

# FINANCING GLOBAL HEALTH 2012:

THE END OF THE GOLDEN AGE?

INSTITUTE FOR HEALTH METRICS AND EVALUATION

UNIVERSITY OF WASHINGTON



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Institute for Health Metrics and Evaluation  
2301 Fifth Ave., Suite 600  
Seattle, WA 98121  
USA  
[www.healthmetricsandevaluation.org](http://www.healthmetricsandevaluation.org)

To request copies of this report, please contact:  
Telephone: +1-206-897-2800  
Fax: +1-206-897-2899  
Email: [comms@healthmetricsandevaluation.org](mailto:comms@healthmetricsandevaluation.org)

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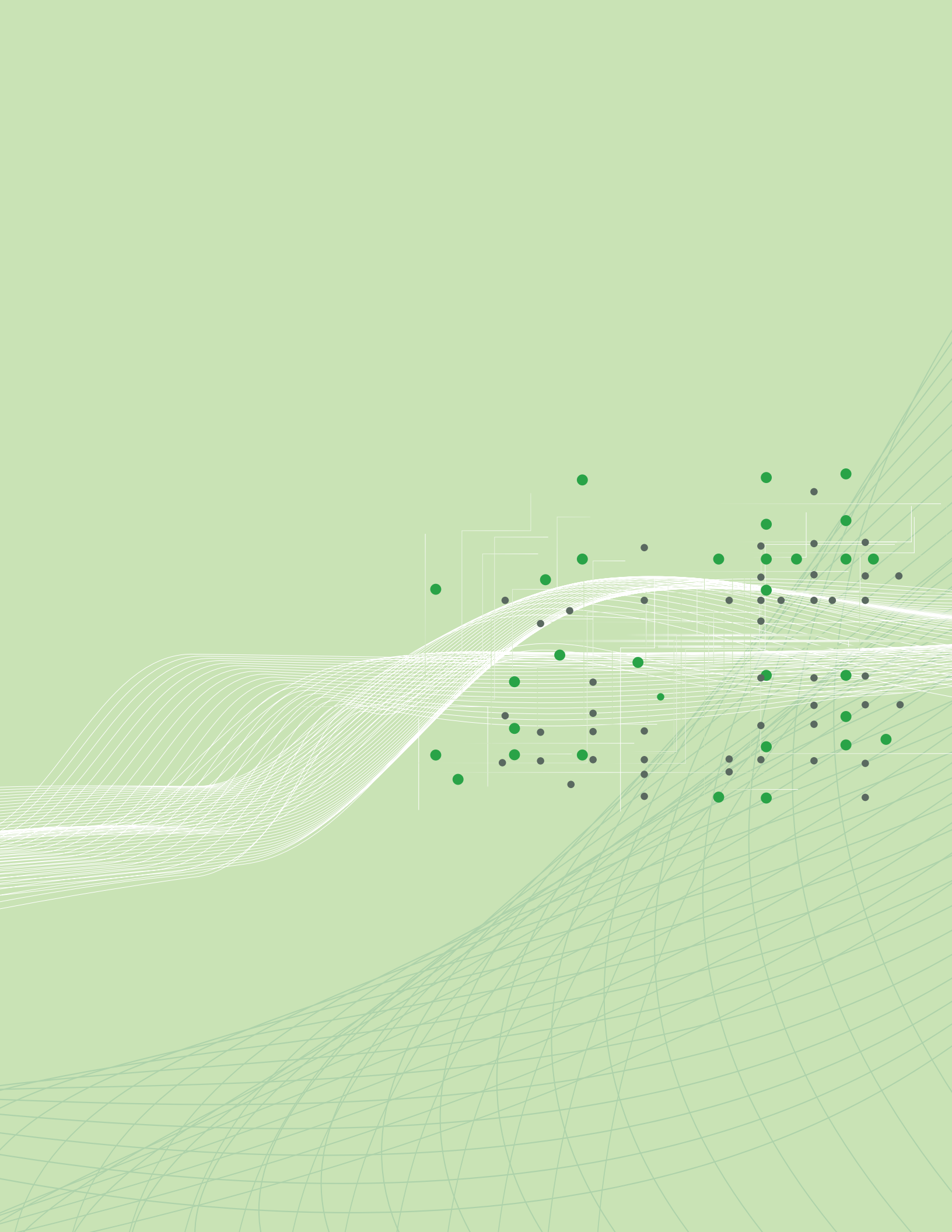
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# FINANCING GLOBAL HEALTH 2012:

## THE END OF THE GOLDEN AGE?

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## ABOUT IHME

The Institute for Health Metrics and Evaluation (IHME) is an independent global health research center at the University of Washington that provides rigorous and comparable measurement of the world's most important health problems and evaluates the strategies used to address them. IHME makes this information freely

available so that policymakers have the evidence they need to make informed decisions about how to allocate resources to best improve population health.

For more information, please visit <http://www.healthmetricsandevaluation.org>.

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## ABOUT *FINANCING GLOBAL HEALTH 2012*

The 2012 edition of *Financing Global Health* is IHME's fourth annual report on the subject of global health expenditure. Tracking development assistance for health (DAH) and government health expenditure (GHE) is a key part of IHME's research agenda. Every year, IHME commits a considerable amount of resources to collecting and analyzing DAH and GHE data. These estimates provide decision-makers and other global health stakeholders with an overview of the extent of funds devoted to health. This report ensures decisions can be informed by the most accurate and up-to-date data. When funding gaps and investment opportunities are identified in a timely manner, the global health community is better able to respond.

In this year's report, IHME built on its past data collection and analysis efforts to monitor the resources made available through DAH and GHE in 2012.

- **Development assistance for health:** IHME collected information from entities that contributed to DAH from 1990 to 2012. Annual reports, publicly available data, and information acquired via correspondence feed into IHME's DAH dataset. Some data are verified through conversations with the respective organizations. All data are then processed into a useable format. Our dataset is complete up to 2010. Some data are available for 2011 and 2012, but not for all organizations tracked. When 2011 or 2012 data are not available, we use statistical models to analyze budget data and historical trends to produce preliminary estimates.
- **Government health expenditure:** Data produced by the World Health Organization for the period of 1995 to 2010 are used to estimate GHE. IHME analyzes this dataset to approximate how much governments spend on health-related activities, how these expenditures change over time, and to what extent DAH impacts government spending.

## RESEARCH TEAM

(Listed alphabetically)

**Benjamin PC Brooks, BS**

*Post-Bachelor Fellow  
IHME*

**Joseph Dieleman, MA**

*Research Assistant  
IHME*

**Joseph Frostad, BA**

*Post-Bachelor Fellow  
IHME*

**Casey Graves, BA**

*Data Analyst  
IHME*

**Annie Haakenstad, MA**

*Project Officer  
IHME*

**Michael Hanlon, PhD**

*Lecturer, Global Health  
IHME*

**Rouselle Lavado, PhD**

*Post-Graduate Fellow  
IHME*

**Katherine Leach-Kemon, MPH**

*Data Development Manager  
IHME*

**Christopher JL Murray, MD DPhil**

*Institute Director and Professor, Global Health  
IHME*

**Annette Tardif, MA**

*Data Analyst  
IHME*

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Finally, we would like to extend our gratitude to the Bill & Melinda Gates Foundation for generously funding IHME and for its consistent support of this research and report.

## ACRONYMS

<b>AMFm</b>	Affordable Medicines Facility – malaria	<b>MDG</b>	Millennium Development Goal
<b>ARV</b>	Antiretroviral	<b>MNCH</b>	Maternal, newborn, and child health
<b>BMGF</b>	Bill & Melinda Gates Foundation	<b>NCD</b>	Noncommunicable disease
<b>DAH</b>	Development assistance for health	<b>NGO</b>	Non-governmental organization
<b>DAH-G</b>	Development assistance for health channeled to governments	<b>ODA</b>	Official development assistance
<b>DAH-NG</b>	Development assistance for health channeled to non-governmental sectors	<b>OECD</b>	Organisation for Economic Co-operation and Development
<b>DALY</b>	Disability-adjusted life year	<b>OECD-DAC</b>	Organisation for Economic Co-operation and Development’s Development Assistance Committee
<b>DFID</b>	UK Department for International Development	<b>PAHO</b>	Pan American Health Organization
<b>DRC</b>	Democratic Republic of the Congo	<b>PEPFAR</b>	US President’s Emergency Plan for AIDS Relief
<b>EC</b>	European Commission	<b>PMTCT</b>	Preventing mother-to-child transmission of HIV
<b>G8</b>	Group of Eight	<b>TB</b>	Tuberculosis
<b>GAVI</b>	GAVI Alliance (formerly the Global Alliance for Vaccines and Immunisation)	<b>UK</b>	United Kingdom
<b>GBD 2010</b>	Global Burden of Diseases, Injuries, and Risk Factors 2010 Study	<b>UN</b>	United Nations
<b>GDP</b>	Gross domestic product	<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>GFATM</b>	The Global Fund to Fight AIDS, Tuberculosis and Malaria	<b>UNFPA</b>	United Nations Population Fund
<b>GHE</b>	Government health expenditure	<b>UNICEF</b>	United Nations Children’s Fund
<b>GHE-A</b>	Government health expenditure as agent	<b>US</b>	United States
<b>GHE-S</b>	Government health expenditure as source	<b>USAID</b>	United States Agency for International Development
<b>HIV/AIDS</b>	Human immunodeficiency virus/ acquired immune deficiency syndrome	<b>WHO</b>	World Health Organization
<b>IBRD</b>	International Bank for Reconstruction and Development		
<b>IDA</b>	International Development Association		
<b>IHME</b>	Institute for Health Metrics and Evaluation		

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## EXECUTIVE SUMMARY

This year's *Financing Global Health* report confirms what many involved in development assistance for health (DAH) expected: After reaching a historic high in 2010, total DAH fell in 2011. However, the relatively small size of the drop is encouraging. Rather than falling sharply as expected, over the past two years DAH has been sustained at levels of spending that would have been inconceivable a decade ago. Despite continued macroeconomic stress, the international community continues to respond to the enduring need for health and health system support across the developing world.

Over the past 20 years, DAH has undergone three major phases of growth. From 1990 to 2001, a "moderate-growth" phase occurred in which annualized growth was a stable but modest 5.9%. Over this period, DAH nearly doubled, growing from \$5.7 billion in 1990 to \$10.8 billion in 2001. After 2001, DAH entered the quickly expanding "rapid-growth" period. Growth exceeded 11.2% on an annualized basis between 2001 and 2010 and almost tripled from 2001, climbing to \$28.2 billion in 2010. However, the advent of the financial crisis has led to stagnation in absolute DAH spending recently and the debut of the most recent "no-growth" phase starting in 2010. A total of \$28.1 billion was disbursed in 2012, a \$53 million drop from 2010. Irrespective of the recent plateau in spending, the long-term trajectory of DAH demonstrates the firm commitment of development assistance partners to realizing positive health outcomes around the world.

Examining the "rapid-growth" phase more closely reveals that the rise in DAH was driven by investments in several key areas. While spending increased in almost all health focus areas, this period was characterized by intensified efforts to combat HIV/AIDS, tuberculosis, and malaria. The launch of the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance (GAVI) propelled DAH growth higher from their respective inceptions to 2010. Support for non-governmental organizations also rose at a rapid clip as their role in DAH evolved from the turn of the century onward. During this stage, DAH provided to all regions increased, although sub-Saharan Africa received an increasing share of DAH vis-à-vis other regions of the world.

The recent stagnation of total DAH in the "no-growth" phase has not occurred without shifts within the

spending envelope. While the level of DAH was maintained from 2010 to 2012, some organizations spent more and others spent less. Throughout the report, the Institute for Health Metrics and Evaluation (IHME) explores the mix of sources, channels, recipients, and health focus areas that have made up these shifts. Also, while IHME's analytical work primarily focuses on DAH, this is not meant to eclipse the prominent role of government health expenditure (GHE); trends in GHE are also assessed in Chapter 5 of this report.

The key findings of *Financing Global Health 2012: The End of the Golden Age?* include:

### Development assistance for health

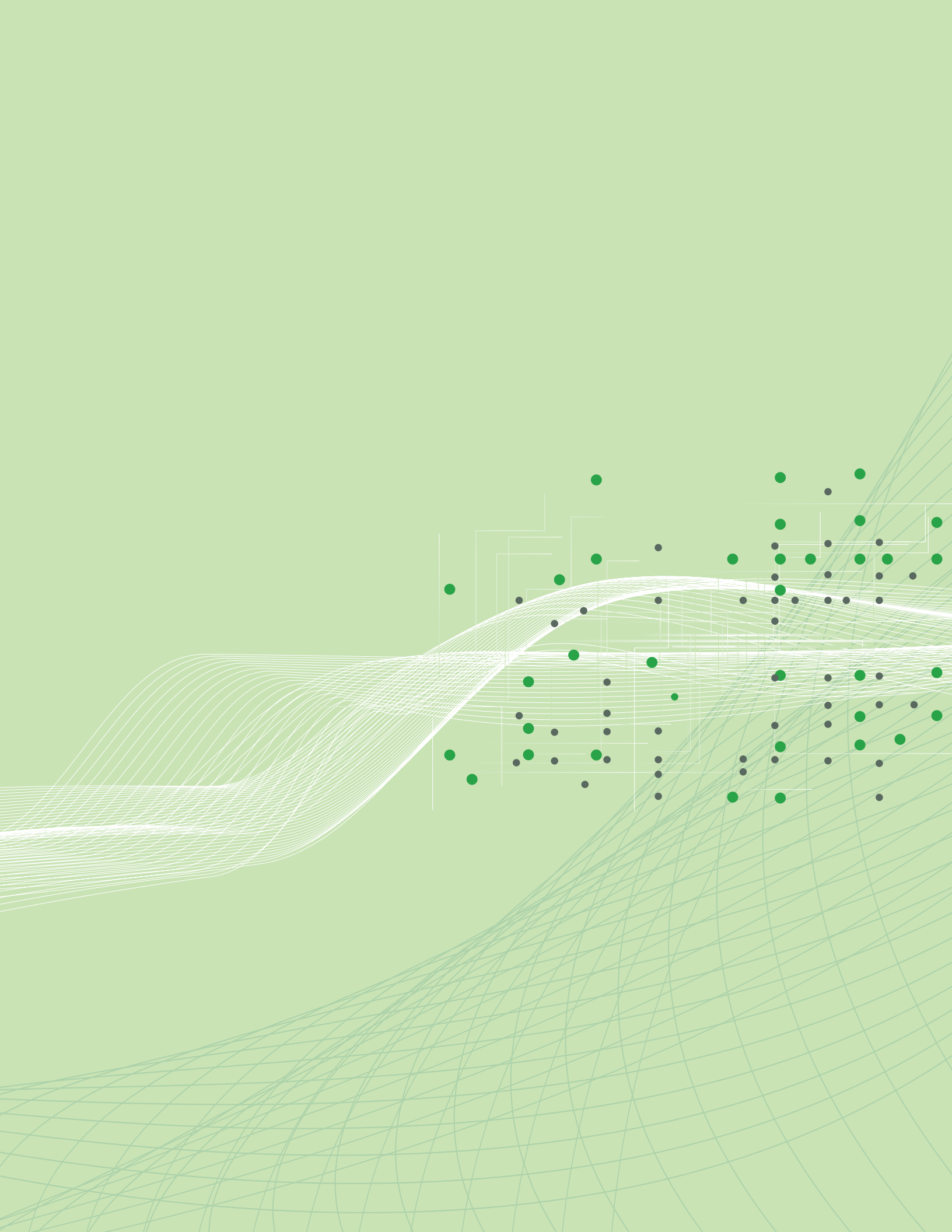
- According to IHME's preliminary estimates, total DAH in 2012 amounted to \$28.1 billion.<sup>i</sup> The 2012 year-over-year increase in DAH was 2.5%.
- In 2012, the DAH channeled through bilateral agencies decreased 4.4%. Among the six largest bilateral channels of DAH, only the spending by the United Kingdom and Australia increased from 2011 to 2012, at rates of 2.3% and 8.1%, respectively.
- GAVI continued to have very strong rates of growth. In 2012, expenditure by GAVI reached an estimated \$1.76 billion in 2012, a 41.9% increase over 2011.
- The sub-Saharan African region received the largest share of DAH. In 2010 (the most recent year for which recipient-level estimates are available), sub-Saharan Africa's share was \$8.1 billion, or 28.7% of total DAH.
- Many of the countries with the highest disease burdens do not receive the most DAH. Of the top 20 countries with the highest all-cause disability-adjusted life years (DALYs), only 12 are among the top 20 recipients of DAH. However, seven of the remaining eight countries are classified as middle income by the World Bank.
- With respect to the DAH allocated to specific health focus areas, DAH for HIV/AIDS, tuberculosis, and maternal, newborn, and child health continued to grow through 2010 (the most recent year for which focus area estimates are available). DAH for health sector support, noncommunicable diseases, and malaria fell slightly from 2009 to 2010.

<sup>i</sup>All dollar figures in this report are reported in 2010 US dollars.

## Government health expenditure

- Even at the peak of DAH in 2010, the spending by governments on health as sourced domestically (GHE-S) was \$521 billion, which was more than 18 times higher than total DAH in the same year. GHE-S grew 6% from 2009 to 2010 (the most recent year for which estimates are available).
- Governments in East Asia – primarily China – disbursed the most on health, at \$159.6 billion in 2010.
- Across the globe, the share of DAH funneled to governments (DAH-G) as a part of total spending by governments on health was typically less than 10%. However, in certain countries in Asia and Western and Southern Africa, DAH-G amounted to more than half of total government health expenditure.

The evolution of DAH over the past two decades illustrates the cumulative effect of a large number of decision-makers prioritizing population health. Major changes in the global health landscape have transpired during this time. The shifts in growth and spending emphasize the continued importance of tracking these funding flows, which ensures that decision-makers can make choices about resource allocation with full information.



## INTRODUCTION

Into 2012, the global economic and financial crisis continued to have an impact on development assistance for health (DAH). Donor governments and the entities they fund are facing pressure to cut budgets across all sectors. The Netherlands, Japan, Canada, Spain, and Italy are all projected to cut development aid over 2011 to 2013.<sup>1-6</sup> In fact, the majority of Organisation for Economic Co-operation and Development (OECD) countries have made cuts to aid budgets since 2011.<sup>7</sup> A brief assessment by the Development Policy Centre finds that very few countries will be able to meet the 0.7% gross domestic product (GDP) aid spending target, although a few remain committed to that goal.<sup>7</sup> The enduring impact of the crisis is reflected in our 2011 and 2012 preliminary estimates of DAH, which indicate that after a decade-long “golden age” of rapid growth, DAH has leveled off.

The mobilization of funds at the international level over the past decade has been crucial to accelerating progress toward the Millennium Development Goals (MDGs). In an assessment of Avahan, an HIV-prevention initiative in India, greater spending was significantly associated with reduced HIV rates.<sup>8</sup> An evaluation of Mexico’s Human Development Program Oportunidades shows that the program helped change health behaviors that led to improved health outcomes.<sup>9</sup> The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) reports to have supported the purchase of 200 million insecticide-treated bed nets.<sup>10</sup> Recent research published in *PLoS Medicine* finds that significant reductions in child mortality have accompanied the recent scale-up in insecticide-treated bed nets.<sup>11</sup> While these successes are notable, further efforts are needed to achieve the 2015 MDG targets. Consequently, these gains are overshadowed by concern about the potential for lower levels of DAH in the future.

As will be illustrated throughout *Financing Global Health 2012*, DAH has progressed through three distinct phases of growth. From 1990 to 2001, increases were modest and stable as DAH progressed through a “moderate-growth” phase. From 2001 to 2010, a “rapid-growth” phase took hold. This phase was propelled by the launch of new organizations dedicated to improving population health and health systems, as well as enhanced support on the part of traditional bilateral and multilateral partners. Finally,

more recently, DAH has entered a “no-growth” phase. DAH appears to have plateaued since its peak in 2010.

The pace of growth and the shifts in the composition of DAH have coincided with considerable changes in the macroeconomic landscape. Over the past decade, a number of developing countries have grown steadily, many of them attaining upper-middle income status. Meanwhile, OECD countries have recently faced economic hardships. While developed-country governments work to rein in spending, developing countries have managed to maintain their economic gains. Some recipient countries have themselves begun providing development assistance.

Traditional DAH channels are being forced to recalibrate policies and practices to adapt to a new global health financing landscape. As more low-income countries graduate to middle-income status, different countries become eligible to apply through the different funding mechanisms of the World Bank, GFATM, the GAVI Alliance (GAVI), and other DAH partners. This new reality is particularly pertinent given upcoming replenishment cycles. In 2013, the World Bank’s International Development Association (IDA), GFATM, and others will return to donor countries to refresh their funding pools. For some channels, a shrinking number of eligible countries will require the reconsideration of objectives and operating principles.

This evolution in funding is occurring as new information emerges about epidemiological profiles around the world. The Global Burden of Diseases, Injuries, and Risk Factors 2010 Study (GBD 2010), published in *The Lancet* in December 2012, revealed that while the world’s population is living longer, more and more people are suffering from noncommunicable diseases (NCDs) and injuries.<sup>12</sup> GBD 2010 was a comprehensive, multiyear research endeavor that engaged almost 500 collaborators to produce comparable estimates for more than 291 conditions and injuries and 67 risk factors. GBD 2010 also showed that ischemic heart disease was the leading cause of burden in 2010, followed by lower respiratory infections, diarrheal disease, and HIV/AIDS. Malaria and tuberculosis (TB) continue to make up a substantial proportion of the global burden. In fact, another recent study by the Institute for Health Metrics and Evaluation (IHME) found that malaria affects adult mortality significantly more than previously thought.<sup>13</sup>

GBD 2010 also found that child mortality and maternal disorders have declined, although one-fourth of the global burden is still due to disease and injuries in children under 5 years of age. Finally, mental health disorders and injuries are increasingly contributing to the global burden. In terms of the top causes, road injuries increased from a ranking of 12th to 10th (34% increase), while major depressive disorder increased from 15th to 11th (37% increase).

The information produced by GBD 2010 has led to a number of significant improvements in this edition of *Financing Global Health*. GBD 2010's comprehensive and comparable estimates of disability-adjusted life years (DALYs) considerably augment the precision with which we can relate the burden of disease to DAH. DALYs combine years of life lived with disability (YLDs, or years of life spent in a health state that is less than ideal) and years of life lost due to premature mortality (YLLs). DALYs serve as a comparable measurement of the impact of diseases and injuries across countries. This report pairs DALYs with DAH to assess DAH allocated

per DALY. Furthermore, while the World Bank's regional classifications are employed throughout the report, we also use GBD regions. The 21 GBD regions were developed to represent epidemiological profiles, based on levels of adult mortality, under-5 mortality, and the major drivers of health outcomes. For expositional convenience, these GBD regions are combined into super-regions throughout this report.

This year's report consists of chapters that emphasize the most important characteristics of DAH. Chapter 1 focuses on the broad trends in DAH and features our 2012 estimates as well as portrays changes in spending over time. In Chapter 2, we assess DAH by the destination of funds, and recipient-level trends are explored. Chapter 3 examines the diseases and other health focus areas targeted by DAH. In Chapter 4, we report the sources of DAH by country and channel. Lastly, in Chapter 5, we report trends in government health expenditure (GHE) in the developing world. A discussion of the methods of analysis and data collection can be found in Annex A, and Annex B contains the data itself.

CHAPTER 1:

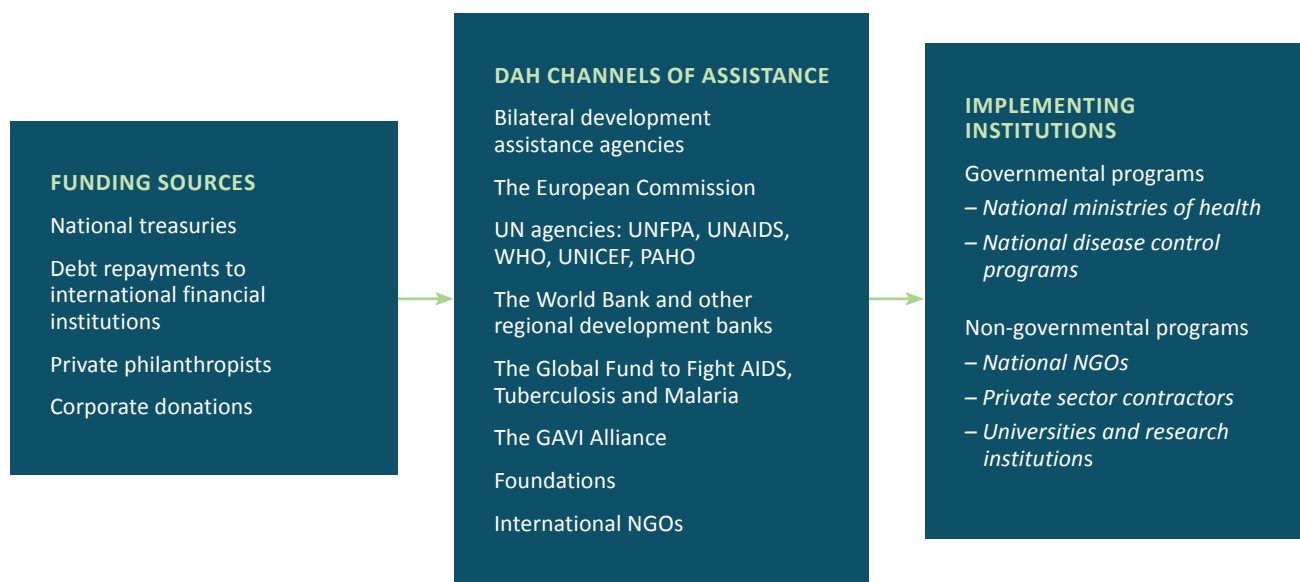
# OVERVIEW OF DEVELOPMENT ASSISTANCE FOR HEALTH TRENDS

Since the inception of the first edition of *Financing Global Health* in 2009, IHME has released up-to-date annual estimates of DAH from 1990 onward. This chapter relies on these estimates, including preliminary estimates for 2011 and 2012, to explore trends in DAH over the last two decades. The evolution of growth in DAH, as will be shown, varies from broader trends in official development assistance (ODA).

To facilitate the tracking of DAH, IHME utilizes a framework that identifies the entities involved in different steps of the transfer of DAH from source to recipient countries. Figure 1 represents this flow of funds. Isolating actors in this manner allows IHME to eliminate

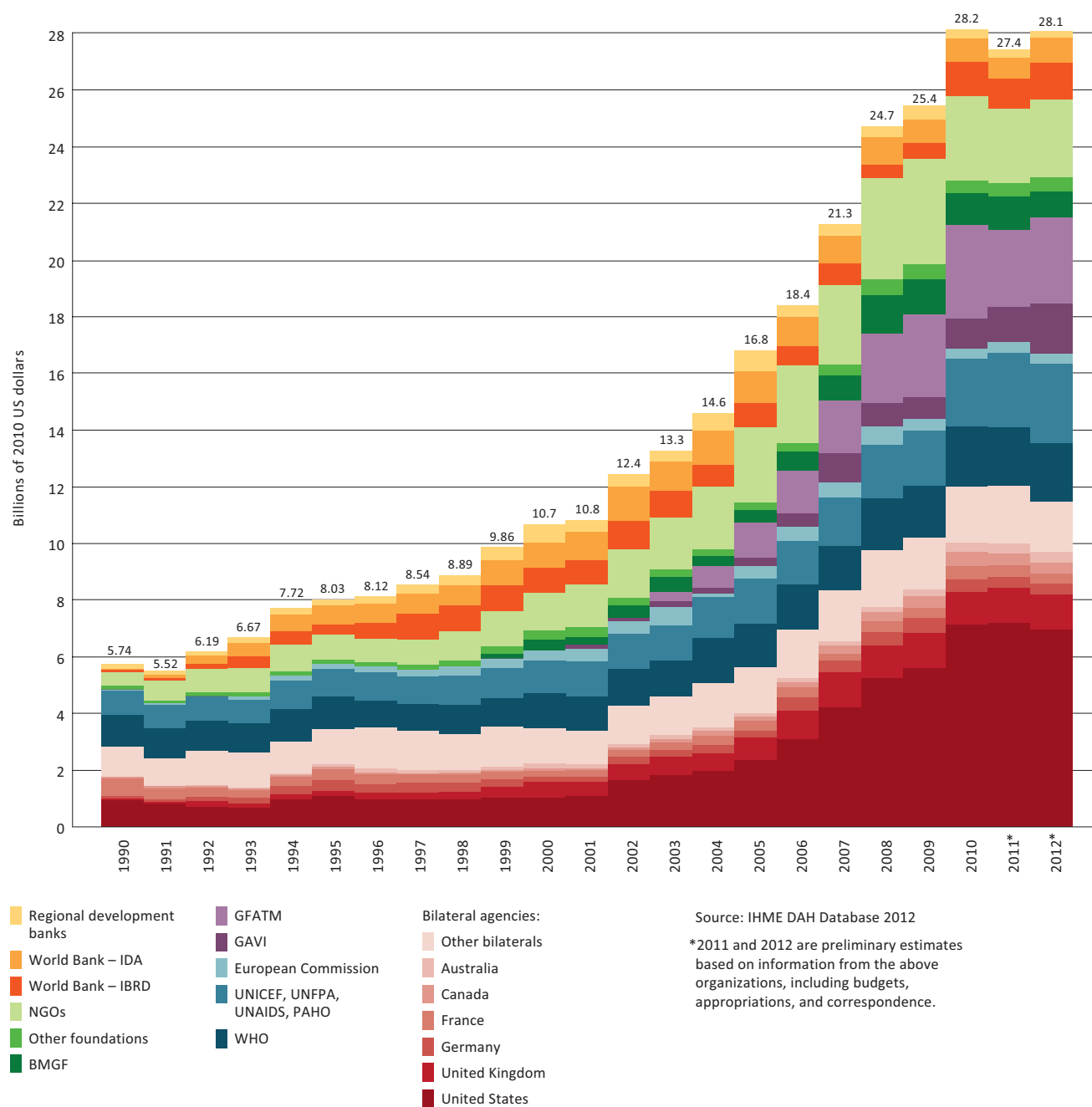
any double counting among resource flows.<sup>ii</sup> Sources constitute the origin of the financial resources available for DAH, and include national treasuries and private donors in developed countries and loan repayments by governments in developing countries. These resources are transferred through channels of assistance such as bilateral and multilateral development assistance entities, United Nations (UN) agencies, non-governmental organizations (NGOs), and development banks. These actors serve as intermediaries in the resource chain. Finally, IHME identifies implementing institutions as the governmental organizations or NGOs that execute programs to ameliorate health at the country level. A complexity of this framework is that, in some cases,

FIGURE 1:  
Resource flows for DAH



<sup>ii</sup> To produce estimates for each channel, funding that originates in one channel but flows through another is subtracted from the first. For example, funding from Germany that flows through GAVI would be subtracted from the total DAH counted as provided by Germany but would be included in the total for GAVI.

**FIGURE 2:**  
DAH by channel of assistance, 1990-2012



channels may also serve as implementing institutions. When a UN agency such as the World Health Organization (WHO) runs a polio-eradication campaign, for example, it is acting as both a channel and an implementing institution.

### DAH by channel of assistance

After two decades of consistent growth, our preliminary estimates show that DAH peaked in 2010. The

*Financing Global Health 2012* estimates reveal that DAH reached a historic high of \$28.2 billion in 2010, but fell in 2011 for the first time since DAH could be tracked. As shown in Figure 2, total DAH amounted to \$27.4 billion in 2011. This could be a short-term trend, as our preliminary 2012 estimates indicate a slight uptick from 2011, with DAH increasing to \$28.1 billion. However, projections for further cutbacks in development assistance do not augur well for a return to the rapid growth that punctuated the 2001 to 2010 era.

Examining growth in DAH since 1990 reveals three clear trends. From 1990 to 2001, DAH was marked by consistent but modest rates of growth. Annualized growth was 5.9% during this “moderate-growth” period. In 2001, however, DAH entered a period of “rapid growth.” From 2001 to 2010, growth proceeded at a very strong pace of 11.2% in annualized terms. Finally, our preliminary estimates suggest that DAH passed into a “no-growth” phase starting in 2010, with total DAH wavering around \$28 billion. DAH decreased less than 0.1% in annualized terms from 2010 to 2012.

Our 2011 and 2012 estimates of DAH correspond with the evolving response of OECD countries to the global financial crisis. Traditional development assistance partners, particularly in Europe, are adjusting to new fiscal and economic realities. As a result, bilateral aid agencies are being asked to tighten their budgets. Our preliminary 2012 estimates of DAH reflect these circumstances: On the whole, the DAH provided by bilateral agencies dropped 4.4% from 2011 to 2012. Among the six bilaterals contributing the most to DAH, aid from France dropped most substantially. Although French DAH fell 13% from 2011 to 2012, French bilateral spending nevertheless amounted to \$352 million in 2012. The drop in German DAH was the second most significant, with a 9.1% decrease. Even so, Germany persisted in contributing \$370 million of DAH through the end of 2012. Canada’s DAH also dropped 5.7% to \$379 million in 2012. Finally, DAH from the biggest source, the United States, fell 3.3%, disbursing \$7 billion of DAH in 2012.

Reductions in DAH did not occur uniformly across bilateral agencies. In fact, certain bilateral partners provided more DAH in 2012 than in 2011. The United Kingdom, because of a national decision to prioritize development assistance,<sup>14,15</sup> stands out among European countries for its commitment to DAH. The UK’s DAH rose 2.3% to \$1.3 billion in 2012. Australia, which has weathered the global financial crisis fairly well,<sup>16</sup> also contributed more DAH in 2012. Australia spent approximately \$407 million in 2012, an 8.1% gain over 2011.

Likewise, the trends in DAH varied among different multilateral organizations. On the whole, the UN agencies providing support to health and health systems continued their steady and consistent rise. UN DAH grew 3.4% in 2012. However, expenditure by the WHO fell 2% in 2012; total WHO disbursements amounted to only \$2.1 billion in 2012. This drop was offset by increased expenditure from other UN organizations included in our estimates, such as the United Nations

Children’s Fund (UNICEF) and United Nations Population Fund (UNFPA), which expanded by approximately 7.5%, to a total of \$2.8 billion in 2012.

Since 2000, public-private partnerships have played a key role in the global health field. GAVI continued to grow rapidly through 2012, as DAH disbursements increased to \$1.8 billion, a year-over-year change of 41.9%. GFATM, on the other hand, has not enjoyed the same level of support in recent years. In 2011, GFATM spending dropped 17% from 2010. GFATM recovered some of that loss in 2012, increasing by an estimated 12.3%. Despite this mild recovery, GFATM’s expenditure in 2012 remained below its 2010 peak of \$3.3 billion. Total GFATM spending in 2012 reached just under \$3.1 billion. The launch of a new GFATM funding model was announced in 2012, as the organization is entering a new replenishment period. This may have an effect on future spending, as it is anticipated to increase transparency and accountability as well as enhance GFATM’s impact.<sup>17</sup>

Different lending institutions also engage in disbursements that we consider to be DAH. With new leadership at its helm and a renewed focus on human development,<sup>18</sup> the World Bank grew significantly in 2012, according to our preliminary estimates. In 2012, \$1.3 billion was disbursed by the World Bank’s International Bank for Reconstruction and Development (IBRD). The IDA arm of the World Bank spent just slightly less at \$912 million, according to our 2012 preliminary estimates. Both IDA and IBRD grew approximately 22% year over year. IDA, notably, will also embark on a new replenishment cycle in 2013, underpinned by a shrinking pool of eligible countries.

In contrast to the World Bank, regional banks did not exhibit growth from 2011 to 2012. Lending by these entities, which disburse DAH on a regional basis and include the African Development Bank, the Asian Development Bank, and the Inter-American Development Bank, decreased 17.2% from 2011 to 2012. They distributed just over \$234 million in 2012.

The contributions made by foundations to DAH also shifted from 2011 to 2012. The Bill & Melinda Gates Foundation (BMGF) contributed an estimated \$899 million of DAH in 2012. As with all the channels, funds are only assigned once to avoid double counting; BMGF contributions to UNICEF, for example, are deducted from BMGF’s total because they are included in UNICEF’s total. After removing DAH that would have been double counted, BMGF’s DAH fell in 2012. DAH disbursements by all other foundations in 2012



amounted to \$511 million. This was an increase of 5.3% over 2011.

Finally, IHME tracks the DAH expended by US NGOs. While providing estimates of all NGO spending would be ideal, data on these organizations are sparse, particularly for entities operating outside the US. Therefore, IHME has not yet been able to generate refined estimates for this category of DAH. US NGOs suffered severe cutbacks during the 2009 to 2010 period, falling more than 20%. Contrary to expectations, this trend did not continue into 2012. In 2012, NGOs maintained their share of expenditure. The DAH distributed to NGOs amounted to \$2.7 billion in 2012, a 4.3% increase from 2011. While NGO DAH has not been restored to its peak of \$3.7 billion in 2009, the 2012 DAH numbers exhibit a minor bounce-back in US NGO spending.

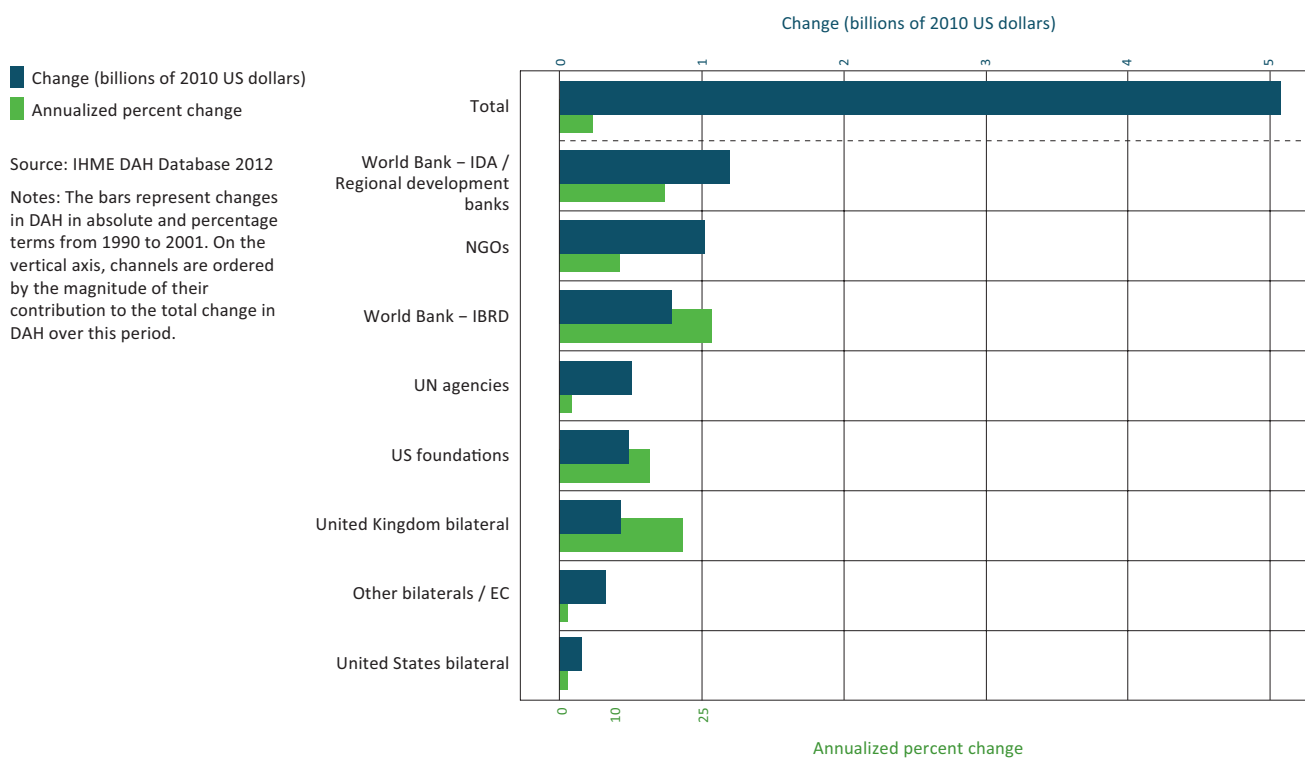
In an effort to ensure that we produce the most accurate estimates possible, the information used to produce the preliminary estimates is updated every year. For this reason, the preliminary 2010 and 2011 estimates, as reported in *Financing Global Health 2011*, have changed slightly in the 2012 edition because new information came to light that helped to refine them. In

this edition, the 2010 estimate of total DAH has been adjusted from \$26.7 billion to \$28.2 billion. The 2011 estimate was also revised from \$27.7 billion to \$27.4 billion. These adjustments were driven by a number of factors, most importantly by new information about the disbursements made by the World Bank’s IBRD. IBRD responded more swiftly to the financial crisis than expected, disbursing large sums of DAH through its fast-acting Development Policy Loans. As a result, funds that we initially forecasted to be disbursed in 2011 and beyond were actually disbursed in 2010. Spending by IDA, UNICEF, and NGOs was also higher than expected in 2010.

### The “moderate-growth” phase

From 1990 to 2001, DAH grew at a moderate but consistent rate of 5.9% on an annualized basis, as displayed in Figure 3. This “moderate-growth” phase took place, however, as total ODA stagnated. According to the OECD, ODA dropped almost \$7 billion between 1990 and 2001.<sup>19</sup> While DAH and ODA are not entirely comparable (DAH includes the contributions of NGOs and private foundations), over that same period, total DAH nearly doubled.

**FIGURE 3:**  
Change in DAH by channel of assistance, 1990-2001



During this period, DAH was driven up by \$5.1 billion in spending by a number of actors, most predominantly by the World Bank’s IDA and the regional development banks. These entities grew a combined \$1.2 billion or 18.6% annually. NGOs also expanded their DAH spending considerably in absolute terms, growing by \$1 billion. With the establishment of BMGF and other philanthropic organizations, US foundations’ DAH spending jumped 15.9%, with contributions rising just under \$484 million. The UK’s bilateral DAH enlarged substantially in annual percentage terms (21.7%), growing by \$434 million.

### The “rapid-growth” phase

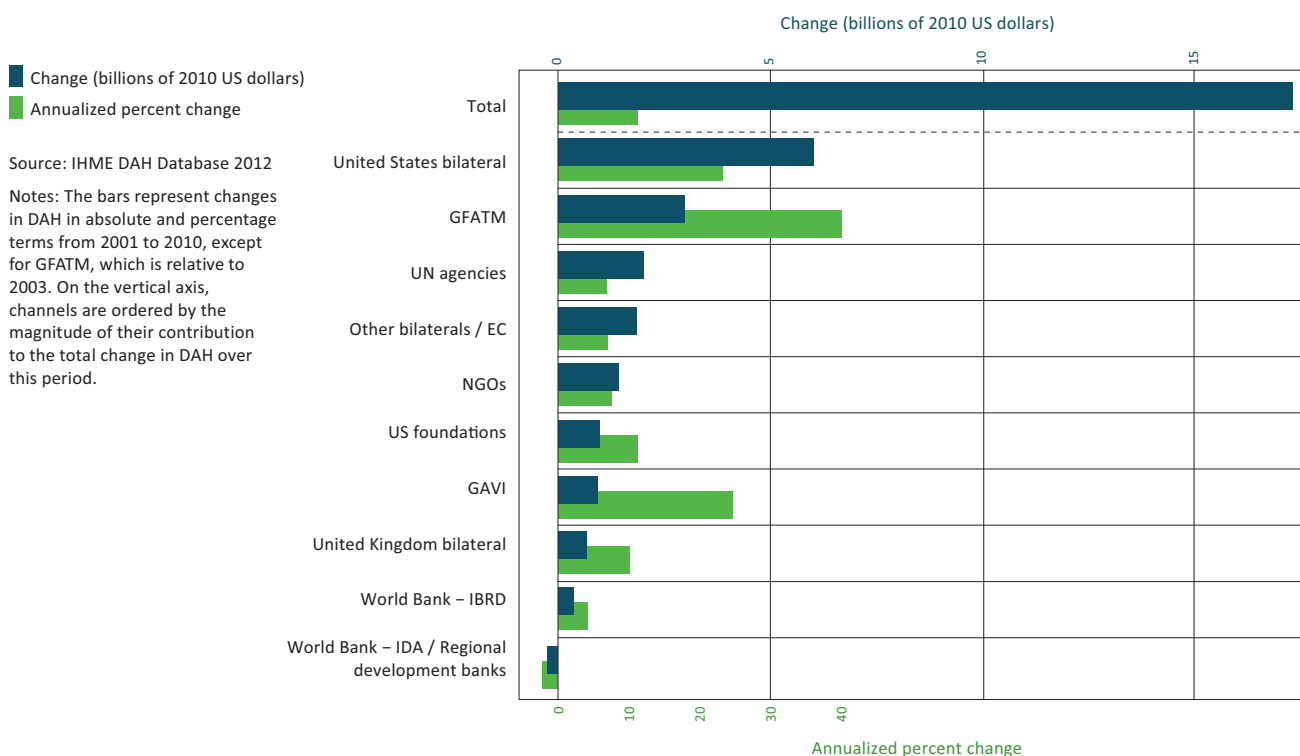
Over the course of the “rapid-growth” phase, DAH grew at a strong 11.2% on an annualized basis, increasing by \$17.3 billion from 2001 to 2010. Development assistance partners also expanded their support for wider ODA during the same period. ODA rose from \$92.2 billion in 2001 to \$148.4 billion in 2010, as displayed in Table 1 (on page 18). However, the consistently sizeable pace of growth in DAH demonstrates the serious commitment of development assistance partners to addressing health issues afflicting the developing world.

Around the turn of the 21st century, a flurry of activity focused on global health issues, catalyzing a “golden age” of increases in DAH. At the Millennium Summit in 2000, UN members launched the MDGs, three of which focus directly on health. Also in 2000, at the Group of Eight (G8) Summit in Okinawa, Japan, G8 governments noted that six diseases, including HIV/AIDS, TB, and malaria, were the main causes of death worldwide and prioritized combating them.<sup>20</sup> Finally, over the course of the three years that followed, a number of crucial global health organizations, including the US President’s Emergency Plan for AIDS Relief (PEPFAR), GFATM, GAVI, and others were created, entailing the commitment of substantial amounts of funds to their objectives and operation.

Among the organizations that took off during this period, public-private partnerships underwent the most substantial expansion. Funding for GAVI, created in 2000, and GFATM, launched in 2002, rose significantly as DAH entered its rapid-growth phase. GFATM increased 40.2% on an annualized basis from 2003 until 2010. GAVI realized an annualized growth rate of 24.7% from 2001 to 2010.

Similar growth occurred in spending on DAH by bilateral and multilateral aid agencies. The US contributed

**FIGURE 4:**  
Change in DAH by channel of assistance, 2001-2010



34.8% to the total annual rise in DAH spending. This amounted to \$6 billion in increased US DAH and annualized growth of 23.2%. The UK increased its DAH by 10.1% in annualized terms (\$678 million). Other bilaterals, including the European Commission (EC), expanded 7% annually, a rise of \$1.9 billion from 2001 to 2010. With respect to development banks, however, rates of growth were mixed. The World Bank’s IBRD increased (4.1%) during this time.

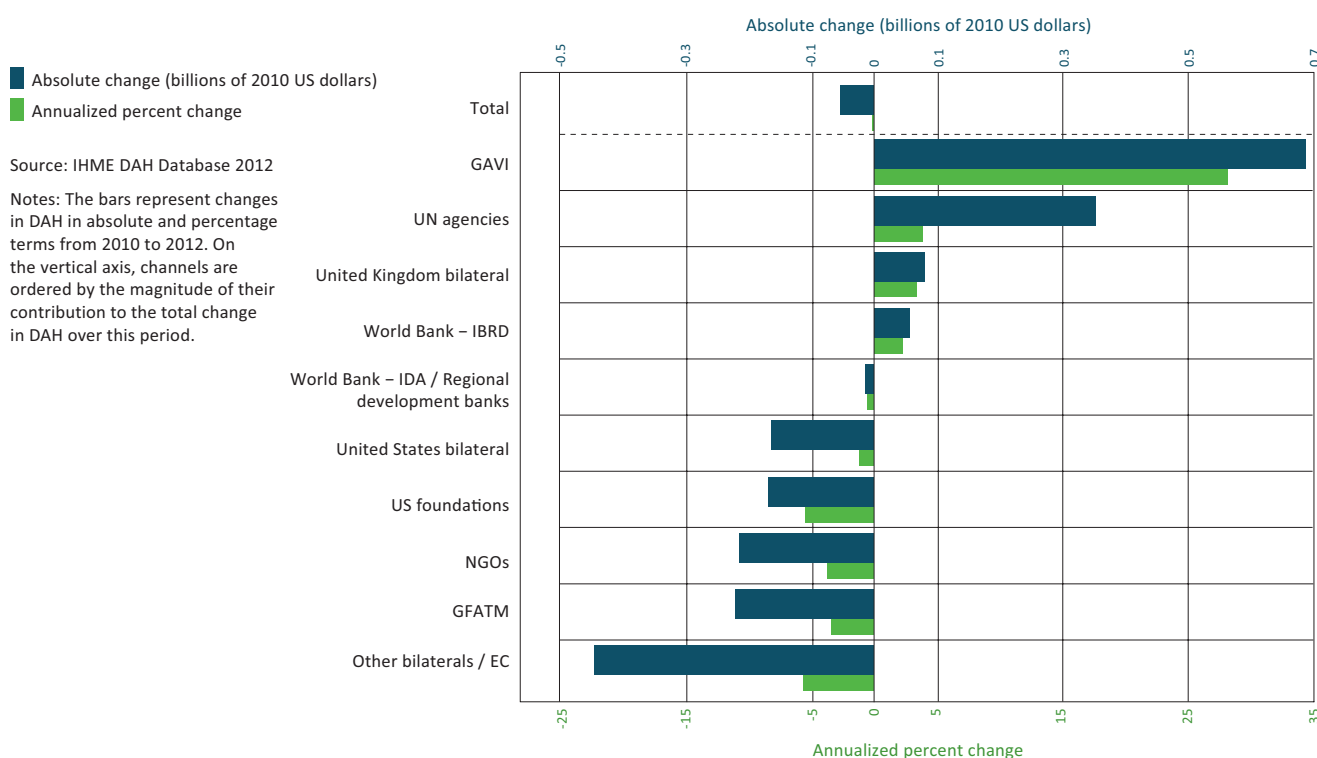
It is also during this rapid-growth period that actors outside of traditional bilateral and multilateral circles began to take on a more prominent role in disbursing DAH. The largest foundation now in operation, BMGF, contributed significantly to DAH as the field expanded from 2001 to 2010. BMGF was formally established in 1999 and grew rapidly from its inception onward. US foundations, including BMGF and other private foundations, increased \$974 million with an 11.3% annualized growth rate from 2001 to 2010. NGOs also expanded rapidly as they took on an increasingly prominent role in supporting health systems across the developing world during this period. Spending by NGOs (predominantly US organizations) climbed \$1.4 billion with growth of 7.6% in annualized terms from 2001 to 2010.

### The “no-growth” phase

According to our latest estimates, DAH hit its peak in 2010 with a historic high in spending of \$28.2 billion. Since 2010, as the shock of the financial crisis began to translate into reductions in development assistance, DAH entered a “no-growth” phase. Figure 5 shows that this period of stagnation has involved a decline in DAH of less than 0.1% in annualized terms and an absolute drop of \$53 million from 2010 to 2012. While DAH has not continued along the strong upward trend observed during the rapid-growth phase, the plateau suggests that international development partners have maintained their commitment to DAH at a fairly stable level.

Shifts within the entire spending envelope underpin the stagnation in DAH. The small aggregate change masks notable decreases and increases across channels. From 2010 to 2012, the most significant change, in absolute and percentage terms, was in spending by GAVI. GAVI spending increased 28.2% in annualized terms, a \$688 million jump from 2010. UN agencies also increased their DAH, contributing \$354 million more in 2012, a 3.9% annual rise. This was in large part driven by UNICEF’s increased expenditure rather than

**FIGURE 5:**  
Change in DAH by channel of assistance, 2010-2012



a uniform increase across agencies. UNICEF played a prominent role in addressing health-related aspects of the response to the natural disasters in Haiti and Pakistan in 2010. Among bilaterals, the UK expanded DAH most notably, with annual growth of 3.4%, an increase of \$80 million, following the UN in absolute and percentage terms. IBRD spending grew 2.3% annually with an absolute change of \$56 million between 2010 and 2012.

Growth in spending by GAVI, as well as by the UN, IBRD, the UK, and a few other bilaterals offset the contraction in other channels, which also occurred across different institution types. GFATM spending shrank 3.4% annually, although, as noted previously, a sharp decrease from 2010 to 2011 was offset by a recovery from 2011 to 2012. IDA's spending also decreased during this period. This arm of the World Bank has seen a shrinking eligibility pool, as fewer countries are considered low income or find it difficult to borrow on world markets. The increase in DAH spending by the UK compensated somewhat for a drop by the US, which shrank 1.2% annually from 2010 to 2012, an absolute decrease of \$164 million. From 2010 to 2012, DAH provided by US foundations and NGOs decreased at rates similar to the bilateral aid agencies: around 5.5% and 3.7%, respectively, on an annual basis. The reduction in EC and other bilateral spending constituted the most significant drop at \$447 million, a 5.6% annualized decrease from 2010.

In sum, these shifts reveal an increasingly prominent role for multilaterals, including the UN, World Bank, and GAVI. The overall contraction was largely driven by decreases in bilateral spending, including the US and EC, as well as reductions in expenditure by NGOs and GFATM. The increase in GAVI spending, coupled with the decreases in GFATM spending, indicates significantly increased spending on vaccines and reductions in expenditure on TB, HIV/AIDS, and malaria programs. With the exception of the UK and a few other bilaterals, bilateral spending is down significantly.

## DAH versus ODA trends

The trends in DAH were not always reflective of patterns in wider ODA. Table 1 reports the total ODA and DAH at a baseline of 1990 and at the end of the moderate- and rapid-growth phases. Due to the lag in reporting, total ODA and DAH in the no-growth phase are examined only for 2011. While DAH was rising modestly from 1990 to 2001, ODA, in fact, stagnated. ODA decreased from \$99 billion in 1990 to \$92.2 billion 2001. However, over the course of DAH's rapid-growth phase, ODA also experienced strong growth. In 2010, total ODA had increased to an all-time high of \$148.4 billion, just as DAH reached its historic peak of \$28.2 billion. ODA's rise was not quite as strong as the growth in DAH over that period. As ODA expanded 61% between 2001 and 2010, DAH almost tripled concurrently. Discussing the more recent period of stagnation is difficult, since IHME relies on preliminary estimates for DAH, and ODA figures are not currently available for 2012. However, the no-growth phase appears to be affecting both ODA and DAH. In 2011, year-over-year decreases were observed in both DAH (2.6%) and ODA (1.2%).

Since DAH is not exactly comparable to ODA (DAH includes contributions from NGOs and foundations), we also examined the portion of ODA spent on health relative to total ODA.

Although it does not coincide with the absolute increases in DAH observed, the share of health ODA has also grown over the last two decades. As a portion of total ODA, health ODA grew most rapidly from 1990 to 2000. In 1990, the share of health ODA was less than 2%.<sup>19</sup> By 2000, this share had climbed to almost 8%. Health ODA expanded at a moderate pace while ODA stagnated. From 2000 to 2004, however, health ODA remained stable, as health ODA and total ODA both climbed quickly during this period. Since 2004, the portion of health ODA has fluctuated, dropping first to almost 7% in 2006, followed by a jump to almost 12% by 2007. By 2010, health ODA was more than 12% of total ODA.

**TABLE 1:**  
Select total DAH and ODA, 1990-2011

	Baseline	End of moderate-growth phase	End of rapid-growth phase	Beginning of no-growth phase
Year	1990	2001	2010	2011
DAH	\$5.7 billion	\$10.8 billion	\$28.2 billion	\$27.4 billion
ODA	\$99.0 billion	\$92.2 billion	\$148.4 billion	\$146.6 billion

Source of total ODA: OECD.Stat Extracts, Total Flows by Donor [online database]. Paris: Organisation for Economic Co-operation and Development; 2012 Dec 17. <http://stats.oecd.org/Index.aspx?datasetcode=TABLE1#>

CHAPTER 2:

# RECIPIENTS OF DEVELOPMENT ASSISTANCE FOR HEALTH

Recipients of DAH span regions and, to a certain extent, income levels; both low- and middle-income countries receive DAH. In recent years, more and more countries have attained middle-income status. From 1999 to 2012, 33 low-income countries graduated to middle-income or lower-middle-income status.<sup>21,22</sup> As these transitions proceed, bilaterals and public-private partnerships are considering whether and when development aid may be phased out.<sup>23</sup> Even so, our 2010 estimates do not reveal drastic drops of DAH in these countries. This may become apparent in future years, however, as this chapter does not feature 2012

estimates because of the lag between spending and reporting. The most recent year for which recipient-level estimates are available is 2010.

This chapter explores the current state of regional, economic, and burden-based variation in recipients of DAH, including the shifting regional focus of DAH during the 2001 to 2010 rapid-growth period. Among the regions highlighted, sub-Saharan Africa received a substantial share of increased funding over this period. Other regions' levels of DAH also expanded during this time.

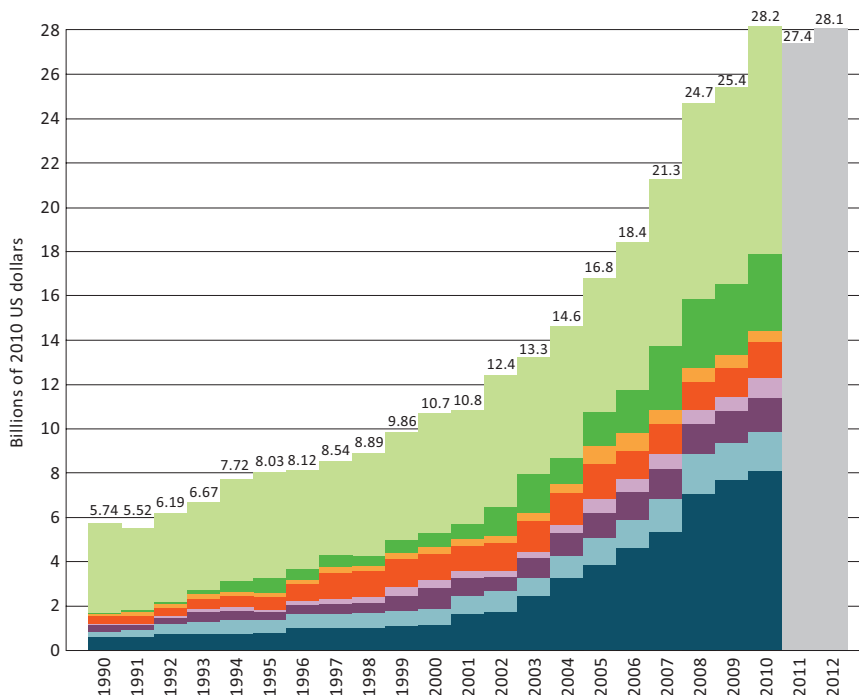
**FIGURE 6:**  
DAH by focus region, 1990-2010

Health assistance for which we have no recipient country or region information is coded as "unallocable."

- Unallocable
- Global
- North Africa / Middle East
- Latin America and Caribbean
- Europe and Central Asia
- East Asia and Pacific
- South Asia
- Sub-Saharan Africa
- Preliminary estimates

Sources: IHME DAH Database 2012 and IHME DAH Database (Country and Regional Recipient Level) 2012

Notes: 2011 and 2012 are preliminary estimates based on information from channels of assistance, including budgets, appropriations, and correspondence. Data were unavailable to show total DAH by focus region for 2011 and 2012.



## DAH by region

Regional variation in DAH flows is displayed in Figure 6 (on page 19). From 1990 to 2001, sub-Saharan Africa received a modest but still substantial proportion of DAH. Among the DAH allocable regionally in 1999, sub-Saharan Africa received 24.4% of the total.

As DAH entered its rapid-growth phase, sub-Saharan Africa's receipt of DAH grew at a similarly rapid pace, growing 19.6% in annualized terms from 2001 to 2010. Since the turn of the century, this region has consistently received a larger proportion of spending, and, by 2010, DAH flowed predominantly to sub-Saharan Africa. In 2010, the proportion of DAH disbursed to sub-Saharan Africa had risen to 56% of the total allocable to regions. IHME estimates that \$8.1 billion in DAH was allotted to sub-Saharan Africa in 2010, a 5.5% increase from 2009.

As the sub-Saharan African region has the most numerous low-income countries, the economic status of the region clearly plays a role in the large share of DAH expended in sub-Saharan Africa. Epidemiological trends provide another explanation for the region's receipt of the highest share of DAH over the last two decades. In most other regions, communicable diseases have decreased considerably as a share of burden. While these ailments have also diminished in sub-Saharan Africa, communicable, maternal, neonatal, and nutritional disorders continue to account for 67% to 71% of DALYs.<sup>12</sup> These conditions account for 76% of deaths in this area of the world.<sup>24</sup> These types of health issues are more prominently favored in DAH spending, as Chapter 3 shows.

The second-highest amount of DAH is spent at the global level. The global DAH category includes research and development, such as the advancement of a malaria vaccine and drugs for multidrug resistant TB, as well as other health-related activities that cannot be directly tied to a specific country or region, including the creation of public goods or projects for multiple regions. From 2009 to 2010, spending in this category rose 7.2% to a total of \$3.5 billion.

In almost all regions, DAH increased on the whole from 2009 to 2010. The North Africa/Middle East region was the exception; the DAH disbursed in this region decreased 8.1% from 2009 to 2010. Nonetheless, \$519 million was spent in North Africa/Middle East in 2010. In contrast, in South Asia, DAH increased 4.4% to \$1.8 billion. Growth in East Asia and the Pacific was 8%, amounting to \$1.6 billion in total DAH in 2010. With

a rate of growth of 38.8% in 2009, the DAH allocated to Europe and Central Asia jumped considerably; total DAH spending in the region was \$900 million. Growth in Latin America and the Caribbean was similarly strong at 23%. In that region, \$1.6 billion of DAH was expended in 2010.

Unfortunately, due to the manner in which DAH is reported, IHME is unable to assign a substantial amount of expenditure to specific countries or regions. In 2010, 36.4% of DAH could not be allocated to either a particular region or the global category. Even so, as Figure 6 illustrates, the proportion of funding categorized as unallocable has diminished over time. In 1990, 70.8% of DAH was designated as unallocable. The decline in unallocable DAH is evidence of better reporting and improved transparency of development assistance disbursements.

## DAH by country

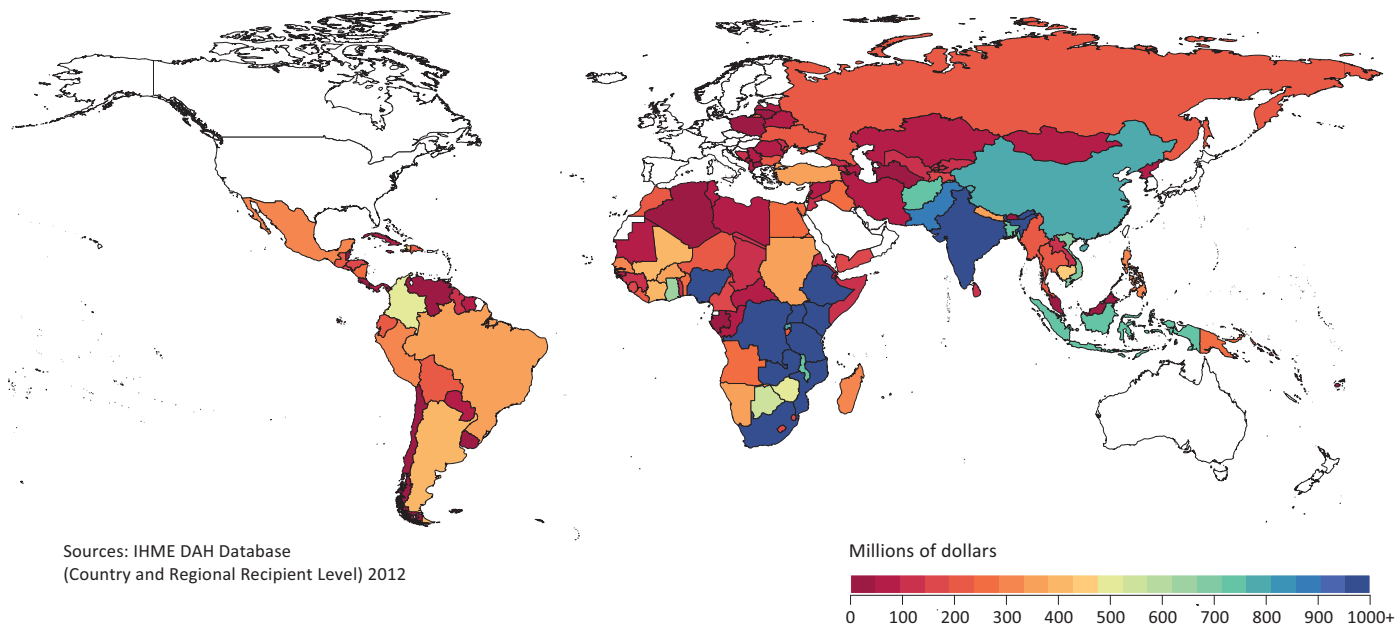
The total amount of DAH allocated at the country level is subject to a number of considerations. Population, disease burden, income, and geopolitical factors all play a part to varying degrees in different countries. This section features country-level estimates of DAH for 2010 that can be used to explore these factors.

Figure 7 illustrates the total DAH disbursed from 2008 to 2010 by country. In terms of total volume, India and a number of countries in sub-Saharan Africa received upwards of a billion dollars of DAH between 2008 and 2010. A few countries in Southeast Asia, China, and select countries in sub-Saharan Africa received below the billion-dollar mark but received between \$600 and \$800 million over those three years. The majority of countries, even populous countries such as Brazil, Mexico, and Russia, received less than \$500 million in total DAH. It is notable that middle-income countries were represented across the spectrum of spending. Despite questions about whether too much aid is being disbursed to middle-income countries,<sup>25</sup> DAH to countries such as China and India remained substantial in 2010.

Figure 8 displays the top 10 recipients of total DAH from 2008 to 2010, in order of the amount of funds received. Excluding India, the top recipients were sub-Saharan African countries, reflecting the high burden and low income levels of that region. Nigeria, with the biggest population in sub-Saharan Africa, received the second highest levels of DAH. Uganda and Kenya received significant levels of aid due to their HIV/AIDS burden, as well as a high number of DALYs overall.

**FIGURE 7:  
Total DAH, 2008-2010**

Countries that were ineligible for DAH based on their World Bank income classification are shown in white. DAH received is shown in millions of real 2010 US dollars.

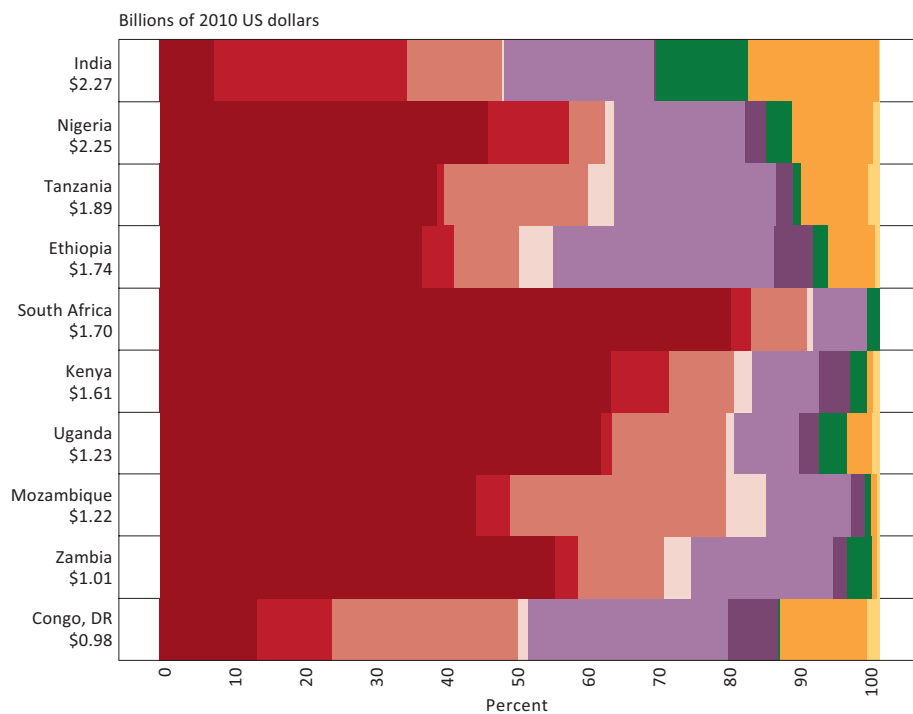


**FIGURE 8:  
Top 10 country recipients of DAH by channel of assistance, 2008-2010**

The amount of DAH received by each country in billions of 2010 US dollars is shown below the name of the country. Only DAH allocable by country is reflected in the figure.

- United States
- United Kingdom
- Other European bilaterals / EC
- Other bilaterals
- GFATM
- GAVI
- BMGF
- World Bank
- Regional development banks

Source: IHME DAH Database (Country and Regional Recipient Level) 2012



That two middle-income countries, India and South Africa, received enough DAH to be among the top 10 recipients highlights the contradictions informing discussions about continued aid to middle-income countries. India reportedly allocated \$547 million to foreign aid in 2008.<sup>26</sup> South Africa also provided approximately 0.03% of its gross national income as foreign assistance in 2010.<sup>27</sup>

With the exceptions of India and the Democratic Republic of the Congo (DRC), US bilateral assistance, through the United States Agency for International Development (USAID), PEPFAR, the President’s Malaria Initiative, and other initiatives, played the prominent role in funding the top 10 recipients of DAH. In South Africa, US bilateral assistance comprised close to 80% of DAH expenditure, mostly due to the active role of PEPFAR. In India, the UK contributed the biggest proportion of funds. India has been the single largest recipient of UK aid historically.<sup>28</sup> However, the UK Department for International Development (DFID) announced in November 2012 that it will be phasing out its aid to India; existing programs should be completed by 2015.<sup>29</sup> A mix of bilaterals and GFATM made up the bulk of spending in the DRC. Across recipients, GFATM spent the second

highest proportion of DAH in these countries after the US.

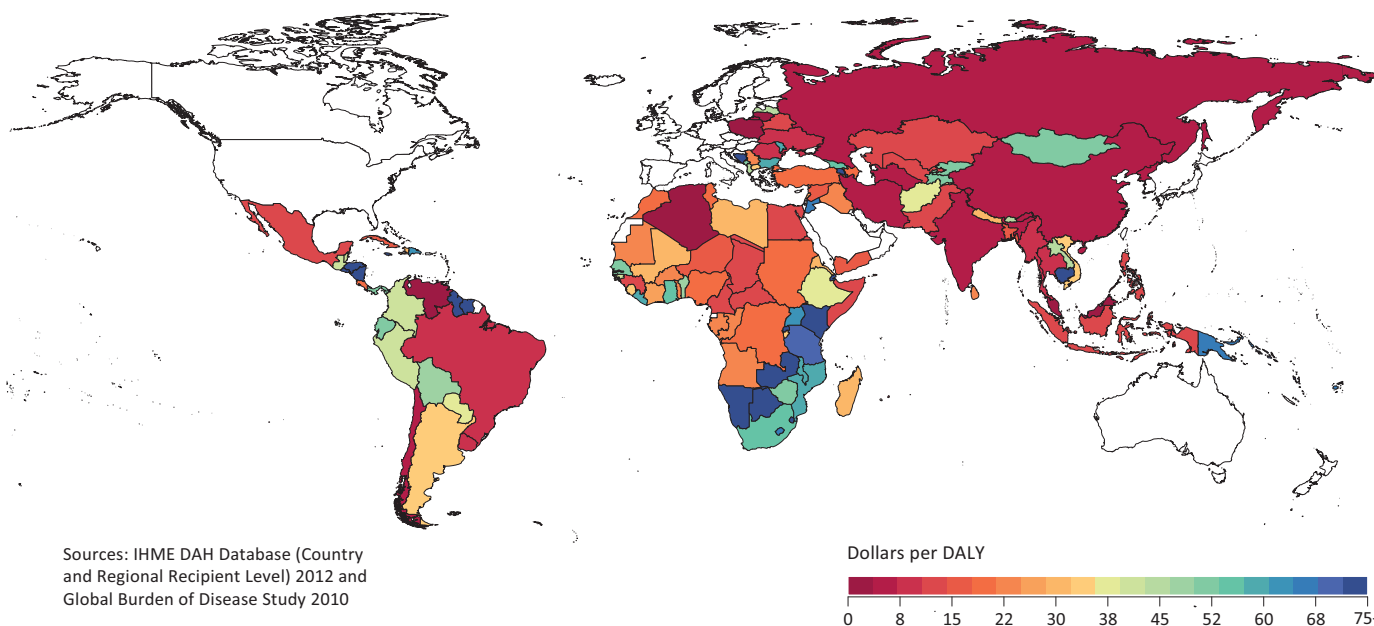
With respect to the recipients of the highest absolute DAH from 2004 to 2009, the 2008 to 2010 assessment exposed changes in the recipient countries. The top recipients over 2004 to 2009 included China as 10th, but in the period from 2008 to 2010, the DRC replaced China in that slot. South Africa also moved from seventh to fifth, with a significant amount of support from PEPFAR. The mix of sources of DAH did not vary significantly across the two periods. US bilateral and GFATM DAH constituted the highest proportion of spending in the top 10 recipients of DAH over 2004 to 2009 and 2008 to 2010.

### DAH and burden of disease

Representing DAH in terms of volume falls short of accounting for factors such as population size and disease burden, which are important for assessing DAH at the country level. In contrast to the total DAH map, Figure 9 presents DAH across the globe in terms of DAH per all-cause DALY, exposing the relationship between burden and DAH. DALYs quantify a population’s health relative to the normative goal of living a full life in good health. As more members of the population suffer from

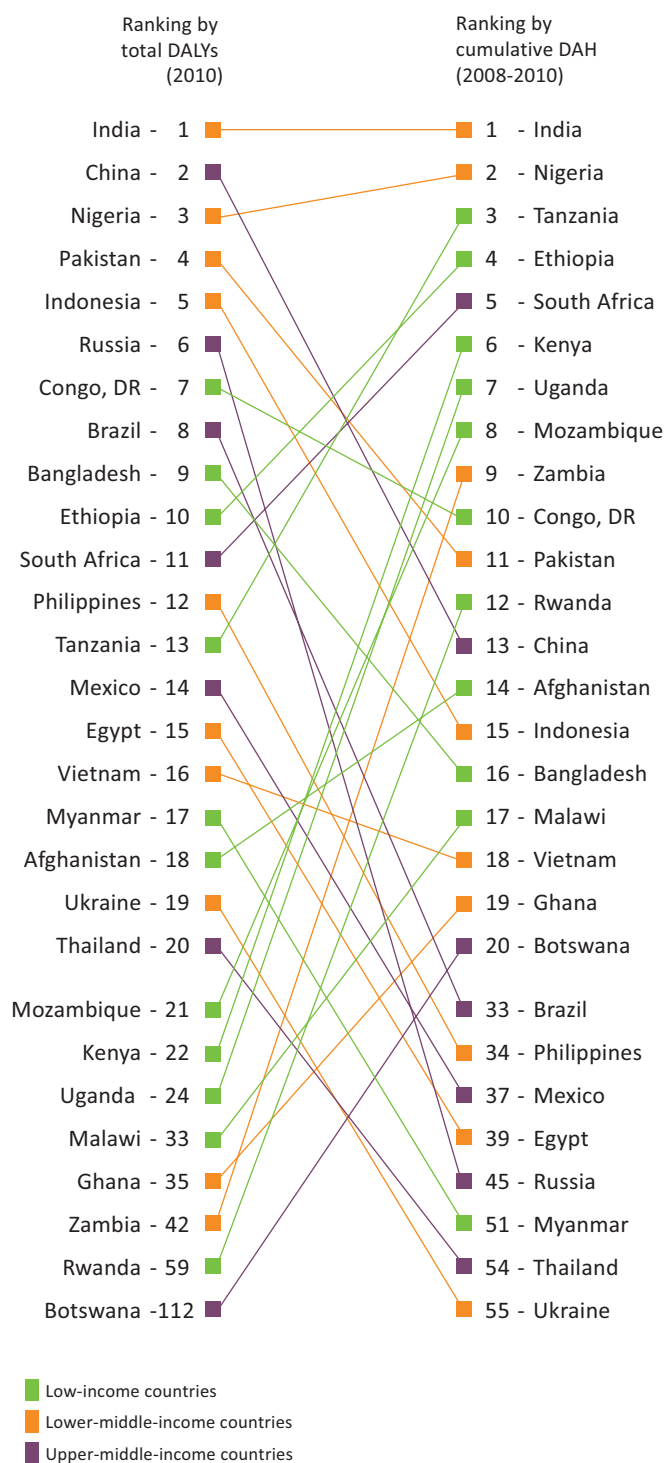
**FIGURE 9:**  
**Total DAH per all-cause DALY, 2008-2010**

DALY estimates for 2010 are from the Global Burden of Disease Study 2010. Countries that were ineligible for DAH based on their World Bank income classification are shown in white. DAH received is shown in real 2010 US dollars.





**FIGURE 10:**  
**Top 20 countries by 2010 all-cause burden of disease**  
**versus cumulative 2008-2010 DAH**



Sources: IHME DAH Database (Country and Regional Recipient Level) 2012 and Global Burden of Disease Study 2010

illness or disability, or die prematurely, a country's DALYs increase. The level of DALYs at the country level is influenced by the composition of injuries and illnesses as well as population size. DALYs are one of the main summary measures of population health produced by GBD 2010. A key component of GBD 2010 is the aspect of comparability between DALYs across countries, diseases, and injuries. The dollar of DAH per DALY metric likewise provides a comparable assessment of how DAH aligns with a country's burden of disease.

In general, DAH per DALY ranged from less than a dollar to approximately \$25 per DALY across regions. This includes regions with higher per capita income, such as North Africa/Middle East, Europe, and Central Asia, as well as regions with lower GDP per capita, such as South Asia. Most countries in sub-Saharan Africa received more than \$10 per DALY, however, and countries in Southern Africa received some of the highest DAH per DALY, with some values exceeding \$75 per DALY. A number of countries in South America and a few in Central Asia and Europe received more than \$40 per DALY as well.

Furthermore, relative to the total DAH map, Figure 9 shows that the DAH received by most middle-income countries in terms of their DALYs was low. Whereas China and India were at the higher end of the spectrum in terms of total DAH, they received some of the lowest DAH per DALY, as they harbor the two largest populations in the world and high disease burdens. Mexico, Brazil, and Russia also received less than \$15 per DALY. An exception is South Africa, where DAH per DALY was above \$50.

This map does not present disease-specific DALYs, such as those for HIV/AIDS, although that disease burden is included in the final tally. HIV/AIDS DAH per HIV/AIDS DALY as well as other disease-specific spending is explored in Chapter 3, which covers DAH by health focus area.

The relationship between all-cause DALYs and DAH is represented in Figure 10. In the left-hand column, countries are listed in order according to their disease burden, as represented by 2010 DALYs. On the right, countries are ordered based on the total amount of DAH received between 2008 and 2010. The lines connect the countries on the lists, displaying the misalignment that exists more often than not between DALYs and DAH. This is true across income groups and regions. Only India, Nigeria, and Vietnam had comparable DAH and DALY levels, relative to other countries on the list. A number of upper-middle-income countries – Russia, Brazil, Mexico, and Thailand – received particularly low DAH relative to burden.

CHAPTER 3:

# DEVELOPMENT ASSISTANCE FOR HEALTH TO SPECIFIC HEALTH FOCUS AREAS

In Chapter 2, total DAH and all-cause DALYs were considered side-by-side, facilitating an assessment of the relationship between spending and burden of disease. However, these metrics encapsulate an amalgam of disease and health issues. To unpack this mix, we explore the DAH dedicated to specific health focus areas and the corresponding DALYs in this chapter. IHME classifies spending into six major categories: HIV/AIDS; maternal, newborn, and child health (MNCH); malaria; TB; NCDs; and health sector support. Examining each of these six areas in depth allows us to

further assess any association between DAH disbursements and burden of disease.

Assessing trends in DALYs and DAH for specific health focus areas exposes disconnects between burden and international development spending. NCD programs notably receive very little DAH relative to the associated burden. The lack of association between DAH and DALYs is not surprising given the poor information on burden previously available. Few decision-makers have access to full information on the composition of burden

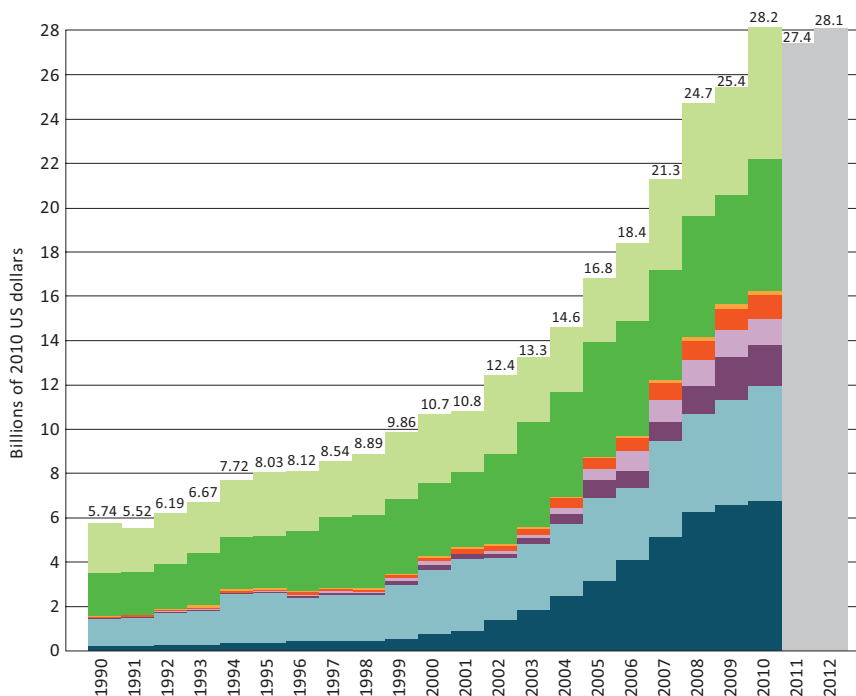
**FIGURE 11:**  
**DAH for HIV/AIDS; maternal, newborn, and child health; malaria; tuberculosis; noncommunicable diseases; and health sector support, 1990-2010**

DAH for which we did not have information on disease focus is coded as "unallocable." DAH for other health focus areas not yet tracked by IHME is coded as "other."

- Unallocable
- Other
- Noncommunicable diseases
- Tuberculosis
- Health sector support
- Malaria
- Maternal, newborn, and child health
- HIV/AIDS
- Preliminary estimates

Sources: IHME DAH Database 2012 and IHME DAH Database (Country and Regional Recipient Level) 2012

Notes: 2011 and 2012 are preliminary estimates based on information from channels of assistance, including budgets, appropriations, and correspondence. Data were unavailable to show total DAH by health focus area for 2011 and 2012.



in their own national context, let alone across regions. For this reason, GBD 2010 makes strides toward better decision-making about the diseases and injuries that afflict national populations. Similar to Chapter 2, this chapter features the DALYs produced through GBD 2010. As these and other GBD estimates are taken up and utilized, improved decision-making regarding the allocation of DAH will be possible.

This chapter also reveals that the rapid-growth phase involved accelerated increases in the DAH devoted to certain health focus areas. While all health focus areas examined grew from 2001 to 2010, the strong rate of growth was driven predominantly by increases in DAH for HIV/AIDS as well as malaria, TB, and health sector support. DAH for MNCH and NCDs grew at a stable, albeit less rapid, pace during the 2001 to 2010 period. MNCH is a health focus area that has received strong support since 1990. Other areas, rather, simply grew faster.

More recently, decreases in certain health focus areas have interrupted the consistent growth trend. Although IHME is only able to report estimates from 2010 due to a lag in reporting, we observed an indication of a downward tendency in certain areas from 2009 to 2010. The DAH provided to address NCDs, malaria, and health system support declined slightly from 2009 to 2010. The remaining health focus areas highlighted by IHME continued to grow.

In future years, IHME anticipates expanding this section by breaking out health focus areas further. Increasingly, disease- and intervention-specific groups are interested in knowing the amount of DAH allocated to their work as they help decision-makers address funding gaps, investment decisions, and trade-offs between different programs. Furthermore, IHME expects to expand its health financing work to estimate broader expenditure on all major diseases, including the public and private domestic sources of funds allocated to treatment and prevention. Using the updated estimates of burden produced through GBD 2010 will allow IHME to generate accurate approximations of this spending.

## DAH by health focus area

As Figure 11 illustrates, the composition of DAH in terms of health focus areas did not change substantially over the 2009 to 2010 period. Among the DAH classified as devoted to a specific health issue, HIV/AIDS constituted the most substantial portion (30.5%) in 2010. Since 2000, DAH for HIV/AIDS has expanded rapidly with the creation of HIV/AIDS-specific organizations, such as PEPFAR and GFATM, as well as the increase in support for the Joint United Nations Programme on HIV/AIDS (UNAIDS). At 23.3% of allocable health focus area spending, MNCH was the next most substantial. MNCH has been a major portion of DAH spending since 1990; however, because HIV/AIDS and other spending expanded quickly over the period, MNCH's share of the total diminished over time. The DAH allocated to the other major health focus areas considered has also risen substantially over the past 10 years. These areas all composed a relatively small share of expenditure: the DAH allocated to malaria (8.4%), health sector support (5.3%), and TB (4.9%) each amount to less than 10% of spending. NCDs constituted by far the smallest health focus area tracked, as total expenditure amounted to just \$185 million or 0.8% of the total allocable DAH in 2010.

Due to data quality, a significant proportion of expenditure cannot be categorized easily into one of the six health focus areas. The largest categories among health focus areas are "unallocable" (21.2%) and "other" (21.1%). If the DAH target is known but does not fit into one of the health focus areas highlighted, the expenditure is allocated to "other." DAH that cannot be linked to a specific purpose is assigned to the "unallocable" category. While the fraction of DAH that IHME has been able to allocate to specific health focus areas has increased over time, this continued ambiguity highlights the need for better reporting of DAH.

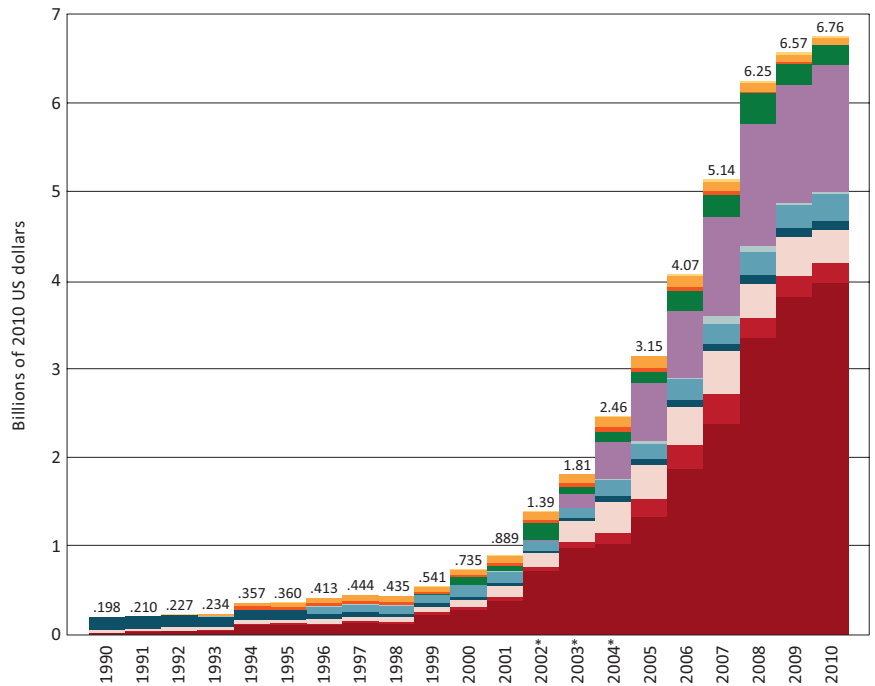
DAH for most of the health focus areas expanded in absolute terms from 2009 to 2010, although support for several key issue areas fell. Growth in DAH for MNCH and TB was the most impressive among health focus areas, at 8.8% and 13.8%, respectively, from 2009 to 2010. HIV/AIDS spending increased at a slower, although still substantial, 2.8%. In contrast, we observed drops in the DAH provided for malaria (4.2%), NCDs (5.1%), and health sector support (2.5%) in 2010, balking the growth trend overall.

**FIGURE 12:**  
**DAH for HIV/AIDS by channel of assistance, 1990-2010**

- Regional development banks
- World Bank – IDA
- World Bank – IBRD
- BMGF
- GFATM
  
- United Nations and European Commission:
- EC
- UNAIDS
- WHO
  
- Bilateral agencies:
- Other
- United Kingdom
- United States

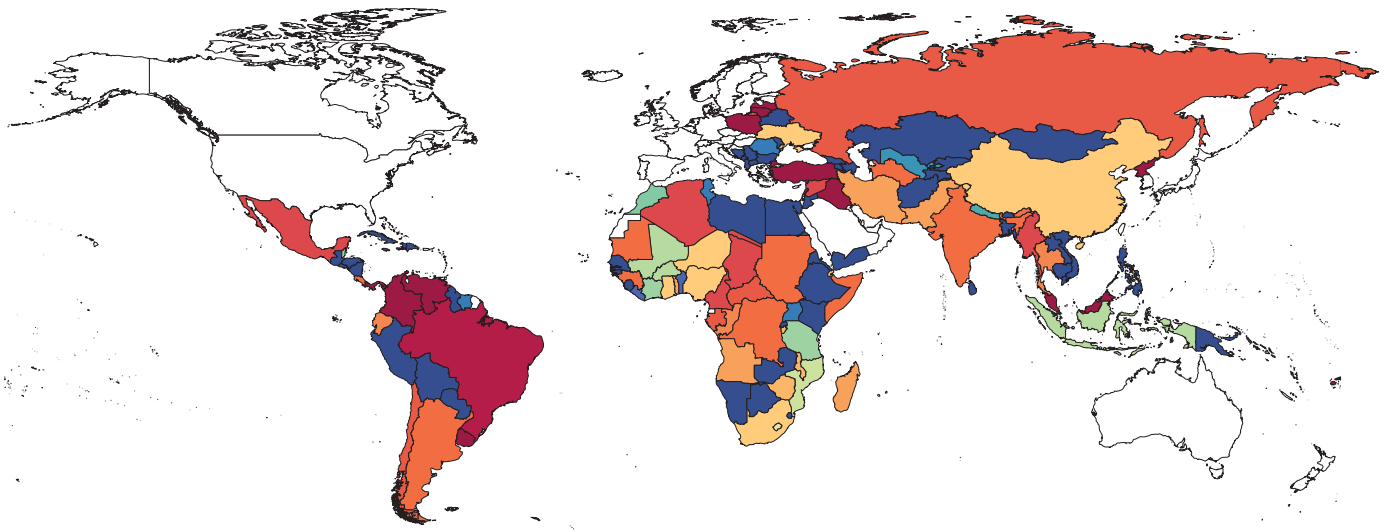
Sources: IHME DAH Database 2012 and IHME DAH Database (Country and Regional Recipient Level) 2012

\*2002-2004 US bilateral project descriptions lack detail, and thus disease-specific DAH totals for those years may be incomplete.

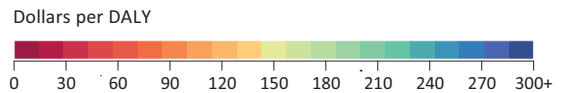


**FIGURE 13:**  
**HIV/AIDS DAH, 2008-2010, per related DALY, 2010**

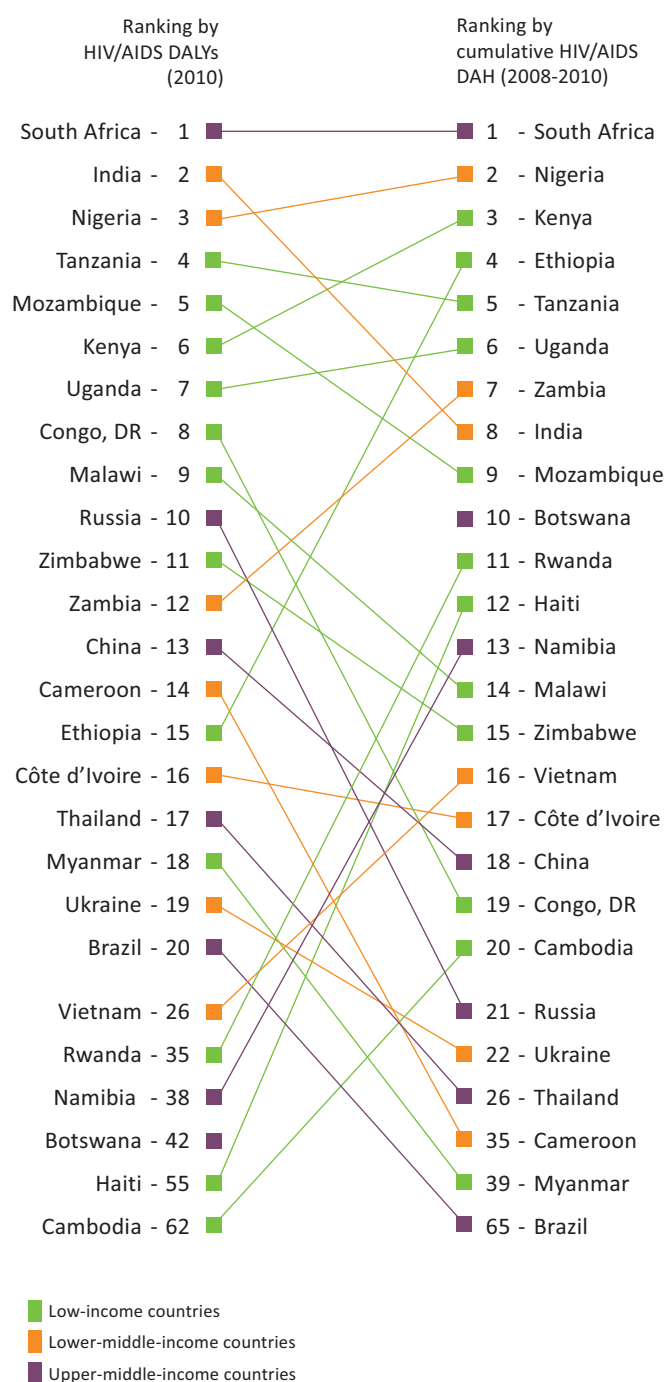
DALY estimates for 2010 are from the Global Burden of Disease Study 2010. Countries that were ineligible for DAH based on their World Bank income classification are shown in white. DAH received is shown in real 2010 US dollars.



Sources: IHME DAH Database (Country and Regional Recipient Level) 2012 and Global Burden of Disease Study 2010



**FIGURE 14:**  
**Top 20 countries by 2010 HIV/AIDS burden of disease versus cumulative 2008-2010 HIV/AIDS DAH**



Sources: IHME DAH Database (Country and Regional Recipient Level) 2012 and Global Burden of Disease Study 2010

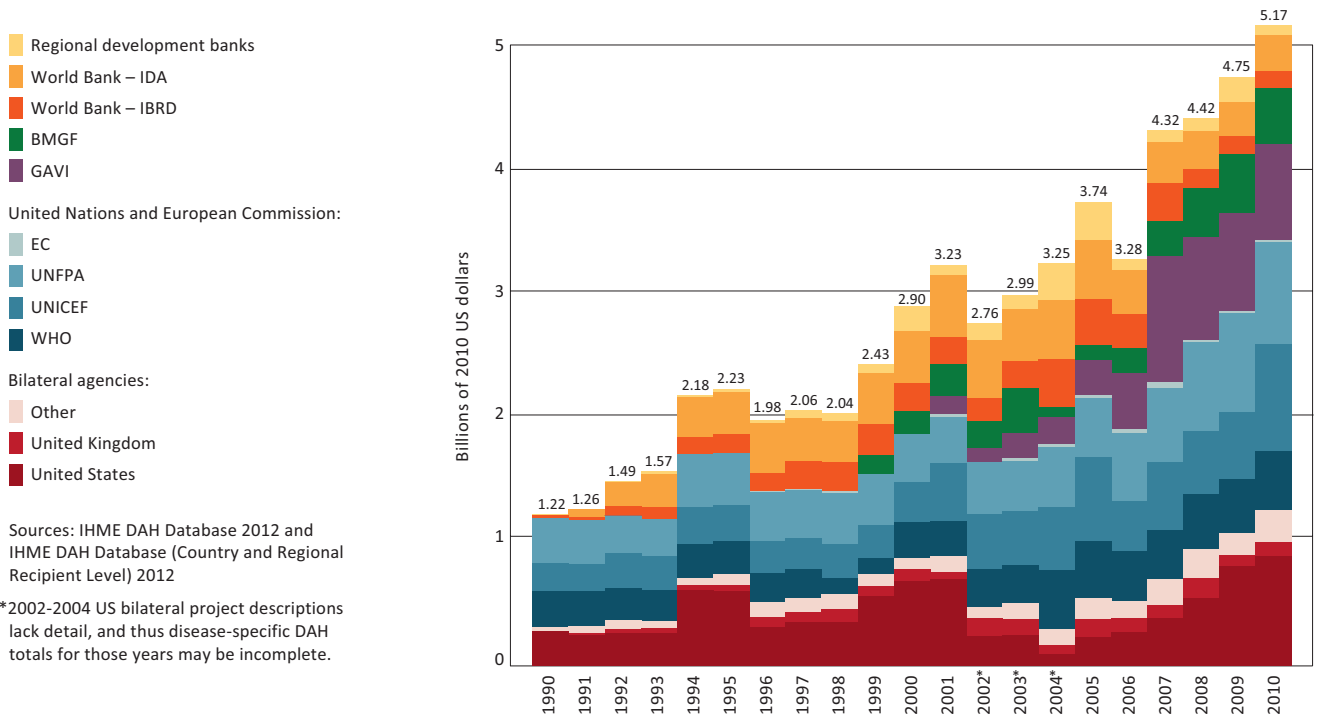
## DAH for HIV/AIDS

As shown in Figure 12, DAH for HIV/AIDS expanded at a tremendous rate from 1998 onward. The expansive increase is due largely to the commitment of US bilaterals, mainly through PEPFAR and USAID. US bilaterals funded more than half (58.8%) of DAH for HIV/AIDS, with \$4 billion in DAH spent in 2010, a 4.2% increase from 2009. GFATM was also vital to the rapid surge in DAH spending and contributed the second largest proportion of DAH to HIV/AIDS. After a dip in funding flows from 2008 to 2009, GFATM's disbursements for HIV/AIDS rose 8.1% in 2010 (\$1.4 billion).

This rapid uptick in spending was a response to the rise of the HIV/AIDS epidemic since 1990. According to GBD 2010, HIV/AIDS was only the 33rd cause of global DALYs in 1990. By 2010, it was the fifth, a 351% increase.<sup>12</sup> These burden numbers persist despite major declines in HIV/AIDS mortality since 2005 and the expansive roll-out of antiretroviral (ARV) treatment and preventing mother-to-child transmission of HIV (PMTCT) programming. Even so, in 2012, the global advocacy group ONE released a report stating that the world is not on track to reach the MDG HIV/AIDS targets. According to ONE, 8.4 million people are still in need of treatment and 2.5 million people continue to be infected annually.<sup>30</sup> UNAIDS, in a report in July 2012, estimates that an additional \$2 to \$3 billion is required annually to meet treatment and prevention needs.<sup>31</sup>

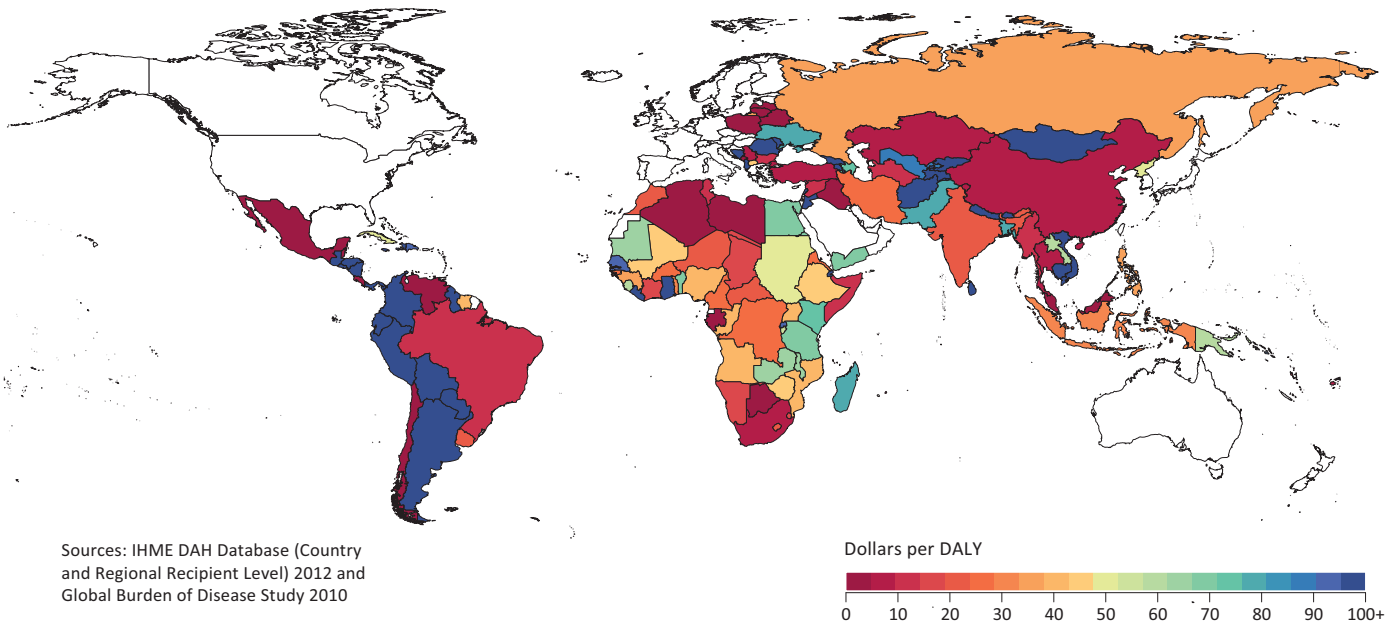
The shortfall is particularly important for sub-Saharan Africa, where about half of those estimated resources are needed, according to ONE. In South and East sub-Saharan Africa, HIV/AIDS is the most significant source of DALYs. It also ranks in the top 10 absolute DALYs for Central and West sub-Saharan Africa as well as Eastern Europe. This is evident in the "Ranking by HIV/AIDS DALYs" column of Figure 14, in which the countries with the highest HIV/AIDS DALYs are displayed. Of the top 20, 13 are located in sub-Saharan Africa. Figure 13 illustrates that most countries in the region received between \$40 and \$160 per HIV DALY. Certain countries in sub-Saharan Africa received upwards of \$300 per HIV/AIDS DALY. Figure 14 also displays the relationship between DALYs and DAH for HIV/AIDS. Notably, South Africa ranked first in both HIV/AIDS DAH and HIV/AIDS DALYs. However, disconnects between burden and DAH existed for Cameroon, Myanmar, and Brazil, which had particularly low levels of HIV/AIDS DAH given their burden.

**FIGURE 15:**  
**DAH for maternal, newborn, and child health by channel of assistance, 1990-2010**

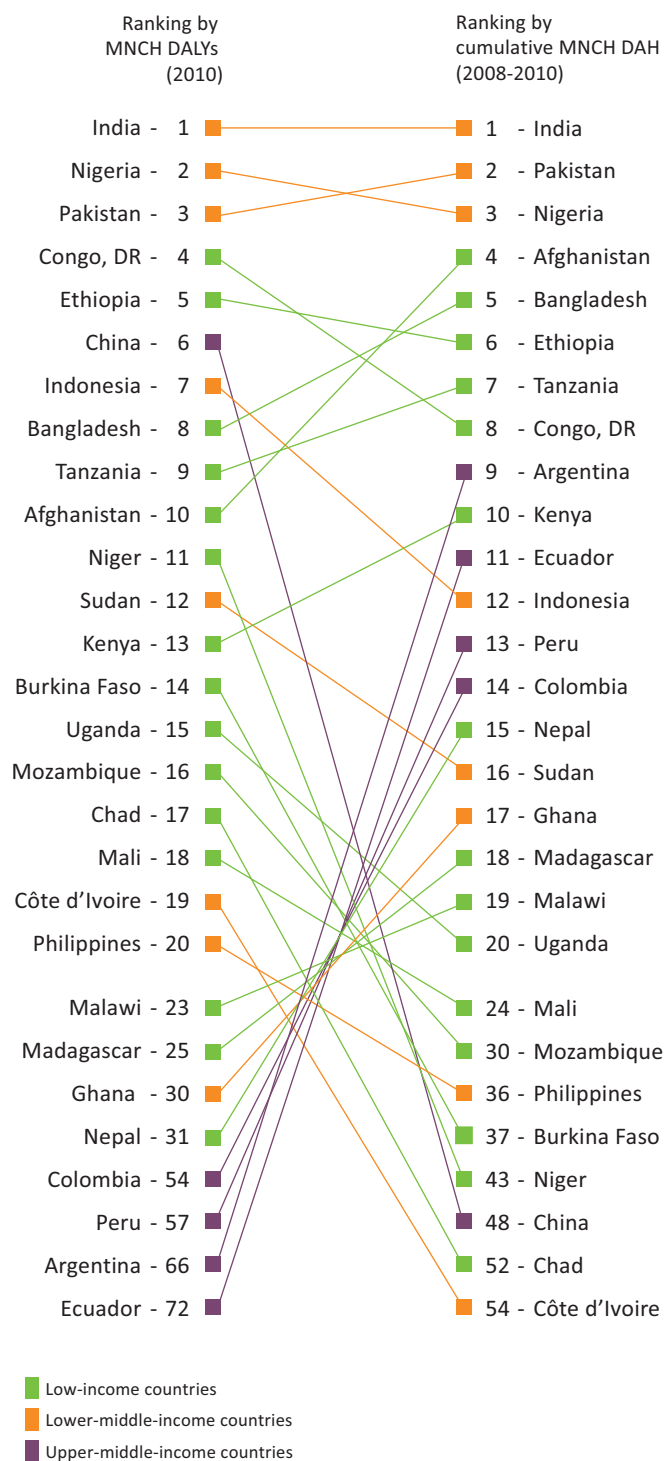


**FIGURE 16:**  
**Maternal, newborn, and child health DAH, 2008-2010, per related DALY, 2010**

DALY estimates for 2010 are from the Global Burden of Disease Study 2010. Countries that were ineligible for DAH based on their World Bank income classification are shown in white. DAH received is shown in real 2010 US dollars.



**FIGURE 17:**  
**Top 20 countries by 2010 maternal, newborn, and child health (MNCH) burden of disease versus cumulative 2008-2010 MNCH DAH**



Sources: IHME DAH Database (Country and Regional Recipient Level) 2012 and Global Burden of Disease Study 2010

## DAH for maternal, newborn, and child health

Compared to the rapid growth rates of HIV/AIDS DAH, expenditure on MNCH has not grown as quickly, although increases were still steady from 1990 onward. MNCH DAH, at \$1.22 billion in 1990, made up a much more substantial share of total DAH two decades ago. By 2010, MNCH spending reached almost \$5.2 billion, an 8.8% increase from 2009. According to our 2010 estimates, as shown in Figure 15, the US was the single largest contributor to MNCH, spending approximately 17.1% of the total in 2010. UNICEF (16.6%) and UNFPA (15.9%) followed closely behind the US in terms of their share of expenditure on MNCH. GAVI also made up a major proportion of spending on MNCH, at 14.9% of MNCH DAH in 2010; spending in this health focus area increasingly concentrates on vaccinations.

MNCH growth trends from 2009 to 2010 coincide with the creation of new MNCH initiatives. The Every Woman Every Child initiative has received over \$20 billion in commitments since its inception in 2010.<sup>32</sup> In 2012, the London Summit on Family Planning also succeeded in mobilizing billions of dollars for MNCH.<sup>33</sup> The debut of the spending associated with Every Woman Every Child and other maternal and child health initiatives is manifested in MNCH growth rates. In 2010, UNICEF spending on MNCH jumped 60.9% (the response to the earthquake in Haiti and the floods in Pakistan also contributed to this rise).<sup>34</sup> MNCH DAH disbursements also grew significantly for the UK (38.8%). Other actors engaged in supporting MNCH also increased the DAH provided for the sector. A surge in funding for the WHO's programs on MNCH (8.5%) as well as US bilateral (9.4%) and UNFPA support (2.3%) bolstered sector-wide growth.

These investments in the MNCH focus area have risen with the decrease of global MNCH DALYs. Among children younger than 5 years of age, global DALYs declined from 41% in 1990 to 25% in 2010.<sup>12</sup> In 1990, maternal disorders were 0.9% of global DALYs, by 2010 these disorders made up 0.6%. However, globally, a quarter of the global burden remains a result of disease and injury in children younger than 5.

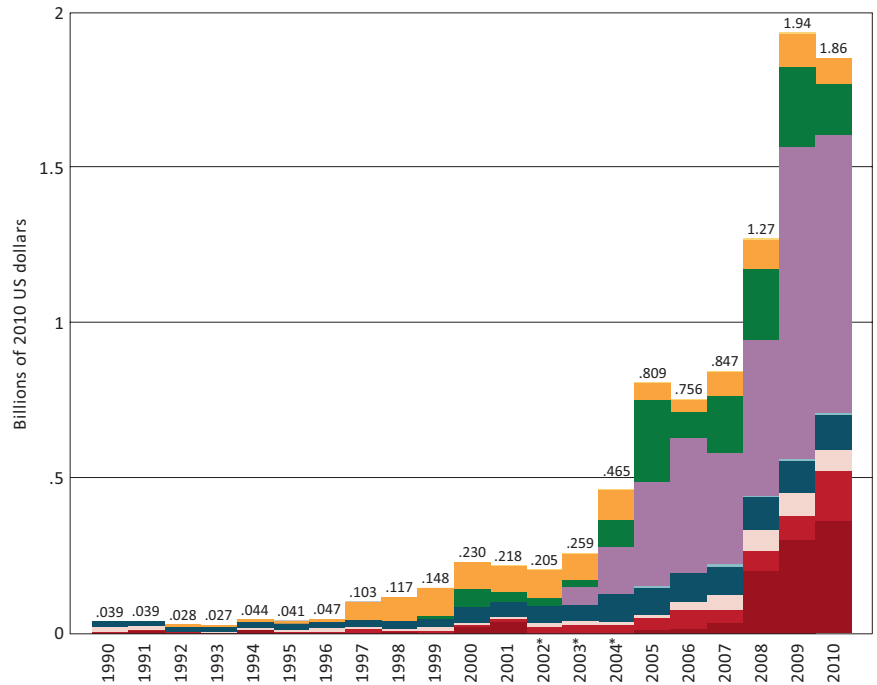
Among the 10 countries with the highest MNCH DALYs, as displayed in Figure 17, eight received among the highest amounts of MNCH DAH, all of which are low- or lower-middle-income countries. China is the only upper-middle-income country ranked in the top 20 and it received vastly less MNCH DAH in relative terms, at 48th among recipients of cumulative MNCH

**FIGURE 18:**  
**DAH for malaria by channel of assistance, 1990-2010**

- Regional development banks
- World Bank – IDA
- BMGF
- GFATM
- United Nations and European Commission:
- EC
- WHO
- Bilateral agencies:
- Other
- United Kingdom
- United States

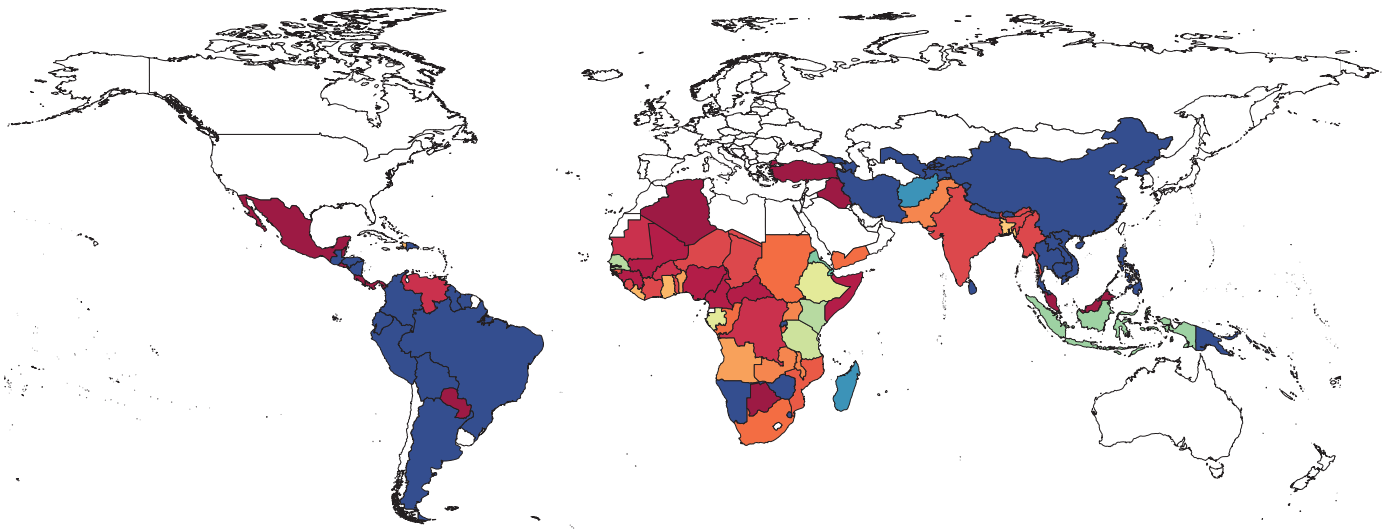
Sources: IHME DAH Database 2012 and IHME DAH Database (Country and Regional Recipient Level) 2012

\*2002-2004 US bilateral project descriptions lack detail, and thus disease-specific DAH totals for those years may be incomplete.

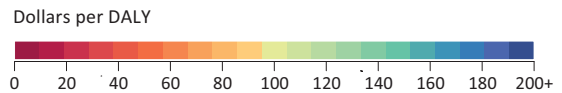


**FIGURE 19:**  
**Malaria DAH, 2008-2010, per related DALY, 2010**

DALY estimates for 2010 are from the Global Burden of Disease Study 2010. Countries that were ineligible for DAH based on their World Bank income classification and countries not considered malaria-endemic by the *World Malaria Report 2011* are shown in white. DAH received is shown in real 2010 US dollars.

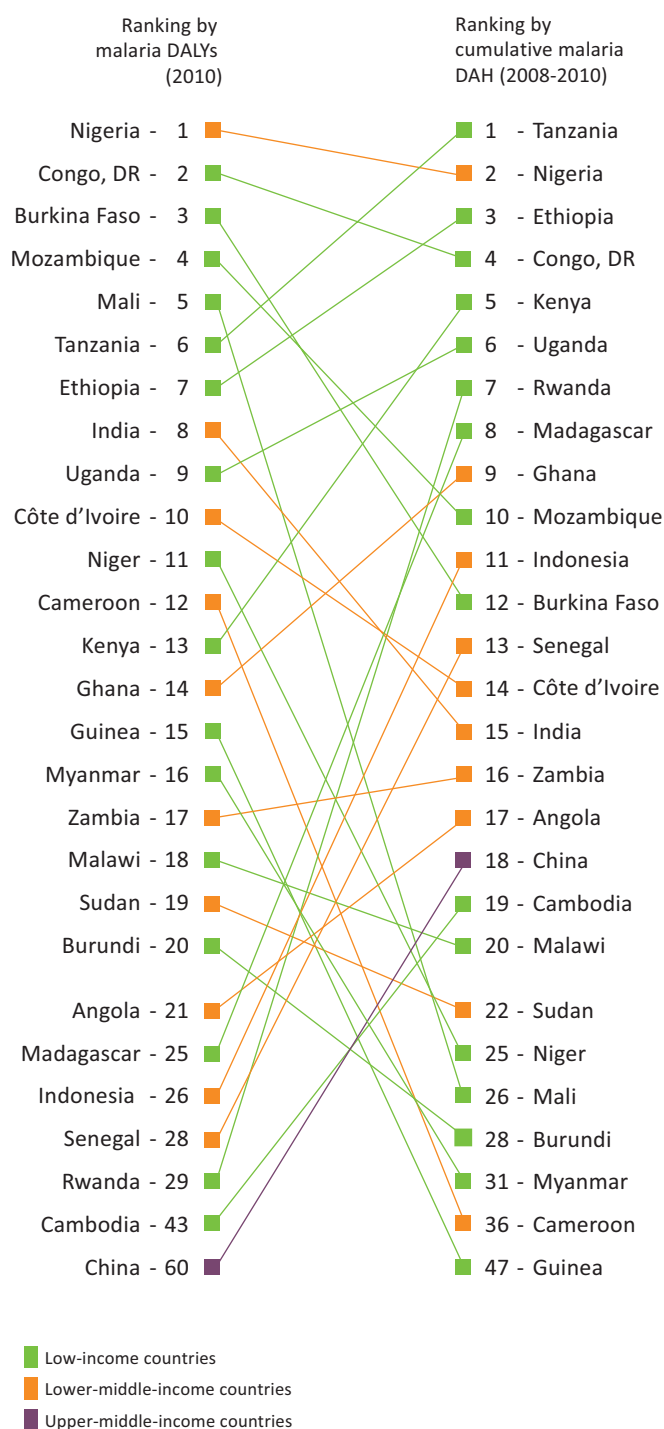


Sources: IHME DAH Database (Country and Regional Recipient Level) 2012, Global Burden of Disease Study 2010, and *World Malaria Report 2011*





**FIGURE 20:**  
**Top 20 countries by 2010 malaria burden of disease versus cumulative 2008-2010 malaria DAH**



Sources: IHME DAH Database (Country and Regional Recipient Level) 2012 and Global Burden of Disease Study 2010

DAH. However, a number of upper-middle-income countries with lower DALYs (Argentina, Peru, and Colombia) received some of the highest absolute levels of DAH for MNCH. This is highlighted in Figure 16 (on page 28), which shows that MNCH DAH per MNCH DALY was relatively high in parts of Central and South America. Worldwide, MNCH DAH per DALY ranged from less than \$5 in select countries, including a few upper-middle-income countries, to over \$100 in parts of the Central and South America region.

### DAH for malaria

Unlike DAH for HIV/AIDS and MNCH, spending on malaria dipped from 2009 to 2010. Total DAH for malaria amounted to almost \$1.9 billion, a decrease of 4.2% from 2009. The cutback in spending was driven by a number of actors, including the EC, other bilaterals, GFATM, and other organizations, all of which reduced spending on malaria DAH in 2010. According to our estimates, US and UK expenditures on malaria were up 20.4% and 103.5%, respectively, in 2010. The large increase in UK spending was the result of a significant investment in GFATM's Affordable Medicines Facility – malaria (AMFm). Reflecting the 2010 decline, the Roll Back Malaria Partnership, the global entity focused on reducing malaria, identified a \$3.6 billion gap in spending if global malaria targets are to be met by 2015.<sup>35</sup>

However, as shown in Figure 18, the drop follows strong growth since 2005, including a \$664 million jump in malaria DAH from 2008 to 2009 (a 52.1% increase). This rise was principally due to increased investments by GFATM, which more than doubled from 2008 to 2009. The creation in 2005 of the President's Malaria Initiative, launched with US funding, has also driven this increase in recent years. Furthermore, BMGF, through increased investment in programs such as PATH's Malaria Vaccine Initiative, has contributed significantly to malaria DAH.

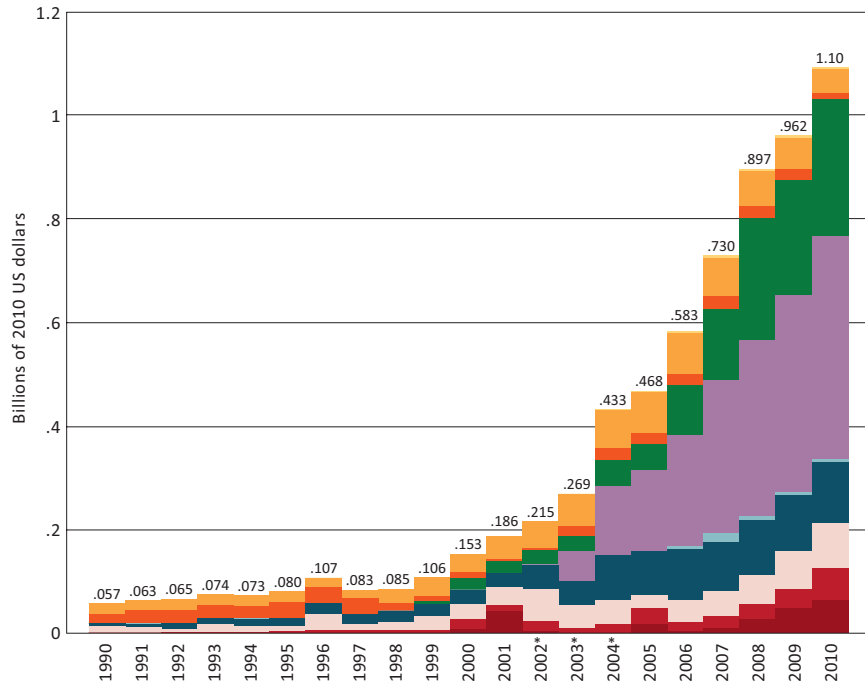
The expansion of malaria program support was built on the recognition that malaria accounts for 3.3% of total global DALYs.<sup>12</sup> Furthermore, according to new research by IHME in 2012, 22.6% of the global malaria burden occurs in adults over the age of 15 years – a previously unknown cause of adult disease burden.<sup>13</sup> Malaria also predominantly affects developing countries. The countries afflicted with the highest malaria DALYs, as shown in Figure 20, are all classified as low-income or lower-middle-income

**FIGURE 21:**  
**DAH for tuberculosis by channel of assistance, 1990-2010**

- Regional development banks
- World Bank – IDA
- World Bank – IBRD
- BMGF
- GFATM
- United Nations and European Commission:
  - EC
  - WHO
- Bilateral agencies:
  - Other
  - United Kingdom
  - United States

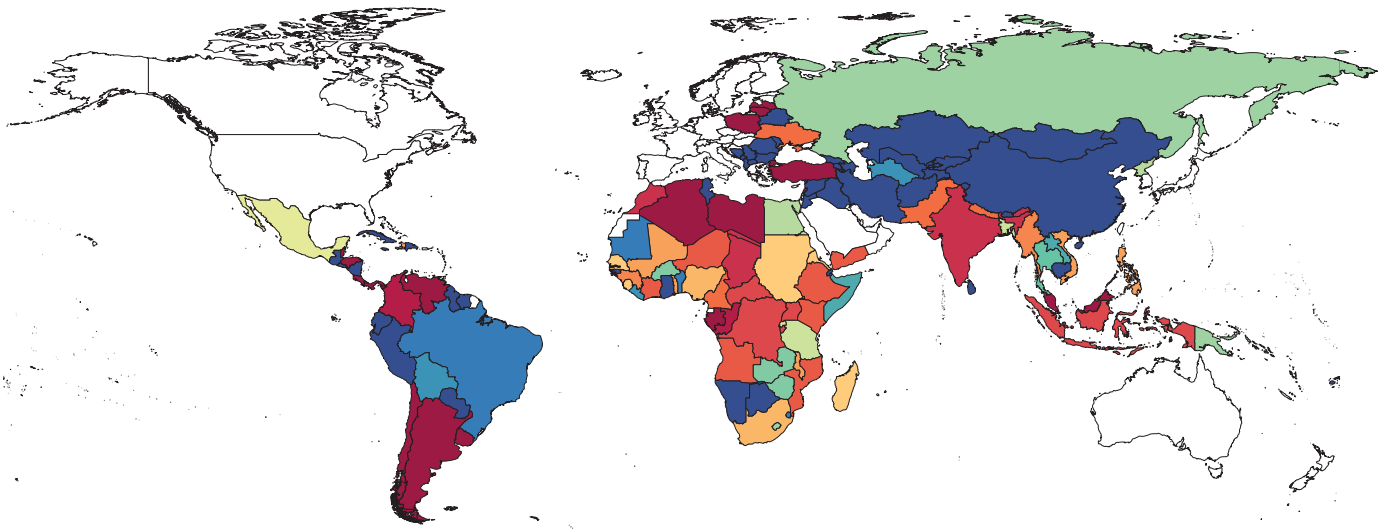
Sources: IHME DAH Database 2012 and IHME DAH Database (Country and Regional Recipient Level) 2012

\*2002-2004 US bilateral project descriptions lack detail, and thus disease-specific DAH totals for those years may be incomplete.

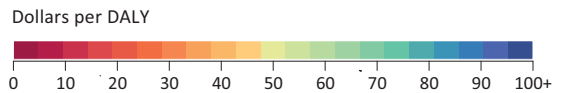


**FIGURE 22:**  
**Tuberculosis DAH, 2008-2010, per related DALY, 2010**

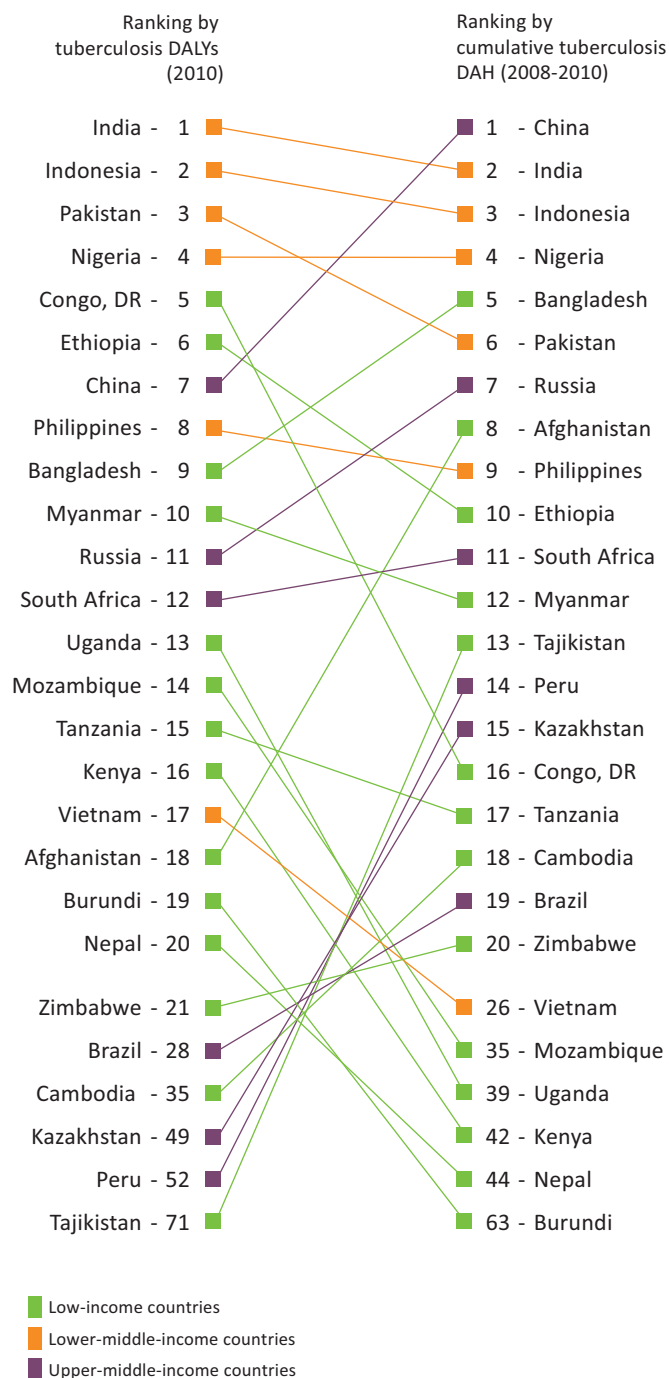
DALY estimates for 2010 are from the Global Burden of Disease Study 2010. Countries that were ineligible for DAH based on their World Bank income classification are shown in white. DAH received is shown in real 2010 US dollars.



Sources: IHME DAH Database (Country and Regional Recipient Level) 2012 and Global Burden of Disease Study 2010



**FIGURE 23:**  
**Top 20 countries by 2010 tuberculosis burden of disease versus cumulative 2008-2010 tuberculosis DAH**



Sources: IHME DAH Database (Country and Regional Recipient Level) 2012 and Global Burden of Disease Study 2010

countries. China is the only upper-middle-income country to appear among the top 20 recipients of DAH for malaria. Malaria is also most concentrated in sub-Saharan Africa; only one non-African country, India, ranks among the countries with the highest malaria burden. Spending on malaria in terms of DAH per DALY, as exhibited in Figure 19 (on page 30), is high in most of South America as well as East Asia and the Pacific because the relative burden was low. Sub-Saharan Africa as a whole, and particularly West and Central sub-Saharan Africa, received relatively low levels of malaria DAH per malaria DALY.

### DAH for tuberculosis

Worldwide, TB accounts for 2% of all DALYs and ranks 13th overall in terms of causes of disease.<sup>12</sup> In October 2012, the WHO’s Stop TB Department announced that the world had achieved the MDG target of halting and reversing the TB epidemic and was also on track to reduce TB prevalence by 50% by 2015. According to the *Global Tuberculosis Report 2012*, however, Africa and Europe lag behind the rest of the world in making progress toward these goals.<sup>36</sup>

Figure 21 illustrates that TB programs have benefited from a significant increase in funding since 2004. This trend continued on to 2010, with year-over-year growth of 13.8%. A total of \$1.1 billion in DAH was spent on TB in 2010. As with malaria, this funding can be largely attributed to GFATM, which contributed 39.4% of funds and spent \$432 million on TB in 2010. BMGF also provided substantial support to TB programs, disbursing 24.2% of total TB DAH in 2010. Although a good portion of these contributions are expected to continue in coming years, the *Global Tuberculosis Report* also emphasized a funding gap of \$1.4 billion for research and \$3 billion for control and care annually between 2013 and 2015.<sup>36</sup>

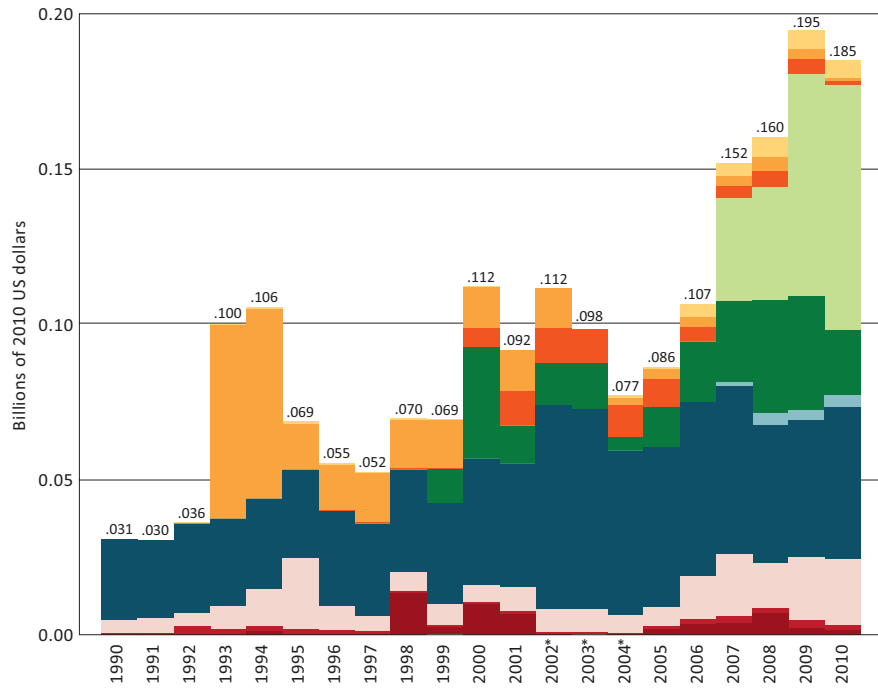
Figure 23 indicates that TB is present in countries across income levels, including the upper-middle-income countries of China, Russia, and South Africa. These and other upper-middle-income countries (Peru, Kazakhstan, and Brazil) were ranked among the top 20 recipients of cumulative TB DAH from 2008 to 2010. Kazakhstan and Peru in particular received large amounts of DAH for TB despite relatively small burdens. This mix of spending and burden is also evident in Figure 22. Globally, DAH per TB DALY ranged from under \$5 to over \$100 across regions. A few countries in South America and East and Central Asia received especially high levels of DAH per DALY.

**FIGURE 24:**  
**DAH for noncommunicable diseases by channel of assistance, 1990-2010**

- Regional development banks
- World Bank – IDA
- World Bank – IBRD
- Bloomberg Family Foundation
- BMGF
- United Nations and European Commission:
  - EC
  - WHO
- Bilateral agencies:
  - Other
  - United Kingdom
  - United States

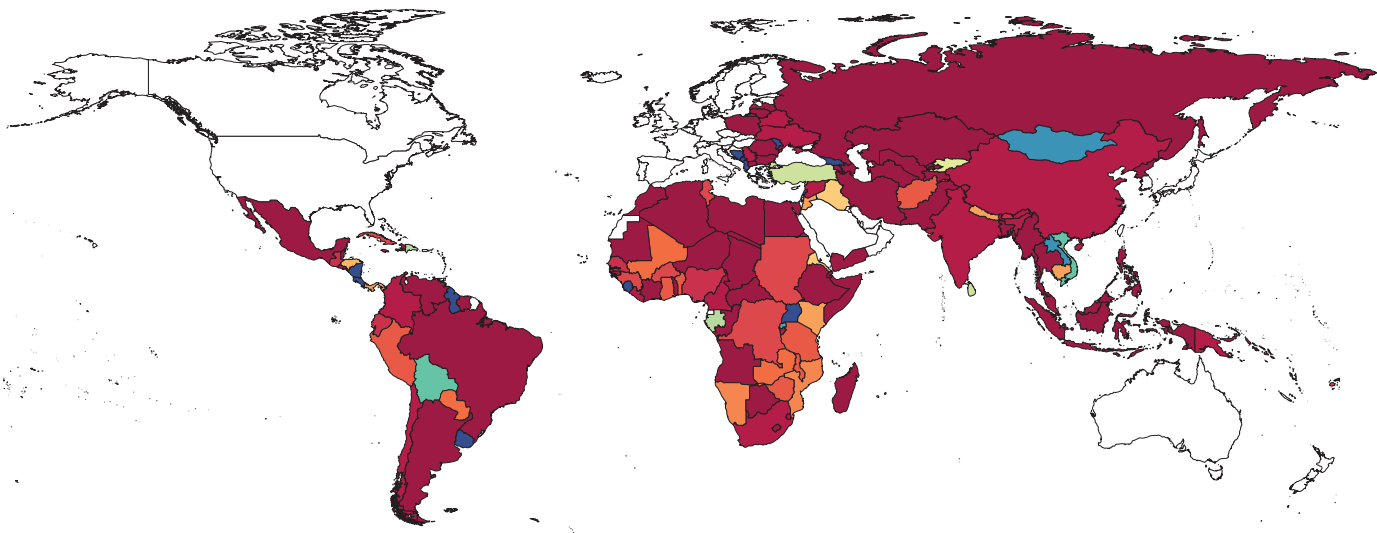
Sources: IHME DAH Database 2012 and IHME DAH Database (Country and Regional Recipient Level) 2012

\*2002-2004 US bilateral project descriptions lack detail, and thus disease-specific DAH totals for those years may be incomplete.

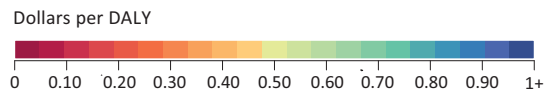


**FIGURE 25:**  
**Noncommunicable diseases DAH, 2008-2010, per related DALY, 2010**

DALY estimates for 2010 are from the Global Burden of Disease Study 2010. Countries that were ineligible for DAH based on their World Bank income classification are shown in white. DAH received is shown in real 2010 US dollars.



Sources: IHME DAH Database (Country and Regional Recipient Level) 2012 and Global Burden of Disease Study 2010



### DAH for noncommunicable diseases

NCDs include cancer, diabetes, heart disease, and other illnesses that are noninfectious and nontransmissible. In 2011, a high-level UN meeting on NCDs was convened to emphasize the need to address NCDs' growing share of burden, among other issues.<sup>37</sup> However, NCDs have not traditionally been a chief focus of development assistance for health, and NCD DAH remains a very small portion of total spending. Out of \$28.2 billion of DAH in 2010, DAH for NCDs amounted to \$185 million. Similar to DAH for malaria, expenditure on NCDs fell 5.1% in 2010. This is displayed in Figure 24.

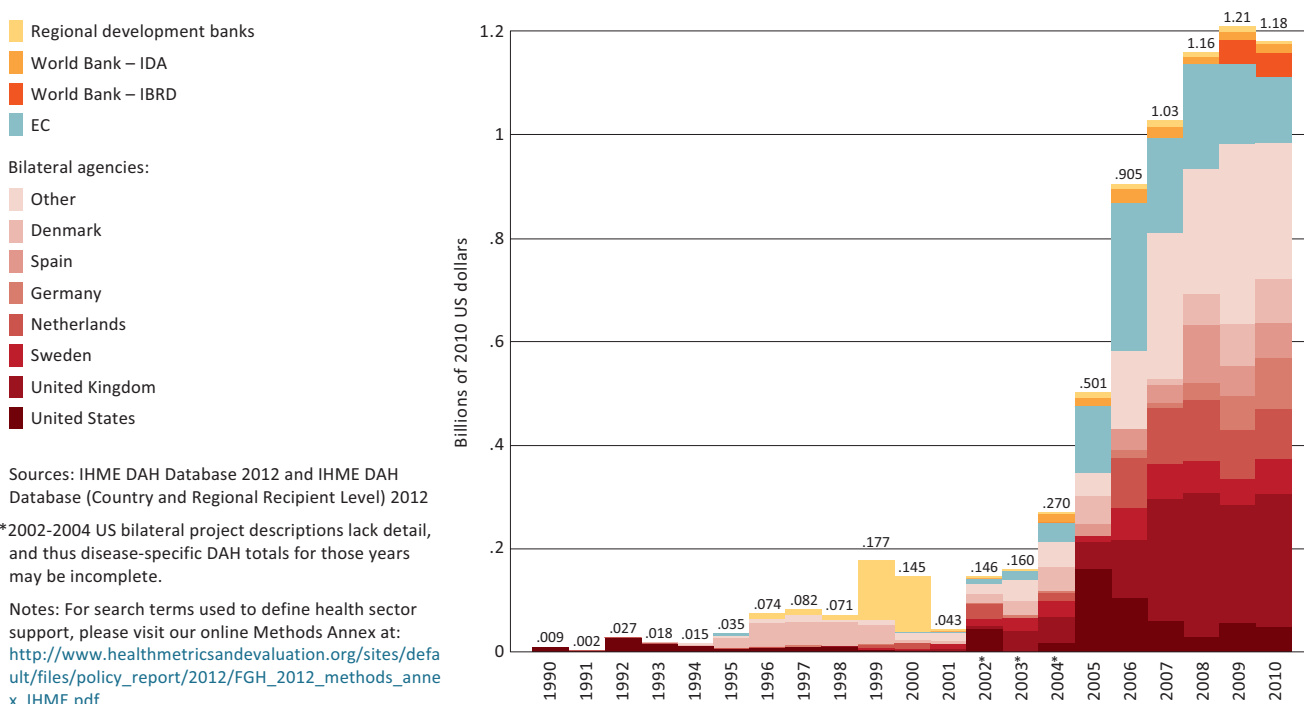
The results of GBD 2010 underscore the growing importance of this health focus area. Since 1990, the global burden of disease has shifted substantially away from communicable diseases to NCDs. As a portion of global DALYs in 1990, 43% were NCDs; by 2010, NCDs had risen to 54% of global DALYs.<sup>12</sup> As people live longer and communicable diseases are tackled more systematically, NCDs will be an increasingly important issue for health systems in low- and middle-income countries. Investing in preventive measures now can prevent the need for expensive curative care in the future.<sup>38</sup>

Since 1990, the WHO has been one of the most consistent supporters of DAH for NCDs, providing \$49 million or 26.5% of this funding in 2010. In recent years, the Bloomberg Family Foundation, which focuses on smoking prevention and other issues, has committed an increasing share of its resources to NCDs and now accounts for 42.7% of NCD DAH (\$79 million). Spending on NCD DAH per DALY is low across regions. Figure 25 shows that countries that received the highest NCD DAH per DALY were allocated, at most, \$1 per NCD DALY. We refrained from ranking countries by NCD DAH or DALYs associated with NCDs because spending on NCDs is low enough to be subject to a large amount of variability and thus be unrepresentative of trends overall (i.e., a single project could make a recipient highly ranked).

### DAH for health sector support

DAH for health sector support includes disbursements made directly to developing-country governments to spend on health system strengthening or other health priorities. DAH for health sector support is particularly hard to separate from DAH for diseases or MNCH because definitions of health sector support are not

**FIGURE 26:**  
DAH for health sector support by channel of assistance, 1990-2010



applied uniformly. DAH for health sector support took off after development assistance partners committed to this particular approach in the 2005 Paris Declaration on Aid Effectiveness.<sup>39</sup> The declaration emphasizes the alignment of development assistance with country-government priorities and stresses the use of development assistance to strengthen national systems, in line with creating sustained domestic capacity. The effect of the Paris Declaration is evident in the growth of DAH for health sector support from 2005 onward; from 2005 to 2010, health sector support increased almost \$700 million.

As shown in Figure 26 (on page 35), European bilateral development organizations provided the bulk of funding for health sector support. Despite strong support from most European agencies, total DAH for health sector support contracted 2.5% from 2009. Among the European bilaterals highlighted in Figure 26, only the EC's DAH dropped significantly (17.2%). The UK, which provides the most significant amount of DAH for health sector support, contributed \$258 million in 2010, a 13.5% increase from 2009. We also observed growth in the DAH provided by Germany (50.9%), Sweden (31.5%), Spain (14.4%), and the Netherlands (2.9%). DAH from the US for health sector support, meanwhile, decreased 14.5% from 2009 to 2010.

CHAPTER 4:

# SOURCES OF DEVELOPMENT ASSISTANCE FOR HEALTH

The rapid-growth phase, in addition to concentrating on certain health focus areas, was characterized by the emergence of new sources of DAH as well as large increases in DAH from traditional sources. This chapter explores the variation in sources of DAH over time up until 2010 (the most recent year for which estimates are available). The peak of DAH in 2010 coincides with growth in DAH for most sources, although several prominent bilateral actors reduced spending from 2009 to 2010.

In the more recent no-growth phase, development assistance has come under increased pressure due to the lackluster economic recovery and the consequent

adoption of austerity measures in OECD countries. Among the top 15 donors, eight expected development assistance to drop in 2012.<sup>7</sup> However, the UK and Australia, in addition to several other OECD countries, remained committed to their development assistance targets.<sup>7</sup> The OECD’s Development Assistance Committee (OECD-DAC) bilateral aid is projected to grow only 1.3% in 2013, a significant slowing relative to the rapid- and moderate-growth phases.<sup>40</sup>

### Sources of DAH

In 2010, DAH reached a peak of \$28.2 billion as part of a historic high in ODA, which climbed to \$148.4 billion.<sup>19</sup>

FIGURE 27:  
DAH by source of funding, 1990-2010

Funds from channels for which we were unable to find disaggregated revenue information as well as interagency transfers from non-DAH institutions are included in “unallocable.” “Other” refers to interest income, currency exchange adjustments, and other miscellaneous income.



Source: IHME DAH Database 2012

Notes: 2011 and 2012 are preliminary estimates based on information from channels of assistance, including budgets, appropriations, and correspondence. Data were unavailable to show total DAH by source of funding for 2011 and 2012.

The US was the single largest contributor to both ODA and DAH. In 2010, the US provided the second-highest real level of ODA ever recorded, at \$30.4 billion.<sup>40</sup> US DAH alone amounted to \$10 billion or 35.6% of total DAH, as represented by Figure 27 (on page 37). This was a 19.6% increase on 2009 spending.

The trends in European bilateral spending were mixed, reflecting the economic and political climate prevailing in Europe. While a number of bilateral agencies in fact increased their DAH, the pressure to slash budgets and the implementation of austerity measures were also observed. The UK provided the second highest level of DAH among sources in 2010 (\$2.3 billion), constituting 8.2% of the total, but decreased its spending relative to 2009 (17.2%). France also increased its DAH to \$1.17 billion, a 22% increase. Norway increased less than a half a percent to \$704 million. In contrast, Germany's DAH of \$947 million contracted 9.5% from 2009. The DAH provided by Spain (\$596 million) and the Netherlands (\$552 million) also shrank by 25.4% and 5.9%, respectively.

Outside of Europe, the other most prominent donors increased their DAH disbursements. In 2010, the DAH

provided by Japan amounted to \$867 million, a 17.2% increase on 2009. Canada's DAH in 2010 increased substantially (31.3%) to \$883 million. Australia's DAH (\$521 million) grew a significant 56.7% in 2010.

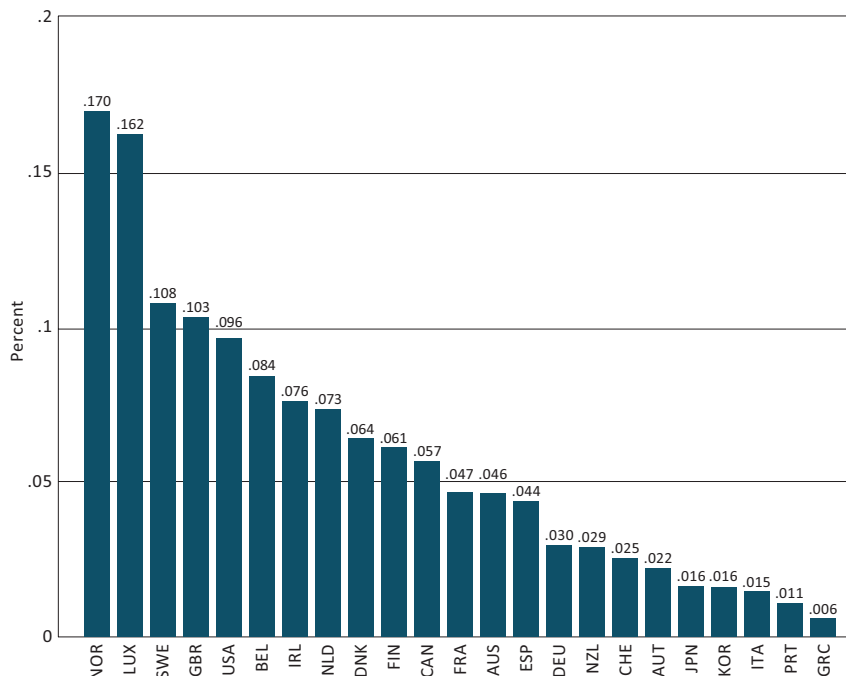
A solid majority of OECD countries increased their DAH disbursements from 2009 to 2010. However, looking to 2012 and beyond, projections of decreased ODA flows augur poorly for DAH. Japan's 2012 budget for ODA projected a 2% contraction in ODA.<sup>2</sup> Similarly, Canada and France announced their aid budget would shrink from 2012 to 2013.<sup>3,41</sup> The Netherlands announced it would be spending \$1.2 billion less in ODA in 2012.<sup>7</sup>

A number of countries were also projected to increase ODA, an indication of the potential continuation of the no-growth phase of DAH. Australia anticipated that DAH would increase in 2012.<sup>42</sup> The UK, while unable to spend as much as initially projected, also has committed to meeting its spending goals in coming years.<sup>43</sup> Norway announced a total of \$4.7 billion of ODA would be disbursed in 2012, a record high for Norway.<sup>44,45</sup> Germany also announced that its 2012 budget would increase.<sup>46</sup>

**FIGURE 28:**  
DAH as a percentage of gross domestic product, 2010

The countries included are the 23 members of the OECD-DAC.

- AUS = Australia
- AUT = Austria
- BEL = Belgium
- CAN = Canada
- CHE = Switzerland
- DEU = Germany
- DNK = Denmark
- ESP = Spain
- FIN = Finland
- FRA = France
- GBR = United Kingdom
- GRC = Greece
- IRL = Ireland
- ITA = Italy
- JPN = Japan
- KOR = South Korea
- LUX = Luxembourg
- NLD = Netherlands
- NOR = Norway
- NZL = New Zealand
- PRT = Portugal
- SWE = Sweden
- USA = United States



Sources: IHME DAH Database 2012 and World Bank World Development Indicators



### DAH as a share of GDP

In 2002, development assistance partners signed the Monterrey Consensus, which committed signees to contributing 0.7% of gross national product to development assistance.<sup>47</sup> Among OECD-DAC countries, only Denmark, Luxembourg, the Netherlands, Norway, and Sweden reached those targets in 2010.<sup>48</sup> Many other countries, however, have maintained their commitments to eventually attain that spending goal, notwithstanding the global financial crisis.<sup>7</sup>

DAH as a percentage of GDP was relatively stable from 2009 to 2010, as depicted in Figure 28. It is important to note that changes in total GDP influence this measure as much as fluctuations in DAH. As a percentage of GDP, Norway continues to top the list of donor countries, followed closely by Luxembourg. Norway's contribution to DAH as a percentage of GDP dropped from 0.186% in 2009 to 0.17% in 2010. Luxembourg gained in percent terms, rising from 0.144% to 0.162%. Sweden's support also decreased from 0.123% to 0.108% of GDP. Since 2009, these top three donors have remained constant, while small shifts occurred in the position of the other contributors. The US moved from fourth (0.091%) to

fifth (0.096%), while the UK moved up to fourth to 0.103% in 2010.

### Public sector DAH

Among the different sources of public-sector DAH, countries favored different modes of delivery. Figure 29 illustrates that the US and Canada tended to provide relatively more funding to NGOs than European countries, which preferred to channel support through their bilateral agencies. The US provided 52.9% of DAH through NGOs while 48% of Canada's DAH also flowed through these organizations. Korea, on the other end of the spectrum, channeled 80.6% of DAH through governmental entities. Certain European countries even favored particular multilaterals. Relative to the other countries, Finland and Austria allocated a high proportion of DAH to UNFPA. France spent a relatively high proportion of its DAH supporting GFATM (35%). Germany, Japan, and Italy tended to favor a mix of bilateral and multilateral organizations.

Including all sources, 38.7% of DAH was channeled to NGOs, 25% flowed through governmental entities, and the remaining was split among UN agencies and other

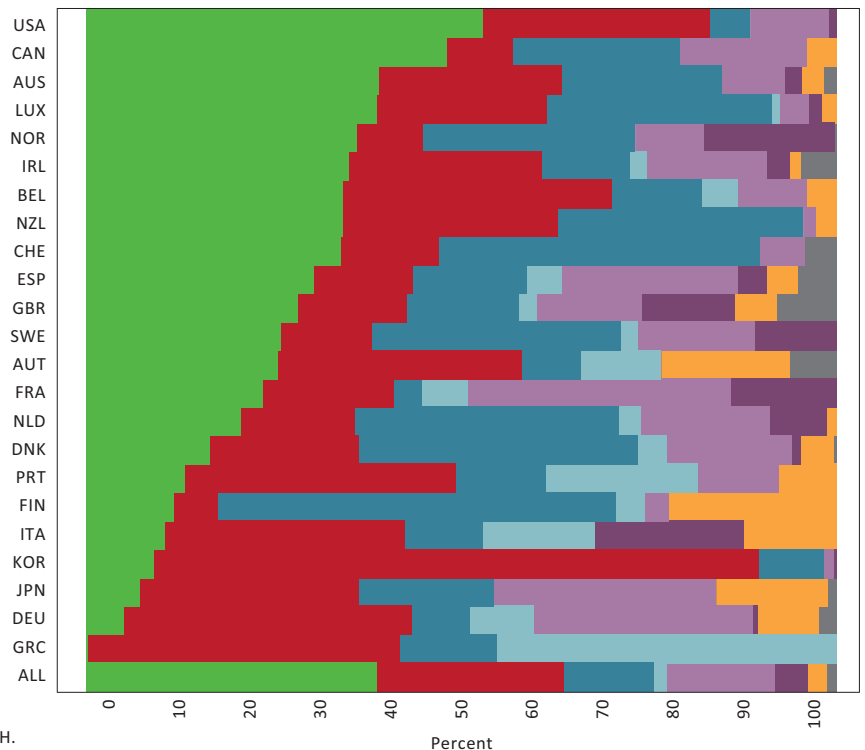
**FIGURE 29:**  
Public sector DAH (donor-country-specific) by channel of assistance, 2010

The composition of DAH from the 23 member countries of the OECD-DAC is shown.

- ALL = All-country average
  - AUS = Australia
  - AUT = Austria
  - BEL = Belgium
  - CAN = Canada
  - CHE = Switzerland
  - DEU = Germany
  - DNK = Denmark
  - ESP = Spain
  - FIN = Finland
  - FRA = France
  - GBR = United Kingdom
  - GRC = Greece
  - IRL = Ireland
  - ITA = Italy
  - JPN = Japan
  - KOR = South Korea
  - LUX = Luxembourg
  - NLD = Netherlands
  - NOR = Norway
  - NZL = New Zealand
  - PRT = Portugal
  - SWE = Sweden
  - USA = United States
- Unspecified
  - World Bank – IDA
  - Global health partnerships:
    - GAVI
    - GFATM
  - United Nations and European Commission:
    - EC
    - UN agencies (WHO, UNICEF, UNAIDS, UNFPA)
  - Bilateral:
    - Governments
  - Non-governmental channels:
    - NGOs, PPPs, other

Source: IHME DAH Database 2012

Notes: "Unspecified" indicates donor country did not report the specific channel that would first receive its DAH.



multilaterals. A very small proportion was unspecified (1.3%). The high proportion of spending on NGOs overall was driven predominantly by the large amount of DAH provided by the US to NGOs.

### NGO spending

The role of NGOs in the provision of DAH has become more prominent over the last two decades. NGOs increasingly contribute to improvements in health systems and the provision of health services the world over. The upsurge in DAH has, in fact, coincided with increased spending by NGOs. However, the trend picked up even earlier for NGOs. As Figure 30 shows, US NGO spending increased at a rapid pace from 1996 onward.

US NGOs were also hit hard by the financial crisis. After peaking at \$3.7 billion in 2009, spending by US NGOs dropped precipitously, decreasing approximately 20% from 2009 to 2010, according to IHME's preliminary estimates. The decrease continued from 2010 to 2011 (11.1%), but some recovery was evident from 2011 to 2012, with growth of 4.3%. It must be noted that, due to more information coming to light, the 2009 and 2010 DAH totals for US NGOs have been refined. IHME

originally estimated the 2009 figure to amount to \$3.2 billion; given improved data, this has been adjusted to \$3.7 billion. The 2010 figure has also been changed from an original estimate of \$2.5 billion to \$2.96 billion in this year's report. Over 2009 to 2010, NGOs disbursed more than initially expected on health.

The absolute drop from 2009 to 2012 occurred across revenue sources, but contributions from other public (i.e., government) and international organizations fell most significantly. However, in 2012, contributions to US NGOs from this category amounted to just 7.7% of total spending. BMGF contributions also fell significantly, although as noted, these tend to fluctuate as disbursements are often made in large installments. BMGF contributions amounted to 2.6% of US NGO spending in 2012. The most significant source of funding in 2012 was provided by US public sources (44%), followed by private financial contributions excluding BMGF (35.4%). Private in-kind donations, which consist of donation of medical supplies and pharmaceuticals, made up 10.3% of contributions to NGOs. All sources provided less DAH to NGOs in 2012 than at the NGO DAH peak in 2009.

**FIGURE 30:**  
**Total overseas health expenditure by US NGOs, 1990-2012**

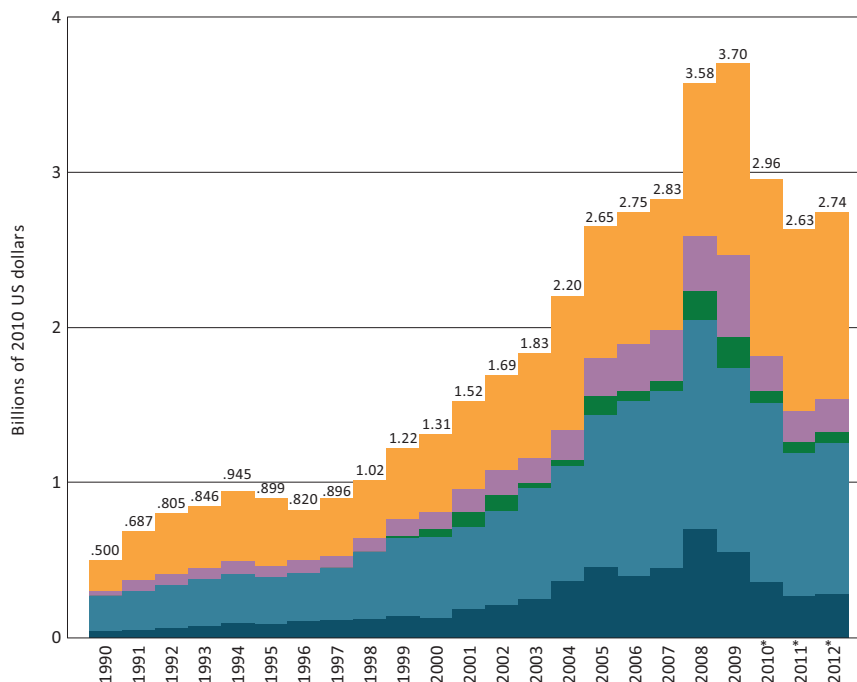
Total health spending is disaggregated by shares of revenue received from the US government, other public sources of funding and international organizations, BMGF, financial donations from private sources, and in-kind donations from private sources.

- US public
- Other public and international organizations
- BMGF
- Private financial contributions
- Private in-kind donations

Source: IHME DAH Database (NGOs) 2012

\*Data from 2010-2012 are based on preliminary estimates.

Notes: Data reflect US-based NGOs registered with USAID.



**TABLE 2:**  
**US-based NGOs with the highest cumulative overseas health expenditures, 2006-2009**

Expenditures shown in millions of 2010 US dollars.

Rank	NGO	Overseas health expenditure, adjusted	Overseas health expenditure, unadjusted	Overseas expenditure, unadjusted	Percent of revenue from private sources	Percent of revenue from in-kind contributions
1	Population Services International	1,401.59	1,401.66	1,535.22	17	0
2	Catholic Relief Services	808.63	813.91	2,505.06	33	1
3	Food For The Poor	747.95	2,820.52	4,439.78	98	90
4	PATH	601.25	612.21	648.82	84	2
5	Management Sciences for Health	515.06	515.06	566.35	1	0
6	William J. Clinton Foundation	442.75	448.67	524.84	67	2
7	United Nations Foundation	380.54	404.21	507.78	92	7
8	Elizabeth Glaser Pediatric AIDS Foundation	356.92	358.25	376.96	16	0
9	CARE	305.47	306.26	2,465.63	26	0
10	Pathfinder International	303.33	303.33	341.56	21	0
11	Academy for Educational Development	286.03	287.79	1,172.50	12	1
12	MAP International	285.94	1,367.75	1,465.55	100	97
13	Save the Children	281.16	292.47	1,518.85	50	5
14	World Vision	280.48	380.64	3,413.35	76	32
15	Brother's Brother Foundation	252.49	1,345.25	1,941.37	100	99
16	International Medical Corps	246.52	364.45	388.71	50	40
17	Project HOPE	227.91	559.91	604.82	92	73
18	Catholic Medical Mission Board	204.39	846.72	871.97	100	93
19	Feed the Children	201.60	691.25	1,905.40	100	87
20	Population Council	184.64	194.65	264.13	37	6

Source: IHME DAH Database (NGOs) 2012

Notes: Overseas health expenditure for 2010-2012 is not included because of data limitations. Data reflect NGOs registered with USAID. Adjusted overseas health expenditure reflects deflated overseas health expenditure from private in-kind donations plus unadjusted overseas health expenditure from all other revenue sources (private financial contributions, BMGF, US public, and other public).

Table 2 displays the US NGOs with the highest cumulative overseas health expenditures, which varied little from that reported in last year's *Financing Global Health*. Population Services International topped both the 2012 and 2011 rankings. Catholic Relief Services, Food For The Poor, PATH, and Management Sciences for Health were all among the top five in the 2011 edition as well. However, International Medical Corps and Feed the Children joined the top 20 US NGOs list, while the Carter Center and ChildFund International dropped off for the 2006 to 2009 period.

Due to reporting limitations, IHME is only able to generate estimates for US-based NGOs. Our estimates of NGO expenditure are based on financial data

provided by a sample of the US-based NGOs that spend the greatest amount of money overseas. For the most part, US-based NGOs that do not appear in the data from USAID's annual *Report of Voluntary Agencies* were, unfortunately, also not included in our estimates. In contrast to many bilateral and multilateral organizations, most NGOs do not publish complete and standardized health expenditure data. IHME's research on health expenditure by NGOs would be strengthened if these data were reported systematically. In an encouraging development, many UK-based NGOs have begun reporting their financial data in line with the International Aid Transparency Initiative.

## CHAPTER 5:

# GOVERNMENT HEALTH EXPENDITURE

*Financing Global Health 2012* focuses primarily on DAH, but this is not meant to eclipse the very prominent role of government health expenditure (GHE) in covering the costs of health care in developing countries. GHE constitutes the vast majority of spending on health. Although DAH also contributes to GHE, we make a special effort to isolate the spending by governments in which the funds are sourced domestically (GHE-S) to understand the contribution governments make from tax revenues and other sources of income. In 2010, while total DAH reached \$28.2 billion, GHE for the same set of countries was more than 18 times higher, at \$521 billion. Our GHE-S estimates underline the vital part governments play in supporting the provision of health services to billions of people across the world.

As discussed in Chapter 4, the lasting impact of the financial crisis on OECD countries may lead to continued stagnation or even future decreases in levels of DAH. As OECD governments begin weighing the trade-offs involved in different spending cutbacks, a number are considering reductions in aid to middle-income countries.<sup>23</sup> This may not happen for some time, as aid is phased out slowly. However, as aid is siphoned more toward low-income countries, increasing the ability of middle-income countries to collect taxes to cover health care and other costs is now on the agenda of development assistance partners.<sup>52</sup> In coming years, developing countries may rely even more substantially on GHE to finance health services.

### Government health expenditure from domestic sources

Figure 31 shows that, in 2010, the bulk of governmental spending on health was in East Asia (\$160 billion) at 30.6% of total GHE in GBD developing regions. This is consistent with the large population in that region and the sheer magnitude of growth observed there over the last 10 years. Tropical Latin America followed in terms of GHE spending in 2010 (\$91.2 billion). North Africa/

Middle East, at \$83.8 billion, had the third highest GHE among GBD developing regions.

In comparison, the total GHE for all of sub-Saharan Africa was \$29.4 billion in 2010. While this sum was small compared to other regions, governmental expenditure on health was nonetheless 3.6 times larger than the combined DAH disbursed in sub-Saharan Africa. The total GHE provided throughout sub-Saharan Africa has increased consistently since 2001. However, these increases must be considered relative to the Abuja Declaration targets: In 2001, African Union governments pledged to provide at least 15% of their annual budgets to health.<sup>53</sup> By 2011, 26 African countries had increased government expenditure on health, although only one had reached that target. In another 20 countries, the proportion of government expenditure on health had decreased or remained stagnant.<sup>54</sup>

Much like DAH, GHE growth rates have been consistently high over the last 10 years. As displayed in Figure 31, GHE has grown reliably over the last decade; substantial growth has ensued every year since 1995. The increase from 2009 to 2010, at 6% growth, was somewhat smaller than in previous years, which topped 15.7% from 2008 to 2009 and 10.7% from 2007 to 2008. The region with the highest growth from 2009 to 2010 was East Asia, which bounded up 10.1%. Also experiencing respectable rates of growth were Southeast Asia (7.6%), the Caribbean (7.3%), and Latin America (5.7%). On the whole, GHE in sub-Saharan Africa shrank 3.2%, although this was driven by a decrease in governmental spending in Central sub-Saharan Africa (35.4%).

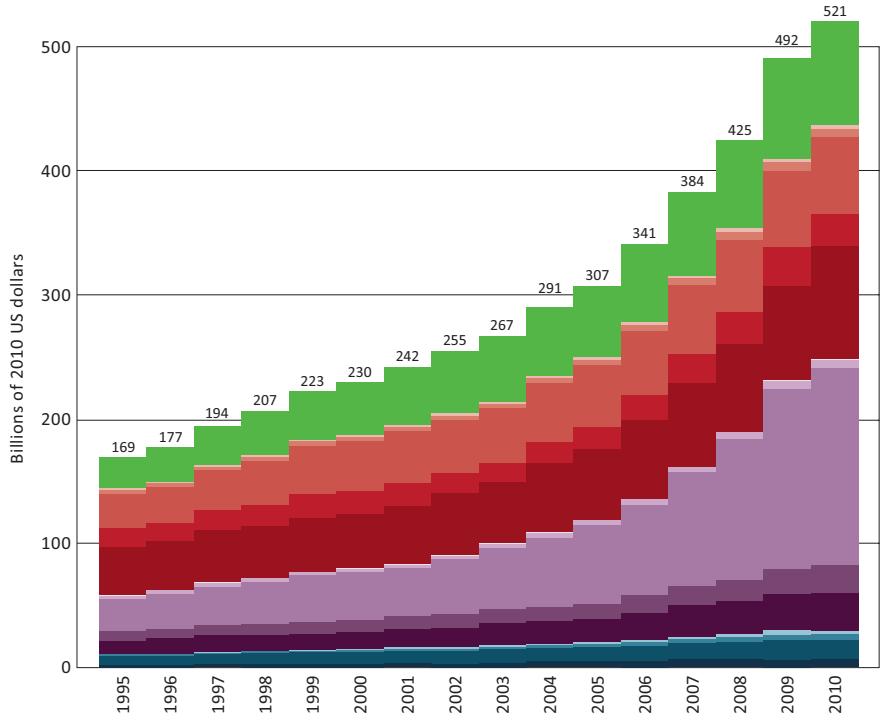
### DAH provided to governments versus non-governmental organizations

Research by IHME and others has identified that the DAH distributed through governments (DAH-G) has a different effect on governmental behavior than the effect of DAH allocated to NGOs (DAH-NG).<sup>55</sup> For this reason, IHME makes a special effort to parse out DAH-G

**FIGURE 31:**  
**GHE-S by Global Burden of Disease developing region, 1995-2010**

- North Africa / Middle East
- Caribbean
- Latin America, Andean
- Latin America, Central
- Latin America, South
- Latin America, Tropical
- Oceania
- Asia, Central
- Asia, East
- Asia, South
- Asia, Southeast
- Sub-Saharan Africa, Central
- Sub-Saharan Africa, East
- Sub-Saharan Africa, South
- Sub-Saharan Africa, West

Source: IHME Government Health Spending Database (Developing Countries) 2012

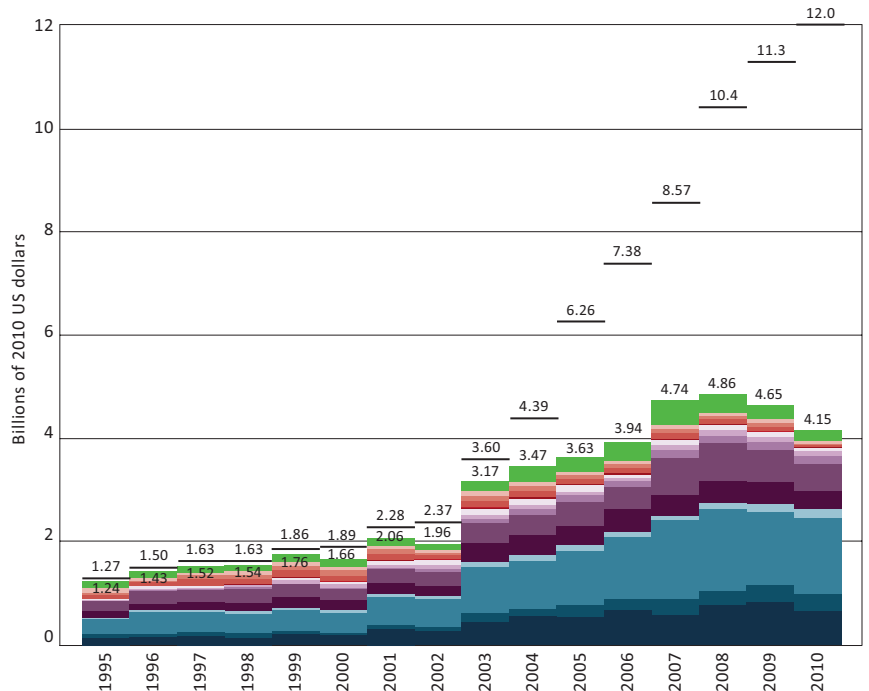


**FIGURE 32:**  
**DAH-G by Global Burden of Disease developing region, 1995-2010**

The upper-most number in each column is the sum of DAH-G and DAH-NG for that year.

- North Africa / Middle East
- Caribbean
- Latin America, Andean
- Latin America, Central
- Latin America, South
- Latin America, Tropical
- Oceania
- Asia, Central
- Asia, East
- Asia, South
- Asia, Southeast
- Sub-Saharan Africa, Central
- Sub-Saharan Africa, East
- Sub-Saharan Africa, South
- Sub-Saharan Africa, West

Source: IHME DAH Database (Country and Regional Recipient Level) 2012

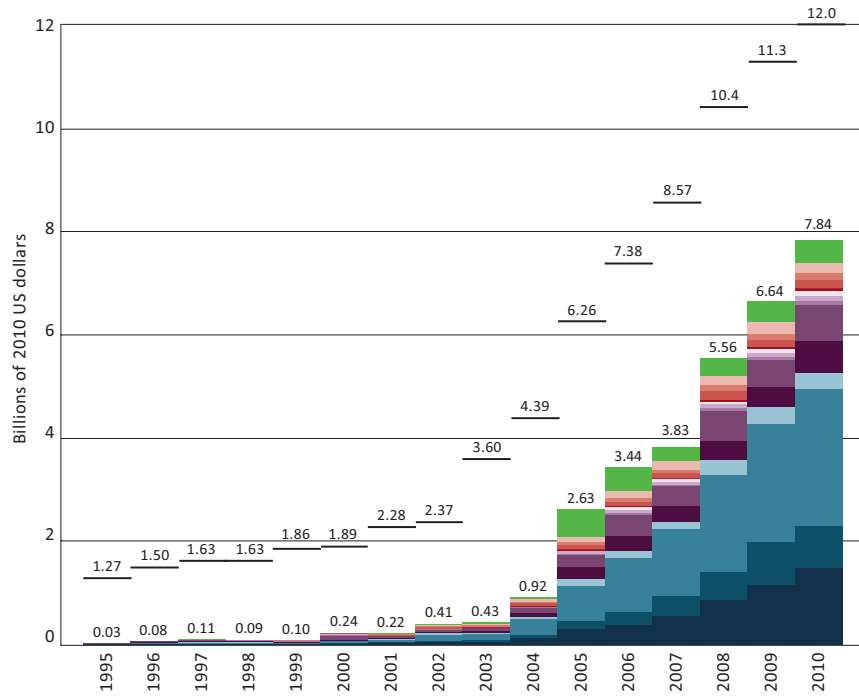


**FIGURE 33:**  
**DAH-NG by Global Burden of Disease developing region, 1995-2010**

The upper-most number in each column is the sum of DAH-G and DAH-NG for that year.

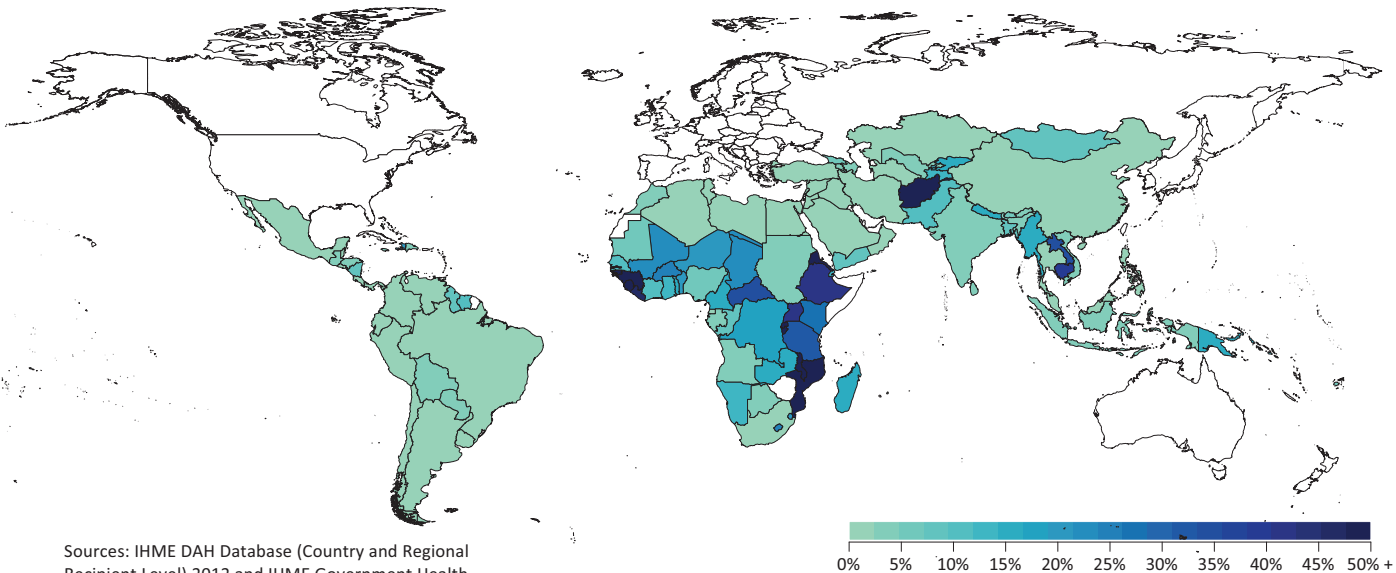
- North Africa / Middle East
- Caribbean
- Latin America, Andean
- Latin America, Central
- Latin America, South
- Latin America, Tropical
- Oceania
- Asia, Central
- Asia, East
- Asia, South
- Asia, Southeast
- Sub-Saharan Africa, Central
- Sub-Saharan Africa, East
- Sub-Saharan Africa, South
- Sub-Saharan Africa, West

Source: IHME DAH Database (Country and Regional Recipient Level) 2012



**FIGURE 34:**  
**DAH-G as a percentage of GHE, 2008-2010**

DAH channeled through developing country governments shown as a percentage of total government health spending. Estimates only shown for Global Burden of Disease developing countries excluding countries for which data were unavailable.



Sources: IHME DAH Database (Country and Regional Recipient Level) 2012 and IHME Government Health Spending Database (Developing Countries) 2012

and DAH-NG. The DAH-G/DAH-NG dataset is produced with different methods and according to different interpretations of development assistance than the DAH data. See the online Methods Annex for further details.

Splitting DAH into these two spending silos reveals how the composition of DAH has changed drastically since 1995. Figure 32 (on page 43) and Figure 33 were created to expose the changes in these two funding streams. Over time, DAH has flowed increasingly to NGOs. Figures 32 and 33 illustrate this trend (the horizontal bars represent the sum of DAH-G and DAH-NG in the corresponding year). In 1995, DAH was mainly distributed to governments; NGOs received approximately \$30 million, 2.4% of total DAH allocable to either DAH-G or DAH-NG. By 2010, DAH-NG made up 65.3% of that total, with more than \$7.8 billion of DAH-NG spent over that year. This mass increase of DAH-NG spending corresponds with the rapid-growth phase of 2001 to 2010, illuminating the key role this type of DAH played in the accelerated rate of growth over the past decade.

DAH-G has made up an increasingly smaller proportion of DAH in recent years; it has also decreased in absolute dollar terms. As Figure 32 illustrates, DAH-G reached a historic high of \$4.86 billion in 2008. Since then, the level of funds dedicated to this form of DAH has slowly declined. At \$4.5 billion, DAH-G shrank 10.8% from 2009 to 2010. DAH-G contracted across regions, with the exception of Central Asia and Central and East sub-Saharan Africa. Sub-Saharan Africa, at 63.2% of total DAH-G in 2010, received the vast majority of DAH-G.

In contrast to DAH-G, DAH-NG increased tremendously from 2001 through 2010. DAH-NG reached \$7.8 billion in 2010. This is \$3.7 billion higher than DAH-G that same year. From 2009 to 2010, DAH-NG increased 18.1% and growth was observed across regions, with the exception of the Caribbean. DAH-NG in Southeast Asia grew significantly (53.1%), as did South Asia (39.9%). Sub-Saharan-Africa, which received the most substantial portion of DAH-NG (67.2%), also grew in 2010 (14.6%).

Finally, the amount provided to governments as DAH must be considered with respect to total government spending on health. In most countries that receive DAH, this development assistance makes up only a small amount of total spending by governments on health. Figure 34 puts that relationship in perspective

by comparing DAH-G to GHE. Most countries received less than 10% of governmental funds spent on health as DAH. This was true across most of South America, North Africa, and Asia. Even in India, the country that received the most absolute DAH, the government still supplied the vast majority of public health financing.

However, certain countries in sub-Saharan Africa and Asia receive a much higher proportion of DAH-G relative to total government expenditure on health, as Figure 34 highlights. In West and South sub-Saharan Africa as well as in a few countries in Asia, DAH makes up a major proportion of government health expenditure. The reliance of these health systems on DAH, as measured by DAH's share of government health spending, should be considered in light of the decreasing levels of DAH-G from 2008 to 2010, as shown in Figure 32. Given the reliance on outside sources of funding, these governments should be aware of the vulnerability of their health systems to drops in DAH.

## CONCLUSION

A new era in development assistance for health (DAH) is emerging. After a decade and a half of sustained growth, DAH dropped in 2011 for the first time since 1990. Preliminary estimates by the Institute for Health Metrics and Evaluation (IHME) reveal that DAH has been marked by stagnation since 2010. This plateau raises a number of considerations as the global health community enters a new age of DAH.

The stagnation has thus far not been uniform across institutions. Our preliminary estimates show that while bilaterals dropped, multilaterals continued to grow. Among public-private partnerships, GAVI Alliance financing sustained its impressive trajectory, while that of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) decreased slightly from 2010 to 2012. Non-governmental organizations sustained their share.

The DAH flatline follows a decade of impressive growth rates. From 2001 to 2010, DAH grew tremendously, with increases across funding streams for the myriad of organizations that provide DAH. Public-private partnerships, foundations, and non-governmental organizations benefited most substantially as their role in DAH evolved. Spending by bilaterals also increased significantly, while multilaterals maintained consistent growth throughout the period.

The golden age of consistently higher growth in DAH relative to official development assistance (ODA) may have also ended. Previously, DAH growth significantly outpaced increases in broader ODA. Over the course of the moderate-growth period (1990 to 2001) and rapid-growth period (2001 to 2010), the portion of ODA dedicated to health increased substantially. As the no-growth phase emerges, there is evidence that a new trend is materializing: The drop in DAH from 2010 to 2011 coincides with a comparable decrease in ODA.

These changes come as the global health community embarks on a new funding cycle. Donors will consider the replenishment of funds of the International Development Association (IDA), GFATM, and other organizations in 2013. The fiscal adjustments of Organisation for Economic Co-operation and Development countries, the graduation of many countries to middle-income status, and the impending 2015 Millennium Development Goals (MDGs) deadline will all play into these fundraising efforts. IDA-eligible countries have dwindled to one-third of the original pool, which are almost exclusively located in sub-Saharan Africa (80%). Creating a transitional “IDA+” window has been posed as a suggestion to smooth countries’

transitions out of IDA eligibility. Expanding IDA objectives is being explored as well.<sup>56</sup> Also, GFATM will be convening donors to replenish funds in 2013. In recent years, GFATM has tightened its eligibility criteria for upper-middle-income countries and, in late 2012, announced it will be introducing a new funding model as well.

If the stagnation continues, other sources of financing may become increasingly important to meeting global health needs, including progress toward the MDGs. We are still far from achieving these targets in many countries, and DAH has buoyed progress toward these objectives. However, traditional aid partners are reconsidering their development assistance policies as they weigh budgetary cutbacks. Furthermore, as countries graduate to middle-income status, questions are being raised about the continued role of ODA. It has been suggested that government health expenditure, private-sector funding, and innovative financing mechanisms, such as public-private partnerships, may increasingly address health needs in middle-income as well as low-income countries in years to come.<sup>57</sup> Boosting the capacity of middle- and low-income countries to mobilize domestic resources has also been on the agenda of late.<sup>49-51</sup>

As development assistance partners make decisions about new funding commitments, the shifts in DAH, as exposed in *Financing Global Health 2012*, should be kept in mind. Fluctuations in funds and the consequent implications for the institutional and health focus mix will impact the international community’s ability to face global health challenges. If DAH for certain health focus areas, such as malaria, noncommunicable diseases, and health system support, continues to wane, decision-makers need to be cognizant of the impact. If bilateral spending continues to drop, the increasing prominence of other actors must be taken into consideration. Furthermore, attention will also have to be paid to income-based allocation of funds. Any retreat from DAH for middle-income countries should be observed closely, as three-quarters of the world’s poor now reside in middle-income countries.<sup>58</sup>

Accurate and timely information is thus increasingly necessary if decision-makers are to respond to a quickly evolving global health landscape. Fortunately, this type of information is more likely to be at the fingertips of policymakers due to efforts like *Financing Global Health*. In years to come, this publication and others can ensure stakeholders are able to make informed decisions about a multitude of global health challenges.



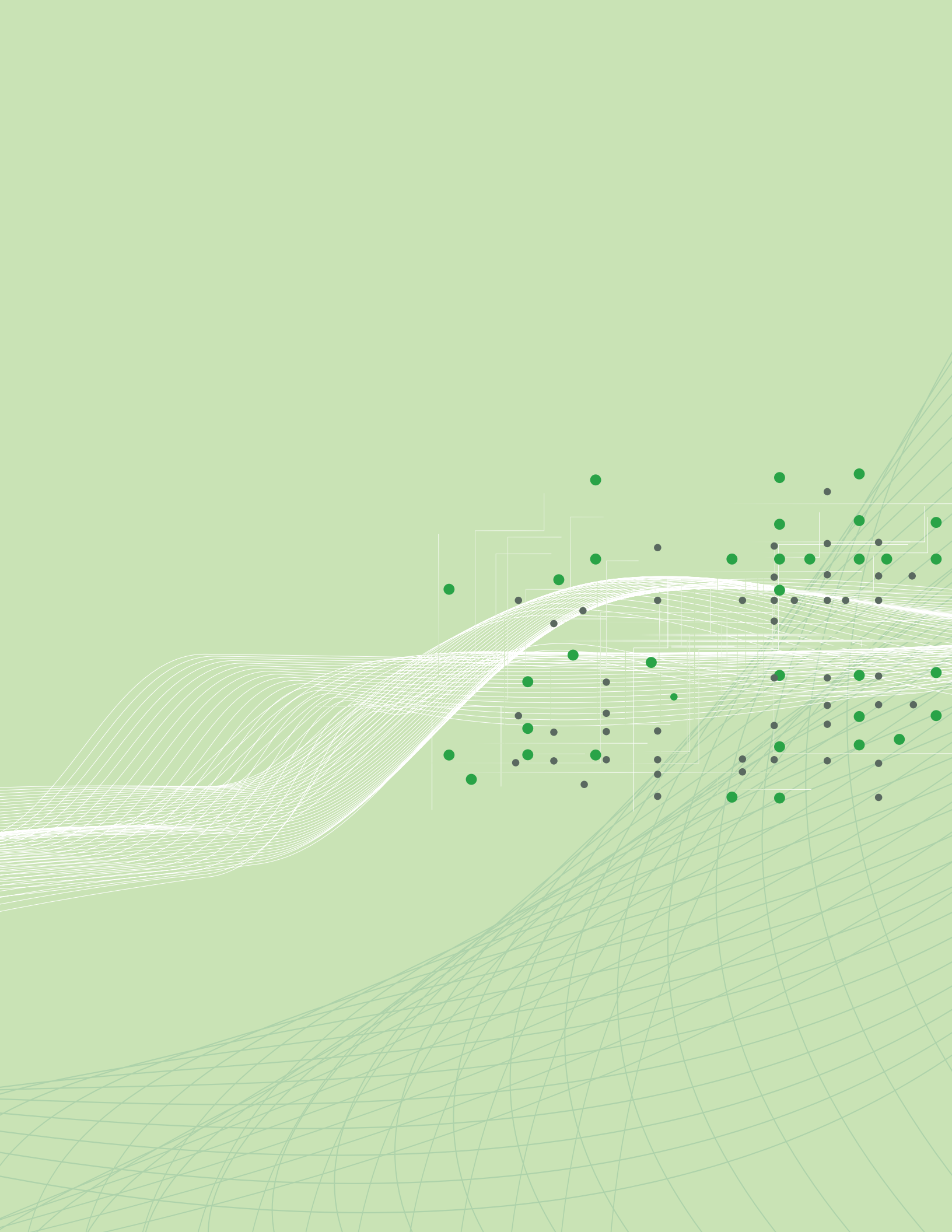
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## ANNEX A: METHODS

IHME relies on a variety of data sources and methods to produce the *Financing Global Health* report. Accounting methods and statistical models are used to generate our annual database and to estimate the most up-to-date financing levels and trends. In this annex, we briefly describe those data and methods. For further information about the sources and methods used in this report, please refer to our online Methods Annex, available at: [http://www.healthmetricsandevaluation.org/sites/default/files/policy\\_report/2012/FGH\\_2012\\_methods\\_annex\\_IHME.pdf](http://www.healthmetricsandevaluation.org/sites/default/files/policy_report/2012/FGH_2012_methods_annex_IHME.pdf)

Data compilation and collation is a yearlong effort. Our objective is to track all health-related contributions to developing countries made through public and private channels for the period of 1990 to 2012. IHME analysts collect government documents, annual reports, audited financial statements, datasets from public and private organizations, and tax forms. For several channels, publicly available information is supplemented by private correspondence. Table A1 summarizes the sources used in this year's report.

These data allow IHME to generate estimates of DAH by channel, country (recipient and source), and health focus area. A significant hurdle to estimating DAH in recent years is the lag between the disbursement of funds and the publication of spending figures. Few organizations publish comprehensive financial data concurrent with the disbursement of funds. All available data are used to approximate spending for 2011 and 2012. While IHME's estimates of DAH are preliminary, they are also valuable, as they supply policymakers with access to timely data.

Our estimates account for transfers between the channels to avoid double counting. For example, BMGF is a large funder of both GAVI and the GFATM. Yet in this report, funds from BMGF to those channels are assigned to GAVI and GFATM (BMGF remains the source of those funds, but DAH is assigned to the channel based on who is directly distributing funds to recipients). To generate estimates of the expenditure by NGOs, we collected financial data on health expenditure from the largest NGOs and a random sample of smaller NGOs in

**TABLE A1:**  
**Sources of DAH data**

Source	Data
Bilateral agencies in 23 OECD-DAC member countries and the EC	OECD-DAC aggregate database and the Creditor Reporting System, budget documents, annual reports, and correspondence
UN agencies: PAHO, UNAIDS, UNFPA, UNICEF, and WHO	Financial reports and audited financial statements, annual reports, budget documents, and correspondence
World Bank, Asian Development Bank, African Development Bank, and Inter-American Development Bank	Online project databases and compendium of statistics
GAVI	GAVI annual reports, country fact sheets, OECD Creditor Reporting System, and correspondence
GFATM	Online grant database and pledges
NGOs registered in the US*	USAID Report of Voluntary Agencies, tax filings, financial statements, annual reports, <i>RED BOOK Drug References</i> , WHO's Model List of Essential Medicines, and correspondence
BMGF and other private US foundations*	Foundation Center's grants database, tax filings, and correspondence

\*Non-US private foundations and NGOs were not comprehensively tracked due to lack of data.

the US. We do not comprehensively track private donations from countries outside of the US due to the lack of standardized and complete reporting. Studies have indicated non-US countries in the OECD's DAC provided 60% as much private contributions as the US in 2008. As the quality, comparability, and availability of data for private DAH outside of the US improves, IHME aspires to track these contributions as well.

To identify the amount of DAH allocated to different health focus areas, we used project codes, titles, and descriptions reported by channels of funding. For the World Bank's expenditure, we used project-level sector and theme codes to allocate funds. We classified all DAH from UNAIDS as DAH for HIV/AIDS and all expenditures by GAVI, UNICEF, and the UNFPA to MNCH. For those projects targeted toward multiple health focus areas (such as a project for both HIV/AIDS and TB), we assume those projects are divided equally among these areas.

Last year, our preliminary estimates of total DAH for 2010 and 2011 were \$26.7 and \$27.7 billion, respectively (measured in 2010 US dollars). This year, we report \$28.2 billion of DAH in 2010 and revised our preliminary estimate for 2011 to \$27.4 billion. Large projects can be disbursed over many years, and there are lags in obtaining project-level disbursement data. We typically rely on statistical modeling to determine which fraction of a project's budget is disbursed in the most recent years. In response to the financial crisis, organizations like the World Bank altered their operating practices to "front load" disbursements (prioritizing projects that released funds quickly). Last year, our models failed to anticipate that change. As a result, funds we had previously assigned to 2011 were actually disbursed in 2010.

We estimate government health spending through 2010, as data for more recent years are incomplete. The WHO is the only organization to regularly publish estimates of GHE in their National Health Accounts database. However, a large quantity of data were either missing or created by WHO using modeling techniques that could not easily be replicated by others (in 2009, 53% of the data were either missing or modeled). Furthermore, the WHO data report government health

expenditure as agent (GHE-A), which is government health spending financed by both domestic sources and foreign donors. In order to obtain government health expenditure as source (domestically generated expenditure, or GHE-S) from the WHO data, IHME subtracts its estimates of DAH channeled to governments (DAH-G) from GHE-A provided by WHO. While this process is conceptually simple, a number of statistical issues exist in reality, such as measurement error, currency conversions, and missingness.





## ANNEX B: STATISTICS

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**TABLE B1:**  
**DAH by channel of assistance, 1990-2012**

Channel	1990	1991	1992	1993	1994	1995	1996	1997	1998	
Bilateral development agencies										
United States	927.22	798.51	702.04	659.23	968.34	1,082.22	966.50	968.30	956.86	
United Kingdom	56.28	65.75	187.65	167.20	171.51	180.88	214.94	225.22	281.29	
Germany	97.37	114.94	157.28	190.19	291.44	380.00	315.05	353.72	296.58	
France	616.89	372.94	330.28	268.11	313.76	378.01	340.90	287.46	304.60	
Canada	58.98	59.36	47.30	45.70	63.09	91.95	70.45	56.90	59.77	
Australia	10.47	13.39	42.48	49.63	72.45	84.26	130.97	100.91	96.98	
Other bilaterals	1,056.17	981.88	1,209.71	1,239.22	1,117.66	1,252.22	1,457.94	1,391.07	1,266.04	
United Nations										
Joint United Nations Programme on										
HIV/AIDS (UNAIDS)	-	-	-	-	-	-	78.37	77.01	86.84	
United Nations Population Fund (UNFPA)	362.29	349.88	301.60	295.08	427.52	418.80	398.96	392.03	413.31	
United Nations Children's Fund (UNICEF)	225.18	217.47	280.22	274.16	292.20	286.24	257.74	253.27	267.44	
World Health Organization (WHO)	1,102.50	1,064.75	1,046.96	1,024.33	1,152.21	1,128.70	947.71	931.27	1,027.53	
Pan American Health Organization (PAHO)	277.34	267.84	275.07	269.13	285.50	279.67	264.23	259.65	292.45	
European Commission (EC) <sup>1</sup>	52.40	39.81	28.62	101.82	175.62	181.47	199.69	244.01	305.34	
Public-private partnerships										
GAVI Alliance (GAVI)	-	-	-	-	-	-	-	-	-	
Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)	-	-	-	-	-	-	-	-	-	
Bill & Melinda Gates Foundation (BMGF)	-	-	-	-	-	-	-	-	-	
Other foundations <sup>2</sup>	118.64	115.28	140.65	173.43	151.01	141.15	174.02	167.35	213.60	
Non-governmental organizations (NGOs) <sup>2</sup>	499.79	686.78	805.26	845.81	945.25	898.62	820.47	895.64	1,015.12	
World Bank										
International Bank for Reconstruction and Development (IBRD)										
	62.79	98.12	184.83	405.67	449.80	352.96	545.94	915.62	937.16	
International Development Association (IDA)	31.50	100.22	293.40	476.48	599.86	653.67	690.98	688.90	687.80	
Regional development banks										
African Development Bank (AfDB)	66.35	64.07	62.59	61.24	95.41	73.71	75.23	93.88	63.02	
Asian Development Bank (ADB)	29.47	28.58	42.96	63.21	62.63	74.29	53.11	61.64	130.51	
Inter-American Development Bank (IDB)	90.26	82.52	54.61	64.18	87.60	87.28	112.85	177.47	188.93	
<b>Total</b>	<b>5,741.88</b>	<b>5,522.08</b>	<b>6,193.51</b>	<b>6,673.80</b>	<b>7,722.85</b>	<b>8,026.11</b>	<b>8,116.05</b>	<b>8,541.33</b>	<b>8,891.16</b>	

**Preliminary estimates based on information from channels of assistance, including budgets, appropriations, and correspondence.**

Source: IHME DAH Database 2012

Notes: In millions US\$, 2010. Development assistance for health (DAH) includes both financial and in-kind contributions for activities aimed at improving health in low- and middle-income countries. This table disaggregates DAH by the institutional channel through which DAH flowed to low- and middle-income countries. Dashes indicate inapplicable.

<sup>1</sup> Includes funds from the European Development Fund and the European Commission budget.

<sup>2</sup> Only includes organizations incorporated in the United States.

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
	1,028.60	1,005.15	1,085.31	1,632.98	1,828.50	1,957.70	2,338.77	3,084.50	4,217.62	5,255.10	5,605.94	7,119.53	7,193.05	6,955.27
	375.53	567.47	490.20	576.24	629.19	627.54	800.16	1,015.74	1,233.31	1,128.30	1,229.25	1,168.61	1,221.00	1,248.59
	270.63	194.17	191.79	239.51	261.71	278.93	252.79	449.56	393.34	474.01	522.34	434.46	407.11	370.20
	261.70	202.81	217.17	248.98	244.38	350.08	341.04	357.77	252.45	392.29	372.60	480.21	405.11	352.29
	57.79	83.70	86.77	90.96	133.13	152.55	144.65	186.62	295.54	320.12	409.82	494.85	401.66	378.69
	119.46	161.87	136.05	124.22	123.89	123.82	124.42	142.88	154.74	191.63	230.35	339.06	376.59	407.04
	1,411.97	1,244.87	1,156.75	1,339.90	1,367.70	1,570.59	1,613.42	1,721.44	1,801.05	1,994.08	1,833.28	1,973.01	2,010.48	1,769.64
	85.58	132.87	129.93	113.30	110.91	179.97	174.15	235.83	229.26	266.46	263.34	293.28	289.08	272.53
	407.31	383.88	375.40	417.11	408.32	485.65	469.97	531.45	598.80	715.12	805.61	823.80	812.80	970.21
	263.56	323.16	463.42	436.74	431.08	501.83	673.91	402.51	544.38	505.58	528.60	847.32	1,093.61	1,197.11
	1,012.63	1,256.97	1,229.20	1,307.67	1,280.09	1,605.63	1,553.79	1,585.59	1,541.45	1,837.46	1,815.92	2,120.35	2,093.12	2,051.14
	288.21	287.33	280.99	274.57	268.79	272.75	263.94	358.82	348.83	384.14	379.63	423.12	414.59	371.13
	348.38	366.20	429.23	441.00	666.21	103.05	445.20	530.82	542.51	659.78	397.29	359.27	389.22	355.75
	–	2.80	146.47	118.71	208.14	218.66	283.42	450.03	1,023.17	827.67	755.55	1,068.00	1,237.18	1,755.68
	–	–	–	16.39	309.79	774.66	1,244.54	1,504.90	1,872.90	2,448.42	2,927.50	3,292.85	2,733.47	3,069.94
	163.49	373.79	276.87	413.71	545.24	345.35	472.27	676.35	878.57	1,364.71	1,261.53	1,123.28	1,152.04	898.77
	273.23	347.15	326.62	288.03	252.03	243.21	257.37	295.45	374.76	552.23	531.34	454.15	484.76	510.63
	1,222.01	1,314.64	1,524.99	1,690.82	1,833.01	2,204.46	2,653.73	2,745.91	2,829.93	3,579.26	3,703.46	2,960.04	2,631.10	2,744.27
	936.33	889.44	851.87	1,028.88	959.81	792.64	837.52	703.83	748.75	476.10	551.01	1,225.43	1,053.97	1,281.87
	860.07	891.42	1,010.76	1,185.33	1,005.74	1,203.73	1,151.06	1,032.05	966.47	964.55	842.82	822.33	750.45	912.24
	62.11	45.44	42.67	81.99	42.72	91.13	150.20	91.66	88.93	113.29	112.45	117.78	113.73	114.58
	222.04	385.32	161.19	159.30	161.52	141.85	178.84	171.77	178.54	109.03	209.08	85.37	75.83	53.56
	190.36	220.55	203.44	213.74	185.96	376.52	388.19	136.08	161.58	165.10	156.36	133.70	93.30	66.04
	9,860.96	10,681.02	10,817.05	12,440.11	13,257.86	14,602.32	16,813.36	18,411.58	21,276.90	24,724.44	25,445.08	28,159.76	27,433.25	28,107.15

**TABLE B2:**  
**DAH by source of funding, 1990-2010**

Funding source	1990	1991	1992	1993	1994	1995	1996	1997	1998
National treasuries									
Australia	27.57	30.20	61.55	72.66	115.95	112.82	173.04	137.26	119.43
Austria	35.00	15.30	12.20	13.11	18.59	15.13	17.70	69.09	34.92
Belgium	76.98	103.02	116.71	119.84	116.11	122.11	120.98	110.30	113.25
Canada	132.16	132.70	122.09	125.10	166.26	170.19	146.88	152.12	130.28
Denmark	92.43	104.40	129.70	143.04	153.46	150.45	225.53	187.32	132.63
Finland	99.64	100.91	68.45	57.54	53.55	48.12	51.01	44.29	46.29
France	669.16	425.86	393.43	359.13	471.40	503.82	505.04	403.97	418.26
Germany	203.66	223.03	279.32	346.44	561.19	645.47	536.58	549.79	504.32
Greece	1.60	1.55	1.50	1.47	2.15	9.44	15.86	17.49	18.47
Ireland	4.19	4.33	5.82	2.41	12.99	30.33	31.74	6.67	30.61
Italy	290.31	272.58	244.99	230.40	215.54	188.38	217.73	124.33	158.60
Japan	427.47	475.56	521.18	705.70	683.02	845.20	744.22	906.04	804.06
Korea	1.06	2.01	4.09	5.58	7.67	10.63	11.54	33.92	39.63
Luxembourg	1.46	1.40	9.42	9.45	4.04	18.48	19.50	29.68	31.80
Netherlands	170.78	147.33	248.14	252.40	183.69	229.76	292.49	288.84	299.33
New Zealand	1.43	2.41	2.93	3.81	56.17	53.39	4.64	4.49	5.94
Norway	123.22	115.47	125.38	117.45	100.25	94.92	155.98	146.94	118.90
Portugal	1.34	1.30	3.12	3.46	9.20	11.07	14.67	19.76	18.42
Spain	18.71	37.88	121.93	127.31	97.59	177.59	269.25	216.67	192.48
Sweden	337.18	270.94	315.69	310.01	258.30	266.78	223.35	215.21	196.74
Switzerland	82.50	76.55	65.51	64.28	87.81	71.86	69.30	84.75	53.64
United Kingdom	148.06	155.99	278.78	259.88	309.09	317.99	343.20	395.19	468.99
United States	1,397.12	1,387.96	1,490.81	1,434.24	1,840.52	1,865.17	1,748.16	1,743.07	1,736.16
Other	134.37	131.16	170.81	167.11	213.50	209.14	122.17	120.05	336.91
Private philanthropy									
Bill & Melinda Gates Foundation (BMGF)	–	–	–	–	–	–	–	–	–
Corporate donations	44.34	48.39	61.75	77.20	95.17	87.68	103.50	112.15	122.55
Other <sup>1</sup>	428.49	447.31	543.79	600.04	604.76	581.17	622.39	640.32	877.38
Debt repayments (IBRD)	78.95	122.44	222.71	475.92	615.59	538.31	722.50	1,096.49	1,094.41
Other	347.35	335.45	230.48	225.50	278.95	273.26	186.66	183.42	218.48
Unallocable	365.33	348.64	341.24	363.34	390.36	377.46	420.43	501.73	568.28
Total	5,741.88	5,522.08	6,193.51	6,673.80	7,722.85	8,026.11	8,116.05	8,541.33	8,891.16

Source: IHME DAH Database 2012

Notes: In millions US\$, 2010. Development assistance for health (DAH) includes both financial and in-kind contributions for activities aimed at improving health in low- and middle-income countries. This table disaggregates DAH by the primary funding source.

For preliminary estimates of DAH for 2011 and 2012, refer to Table B1. Dashes indicate inapplicable.

<sup>1</sup> Includes private contributions through foundations and NGOs.

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
	165.27	188.19	163.26	150.43	149.56	166.97	223.17	196.41	225.92	298.77	332.25	520.59
	101.41	66.69	40.73	40.89	51.32	44.44	55.01	52.22	63.20	78.76	68.94	82.76
	120.31	132.58	138.56	191.74	179.15	206.37	173.30	210.03	228.16	308.34	308.66	314.26
	150.36	171.24	152.54	247.91	281.96	380.95	508.98	422.33	548.26	589.06	672.34	882.79
	129.97	128.16	107.86	118.60	132.57	154.80	173.99	174.58	192.85	187.32	213.12	196.24
	48.25	48.92	51.97	64.51	68.40	73.83	76.14	86.30	85.69	94.17	95.55	142.38
	390.28	341.59	391.02	467.67	592.58	527.22	691.65	1,001.96	842.89	1,160.64	961.59	1,172.95
	512.73	487.19	498.64	589.82	590.09	520.40	586.44	747.32	797.24	1,004.00	1,047.20	947.31
	12.80	14.87	18.25	17.88	42.57	33.75	50.93	53.53	54.08	36.43	36.34	16.74
	29.58	41.50	52.44	116.19	145.87	156.18	173.61	256.14	275.55	224.64	166.82	154.40
	172.40	153.83	211.28	228.75	327.76	215.50	418.21	393.92	426.41	497.78	277.87	286.56
	854.37	875.98	850.38	643.38	769.57	927.69	837.47	808.81	616.52	671.52	740.01	867.35
	98.01	79.55	79.23	73.21	43.46	82.70	80.60	72.61	85.61	94.20	143.05	153.46
	24.56	34.52	43.01	49.83	48.69	56.45	50.88	68.44	76.92	80.55	76.54	85.38
	299.15	426.58	419.04	408.09	414.27	404.31	446.78	610.66	524.48	727.78	586.53	551.82
	6.50	6.96	9.51	12.40	13.11	16.44	19.63	25.76	26.00	34.78	36.57	40.70
	137.92	154.32	215.59	283.57	312.49	362.26	364.09	379.28	560.13	558.62	702.55	704.12
	18.14	18.82	18.40	22.03	24.79	18.63	24.01	23.94	25.61	23.98	23.33	24.38
	227.58	171.43	184.67	194.93	225.89	223.44	261.24	348.17	456.84	721.84	799.05	596.08
	198.90	181.89	153.10	196.44	217.45	334.40	475.09	486.70	508.81	539.50	483.58	490.54
	129.04	63.96	64.50	78.88	136.56	81.72	75.02	109.64	83.91	94.82	153.82	124.61
	509.93	868.09	848.77	881.53	1,090.69	1,034.16	1,382.27	1,679.77	2,155.24	1,790.92	1,965.81	2,303.52
	1,887.28	2,024.27	2,219.14	3,052.55	3,058.49	3,827.47	4,038.44	4,721.63	5,962.70	7,459.55	8,376.87	10,021.53
	340.83	117.38	106.93	87.89	90.90	141.72	146.34	172.64	214.29	245.85	233.61	357.79
	173.21	436.20	501.36	549.86	626.99	452.66	727.88	872.55	1,170.03	1,915.16	1,813.79	1,711.11
	136.00	125.28	183.81	209.33	248.30	362.13	453.33	394.99	450.17	698.28	553.01	353.15
	1,008.86	1,145.93	1,173.37	1,110.79	1,183.23	1,258.20	1,573.38	1,751.41	1,936.41	2,324.15	2,127.42	2,088.71
	1,111.91	1,115.83	1,087.03	1,410.67	1,270.37	1,133.35	1,297.76	968.16	1,138.14	744.88	853.86	1,550.56
	215.31	234.31	234.65	254.19	284.32	334.70	339.29	510.70	688.35	701.70	642.37	637.87
	650.11	824.94	598.01	686.12	636.44	1,069.49	1,088.45	810.97	856.47	816.44	952.61	780.10
	9,860.96	10,681.02	10,817.05	12,440.11	13,257.86	14,602.32	16,813.36	18,411.58	21,276.90	24,724.44	25,445.08	28,159.76

**TABLE B3:**  
**DAH by focus region, 1990-2010**

Year	Sub-Saharan Africa	South Asia	East Asia and Pacific	Europe and Central Asia	
1990	566.26	267.82	298.74	15.40	
1991	590.28	291.48	253.81	15.27	
1992	697.77	496.03	265.34	58.40	
1993	698.98	570.46	420.93	147.27	
1994	706.28	656.31	390.74	197.96	
1995	771.29	579.77	345.02	119.70	
1996	987.83	633.50	411.97	156.16	
1997	996.61	615.15	460.03	223.20	
1998	981.09	673.47	465.15	249.17	
1999	1,069.45	691.98	685.77	401.65	
2000	1,115.09	724.25	983.96	331.06	
2001	1,612.33	849.04	768.46	316.38	
2002	1,691.19	966.80	623.10	272.57	
2003	2,420.02	854.56	875.48	297.05	
2004	3,257.39	998.03	997.77	376.11	
2005	3,822.48	1,256.22	1,094.88	674.14	
2006	4,612.02	1,240.12	1,279.56	602.30	
2007	5,309.91	1,504.15	1,363.74	684.72	
2008	7,048.44	1,813.36	1,348.13	640.16	
2009	7,723.67	1,672.60	1,435.18	643.63	
2010	8,074.05	1,780.45	1,551.20	895.99	

Sources: IHME DAH Database 2012 and IHME DAH Database (Country and Regional Recipient Level) 2012

Notes: In millions US\$, 2010. Development assistance for health (DAH) includes both financial and in-kind contributions for activities aimed at improving health in low- and middle-income countries. This table disaggregates DAH by region intended to benefit from the assistance. World Bank regional groupings are used.

For preliminary estimates of DAH for 2011 and 2012, refer to Table B1.

<sup>1</sup> Global denotes contributions made toward health research or the creation of public goods for multiple regions or projects that donors categorized as benefiting the entire world.

	Latin America and Caribbean	Middle East and North Africa	Global <sup>1</sup>	Unallocable by region	Total
	364.14	120.63	45.17	4,063.72	5,741.88
	405.16	166.50	57.40	3,742.18	5,522.08
	398.72	162.19	74.62	4,040.44	6,193.51
	491.53	204.83	179.88	3,959.91	6,673.80
	477.63	214.95	487.21	4,591.79	7,722.85
	569.55	212.64	637.74	4,790.41	8,026.11
	773.99	206.35	467.74	4,478.51	8,116.05
	1,189.47	264.80	531.85	4,260.22	8,541.33
	1,183.76	231.37	453.29	4,653.84	8,891.16
	1,237.52	299.57	552.20	4,922.82	9,860.96
	1,170.39	311.27	659.32	5,385.68	10,681.02
	1,133.55	322.97	698.78	5,115.54	10,817.05
	1,294.09	278.06	1,316.58	5,997.73	12,440.11
	1,384.74	327.50	1,776.15	5,322.38	13,257.86
	1,453.60	398.50	1,194.36	5,926.56	14,602.32
	1,551.67	811.93	1,517.84	6,084.21	16,813.36
	1,263.34	812.77	1,908.46	6,693.01	18,411.58
	1,338.14	649.98	2,879.30	7,546.96	21,276.90
	1,229.20	646.96	3,148.55	8,849.64	24,724.44
	1,318.91	565.11	3,243.60	8,842.38	25,445.08
	1,618.47	521.37	3,476.91	10,241.31	28,159.76















Table B4: DAH by target country, 1990-2010, continued

Region/Country	1990		1991		1992		1993		1994		1995		1996		1997		1998		1999	
	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita
Rwanda	8.29	1.16	8.24	1.20	11.30	1.76	7.44	1.26	7.68	1.39	11.36	2.08	11.93	2.10	17.18	2.79	20.02	2.94	21.71	2.91
Sao Tome and Principe	1.33	11.44	0.33	2.77	0.20	1.67	1.92	15.55	2.38	18.99	1.78	13.87	1.59	12.10	1.61	12.08	1.50	11.01	5.01	36.21
Senegal	12.42	1.65	12.58	1.62	14.09	1.77	15.76	1.92	14.67	1.74	13.99	1.61	10.53	1.18	20.37	2.23	31.24	3.32	41.83	4.33
Seychelles	0.09	1.37	0.04	0.66	0.60	9.18	0.36	5.42	0.36	5.46	0.75	11.16	0.35	5.20	0.76	11.18	0.66	9.55	0.53	7.61
Sierra Leone	0.42	0.10	0.11	0.03	0.75	0.18	4.71	1.16	1.29	0.32	1.10	0.27	1.93	0.48	4.24	1.06	3.62	0.89	6.43	1.56
Somalia	15.71	2.38	4.43	0.67	2.28	0.35	3.56	0.55	4.18	0.65	3.08	0.47	2.61	0.39	2.23	0.33	3.40	0.49	3.17	0.44
South Africa	1.42	0.04	0.00	0.00	3.17	0.08	4.00	0.10	12.72	0.31	10.85	0.26	19.89	0.47	24.60	0.57	38.67	0.88	23.19	0.52
Sudan	8.45	0.31	3.81	0.14	5.39	0.19	16.22	0.55	1.91	0.06	3.89	0.13	7.39	0.23	5.14	0.16	7.12	0.21	7.43	0.22
Swaziland	3.35	3.87	3.59	4.04	2.04	2.24	1.21	1.31	7.40	7.81	3.09	3.18	1.07	1.07	1.22	1.20	5.10	4.88	1.20	1.12
Tanzania	38.42	1.51	46.58	1.77	52.81	1.94	56.75	2.02	41.20	1.42	39.65	1.32	61.14	1.98	67.98	2.14	94.63	2.91	93.25	2.79
Togo	1.48	0.38	5.36	1.33	7.84	1.91	1.90	0.45	3.42	0.79	3.25	0.73	3.29	0.72	7.17	1.51	8.42	1.71	3.84	0.75
Uganda	19.66	1.11	45.23	2.46	41.78	2.20	42.65	2.17	46.12	2.27	52.46	2.50	81.26	3.75	69.74	3.12	77.29	3.35	79.54	3.35
Zambia	7.90	1.00	4.91	0.60	19.68	2.35	30.40	3.53	36.56	4.13	48.51	5.31	58.13	6.18	48.52	5.01	30.29	3.04	34.80	3.40
Zimbabwe	11.80	1.13	14.48	1.35	41.35	3.75	45.08	4.00	54.78	4.76	49.99	4.25	48.53	4.06	52.58	4.33	59.38	4.83	46.29	3.72

Source: IHME DAH Database (Country and Regional Recipient Level) 2012

Notes: Development assistance for health (DAH) is in millions of US\$, 2010, and DAH per capita is in US\$, 2010. DAH includes both financial and in-kind contributions for activities aimed at improving health in low- and middle-income countries. Years in which a country was classified as high income by the World Bank is marked as "NA". This table disaggregates financial DAH transfers by the country receiving funds or intended to benefit from research or technical assistance activities. Population data were obtained from the United Nations Population Division. This table only reflects financial DAH from channels of assistance providing project-level detail, specifically: bilateral development agencies, World Bank (IDA and IBRD), ADB, AfDB, IDB, GFATM, GAVI, and BMGF.

	2000		2001		2002		2003		2004		2005		2006		2007		2008		2009		2010	
	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita
	22.19	2.78	30.86	3.70	37.93	4.43	42.58	4.89	75.62	8.55	107.98	11.97	148.19	16.04	160.40	16.91	244.78	25.10	245.32	24.45	305.29	29.60
	5.29	37.58	4.88	34.07	4.24	29.08	3.69	24.86	4.36	28.91	4.24	27.60	4.01	25.71	2.98	18.79	5.30	32.86	3.91	23.86	4.55	27.36
	37.26	3.76	62.40	6.13	46.93	4.49	96.38	8.99	91.38	8.30	102.99	9.12	128.05	11.04	71.51	6.00	98.78	8.08	107.33	8.55	102.78	7.98
	0.09	1.28	0.23	3.19	0.36	4.98	1.17	16.17	1.17	15.98	1.10	14.92	0.16	2.19	0.08	1.05	0.06	0.76	0.15	1.91	0.47	6.06
	5.43	1.28	9.82	2.25	8.83	1.94	19.66	4.15	24.83	5.04	28.10	5.50	26.91	5.10	32.78	6.04	45.86	8.24	39.35	6.90	56.28	9.64
	2.95	0.40	3.17	0.42	4.38	0.56	4.13	0.52	13.96	1.70	16.02	1.91	20.45	2.39	22.90	2.61	23.32	2.60	20.44	2.23	41.91	4.46
	27.26	0.60	51.48	1.13	48.55	1.05	110.97	2.36	124.05	2.60	179.32	3.71	203.57	4.16	333.34	6.74	494.22	9.90	619.94	12.30	588.75	11.59
	8.18	0.23	6.55	0.18	16.51	0.45	15.05	0.40	25.42	0.67	51.98	1.34	66.13	1.67	60.51	1.49	78.80	1.90	112.00	2.64	137.85	3.18
	2.26	2.08	1.04	0.95	0.87	0.79	9.55	8.59	5.35	4.78	24.89	22.05	14.18	12.43	21.04	18.20	29.16	24.87	34.13	28.68	63.67	52.75
	67.58	1.97	101.09	2.88	122.95	3.41	125.24	3.38	218.06	5.73	282.41	7.21	309.71	7.69	423.18	10.22	613.84	14.40	555.96	12.66	722.32	15.98
	2.07	0.39	3.00	0.55	2.02	0.36	9.07	1.59	14.61	2.49	17.25	2.87	13.85	2.24	24.15	3.82	28.25	4.36	32.70	4.92	27.83	4.09
	81.28	3.32	99.49	3.93	124.62	4.77	189.63	7.03	265.87	9.54	290.04	10.07	293.41	9.86	341.62	11.11	374.54	11.79	419.96	12.80	432.32	12.75
	49.36	4.70	72.59	6.75	86.80	7.89	161.09	14.31	202.11	17.56	248.65	21.11	217.18	18.01	267.91	21.68	392.45	30.99	329.93	25.42	284.63	21.39
	31.16	2.49	28.99	2.31	33.78	2.68	47.89	3.81	61.72	4.91	104.72	8.35	102.18	8.15	151.49	12.10	98.45	7.85	199.69	15.85	183.39	14.41

**TABLE B5:**  
**DAH by health focus area, 1990-2010**

Year	HIV/AIDS	Maternal, newborn, and child health	Malaria	Health sector support
1990	198.03	1,217.47	38.58	8.72
1991	210.29	1,259.23	39.39	1.69
1992	226.95	1,485.24	28.19	26.91
1993	234.07	1,567.26	26.79	18.35
1994	357.32	2,181.29	44.30	15.46
1995	360.33	2,233.23	41.00	34.89
1996	412.57	1,980.70	46.60	73.87
1997	443.64	2,056.33	102.78	81.51
1998	435.06	2,034.68	117.47	70.87
1999	540.84	2,427.71	148.27	177.16
2000	735.26	2,899.21	229.52	145.37
2001	889.03	3,231.82	218.43	43.14
2002	1,391.31	2,756.59	205.21	145.90
2003	1,812.39	2,987.20	259.38	159.76
2004	2,460.94	3,245.76	465.31	269.73
2005	3,146.27	3,740.66	809.36	501.04
2006	4,066.41	3,274.72	756.40	904.94
2007	5,137.17	4,319.67	847.46	1,028.89
2008	6,248.21	4,415.50	1,273.81	1,161.30
2009	6,572.18	4,748.34	1,938.35	1,211.33
2010	6,757.36	5,166.81	1,856.67	1,180.90

Sources: IHME DAH Database 2012 and DAH Database (Country and Regional Recipient Level) 2012

Notes: In millions US\$, 2010. Development assistance for health (DAH) includes both financial and in-kind contributions for activities aimed at improving health in low- and middle-income countries. This table disaggregates financial DAH earmarked for HIV/AIDS, maternal, newborn, and child health, malaria, health sector support, tuberculosis, and noncommunicable diseases. We were able to allocate flows from the following channels of assistance by their health focus areas: bilateral development agencies, World Bank (IDA and IBRD), regional development banks, GFATM, GAVI, WHO, UNICEF, UNAIDS, UNFPA, and BMGF. Contributions from remaining channels are shown as unallocable by disease.

For preliminary estimates of DAH for 2011 and 2012, refer to Table B1.



Tuberculosis	Noncommunicable diseases	Other	Unallocable	Total
56.67	30.77	1,950.46	2,241.18	5,741.88
63.13	30.36	1,935.95	1,982.05	5,522.08
65.38	36.04	2,018.08	2,306.72	6,193.51
73.96	100.04	2,389.66	2,263.67	6,673.80
72.53	105.63	2,335.38	2,610.93	7,722.85
79.81	68.66	2,358.37	2,849.83	8,026.11
107.06	55.37	2,732.05	2,707.84	8,116.05
82.95	52.43	3,201.55	2,520.14	8,541.33
84.56	69.68	3,299.39	2,779.47	8,891.16
106.44	69.37	3,358.11	3,033.08	9,860.96
152.55	112.22	3,293.34	3,113.54	10,681.02
186.03	91.79	3,403.56	2,753.27	10,817.05
215.21	111.70	4,053.24	3,560.97	12,440.11
269.36	98.37	4,713.28	2,958.12	13,257.86
432.55	77.00	4,735.82	2,915.21	14,602.32
467.91	86.28	5,157.90	2,903.93	16,813.36
583.21	106.63	5,193.83	3,525.46	18,411.58
730.50	151.95	4,940.84	4,120.41	21,276.90
897.36	160.43	5,439.12	5,128.72	24,724.44
962.48	195.13	4,962.13	4,855.14	25,445.08
1,095.13	185.14	5,945.69	5,972.06	28,159.76





Table B6: Bilateral commitments and disbursements, 1990-2010, continued

Donor Observed/ Estimated <sup>1</sup>	1990		1991		1992		1993		1994		1995		1996		1997		1998		1999		
	Comm <sup>2</sup>	Disb <sup>3</sup>	Comm <sup>2</sup>	Disb <sup>3</sup>	Comm <sup>2</sup>	Disb <sup>3</sup>	Comm <sup>2</sup>	Disb <sup>3</sup>	Comm <sup>2</sup>	Disb <sup>3</sup>	Comm <sup>2</sup>	Disb <sup>3</sup>	Comm <sup>2</sup>	Disb <sup>3</sup>	Comm <sup>2</sup>	Disb <sup>3</sup>	Comm <sup>2</sup>	Disb <sup>3</sup>	Comm <sup>2</sup>	Disb <sup>3</sup>	
<b>South Korea</b>																					
Observed	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Estimated	0.00	0.00	1.80	0.99	3.41	2.22	4.83	3.74	0.00	1.77	6.71	4.85	0.00	1.30	46.76	27.25	31.33	26.31	127.24	87.38	
<b>Spain</b>																					
Observed	7.03	0.00	19.02	0.00	86.92	0.00	64.05	21.78	24.41	12.54	156.47	47.59	182.09	0.00	147.97	103.99	128.78	91.14	167.08	116.02	
Estimated	7.03	5.43	28.33	23.41	120.95	99.66	95.09	100.40	50.19	59.99	156.47	131.98	236.99	217.95	147.97	167.35	129.66	133.46	167.08	158.11	
<b>Sweden</b>																					
Observed	202.17	96.18	31.69	94.62	213.59	120.39	56.08	77.35	101.56	77.20	182.66	119.90	41.13	98.86	63.17	84.99	109.53	53.41	118.35	74.50	
Estimated	202.17	194.84	60.09	138.68	213.59	173.45	170.04	165.12	135.64	140.95	182.66	151.08	85.20	114.73	107.93	114.33	109.53	107.60	118.35	106.00	
<b>Switzerland</b>																					
Observed	65.86	0.00	43.77	0.00	27.02	0.00	20.00	0.00	41.73	0.00	18.83	0.00	31.21	0.00	56.10	0.00	31.80	0.00	48.02	0.00	
Estimated	65.87	43.42	43.78	39.16	27.02	29.98	20.84	22.34	41.73	26.81	18.83	20.32	31.21	22.69	56.10	34.00	31.80	29.75	48.05	34.71	
<b>United Kingdom</b>																					
Observed	100.92	0.00	65.17	0.00	449.71	0.00	130.30	0.00	152.56	0.00	151.56	0.00	278.51	0.00	256.49	0.00	444.56	201.45	584.14	207.09	
Estimated	140.32	51.93	94.31	60.67	449.71	173.14	141.14	154.28	152.56	158.26	172.64	166.89	278.51	198.33	256.49	207.81	444.56	259.55	584.14	346.50	
<b>United States</b>																					
Observed	507.85	11.98	639.14	9.50	544.93	10.44	702.17	1.76	1,281.78	0.00	1,271.29	0.00	659.64	0.00	1,172.82	0.00	1,035.23	0.00	1,311.77	0.00	
Estimated	1,076.60	890.53	1,055.81	929.90	972.95	913.94	897.69	884.21	1,340.82	1,187.34	1,459.94	1,319.53	1,100.97	1,122.47	1,172.82	1,161.90	1,121.68	1,133.97	1,311.77	1,259.07	

Source: IHME DAH Database 2012

Notes: In millions US\$, 2010. This table presents commitments from bilateral development agencies net of identifiable contributions through multilateral channels of assistance (GFATM, GAVI, United Nations agencies, etc.) but does not exclude transfers to NGOs. In-kind donations also are not reflected in this table.

<sup>1</sup> Observed represents unadjusted data, while estimated represents that data have been imputed to correct for missingness.

<sup>2</sup> Commitment estimates have been corrected for missingness using the DAC/CRS coverage ratio.

<sup>3</sup> Disbursement estimates were obtained by computing donor-specific disbursement schedules using information from complete projects where disbursements could be linked over time.

2000		2001		2002		2003		2004		2005		2006		2007		2008		2009		2010	
Comm <sup>2</sup>	Disb <sup>3</sup>	Comm <sup>2</sup>	Disb <sup>3</sup>	Comm <sup>2</sup>	Disb <sup>3</sup>	Comm <sup>2</sup>	Disb <sup>3</sup>	Comm <sup>2</sup>	Disb <sup>3</sup>	Comm <sup>2</sup>	Disb <sup>3</sup>	Comm <sup>2</sup>	Disb <sup>3</sup>	Comm <sup>2</sup>	Disb <sup>3</sup>	Comm <sup>2</sup>	Disb <sup>3</sup>	Comm <sup>2</sup>	Disb <sup>3</sup>	Comm <sup>2</sup>	Disb <sup>3</sup>
0.00 64.70	0.00 67.78	0.00 43.04	0.00 67.08	0.00 45.10	0.00 48.92	0.00 17.14	0.00 28.67	0.00 62.98	0.00 48.71	0.00 99.14	0.00 70.46	41.21 41.21	43.03 43.03	115.18 115.18	51.00 51.00	262.81 262.81	62.97 62.97	152.44 152.44	96.82 96.82	132.89 132.89	137.50 137.50
95.01 95.01	131.77 110.65	88.80 110.90	109.21 106.80	101.38 113.35	73.67 112.39	100.78 123.98	106.20 121.01	141.23 141.23	131.93 136.51	133.90 159.79	160.05 154.51	155.25 155.25	139.82 155.14	234.92 234.92	206.39 215.75	311.14 369.29	315.96 337.50	205.22 367.01	271.45 366.55	222.75 222.85	200.22 255.18
82.18 82.18	57.92 91.97	51.68 51.68	88.09 70.86	136.06 136.06	86.81 96.40	140.99 140.99	110.92 106.52	148.88 178.68	163.29 127.76	331.41 331.41	211.90 199.05	294.39 294.39	252.74 219.33	148.19 260.34	259.04 226.13	153.82 188.29	239.62 204.73	105.03 122.81	167.92 170.84	137.47 152.56	142.26 165.71
41.35 41.35	0.00 33.64	34.53 43.42	0.00 33.74	65.12 65.12	39.52 43.23	36.65 36.65	45.08 35.95	66.30 66.30	47.17 44.60	38.87 40.58	50.66 37.82	36.54 45.92	44.83 36.62	69.92 69.92	44.65 46.19	66.62 66.62	55.90 49.54	48.07 51.39	59.29 45.80	82.92 82.92	57.26 56.53
987.17 987.18	227.05 523.61	364.20 364.20	238.28 458.35	718.38 718.38	473.87 540.49	671.08 671.08	404.39 573.16	635.84 635.84	426.38 575.01	1,203.59 1,203.59	639.00 730.92	1,599.00 1,599.00	887.04 930.58	1,757.06 1,757.06	957.10 1,138.16	940.62 959.87	958.65 1,052.17	1,288.07 1,288.07	909.44 1,134.23	278.69 1,013.39	1,066.45 1,102.26
1,322.09 1,322.11	0.00 1,272.55	1,504.64 1,504.64	0.00 1,396.39	1,982.43 2,257.63	1,591.12 1,928.63	2,463.50 2,463.52	2,337.15 2,166.84	2,763.75 2,763.75	2,345.40 2,460.09	3,132.28 3,132.94	2,718.75 2,798.30	3,810.77 3,811.47	3,156.19 3,356.18	5,060.18 5,060.21	3,644.35 4,335.04	6,365.58 6,365.60	4,684.69 5,437.05	6,074.39 6,074.41	5,383.95 5,568.73	6,511.82 6,511.83	5,612.14 6,068.45

**TABLE B7:**  
**World Bank financial and in-kind DAH, 1990-2010**

Year	International Development Association		International Bank for Reconstruction and Development	
	Financial	In-kind	Financial	In-kind
1990	28.88	2.62	60.65	2.13
1991	93.42	6.79	93.49	4.63
1992	270.84	22.56	175.62	9.21
1993	435.12	41.36	385.64	20.02
1994	545.96	53.90	420.53	29.27
1995	594.15	59.52	331.18	21.78
1996	636.06	54.92	517.46	28.48
1997	643.06	45.84	874.60	41.02
1998	660.80	27.01	901.49	35.67
1999	809.11	50.96	894.63	41.70
2000	818.09	73.33	830.70	58.75
2001	937.84	72.92	793.64	58.23
2002	1,091.41	93.92	953.96	74.92
2003	895.87	109.87	893.11	66.71
2004	1,049.63	154.10	725.07	67.56
2005	1,032.37	118.69	757.60	79.92
2006	918.04	114.01	646.23	57.60
2007	852.36	114.11	682.86	65.90
2008	850.65	113.90	431.52	44.58
2009	741.99	100.84	516.34	34.67
2010	732.14	90.19	1,167.76	57.67

Source: IHME DAH Database 2012

Notes: In millions US\$, 2010. For preliminary estimates of DAH for 2011 and 2012, refer to Table B1.

**TABLE B8:**  
**Regional development banks' financial and in-kind DAH, 1990-2010**

Year	African Development Bank		Asian Development Bank		Inter-American Development Bank	
	Financial	In-kind	Financial	In-kind	Financial	In-kind
1990	61.23	5.11	27.20	2.27	83.31	6.96
1991	59.14	4.94	26.38	2.20	76.16	6.36
1992	57.77	4.82	39.65	3.31	50.40	4.21
1993	56.52	4.72	58.34	4.87	59.24	4.95
1994	88.06	7.35	57.80	4.83	80.85	6.75
1995	68.03	5.68	68.57	5.73	80.56	6.73
1996	69.44	5.80	49.01	4.09	104.15	8.70
1997	86.65	7.24	56.89	4.75	163.79	13.68
1998	58.16	4.86	120.45	10.06	174.37	14.56
1999	57.32	4.79	204.93	17.11	175.69	14.67
2000	41.94	3.50	355.63	29.70	203.56	17.00
2001	39.38	3.29	148.77	12.42	187.76	15.68
2002	75.67	6.32	147.02	12.28	197.27	16.47
2003	39.43	3.29	149.07	12.45	171.63	14.33
2004	84.11	7.02	130.92	10.93	347.51	29.02
2005	138.63	11.58	165.06	13.78	358.27	29.92
2006	84.60	7.06	158.53	13.24	125.59	10.49
2007	82.07	6.85	164.78	13.76	149.13	12.45
2008	104.56	8.73	100.63	8.40	152.38	12.72
2009	103.78	8.67	192.97	16.11	144.31	12.05
2010	108.71	9.08	78.79	6.58	123.40	10.30

Source: IHME DAH Database 2012

Notes: In millions US\$, 2010. For preliminary estimates of DAH for 2011 and 2012, refer to Table B1.

**TABLE B9:**  
**Financial and in-kind contributions by GFATM and GAVI, 2000-2010**

Year	GFATM		GAVI	
	Financial	In-kind	Financial	In-kind
2000	–	–	2.48	0.32
2001	–	–	142.67	3.80
2002	1.08	15.32	109.93	8.78
2003	271.56	38.24	202.90	5.24
2004	716.70	57.96	170.39	48.28
2005	1,163.08	81.46	251.99	31.43
2006	1,412.15	92.75	428.16	21.87
2007	1,791.56	81.34	960.47	62.70
2008	2,288.46	159.96	749.59	78.09
2009	2,769.39	158.12	472.74	282.81
2010	3,044.49	248.36	771.54	296.47

Source: IHME DAH Database 2012

Notes: In millions US\$, 2010. For preliminary estimates of DAH for 2011 and 2012, refer to Table B1. Dashes indicate inapplicable.



**TABLE B10:**  
**WHO, regular and extrabudgetary income and expenditure, 1990-2010**

Year	Regular budget income	Regular budget expenditure	Extrabudgetary income	Extrabudgetary expenditure <sup>1</sup>	Total income	Total expenditure	Development assistance for health <sup>2</sup>
1990	539.30	453.14	667.71	697.46	1,207.01	1,150.61	1,102.50
1991	520.84	437.63	644.84	673.58	1,165.68	1,111.21	1,064.75
1992	541.11	430.17	618.88	647.24	1,160.00	1,077.41	1,046.96
1993	529.41	420.87	605.51	633.25	1,134.92	1,054.12	1,024.33
1994	480.10	528.96	640.65	654.92	1,120.75	1,183.88	1,152.21
1995	470.31	518.17	627.58	641.56	1,097.89	1,159.74	1,128.70
1996	599.71	463.22	572.95	508.56	1,172.66	971.79	947.71
1997	589.31	455.19	563.01	499.74	1,152.32	954.93	931.27
1998	550.83	461.28	697.98	579.85	1,248.80	1,041.12	1,027.53
1999	542.84	454.59	687.86	571.44	1,230.70	1,026.03	1,012.63
2000	538.78	451.65	967.90	822.69	1,506.69	1,274.35	1,256.97
2001	526.88	441.67	946.52	804.51	1,473.40	1,246.19	1,229.20
2002	482.41	446.26	915.48	885.21	1,397.89	1,331.47	1,307.67
2003	472.24	436.86	896.18	866.54	1,368.42	1,303.40	1,280.09
2004	486.68	442.17	1,305.73	1,197.91	1,792.40	1,640.08	1,605.63
2005	470.96	427.89	1,263.56	1,159.23	1,734.52	1,587.12	1,553.79
2006	485.02	416.83	1,645.63	1,306.98	2,130.64	1,723.82	1,585.59
2007	471.51	405.23	1,599.81	1,270.60	2,071.33	1,675.83	1,541.45
2008	434.52	411.89	1,450.89	1,483.84	1,885.41	1,895.73	1,837.46
2009	429.43	407.06	1,433.88	1,466.44	1,863.30	1,873.50	1,815.92
2010	538.34	388.56	1,811.72	1,760.00	2,350.07	2,148.56	2,120.35

Source: IHME DAH Database 2012

Notes: In millions US\$, 2010. For preliminary estimates of DAH for 2011 and 2012, refer to Table B1.

<sup>1</sup> Includes the Voluntary Fund for Health Promotion, other WHO funds, and interagency trust funds.

<sup>2</sup> Excludes expenditures from trust funds and associated entities not part of WHO's program of activities and supply services funds.

**TABLE B11:**  
**Bill & Melinda Gates Foundation global health commitments, disbursements, and in-kind contributions, 1999-2010**

	1999	2000	2001	2002
Commitments	1,515.39	748.10	612.39	438.53
Disbursements	433.47	691.53	1,023.34	602.20
Country governments and IGOs (excluding UN)	12.74	8.73	7.32	6.38
UN agencies	81.68	59.06	30.75	48.35
World Bank	0.00	45.51	12.88	83.99
GAVI	222.92	187.02	518.19	0.00
GFATM	–	–	–	59.99
Public-private partnerships (excluding GAVI and GFATM)	2.04	36.16	21.72	158.28
Universities and research institutions	47.75	151.71	97.65	91.27
NGOs <sup>1</sup> and corporations	65.71	202.35	334.23	153.14
Foundations	0.64	1.00	0.61	0.80
In-kind	3.09	51.01	62.91	82.91

Source: IHME DAH Database 2012 (Disbursements) and BMGF Online Grants Database (Commitments)

Notes: In millions US\$, 2010.

For preliminary estimates of DAH for 2012, refer to Table B1. Dashes indicate inapplicable.

<sup>1</sup> Includes nonresearch-focused NGOs based in low-, middle-, and high-income countries.

**TABLE B12:**  
**US NGO expenditures, 1990-2012**

	1990	1991	1992	1993	1994	1995	1996	1997	1998
Total overseas health expenditure	499.79	686.78	805.26	845.81	945.25	898.62	820.47	895.64	1,015.12
Amount of overseas health expenditure financed from:									
Revenue from US government	199.04	315.19	398.62	397.19	453.72	438.42	322.17	369.33	374.76
Revenue from other governments	31.34	73.04	71.90	72.14	84.02	71.02	83.91	76.30	85.88
BMGF grants	--	--	--	--	--	--	--	--	--
Private financial revenue	225.08	250.16	272.99	299.28	312.34	301.50	310.89	337.86	431.94
Private in-kind revenue	44.34	48.39	61.75	77.20	95.17	87.68	103.50	112.15	122.55
Average percent revenue from:									
US government	19.82	17.52	18.27	19.78	20.62	20.79	20.27	20.13	18.97
Private financial contributions	60.36	62.89	61.01	58.99	56.99	56.82	54.86	54.70	55.52
Private in-kind contributions	15.33	14.46	15.61	16.09	16.83	16.24	18.49	18.74	19.38
Average health fraction	20.73	20.11	20.29	20.62	20.88	21.18	21.41	22.02	22.20
Number of US NGOs in sample	267	339	390	418	438	429	434	439	452

Source: IHME DAH Database (NGOs) 2012

Notes: Dashes indicate inapplicable.

Total overseas health expenditure (in millions US\$, 2010) is the sum of the product of each US NGO's overseas expenditure multiplied by the actual or estimated health expenditures as a fraction of total expenditure.

Amount of overseas health expenditure (in millions US\$, 2010) financed by revenue from each source is the sum of the product of each US NGO's fraction of revenue from a given source and the overseas health expenditure. Overseas health expenditure financed by private in-kind revenue reflects deflation to 18.3% of original value to compensate for exaggerated market valuation of in-kind drugs and commodities.

	2003	2004	2005	2006	2007	2008	2009	2010
	976.37	1,055.46	1,138.37	1,391.56	1,941.79	2,790.83	1,946.12	811.11
	657.24	491.64	911.88	947.68	1,294.50	1,837.28	1,826.95	1,443.29
	0.21	6.26	11.37	7.30	10.99	23.63	39.10	30.19
	39.96	34.43	75.75	120.97	77.05	221.84	278.54	311.38
	4.70	4.57	0.11	6.61	6.30	23.14	52.89	8.86
	4.11	5.71	170.58	0.00	78.04	76.41	75.52	75.00
	58.73	57.11	0.00	108.16	104.06	102.12	210.97	10.69
	66.96	123.75	151.59	156.79	216.49	246.23	173.52	146.47
	109.75	93.42	148.66	202.57	282.86	347.60	323.32	287.20
	133.22	162.66	348.87	324.40	498.13	620.84	527.57	437.84
	239.61	3.73	4.95	20.87	20.58	175.47	145.52	135.67
	89.54	93.19	125.19	168.12	231.72	358.80	354.40	361.69

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010*	2011*	2012*
	1,222.01	1,314.64	1,524.99	1,690.82	1,833.01	2,204.46	2,653.73	2,745.91	2,829.93	3,579.26	3,703.46	2,960.04	2,631.10	2,744.27
	456.31	506.37	572.00	613.79	674.48	865.12	848.63	852.47	846.18	991.92	1,236.34	1,140.30	1,169.51	1,206.48
	112.83	110.33	142.80	156.65	164.06	193.63	250.76	304.77	326.44	348.60	531.10	232.21	201.55	212.51
	9.72	51.23	99.68	106.13	31.91	38.33	119.29	60.95	68.75	192.58	198.88	71.29	67.99	71.70
	507.15	521.43	526.70	604.93	714.26	745.25	981.73	1,132.73	1,138.40	1,347.88	1,184.14	1,160.22	921.88	970.18
	136.00	125.28	183.81	209.33	248.30	362.13	453.33	394.99	450.17	698.27	553.00	356.02	270.16	283.40
	18.90	18.83	18.47	18.32	18.31	18.25	15.96	15.29	14.69	14.53	15.78	15.13	15.13	15.13
	55.86	53.93	54.10	54.75	55.77	56.54	59.30	58.36	59.50	59.66	58.32	59.54	59.54	59.54
	19.25	20.09	20.88	20.24	20.32	19.61	18.65	19.98	18.96	18.40	17.89	18.00	18.00	18.00
	22.12	22.61	23.36	23.11	23.38	23.55	23.92	24.38	24.59	24.68	24.91	24.54	24.54	24.54
	456	460	475	509	535	539	528	556	573	575	582	582	582	582

Average percent of revenue from the US government, private financial contributions, and private in-kind contributions represent the average fraction of US NGOs' total revenue from a given source.

Average health fraction is the average of US NGOs' actual and estimated health expenditure as a percentage of total expenditure.

Number of US NGOs is the number present in the USAID Report of Voluntary Agencies in a single year.

\*Revenue and health fractions for 2010-2012 are not available due to lack of more detailed revenue data as in previous years. Thus, the mean revenue and health percentages from 2005-2009 are used for 2010-2012.

**TABLE B13:**  
**Government health expenditure as source, 1995-2010**

GBD region	1995	1996	1997	1998	1999	2000	2001
North Africa / Middle East	25.52	27.95	31.40	35.76	38.97	42.44	46.82
Caribbean	0.97	1.13	1.30	1.35	1.39	1.58	1.48
Latin America							
Andean	2.99	3.23	3.13	3.11	3.43	3.30	3.46
Central	27.92	28.69	32.38	35.73	39.32	40.42	41.76
Southern	15.13	15.19	15.73	16.94	18.84	18.56	18.68
Tropical	39.22	38.94	42.36	41.70	44.06	43.84	47.18
Oceania	0.27	0.27	0.25	0.30	0.31	0.31	0.32
Asia							
Central	2.84	2.78	2.99	2.97	2.47	2.50	2.67
East	25.89	28.21	31.13	34.15	37.24	38.71	38.63
South	7.36	7.80	8.44	9.02	9.77	10.09	10.23
Southeast	10.83	12.19	12.94	12.20	12.66	13.21	14.90
Sub-Saharan Africa							
Central	0.28	0.71	0.78	0.76	0.69	0.81	1.21
East	1.15	1.15	1.33	1.52	1.43	1.82	1.91
Southern	7.07	7.20	8.25	8.73	9.45	9.53	9.92
West	1.97	1.95	2.09	2.45	2.55	2.65	2.95

Source: IHME Government Health Spending Database (Developing Countries) 2012

Notes: In billions US\$, 2010. Government health expenditure as source (GHE-S) includes funds raised by recipient country governments from internal resources. This table disaggregates GHE-S by Global Burden of Disease developing regions from base data sources of the World Health Organization (WHO) National Health Accounts.

**TABLE B14:**  
**DAH allocated to government or non-government recipients, 1995-2010**

GBD region	1995		1996		1997		1998		1999		2000		2001	
	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov
North Africa / Middle East	132.21	5.41	122.48	2.96	124.05	15.79	109.47	5.90	151.36	12.46	146.50	12.23	141.95	17.74
Caribbean	108.86	0.16	53.43	0.43	53.70	0.71	72.57	1.00	86.36	4.78	66.98	5.78	63.93	5.00
Latin America														
Andean	44.84	0.21	38.36	1.37	59.26	1.27	86.83	1.97	78.24	1.82	114.31	2.34	88.18	21.75
Central	62.39	0.55	72.91	1.33	144.36	2.84	88.26	4.47	130.05	5.10	102.98	3.12	125.73	6.00
Southern	4.80	0.14	2.19	0.24	1.05	0.11	1.15	0.09	2.93	0.08	1.25	0.05	2.06	0.23
Tropical	3.20	0.09	2.30	0.19	3.04	0.31	11.79	1.95	12.67	10.90	12.40	4.20	19.52	0.23
Oceania	8.33	0.00	40.89	0.00	27.47	0.00	13.51	0.26	38.07	0.03	38.57	6.12	68.24	0.00
Asia														
Central	19.07	0.09	34.06	0.58	26.78	0.26	36.09	0.22	73.39	0.32	66.33	11.72	61.69	1.70
East	8.28	0.19	19.29	0.54	27.06	0.86	38.58	1.16	16.48	4.93	27.02	22.68	22.79	11.32
South	193.44	6.61	239.33	22.14	214.49	19.43	274.99	12.92	242.97	13.36	207.60	70.12	264.90	26.27
Southeast	132.31	3.21	131.80	8.73	168.03	20.27	162.89	22.99	207.09	7.37	200.07	22.65	215.77	27.77
Sub-Saharan Africa														
Central	34.08	0.28	41.20	0.49	42.33	3.33	42.04	3.24	52.94	4.52	55.30	5.01	60.86	14.61
East	290.62	13.00	407.86	22.80	379.35	28.16	377.50	26.14	404.75	20.15	375.01	44.36	538.06	43.68
Southern	60.16	1.76	71.08	1.43	73.95	4.91	84.52	3.82	64.56	3.85	57.42	7.13	72.59	24.66
West	138.38	1.66	149.56	13.51	175.34	7.51	139.94	7.37	201.04	6.29	187.06	18.56	315.02	22.48

Source: IHME DAH Database (Country and Regional Recipient Level) 2012

Notes: In millions US\$, 2010. Development assistance for health (DAH) includes both financial and in-kind contributions, excluding loans, for activities aimed at improving health in low- and middle-income countries. This table disaggregates financial DAH transfers by the recipient sector and Global Burden of Disease developing region.

	2002	2003	2004	2005	2006	2007	2008	2009	2010
	50.37	53.07	55.79	57.67	63.22	67.75	71.03	81.63	83.77
	1.73	1.64	1.82	2.00	2.37	2.35	2.57	2.98	3.20
	3.88	3.58	3.71	4.11	4.26	5.14	6.59	6.63	6.57
	42.34	43.98	47.88	49.54	52.11	56.29	57.87	61.55	61.68
	16.12	15.50	16.38	18.25	20.06	22.87	26.02	31.14	26.43
	50.54	49.55	56.33	56.86	63.76	67.71	71.22	76.42	91.16
	0.30	0.26	0.31	0.31	0.32	0.30	0.30	0.36	0.37
	2.80	3.12	3.68	4.27	4.52	4.28	5.08	6.32	6.52
	44.53	49.88	56.35	63.16	72.56	91.48	113.53	144.90	159.56
	10.54	10.53	11.18	12.63	14.31	15.49	17.47	20.92	21.89
	15.89	18.39	18.42	18.69	22.06	25.46	26.16	28.35	30.52
	1.07	1.21	1.06	1.17	1.69	2.03	2.89	4.81	3.10
	2.09	2.00	2.07	2.39	2.98	3.03	3.26	3.77	4.06
	10.09	10.70	10.78	11.56	12.19	13.19	14.42	15.66	15.76
	2.62	3.59	4.74	4.76	4.94	6.27	6.33	6.10	6.44

	2002		2003		2004		2005		2006		2007		2008		2009		2010	
	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov
	132.63	33.36	203.44	24.70	317.12	38.77	280.19	547.85	387.21	459.41	482.34	272.97	363.53	342.09	276.35	394.07	197.45	451.63
	41.87	14.74	81.52	29.62	69.83	49.25	60.19	97.97	50.78	147.42	70.65	169.44	73.45	192.56	84.61	231.27	69.52	199.86
	46.15	28.28	91.44	25.40	96.55	28.44	74.53	59.21	85.06	61.50	87.96	57.24	53.37	101.92	71.67	108.99	20.50	117.71
	84.55	26.14	134.33	14.58	124.46	43.82	90.30	72.43	92.15	85.14	106.61	108.05	89.45	172.41	79.70	149.62	42.08	172.25
	2.22	0.99	9.97	7.44	7.68	15.53	8.14	14.32	10.72	4.90	6.70	12.19	10.11	10.18	8.86	1.96	0.92	5.38
	16.41	1.53	30.67	0.21	29.29	4.29	19.81	17.47	21.14	9.82	21.39	12.14	16.70	31.48	12.86	34.43	8.55	50.10
	89.17	0.34	102.40	0.65	115.58	3.77	129.08	6.79	67.27	55.07	83.30	44.57	99.29	45.69	86.05	77.71	55.05	100.46
	66.86	6.86	79.58	4.10	80.83	7.51	67.55	61.16	63.86	70.29	112.03	50.49	113.74	76.89	107.03	76.16	112.71	82.64
	55.07	6.81	84.80	6.06	118.44	9.95	134.39	11.12	117.22	28.97	162.94	38.59	140.11	58.90	161.14	66.43	143.15	75.04
	289.67	46.31	391.79	50.24	389.78	96.58	470.23	243.55	427.21	410.39	697.94	384.81	722.23	588.98	608.03	510.19	510.76	713.56
	181.26	30.42	358.60	38.49	382.16	76.22	350.22	218.54	426.80	281.61	415.29	294.93	439.99	350.51	431.21	394.83	367.65	604.44
	61.60	24.09	91.32	24.34	118.64	48.91	115.85	149.91	95.53	154.50	75.58	154.25	119.68	298.69	144.40	320.25	158.95	322.52
	535.71	126.19	902.66	115.45	920.86	298.88	1,061.07	662.24	1,198.29	1,033.16	1,534.15	1,288.95	1,573.11	1,871.02	1,421.08	2,299.63	1,482.36	2,647.82
	94.97	12.33	178.52	35.57	150.57	62.08	235.57	168.17	230.91	254.66	306.91	389.71	282.76	553.50	335.67	817.81	333.95	823.38
	261.34	53.02	433.08	53.04	549.33	132.94	531.16	298.47	667.15	381.34	576.37	554.39	764.12	860.24	823.39	1,161.33	650.14	1,474.55







Institute for Health Metrics and Evaluation  
2301 Fifth Ave., Suite 600  
Seattle, WA 98121  
USA  
[www.healthmetricsandevaluation.org](http://www.healthmetricsandevaluation.org)

Telephone: +1-206-897-2800  
Fax: +1-206-897-2899  
E-mail: [comms@healthmetricsandevaluation.org](mailto:comms@healthmetricsandevaluation.org)