Recent Trends in Official Development Assistance to Health

This note analyses statistical data on Official Development Assistance (ODA) to the health sector reported to the Development Assistance Committee (DAC) of the OECD.

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.

A first study of this nature was carried out by the DAC Secretariat in 2000, and the present document is an update. Any questions about this note can be addressed to the DAC Secretariat (send e-mail to dac.contact@oecd.org).

1. 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.

In annual DAC statistics, data on aid to health are available from 1971 onwards. Detailed analysis on the basis of CRS data is possible since the 1990s only. The coverage of the CRS database in the health sector is estimated to be around 75-80% up to 1998. The 20% data gap for this period relates to technical co-operation activities by France, Germany, Japan and to incomplete reporting by USA[1]. From 1999 to 2002, the data gap gradually reduced thanks to better reporting from France, Germany and USA. Since 2003, the coverage is almost 100%, as Japan has reported its technical co-operation activities.

The DAC seeks to collect data on aid activities by multilateral organisations on the same basis as it does for bilateral donors. At present, sufficiently detailed data are received from the European Commission, the World Bank group, the regional developments banks, IFAD, the Global Fund to fight against AIDS, Tuberculosis and Malaria (GFATM), and a number of UN agencies (UNAIDS, UNFPA, UNICEF) witch together account for approximately 85% of multilateral ODA. Sectoral data are missing for UNDP, UNHCR, UNRWA and UNTA. This does not greatly affect trend analysis but implies, of course, underestimation of aid to health extended to individual recipient countries. Multi-bilateral aid is classified in DAC statistics as bilateral[2].

[1] Only USAID data were reported in CRS.

[2] 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").

2. The DAC statistical definition of aid to health

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, witch 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).

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.

The sectoral statistics have their limitations. In DAC reporting (as well as in most members' internal reporting system), 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 in which 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.

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.

The Statistical Working Party of the DAC[3] has discussed the problem of underestimation at length and is studying ways of introducing a multiple purpose coding system.

[3] 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"[4]

DAC 5 CODE	CRS CODE	DESCRIPTION	Clarifications / Additional notes on coverage
120	**HEALTH**		
121	**Health, general**		
	12110	Health policy and administrative management	Health sector policy, planning and programmes; aid to health ministries, public health administration; institution capacity building and advice; medical insurance programmes; unspecified health activities.
	12181	Medical education/training	Medical education and training for tertiary level services.
	12182	Medical research	General medical research (excluding basic health research).
	12191	Medical services	Laboratories, specialised clinics and hospitals (including equipment and supplies); ambulances; dental services; mental health care; medical rehabilitation; control of non-infectious diseases; drug and substance abuse control [excluding narcotics traffic control (16063)].
122	**Basic health**		
	12220	Basic health care	Basic and primary health care programmes; paramedical and nursing care programmes; supply of drugs, medicines and vaccines related to basic health care.
	12230	Basic health infrastructure	District-level hospitals, clinics and dispensaries and related medical equipment; excluding specialised hospitals and clinics (12191).
	12240	Basic nutrition	Direct feeding programmes (maternal feeding, breastfeeding and weaning foods, child feeding, school feeding); determination of micro-nutrient deficiencies; provision of vitamin A, iodine, iron etc.; monitoring of nutritional status; nutrition and food hygiene education; household food security.
	12250	Infectious disease control	Immunisation; prevention and control of malaria, tuberculosis, diarrheal diseases, vector-borne diseases (e.g. river blindness and guinea worm), etc.
	12261	Health education	Information, education and training of the population for improving health knowledge and practices; public health and awareness campaigns.
	12281	Health personnel development	Training of health staff for basic health care services.
130	**POPULATION POLICIES/PROGRAMMES AND REPRODUCTIVE HEALTH**		
	13010	Population policy and 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	STI 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.

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

3. Recent trends in aid to health (including reproductive health)[5]

Chart 1 below illustrates the evolution in aid to health since 1973. There is a constant growth as aid to health increases from a few hundred million US dollars a year to 7 billion a year. Data converted to constant dollars show that there was real growth over the whole period (average annual growth of 5.4%). It is worth noting that aid to health continued to grow between 1992 and 2000, despite a marked fall in total ODA during this period (see evolution of ODA/GNI ratio in Chart 2), and even accelerated over the last period (growth of 13% in the 5-year average between 1998 and 2002). DAC members' commitments of bilateral aid to health over the 30-year period amounted to a total of US$ 66 billion (current), and ODA lending to health by the multilateral development banks to US$ 18 billion.

Chart 1. Aid to health 1973-2004: 5-year moving average, commitments
Source: CRS and DAC statistics

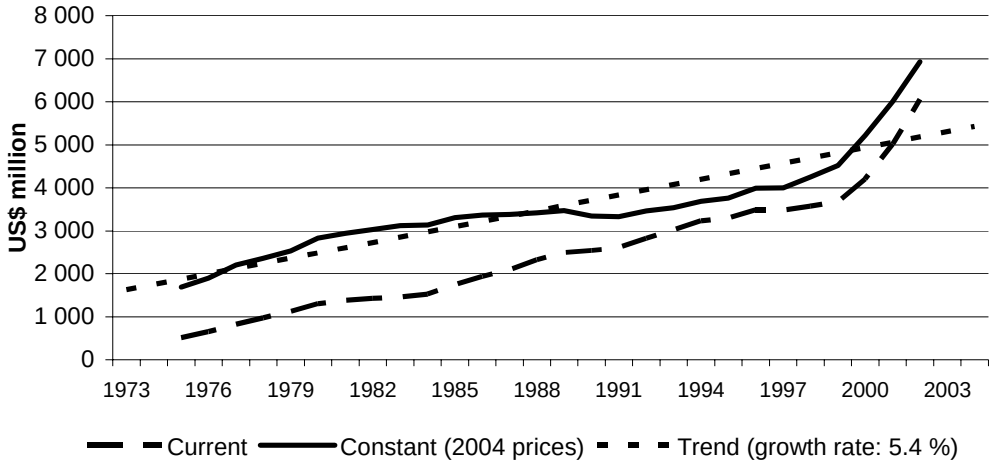
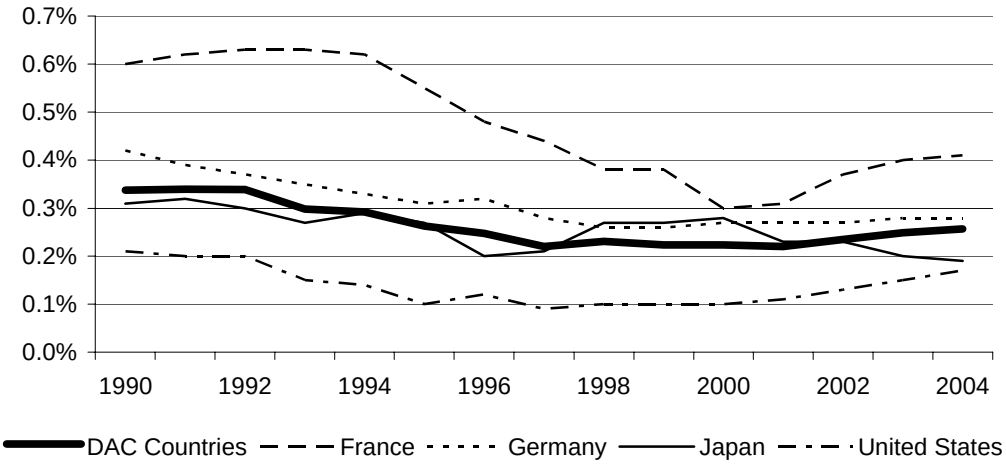


Chart 2. Evolution in ODA/GNI ratio 1990-2004
Source: DAC statistics



[5] 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.

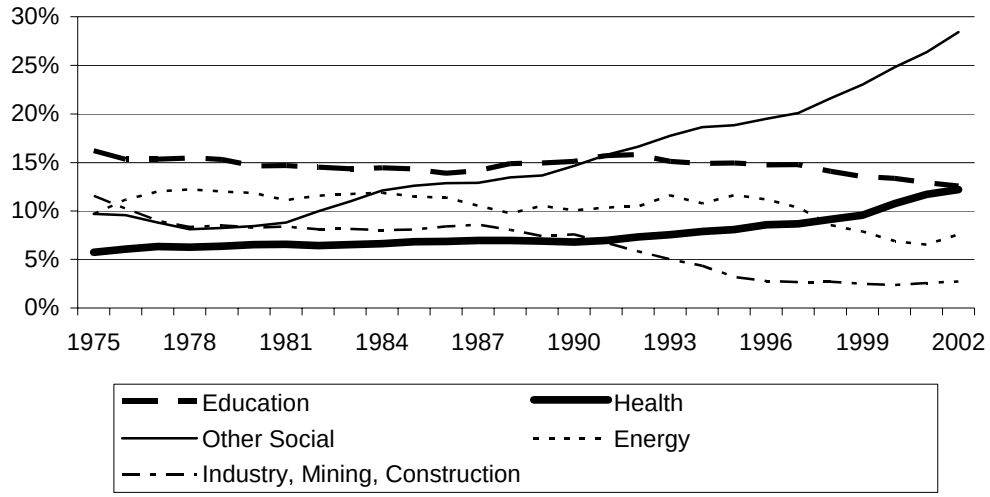
Table 2. Aid to health 1996-2004:
annual average commitments and share in total sector allocable aid[6], constant 2004 prices
Source: CRS and DAC statistics

	US$ million			% of Donor Total			% All Donors		
Donors	1996-1998	1999-2001	2002-2004	1996-1998	1999-2001	2002-2004	1996-1998	1999-2001	2002-2004
Australia	100	178	99	11	18	11	2	3	1
Austria	28	51	17	10	17	7	1	1	0
Belgium	66	92	124	19	19	16	1	2	2
Canada	45	87	214	6	13	17	1	2	3
Denmark	104	77	110	13	9	13	2	1	1
Finland	15	22	37	8	10	13	0	0	0
France	236	211	266	5	6	8	5	4	3
Germany	222	168	233	5	5	6	5	3	3
Greece	8	6	9	22	6	5	0	0	0
Ireland	15	33	96	22	21	35	0	1	1
Italy	33	55	84	10	12	16	1	1	1
Japan	402	327	423	3	4	5	9	6	5
Luxembourg	19	22	31	31	24	29	0	0	0
Netherlands	177	212	240	11	15	12	4	4	3
New Zealand	-	7	10	-	7	10	-	0	0
Norway	58	130	134	10	14	13	1	2	2
Portugal	12	11	10	12	5	5	0	0	0
Spain	159	140	114	18	13	11	4	3	1
Sweden	83	99	142	9	13	13	2	2	2
Switzerland	36	45	49	9	8	7	1	1	1
United Kingdom	309	647	691	16	22	23	7	12	9
United States	866	1 207	2 213	21	18	18	19	22	28
Total DAC	**2 993**	**3 828**	**5 347**	**8**	**11**	**13**	**66**	**71**	**68**
AfDF	70	82	94	11	9	8	2	2	1
AsDF	51	95	54	3	7	4	1	2	1
EC	304	451	359	10	8	6	7	8	5
IDA	1 050	659	810	16	11	11	23	12	10
IDB Sp.Fund	51	19	2	9	4	0	1	0	0
UNICEF	-	114	149	-	41	36	-	2	2
UNFPA	-	87	239	-	100	100	-	2	3
GFTAM	-	-	744	-	-	100	-	-	9
UNAIDS	-	37	118	-	100	100	-	1	1
Total Multilateral	**1 527**	**1 544**	**2 568**	**12**	**10**	**14**	**34**	**29**	**32**
Total	**4 520**	**5 372**	**7 915**	**9**	**11**	**13**	**100**	**100**	**100**

Table 2 presents data on aid to health for individual donors. The share of bilateral and multilateral aid to health has remained relatively stable during the period 1996-2004 (two thirds and one-third respectively). The United States is the largest bilateral donor in the sector in value terms (over the whole period) and Ireland is the largest one proportionately (35% in 2002-2004). Other donors that have extended 20% or more of their bilateral ODA to the health sector in 2002-2004 are Luxembourg (29%) and the United Kingdom (23%). The share of aid to health in DAC countries total bilateral ODA has been increasing, from 8% in 1996-1998 to 13% in 2002-2004. Multilateral contributions have increased since 1999, due to the creation of GFTAM. All in all, approximately 13% of DAC countries' total bilateral ODA and of multilateral donors' iad 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.

[6] As only a proportion of aid can be allocated to sectors, the denominator for measuring aid to specific sectors should comprise only aid that can be so apportioned. Otherwise there is an implicit assumption that none of the aid unallocable by sector benefits the specific sectors under review. The denominator used to calculate shares of aid to health in total aid is **"sector-allocable"** aid, i.e. aid excluding general programme assistance, debt, humanitarian aid.

Chart 3. Aid to health as a share of total sector allocable aid 1973-2004, 5-year moving average, commitments
Source: DAC statistics



Sub-sectors

The sub-sectoral breakdown has changed in favour of reproductive health over time (Chart 4): funds for this sector, representing 39% (US$ 1.7 billion) of aid to health in 1999-2001, rose to 46% (US$ 3.2 billion) in 2002-2004 whereas the share of general health programmes decreased from 28% to 21% (US$ 1.3 billion to US$ 2 billion).

Chart 4. Aid to health 1996-2004, US$ million, constant 2004 prices 2-year moving average, commitments
Source: CRS & DAC statistics

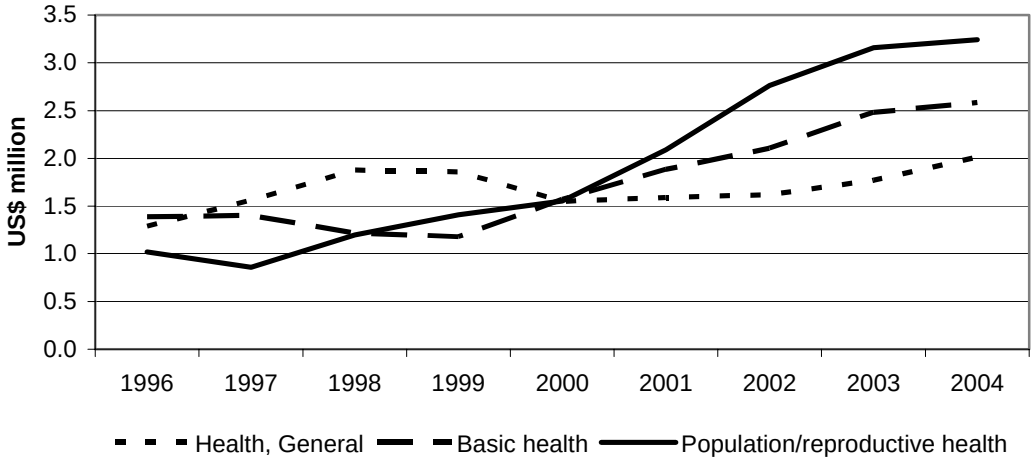


Chart 5 below shows the detailed sub-sectoral breakdown of aid to health. The inner pie represents the breakdown for DAC countries bilateral aid: approximately one third of contributions are in support of basic health, slightly over two fifths in support of reproductive health care/population activities, with the remainder covering general health programmes and medical (non-basic) health services. The outer pie is for total aid, including multilateral contributions. Multilateral aid to health (not plotted separately) consists primarily of STI control including HIV/AIDS (31% of total multilateral aid to health), but general health sector programmes are also important (25%).

Comparing Charts 5 and 6 reveals a big increase in aid towards STI control including HIV/AIDS between the two periods 1990-98 and 1999-2004 (12% and 25% respectively of total aid to health), and it increased further to one third of total aid to health in 2003-2004.

Health education, health personnel development, medical education/training and medical research represent less than 4% 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.

Charts 5 and 6. Sub-sectoral breakdown of aid to health in 1990-1998 and 1999-2004, commitments
(Inner: bilateral; outer: total ODA)
Source: CRS statistics

Chart 5. 1990-1998

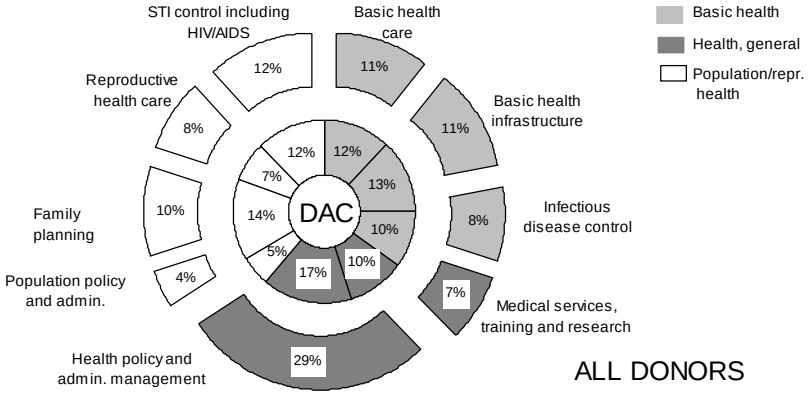
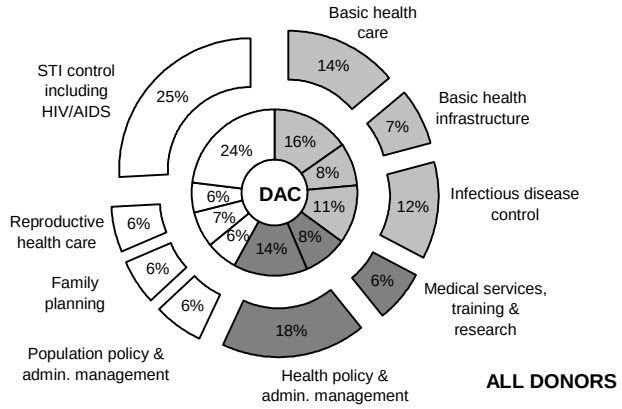


Chart 6. 1999-2004



Sector programmes

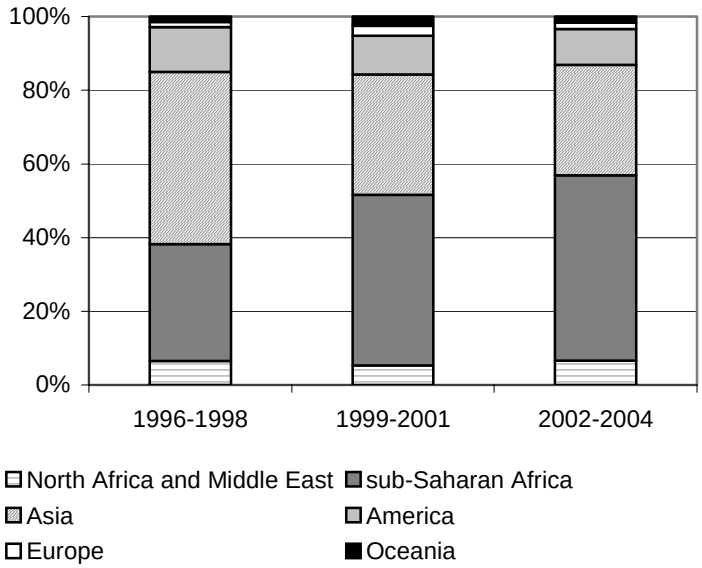
Aid to health may be delivered in the form of sector programmes, sector budget support or pooled funding. In these cases, the sub-sectoral breakdown is captured only if the sector programmes entirely focus on sub-sectors (e.g. on basic health rather than general health) or if the donor reports the commitments at a component level which is, however, usually not the case. Sector programmes reported at a more general level (e.g. "Health Sector Strategic Plan") are not broken down by sub-sectors.

Sector programmes are separately identified in the CRS through a "flag".[7] A review of DAC members' reporting on sector programmes conducted in 2006 highlighted that during the last five years, aid extended in form of sector programmes had been increasing, but it remained a small share of total aid to health. Sector programmes represented 15% of DAC members' allocations to health in 2003 and 13% in 2004. Furthermore, the bulk of sector programmes in the health sector had been reported as *basic health*, and was thus captured at a sub-sectoral level rather than general level.

Recipients

Chart 7 and Table 3 below illustrate trends in the geographical distribution of aid to health. Sub-Saharan Africa has been the largest recipient region of aid to health since 1999. In 2002-2004, it received half of total aid to health.

Chart 7. Aid to health 1996-2004 by region, commitments
Source: CRS statistics



[7] Sector programme aid is defined to comprise "contributions to carry out wide-ranging development plans in a defined sector such as agriculture, education, transportation, etc." The Directives further specify that "assistance is made available "in cash" or "in kind", with or without restriction on the specific use of the funds, but on the condition that the recipient executes a development plan in favour of the sector concerned." Sector budget support is not defined as such in the current Directives, but falls under the definition of sector programme aid.

Table 3. Main recipients of aid to health 1996-2004: Annual average US$ million, commitments
Source: CRS statistics

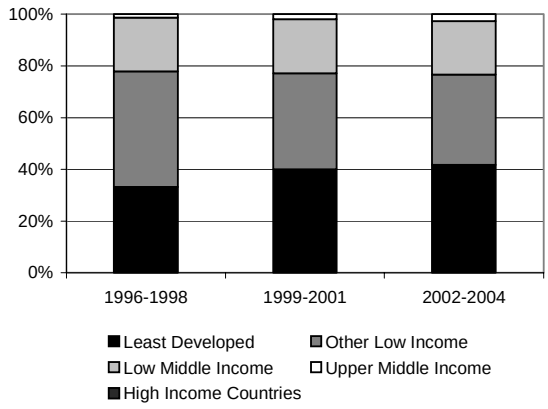
1996-1998		1999-2001		2002-2004	
India	701	India	317	India	382
Bangladesh	190	Indonesia	189	Nigeria	359
Egypt	121	Nigeria	176	China	265
Viet Nam	114	Bangladesh	158	Tanzania	230
China	101	Tanzania	133	Uganda	208
Ethiopia	80	Kenya	116	Zambia	204
Tanzania	79	Mozambique	106	Mozambique	180
Indonesia	70	Uganda	104	Ethiopia	173
Uganda	63	China	84	Kenya	162
Kenya	61	Bolivia	83	Congo Dem.Rep.	159

The statistics by recipient can be analysed from another angle. Table 4 below 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 8 below. Aid to health in least-developed countries has increased in the last few years, after a decrease during the 1990s.

Table 4. Main recipients of aid to health 1996-2004: Share of total sector allocable aid (%), commitments
Source: CRS statistics

1996-1998		1999-2001		2002-2004	
Nigeria	57	Eritrea	41	Barbados	63
Sudan	50	Nigeria	37	Botswana	55
Congo Dem.Rep.	49	St. Helena	36	Swaziland	52
St. Helena	41	Liberia	35	Zimbabwe	49
Burundi	39	Zimbabwe	32	Liberia	43
Afghanistan	36	Myanmar	31	Myanmar	42
Irak	35	Cook Islands	30	Nigeria	39
Sierra Leone	34	Congo Dem.Rep.	29	Tonga	38
Dominican Rep.	33	Sudan	28	Haiti	38
Gambia	32	Suriname	26	Zambia	35

Chart 8. Aid to health 1996-2004 by income group, commitments
Source: CRS statistics



Charts 9 and 10 below show the breakdown of aid to health between regions and sub-sectors. Aid to health, and population programmes in particular, seem to be priority sectors in sub-Saharan Africa: 25% of total sector allocable aid is allocated to the health sector, and more than half of this amount finance population programmes (especially HIV/AIDS control). Further details on the geographical breakdown of aid to health are given in the Annex.

Chart 9. Sub-sectoral breakdown of aid to health 2003-2004 by region, commitments
Source: CRS statistics

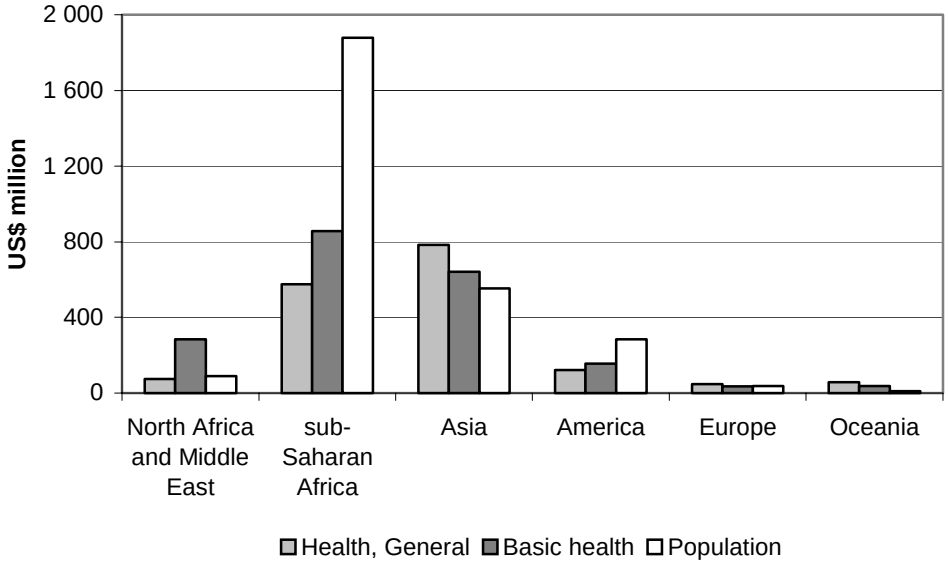
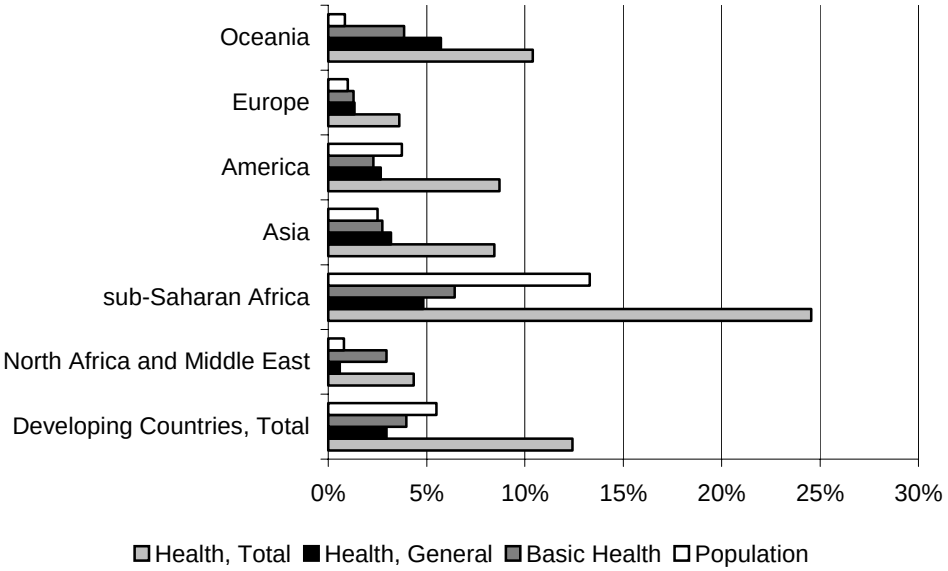


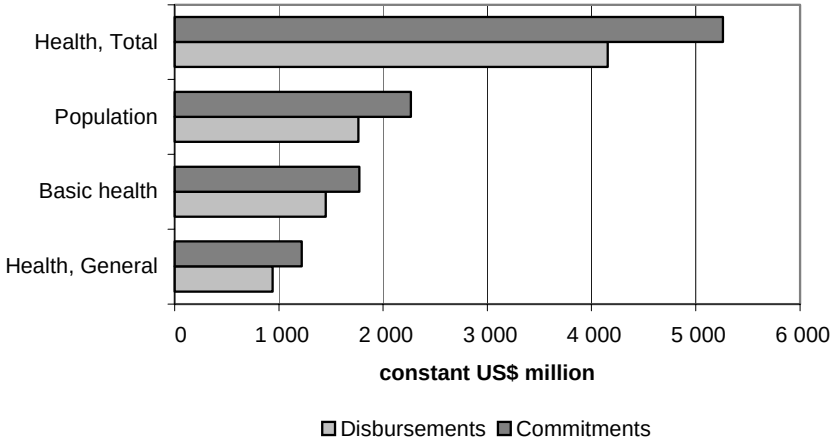
Chart 10. Sub-sectoral breakdown of aid to health as a share of total sector allocable aid 2003-2004 by region, commitments
Source: CRS statistics



Disbursements

The above analyses are based exclusively on commitments. CRS data on disbursements have been virtually complete since 2002 for DAC members. For the period 2002-2004, analyses based on disbursements lead to the same findings as that based on commitments. For example, Chart 11 suggests that the sectoral breakdown of aid to health is similar whether calculated on a commitment or a disbursement basis. The fact that commitment figures are higher than disbursements over this period indicates increased focus of aid to health in donor programmes. Commitments are multi-year and subsequent disbursements spread over several years. An increase in aid allocations (commitments) to the health sector will thus be visible in disbursement data with a few years' time lag.

Chart 11. Comparison between Commitments and Disbursements: bilateral aid to health, 2002-2004
Source: CRS statistics



4. Other health-related activities

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) means 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 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.

It is difficult to estimate the magnitude of other health-related activities. Multisectoral urban and rural development programmes have on average amounted to US$ 1.7 billion (2004 prices) a year in the period 1996-2004. Activities reported as other social services (purpose codes 16010, 16020 and 16050) have added up to US$ 1.4 million a year. While no estimate can be given on the part directed to the health sector, it seems reasonable to suggest 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 sub-sectoral breakdown of their assistance are available only for a few DAC countries. If these were applied to total aid to NGOs, 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 poor people. In 1996-2004, total (bilateral and

multilateral) aid to basic education and basic water supply and basic sanitation averaged US$ 2.3 billion a year.

Thus, over the period 1996-2004, a total of US$ 10.7 billion of ODA can be expected to have had some measurable impact on health outcomes. Within this figure, aid to the health sector itself totalled US$ 5.3 billion, US$ 2.1 billion of which went to reproductive health.

To sum up:

- **Aid to health has increased steadily since 1975, with an average annual growth rate of 5.4% (in real terms). Aid to health continued to grow since in the mid 1990s, despite a marked fall in total ODA during that period. In 2002-2004, it was more than US$ 7 billion a year.**
- **In recent years, approximately 13% of DAC countries' total bilateral ODA and of multilateral contributions has been directed to health.**
- **Approximately one third of contributions are in support of basic health, slightly over two fifths in support of reproductive health care/population activities, with the remainder covering general health programmes and medical (non-basic) health services.**

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

DAC 5 CODE	CRS CODE	DESCRIPTION	Clarifications / Additional notes on coverage
160	**OTHER SOCIAL INFRASTRUCTURE AND SERVICES**		
	16010	Social/welfare services	Social legislation and administration; institution capacity building and advice; social security and other social schemes; special programmes for the elderly, orphans, the disabled, street children; social dimensions of structural adjustment; unspecified social infrastructure and services, including consumer protection.
	16020	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; occupational safety and health; combating child labour.
	16050	Multisector aid for basic social services	Basic social services are defined to include basic education, basic health, basic nutrition, population/reproductive health and basic drinking water supply and basic sanitation.
400	**MULTISECTOR/CROSS-CUTTING**		
	43030	Urban development and management	Integrated urban development projects; 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	Integrated rural development projects; e.g. regional development planning; promotion of decentralised and multi-sectoral competence for planning, co-ordination and management; implementation of regional development and measures (including natural reserve management); land management; land use planning; land settlement and resettlement activities [excluding resettlement of refugees and internally displaced persons (72030)]; functional integration of rural and urban areas; geographical information systems.

Annex

Tables showing
(i) top ten donors of aid to health by region in absolute terms and as a share of sector-allocable aid;
(ii) top ten recipients of aid to the health sector by region in absolute terms and as a share of sector-allocable aid

Table A1: Top Ten Donors in North Africa and Middle East, 2002-2004

US$ million		%
United States	236	58%
EC	32	8%
IDA	21	5%
France	19	5%
Japan	17	4%
UNFPA	15	4%
Italy	12	3%
Spain	10	2%
GFTAM	8	2%
UNICEF	6	1%
Other	30	7%
Total	407	100%

% Total Sector Allocable	
GFTAM	100%
UNAIDS	100%
UNFPA	100%
New Zealand	36%
UNICEF	29%
Switzerland	25%
IDA	13%
Austria	11%
Ireland	11%
Italy	11%
Total	5%

Table A2: Top Ten Donors in sub-Saharan Africa, 2002-2004

US$ million		%
United States	697	22%
GFTAM	449	14%
IDA	399	13%
United Kingdom	274	9%
EC	124	4%
Netherlands	117	4%
France	94	3%
Denmark	88	3%
Canada	86	3%
AfDB	85	3%
Other	724	23%
Total	3 138	100%

% Total Sector Allocable	
UNFPA	100%
UNAIDS	100%
GFTAM	100%
Australia	47%
United States	46%
UNICEF	38%
Ireland	32%
United Kingdom	29%
Italy	27%
Spain	24%
Total	21%

Table A3: Top Ten Donors in Asia, 2002-2004

US$ million		%
United States	350	19%
IDA	321	17%
United Kingdom	257	14%
Japan	201	11%
GFTAM	149	8%
Germany	129	7%
EC	62	3%
UNFPA	60	3%
AsDB	54	3%
UNICEF	47	3%
Other	237	13%
Total	1 866	100%

% Total Sector Allocable	
GFTAM	100%
UNAIDS	100%
UNFPA	100%
Luxembourg	47%
UNICEF	36%
United Kingdom	22%
Spain	17%
United States	16%
Finland	16%
Austria	14%
Total	10%

Table A4: Top Ten Donors in America, 2002-2004

US$ million		%
United States	166	27%
GFTAM	119	20%
Japan	50	8%
Spain	39	6%
UNFPA	29	5%
France	27	4%
EC	25	4%
IDA	24	4%
Canada	23	4%
Italy	17	3%
Other	85	14%
Total	605	100%

% Total Sector Allocable	
GFTAM	100%
UNAIDS	100%
UNFPA	100%
Luxembourg	41%
UNICEF	30%
Greece	19%
Finland	19%
Italy	18%
Japan	14%
France	14%
Total	11%

Table A5: Top Ten Recipients in North Africa and Middle East, 2002-2004

US$ million		%
Iraq	155	38%
Palestinian Admin. Areas	58	14%
Egypt	56	14%
Yemen	36	9%
Jordan	31	8%
Morocco	30	7%
Syria	19	5%
Tunisia	5	1%
Iran	4	1%
Lebanon	4	1%
Other	8	2%
Total	407	100%

% Total Sector Allocable	
Syria	16%
Palestinian admin. areas	12%
Yemen	12%
Jordan	8%
Iran	6%
Egypt	5%
Oman	5%
Bahrain	5%
Iraq	4%
Morocco	4%
Total	5%

Table A6: Top Ten Recipients in sub-Saharan Africa, 2002-2004

US$ million		%
Nigeria	361	12%
Tanzania	230	7%
Zambia	187	6%
Mozambique	179	6%
Uganda	174	6%
Ghana	155	5%
Kenya	153	5%
Ethiopia	151	5%
South Africa	147	5%
RDC	144	5%
Other	1 255	40%
Total	3 138	100%

% Total Sector Allocable	
Zimbabwe	46%
Botswana	46%
Nigeria	37%
Swaziland	36%
Liberia	33%
Zambia	31%
St. Helena	30%
Malawi	30%
Uganda	25%
Rwanda	24%
Total	21%

Table A7: Top Ten Recipients in Asia, 2002-2004

US$ million		%
India	400	21%
China	255	14%
Pakistan	147	8%
Indonesia	140	8%
Viet Nam	132	7%
Cambodia	109	6%
Afghanistan	102	5%
Bangladesh	102	5%
Nepal	86	5%
Philippines	58	3%
Other	334	18%
Total	1 866	100%

% Total Sector Allocable	
Myanmar	43%
Cambodia	21%
Nepal	18%
Turkmenistan	18%
Kyrgyz Rep.	17%
Pakistan	15%
India	13%
Uzbekistan	12%
Bhutan	12%
Georgia	11%
Total	10%

Table A8: Top Ten Recipients in America, 2002-2004

US$ million		%
Haiti	72	12%
Bolivia	55	9%
Honduras	50	8%
Peru	50	8%
Nicaragua	45	7%
Guatemala	43	7%
Brazil	28	5%
El Salvador	24	4%
Dominican Republic	23	4%
Ecuador	23	4%
Other	191	32%
Total	605	100%

% Total Sector Allocable	
Barbados	62%
Haiti	31%
Trinidad & Tobago	29%
Cuba	25%
Guatemala	18%
Argentina	17%
Guyana	17%
El Salvador	16%
Chile	16%
Dominican Republic	16%
Total	11%