any funding to countries that are members of the Group of Eight (G8) or the European Union (EU), including those with a firm date for EU admission.[20] It is important to note that the OECD no longer collects data on "official aid" (OA), funding provided to countries and territories in transition, such as some of those in Central and Eastern Europe and the former Soviet States, although some do receive significant donor support for health.

Data are in nominal dollars, not adjusted for inflation or exchange rate fluctuations (unless otherwise noted) and represent gross annual new grant, concessional loan and/or equity investment disbursements in US$, from 2002-2013. ODA totals used in this paper have not been adjusted to reflect offsets corresponding to prior-loan repayments, which are neither identifiable with sub-sector financing nor universally available to lenders for re-obligation. To adjust figures for inflation and exchange rate changes, published DAC deflators were used. They are available at http://www.oecd.org/document/6/0,3343,en_2649_34447_41007110_1_1_1_1,00.html

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

The sub-sectors used in this analysis are derived from the OECD CRS "Health", "Population Policies/Programs and Reproductive Health" and "Other Social Infrastructure and Services – Social Mitigation of HIV/AIDS" sub-sectors as follows:

Sub-Sector	OECD Sub-sector Codes
Basic Health & Infrastructure	12191 - Medical services 12220 - Basic health care 12230 - Basic health infrastructure 12261 - Health education
Health Management & Workforce	12110 - Health policy and administrative management 12181 - Medical education/training 12281 - Health personnel development
Research	12182 - Medical research
Nutrition	12240 - Nutrition
Other Infectious Diseases	12250 - Infectious disease control
Malaria	12262 - Malaria control
TB	12263 - Tuberculosis control
FP/RH	13010 - Population policy and administrative management 13020 - Reproductive health care 13030 - Family planning 13081 - Personnel development for population and reproductive health
HIV/AIDS	13040 - STD control including HIV/AIDS 16064 - Social Mitigation of HIV/AIDS

Data for the European Commission (EC) represent funds from the European Union's budget, as distinct from funding from member state budgets. The OECD DAC and CRS databases include EC funding as part of the multilateral sector; for the purposes of this paper, the EC is considered a donor government rather than a multilateral organization.

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

Endnotes

[1] KFF. Financing the Response to AIDS in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2014; July 14, 2015.

[2] See the Global Fund, www.theglobalfund.org/.

[3] See PEPFAR, www.pepfar.gov/.

[4] Data in this report are not directly comparable to prior year reports. First, prior to 2011, reports analyzed commitments, not disbursements, as reported here. Second, donors may change data in the DAC database over time and this report reflects the most current data for the period, as of the data extraction date. Finally, prior Kaiser reports analyzed donor contributions to health as defined by the OECD DAC, but expanded this definition to include the water sector. Starting with the 2011 report, the water sector has been considered as a separate sector.

[5] "Health" funding in this analysis combines data from three OECD CRS subsectors: (1) Health; (2) Population Policies/Programs & Reproductive Health (which includes HIV/AIDS & STDs); & (3) Other Social Infrastructure and Services - Social Mitigation of HIV/AIDS. The first 2 constitute the OECD's statistical definition of health (see, OECD. Recent Trends in Official Development Assistance to Health, 2006).

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

[7] Author analysis of data obtained via online query of the OECD Development Assistance Committee (DAC) Database and Creditor Reporting System (CRS), November 7, 2012 (www.oecd.org/dataoecd/50/17/5037721.htm).

[8] The 24 DAC member governments are: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Japan, Luxembourg, Netherlands, New Zealand, Norway, Portugal, South Korea, Spain, Sweden, Switzerland, United Kingdom, United States, and European Commission.

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

[10] See, for example: Grepin KA, Leach-Kemon K, Schneider M, Sridar D. "How to do (or not to do) . . . Tracking data on development assistance for health", Health Policy and Planning; 27: 527-534; 2012; Murray CJL, Anderson B, Burstein R, Leach-Kemon K, Schneider M, Tardiff A, Zhang R. "Development Assistance for Health: Trends and Prospects", Lancet; 378: 8-10; July 2011; Ravishankar N, Gubbins P, Cooley RJ, Leach-Kemon K, Michaud CM, Jamison DT, Murray CJL. "Financing of global health: tracking development assistance for health from 1990 to 2007", Lancet; 373: 2113–24; June 20, 2009; Schieber GJ et al. "Financing Global Health: Mission Unaccomplished," Health Affairs, Vol. 26, No. 4, July/August 2007.

[11] See OECD. "Development: Aid to developing countries falls because of global recession." http://www.oecd.org/dac/aidstatistics/developmentaidtodevelopingcountriesfallsbecauseofglobalrecession.htm.

[12] See also: OECD, "Development Aid from OECD Countries Fell 5.1% in 2006," April 3, 2007 (http://www.oecd.org/document/17/0,2340,en_2649_201185_38341265_1_1_1_1,00.html).

[13] 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.)

[14] 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.

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

[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 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.

[17] The U.S. reports its maternal and child health (MCH) funding under several CRS sub-sectors. In recent years, this funding has largely be reported under the "Reproductive health care" (13020) subsector. As a result, funding for the family planning and reproductive health subsector may appear higher than its true value.

[18] See OECD, "Non-DAC Countries reporting their development assistance to the DAC," http://www.oecd.org/dac/aidstatistics/non-daccountriesreportingtheirdevelopmentassistancetothedac.htm

[19] See Global Fund Donors and Contributions, http://www.theglobalfund.org/en/about/donors/public/.

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

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