other discrimination. Such programmes seek to fully involve the poor, through community and non-governmental organisations at all stages, from determining the priorities of the programme to its implementation. Considerable success has also been achieved through partnership with civil society and the private sector (as in the case of polio eradication).

The Five Year Review of the World Summit on Social Development (Copenhagen +5) endorsed an approach that also goes beyond health programmes *per se* to include the impact of policies and programmes in other sectors that affect health – for example in employment and environmental policies. This is, in effect, the application of policy coherence to health objectives.

3. ODA flows to health: A statistical overview

A new analysis of the statistics provided by DAC Members on the purposes of their aid has thrown light on recent aid flows to the health (including reproductive health) sector. This overview quantifies these flows, examines their share in total ODA, and looks at the geographical (recipient) breakdown. Box V-2 briefly describes the statistical reporting systems of the DAC from which all data have been derived.

The DAC statistical definition of aid to health

In their statistical reporting, DAC Members are requested to assign to 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 V-1 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 analyses based on the Creditor Reporting System (CRS) 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).

The comparability of data between DAC Members (*i.e.* the consistency of each Member's reporting with the definition) is assessed to be good. Moreover, the DAC sector classification is being increasingly 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.

But 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 an overview 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 but they fail to capture aid to health delivered within multisector (*e.g.* basic social services) programmes. In other

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Box V-2.

Aid to health as measured in the DAC reporting systems

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.

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.

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.

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. 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.*

At the total level, the data gap for the UN can be estimated to represent roughly 10% of total ODA to health. EDF funding in the health sector has been of the order of USD 80 million a year (5% of total EDF). They do not therefore greatly affect trend analysis but imply, of course, underestimation of aid to health extended to individual recipient countries.

* 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").

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 underestimate the amounts effectively made available. It should also be noted

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Table V-1.

DAC statistical definition of "aid to health"*

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

* 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.

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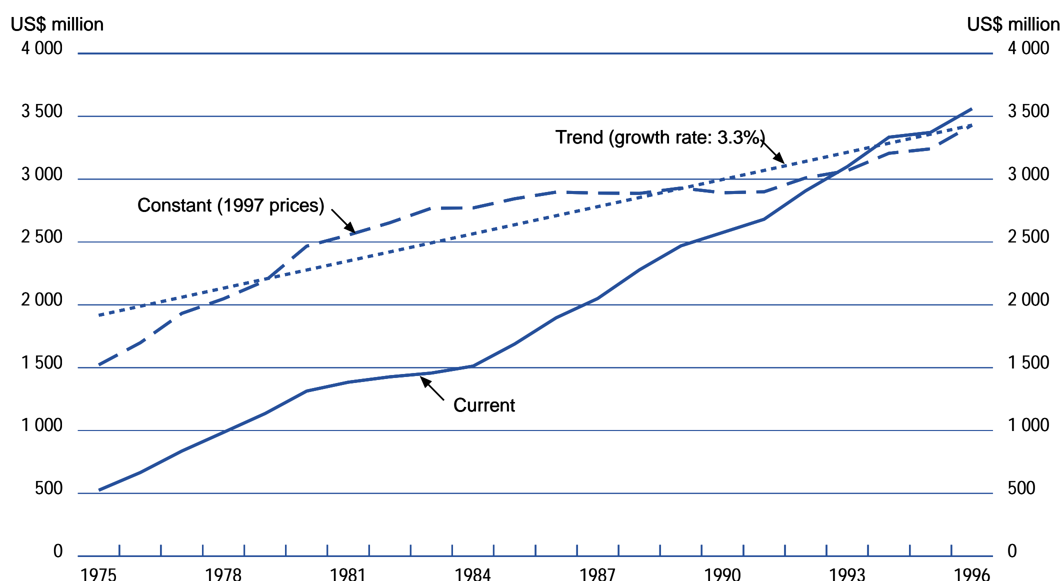
that the definition of aid to health excludes aid to other sectors which may have a direct or indirect effect on health status, *e.g.* water and sanitation or education. Medical assistance in natural disasters and other emergency situations is also excluded.

Recent trends[1]

Chart V-1, which illustrates the evolution in aid to health since 1975, shows constant growth as aid to health increases from a few hundred million USD a year to 3.5 billion a year. Data converted to constant dollars show that there was real growth over the whole period with an average annual growth of 3%. It is noteworthy that aid to health has continued to grow since 1992, despite a marked fall in total ODA from that time. (See evolution of ODA/GNP ratio in Chart V-2.) DAC countries' commitments of bilateral aid to health in 1990-98 amounted to a total of USD 16 billion (current), and ODA lending to health by the multilateral development banks to USD 7 billion.

Table V-2 presents data on aid to health for individual donors. The share of bilateral and multilateral ODA to health has remained relatively stable in the

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



Source: CRS and DAC statistics.

1. If not otherwise stated, statistics shown relate to bilateral and multilateral ODA to health (excluding the UN and the EC budget). 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.

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Table V-2.

Aid to health 1990-98: Annual average commitment and share in total aid

	USD 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	**1 286**	**1 841**	**2 185**	**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**	**1 122**	**6**	**8**	**10**	**34**	**31**	**34**
Total	**1 957**	**2 667**	**3 307**	**4**	**6**	**7**	**100**	**100**	**100**

Source : CRS Statistics

Notes:

Ireland and **Luxembourg** do not report to the CRS and are therefore excluded from the analysis in this chapter. According to DAC statistics, 14% of Ireland's total bilateral ODA (on the average USD 11 million a year) was extended to health in 1996-98. The corresponding figure for Luxembourg was 23% (USD 15 million a year). **Greece** is not included as it only became a Member of the DAC in 1999.

Data for **France, Germany, Japan** and **Portugal** partially exclude their technical co-operation activities and therefore underestimate their aid to health in value terms. However, this has very little effect on the share calculations. For France, aid to health including technical co-operation represented 4% of its total bilateral ODA in 1990-92, 3% in 1993-95 and 4% in 1996-98. The corresponding figures for Germany were 2%, 4% and 4%, for Japan 2%, 2% and 3% and for Portugal 1%, 2% and 6%.

Data for the **United States** cover the USAID programme only and slightly overestimate the share of aid to health in its total bilateral ODA. From 1995 onwards, sector coding is based on strategic objectives rather than individual aid activities.

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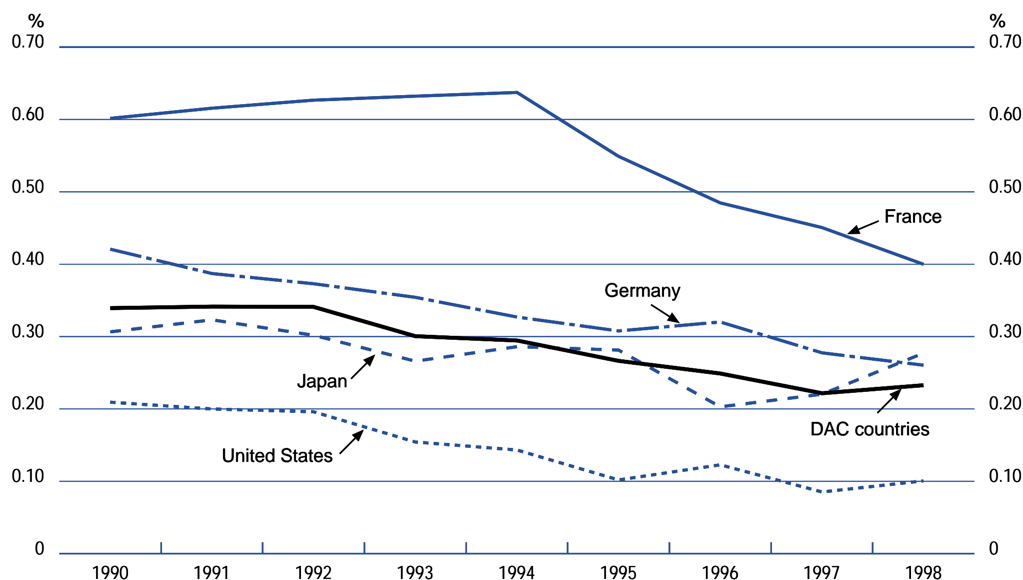
Chart V-2. **ODA/GNP ratio, 1990-98**



Source: DAC statistics.

1990s (two thirds and one third respectively). The United States is the largest bilateral donor in the sector in value terms over the whole period. Donors that have extended 10% or more of their bilateral ODA to the health sector in recent years are Belgium, Denmark, Spain, the United Kingdom and the United States. The share of aid to health in DAC countries' total bilateral ODA is increasing, from 4% at the beginning of the 1990s to 6% in 1998. Multilateral contributions have increased as well, in particular those of the World Bank. In 1996-98, 14% of IDA lending 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 V-3 illustrates the evolution of this share in time and in comparison with that of some other sectors.

Chart V-4 shows the sub-sectoral breakdown of ODA to health. The inner circle 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 circle 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).

The sub-sectoral breakdown has remained relatively stable over time,

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

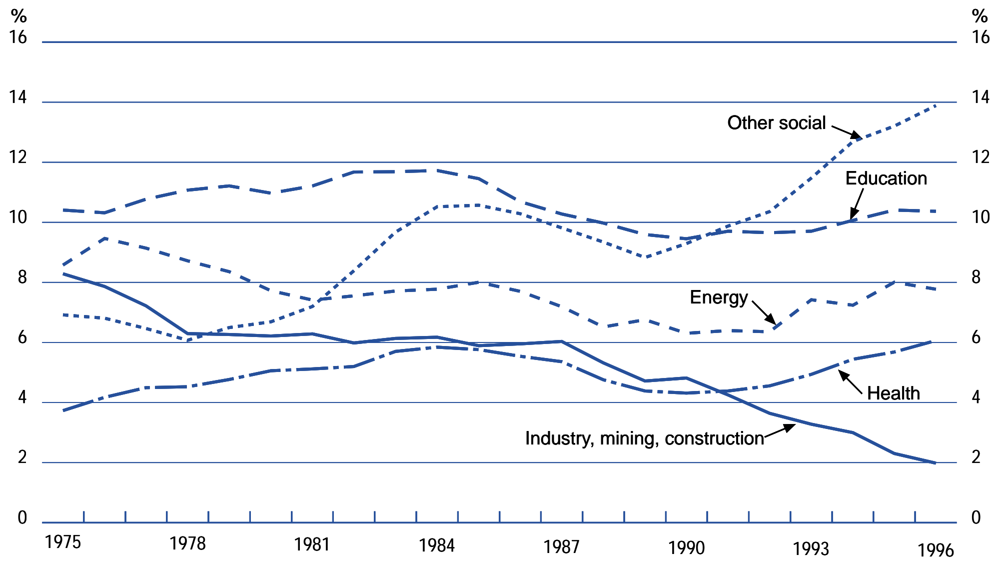
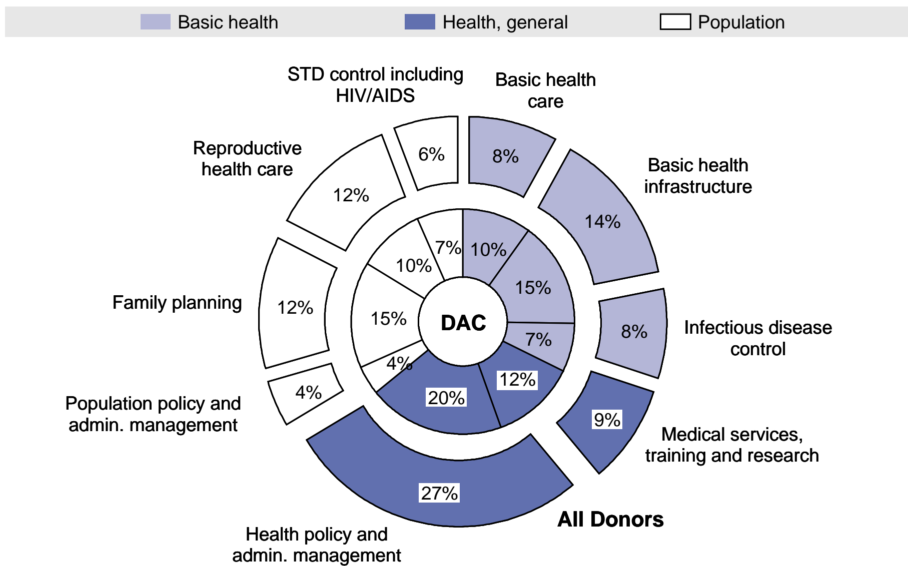
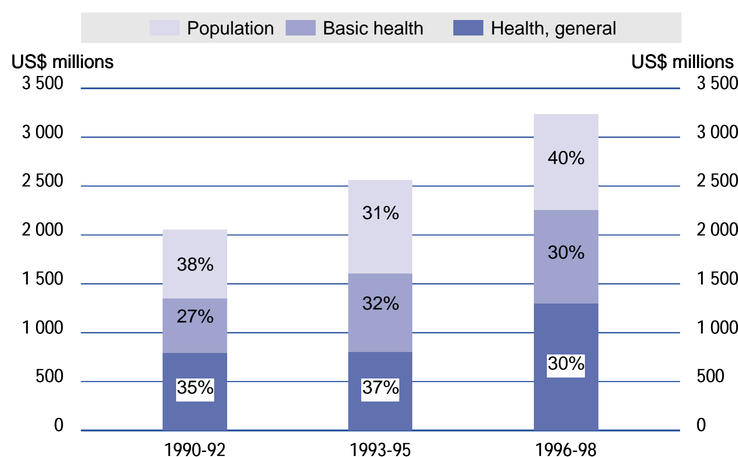


Chart V-4. **Sub-sectoral breakdown of aid to health, 1990-98**
(Inner: bilateral; outer: total ODA)



Source: CRS statistics.

Chart V-5. **Aid to health, 1990-98**
Constant (1997) prices



Source: CRS statistics.

although some changes have occurred within the sub-sectors. For example, funds for control of sexually-transmitted diseases 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 V-5 presents the evolution in the sub-sectoral breakdown of aid to health by all donors, measured in constant dollars.

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 to 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 V-6 and Table V-3 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 also received sizeable bilateral grants in support of the health sector. These originate from a variety of donors, the largest being Germany, Sweden, the

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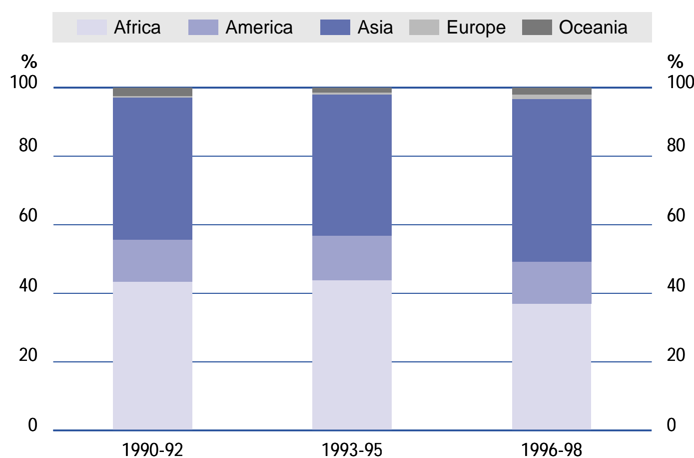
Table V-3.

Main recipients of aid to health, 1990-98

Top Ten by Absolute Value Annual average USD million						Top Ten in % of Total Receipts	
	1990-92		1993-95		1996-98		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

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



Source: CRS statistics.

United Kingdom and the United States. Aid to health in Africa 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 is also the case for total aid. Uganda is the only African country that has remained among the top ten recipients of aid to health throughout the 1990s.

The statistics by recipient can be analysed from another angle. The right-hand side of Table V-3 lists the ten countries where aid is focused on the health sector,

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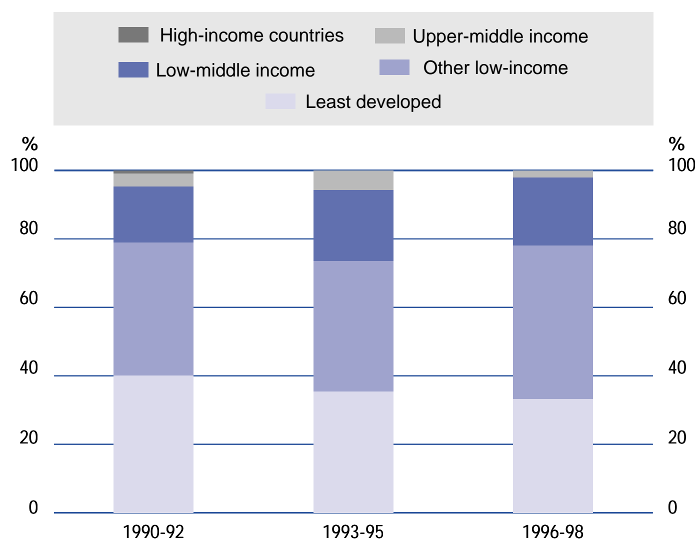
Chart V-7. **Aid to health by income group, 1990-98**



Source: CRS statistics.

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 V-7. Aid to health in least developed countries 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 Table V-4.

Finally, Table V-5 presents some data on Other Official Flows (OOF)[2] to health. Bilateral donors extend very few OOF loans to the sector. IBRD lending to health is USD 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 USD 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 18% to medical research.

Other health-related activities

As explained above, 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) means that statistics do not capture aid

2. 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.

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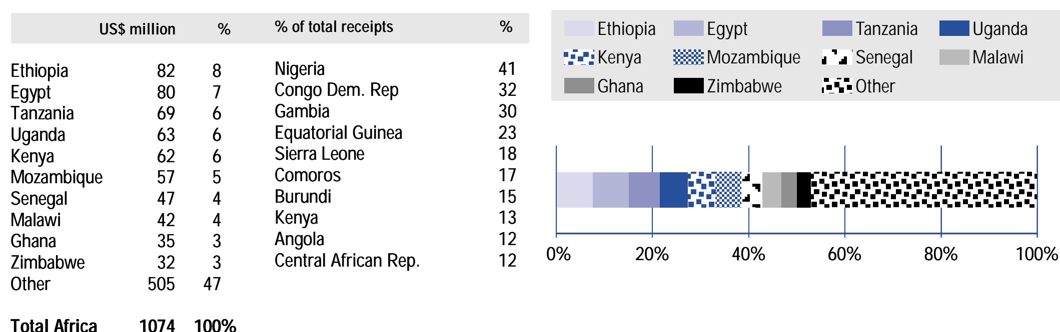
Table V-4. Top ten recipients of aid to health in Africa, Latin America and the Caribbean, and Asia, 1996-98

Annual average, by absolute value and as a percentage of total ODA receipts

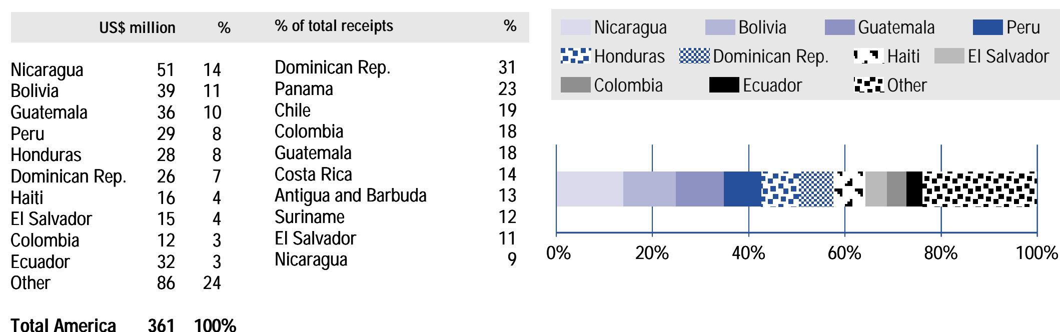
Top ten recipients in Africa, 1996-98



	US$ million	%
Ethiopia	82	8
Egypt	80	7
Tanzania	69	6
Uganda	63	6
Kenya	62	6
Mozambique	57	5
Senegal	47	4
Malawi	42	4
Ghana	35	3
Zimbabwe	32	3
Other	505	47
Total Africa	**1074**	**100%**

% of total receipts	%
Nigeria	41
Congo Dem. Rep	32
Gambia	30
Equatorial Guinea	23
Sierra Leone	18
Comoros	17
Burundi	15
Kenya	13
Angola	12
Central African Rep.	12

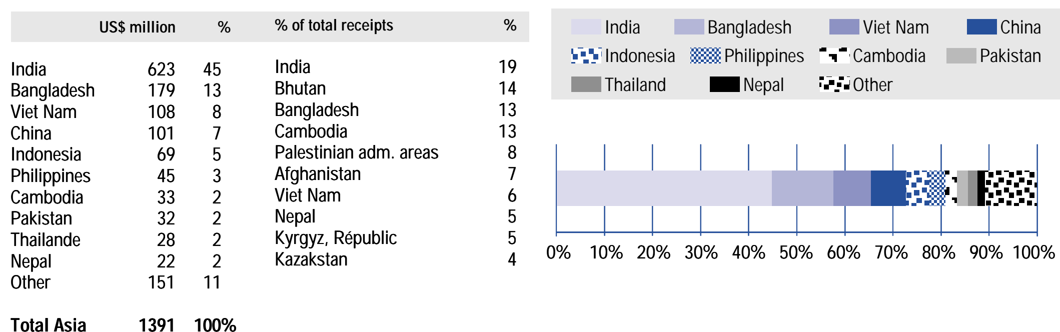
Top ten recipients in Latin America and the Caribbean, 1996-98



	US$ million	%
Nicaragua	51	14
Bolivia	39	11
Guatemala	36	10
Peru	29	8
Honduras	28	8
Dominican Rep.	26	7
Haiti	16	4
El Salvador	15	4
Colombia	12	3
Ecuador	32	3
Other	86	24
Total America	**361**	**100%**

% of total receipts	%
Dominican Rep.	31
Panama	23
Chile	19
Colombia	18
Guatemala	18
Costa Rica	14
Antigua and Barbuda	13
Suriname	12
El Salvador	11
Nicaragua	9

Top ten recipients in Asia, 1996-98



	US$ million	%
India	623	45
Bangladesh	179	13
Viet Nam	108	8
China	101	7
Indonesia	69	5
Philippines	45	3
Cambodia	33	2
Pakistan	32	2
Thailande	28	2
Nepal	22	2
Other	151	11
Total Asia	**1391**	**100%**

% of total receipts	%
India	19
Bhutan	14
Bangladesh	13
Cambodia	13
Palestinian adm. areas	8
Afghanistan	7
Viet Nam	6
Nepal	5
Kyrgyz, Républic	5
Kazakstan	4

Source: CRS statistics.

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Table V-5.

Other Official Flows to health 1990-98: Annual average commitments

By donor US$ million	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	1 022.7	Nigeria	46.0	0.0	1.0

Source : CRS statistics.

to health extended as part of wider social sector programmes or multisector programmes.[3] Secondly, a part of official support to NGO 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.

4. More aid to health needed

It is difficult to estimate the magnitude of other health-related activities. Multisectoral urban and rural development programmes amounted on average to USD 1.1 billion a year in the 1990s. Activities reported as other social services have added up to USD 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 several 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" (see Annex V-1), as these specifically target the poor groups of populations. In 1997-98, DAC Members' bilateral aid to basic education and poverty-focused water

3. The DAC sectors/purpose likely to include some health activities are: employment policy and administrative management; social welfare services; multisector aid for basic social services; urban development and management and rural development.

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