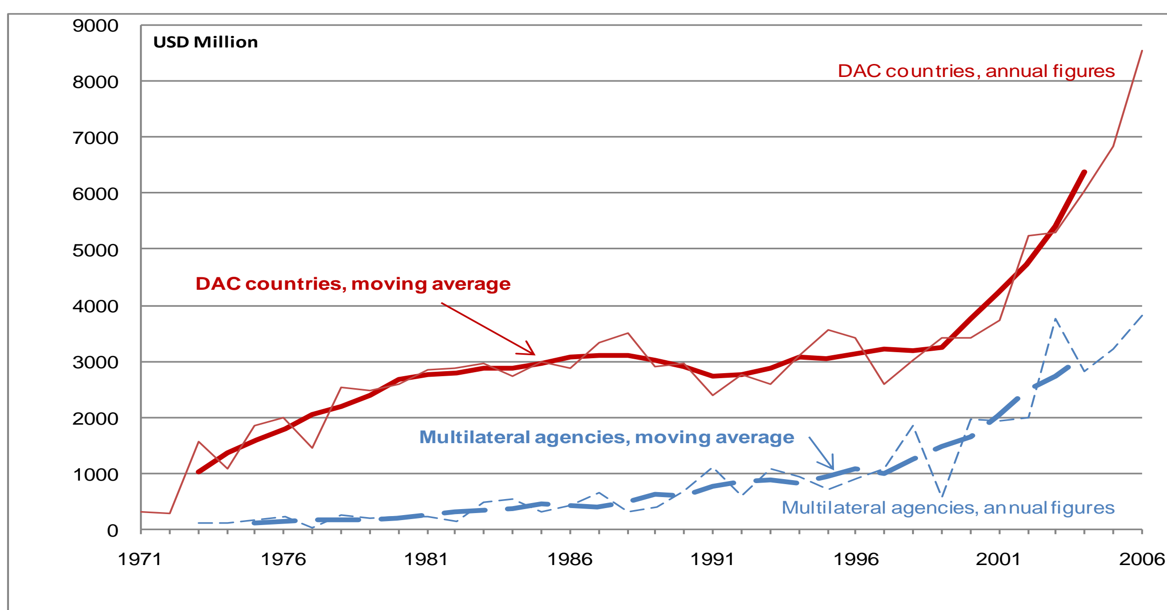
Measuring Aid to Health

Statistics presented in this note relate to Official Development Assistance (ODA) for health, population programmes and reproductive health (hereafter referred to as aid to health) and do not cover other official flows or private funding.

After stagnating in the 1980s and 1990s, aid to health has risen sharply in recent years. In 2006, DAC countries' bilateral aid to health amounted to **USD 8.6 billion** and multilateral agencies' aid to **USD 4 billion**. Average annual growth over the period 1980-2006 was 9% but this accelerated over the most recent years (15% annually from 2000 to 2006).

Chart 1. Trends in aid to Health

1973-2006, 5-year moving averages and annual figures, constant 2006 prices



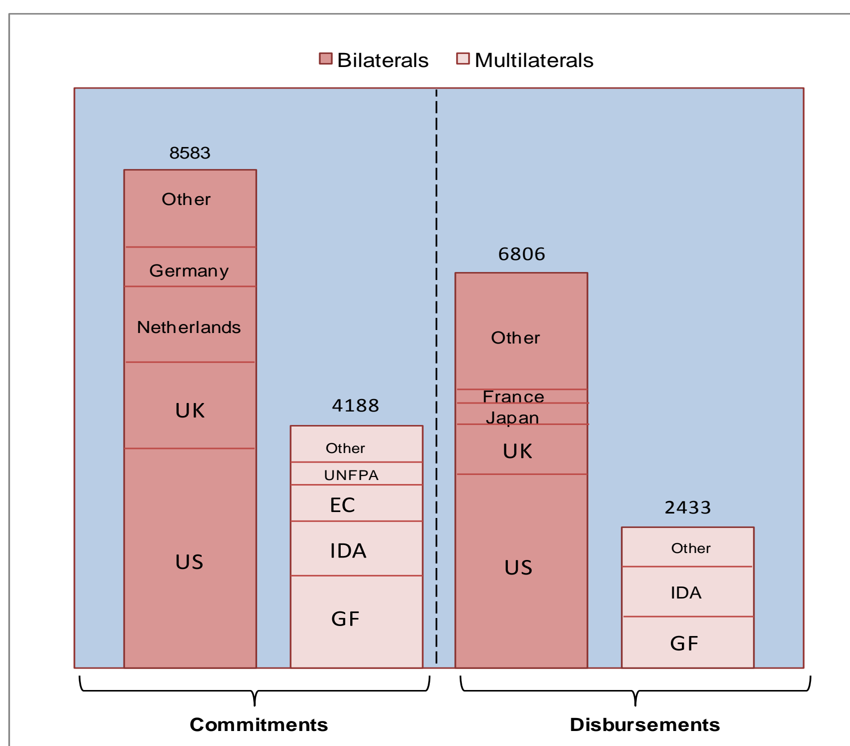
The trend in aid to the health sector is set by a few donors (see Chart 2 and Table 1): in 2005-2006, three-quarters of DAC members' total bilateral aid commitments to health were extended by the United States, the United Kingdom, the EC, the Netherlands and Germany. On a disbursements basis, the order is again the United States, the United Kingdom and the EC, but followed by Japan, France and Canada.

As regards multilateral agencies, the increase in aid to health over the period 2002-2006 is largely due to the creation of the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund), which committed USD 5.3 billion (cumulative total) over the period.

Overall, the data indicate an increased prioritisation of the health sector in donors' aid programmes with 16% of total DAC countries' bilateral sector-allocable aid dedicated to health in 2005-2006 (see Table 2), compared with 12% in 2001-2002. The donors that extend the highest proportions of their aid to the health sector are Ireland (36% in 2005-2006), the United Kingdom (33%), Luxembourg (32%), the United States (23%) and Greece (21%).

Chart 2. Aid to health by top donors

2005-06, annual average commitments and disbursements, USD million, constant 2006 prices



Note: IDA did not report disbursement data, and the chart is based on an estimate.

Sub-Saharan Africa has been the largest recipient region of aid to health since 1999. In 2005-2006, it received almost a half of total aid to health. Asia ranked second, and received 30% of total aid to health.

Table 1. Main recipients and donors of DAC members' bilateral aid to the Health sector

2005-06 average commitments in millions of USD, constant 2006 prices

USD million, average 2005/2006	United States	United Kingdom	EC	Netherlands	Germany	*Other DAC members*	Total DAC members	*% of aid to health to all recipients*
India	78	466	21	0	6	109	**681**	*7%*
Bangladesh	21	107	70	25	1	91	**314**	*3%*
Kenya	165	31	3	0	5	51	**255**	*3%*
South Africa	172	7	28	3	5	37	**252**	*3%*
Zambia	114	0	9	53	7	62	**246**	*3%*
Mozambique	84	3	2	14	1	130	**234**	*3%*
Uganda	20	0	1	0	0	5	**26**	*0%*
Nigeria	128	65	12	0	3	21	**228**	*2%*
Iraq	224	0	0	0	1	1	**227**	*2%*
Tanzania	9	0	0	0	2	21	**32**	*0%*
*Other recipients**	*2857*	*733*	*489*	*408*	*306*	*1927*	***6721***	***73%***
Total amount	**3873**	**1413**	**635**	**503**	**339**	**2455**	**9217**	
% of aid to health from all DAC members	***42%***	***15%***	***7%***	***5%***	***4%***	***27%***		

A large portion of bilateral donors' contributions to the health sector (21%) cannot be broken down by recipient. They consisted in donors' contributions to Public Private Partnerships (International AIDS Vaccine Initiative, International Partnership on Microbicides) and to international NGOs (International Planned Parenthood Federation) classified as bilateral aid in DAC statistics (see technical note in Annex). They also included contributions to research institutes, and international programmes fighting against specific diseases (*global polio eradication initiative* of UNICEF, *polio immunization programme* and *measles immunization programme* of WHO, and other programmes for avian flu, malaria and tuberculosis control). More than a half of non-geographically allocated contributions benefited HIV/AIDS control.

Table 2. Aid to health by donor

2003-06, annual average commitments and disbursements, shares in total sector-allocable aid, constant 2006 prices

	Commitments, USD million		Disbursements, USD million		*% of Donor Total*	*% All donors*
	2003-2004	2005-2006	2003-2004	2005-2006	*2005-2006*	*2005-2006*
Australia	113	164	125	189	*14*	*1*
Austria	21	26	8	11	*10*	*0*
Belgium	105	127	94	107	*15*	*1*
Canada	297	302	174	282	*19*	*2*
Denmark	128	122	63	73	*11*	*1*
Finland	33	44	22	36	*10*	*0*
France	270	289	248	298	*7*	*2*
Germany	240	339	221	232	*7*	*3*
Greece	19	31	19	31	*21*	*0*
Ireland	106	132	106	132	*36*	*1*
Italy	79	92	53	43	*13*	*1*
Japan	550	262	254	301	*3*	*2*
Luxembourg	32	42	33	42	*32*	*0*
Netherlands	220	503	250	232	*15*	*4*
New Zealand	12	24	10	16	*13*	*0*
Norway	150	295	123	228	*18*	*2*
Portugal	10	10	10	10	*5*	*0*
Spain	121	144	119	149	*10*	*1*
Sweden	139	312	132	225	*17*	*2*
Switzerland	47	37	43	45	*5*	*0*
United Kingdom	676	1413	467	740	*33*	*11*
United States	2577	3873	2183	3384	*23*	*30*
Total DAC countries	5946	8583	4758	6806	*16*	*67*
AfDF	86	156	n.a.	n.a.	*12*	*1*
AsDF	84	32	n.a.	n.a.	*3*	*0*
EC	563	635	159	521	*7*	*5*
Global Fund	998	1609	430	1140	*100*	*13*
IDA	947	948	n.a.	n.a.	*15*	*7*
IDB Special Fund	3	36	n.a.	n.a.	*8*	*0*
UNAIDS	144	162	144	162	*100*	*1*
UNFPA	321	392	321	392	*100*	*3*
UNICEF	152	160	152	160	*31*	*1*
UNRWA	53	60	53	60	*19*	*0*
Total Multilateral	3351	4188	1259	2433	*20*	*33*
Total	9297	12770	6017	9239	*17*	*100*

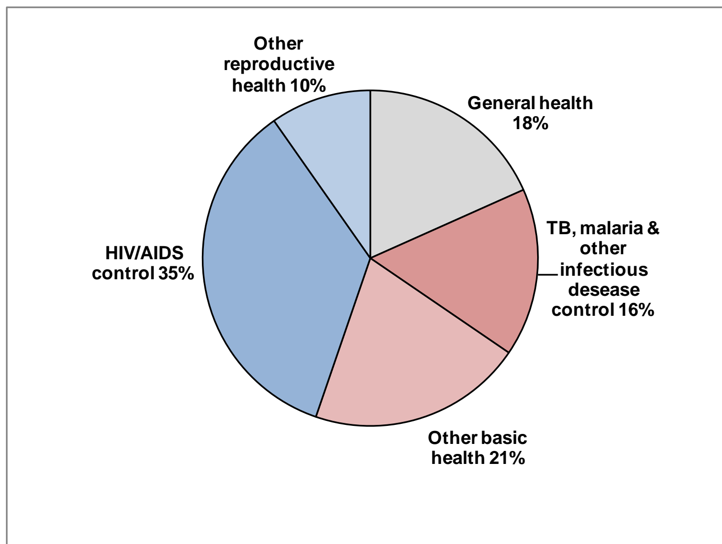
Notes:

Disbursement data: for Denmark, the coverage is not complete and data are partial estimates; for Finland, the figure for 2003-2004 refers to 2003 only and for 2005-2006 to 2006 only; for Luxembourg the figure for 2003-2004 refers to 2004 only.

Sector-allocable aid: in order to better reflect the sectoral focus of donors' programmes, when calculating the share of aid to health in total bilateral aid (column "% of Donor Total"), contributions not susceptible to allocation by sector are excluded from the denominator (general budget support, actions relating to debt, humanitarian aid, administrative costs and other internal transactions in the donor country).

Chart 3. Sub-sectoral breakdown of aid to health

Commitments in 2005-2006, constant 2006 prices



The sub-sectoral breakdown has changed over time in favour of reproductive health, in particular HIV/AIDS control which has been a growing priority in donors' health aid programmes: the share of aid to HIV/AIDS control in total aid to health increased from 25% in 2000-2004 to 35% in 2005-2006.

Aid to tuberculosis, malaria and other infectious disease control increased much more modestly from 12% to 16% over the same period.

Annex - Technical note

Monitoring aid flows to the health sector

DAC statistics - CRS Aid Activity database

DAC and CRS data are the unique source for official, standard and comparable statistics on ODA.

The OECD Development Assistance Committee (DAC) collects aid flows at activity level through the Creditor Reporting System (CRS) and expanded CRS (CRS++), and in the form of aggregates through the annual DAC Questionnaire. The data collection is based on a standard methodology and agreed definitions. Data can be used to analyse trends and compare the efforts of donors.

Aid to health is sub-divided in 2 sectors and 17 sub-sectors.

The DAC definition of aid to health includes “basic health”, “health, general”, and “population policies/programmes and reproductive health”. The full definition of each sector and sub-sector is given on the last page of this document.

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 supply and sanitation or education. Medical assistance in the context of natural disasters and other emergency situations is also excluded.

Example of data collection at activity level.

For most types of financial flows, the CRS database records the face value of the activity at the date a grant or loan agreement is signed with the recipient (“commitments”). Data on the amounts disbursed each year are available at the activity level also (“disbursements”). Aid flows are measured on a calendar year basis.

Example: UK support to “Final phase of polio eradication in India”, committed in 2002 with subsequent disbursements up to 2006 (current thousand £).

Original commitment

Year	Donor	Agency	Project number	Recipient	Sector code	Amount	Flow type	Currency
2002	UK	DFID	149110001	India	12250	86 000	Grant	£

Subsequent disbursements

Year	Annual disbursement	Cumulative disbursement	Remains to be disbursed
2002	39 386	39 386	46 614
2003	23 511	62 897	23 103
2005	15 490	78 387	7 613
2006	7 287	85 674	326

DAC statistics on ODA for health cover both donors' bilateral activities and their multilateral contributions.

The table below shows the coverage of DAC statistics on **official development assistance** (**ODA) to health**. In addition to their own aid activities in the health sector, donors report on their core contributions to NGOs and PPPs (classified as bilateral aid) and multilateral agencies active in the health sector.

Table A1: Coverage of ODA for health

Official Development Assistance	Notes
Bilateral ODA	Aid activities undertaken directly with an aid recipient, core contributions to NGOs and PPPs, and contributions to specific-purpose programmes and funds managed by international organisations (earmarked funding).
- Aid to health - Aid to population programmes/reproductive health	} Identifiable through *sector codes.* Includes project-type interventions; experts and other technical assistance; sector budget support; basket funds and pooled funding; earmarked funding to programmes and funds targeted to the health sector managed by multilateral agencies and INGOs.
- Core contributions to INGOs working in the health sector e.g. -- Health Action International -- International HIV/AIDS Alliance -- International Planned Parenthood Federation -- Médecins Sans Frontières	Identifiable through *channels of delivery*.
- Core contributions to PPPs working in the health sector e.g. -- Global Alliance for Improved Nutrition -- International AIDS Vaccine Initiative -- International Partnership for Microbicides -- UNITAID	Identifiable through *channels of delivery*.
Multilateral ODA	Donors' contributions to the regular budgets of multilateral agencies.
- Core contributions to multilateral agencies working in the health sector e.g. -- WHO (70%)	70% of core contributions to WHO are reportable as ODA.
-- UNFPA -- Global Fund -- GAVI	} Separately reportable as part of standard aggregate reporting.
-- IFFIm -- UNAIDS	} At present, separately identifiable only for donors reporting in CRS++ format.
- Core contributions to multilateral agencies that work in several sectors e.g. -- UNDP, UNICEF, UNRWA -- European Union Institutions -- World Bank Group including AMCs -- Regional development banks	Donors' aid to health through these agencies can be **estimated** as follows: 1/ the share of each agency's aid flows for health in their total sector allocable aid is calculated (core resources only); 2/ the share obtained in step 1 is multiplied by a donor's contribution to the core resources of the agency concerned.

DAC statistics on developing countries' receipts for health cover official flows originating from bilateral donors and multilateral agencies.

In addition to ODA, DAC statistics measure the receipts of developing countries. The receipts of official flows for developmental purposes, referred to as **official development finance (ODF)**, comprise i) bilateral ODA; ii) bilateral other official flows that are considered as developmental but which have too low a grant element to qualify as ODA; and iii) grants and loans by multilateral agencies. The table below shows the coverage of current data collection on ODF in DAC aggregate statistics (provides data on total ODF to health) and the CRS aid activity database (analyses of ODF to health by recipient and by sub-sector).

Table A2: Coverage of receipts of ODA and other official development finance for health

Outflow of resources from donor countries	Receipts of developing countries Notes on coverage
Bilateral flows (including earmarked funding to specific-purpose programmes and funds managed by international organisations)	At present, data are collected from all DAC members, 7 non-DAC OECD members and 11 other bilateral donors.
- Aid to health - Aid to population prog./ reproductive health -- INGOs and PPPs working in the health sector	- Aggregate data on aid to health are available for all DAC members, Czech Republic, Korea and Turkey. - Activity-level data are available for all DAC members and Korea. *Not covered to avoid double-counting.*
Bilateral OOF	
- OOF to health - OOF to population prog./ reproductive health	*Included. Concerns only a few donors.*
Multilateral flows [funded from the agencies' regular (core) budgets]	At present, **DAC** aggregate statistics cover flows from the multilateral development banks (concessional and non-concessional loans as well as grants), the Global Fund, operational activities of UN agencies and funds, and a few other multilateral agencies. As regards the **CRS**:
- Multilateral agencies working in the health sector - Multilateral agencies working in several sectors	- Complete reporting from **UNAIDS**, **UNFPA** and the **Global Fund**. *- Not covered in CRS: core-funded operational activities of **WHO**.* *- **GAVI** has been classified as a multilateral agency in DAC statistics since June 2008. Data collection is expected to start in 2009.* - Complete reporting from **European Union Institutions** and **UNICEF**. - **AfDB, AsDB** and **IADB** provide activity-level data in a format that is easily convertible to the CRS. Sector codes are assigned by the DAC Secretariat. - The **World Bank** reports aggregate data. Activity-level data are downloaded from the World Bank's website and transformed into the CRS format. The resulting data are approximate and health sector interventions are poorly identified. Discussions to establish an improved reporting procedure are ongoing. *- Not covered in CRS: **UNDP, UNRWA**.*

List of sub-sectors for health

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