



**September 2000**

## **Recent Trends in Official Development Assistance to Health**

*The views expressed in this paper are those of the DAC Secretariat  
and not necessarily those of DAC Members.*

1. This note analyses statistical data on Official Development Assistance (ODA) to the health sector reported to the Development Assistance Committee (DAC) of the OECD. It has been prepared by the DAC Secretariat for the Third Meeting of the Commission on Macroeconomics and Health (WHO) on 9-10 November 2000.
2. The objective of the note is to give an overview of recent aid flows to the health (including reproductive health) sector. In addition to quantifying these flows and examining their share in total ODA, the geographical (recipient) breakdown is reviewed. Section 1 briefly describes the statistical reporting systems of the DAC from which all data have been derived. Section 2 outlines the DAC statistical definition of aid to health and explains factors and limitations that need to be borne in mind when considering the analysis presented in section 3. Section 4 discusses aid to health that may not be captured in DAC statistics.
3. Any questions about this note can be addressed to the DAC Secretariat (send e-mail to [dac.contact@oecd.org](mailto:dac.contact@oecd.org)).

## 1. The DAC reporting systems

4. The DAC collects data on aid flows through two reporting systems: the annual aggregate DAC statistics and the activity-specific Creditor Reporting System (CRS). The two systems are based on the same concepts and definitions, and have been designed to supplement and reinforce each other.

5. Any sectoral analysis should ideally draw on both data sets. The DAC statistics provide an overall picture of the sectoral distribution of aid and of the relative importance of each sector in the total. The CRS shows what lies behind the aggregate figures, allowing assessment of the quality of the data, in particular their consistency with definitions and comparability between Members. Furthermore, the CRS adds a geographical dimension to sectoral analysis but, for that analysis to be pertinent, the completeness of the data has to be assessed in relation to total ODA reported in the DAC.

6. In annual DAC statistics, data on aid to health are available from 1971 onwards. Detailed analysis on the basis of CRS data is possible for the 1990s only. The coverage of the CRS database in the health sector is estimated to be around 75-80% in this period, whereas data for the earlier years excludes a large proportion of aid to health extended in the form of technical co-operation. The 20% data gap in the 1990s relates to technical co-operation activities by France, Germany and Japan.

7. The DAC seeks to collect data on aid activities by multilateral organisations on the same basis as it does for bilateral donors. At present, sufficient data are received from the World Bank group, the regional development banks and IFAD, which together account for approximately 40 % of multilateral ODA. Sectoral data for the European Commission and the United Nations, each of which represents some 30 % of multilateral ODA, are largely incomplete.<sup>1</sup> The European Commission reports sectoral data on the activities of the European Development Fund (EDF), but not yet on those financed through the Commission budget. As regards the UN, sectoral data have been received only from UNICEF but these do not allow for analyses by recipient. Multi-bilateral aid is classified in DAC statistics as bilateral.<sup>2</sup>

8. At the total level, the data gap for the UN can be estimated to represent roughly 10 % of total ODA to health.<sup>3</sup> It does not therefore greatly affect trend analysis but implies, of course, underestimation of aid to health extended to individual recipient countries.

---

<sup>1</sup> The European Commission has a statistical reporting obligation as a Member of the DAC. The banks' and UN organisations' reporting takes place on a voluntary basis, but is strongly recommended by DAC Members.

<sup>2</sup> A contribution is defined as multilateral if: (a) it is extended to a multilateral recipient institution, or (b) it is a fund managed autonomously by a multilateral agency, **and** in either case, the agency pools amounts received so that they lose their identity and become an integral part of its financial assets. Consequently, donors' contributions to the regular budgets of the UN organisations and specialised agencies (called "core funding") are classified as multilateral. Financing of specific projects executed by them ("non-core funding", also called "extra-budgetary funding") is classified as bilateral if the recipient country is specified (e.g. "UNICEF child health programme in Cambodia").

<sup>3</sup> The 10% estimate is based on regular budgets only. It includes 1) total regular budget of UNFPA; 2) 75% of the regular budget of WHO (since not all its activities target developing countries); 3) 17% of the regular budget of UNICEF (based on its reporting to the DAC in 1997 and 1998); and 4) 7% of the regular budget of the UNDP (based on sectoral data available on UNDP web-site). Difficulties in identifying UN agencies' regular budget expenditures separately from the rest have previously caused overestimation of total ODA to health, since adding data on total UN outflows to data on DAC Members' bilateral aid involves double-counting.

## 2. The DAC statistical definition of aid to health

9. In their statistical reporting, DAC Members are requested to assign for each aid activity a sector of destination, and within that sector a detailed purpose code, which identifies “the specific area of the recipient’s economic or social structure which the transfer is intended to foster”. Table 1 below lists the purpose codes defining “aid to health”. Strictly speaking, this definition applies to aid activities since 1996 as the DAC approved a revised sector classification system that year. As the majority of revisions were “clarifications” rather than “changes”, the data prior to and after the revision remain comparable. Detailed CRS-based analyses are hardly affected at all. Analyses based on DAC aggregate data need to take into account the specification of reproductive health as a separate sector, unless aid to health is examined in the wide sense (health including reproductive health).

10. The comparability of data between DAC Members (i.e. the consistency of each Member’s reporting with the definition) is assessed to be good. (The DAC sector classification is increasingly being used in Members’ internal reporting systems.) For those multilaterals reporting sectoral data at the level of individual projects, the definition of “aid to health” is applied in the same way as for bilaterals.

11. The sectoral statistics have their limitations. In DAC reporting (as well as in most Members’ internal reporting systems), each activity can be assigned only one sector/purpose code. This is so that a “pie chart” of total aid by sector can be produced as the total adds up to 100 % of all aid. For activities cutting across several sectors, either a multisector code or the code corresponding to the largest component of the activity is used. Consequently, DAC statistics on aid to health only relate to activities which have health as their main purpose and fail to capture aid to health delivered within multisector (e.g. basic social services) programmes. In other words, while providing a consistent base of statistics on aid to health that permits monitoring trends and assessing orders of magnitude, the DAC systems may somewhat underestimate the amounts effectively made available.

12. The definition of aid to health excludes aid to other sectors which may have a direct or indirect effect on health status, e.g. water and sanitation or education. Medical assistance in natural disasters and other emergency situations is also excluded.

13. The Statistical Working Party of the DAC<sup>4</sup> has discussed the problem of underestimation at length. In brief, data collection at the international level requires pragmatism. In theory, it is possible to conceive a reporting system that would request sectoral information at the level of project components (e.g. estimated spending on health within a rural development programme). All DAC Members agree, however, that such a system would not work in practice and that statistical reporting requirements should, if anything, be simplified. In cases where basic data available through regular statistical reporting to the DAC are not sufficient for analytical purposes, supplementary data collection may therefore need to be undertaken.

---

<sup>4</sup> The Working Party on Statistics is a subsidiary body of the DAC. Its mandate includes, among other things, proposing improvements in the statistical reporting, ensuring the fullest possible comparability of reporting and promoting the wide use of the data in international institutions, developing countries and DAC Member countries.

**Table 1. DAC statistical definition of “aid to health”<sup>5</sup>**

DAC sector	CRS code	Description	Clarifications / Additional notes on coverage
<b>120 HEALTH</b>			
<b>121 Health, general</b>			
	<b>12110</b>	Health policy and administrative management	Health sector policy, planning and programmes; aid to health ministries, public health administration; institution capacity building and advice; medical insurance programmes; unspecified health activities.
	<b>12181</b>	Medical education/training	Medical education and training for tertiary level services.
	<b>12182</b>	Medical research	General medical research (excluding basic health research).
	<b>12191</b>	Medical services	Laboratories, specialised clinics and hospitals (including equipment and supplies); ambulances; dental services; mental health care; medical rehabilitation; control of non-infectious diseases; drug and substance abuse control [excluding narcotics traffic control (16361)].
<b>122 Basic health</b>			
	<b>12220</b>	Basic health care	Basic and primary health care programmes; paramedical and nursing care programmes; supply of drugs, medicines and vaccines related to basic health care.
	<b>12230</b>	Basic health infrastructure	District-level hospitals, clinics and dispensaries and related medical equipment; excluding specialised hospitals and clinics (12191).
	<b>12240</b>	Basic nutrition	Direct feeding programmes (maternal feeding, breastfeeding and weaning foods, child feeding, school feeding); determination of micro-nutrient deficiencies; provision of vitamin A, iodine, iron etc.; monitoring of nutritional status; nutrition and food hygiene education; household food security.
	<b>12250</b>	Infectious disease control	Immunisation; prevention and control of malaria, tuberculosis, diarrheal diseases, vector-borne diseases (e.g. river blindness and guinea worm), etc.
	<b>12281</b>	Health education	Information, education and training of the population for improving health knowledge and practices; public health and awareness campaigns.
	<b>12282</b>	Health personnel developm.	Training of health staff for basic health care services.
<b>130 POPULATION POLICIES/PROGRAMMES AND REPRODUCTIVE HEALTH</b>			
	<b>13010</b>	Population policy and administrative management	Population/development policies; census work, vital registration; migration data; demographic research/analysis; reproductive health research; unspecified population activities.
	<b>13020</b>	Reproductive health care	Promotion of reproductive health; prenatal and postnatal care including delivery; prevention and treatment of infertility; prevention and management of consequences of abortion; safe motherhood activities.
	<b>13030</b>	Family planning	Family planning services including counselling; information, education and communication (IEC) activities; delivery of contraceptives; capacity building and training.
	<b>13040</b>	STD control including HIV/AIDS	All activities related to sexually transmitted diseases and HIV/AIDS control e.g. information, education and communication; testing; prevention; treatment, care.
	<b>13081</b>	Personnel development for population/reproductive health	Education and training of health staff for population and reproductive health care services.

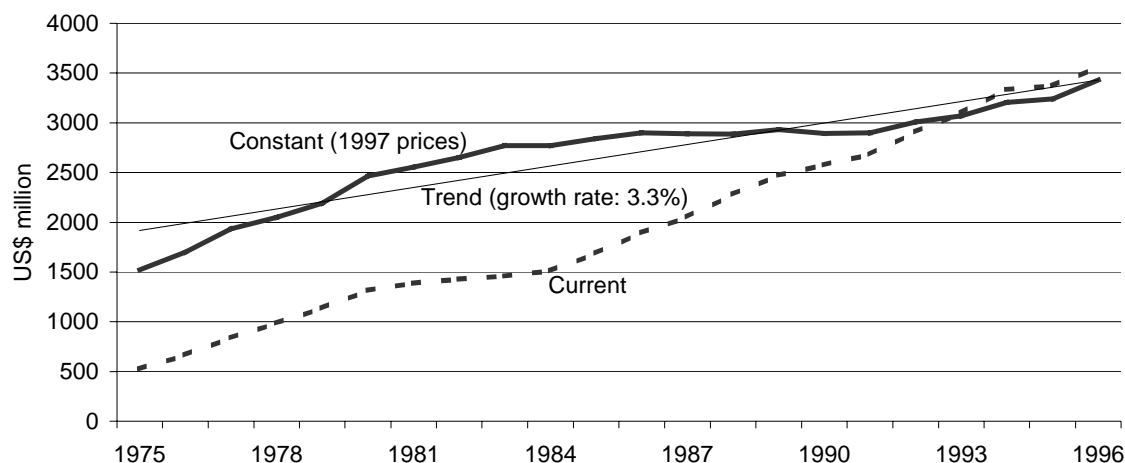
5 . The definition covers, although does not specifically mention, technical assistance in health sub-sectors. This follows from the principles of sector coding which identify the sectors assisted rather than the method of delivery.

### 3. Recent trends in aid to health (including reproductive health)<sup>6</sup>

14. Chart 1 below illustrates the evolution in aid to health since 1975. There is a constant growth as aid to health increases from a few hundred million US dollars a year to 3.5 billion a year. Data converted to constant dollars show that there was real growth over the whole period (average annual growth of 3%). It is worth noting that aid to health has continued to grow after 1992, despite a marked fall in total ODA from that time. (See evolution of ODA/GNP ratio in Chart 2.) DAC countries' commitments of bilateral aid to health over the whole period amounted to a total of US\$ 41 billion (current), and ODA lending to health by the multilateral development banks to US\$ 10 billion.

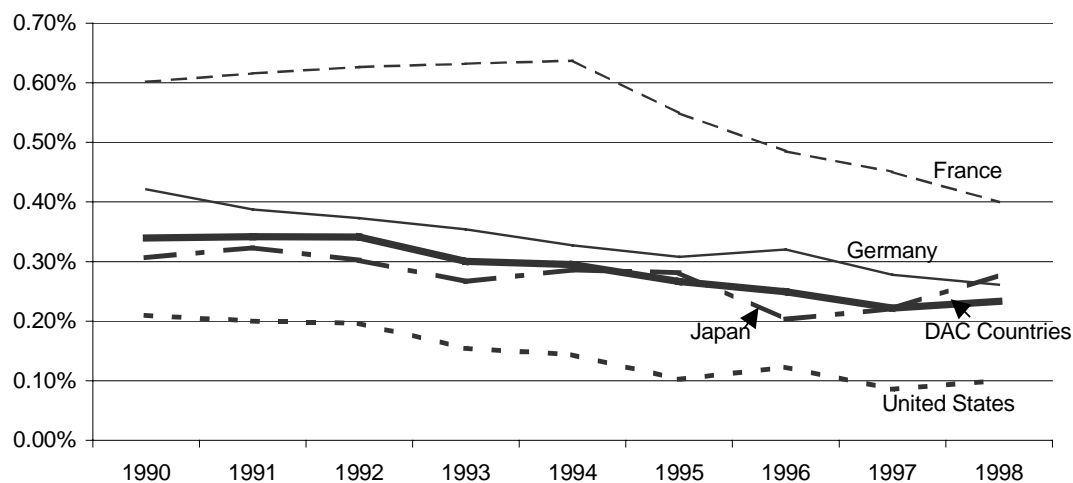
**Chart 1. Aid to health 1973-98: 5-year moving average**

Source: CRS and DAC statistics



**Chart 2. Evolution in ODA/GNP ratio 1990-98**

Source: DAC statistics



<sup>6</sup> If not otherwise stated, statistics shown relate to bilateral and multilateral ODA to health (excluding the UN and the EC budget; see para. 8). Since sectoral data are collected on commitments (rather than disbursements), moving averages are used as the basis for analysis. Averages even out the "lumpiness" of commitments and thereby allow better identification of the underlying trends. In particular, the cyclical nature of World Bank lending calls for the use of average rather than annual data.

**Table 2. Aid to health 1990-98: annual average commitments and share in total aid**

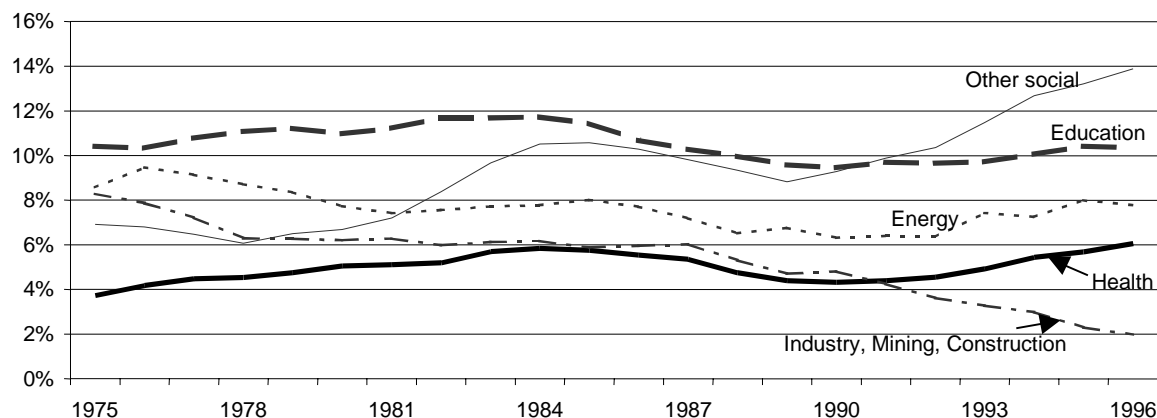
Source: CRS statistics

	US\$ million			% of Donor Total			% All Donors		
	1990-92	1993-95	1996-98	1990-92	1993-95	1996-98	1990-92	1993-95	1996-98
Australia	14	43	76	3%	8%	7%	1%	2%	2%
Austria	9	14	23	3%	9%	6%	0%	1%	1%
Belgium	1	31	56	1%	11%	11%	0%	1%	2%
Canada	31	57	36	3%	5%	3%	2%	2%	1%
Denmark	69	71	90	15%	10%	10%	4%	3%	3%
Finland	32	14	13	6%	7%	7%	2%	1%	0%
France	71	65	100	3%	3%	4%	4%	2%	3%
Germany	37	114	163	1%	3%	5%	2%	4%	5%
Italy	94	31	26	5%	3%	4%	5%	1%	1%
Japan	107	198	242	1%	2%	2%	5%	7%	7%
Netherlands	61	97	140	5%	6%	7%	3%	4%	4%
New Zealand	..	1	..	..	2%	..	..	0%	..
Norway	32	38	42	7%	5%	6%	2%	1%	1%
Portugal	0	0	0	0%	0%	0%	0%	0%	0%
Spain	26	59	117	3%	17%	16%	1%	2%	4%
Sweden	154	92	83	7%	9%	8%	8%	3%	3%
Switzerland	31	19	30	5%	3%	6%	2%	1%	1%
United Kingdom	134	98	214	9%	10%	10%	7%	4%	6%
United States	383	800	733	5%	16%	17%	20%	30%	22%
Total DAC	1286	1841	2185	4%	6%	6%	66%	69%	66%
AfDF	71	57	59	9%	14%	8%	4%	2%	2%
AsDF	33	42	45	3%	5%	3%	2%	2%	1%
EC (EDF)	61	105	83	4%	5%	5%	3%	4%	3%
IDA	485	616	893	8%	10%	14%	25%	23%	27%
IDB Sp.Fund	21	6	42	4%	2%	8%	1%	0%	1%
Total Multilateral	671	826	1122	6%	8%	10%	34%	31%	34%
Total	1957	2667	3307	4%	6%	7%	100%	100%	100%

Note: From 1995 onwards, sector coding of US aid programme is based on strategic objectives rather than individual aid activities.

15. Table 2 presents data on aid to health for individual donors. (See also Tables A1-A2 in Annex.) The share of bilateral and multilateral ODA to health has remained relatively stable in the 1990s (two-thirds and one-third respectively). The United States is the largest bilateral donor in the sector both in value terms (over the whole period) and proportionately (in 1996-98). Other donors that have extended 10% or more of their bilateral ODA to the health sector are Belgium, Denmark, Spain and the United Kingdom. The share of aid to health in DAC countries' total bilateral ODA has been increasing, from 4% in the beginning of 1990s to 6% in 1998. Multilateral contributions have increased as well, in particular those of the World Bank. Fourteen per cent of IDA lending in 1996-98 was for health, in comparison to 8% in 1990-1992. All in all, approximately 7% of DAC countries' total bilateral ODA and of multilateral banks' ODA lending has been directed to health during the most recent years. Chart 3 illustrates the evolution of this share in time and in comparison with that of some other sectors.

**Chart 3. Aid to health as a share of total ODA 1973-98: 5-year moving average** Source: DAC statistics



16. Chart 4 below shows the sub-sectoral breakdown of ODA to health. The inner pie represents the breakdown for DAC countries' bilateral aid: approximately one third of contributions are in support of basic health,

slightly over one third in support of reproductive health care/population activities, with the remainder covering general health programmes and medical (non-basic) health services. The outer pie is for total aid, including lending by the multilateral development banks. Multilateral aid to health (not plotted separately) consists first and foremost of general health sector programmes (40% of total multilateral aid to health), but reproductive health care and infectious disease control are also important (16% and 10% respectively).

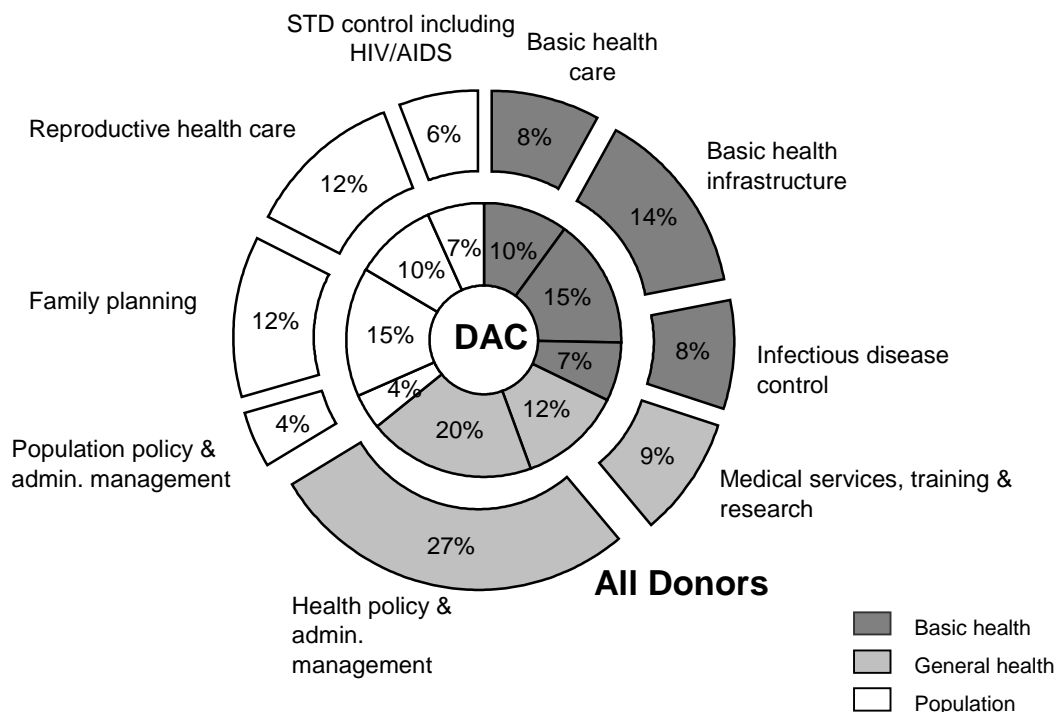
17. The sub-sectoral breakdown has remained relatively stable over time, although some changes have occurred within the sub-sectors. For example, funds for STD control including HIV/AIDS increased in 1994-95 amounting to close to 10% of (bilateral and multilateral) aid to health but dropped to 5% in 1996-98. Aid to basic health care and basic health infrastructure peaked in 1995-96 covering a quarter of total aid to health but dropped to 13% in 1997-98. Chart 5 presents the evolution in the sub-sectoral breakdown of aid to health by all donors, measured in constant dollars.

18. Health education, health personnel development, medical education/training and medical research represent less than 3% of total aid to health. While this appears as a small figure, it can understate the number of activities donors undertake. First, education, training and research programmes are generally of small size in comparison with other projects in the sector. Secondly, education and training components are likely to be incorporated in numerous health programmes but their share of the total cannot be separately identified. Finally, a partial explanation is also the fact that data are missing on a few donors' technical co-operation activities.

**Chart 4. Sub-sectoral breakdown of aid to health in 1990-98**

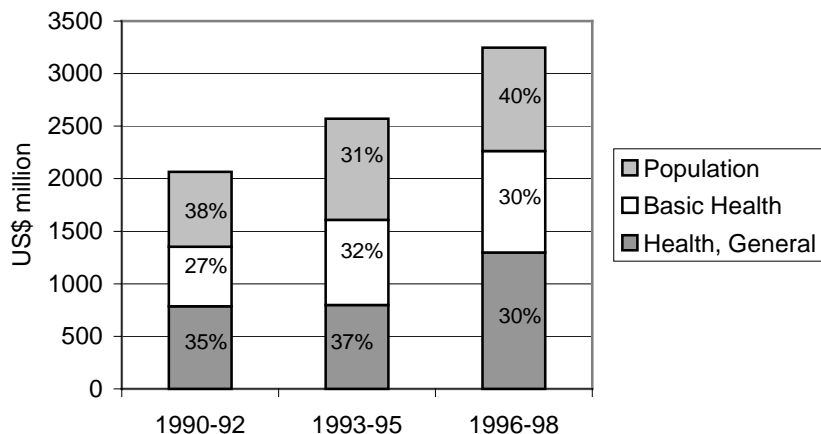
(Inner: bilateral; outer: total ODA)

Source: CRS statistics



**Chart 5. Aid to health 1990-98 in constant (1997 prices) US\$ million**

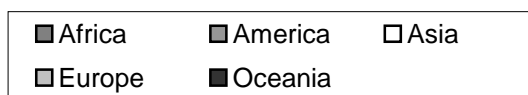
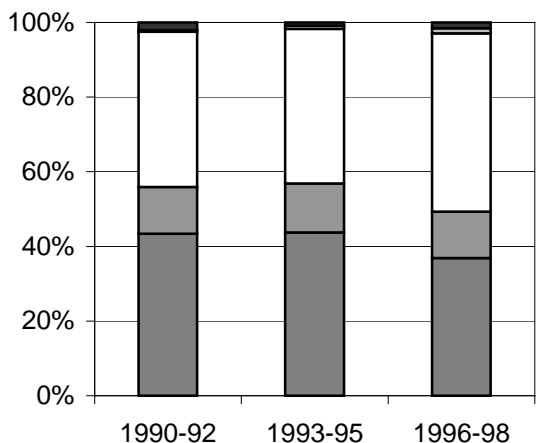
Source: CRS statistics



19. Chart 6 and Table 3 below illustrate trends in the geographical distribution of aid to health. Asia is the largest recipient region, which is also the case for aid in general (all sectors combined). In 1996-1998, it received one half of aid to health (roughly in line with Asia's share of total ODA commitments). The largest health programmes have been undertaken in India, China and Bangladesh. All three countries have received large ODA loans from IDA. India and Bangladesh have received also sizeable bilateral grants in support of the health sector. These originate from a variety of donors, the largest being Germany, Sweden, the United Kingdom and the United States. Aid to health in Africa has decreased in the 1990s, but it still receives by far the largest amounts of aid to health per capita (four times more than Asia), as for total aid too. Uganda is the only African country that has remained among the top-ten recipients of aid to health throughout the 1990s.

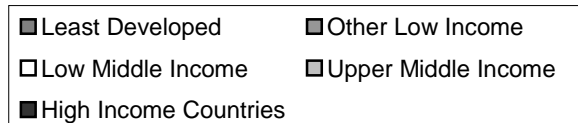
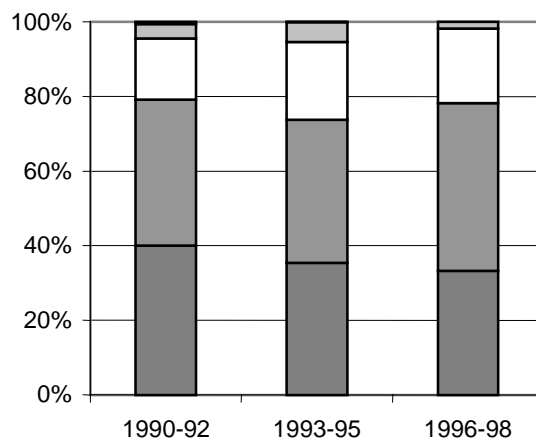
**Chart 6. Aid to health 1990-98 by region**

Source: CRS statistics



**Chart 7. Aid to health 1990-98 by income group**

Source: CRS statistics



**Table 3. Main recipients of aid to health 1990-98**

Source: CRS statistics

Top Ten by Absolute Value Annual average US\$ million						Top Ten in % of Total Receipts	
1990-92			1993-95			1996-98	
India	305	India	268	India	623	Nigeria	41%
Bangladesh	178	China	110	Bangladesh	179	Congo Dem.Rep.	32%
Tanzania	67	Pakistan	92	Viet Nam	108	Dominican Republic	31%
Uganda	66	Uganda	85	China	101	Gambia	30%
Mozambique	59	Mozambique	80	Ethiopia	82	Equatorial Guinea	23%
Kenya	58	Philippines	79	Egypt	80	Panama	23%
China	51	Bangladesh	73	Tanzania	69	Fiji	20%
Nigeria	51	Zambia	71	Indonesia	69	Chile	19%
Pakistan	46	Egypt	67	Uganda	63	India	19%
Indonesia	46	Indonesia	66	Kenya	62	Colombia	18%

20. The statistics by recipient can be analysed from another angle. The right hand side of Table 3 lists the ten countries where aid is focused on the health sector i.e. where the share of aid to health in the country's total receipts is the largest. Yet another approach is to aggregate data on aid to health by income group as shown in Chart 7 above. Aid to health in least developed countries has decreased in the 1990s, but they still receive three times more aid to health per capita than the other income groups on average. Further details on the geographical breakdown of aid to health are given in Tables A3-A8 in the Annex.

21. Finally, Table 4 below presents some data on Other Official Flows<sup>7</sup> (OOF) to health. Bilateral donors extend very few OOF loans to the sector. IBRD lending to health is US\$ 400-600 million a year and has increased during the most recent years. Over the period 1990-98, OOF loans for all donors totalled close to US\$ 8 billion (current). Brazil, Mexico and Indonesia were the main recipient countries. Forty-five per cent of OOF loans to health have been directed to general health sector programmes and eighteen per cent to medical research.

**Table 4. Other Official Flows to health 1990-98: annual average commitments**

Source: CRS statistics

By donor US\$ million	1990-92			1993-95			1996-98		
	1990-92	1993-95	1996-98	Main recipients US\$ million	1990-92	1993-95	1996-98		
AfDB	3.9	20.3	4.9	Brazil	89.0	53.3	305.0		
AsDB	35.0	13.3	59.1	Mexico	60.0	103.3	241.7		
Austria	0.0	0.0	14.3	Indonesia	34.7	105.0	95.8		
France	4.5	6.9	0.6	Venezuela	33.3	68.0	50.0		
IBRD	413.7	404.4	655.7	Morocco	34.7	8.5	44.7		
IDB	67.0	146.1	288.1	Argentina	0.0	0.0	72.1		
Japan	0.0	0.0	0.0	Malaysia	35.0	33.3	0.0		
Netherlands	0.7	0.7	0.0	Chile	62.3	0.0	0.0		
United Kingdom	0.0	3.2	0.0	Turkey	0.0	50.0	4.8		
Grand Total	524.9	594.9	1022.7	Nigeria	46.0	0.0	1.0		

<sup>7</sup> Other Official Flows (OOF) are transactions by the official sector whose main objective is other than development-motivated, or, if development-motivated, whose grant element is below the 25% threshold which would make them eligible to be recorded as ODA.

## 4. Other health-related activities

22. Section 2 above explained that data corresponding to the DAC statistical definition of aid to health would not provide a complete picture of these flows. First, the principle of sector coding (one code per activity) implies that statistics do not capture aid to health extended as part of wider social sector programmes or multisector programmes. Table 5 below lists the DAC sectors/purpose codes which are likely to include such activities. Secondly, a part of official support to NGOs' activities may also be excluded, since this is generally not sector coded in as much detail as project and programme aid. Finally, statistics on aid to health also exclude activities in other sectors which may have direct or indirect effects on health status, e.g. girls' education or safe water and sanitation.

23. It is difficult to estimate the magnitude of other health-related activities. Multisectoral urban and rural development programmes have on the average amounted to US\$ 1.1 billion a year in the 1990s. Activities reported as other social services have added up to US\$ 500 million a year. While no estimate can be given on the part directed to the health sector, it seems reasonable to think that, in any case, the amounts do not exceed a few hundred million dollars a year. NGOs are known to be active in the social sectors, but estimates on the sectoral breakdown of their assistance are available only for a few DAC countries. If these were applied to total aid to NGOs from DAC countries, aid to health would increase by few hundred million dollars a year. As regards education and water supply and sanitation, the best proxy for activities directly promoting better health are those reported as "basic social services", as these specifically target the poor groups of population. In 1997-98, DAC Members' bilateral aid to basic education and poverty-focused water supply/sanitation averaged US\$ 1.1 billion a year.

24. Thus, a total of US\$ 5 billion of ODA can be expected to have some measurable impact on health outcomes. Within this figure, aid to the health sector itself totalled US\$ 3.5 billion, US\$ 2.0 billion of which went to basic health and reproductive health.

25. While these are rough estimates, they do carry an important message: aid to health is much less than what is needed to achieve the international goals for health. According to the 20/20 Initiative, providing universal access to basic health and reproductive health services requires investments of the order of US\$ 100 billion a year for ten years. A further US\$ 100 billion is needed for safe water and sanitation and universal primary education. The 20/20 Initiative suggested that 10% of these costs should be financed by ODA. This means at least US\$ 10 billion of ODA a year should be spent on basic and reproductive health, and another US\$ 10 billion on basic education and water and sanitation. Both amounts are roughly five times present spending on these basic services.

### To sum up:

- **Aid to health has increased steadily since 1975, with an average annual growth rate of 3% (in real terms). Aid to health has continued to grow since 1992, despite a marked fall in total ODA since that time. In 1996-98, it was close to US\$ 3.5 billion a year.**
- **Approximately 7% of DAC countries' total bilateral ODA and of multilateral banks' ODA lending has been directed to health during the most recent years.**
- **Approximately one-third of contributions are in support of basic health, slightly over one third in support of reproductive health care/population activities, the remainder covering general health programmes and medical (non-basic) health services.**
- **Despite the positive trends in aid to health, the current allocations are far below the estimated funding needs in the sector.**

**Table 5. Purpose codes likely to include health-related activities**

DAC sector	CRS code	Description	Clarifications / Additional notes on coverage
<b>160 OTHER SOCIAL INFRASTRUCTURE AND SERVICES</b>			
<b>161 Employment</b>			
	16110	Employment policy and administrative management	Employment policy and planning; labour law; labour unions; institution capacity building and advice; support programmes for unemployed; employment creation and income generation programmes; <b>occupational safety and health</b> ; combating child labour.
<b>163 Other social services</b>			
	16310	Social/welfare services	Social legislation and administration; institution capacity building and advice; social security and other social schemes; <b>special programmes for the elderly, orphans, the disabled, street children</b> ; social dimensions of structural adjustment; unspecified social infrastructure and services, including consumer protection.
<b>400 MULTISECTOR/CROSS-CUTTING</b>			
	43020	Multisector aid for basic social services <sup>8</sup>	Basic social services are defined to include basic education, <b>basic health, basic nutrition, population/reproductive health</b> and water supply and sanitation - small systems.
	43030	Urban development and management	<b>Integrated urban development projects</b> ; local development and urban management; urban infrastructure and services; municipal finances; urban environmental management; urban development and planning; urban renewal and urban housing; land information systems.
	43040	Rural development	<b>Integrated rural development projects</b> ; e.g. regional development planning; promotion of decentralised and multisectoral competence for planning, co-ordination and management; implementation of regional development and measures (including natural reserve management); land management; land use planning; functional integration of rural and urban areas; geographical information systems.

<sup>8</sup> This purpose code was introduced in DAC sector classification in 1999.

## ANNEX

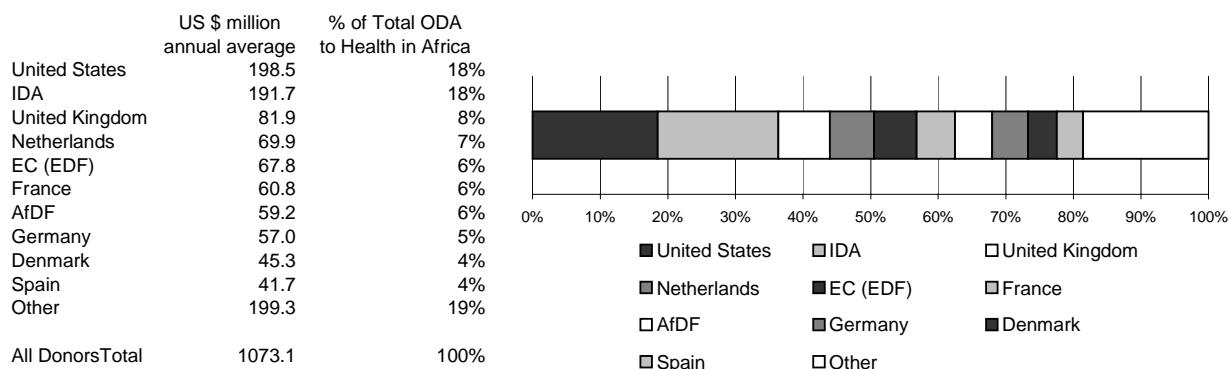
**Table A1: ODA to Health, Top Ten Donors by absolute value**

	1990-92			1993-95			1996-98	
	US\$ million	%		US\$ million	%		US\$ million	%
IDA	485	25%	United States	800	30%	IDA	893	27%
United States	383	20%	IDA	616	23%	United States	733	22%
Sweden	154	8%	Japan	198	7%	Japan	242	7%
United Kingdom	134	7%	Germany	114	4%	United Kingdom	214	6%
Japan	107	5%	EC (EDF)	105	4%	Germany	163	5%
Italy	94	5%	United Kingdom	98	4%	Netherlands	140	4%
France	71	4%	Netherlands	97	4%	Spain	117	4%
AfDF	71	4%	Sweden	92	3%	France	100	3%
Denmark	69	4%	Denmark	71	3%	Denmark	90	3%
Netherlands	61	3%	France	65	2%	Sweden	83	3%
Other	328	17%	Other	412	15%	Other	533	16%
Total	1957	100%	Total	2667	100%	Total	3307	100%

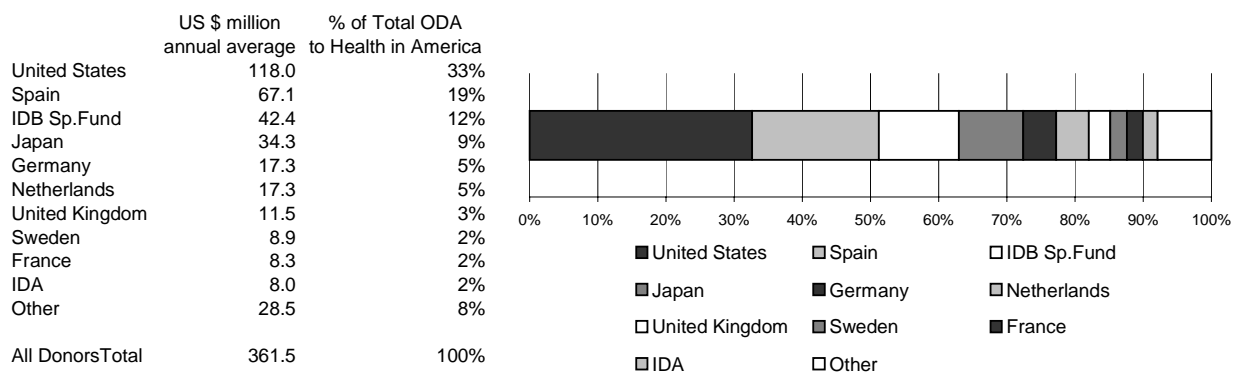
**Table A2: ODA to Health, Top Ten Donors by share in Donor's Total ODA**

	1990-92		1993-95		1996-98
Denmark	15%	Spain	17%	United States	17%
AfDF	9%	United States	16%	Spain	16%
United Kingdom	9%	AfDF	14%	IDA	14%
IDA	8%	Belgium	11%	Belgium	11%
Sweden	7%	Denmark	10%	Denmark	10%
Norway	7%	IDA	10%	United Kingdom	10%
Finland	6%	United Kingdom	10%	AfDF	8%
Switzerland	5%	Sweden	9%	IDB Sp.Fund	8%
Netherlands	5%	Austria	9%	Sweden	8%
United States	5%	Australia	8%	Australia	7%
All Donors Total	4%	All Donors Total	6%	All Donors Total	7%

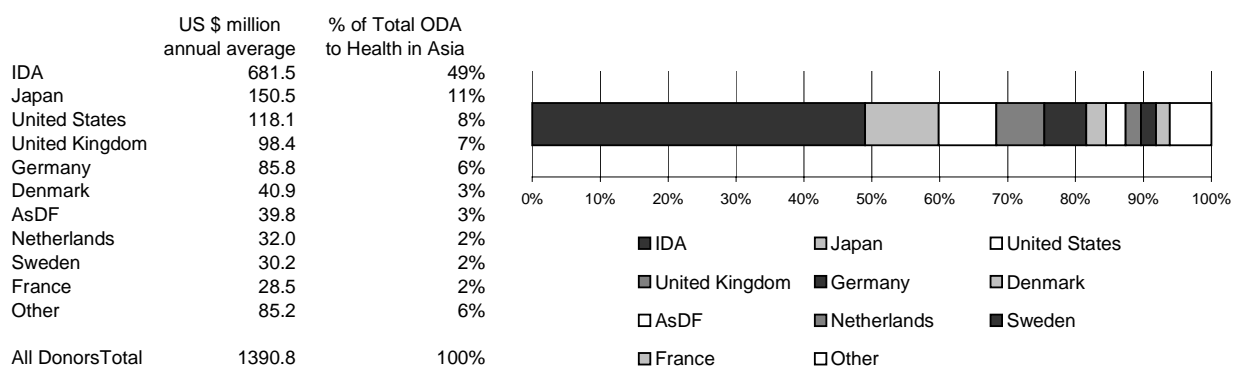
**Table A3: Top Ten Donors in Africa 1996-98**



**Table A4: Top Ten Donors in Latin America and the Caribbean 1996-98**

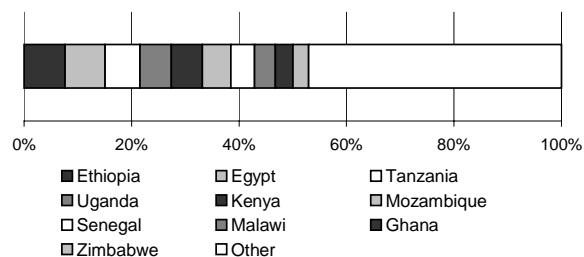


**Table A5: Top Ten Donors in Asia 1996-98**



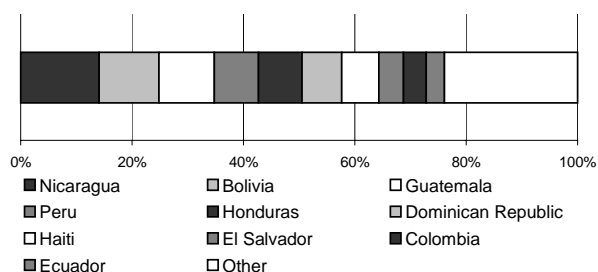
**Table A6: Top Ten Recipients in Africa, 1996-98**  
Annual average, by absolute value and as % of total ODA receipts

US\$ million	%	% of Total Receipts		
Ethiopia	82	8%	Nigeria	41%
Egypt	80	7%	Congo Dem.Rep.	32%
Tanzania	69	6%	Gambia	30%
Uganda	63	6%	Equatorial Guinea	23%
Kenya	62	6%	Sierra Leone	18%
Mozambique	57	5%	Comoros	17%
Senegal	47	4%	Burundi	15%
Malawi	42	4%	Kenya	13%
Ghana	35	3%	Angola	12%
Zimbabwe	32	3%	Central African Rep.	12%
Other	505	47%		
Total Africa	1074	100%		



**Table A7: Top Ten Recipients in Latin America and the Caribbean, 1996-98**  
Annual average, by absolute value and as % of total ODA receipts

US\$ million	%	% of Total Receipts		
Nicaragua	51	14%	Dominican Republic	31%
Bolivia	39	11%	Panama	23%
Guatemala	36	10%	Chile	19%
Peru	29	8%	Colombia	18%
Honduras	28	8%	Guatemala	18%
Dominican Republic	26	7%	Costa Rica	14%
Haiti	24	7%	Antigua & Barbuda	13%
El Salvador	16	4%	Suriname	12%
Colombia	15	4%	El Salvador	11%
Ecuador	12	3%	Nicaragua	9%
Other	86	24%		
Total America	361	100%		



**Table A8: Top Ten Recipients in Asia 1996-98**  
Annual average, by absolute value and as % of total ODA receipts

US \$ million	%	% of Total Receipts		
India	623	45%	India	19%
Bangladesh	179	13%	Bhutan	14%
Viet Nam	108	8%	Bangladesh	13%
China	101	7%	Cambodia	13%
Indonesia	69	5%	Palestinian adm.areas	8%
Philippines	45	3%	Afghanistan	7%
Cambodia	33	2%	Viet Nam	6%
Pakistan	32	2%	Nepal	5%
Thailand	28	2%	Kyrgyz Republic	5%
Nepal	22	2%	Kazakstan	4%
Other	151	11%		
Total Asia	1391	100%		

