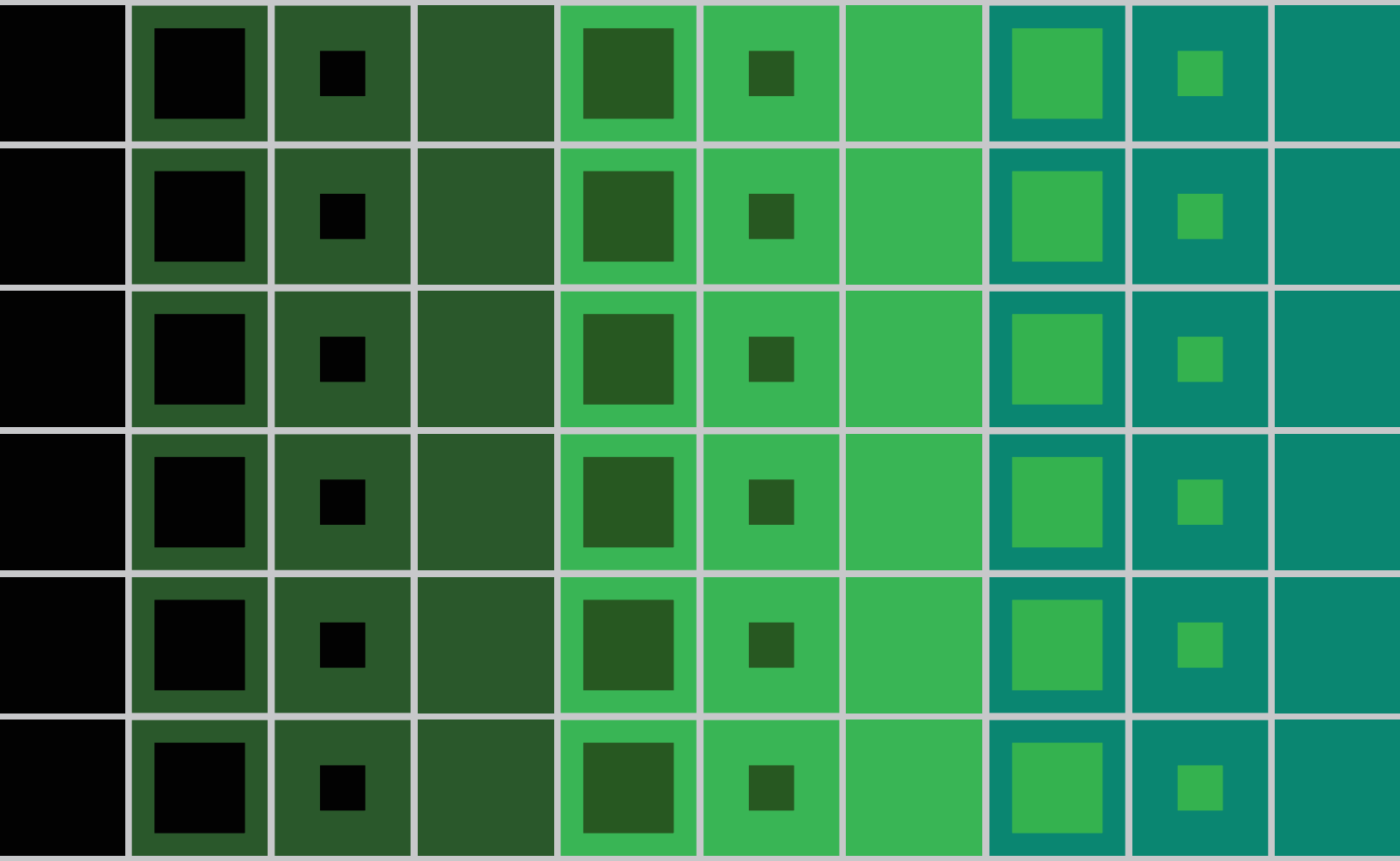
Financing Global Health 2013

Transition in an Age of Austerity



INSTITUTE FOR HEALTH METRICS AND EVALUATION
UNIVERSITY OF WASHINGTON

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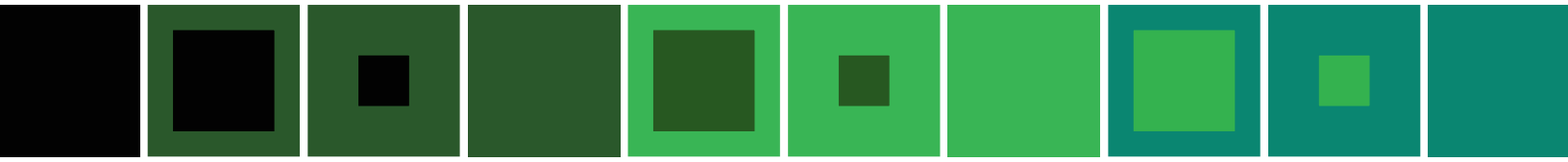

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ABOUT IHME

The Institute for Health Metrics and Evaluation (IHME) is an independent global health research center at the University of Washington. IHME provides rigorous and comparable measurement of the world's most important health problems and evaluates the strategies used to address them. As part of its mandate, IHME makes this information freely available so that policymakers have the evidence they need to make informed decisions about the allocation of resources to best improve population health. For more information, please visit http://www.ihmeuw.org.

ABOUT *FINANCING GLOBAL HEALTH 2013*

Financing Global Health 2013 is the fifth edition of this annually produced report on global health financing. As in previous years, this report captures trends in development assistance for health (DAH) and government health expenditure as source (GHE-S). Health financing is one of IHME's core research areas, and the aim of the series is to provide much-needed information to global health stakeholders. Updated GHE and DAH estimates allow decision-makers to pinpoint funding gaps and investment opportunities vital to improving population health.

This year, IHME made a number of improvements to the data collection and methods implemented to produce *Financing Global Health* estimates. Both government health expenditure and development assistance for health estimates were updated and enhanced in 2013.

- **Development assistance for health:** To develop DAH estimates, IHME collects data from organizations that provided funding for health projects in developing countries from 1990 through 2013. These data include annual reports, publicly available budgets, tax returns, and other information obtained through correspondence. Conversations with global health partners allow IHME to validate these data. Data are then processed into a form usable for analysis. This year's dataset is complete up until 2011 because a number of organizations are not able to produce budgetary documents until two years after the expenditure period. In cases where 2012 and 2013 data are not available, IHME uses statistical methods that rely on previous trends in spending and budget data to produce preliminary estimates.

- **Government health expenditure as a source:** IHME uses data produced by the World Health Organization (WHO) to provide estimates of GHE. Using DAH estimates, IHME employs the WHO's GHE data to approximate how much governments spend on health-related activities out of their own treasuries as well as how these expenditures vary over time.

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The IHME community contributed greatly to the production of this year's report. In particular, we thank IHME's Board for their continued leadership, Annie Haakenstad for writing the report, Casey Graves for data collection and analysis, William Heisel for editorial guidance, Adrienne Chew for editing, Patricia Kiyono for production oversight, Katherine Leach-Kemon for publication management, and Ryan Diaz for design.

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

ACRONYMS

ADB	Asian Development Bank
AfDB	African Development Bank
BMGF	Bill & Melinda Gates Foundation
DAH	Development assistance for health
DAH-G	Development assistance for health channeled to governments
DAH-NG	Development assistance for health channeled to the non-governmental sector
DALY	Disability-adjusted life year
DFID	United Kingdom's Department for International Development
DRC	Democratic Republic of the Congo
EC	European Commission
GAVI	The GAVI Alliance
GBD 2010	Global Burden of Diseases, Injuries, and Risk Factors Study 2010
GDP	Gross domestic product
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GHE	Government health expenditure
GHE-A	Government health expenditure as an agent
GHE-S	Government health expenditure as a source
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IDB	Inter-American Development Bank
IHME	Institute for Health Metrics and Evaluation
MDGS	Millennium Development Goals
MNCH	Maternal, newborn, and child health
NCD	Non-communicable disease
NGOS	Non-governmental organizations
OECD	Organisation for Economic Co-operation and Development
PAHO	Pan American Health Organization
PEPFAR	United States President's Emergency Plan for AIDS Relief
SWAPS	Sector-wide approaches
TB	Tuberculosis
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US	United States
USAID	United States Agency for International Development
WHO	World Health Organization

FIGURES AND TABLES

Executive summary

The global health financing trends depicted in *Financing Global Health 2013: Transition in an Age of Austerity* underline the resilience of development assistance for health (DAH). The updated estimates produced by the Institute for Health Metrics and Evaluation (IHME) show that despite lackluster economic growth and fiscal cutbacks in many Organisation for Economic Co-operation and Development (OECD) countries, total DAH remained steady in 2013. Preliminary estimates set DAH at an all-time high of $31.3 billion in 2013.[i] With 3.9% growth from 2012 to 2013, the year-over-year increase falls short of the rapid rates seen over 2001–2010, which topped 10% annually. However, DAH has hovered above more than $30 billion annually since 2010. The maintenance of substantial levels of international funding is a sign of the international development community's enduring support for global health as the deadline to attain the Millennium Development Goals (MDGs) nears.

This year's report unveils new perspectives on the data that emphasize shifts in the prominence of DAH partners. Bilateral aid agencies on the whole have reduced their DAH contributions, and their share of DAH has diminished since 2011. In addition, contributions from the World Bank's International Bank for Reconstruction and Development peaked in 2010. Over the same period, the major public-private partnerships, notably the GAVI Alliance (GAVI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), continued to expand, sustaining health assistance at current levels. Growth in DAH from non-governmental organizations (NGOs), especially those based in the United States, has also helped offset declines in spending by other development actors. The growing role of public-private partnerships and NGOs, coupled with contraction in bilateral agencies and development banks, entails shifts in the modes of DAH delivery.

Epidemiological data also enhance updated estimates of DAH. Pairing DAH with disability-adjusted life years (DALYS) reveals imbalances between disease burden and international investments. Non-communicable diseases (NCDs), while a prominent and rising portion of disease burden in the developing world, are not a primary focus of DAH. However, DAH for non-communicable diseases did expand from 2010 to 2011. The DAH allocated to maternal, newborn, and child health (MNCH) also grew substantially, reflecting donors' continued support for the unfinished agenda of MDGs 4 and 5, which aim to reduce child and maternal mortality. Concurrently, the DAH disbursed in the fight against the main infectious diseases, HIV/AIDS, tuberculosis (TB), and malaria, contracted on the whole. Health focus area estimates highlight a minor shift away from communicable disease spending on HIV/AIDS, TB, and malaria within total DAH.

A host of enhancements have improved this year's dataset while ensuring methodological continuity across previous editions of the report. Estimates of spending by each of the main development assistance partners, health focus areas, and geographical units have been fine-tuned. Newly developed methods track

i All dollar figures in this report are provided in 2011 US dollars.

spending from NGOs based outside of the US, parse out the DAH provided to tobacco control, and elucidate the allocations of non-governmental organizations across health focus areas.

The key findings of *Financing Global Health 2013: Transition in an Age of Austerity* include the following:

Development assistance for health

- According to IHME's preliminary estimates, total DAH in 2013 amounted to $31.3 billion. The year-over-year increase in DAH was 3.9%.
- While the United States continued to be the single largest channel of DAH, at $7.4 billion, 2013 marks the second consecutive year of reduction in DAH from the US. US DAH peaked in 2011 at $8.3 billion.
- Although the United Kingdom is recalibrating the countries and health areas it targets, the DAH disbursed by the UK continued to rise in 2013. DAH from the UK amounted to $1.2 billion in 2013, a 24.7% increase over 2012 disbursements.
- The spending of public-private partnerships also grew substantially in 2013. GAVI's disbursements reached an estimated $1.5 billion in 2013, a 32% increase relative to 2012 levels. GFATM grew 16.8%, with 2013 DAH expenditure of $4 billion.
- DAH from NGOs increased by 2.4% between 2011 and 2013. Of the NGOs IHME can track, those based in the US spent $4 billion in 2013, while NGOs based outside the US spent $895 million that same year.
- Across regional groupings, sub-Saharan Africa received the largest portion of DAH. In 2011 (the most recent year for which recipient-level estimates are available), sub-Saharan Africa's share was $8.8 billion, or 28.6% of total DAH.
- The HIV/AIDS sector was the beneficiary of the most substantial share of DAH among health focus areas in 2011 (the most recent year for which focus area estimates are available). HIV/AIDS assistance amounted to $7.7 billion in 2011. This was a 1.2% increase from 2010.
- The share of DAH targeting maternal, newborn, and child health continued to grow. In 2011, MNCH received $6.1 billion, a 17.7% increase from 2010.
- IHME's updated estimates of DAH also show that non-communicable diseases and tobacco control received little funding, particularly as compared to the major portion of burden of disease associated with these health issues. In 2011, a total of just $377 million was provided in the fight against NCDs, while $68 million was channeled to tobacco-related programs.
- Many of the countries with the highest disease burdens do not receive the most DAH. Of the countries with the top 20 DALYs, only 13 are among the top 20 recipients of DAH.

Government health expenditure as a source

- Spending by governments on health as sourced domestically (GHE-S) was $613.5 billion in 2011. This means that, on average, countries spent 20 times more of their own resources on health than they received in assistance. Furthermore, government health spending grew at a faster pace than assistance. This spending grew 7.2% from 2010 to 2011 (the most recent year for which estimates are available).
- The amount of total health spending represented by DAH varied widely by country. The share of DAH funneled to governments (DAH-G) as a part of total

spending by governments on health was typically less than 10%. However, in certain countries in Asia and Western and Southern Africa, DAH channeled to governments amounted to more than half of total government health expenditure.

Overall, while many OECD countries are still grappling with stunted economic growth, health assistance has not radically contracted, emphasizing the high priority numerous global health stakeholders place on global health. The enduring level of DAH and the shifts in composition emphasize the importance of tracking these financial flows. Timely and comprehensive estimates of DAH provide information vital to informed decision-making by donors, policymakers, and health practitioners alike.

BOX 1

Putting development assistance for health in context

- **Development assistance for health: relatively small but growing.** Donors disbursed a total of $31.3 billion to improve health in low- and middle-income countries in 2013. This is more than five times larger than the development assistance for health provided in 1990. However, this is also less than 1% of what developed countries spent on improving and maintaining the health of their own countries.[ii]

- **Support for the most vulnerable.** Assistance for maternal, newborn, and child health reached $6.1 billion in 2011. Funding for this area increased more than any other between 2009 and 2011. However, maternal, newborn, and child health spending per live birth remains just $51.[iii]

- **Non-governmental organization contributions as a key catalyst.** Since 1990, NGO global health expenditure has grown 11% annually, at points outpacing total development assistance for health. NGO contributions span all areas of global health. NGOs also spend more annually than any one of the major multilateral agencies.

ii Government health spending data are derived from the WHO, available at http://www.who.int/nha/en/.

iii Live births were estimated as part of the Global Burden of Disease Study 2010. For more information, visit http://www.ihmeuw.org/gbd.

Introduction

In the wake of the financial crisis, governments have scrutinized spending across their fiscal space. Development assistance is often one of the first items discussed for the budgetary chopping block.[1-5] Nevertheless, the Institute for Health Metrics and Evaluation's (IHME) estimates show development assistance for health (DAH) continues to grow. In fact, DAH reached the highest level ever recorded in 2013. While the most recent increases fall short of the rapid growth rates observed over 2001–2010, a year-over-year increase persisted in 2013. The enduring provision of DAH during a time of fiscal constraint is testament to the international community's solid commitment to global health.

DAH is also increasingly marked by transition. Sources and recipients of DAH have shifted in recent years. Levels of spending have been maintained by a number of key actors, notably the United Kingdom, non-governmental organizations, and public-private partnerships. The contributions of other development assistance partners have not grown substantially and in some cases have contracted. Additionally, weighing priorities in a constrained resource environment has led some Organisation for Economic Co-operation and Development countries to reduce or phase out DAH to middle-income countries, despite the hefty disease burdens and large, impoverished populations present in these areas.

The international community's focus on the next epoch of global health is also a sign of its resolve to maintain DAH. With the conclusion of the Millennium Development Goals (MDGs) approaching, a new set of broad goals and measurable targets was prominent in high-level discussions about global health throughout 2013. While it is difficult to determine causation, a rapid rise in DAH followed the establishment of the MDGs. The health interventions associated with MDGs 4, 5, and 6 continue to be the focus of the international community, and development assistance for HIV/AIDS and maternal, newborn, and child health sustained growth through 2011. Regardless of the outcome of the post-2015 discussions, it is likely that the targets established will shape priorities in DAH in the coming decade.

Replenishment activities punctuated the 2013 global health landscape and signaled continued support for DAH. The Global Fund to Fight AIDS, Tuberculosis and Malaria put the final touches on its new funding model and has already received pledges of support to continue its work. The World Bank's International Development Association also convened development assistance partners to successfully raise financial support for its lending activities.

Finally, better information about the burden of disease emphasizes the impact of the epidemiological transition to non-communicable diseases in the developing world. In 2013, IHME built upon the Global Burden of Diseases, Injuries, and Risk Factors Study 2010 methods and data. New findings published across a number of academic journals highlighted the growing burden of non-communicable diseases.[6-8]

This shifting global health landscape informed enhancements to this edition of *Financing Global Health*. This year, IHME focused on improving estimates of DAH by channel and refining health focus area allocation methods. IHME substantially reduced the "other" and "unallocable" categories and added a new health focus

area: tobacco control. IHME also now splits up non-governmental organization funding into health focus areas, further improving the estimates of funds allocated to distinct global health activities.

This edition of *Financing Global Health* is structured to emphasize improvements to the methods and data as well as the stories and figures that highlight evolving global health funding flows. Chapter 1 focuses on macro trends in DAH, featuring changes in the most prominent channels and shifts in the distribution of types of channels over time. In Chapter 2, we focus on recipient countries and the DAH they received. Chapter 3 delves into the types of interventions and activities typically supported by DAH, as distinguished by diseases, certain risk factors (tobacco use), and health sector support. Chapter 4 concentrates on the origin of funds and the composition of their support across time, income, and organizations. Finally, Chapter 5 features IHME's estimates of government health expenditure, a less discussed but nonetheless vital component of global health financing.

CHAPTER 1

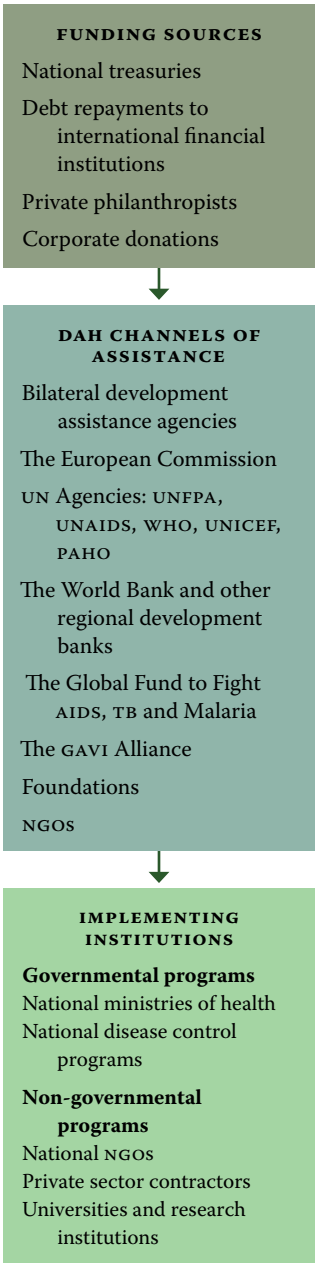
Overview of development assistance for health trends

This chapter uses estimates of development assistance for health (DAH) produced by the Institute for Health Metrics and Evaluation (IHME) to explore trends in global health financing from 1990 to 2013. Capturing DAH requires a framework designed specifically for parsing out the intricate flow of funds. Displayed in Figure 1, this framework provides a coherent foundation for IHME to categorize disparate funding streams into stages of disbursements. Moreover, it allows researchers to address double-counting that would otherwise lead to overestimation.

Using this approach, IHME tracks the flow of funds from their origin to their final destination in low- and middle-income countries. As shown in Figure 1, sources, or the origin of funds, typically consist of national treasuries or the private holdings of philanthropists and corporations. Sources transfer funds to channels, which are the multilateral and bilateral aid agencies, development banks, non-governmental organizations, and other actors that manage the distribution and delivery of development assistance. Because these organizations are relatively few in number and their financial data are readily available, IHME collects data primarily from channels. The flow of funds concludes with implementing institutions: the governmental and non-governmental entities that manage health systems, provide clinical care, and implement public health measures in developing countries.

Sources, channels of assistance, and implementing institutions are not mutually exclusive. A developed country government, for example, can serve as both a source and a channel. For instance, Germany acts as both when funds originating with the German tax base are provided as DAH through the country's bilateral aid agencies. Some channels also act as implementing institutions. The World Health Organization (WHO) plays the role of channel and implementing institution in amassing polio eradication funds and then providing immunizations directly to individuals.

FIGURE 1
Sources, channels, implementing institutions

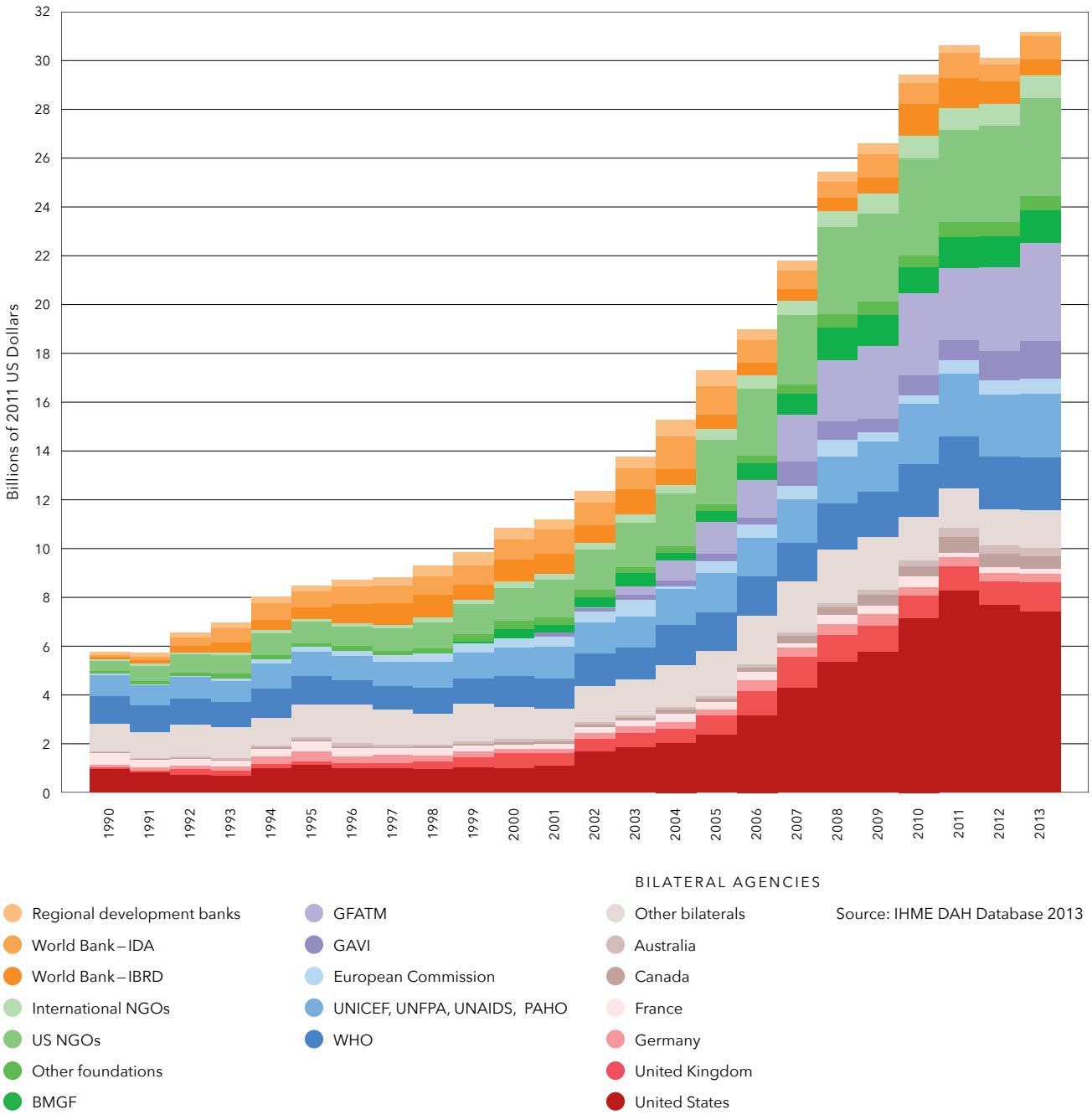


DAH BY CHANNEL OF ASSISTANCE

2013 marks the largest amount of DAH ever recorded. Preliminary estimates set 2012 DAH at $30.1 billion and 2013 DAH at $31.3 billion. DAH continued to climb in 2013 despite the lingering effects of the global financial crisis and the austerity measures implemented across Organisation for Economic Co-operation and Development countries. Budget cuts were instituted in the United States, the United Kingdom, Germany, France, Italy, Spain, and others as a response to the economic downturn.[9,10] Official development assistance, including DAH, was widely discussed as a potential target of spending cutbacks.[1-5] Thus, while the 1.1% increase in DAH from 2011 to 2013 falls short of the annualized growth of 11.3% observed over

FIGURE 2

DAH by channel of assistance, 1990–2013



2001–2010, the expansion is nonetheless an encouraging development for global health, particularly as the deadline for the Millennium Development Goals draws near.

The overarching trend is underpinned by shifts in the spending of different development assistance partners. Over 2012–2013, public-private partnerships led growth rates among channels. Certain non-governmental organizations (NGOs) also contributed substantially to this growth. Simultaneously, bilateral agencies' contributions on the whole remained steady. Decreases in DAH by a few major bilateral agencies

were offset by substantial increases by other countries, with the UK leading bilateral DAH growth. The DAH disbursed by most other types of development assistance partners, including United Nations (UN) agencies, development banks, and private foundations, also remained relatively unchanged.

Over 2012–2013, the UK's bilateral assistance, fed mostly through the Department for International Development (DFID), fueled growth in total DAH. UK DAH grew from $976 million in 2012 to $1.2 billion in 2013, a year-over-year increase of 24.7%. The increased investments were mostly made in low-income countries in sub-Saharan Africa as the UK continues to phase out development assistance to select middle-income countries. In addition to discontinuing aid to India, in early 2013 the United Kingdom announced it would end development assistance to South Africa by 2015.[11,12]

Spending by the European Commission (EC) underwent minor growth. The EC's DAH rose slightly, from $616 million in 2012 to an estimated $630 million in 2013. The DAH provided by individual countries in Europe also grew. IHME estimates that Swiss DAH grew 6.8% to $59 million in 2013. Reinforced by a strong economy, Switzerland plans to maintain increases in development assistance into 2014.[13] After years of cutbacks to development assistance, Italy's DAH rose 2.3% to $68 million in 2013, as the government sought to invest in sectors where Italy could establish a comparative advantage, including global health.[14] Swedish DAH grew an estimated 7.6%, to $152 million, in 2013. IHME's preliminary estimates show that the DAH of Austria, Belgium, Denmark, and Finland increased from 2012 to 2013 as well.

Elsewhere in Europe, the contributions of major bilateral agencies fell slightly vis-à-vis historical levels. German bilateral health aid dropped 2%, decreasing from $354 million in 2012 to $347 million in 2013. The reductions in German official development assistance were reportedly tied to efforts to minimize the borrowing of Germany's development ministry.[15] Spain's DAH also incurred cutbacks, dropping from $75 million in 2012 to $74 million in 2013 according to IHME's preliminary estimates. French DAH contracted slightly as well, decreasing from $231 million in 2012 to $207 million in 2013. However, French commitments to global health will be bolstered in coming years with an augmentation of taxes on the purchase of airline tickets. These funds will reportedly be used in part to combat HIV/AIDS, malaria, tuberculosis, and other infectious diseases.[16]

In North America, preliminary estimates show DAH is contracting. After peaking in 2011 at $8.3 billion, US bilateral assistance fell 7.2% from 2011 to 2012 and 3.4% from 2012 to 2013, leaving 2013 US DAH at $7.4 billion. This decrease can be tied to budget sequestration measures, which had an across-the-board impact on US government spending, including global health.[17] Despite the contraction in expenditure, global health continues to be high on the US development agenda. In 2012, the US established the Office of Global Health Diplomacy, which aims to provide diplomatic support to the US's Global Health Initiative.[18] The US also continues to prioritize the President's Emergency Plan for AIDS Relief (PEPFAR).[19]

Decreases were also observed in Canadian bilateral assistance. Canada's DAH dropped from $542 million to $491 million over 2012–2013. Notably, Canada implemented changes in its aid infrastructure in 2013. The Canadian International Development Agency was transferred to the Ministry of Foreign Affairs, a move intended to more closely align Canada's development aid with trade and foreign policy objectives.[20]

Among other bilateral agencies, Australia's bilateral aid remained nearly steady. Australia provided $339 million of DAH in 2013, which was an increase of 2.1% over 2012. However, in 2013, a new Australian government announced plans to reduce development assistance in coming years.[21]

The World Bank's International Bank for Reconstruction and Development (IBRD) and International Development Association (IDA) displayed different trends in expenditure, as tied to the role these distinct institutions play in financing global health. In 2010, IBRD responded to the economic crisis with large disbursements of aid. As the need associated with the crisis subsided, IBRD DAH has also been reduced. Nonetheless, in 2013, IBRD's contribution to DAH amounted to $883 million, an amount larger than any year between 2004 and 2009. In contrast, DAH from IDA, which focuses on low-income countries, and which convened replenishment meetings throughout 2013, jumped a substantial 21.4% relative to 2012.[22] Its DAH reached $861 million in 2013.

Following a decade of rapid growth, public-private partnerships continued their rise into 2013. The GAVI Alliance (GAVI), at $1.5 billion in 2013, grew markedly, increasing an estimated 32% from an already substantial $1.2 billion in 2012. Buoying GAVI's growth was the Islamic Development Bank, which announced the release of substantial contributions to GAVI in 2013.[23] Funds will be used to vaccinate over 400 million children across 29 Islamic Development Bank countries.

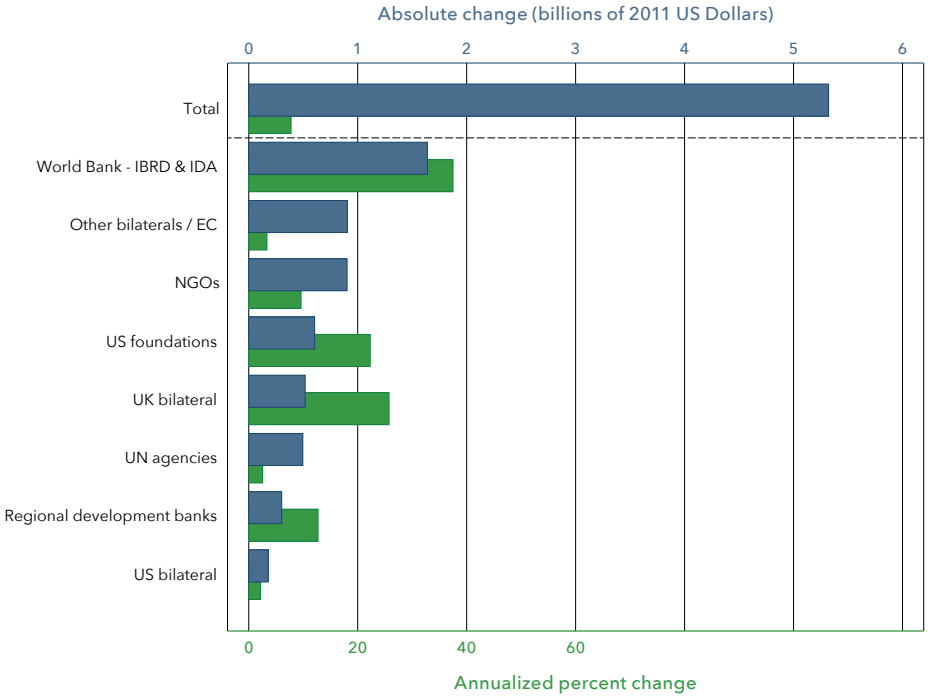
The other major public-private partnership in global health, the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), eclipsed its previous peak with expenditure of $4 billion in 2013. This was an increase of 16.8% from 2012 levels. Part of GFATM's recent expansion is related to reforms in its disbursement structure and other operations. The 2013 uptick was fueled by advance disbursements in six countries and three regional organizations, providing access to more than $400 million in funds that were part of the initial deployment of the New Funding Model.[24] Even before the New Funding Model was finalized, GFATM received substantial commitments from the UK ($1.6 billion)[25] and Nordic countries ($750 million).[26] The US announced a budget request of almost $1.7 billion for GFATM in 2014, the largest commitment of any country to the public-private partnership.[27] These commitments follow a $759 million pledge made by the Bill & Melinda Gates Foundation (BMGF) in 2012.[28]

Turning to other multilateral organizations, the WHO and other UN agencies essentially maintained the level of DAH disbursed. IHME's preliminary estimates show that the WHO's contribution dropped slightly, from $2.17 billion in 2012 to $2.15 billion in 2013, a 0.9% decrease. Underlying this reduction was the announcement of major shifts in the WHO's allocations across focal areas. Increases in expenditure on non-communicable diseases (20.5%) and preparedness, surveillance, and response (31.7%) offset a 51.4% cut in outbreak and crisis response and a 7.9% reduction in disbursements on communicable diseases.[29] IHME estimates of the DAH provided by UN agencies, including the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Pan American Health Organization, show growth of 3.6%, amounting to a combined total of $2.6 billion in 2013.

Finally, a large increase in the DAH provided by NGOs contributed to the sustained DAH total. In an effort to better track NGO spending, IHME produced estimates of both US-based and internationally based NGOs in 2013. Spending by US-based NGOs reached $4 billion in 2013, an increase of 1.8% from 2012. Spending

FIGURE 3

Change in DAH by channel of assistance, 1991–2000



Source: IHME DAH Database 2013

Notes: The bars represent changes in DAH in absolute and percentage terms from 1991 to 2000. On the vertical axis, channels are ordered by the magnitude of their contribution to the total change in DAH over this period.

by internationally based NGOs, which include NGOs based outside the US that receive some support from the US government, or otherwise report expenditure to the US, reached $895 million in 2013. These newly developed estimates reveal the slight contraction in internationally based NGO spending since 2012, as a 0.3% decrease was observed.

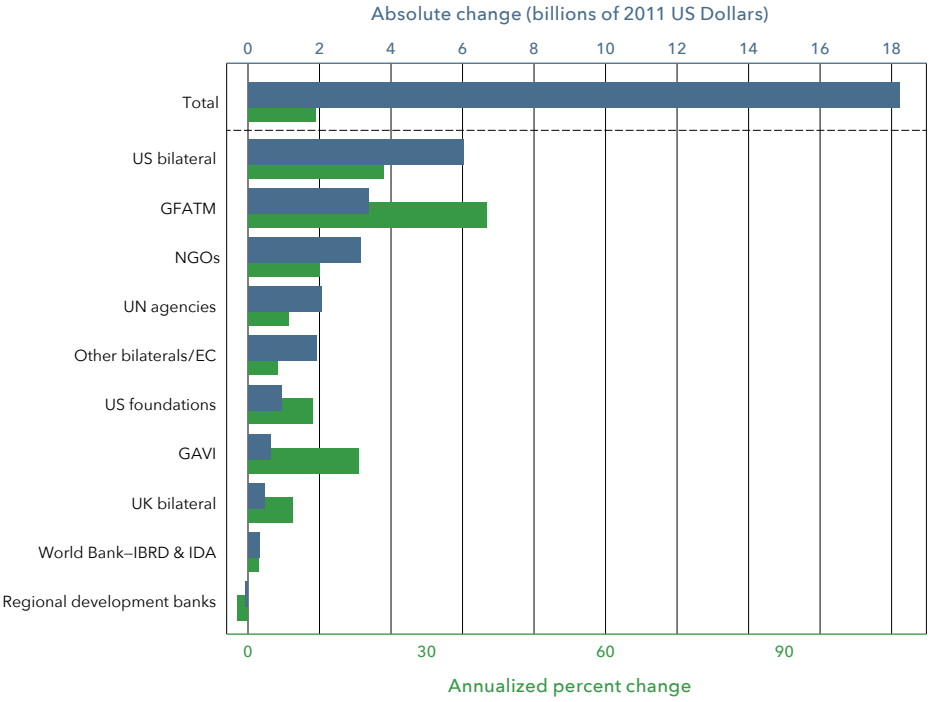
CHANGES IN CONTRIBUTIONS ACROSS PERIODS

Over more than two decades, three periods of growth in DAH can be distinguished: 1991–2000, 2001–2010, and 2011–2013. In the initial period of DAH highlighted (1991–2000), funding grew steadily and consistently, although less rapidly than in the subsequent timespan. From 1991 to 2000, total DAH grew by over $5.1 billion, with annualized growth of 7.3%. Across organizations, the World Bank's IDA and IBRD grew the most in absolute terms: $1.4 billion more in DAH was disbursed in 2000 than in 1991 by these institutions. The most substantial growth rate in this period was observed in UK bilateral assistance, which increased more than 25.8% in annualized terms during this time. With annualized growth of 22.3% and an absolute increase of $605 million, the strong growth of US foundations, shown in Figure 3, captures the launch of BMGF and the growing contributions of other private foundations. Over the same period, US bilateral assistance did not increase at rates comparable to later periods. Annualized growth amounted to 2.2%, an absolute increase of $179 million for US bilateral agencies.

In contrast, the 2001–2010 period sets itself apart with extraordinary rates of growth. As shown in Figure 4, this period followed the launch of the Millennium Development Goals and the release of ambitious health-related targets. Rapid

FIGURE 4

Change in DAH by channel of assistance, 2001–2010



Source: IHME DAH Database 2013

Notes: The bars represent changes in DAH in absolute and percentage terms from 2001 to 2010, except for GFATM, which is relative to 2003. On the vertical axis, channels are ordered by the magnitude of their contribution to the total change in DAH over this period.

growth was largely driven by massive investments aimed at advancing these goals, including the fight against HIV/AIDS, malaria, tuberculosis, and child and maternal mortality, realized in the establishment of public-private partnerships.

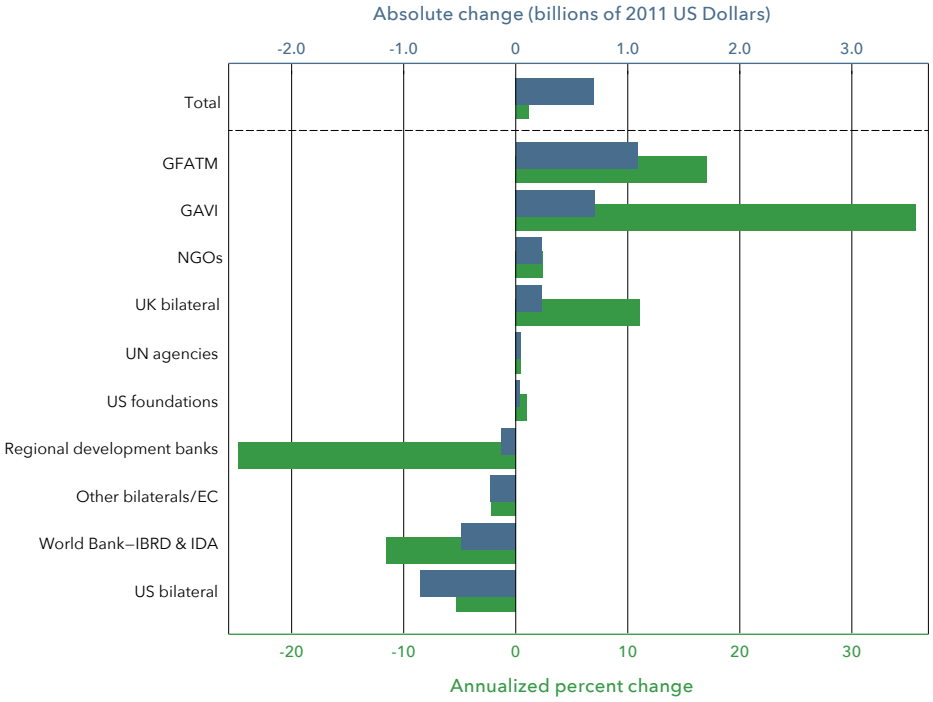
Figure 4 displays the much higher rates of growth that ensued over the 2001–2010 period. The most prominent increase was in US bilateral assistance. In addition to increased investments by the traditional US-based global health channels, such as the United States Agency for International Development (USAID), growth was also driven by the establishment of two organizations focused exclusively on infectious diseases: PEPFAR and the US President's Malaria Initiative.

Figure 4 also captures changes in multilateral contributions to DAH. The launch of GAVI and GFATM took place in this period. Due to their nascence on the global health stage during this time, their annualized growth rates are considerably high, at 40.1% and 18.6% for GFATM and GAVI, respectively. This contrasts with trends in the DAH provided by regional development banks. These entities were the only organizations to undergo reductions in DAH over 2001–2010, although the decrease, both in absolute ($57 million) and percentage terms (1.7%), was slight.

More recently, a mix of expansion and contraction has underpinned minor growth in total DAH, as shown in Figure 5. Increases continued to be led by investments focused predominately on communicable diseases. GAVI and GFATM grew considerably from 2011 to 2013. GAVI's rise during the 2011–2013 period is particularly impressive, with growth of 35.7% annually over 2011–2013, an increase of $708 million. GFATM's absolute increase is even higher, evidence of renewed support. Global Fund DAH increased by $1.1 billion between 2011 and 2013, with an annualized growth rate of 17.1%. Among bilateral agencies, the UK led in absolute ($231 million) and annualized growth (11.1%). The DAH provided by NGOs also expanded, with a $231 million absolute increase and 2.4% in annualized growth.

FIGURE 5

Change in DAH by channel of assistance, 2011–2013



Source: IHME DAH Database 2013

Notes: The bars represent changes in DAH in absolute and percentage terms from 2011 to 2013. On the vertical axis, channels are ordered by the magnitude of their contribution to the total change in DAH over this period.

Drops in expenditure were also observed. Falling substantially in percentage terms but minimally compared to DAH on the whole were the development banks. The trend across the African Development Bank (AfDB), the Asian Development Bank (ADB), and the Inter-American Development Bank (IDB) was a reduction of 24.8% in annualized terms over the period. This cutback amounted to $132 million. The largest absolute reduction in DAH, however, was observed in US bilateral contributions. The collection of US agencies that provide DAH decreased their spending by $857 million, a 5.3% drop in annualized terms.

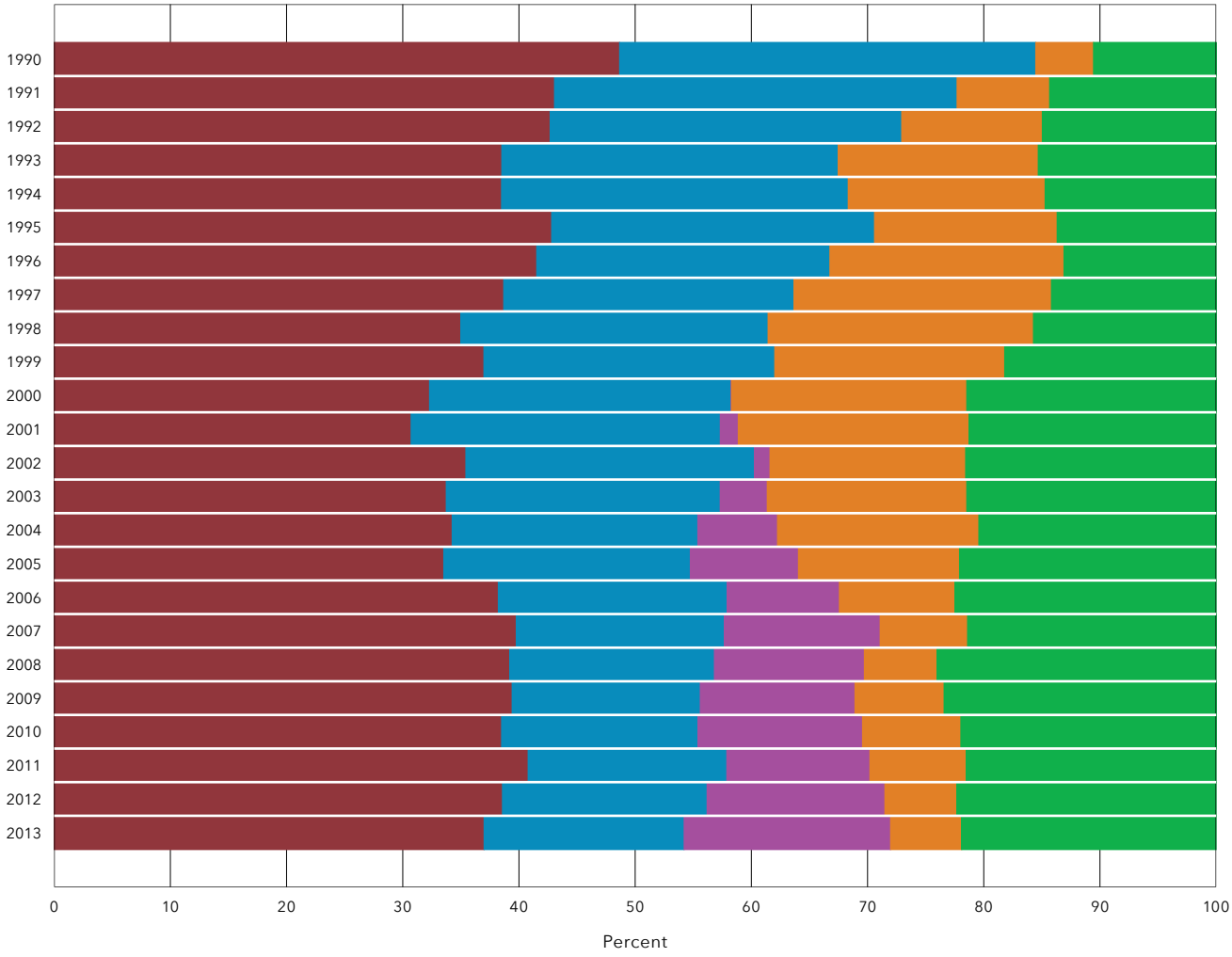
SHIFTS IN TYPES OF CONTRIBUTIONS OVER TIME

Public-private partnerships, bilateral agencies, UN agencies, NGOs, and development banks make up the main organizational typologies prominent in the field of development assistance for health. Each of these organizational types is subject to different pressures, capacities, and funding streams. These entities also target different health focus areas and deliver funds in unique manners. To explore transitions in the DAH landscape, Figure 6 aggregates channels into broader categories and displays the share of DAH each organizational type has contributed over time.

Figure 6 shows that the shares of DAH expended by NGOs and foundations, bilaterals, and public-private partnerships have changed substantially since 1990. In 1990, bilateral agencies channeled 48.7% of DAH. By 2013, preliminary estimates set their share at 37%. The portion of DAH provided by private foundations and NGOs has also risen consistently during this period. NGOs and private foundations provided 10.6% of funds in 1990. By 2013, these organizations were responsible for the disbursement of 21.9% of DAH. The launch of BMGF is a primary driver of this growth. Public-private partnerships, however, exhibit the most impressive growth in shares of DAH.

FIGURE 6

Changes in types of contributions, 1990–2013



Source: IHME DAH Database 2013

Since GAVI and GFATM were established at the turn of the century, they did not contribute to DAH in 1999. However, by 2013, these public-private partnerships together provided 17.8% of total DAH.

In contrast, the portion of DAH provided by UN agencies and development banks has declined since 1990. UN agencies spent 35.8% of all funds allocated to global health in 1990. By 2013, this had dwindled to 17.2%. Development banks have incurred the most substantial reductions in relative disbursements. At their peak in 1998, development banks contributed 22.8% of total DAH. By 2013, these entities provided only 6.1% of DAH. While these organizations continue to play a core function in the global health landscape, other types of structures are increasingly prevalent.

CHAPTER 2

Recipients of development assistance for health

Both low- and middle-income countries are eligible for development assistance for health (DAH). In addition to income, burden of disease, which varies widely across income levels, plays into the investment choices of development assistance partners. To assess spending trends while controlling for these factors, this chapter harnesses World Bank income classifications and epidemiological data from the Global Burden of Diseases, Injuries, and Risk Factors Study 2010 (GBD 2010).

Sourced from GBD 2010, disability-adjusted life years (DALYs) are the primary unit of disease burden utilized. DALYs incorporate years of life lost to premature mortality and years of life lived with disability to provide a single metric of burden. A substantial amount of premature mortality and disability translates into a high level of DALYs in a given country.

This chapter examines DAH and DALYs side by side, showing that the low-income countries with the most substantial infectious disease burdens generally receive more support, although some imbalance is present. The Institute for Health Metrics and Evaluation (IHME) also combines DAH and DALYs into a single measurement, DAH per DALY, to encapsulate the disbursements allocated per unit of disease burden. Sub-Saharan Africa stands out as benefiting from increasingly high levels of DAH across different metrics. In contrast, middle-income countries, particularly upper-middle-income countries, increasingly receive less development assistance for health.

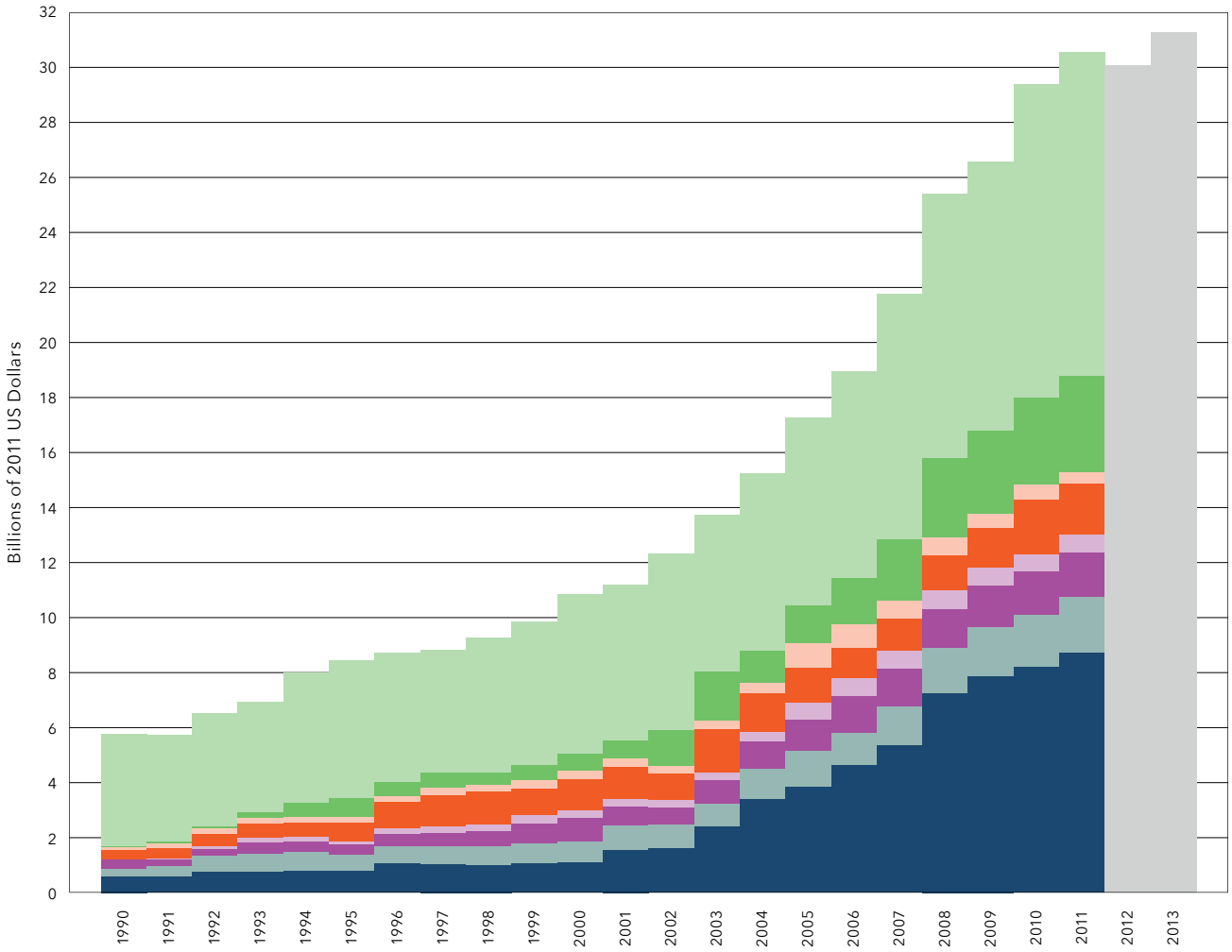
DAH BY REGION

Figure 7 displays DAH by developing country region from 1990 to 2011. Due to a lag in reporting, IHME is unable to allocate funds by region for 2012 and 2013. Furthermore, going back in time, a portion of funds, distinguished as "unallocable," cannot be allocated to a specific geographic region because some financial data do not contain region- or country-level information. Among the funds IHME can allocate, Figure 7 shows that regional allocations are shifting beneath the slightly growing total. Declines in the DAH provided to Latin America and the Caribbean, Europe and Central Asia, and North Africa and the Middle East were offset by growth across sub-Saharan Africa, South Asia, and East Asia and the Pacific in 2011.

Figure 7 also shows that DAH is chiefly focused on sub-Saharan Africa. In 2011, the region received 46.5% of total allocable aid. DAH to sub-Saharan Africa reached $8.8 billion in this year, a 6.1% increase over 2010. Income and epidemiological trends are clearly important in driving DAH to the subcontinent. The share of DALYs attributed to the major infectious diseases, HIV/AIDS, malaria, and tuberculosis, at 24.7%, is highest across the regions considered. The DALYs associated with maternal and child conditions are also substantial, at 35.6% of total disease burden in the

FIGURE 7

DAH by focus region, 1990–2011



Source: IHME DAH Database 2013

Notes: Health assistance for which no recipient country or region information is available is coded as "unallocable." Due to data limitations, estimates are unavailable for DAH by focus region for 2012 and 2013.

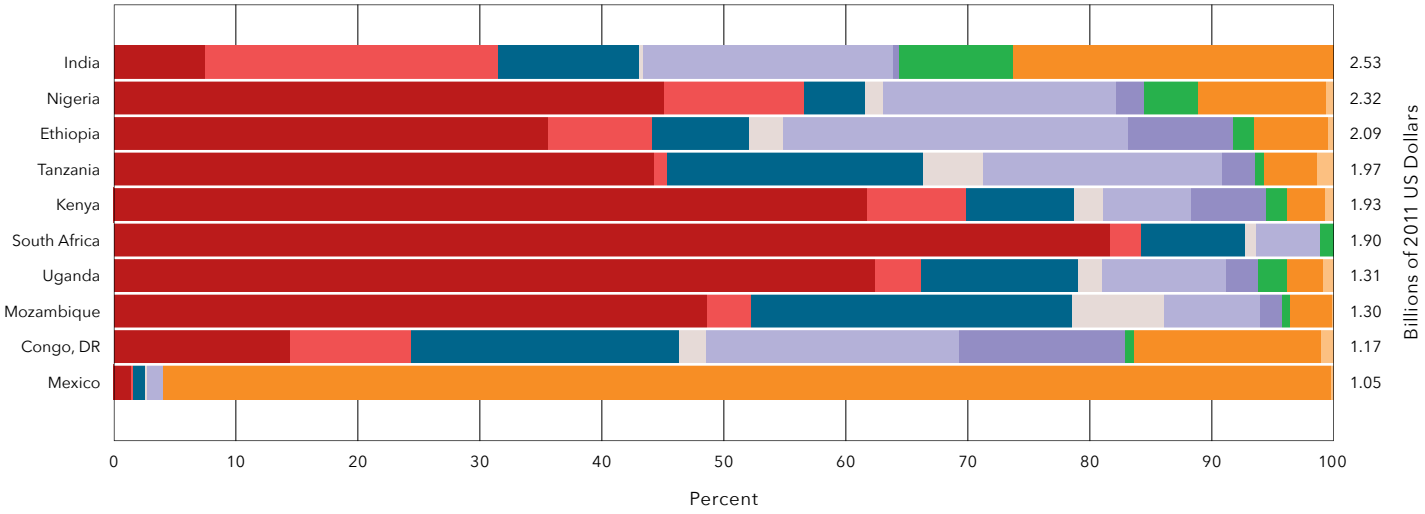
region. Furthermore, more low-income countries are located in sub-Saharan Africa than in any other region, evidence of DAH's concentration in areas with low gross domestic product.

After sub-Saharan Africa, the "global" category received the second-highest share of DAH in 2011. The "global" grouping includes funds disbursed for global health activities that cannot be tied to a specific geographic area, such as research and development, international conferences, and other global health public goods. In 2011, $3.5 billion in DAH was provided to these global activities, a 10.8% increase over 2010. Notably, this category grew the most across regional allocations over 2010–2011, an indication of the increasingly interconnected and global nature of development assistance for health.

South Asia received the next largest share of total DAH. In 2011, the region received 10.7% of DAH, with $2 billion disbursed in the region. Spending in this

FIGURE 8

Top 10 country recipients of DAH by channel of assistance, 2009–2011



Source: IHME DAH Database 2013

Notes: The amount of DAH received by each country in billions of 2011 US dollars is shown on the right of the figure. The amount reflects only DAH allocable by country.

region grew 8.2% over 2010. South Asia harbors a large population; communicable diseases also make up a large share of its burden. However, it remains to be seen if DAH will continue to grow in future years, as the UK, India's biggest development assistance partner, announced it would discontinue its provision of development assistance to the country by 2015.[11]

Compared to South Asia, the disease burden in the Latin America and Caribbean region is smaller. The region also has a smaller and increasingly wealthier population. However, the DAH allocated to Latin America and the Caribbean was only slightly less than South Asia's in 2011. The Latin America and Caribbean region received 9.7% of DAH, or $1.8 billion, in 2011. This was a $157 million decline relative to 2010.

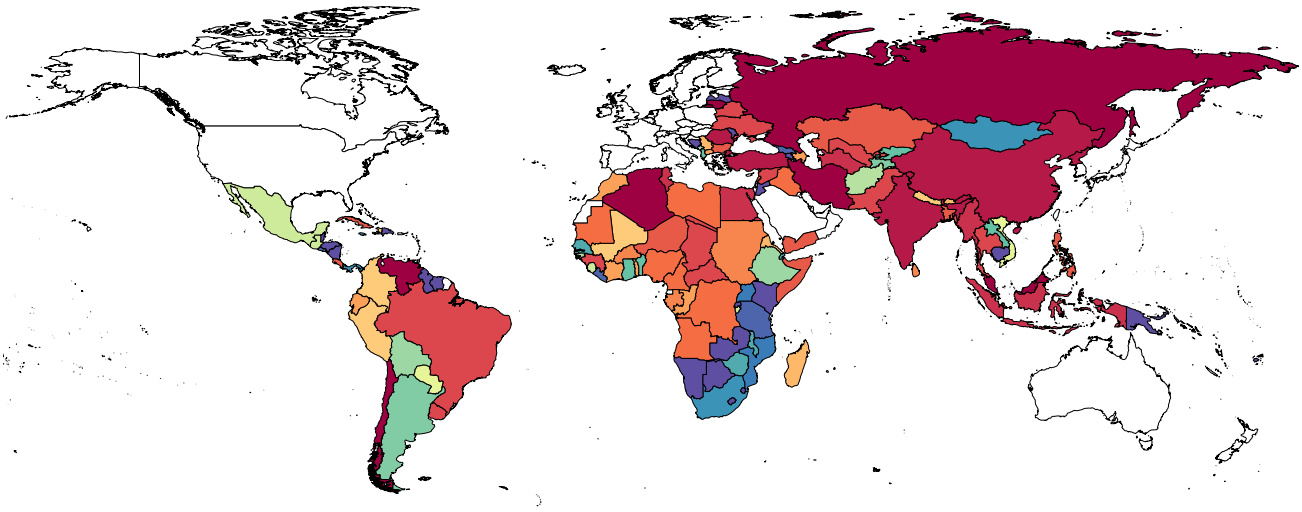
Across other regions, trends varied. The DAH disbursed in Europe and Central Asia increased from $618 to $656 million from 2010 to 2011. The region's share of total DAH was 3.5% in 2011. The North Africa and Middle East region fell an estimated 20.7% to $429 million in 2011. East Asia and Pacific, meanwhile, grew slightly. In 2010, DAH to the region grew to $1.6 billion in 2011, a 2.1% increase. This amounted to 8.7% of total DAH.

Figure 8 displays the top 10 recipients of DAH, ranked by the cumulative DAH received over 2009–2011. This list consists mostly of sub-Saharan African countries, highlighting the role of income status and infectious disease burden in DAH disbursements. Two populous middle-income countries, India and Mexico, are the only countries on the list located in other regions. Mexico's appearance in the rankings can be explained by an International Bank for Reconstruction and Development (IBRD) project approved in 2010, which provided more than $1 billion to the Mexican government with the objective of strengthening health insurance coverage and health system performance.[30]

Infectious disease burden clearly plays a role in driving countries to the top of the DAH recipient list. Nine of the 10 countries on the list are among the top 20 nations in terms of HIV/AIDS burden. These nine recipients also receive some of the largest disbursements of DAH for HIV/AIDS. Most countries listed also rank high among nations with the greatest malaria DALYs and DAH.

FIGURE 9

DAH per all-cause DALY, 2009–2011



Source: IHME DAH Database 2013

Notes: Countries that were ineligible for DAH based on their World Bank income classification are shown in white. DAH received is shown in real 2011 US dollars.

US bilateral agencies contributed the bulk of DAH to the top 10 recipients of DAH. In six of these countries, US bilateral assistance made up more than 40% of DAH received. After US bilateral aid, GFATM contributed prominently to most of these countries in 2011. In India, historical ties play a role in the channels of DAH that are prominent; UK's bilateral assistance was responsible for the largest share of DAH in India from 2009 to 2011. In the Democratic Republic of the Congo (DRC), where civil conflict and other strife have occurred for some time, a myriad of international players are active in the provision of development assistance for health.

DISABILITY-ADJUSTED LIFE YEARS AND DAH

Levels of DAH at the regional and country levels reveal where funds are concentrated but do not capture burden of disease, one indicator of the level of need in a given country. To explore variations in the alignment between DAH and DALYs at the country level, the map displayed in Figure 9 depicts DAH per DALY. To produce DAH per DALY, cumulative DAH from 2009 to 2011 is divided by 2010 all-cause DALYs, a measure of the sum of all types of disease burden.

Figure 9 shows that DAH per DALY ranges from approximately zero to more than $75 in some countries. India stands out as receiving some of the lowest levels of DAH per DALY despite topping the list of absolute DAH recipients. Due to its large population and substantial disease burden, India ranks low among recipients when measured by DAH per DALY. In contrast, some countries that receive among the highest absolute levels of DAH also receive substantial DAH per DALY, including Kenya, Tanzania, and Zambia, all of which, notably, suffer from a high burden of HIV/AIDS and malaria. Other recipients of the highest levels of DAH per DALY tend to be small low-income countries, including a number of small island developing states. Low

levels of DAH per DALY are observed in middle-income countries, such as India, China, Russia, and Chile, where infectious disease prevalence is lower and non-communicable diseases are on the rise.

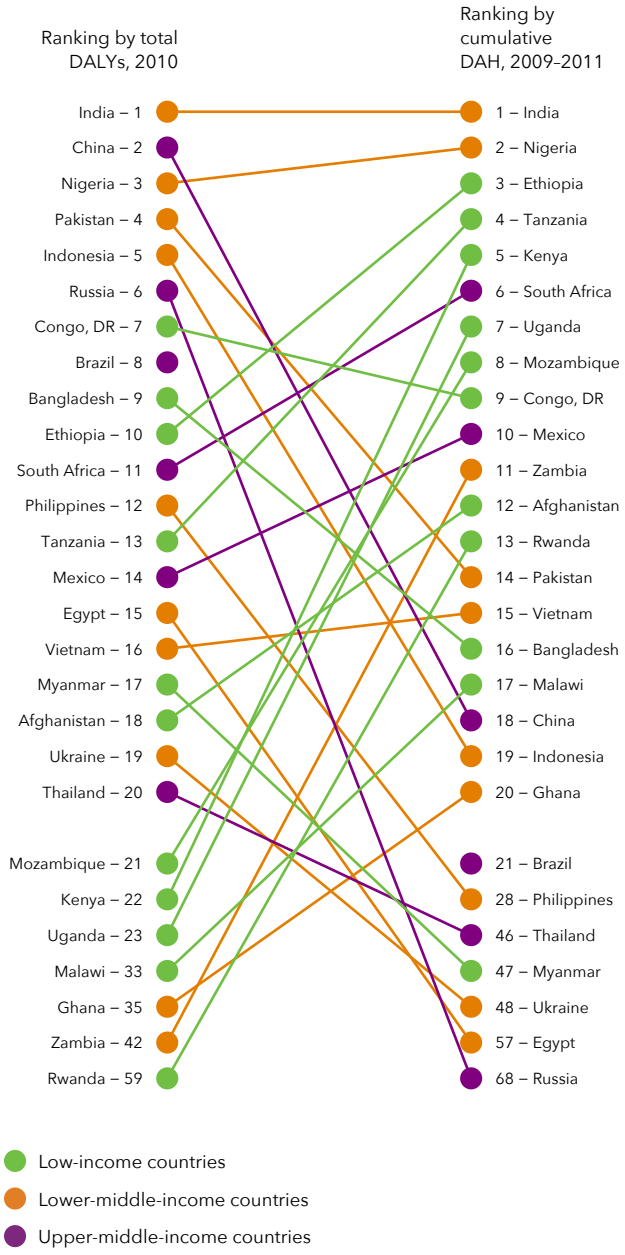
Figure 10 further explores the relationship between burden and DAH by portraying the ranking of countries by 2010 DALYs and the DAH disbursed from 2009 to 2011. Countries are also color-coded according to income status, exposing how level of economic development comes into play in these rankings. While six upper-middle-income countries are found among those countries with the highest disease burden, only three are top recipients of DAH. South Africa, with its substantial HIV/AIDS burden, and Mexico, as a recipient of sizeable loans from IBRD, figure among the top 20 DAH recipients. As the most populous country in the world, China also receives enough DAH to place it among the top 20 recipients. Two other very populous countries, India and Nigeria, rank highest among DALYs and DAH, exposing a certain amount of alignment at the highest ranks of DAH and DALYs. Imbalance is more evident among the remaining top 10 recipients of cumulative DAH, which are all low-income countries. Across the top 10 DAH recipients, only four countries had enough DALYs to put them among the top 10 in terms of disease burden.

Substantial variation in DAH per DALY is also evident across time. Figure 11 shows cumulative DAH for distinct five-year periods, divided by the total DALYs present in the last year of that period. Representing DAH trends in this way shows how drastically funding per DALY in sub-Saharan Africa has grown since 1990, even while controlling for burden. Over 1991–1995, the DAH per DALY received by sub-Saharan Africa was below that of both the North Africa and Middle East and Latin America and Caribbean regions. By 2006–2010, sub-Saharan Africa received almost $20 more per DALY than the next-highest region, as measured by cumulative DAH over that period. This was almost a tripling in DAH per DALY as compared to the 2001–2005 period.

In most regions, DAH per DALY has climbed over time. However, Latin America and the Caribbean stands out as an exception, as Figure 11 shows stagnation between the 2001–2005 and 2006–2010 periods. The region nonetheless received the second-highest DAH per DALY in 2006–2010 after sub-Saharan Africa, at more than $40 per DALY. The level of DAH per DALY in North Africa and the Middle East is typically lower than DAH per DALY in Latin America and the

FIGURE 10

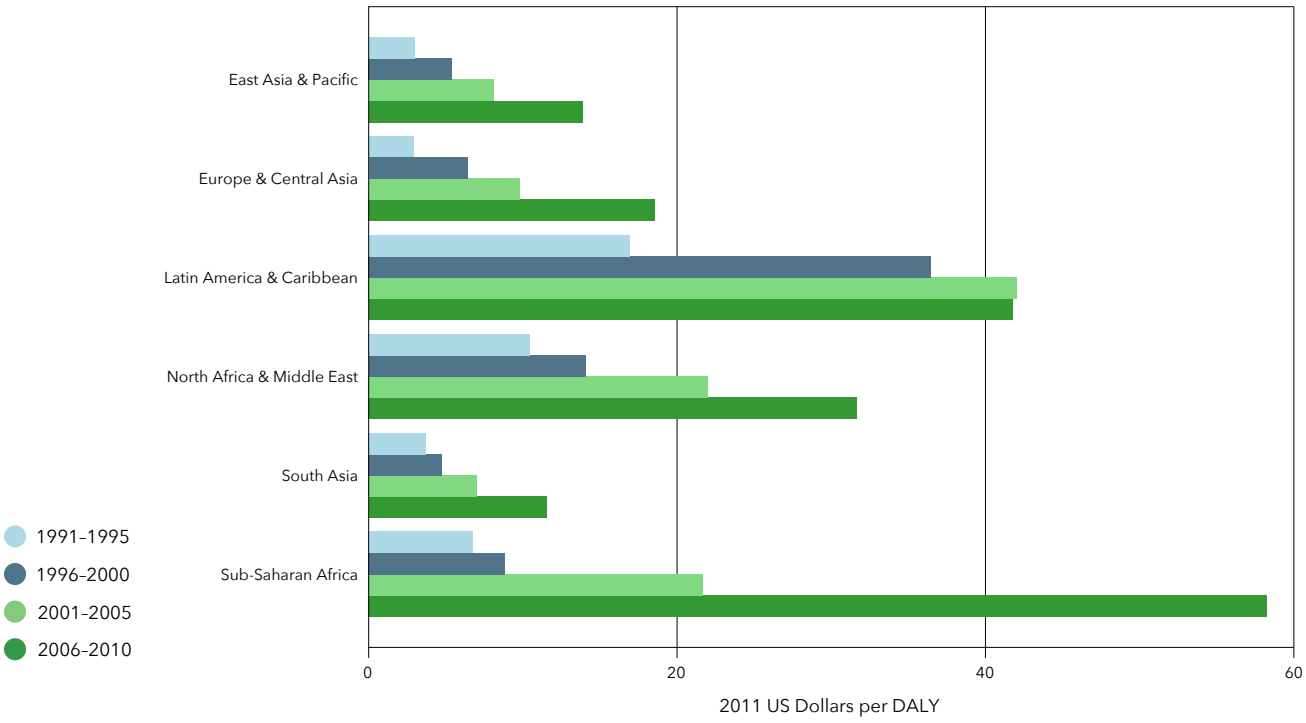
Top 20 countries by 2010 all-cause burden of disease versus cumulative 2009–2011 DAH



Sources: IHME DAH Database 2013 and Global Burden of Disease Study 2010

FIGURE 11

DAH over five-year periods per all-cause DALY, by region, 1991–2010



Sources: IHME DAH Database 2013 and Global Burden of Disease Study 2010

Note: The bars represent cumulative DAH across each five-year period.

Caribbean. Over 2006–2010, North Africa and the Middle East received more than $30 in DAH per DALY. This amounted to a 44% increase from the 2001–2005 period.

The other three regions highlighted have had consistently lower, yet rising, DAH per DALY. Europe and Central Asia received around $20 in international assistance per DALY over 2006–2010, a close to 90% increase over 2001–2005. In the East Asia and Pacific region, DAH per DALY over 2006–2010 amounted to approximately $14, while South Asia received $12. The regions' DAH per DALY increased by almost 72% and 64%, respectively, over the 2001–2005 period.

CHAPTER 3

Development assistance for health to specific health focus areas

Parsing out funding streams by health focus area highlights diseases and conditions around which the international community has coalesced. The Institute for Health Metrics and Evaluation (IHME) breaks down development assistance for health (DAH) by seven health focus areas: maternal, newborn, and child health (MNCH); non-communicable diseases (NCDs); HIV/AIDS; tuberculosis (TB); malaria; and health sector support. A special component of *Financing Global Health 2013* is the parsing of NCDs into a new health focus sub-area, tobacco control. Tobacco use is one of the leading risk factors worldwide. This chapter also pairs health focus area estimates with disease-specific disability-adjusted life years (DALYs) to further explore the relationship between burden of disease and international spending on health.

The DAH disbursed to each health focus area is examined from several perspectives in this chapter. First, the breakdown of health focus areas is discussed in order to provide an overview of trends in spending. Subsequently, each health focus area is examined, highlighting the channels prominent in each. Finally, the DAH of each health focus area is paired with the corresponding DALYs to explore the relationship between spending and burden at the country and regional levels, as well as over time.

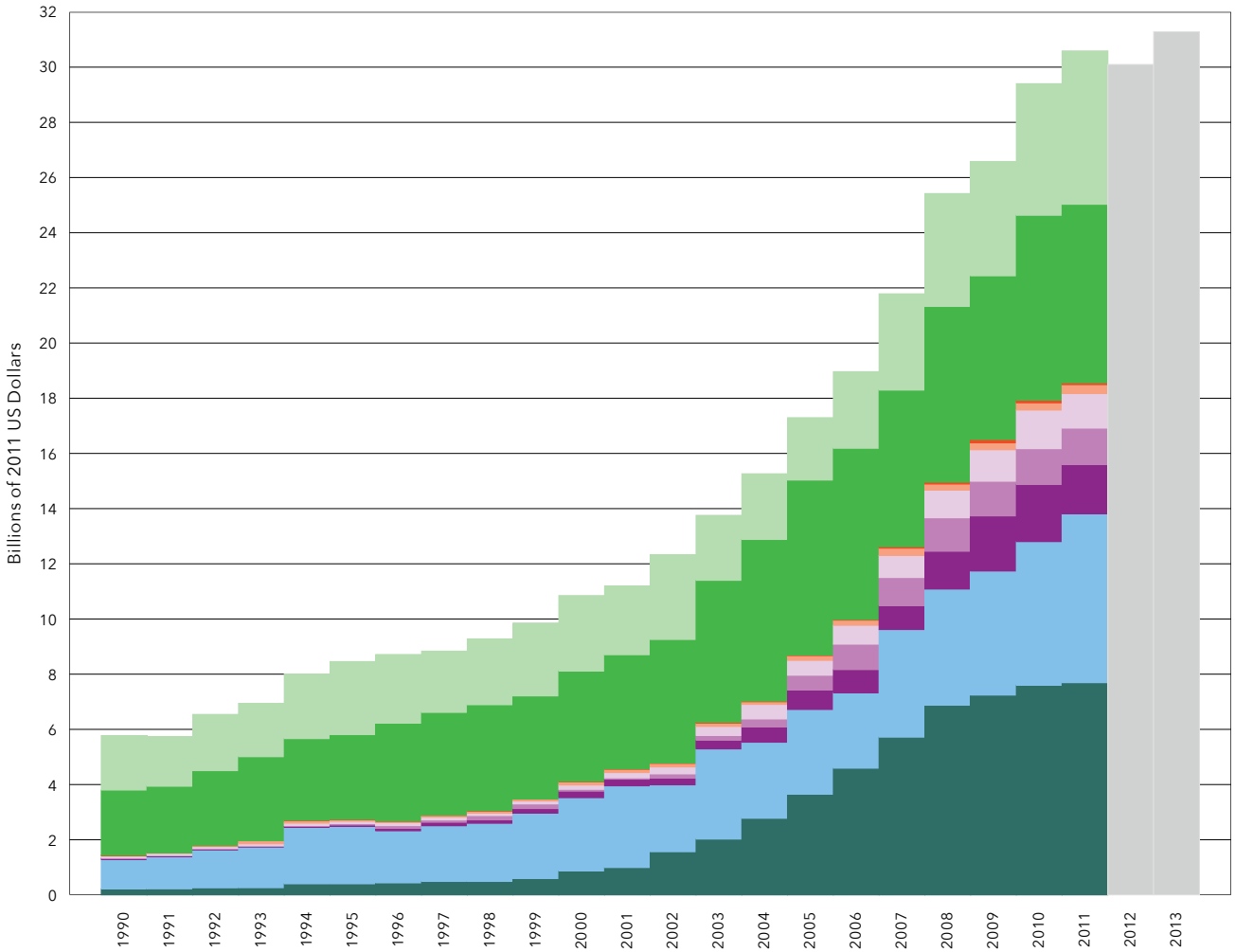
OVERVIEW OF HEALTH FOCUS AREA TRENDS

The overview of health focus area trends is depicted in Figure 12. Clearly, HIV/AIDS, malaria, and TB stand out as making up a major portion of global health support in 2011. However, investments in these areas did not increase as much as the DAH allocated to NCDs and MNCH in 2011. The composition of total DAH shifted slightly toward MNCH and NCDs and away from HIV/AIDS, TB, and malaria from 2010 to 2011. (Data limitations prevent DAH from being parsed across health focus areas for 2012 and 2013.)

This shift away from HIV/AIDS, TB, and malaria is significant. While these are dire health problems in low-income countries, the Global Burden of Diseases, Injuries, and Risk Factors Study 2010 illuminated the ongoing epidemiological shift toward NCDs. NCDs, such as ischemic heart disease, diabetes, cancer, and other illnesses, now contribute 49.8% of the disease burden in low- and middle-income countries. At $377 million in expenditure and only 1.2% of total DAH, NCDs remain one of the smallest areas of funding. Although DAH for NCDs increased more than a number of other health focus areas, with growth of 4.6% from 2010 to 2011, development assistance partners still do not concentrate the bulk of their efforts on this issue. The levels of spending allocated to other health focus areas are vastly higher; DAH for HIV/AIDS, for example, was 20 times higher than assistance for NCDs in 2011.

FIGURE 12

DAH for HIV/AIDS; maternal, newborn, and child health; malaria; health sector support; tuberculosis; non-communicable diseases; and tobacco, 1990–2011



Source: IHME DAH Database 2013

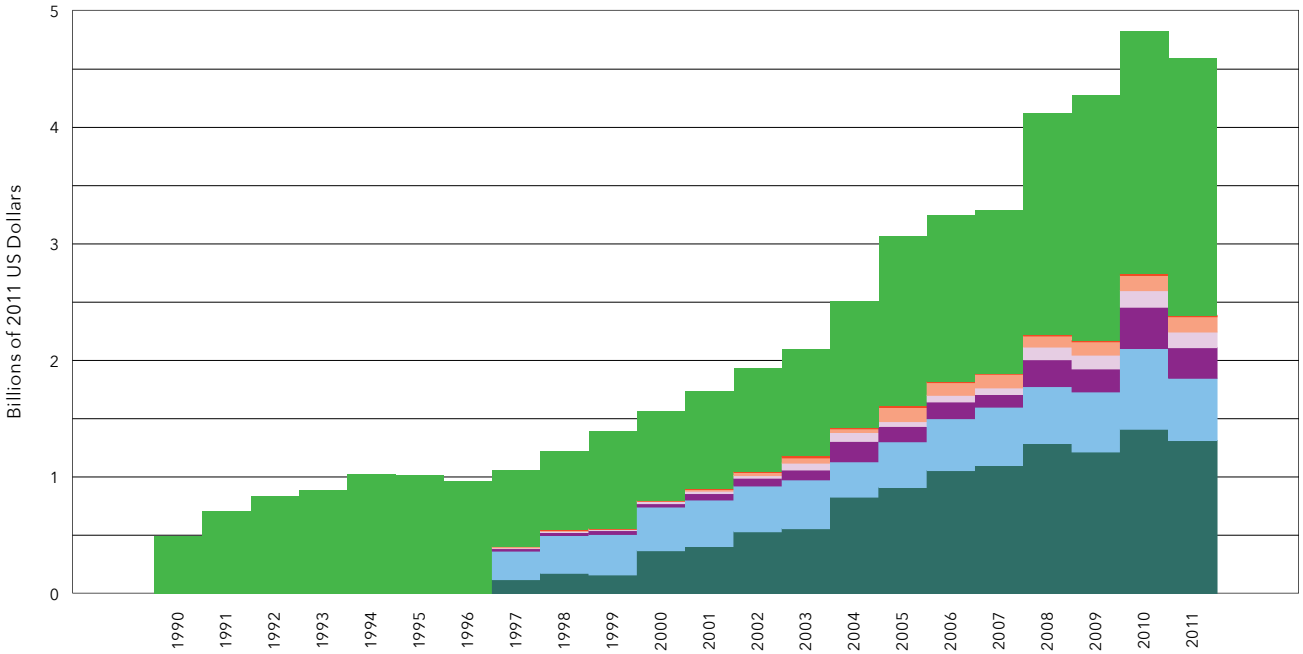
Notes: Health assistance for which we have no health focus area information is designated as "unallocable." DAH for other health focus areas not yet tracked by IHME is coded as "other." Due to data limitations, estimates are unavailable for DAH by health focus area for 2012 and 2013.

A subset of DAH for NCDs is allocated to tobacco control in this year's report. Tobacco control is an essential input to improving population health in the developing world because of the major impact this risk factor has on health in these areas. Yet, as Figure 12 highlights, a very small portion of DAH is allocated to tobacco control. DAH for this health focus area amounted to $68 million in 2011, which was 0.2% of total development assistance for health. A few key organizations are investing substantially in the rapidly expanding efforts to address tobacco control, but these efforts fall far short of spending on other health focus areas.

Another noteworthy finding revealed by Figure 12 is the rapidly and substantially expanding investment in MNCH. MNCH, the second-largest health focus area (20%), received a major boost from 2010 to 2011. In 2011, $6.1 billion was spent on MNCH

FIGURE 13

NGO DAH by health focus area, 1990–2011



Source: IHME DAH Database 2013

activities, a jump of 17.7% over 2010 levels. These efforts may be related to the push to achieve Millennium Development Goals 4 and 5, which aim to considerably reduce child mortality and improve maternal health by 2015. Furthermore, spearheaded by the Bill & Melinda Gates Foundation (BMGF), the UK Government, and other organizations, maternal and child health interventions are increasingly high on the agenda.

Among the major communicable diseases, only HIV/AIDS exhibited growth, albeit slight, in funding flows from 2010 to 2011, increasing 1.2% over 2010 levels. DAH for HIV/AIDS, which amounted to $7.7 billion in 2011, also remained the largest health focus area, receiving 25.1% of total DAH in 2011. Malaria DAH, accounting for 5.8% of DAH in 2011, contracted 13.9% compared to 2010 levels and amounted to $1.8 billion in 2011. TB DAH followed suit, decreasing 9.8% in 2011. Its share of DAH was just smaller than malaria DAH. With investments of $1.3 billion, TB DAH was 4.1% of total DAH in 2011. The minor contraction in TB and malaria aid reflects the Global Fund to Fight AIDS, Tuberculosis and Malaria's (GFATM) efforts to improve its funding mechanisms during this time. While it is too soon to estimate, increases in funding in the fight against HIV/AIDS, TB, and malaria are expected as renewed and improved Global Fund disbursements are implemented.

Finally, funding for health sector support, which includes DAH channeled directly to governments for improving health systems and population health, increased during this time. Health sector support grew by 1.6% from 2010 to 2011 to $1.3 billion. The portion of DAH allocated to health sector support, while still higher than DAH for NCDs, was just 4.3% of total DAH in 2011.

This year, IHME made strides in reducing the "unallocable" portion of its DAH health focus area estimates. This contributed to reducing unallocable DAH by 20.1% and increased the "other" category, which includes spending on health focus areas

outside of those listed, by 12.7%. Even so, because not all data sources fully disclose the types of programs implemented or investments made, 18.2% of DAH disbursed in 2011 cannot be tied to a specific health focus area.

To delve further into DAH trends, IHME also developed non-governmental organization (NGO)-specific estimates of health focus areas for *Financing Global Health 2013*, which are displayed in Figure 13. This reveals that NGOs' allocation of funds to health focus areas does not vary markedly from the distribution of DAH on the whole. At $1.3 billion, a large portion of NGO funds is invested in HIV/AIDS. In 2011, 27.9% of NGO expenditure focused on HIV/AIDS, which is just slightly larger than the share of HIV/AIDS DAH overall (25.1%). NGO malaria expenditure was also in a similar range, at 5.6% for NGO spending, compared to 5.8% overall. Similar to its portion of overall DAH, MNCH received the second-largest share of NGO DAH. However, this health focus area received 11.3% of funds in 2011, a relatively smaller portion than MNCH DAH overall (20%). NGOs spent 2.9% on TB activities, which is also smaller than TB DAH on the whole (4.1%). Finally, with respect to NCDs, at 3%, the share of NGO spending on this health focus area is higher than the NCD share of total DAH, 1.2%.

MATERNAL, NEWBORN, AND CHILD HEALTH

The DAH disbursed to MNCH includes spending on vaccinations, antenatal, postnatal, and maternal care, and other expenditures vital to maintaining the health of children and mothers. The burden of disease associated with MNCH is highest in sub-Saharan Africa, where maladies such as diarrhea in children and complications associated with childbirth have a major impact on population health. South Asia, with its large, impoverished population, also suffers a high level of DALYs associated with these types of illnesses.

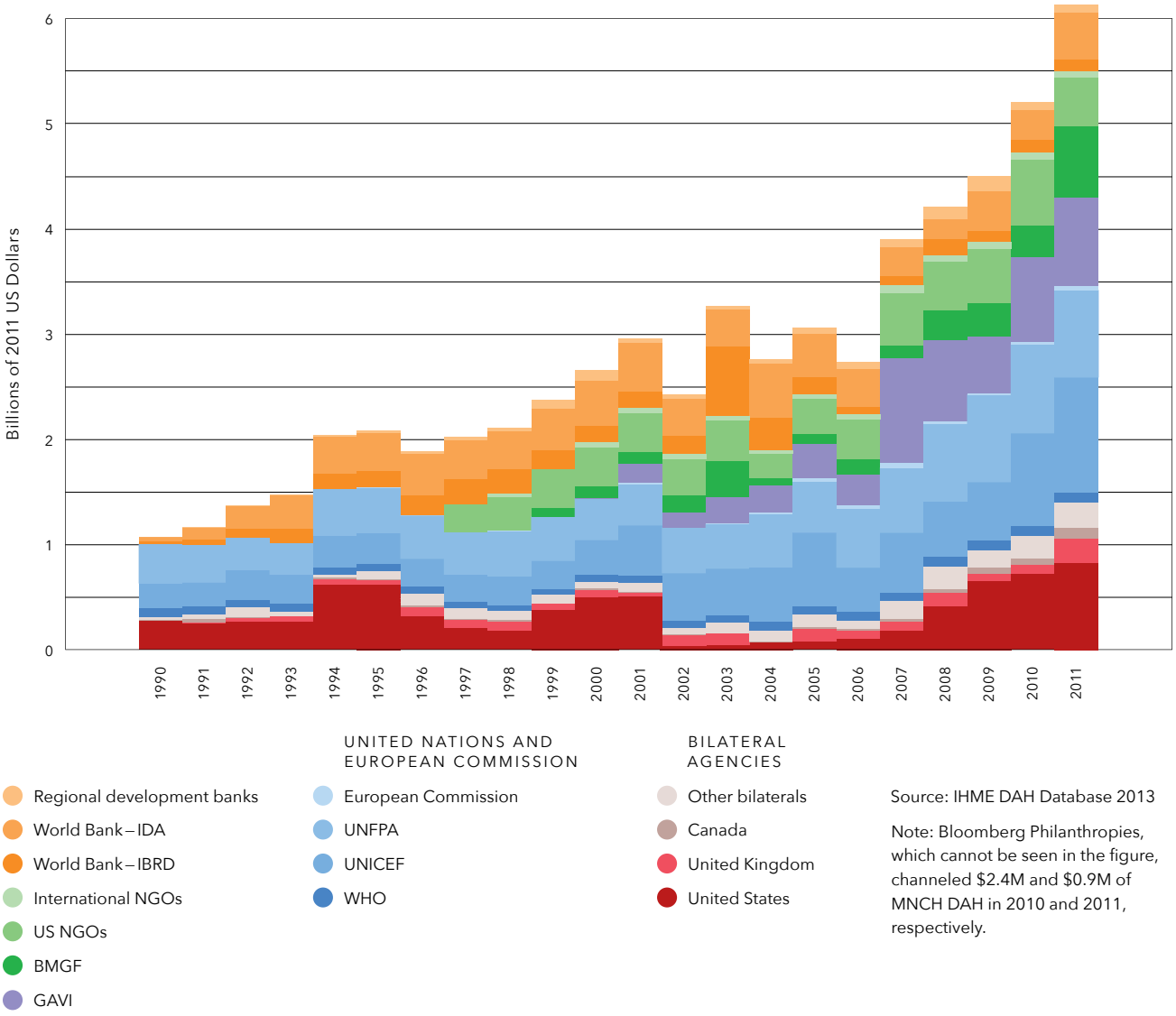
Across regions, major growth in spending on MNCH was key to bolstering the DAH total in 2011. Figure 14 depicts DAH for MNCH broken down by channel from 1990 to 2011. This shows that, unlike the mostly declining or stagnating major health focus areas, MNCH grew substantially from 2010 to 2011. Expenditure on this health focus area amounted to $6.1 billion in 2011. Total DAH for MNCH grew absolutely by $920 million over 2010 levels, a 17.7% increase. Despite its rapid growth, maternal, newborn, and child health spending per live birth remains just $51.

Major spending by a number of channels drove the growth in DAH for MNCH. UK and BMGF contributions were the primary sources of the increase in this health focus area. In 2010, UK bilateral assistance to MNCH amounted to just $88 million. By 2011, this had risen to $238 million, an immense 171% rise. BMGF also augmented disbursements to MNCH activities to a total of $674 million in 2011, an increase of 119% or $366 million. US bilateral and GAVI Alliance (GAVI) spending also contributed to the increase, growing 13.6% and 4.6%, respectively in 2011. US bilateral assistance amounted to $823 million in 2011, an increase of almost $100 million over 2010. With a rise of just under $40 million relative to 2010, GAVI's contribution was $841 million in 2011. The World Health Organization's (WHO) contribution remained relatively steady in 2011, with expenditure of $98 million, a 0.4% decrease over 2010 levels.

The 2011 growth in DAH for MNCH preceded a number of events in 2012 and 2013 that catalyzed additional funding for this health focus area. The London Summit on Family Planning, hosted jointly by BMGF and the UK Government, mobilized

FIGURE 14

DAH for maternal, newborn, and child health by channel of assistance, 1990–2011



Source: IHME DAH Database 2013

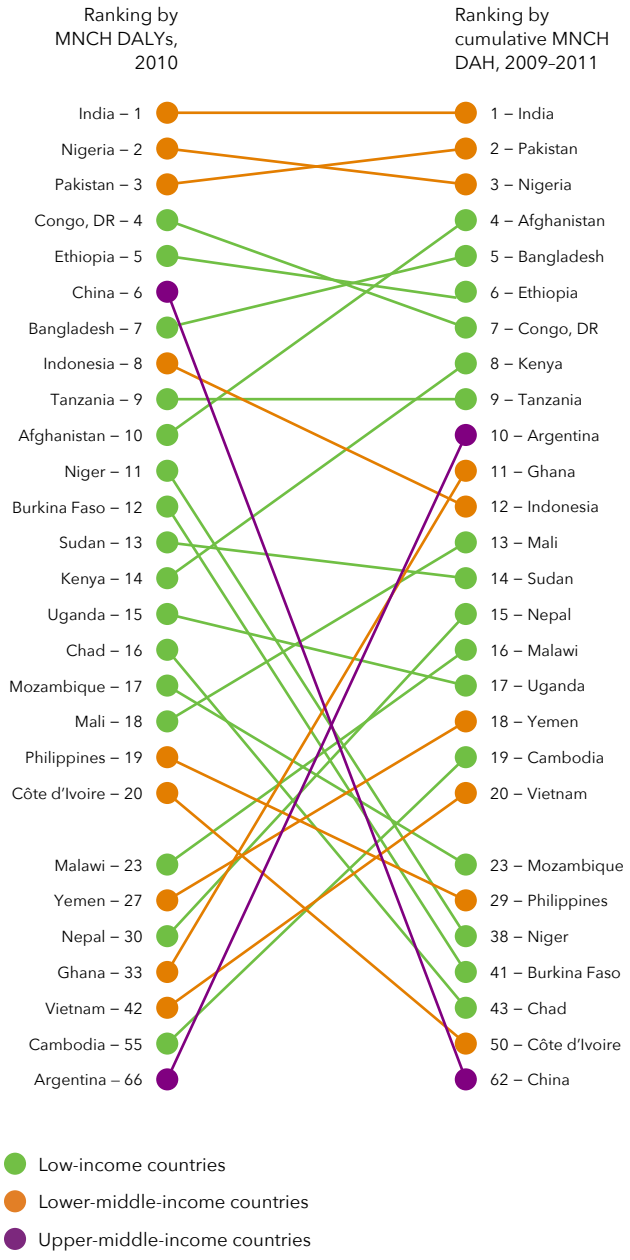
Note: Bloomberg Philanthropies, which cannot be seen in the figure, channeled $2.4M and $0.9M of MNCH DAH in 2010 and 2011, respectively.

commitments of more than $4.6 billion in 2012.[31] At the 2013 Global Vaccine Summit, donors pledged $4 billion, including reported contributions from the UK, Canada, Norway, the Abu Dhabi royal family, the Islamic Development Bank, and Germany.[32] Also in 2013, the Research Council of Norway's Global Health and Vaccination Research Program announced new funding for family planning and MNCH of approximately 244 million Norwegian kroner ($40 million US dollars).[33] These commitments signal the potential for further growth in MNCH in coming years.

Figure 15 shows that population and income status play a role in both DALYs and DAH in this health focus area. The largest low- and middle-income countries, China, India, Indonesia, Nigeria, and Pakistan, figure predominately in the list of maternal, newborn, and child health DALYs. These countries also are ranked prominently in the MNCH funding rankings. A notable absence is Brazil, the fifth-largest country by population, which does not bear a large number of maternal, newborn, and child health DALYs or receive substantial funding for MNCH. Besides these populous

FIGURE 15

Top 20 countries by 2010 maternal, newborn, and child health burden of disease versus cumulative 2009–2011 maternal, newborn, and child health DAH



Sources: IHME DAH Database 2013 and Global Burden of Disease Study 2010

countries, low-income countries are also present in these rankings, highlighting the relationship between income and MNCH burden.

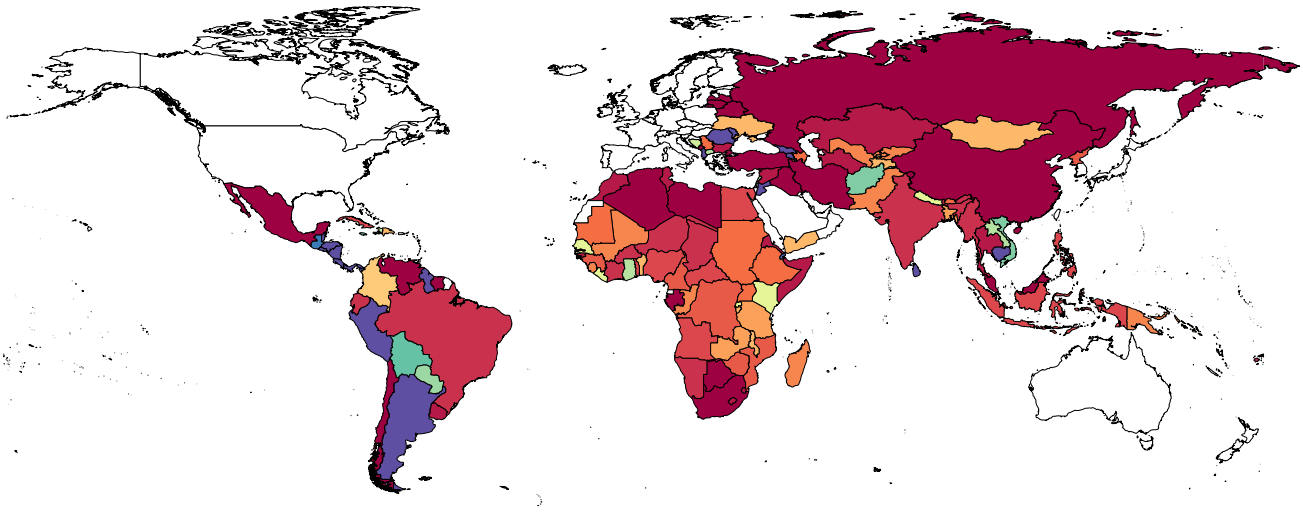
A number of countries are relatively well matched when comparing DAH for MNCH to maternal, newborn, and child health DALYs. India, Nigeria, and Pakistan all sit among the top three of both rankings. The maternal, newborn, and child health DALYs of the Democratic Republic of the Congo (DRC), Ethiopia, Bangladesh, and Tanzania are all ranked within four slots of their respective MNCH funding. Among the countries with the 10 highest DALYs, only China is outside of top DAH disbursements. It is also the only upper-middle-income country on the maternal, newborn, and child health DALYs list. Imbalances are more apparent in the 11th through 20th positions. One upper-middle income country, Argentina, makes an appearance as one of the largest recipients of DAH for MNCH, above a number of populous low- and lower-middle-income countries.

Examining the MNCH assistance per corresponding DALY, as displayed in Figure 16, reveals that a few countries receive substantially more than the vast majority of countries. Argentina, Peru, as well as a number of countries in Central America, the Middle East, and Eastern Europe, received more than $75 per maternal, newborn, and child health DALY. Conversely, more than 35 countries received less than $5 in DAH per maternal, newborn, and child health DALY. Thus, while DAH for this health focus area underwent expansion over 2010–2011, much MNCH burden remains unaddressed.

Trends over time, as shown in Figure 17, reveal that the Latin America and Caribbean region tops DAH per DALY for maternal, newborn, and child health when examined over the 2006–2010 period. Across this timespan, the region received more than $60 per maternal, newborn, and child health DALY. Growth from the 1991–1995 period to the 2006–2010 period amounted to 314%. Major reductions in MNCH burden coupled with the investments of the Pan American Health Organization (PAHO) and others drove this major growth.[34] This sharp uptick in DAH per DALY for maternal, newborn, and child health in this region is unlike the pattern in any other region, where minor growth or stagnation is present over time. Notably, South Asia and sub-Saharan Africa received some of the lowest maternal, newborn, and child health DAH per DALY, at less than $20 over the 2006–2010 period. This rate has not grown much over time for either region, driven more by increases in DALYs than lack of spending on MNCH.

FIGURE 16

Maternal, newborn, and child health DAH, 2009–2011, per related DALY, 2010

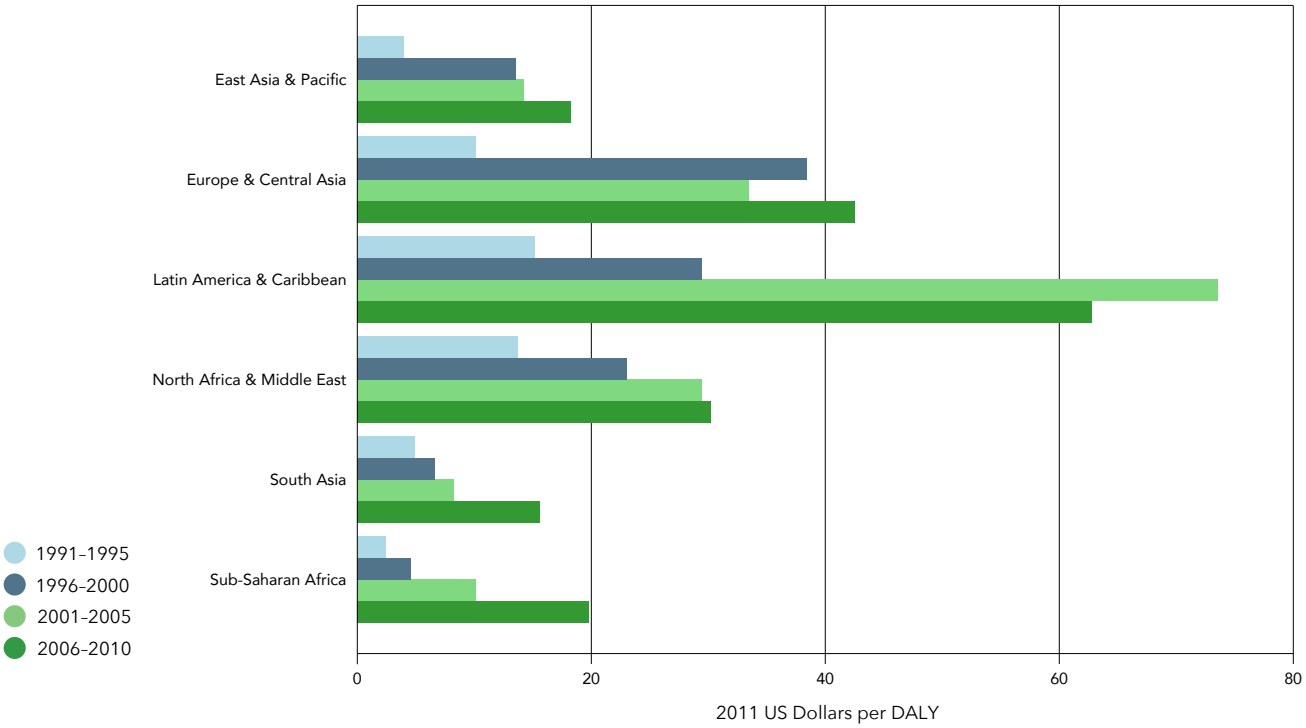


Sources: IHME DAH Database 2013 and Global Burden of Disease Study 2010

Notes: 2010 DALY estimates are from the Global Burden of Disease Study 2010. Countries that were ineligible for DAH based on their World Bank income classification are shown in white. DAH received is shown in real 2011 US dollars.

FIGURE 17

Maternal, newborn, and child health DAH over five-year periods per related DALY, by region, 1991–2010

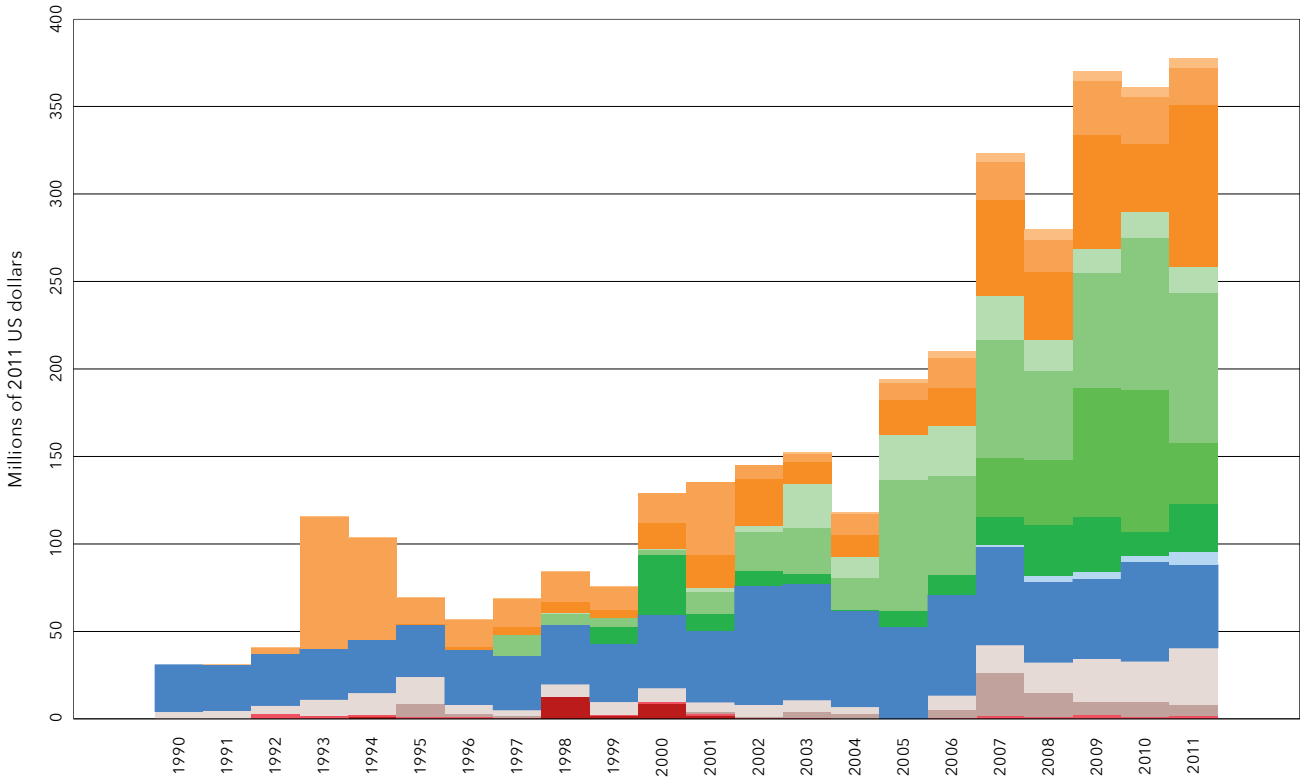


Sources: IHME DAH Database 2013 and Global Burden of Disease Study 2010

Note: The bars represent cumulative DAH over each five-year period.

FIGURE 18

DAH for non-communicable diseases by channel of assistance, 1990–2011



UNITED NATIONS AND EUROPEAN COMMISSION

- European Commission
- WHO

BILATERAL AGENCIES

- Other bilaterals
- Canada
- United Kingdom
- United States

- Regional development banks
- World Bank–IDA
- World Bank–IBRD
- International NGOs
- US NGOs
- Bloomberg
- BMGF

Source: IHME DAH Database 2013

NON-COMMUNICABLE DISEASES

NCDs are on the rise in low- and middle-income countries. Diabetes, heart disease, cancers, and other illnesses increasingly affect population health in these areas. Some organizations are beginning to make NCDs a priority. In 2013, the WHO announced it would increase spending on NCDs by 20.5%.[29] The NCD Alliance, launched in 2009, has mobilized more than 2,000 organizations to put NCDs on the global health agenda.[35] These efforts augur well for future increases in NCD spending. However, across the developing world, internationally supported activities related to these health issues have not kept pace with growing need. Assistance for NCDs remains a small part of DAH overall.

In 2011, DAH for NCDs grew, although the increase remained small relative to DAH on the whole. As depicted in Figure 18, DAH for NCDs, inclusive of spending on tobacco control, amounted to over $377 million in 2011, an increase of 4.6% over 2010. This made up 1.2% of total DAH in 2011.

A wide range of organizations provide DAH to prevent and treat NCDs. However, in 2011, overall funding for NCDs was sustained by a few key actors. Increases in

expenditure by the International Bank for Reconstruction and Development (IBRD) on this health focus area were vital to maintaining NCD spending. Since 2007, IBRD has been a major player in this field, but by 2011 its contributions had grown to 24.5% of total NCD spending. IBRD contributed $93 million to NCDs in 2011, a $54 million increase over 2010. Spending by international and US-based NGOs was effectively level over 2010–2011. Together, these organizations spent just over $100 million on this health focus area in 2011, which was a slight, 1.2% decrease over 2010 expenditure on NCDs.

Select channels, however, experienced major contractions in NCD spending. Notably, the Bloomberg Philanthropies, which has historically been a major supporter of tobacco control (discussed below), reduced its spending considerably in 2011. Bloomberg provided $35 million, 9.2% of total DAH for NCDs, in 2011. This was a major decrease over spending of $81 million in 2010. The WHO's contributions to NCD assistance also decreased in 2011. Although the organization has been a consistent supporter of NCD efforts, in 2011 the WHO provided $47 million, a drop of 16.8% over 2010 levels of DAH for NCDs.

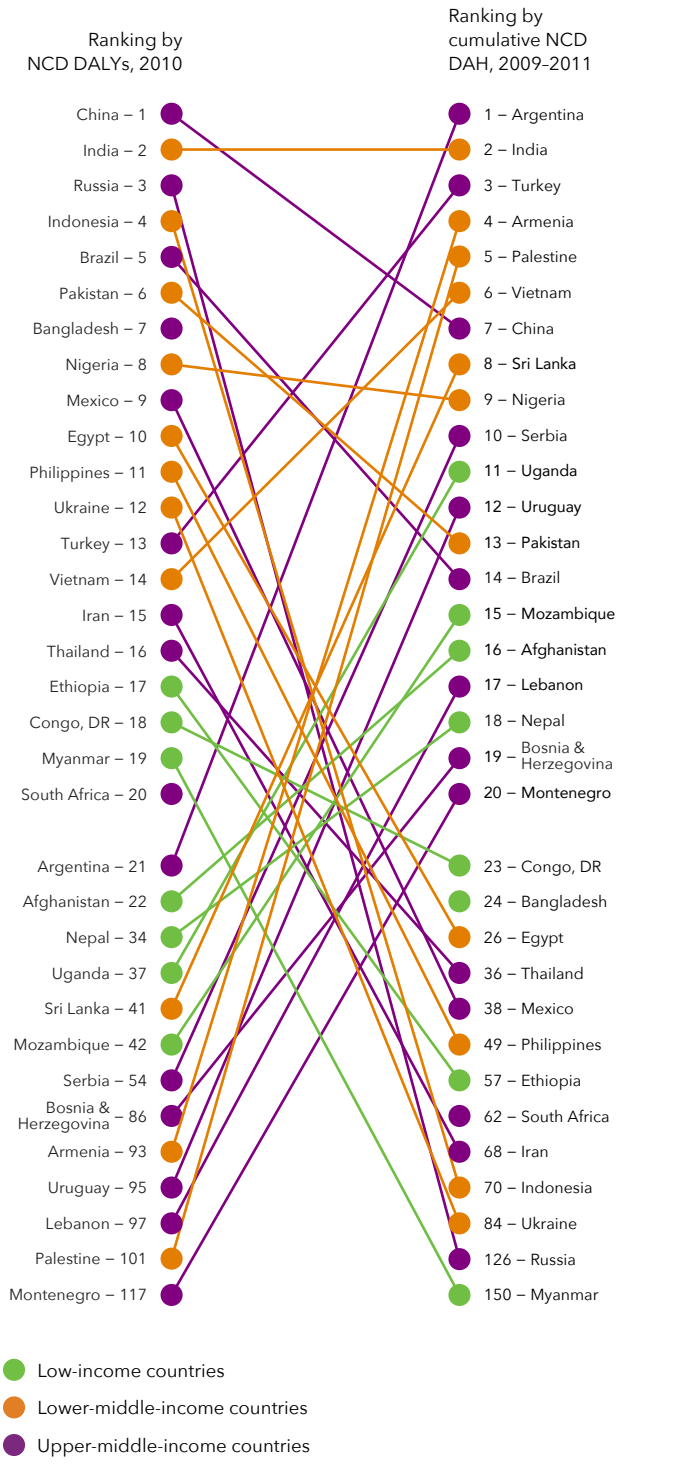
Figure 19 shows that disbursements for NCDs and the DALYs associated with this disease grouping are not well aligned. Of the top 20 recipients of cumulative DAH for NCDs, only seven are among the countries with the top 20 DALYs. Furthermore, income does not appear to play a role in DAH disbursements for this health focus area. Only four low-income countries are among the top 20 recipients of DAH for NCDs. Middle-income countries are widely present across both DALYs and cumulative DAH rankings. India and Nigeria stand apart as two countries that have well-matched DALYs and DAH. India is second on both the DALYs and DAH lists. Nigeria has the eighth-largest disease burden and receives the ninth-highest cumulative DAH.

Exploring DAH per DALY for NCDs, as shown in Figure 20, reveals the low level of investment in this area relative to disease burden. Although DAH per DALY for NCDs reaches more than $1 in some countries, this remains much less than MNCH, HIV/AIDS, or malaria DAH per DALY. The countries receiving the highest DAH per DALY in this health focus area are diverse across regions and income groupings. Argentina, Bolivia, Costa Rica, Nicaragua, Mongolia, Mozambique, Turkey, Uganda, and a number of other countries received substantial amounts of DAH per DALY for NCDs.

Figure 21 also displays the trends in DAH per DALY associated with NCDs over time and by region. The

FIGURE 19

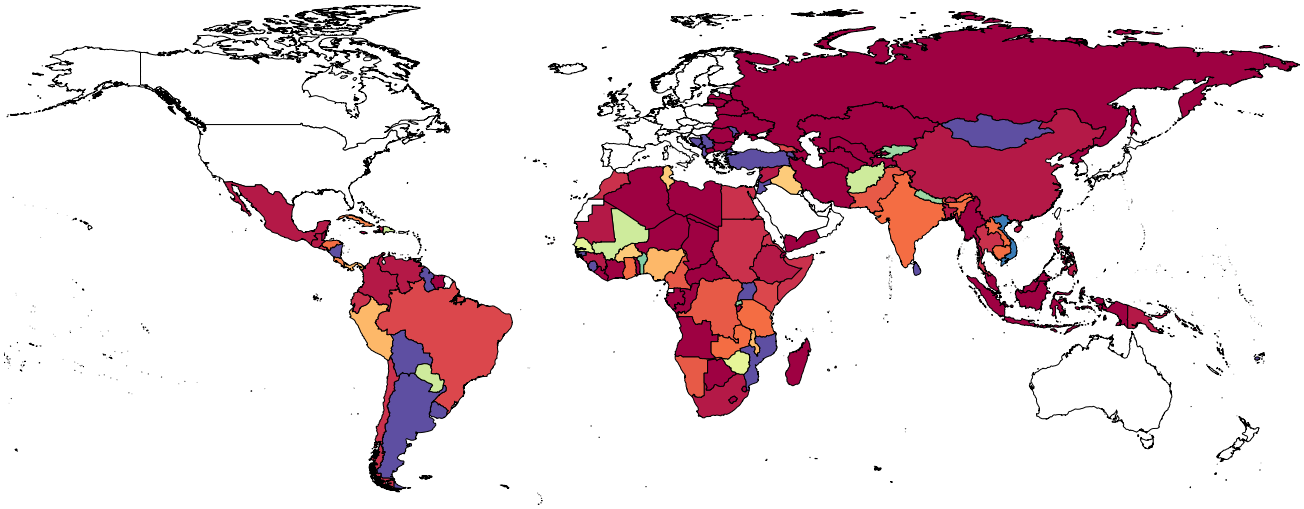
Top 20 countries by 2010 non-communicable burden of disease versus cumulative 2009–2011 non-communicable disease DAH



Sources: IHME DAH Database 2013 and Global Burden of Disease Study 2010

FIGURE 20

Non-communicable disease DAH, 2009–2011, per related DALY, 2010

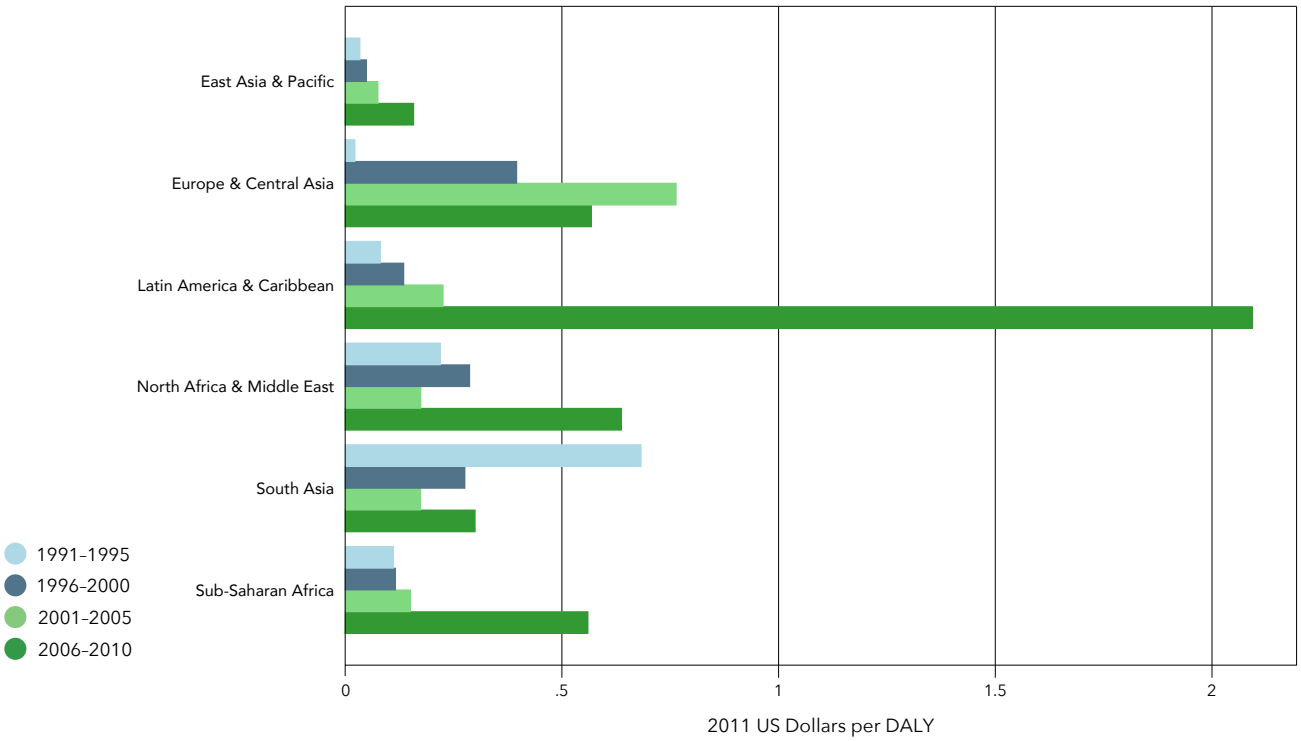


Sources: IHME DAH Database 2013 and Global Burden of Disease Study 2010

Notes: 2010 DALY estimates are from the Global Burden of Disease Study 2010. Countries that were ineligible for DAH based on their World Bank income classification are shown in white. DAH received is shown in real 2011 US dollars.

FIGURE 21

Non-communicable disease DAH over five-year periods per related DALY, by region, 1991–2010

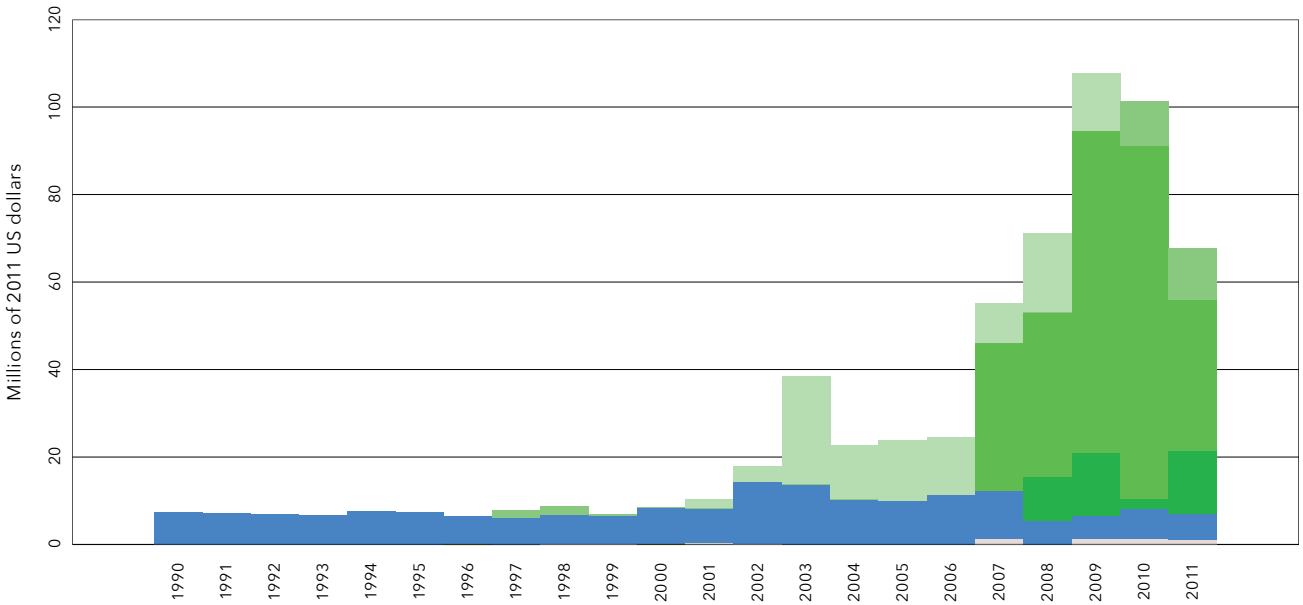


Sources: IHME DAH Database 2013 and Global Burden of Disease Study 2010

Note: The bars represent cumulative DAH over each five-year period.

FIGURE 22

DAH for tobacco control by channel of assistance, 1990–2011



Source: IHME DAH Database 2013

Latin America and the Caribbean region received above and beyond the highest DAH per DALY for NCDs. Cumulative disbursements per DALY over 2006–2010 were drastically higher than the 2001–2005 period, mostly fueled by a push by PAHO. In 2006, PAHO launched a widespread initiative to combat NCDs, entitled the Regional Strategy and Plan of Action on Chronic Diseases. It also established the Collaborative Action for Risk Factor Prevention and Effective Management of NCD.[36] East Asia and Pacific, with a large population and rapidly growing economies, has consistently received some of the lowest DAH per DALY for NCDs. The region has not received more than 16 cents per DALY over the entire two-decade period highlighted.

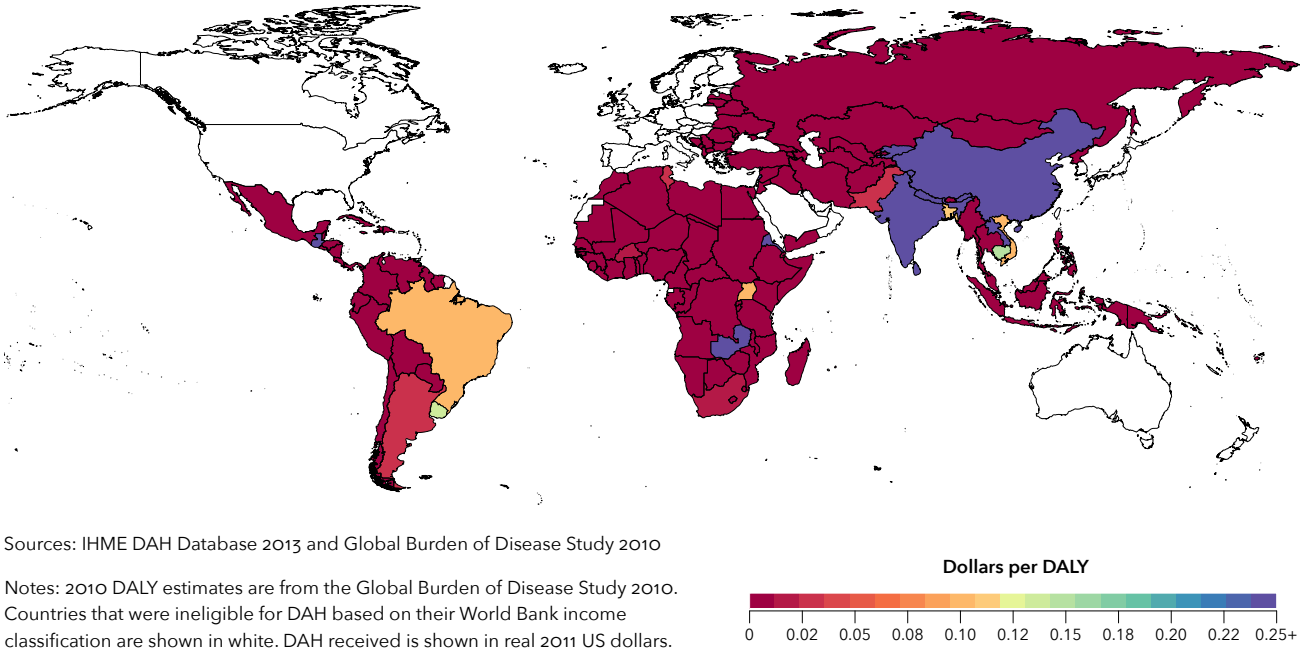
TOBACCO

To drill further into expenditure on NCDs, the DAH allocated to international efforts to control tobacco is featured in *Financing Global Health 2013*. Tobacco use is a highly preventable but growing risk factor and contributes to a substantial amount of burden in low- and middle-income countries, particularly among men. Although tobacco control receives widespread political support, the breadth of funding is still small.

Figure 22 displays the share of DAH for NCDs allocated to tobacco control, which amounted to 18% of total DAH for NCDs in 2011. In 2011, DAH for tobacco control amounted to just under $68 million. As Figure 22 highlights, the Bloomberg Philanthropies commits by far the most on tobacco control among development assistance partners. Established in 2004, Bloomberg Philanthropies has contributed more than $260 million to this area of global health since its inception. Its contributions appear to have peaked in 2010 at $81 million, although in 2011, Bloomberg spending on tobacco control still amounted to $35 million, 51.1% of total tobacco DAH. The foundation works across more than 40 developing countries, where investments

FIGURE 23

Tobacco DAH, 2009–2011, per related DALY, 2010



Sources: IHME DAH Database 2013 and Global Burden of Disease Study 2010

Notes: 2010 DALY estimates are from the Global Burden of Disease Study 2010. Countries that were ineligible for DAH based on their World Bank income classification are shown in white. DAH received is shown in real 2011 US dollars.

range from supporting the passage of legislation to developing tobacco-use monitoring systems.[37]

The WHO has also been a major player in the field of tobacco control, with consistent contributions to this area of global health since 1990. In 2011, WHO spending amounted to $6 million or 8.7% of DAH for tobacco control. The WHO implements various programs to curb tobacco use in developing countries and also serves as the shepherd of the Framework Convention on Tobacco Control, organizing convention summits, supporting research and development, and pushing forward new accords, such as the 2012 Protocol to Eliminate Illicit Trade in Tobacco Products.[38]

BOX 2

Tobacco use

January 2014 marks the 50th anniversary of the US Surgeon General's Report on Smoking and Health, one of the benchmark declarations on the negative health effects of smoking.[39] The World Health Organization's Framework Convention on Tobacco Control (FCTC) has also been in effect for 10 years. The FCTC was the first binding international agreement focused on a chronic, non-communicable disease. Notably, the FCTC is one of the most highly and rapidly signed and ratified conventions—only 10 UN member states have not signed this international treaty.

Despite these and other major pushes to curb smoking, recent research has found that the number of smokers worldwide continues to grow. There are 282 million smokers in China alone, with an estimated 739 million daily smokers across all low- and middle-income countries. Further investments in education and other public health measures could reduce daily smoking and prevent the illnesses associated with a risk factor that has diminished substantially in many countries.

In addition to the low level of funding disbursed, development assistance for tobacco control is very low relative to the DALYs associated with this risk factor. In 2010, 5.3% of all DALYs in low- and middle-income countries were attributable to tobacco use.[40] However, tobacco DAH per DALY at the country level remains the lowest among all of the health focus areas highlighted. At its highest, tobacco DAH per DALY is approximately 25 cents.

The range of DAH per DALY is portrayed in Figure 23. This map shows that investments are concentrated. The bulk of efforts are focused on a few places dispersed across income levels and regions. Notably, two middle-income countries, China and India, received some of the highest tobacco DAH per DALY, in addition to Zambia, Nepal, Eritrea, Guatemala, and a few other low-income countries.

Figure 24 further illuminates the imbalance between tobacco DAH and DALYs, underpinned by trends related to region and income. With the exception of China, India, and Bangladesh, none of the countries with the highest tobacco DALYs received the highest DAH related to tobacco. Many of the countries with the highest tobacco DALYs are located in South and East Asia. Not a single sub-Saharan African country is included in the DALY rankings. Furthermore, few low-income countries are among those with top tobacco DALYs and DAH. As gross domestic product rises, smoking tends to increase as individuals have more disposable income to spend on cigarettes, chewing tobacco, and other tobacco products.[41] Smoking rates tend to level off, however, as countries graduate to high-income status.

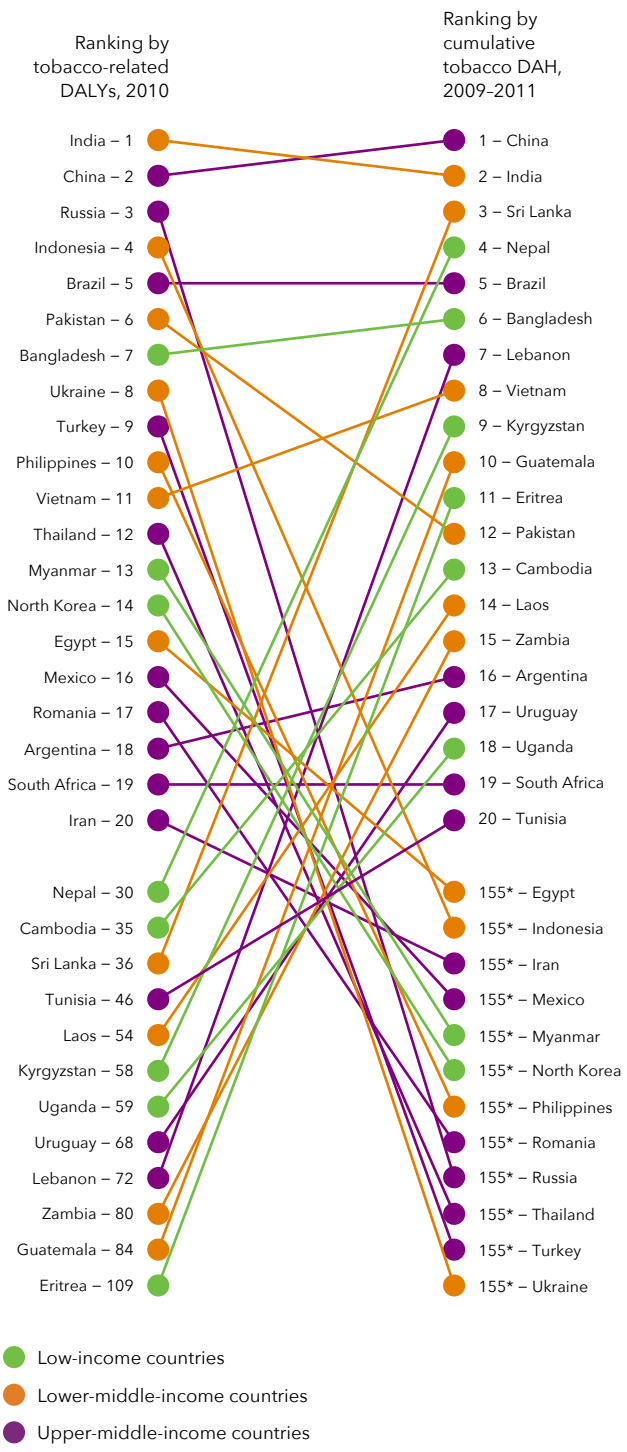
HIV/AIDS

HIV/AIDS was the fifth-leading cause of DALYs in 2010. The burden of HIV/AIDS is concentrated in sub-Saharan Africa; however, 20% of total burden is found in countries where the disease is not among the top 10 causes of DALYs. Recent estimates show that the epidemic peaked in 2005 and has been dropping worldwide since.[42] DAH for HIV/AIDS contributed to these declines in burden by supporting HIV/AIDS services across the globe, including substantial backing for the purchase of antiretroviral drugs in low- and middle-income countries. The upholding of a substantial level of expenditure into 2011 is indicative of the wide international support associated with this major global health issue.

Among health focus areas, HIV/AIDS continued to receive the most substantial funding. In 2011, DAH for

FIGURE 24

Top 20 countries by 2010 tobacco burden of disease versus cumulative 2009–2011 tobacco DAH

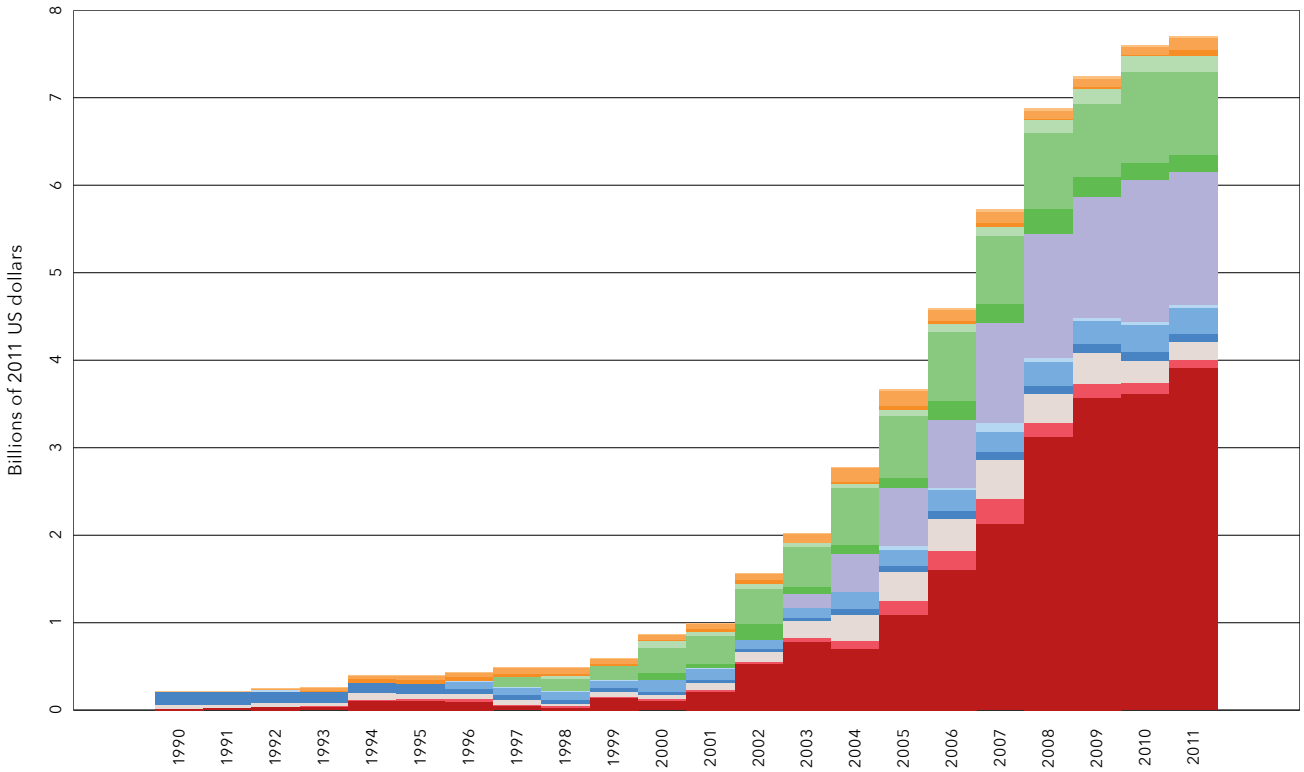


Sources: IHME DAH Database 2013 and Global Burden of Disease Study 2010

*Countries that received $0 DAH for tobacco from 2009–2011 are labeled as 155th rank, as they are tied for receiving the least amount of DAH targeted for tobacco control.

FIGURE 25

DAH for HIV/AIDS by channel of assistance, 1990–2011



- Regional development banks
- World Bank – IDA
- World Bank – IBRD
- International NGOs
- US NGOs
- BMGF
- GFATM

UNITED NATIONS AND EUROPEAN COMMISSION

- European Commission
- UNAIDS
- WHO

BILATERAL AGENCIES

- Other bilaterals
- United Kingdom
- United States

Source: IHME DAH Database 2013

HIV/AIDS reached $7.7 billion, 25.1% of total development assistance for health expenditure. Much like total DAH, HIV/AIDS spending growth from 2010 to 2011 was minor. DAH for this health focus area increased an estimated $94 million over 2010 levels; as shown in Figure 25, the US government and GFATM were the largest contributors.

In 2011, US bilateral agencies boosted their support for HIV/AIDS with a substantial increase of $301 million, contributing a total of $3.9 billion to HIV/AIDS. The US's commitment to this area of global health appears to be robust. GFATM support included in the US fiscal year 2014 budget request was the area of greatest growth in US global health aid.[43]

Backing from GFATM, which is the second-biggest contributor to HIV/AIDS DAH, dropped slightly from 2010 to 2011. In 2011, Global Fund disbursements amounted to an estimated $1.5 billion. As GFATM has revamped its funding and monitoring structure, the dip of 7.1% was not unexpected. However, HIV/AIDS funding may grow in future years, as the GFATM financing cycle re-gears. Furthermore, substantial commitments from OECD governments to GFATM were announced in 2012 and 2013.

Other HIV/AIDS channels stayed level or dropped in 2011. US-based NGOs spent an estimated $940 million on HIV/AIDS, an 8.9% decrease. UK bilateral aid shrank slightly, to $88 million. The Joint United Nations Programme on HIV/AIDS (UNAIDS), the main UN body dedicated to this health focus area, was also more or less stagnant, with a decrease of 2.1% and total spending reaching $302 million in 2011.

Across channels of support, the international community appears to be fairly responsive to the HIV/AIDS burden, as 14 countries feature in the top 20 of both 2010

DALYs and 2009–2011 cumulative DAH. As shown in Figure 26, economic profile does not seem to affect HIV DAH disbursement in the same manner it affects DAH disbursement for other health focus areas. Eleven of the top 20 DAH recipients are classified as low-income by the World Bank.

At more than $300 per DALY in some countries, the DAH per DALY deployed for HIV/AIDS is highest among all health focus areas IHME tracks. The now-shrinking global HIV/AIDS epidemic continues to be concentrated in certain countries in sub-Saharan Africa. Figure 27 highlights Namibia and Botswana as among the countries that receive upward of $300 per DALY. A number of other countries, including Mongolia, Papua New Guinea, Yemen, and Guyana, receive substantial HIV/AIDS DAH per DALY as well.

However, some of the countries with the highest HIV/AIDS burden receive low levels of DAH per DALY. Despite ample funding, disease burden surpasses even substantial DAH investments in some areas. South Africa, Tanzania, Nigeria, and Mozambique suffered from the top-five highest HIV/AIDS burdens. These countries also received among the highest HIV/AIDS DAH. Nonetheless, the high level of disease burden translates into DAH per DALY of less than $40 in these countries, as shown in Figure 27.

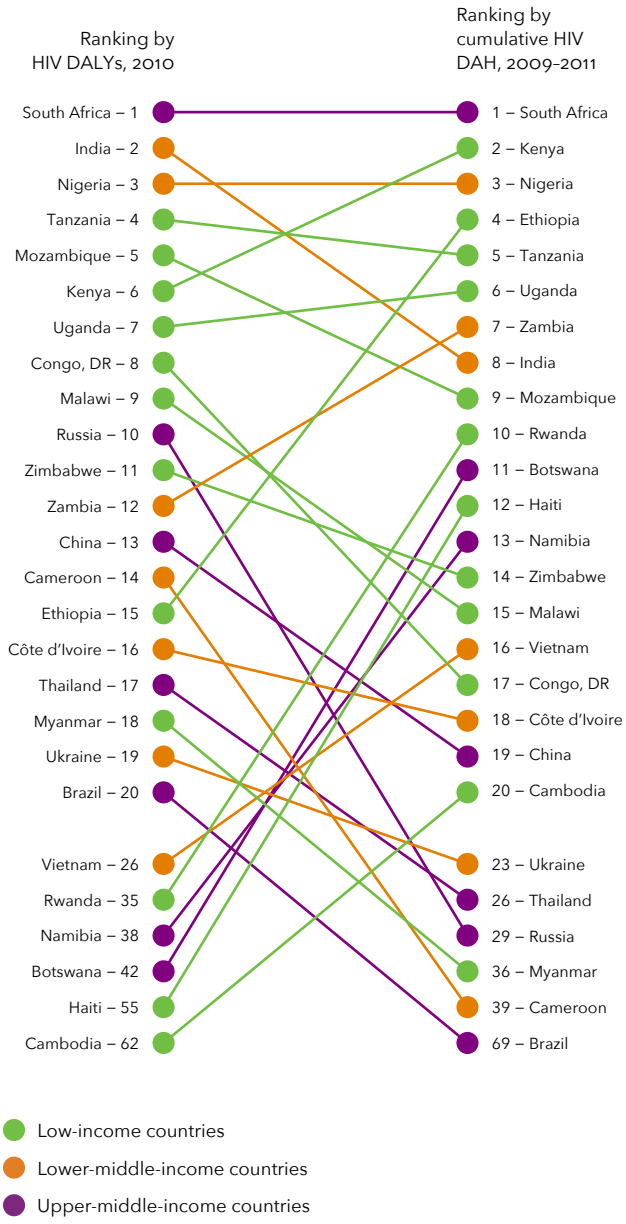
Furthermore, trends over time and across regions show that sub-Saharan Africa on the whole still receives some of the lowest DAH per DALY, at $291 from 2006–2010. As depicted in Figure 28, this rate has expanded over time but still falls far behind the DAH per DALY values observed in North Africa and the Middle East and Latin America and the Caribbean, both of which exceeded $400 cumulatively over 2006–2010. Although at much lower levels of spending, the Europe and Central Asia region and South Asia alone received DAH per DALY amounting to $255 and $138, respectively.

TUBERCULOSIS

HIV-positive individuals are more likely to develop TB, which is increasingly more difficult and costly to treat as multidrug-resistant and extensively drug-resistant strains emerge. The rise in prevalence of HIV/AIDS and TB is not uniform in magnitude and geographic scope, however. Furthermore, TB DAH has not kept pace with HIV/AIDS funding. Figure 29 shows that, following five years of rapid growth, international expenditure on TB declined from 2010 to 2011. TB DAH underwent a 9.8%

FIGURE 26

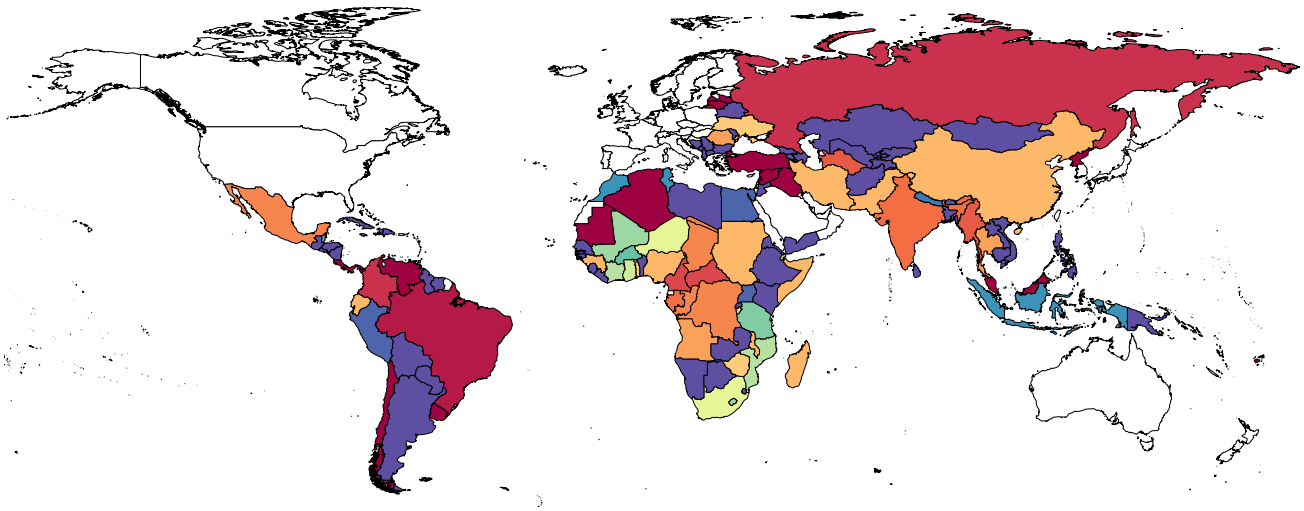
Top 20 countries by 2010 HIV/AIDS burden of disease versus cumulative 2009–2011 HIV/AIDS DAH



Sources: IHME DAH Database 2013 and Global Burden of Disease Study 2010

FIGURE 27

HIV/AIDS DAH, 2009–2011, per related DALY, 2010

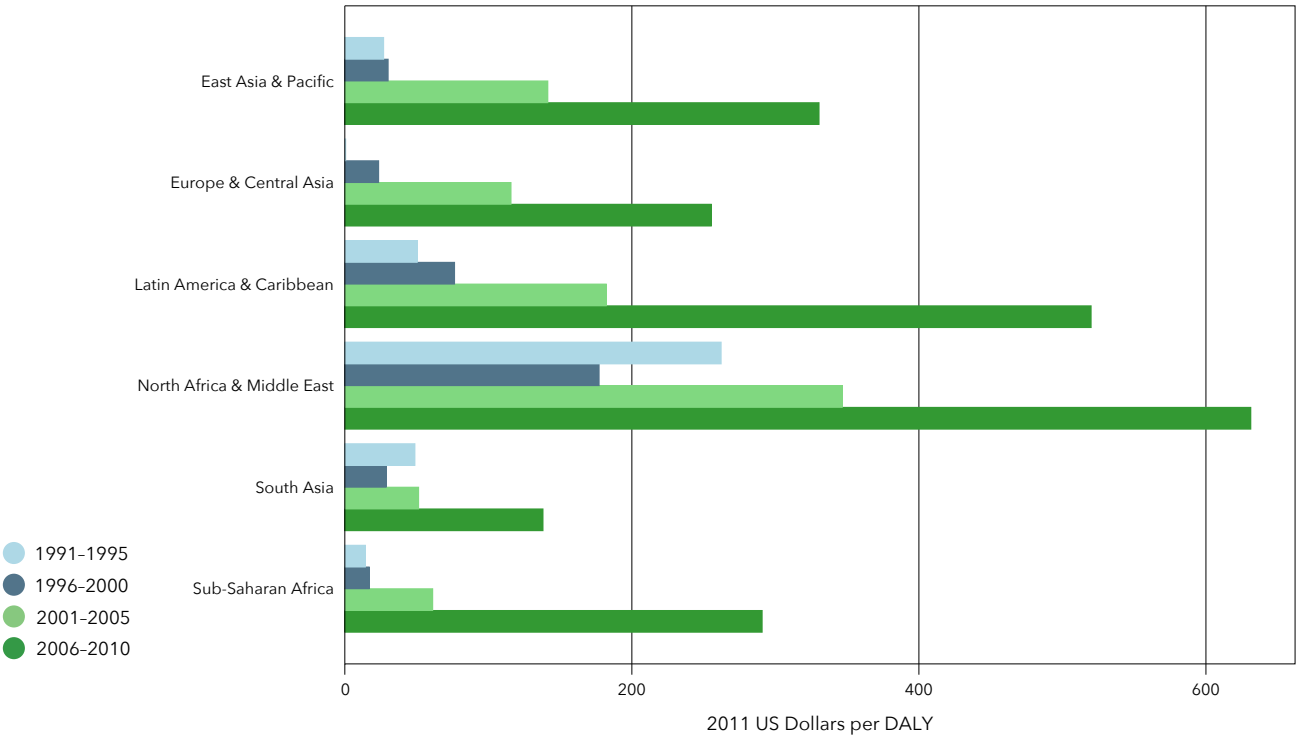


Sources: IHME DAH Database 2013 and Global Burden of Disease Study 2010

Notes: 2010 DALY estimates are from the Global Burden of Disease Study 2010. Countries that were ineligible for DAH based on their World Bank income classification are shown in white. DAH received is shown in real 2011 US dollars.

FIGURE 28

HIV/AIDS DAH over five-year periods per related DALY, by region, 1991–2010

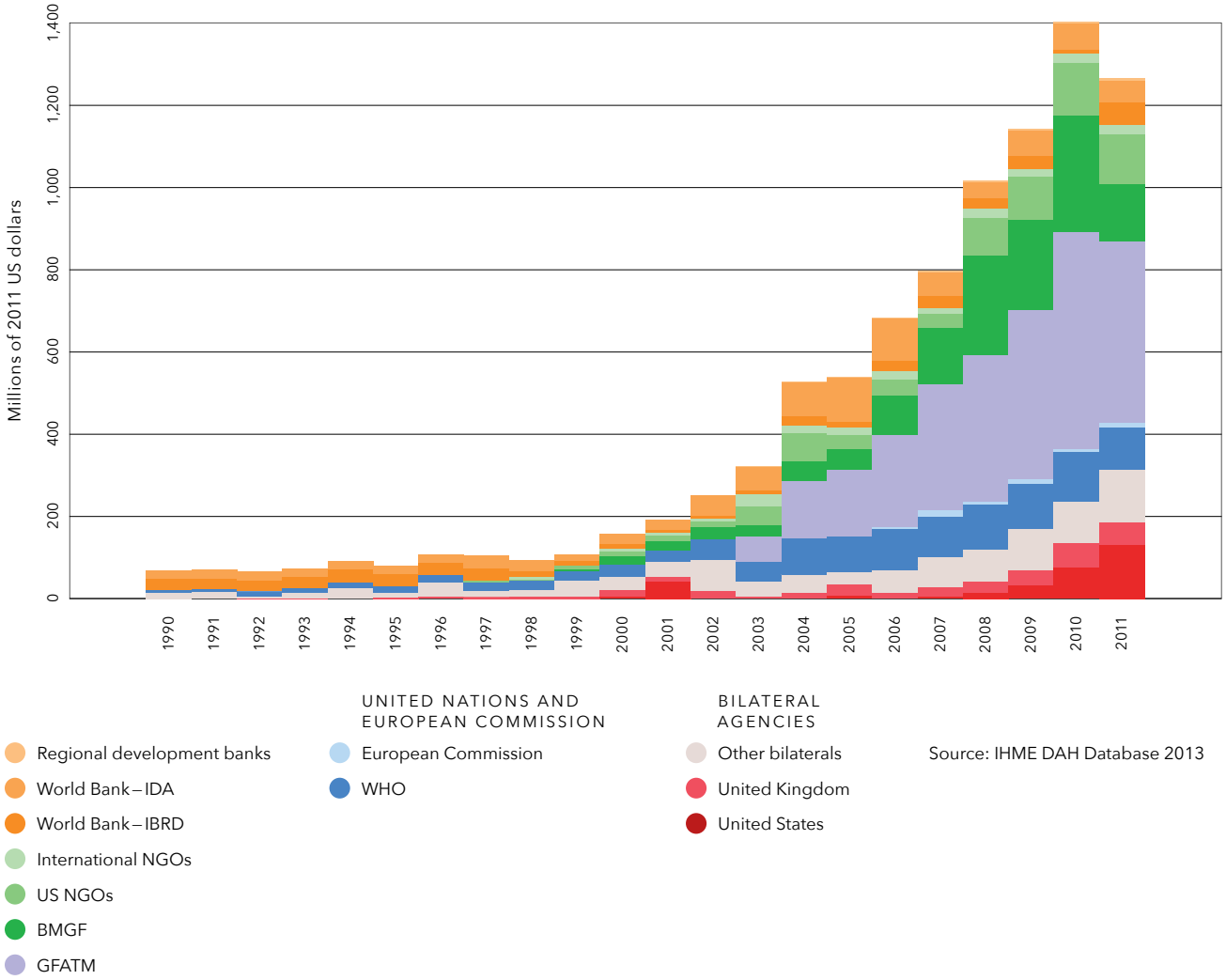


Sources: IHME DAH Database 2013 and Global Burden of Disease Study 2010

Note: The bars represent cumulative DAH over each five-year period.

FIGURE 29

DAH for tuberculosis by channel of assistance, 1990–2011



Source: IHME DAH Database 2013

contraction in 2011, amounting to a drop of $138 million relative to 2010. Total DAH for this health focus area came in at $1.3 billion in 2011, putting spending far from the WHO's target of approximately $2 billion in TB financing annually over 2013–2015.[44]

The drop is due to decreases in financing provided by core TB development assistance partners in 2011, as shown in Figure 29. As the major funder of the fight against TB, GFATM's decrease in expenditure drove the overall reduction in TB DAH. Its TB DAH fell from a high of $529 million in 2010 to $440 million in 2011, a 16.8% decrease. Again, however, Global Fund investments are expected to rebound in 2012 and 2013. Another notable drop was observed in the funds provided by BMGF. In 2010, BMGF funds for TB were an estimated $283 million. By 2011, $140 million was provided by BMGF.

A sharp decrease in TB DAH was avoided mainly because of a major expansion in US bilateral assistance. US DAH for TB rose substantially over 2010 levels. In 2011, 69.5% growth in US bilateral assistance for tuberculosis resulted in $131 million in DAH disbursed for this health focus area.

FIGURE 30

Top 20 countries by 2010 tuberculosis burden of disease versus cumulative 2009–2011 tuberculosis DAH

Sources: IHME DAH Database 2013 and Global Burden of Disease Study 2010

Figure 30 shows that TB DAH as well as DALYs span income levels and regions. While the majority of countries with the highest TB DALYs are low- or lower-middleincome, China, Russia, and South Africa stand out as upper-middle-income countries on the list. On the financing side, multiple upper-middle-income countries receive substantial amounts of DAH for TB. China is ranked second, as it received the second-most absolute DAH focused on TB over 2009–2011. Four other upper-middle-income countries received enough TB DAH to be listed: Argentina, Kazakhstan, Thailand, and Peru.

Figure 31 presents DAH and DALYs together, encapsulating the relationship between burden and development assistance for TB. Efforts to reduce tuberculosis DALYs, as represented by TB DAH per DALY, take place in a wide range of countries. Notably, South America, Central and East Asia, and certain countries in Southern Africa receive levels of TB DAH per DALY of more than $100. In other parts of sub-Saharan and North Africa, as well as in India, TB DAH disbursements are not as high.

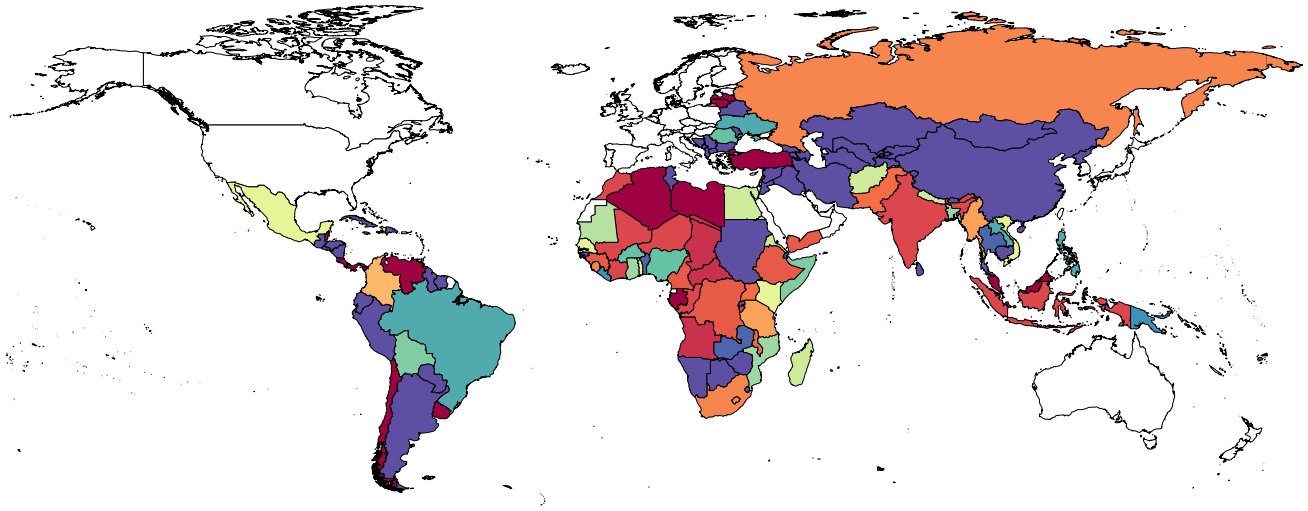
As shown in Figure 32, TB DAH per DALY has almost uniformly grown across regions and time. Levels have increased most substantially in Europe and Central Asia, due largely to the investments of neighboring countries. Latin America and the Caribbean also benefited greatly over the 2006–2010 period. Multidrug-resistant TB has been of concern in this region, and much of the funding has focused on combating this quickly evolving strain of the disease, although its growth in China, India, and Russia is also of note.[45] Sub-Saharan Africa and East Asia and the Pacific have historically received lower levels of TB DAH per DALY, although both received more than $50 cumulatively from 2006–2010. The lower rates are tied to the high level of DALYs in these regions, which even when combined with substantial levels of DAH, convert into lower levels of DAH per respective DALY.

MALARIA

Malaria is another key focus of international efforts to combat infectious diseases. GFATM, BMGF, and the US have, in particular, expanded support for this global health focus area since 2000. Malaria is the fourth leading cause of DALYs in low- and middle-income countries but is most pronounced in sub-Saharan Africa, where *Plasmodium falciparum* affects millions of

FIGURE 31

Tuberculosis DAH, 2009–2011, per related DALY, 2010

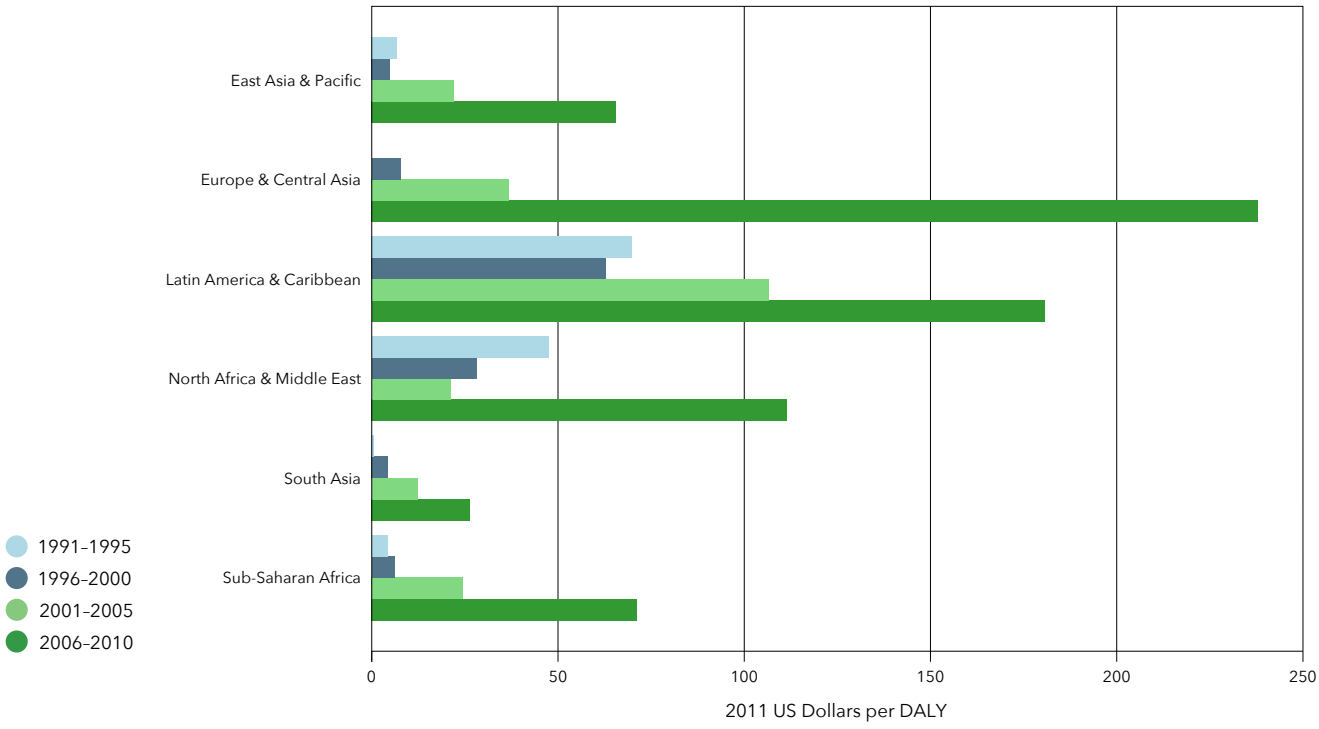


Sources: IHME DAH Database 2013 and Global Burden of Disease Study 2010

Notes: 2010 DALY estimates are from the Global Burden of Disease Study 2010. Countries that were ineligible for DAH based on their World Bank income classification are shown in white. DAH received is shown in real 2011 US dollars.

FIGURE 32

Tuberculosis DAH over five-year periods per related DALY, by region, 1991–2010

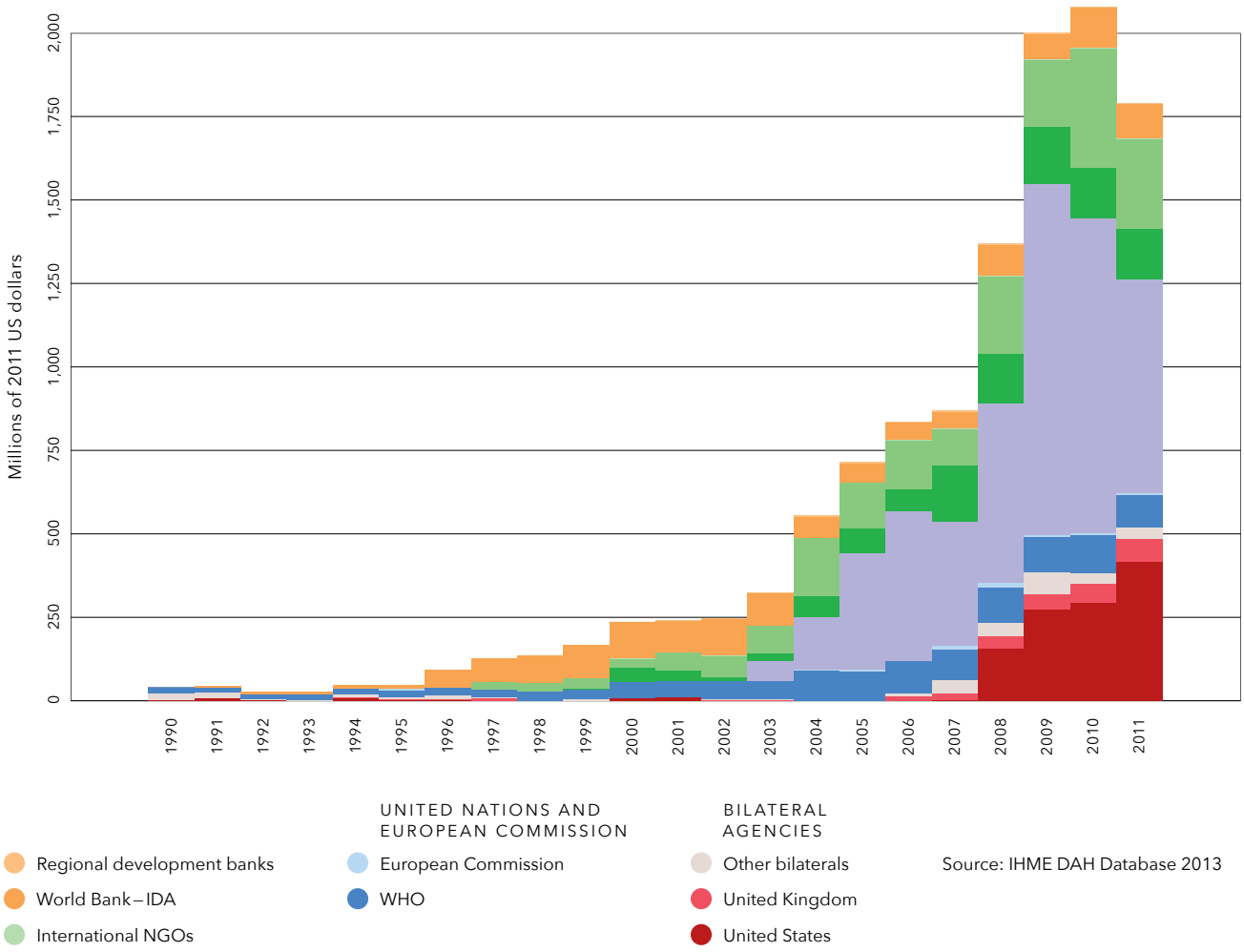


Sources: IHME DAH Database 2013 and Global Burden of Disease Study 2010

Note: The bars represent cumulative DAH over each five-year period.

FIGURE 33

DAH for malaria by channel of assistance, 1990–2011



children and adults annually.[46,47] Outside sub-Saharan Africa, where the disease burden is lower but still present, different strains of malaria, mostly *Plasmodium vivax*, are the leading causes of infection. Development assistance supports a number of activities designed to combat the disease, including the provision of artemisinin-based combination therapies, rapid-diagnostic testing, the distribution of insecticide-treated nets, and indoor residual spraying.

Much like the DAH disbursed for TB, the DAH allocated to malaria declined between 2010 and 2011. At its peak in 2010, malaria DAH was as high as $2.1 billion. By 2011, malaria DAH had decreased 13.9% from that point, with a sum of $1.8 billion disbursed in that year. Despite making up 5.8% of DAH, malaria DAH falls short of the $5.1 billion target for annual financing established in the 2008 Global Malaria Action Plan.[48]

As shown in Figure 33, this downward-sloping trend is driven predominately by reductions in disbursements by GFATM. Providing 35.8% of all international malaria funding, GFATM was by far the biggest channel of DAH in this health focus area in 2011. GFATM disbursed just $641 million in malaria DAH in 2011, a decrease of 32.1% from 2010. Fortunately, GFATM's contribution to malaria is expected to rise in

coming years as the organization deploys newly pledged funds across the three primary disease areas included in its mandate.

Among other channels, both decline and expansion were observed. Contributions from the US, the second-largest development assistance partner in this health focus area, grew $123 million from 2010 to 2011. US malaria DAH amounted to an estimated $416 million in 2011. This 41.8% rise was largely fueled by increased disbursements by the US President's Malaria Initiative. Next after the US, US-based NGOs provided $267 million in funds to malaria activities. This was a contraction of $90 million, or 25.1%, from 2010. Funding from internationally based NGOs also dropped. In 2011, $3.4 billion was disbursed by these entities, a 16% reduction from 2010 levels. Simultaneously, the level of support provided by BMGF was more or less stable. In 2010, BMGF provided $149 million, while in 2011 its contribution amounted to $151 million, a 1.5% increase.

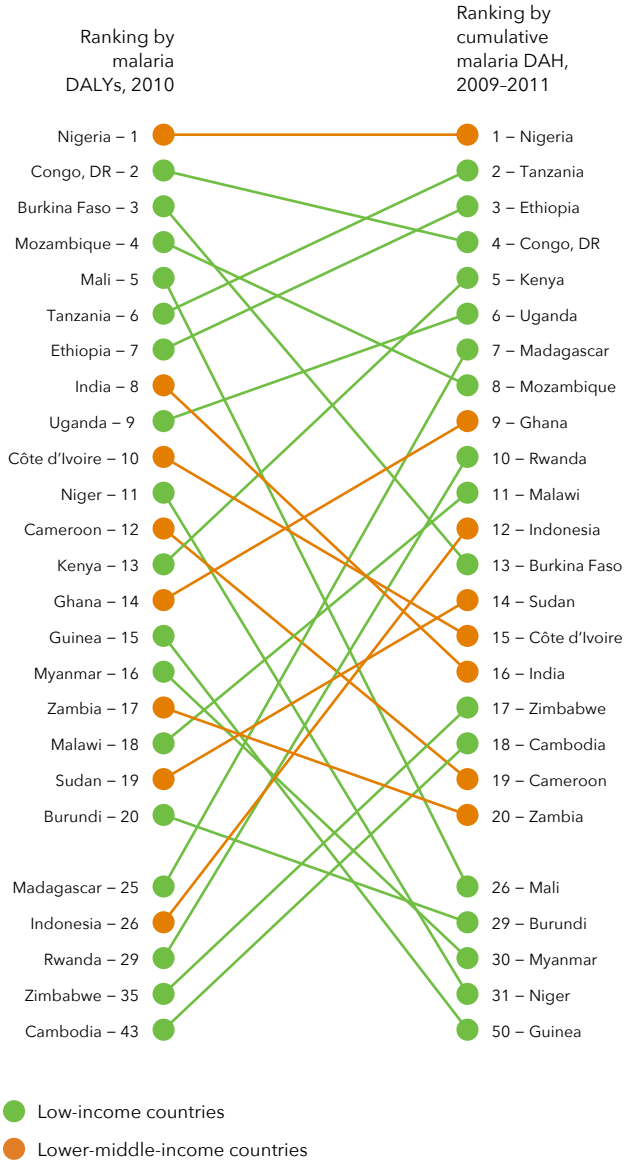
Figure 34 highlights how prominent sub-Saharan Africa is in both malaria burden and malaria control financing. It also shows how well income level and the presence of malaria correspond. Not a single upper-middle-income country is found in the rankings of cumulative DAH and DALYs associated with malaria. The most populous country in sub-Saharan Africa, Nigeria, tops both lists. Nigeria suffers from the highest malaria burden while also receiving the most malaria DAH. Following Nigeria, the next six countries are all low-income and all located in sub-Saharan Africa. Across the top 20 on both rankings, India is the only country not located in the region.

Pairing malaria DAH with malaria DALYs reveals the variation in disbursements across countries when controlling for disease burden. Figure 35 displays this range of DAH per DALY across countries with malaria. Malaria is prevalent in parts of Asia and South and Central America, but rates are highest in sub-Saharan Africa. The high number of DALYs attributed to malaria south of the Sahara drives the DAH per DALY metric downward; malaria DAH per DALY ranges around $20 across sub-Saharan African countries. In South America and East Asia, however, each malaria DALY was associated with more than $200 in DAH in many countries.

Sub-Saharan African DAH per DALY also stands out as low when looking across regions over time. As shown in Figure 36, sub-Saharan Africa received $55 of DAH per DALY cumulatively over 2006–2010. Simultaneously, striking, massive investments in malaria control were

FIGURE 34

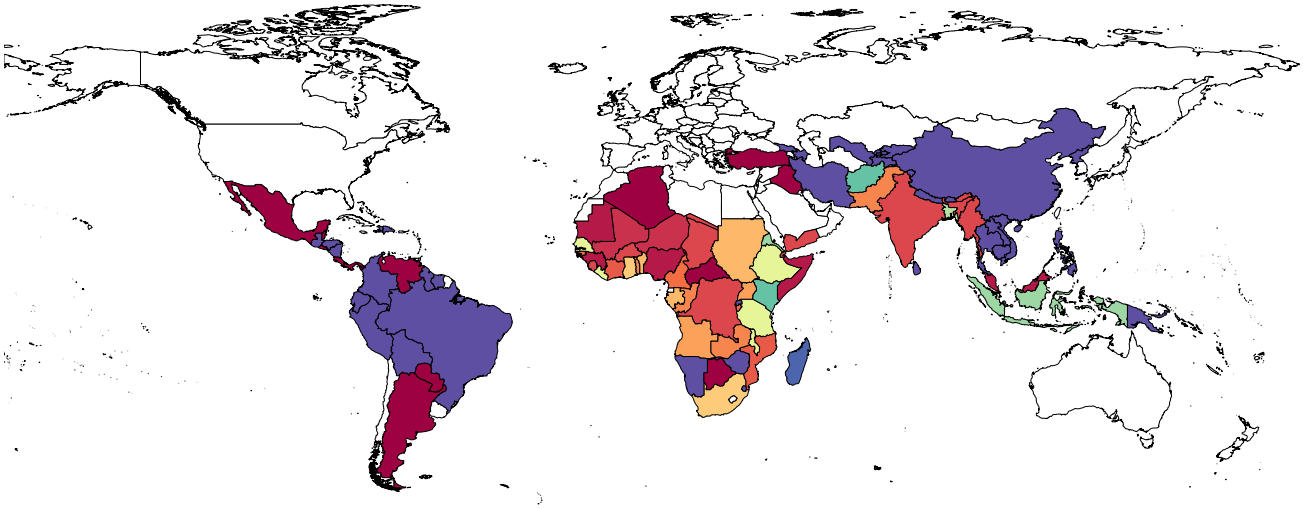
Top 20 countries by 2010 malaria burden of disease versus cumulative 2009–2011 malaria DAH



Sources: IHME DAH Database 2013 and Global Burden of Disease Study 2010

FIGURE 35

Malaria DAH, 2009–2011, per related DALY, 2010

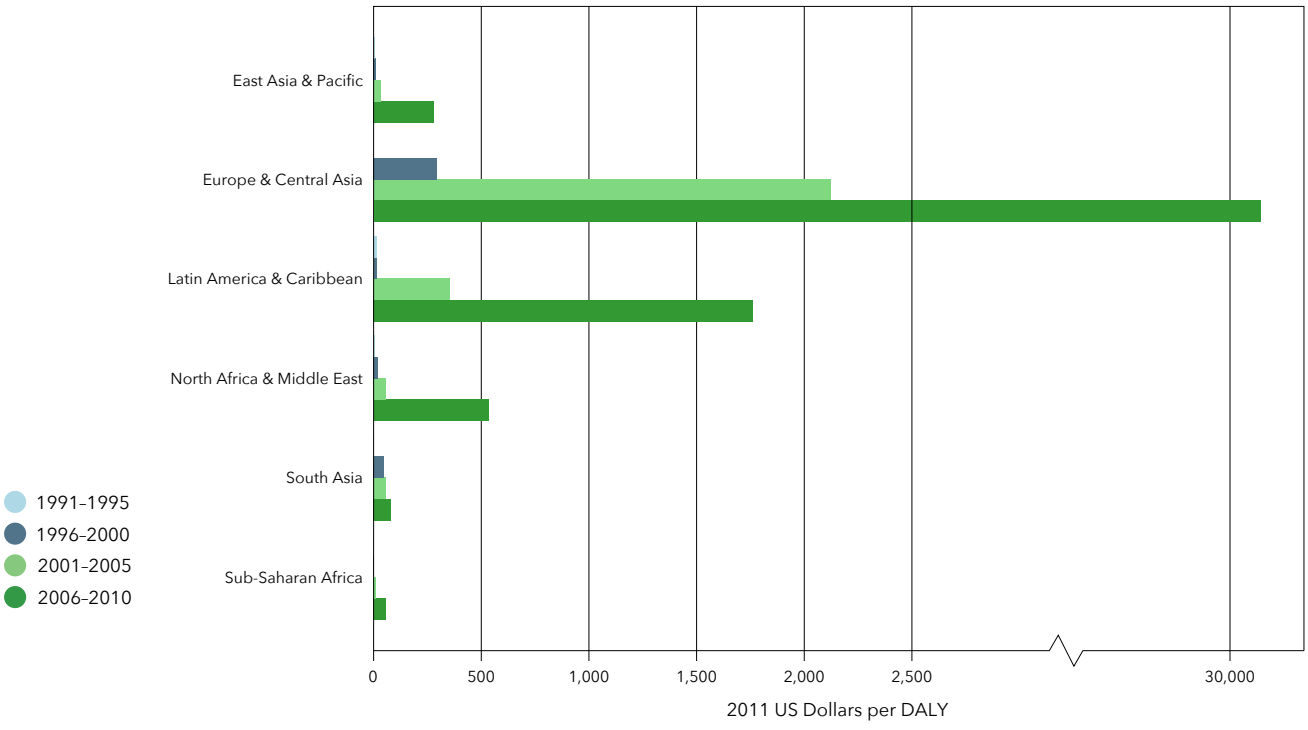


Sources: IHME DAH Database 2013, Global Burden of Disease Study 2010, and World Malaria Report 2012

Notes: 2010 DALY estimates are from the Global Burden of Disease Study 2010. Countries that were ineligible for DAH based on their World Bank income classification and countries not considered malaria-endemic by the World Malaria Report 2012 are shown in white. DAH received is shown in real 2011 US dollars.

FIGURE 36

Malaria DAH over five-year periods per related DALY, by region, 1991–2010

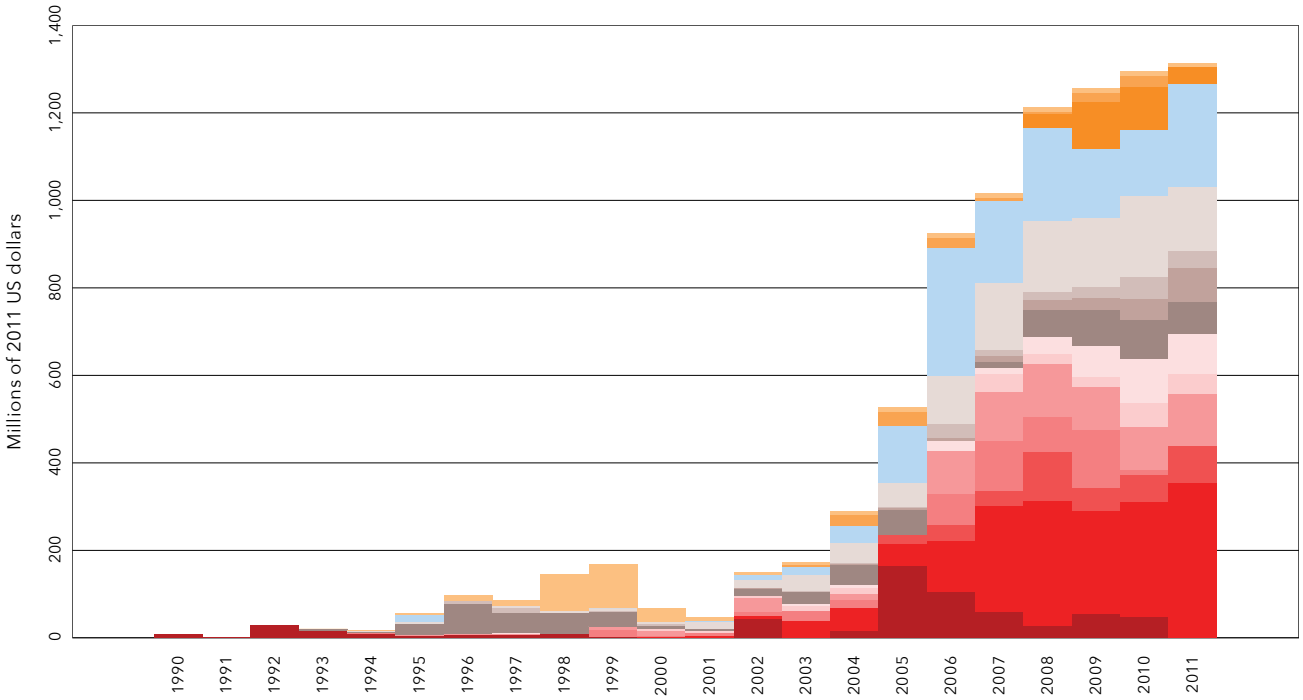


Sources: IHME DAH Database 2013 and Global Burden of Disease Study 2010

Note: The bars represent cumulative DAH over each five-year period.

FIGURE 37

DAH for health sector support by channel of assistance, 1990–2011



Source: IHME DAH Database 2013

made in Europe and Central Asia over 2001–2005 and 2006–2010. Malaria emerged in this region in the mid-1990s.[49] In response, development assistance partners convened a major effort to keep malaria at bay in the region. Lastly, Latin America and the Caribbean also received more than most other regions. Over 2006–2010, $1,762 of DAH per DALY was disbursed.

HEALTH SECTOR SUPPORT

IHME defines health sector support as the DAH provided to developing country governments to spend on general health priorities, such as building health facilities or training personnel. This health focus area has grown because certain bilateral partners emphasized sector-wide approaches (SWAPs) as more effective mechanisms of DAH disbursement. The Paris Declaration on Aid Effectiveness also emphasized SWAPs as in line with basic principles of effectiveness.[50]

The most prominent backers of health sector support are shown in Figure 37. The UK and the European Commission (EC) shored up this area of development assistance for health by providing 26.9% and 18%, respectively, of the total in 2011. UK health sector support rose an estimated 34.7% in 2011, to $354 million. The EC provided $236 million, a 58.5% increase relative to 2010. The Netherlands also expanded its support substantially in 2011, increasing its contribution by 21%, up to $120 million in 2011. Finally, DAH from Denmark also constituted a major portion of health sector support. Its contribution was 5.7% of total funding for this health focus area in 2011. Denmark's funding for health sector support, however, decreased relative to 2010 levels: it provided $75 million in 2011, a 15.5% decrease.

CHAPTER 4

Sources of development assistance for health

Development assistance for health (DAH), by definition, is provided by governments and private organizations in high-income countries to low- and middle-income countries. The provision of DAH is thus influenced by the prevailing economic and political trends in Organisation for Economic Co-operation and Development (OECD) countries. The advent of austerity policies, across-the-board budget cuts, and, in some countries, steadfast commitments to development assistance in recent years have been the drivers of trends in sources of DAH. This chapter explores these sources, as distinguished by country of origin.

Figure 38 displays sources by the country of origin and type of funds. Despite the changes in the DAH landscape, governmental contributions still make up the vast majority of DAH. Non-governmental sources, such as corporate donations, foundations, and debt repayments make up only 23.5% of total DAH. The US government in particular remains the largest donor. In 2011, DAH originating in the US Treasury amounted to $11.2 billion. The creation of the Global Health Diplomacy unit and the increases in funding for the US President's Emergency Plan for AIDS Relief (PEPFAR) denote the US's continued support for global health.

The second largest contributor to DAH in 2011 was the UK government. Its provision of DAH amounted to $2.1 billion in 2011. In contrast to the US, the UK, led by Prime Minister David Cameron, has committed to increasing development assistance while also phasing out contributions to certain middle-income countries. In 2013, it was announced that UK development aid will also cease to target some low-income countries, such as Lesotho, Burundi, and 14 others.[51]

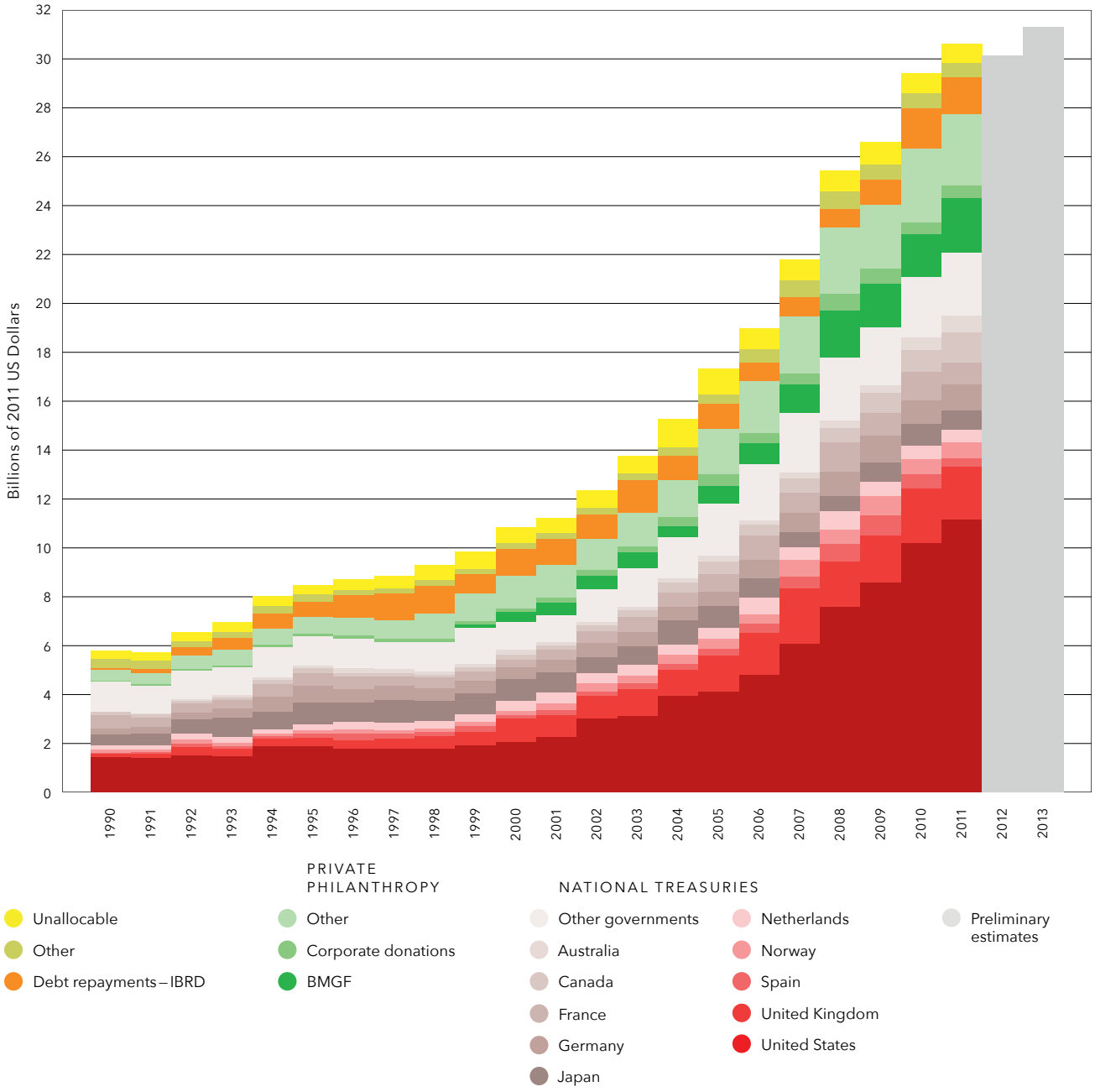
Across Europe, reductions in DAH were observed. Spain decreased its contribution to DAH by 34.2%, totaling just over $376 million in 2011. France, as well, provided less DAH. Its contributions reached $870 million in 2011, a 26.8% drop from 2010. Also slightly down were the Netherlands (4.2%) and Norway (2%), which contributed $528 million and $625 million, respectively, to global health in 2011.

Counteracting these cutbacks were a number of development assistance partners that bolstered their DAH in 2011. In contrast to most other European development assistance partners, Germany augmented DAH. Its contribution grew to $1.1 billion in 2011, a 14.4% increase over 2010. The Australian government provided more DAH as well. Its DAH disbursements grew to $694 million in 2011. Finally, Canada also increased spending. Total DAH sourced from the government of Canada was $1.3 billion in 2011, a 43% increase over 2010.

Private sources also expanded their contributions to DAH from 2010 to 2011. Notably, the investments made by the Bill & Melinda Gates Foundation (BMGF) were augmented by 29.9% over 2010. In 2011, BMGF as a source contributed $2.2 billion. Corporate donations topped $520 million in 2011, which was a 2.1% increase relative to 2010. A small portion of DAH cannot be traced to a specific source due to the format and information provided in datasets utilized. This year just 2.5% of DAH could not be allocated.

FIGURE 38

DAH by source of funding, 1990–2011



Source: IHME DAH Database 2013

Notes: Funds from channels for which we were unable to find disaggregated revenue information as well as interagency transfers from non-DAH institutions are designated as "unallocable." "Other" refers to income from interest, currency exchange adjustments, and other miscellaneous sources of income. Due to data limitations, estimates are unavailable for DAH by source of funding for 2012 and 2013.

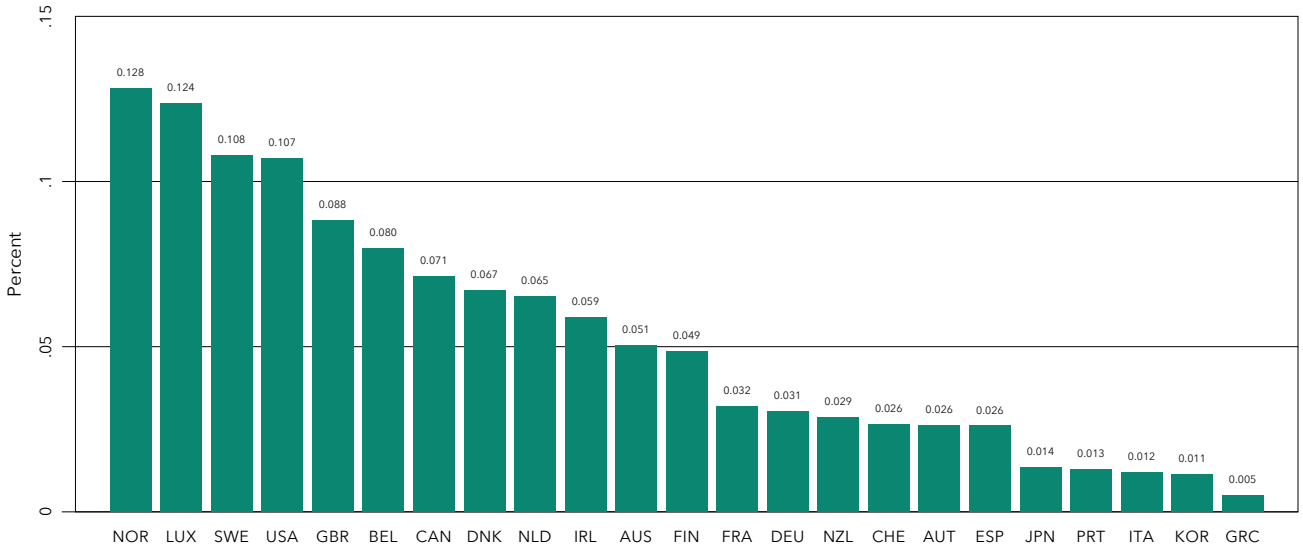
DAH AS A SHARE OF GROSS DOMESTIC PRODUCT

The Monterrey Consensus set an aid target of 0.7% of gross domestic product (GDP). A few countries have achieved this feat, including Denmark, Luxembourg, the Netherlands, Norway, and Sweden. Many others are far from meeting this target. The UK is one development assistance partner that continues its push toward 0.7% of GDP, although it has not yet attained this goal.[52]

In an effort to illustrate how DAH aligns with the Monterrey target, Figure 39 displays DAH as a percentage of GDP. Governments are ranked left to right from highest to lowest. The order has changed little from 2010, although slight shifts have

FIGURE 39

DAH as a percentage of gross domestic product, 2011



Sources: IHME DAH Database 2013 and World Bank World Development Indicators

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

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

occurred. As in 2010, Norway, Luxembourg, and Sweden lead OECD countries in providing the highest proportion of GDP as DAH. However, both Norway's and Luxembourg's shares dropped from 2010 to 2011, to 0.128% and 0.124%, respectively. The US moved up this year, to 0.107%, while the UK dropped to 0.088%. Greece, as in 2010, provided the lowest share of GDP as DAH, as it moved to phase out official development assistance entirely in the wake of its fiscal crisis.

PUBLIC SECTOR DAH

As discussed in Chapter 1, the types of channels prominent in global health have shifted over time. Public-private partnerships have disbursed a larger and larger share of DAH since their emergence on the global health scene around the turn of the 21st century. Figure 40 provides a static look at which governments tend to support public-private partnerships versus other types of channels, such as non-governmental organizations (NGOs), multilateral organizations, development banks, or countries' own bilateral institutions.

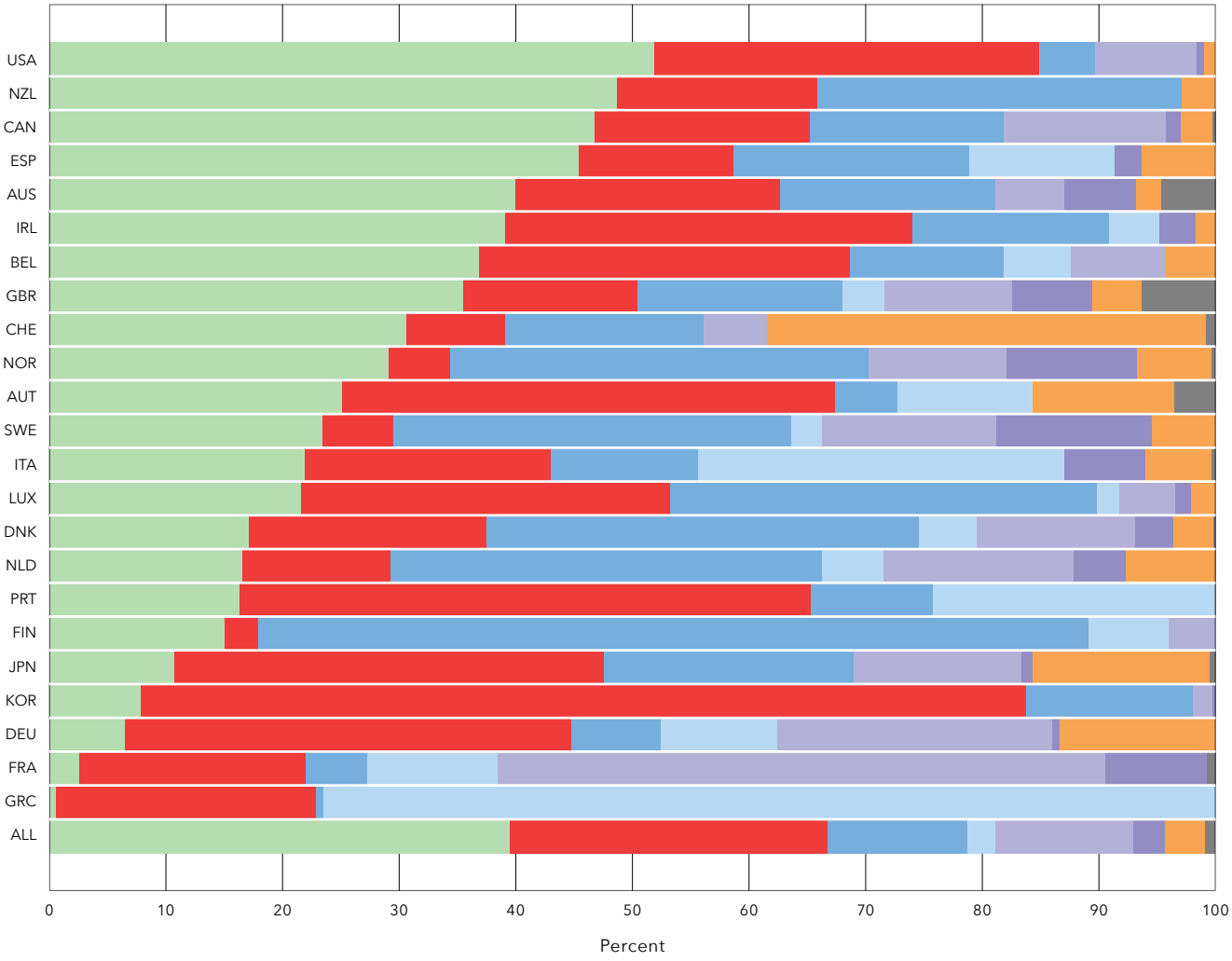
Overall, the US tends to be the biggest supporter of NGOs, as measured by share of US DAH. The US splits the major share of its funds across NGOs (51.8%) and bilateral agencies (33%). Relative to the share furnished by other countries, the US provides a minor portion of funds to the GAVI Alliance (GAVI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

Figure 40 also shows that the UK supports an array of channels. Like the US, the UK provides the bulk of its funds to NGOs (35.5%). However, the UK also provides 15% to bilateral agencies, 17.6% to the UN, and 3.6% to the European Commission (EC). Receiving 6.9% and 10.9%, respectively, the public-private partnerships of GAVI and GFATM also benefit from a considerable share of UK DAH.

As measured by portion of DAH, France is the most substantial supporter of GFATM, contributing 52.1% of its DAH to this public-private partnership. Also in contrast to the US, France provides very little of its DAH to NGOs: this funding amounted to just 2.6% in 2011.

FIGURE 40

Public sector DAH (donor-country-specific) by channel of assistance, 2011



Unspecified
World Bank – IDA

GLOBAL HEALTH PARTNERSHIPS
GAVI
GFATM

UNITED NATIONS AND EUROPEAN COMMISSION
European Commission
UN agencies (WHO, UNICEF, UNAIDS, UNFPA)

BILATERAL AGENCIES
Governments

NON-GOVERNMENTAL CHANNELS
NGOs, public-private partnerships, other

Source: IHME DAH Database 2013

Notes: The composition of DAH from the 23 member countries of the OECD-DAC is shown. "Unspecified" indicates that the donor country did not report the specific channel to which DAH was provided.

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

Across all development assistance partners, South Korea most heavily favors bilateral channels, providing 75.9% of its DAH through this mode of delivery. South Korea provides very little through NGOs (7.8%) and public-private partnerships (1.9%). South Korea does contribute a minor share to UN agencies (14.3%).

One of the biggest supporters of UN agencies, as measured by proportion of DAH, is Finland. In 2011, Finland provided 71.2% of its DAH to these entities. Finland, however, did not provide much to NGOs (15.1%), GFATM (4%), and the EC (6.8%).

More than any other country, Switzerland tends to commit a large share of funds to the World Bank's International Development Association (IDA). In 2011, it contributed 37.6% to IDA, far beyond the share of any other development assistance partner. Switzerland also provided a substantial portion of funds to NGOs (30.6%) and UN agencies (17%) but very little to its bilateral organizations (8.5%) and GFATM (5.4%). Other types of channels were not supported with Swiss funds.

SOURCE OF PUBLIC-PRIVATE PARTNERSHIPS' RESOURCES

Public-private partnerships were established to streamline efforts to address a few key global health areas, with a view to improving the effectiveness of each DAH dollar, and have grown substantially since their inception. This section outlines which sources have been fundamental to this expansion. Examining the sources of funds shows that while GFATM has received support from an array of development assistance partners, GAVI's start-up funds were sourced from just a few key players.

Figure 41 shows the origins of support for GFATM from 2002–2011. Since the inception of GFATM, the United States has been the biggest contributor. Its contribution to GFATM has ranged from 19.6% to 33.4% over this period. GFATM's next-biggest development assistance partner is France. In 2011, the share provided by France was substantial, making up 15.5% of Global Fund receipts. French funds have not dipped below 6.1% of Global Fund financing throughout the course of the organization's existence. Other major contributors in 2011 were the UK (8%) and Germany (8.7%), both of which have consistently supported GFATM. Falling from the pack of contributors in 2011, Italy refrained from providing support, despite having been one of the major donors at the launch of GFATM. The EC also did not contribute in 2011.

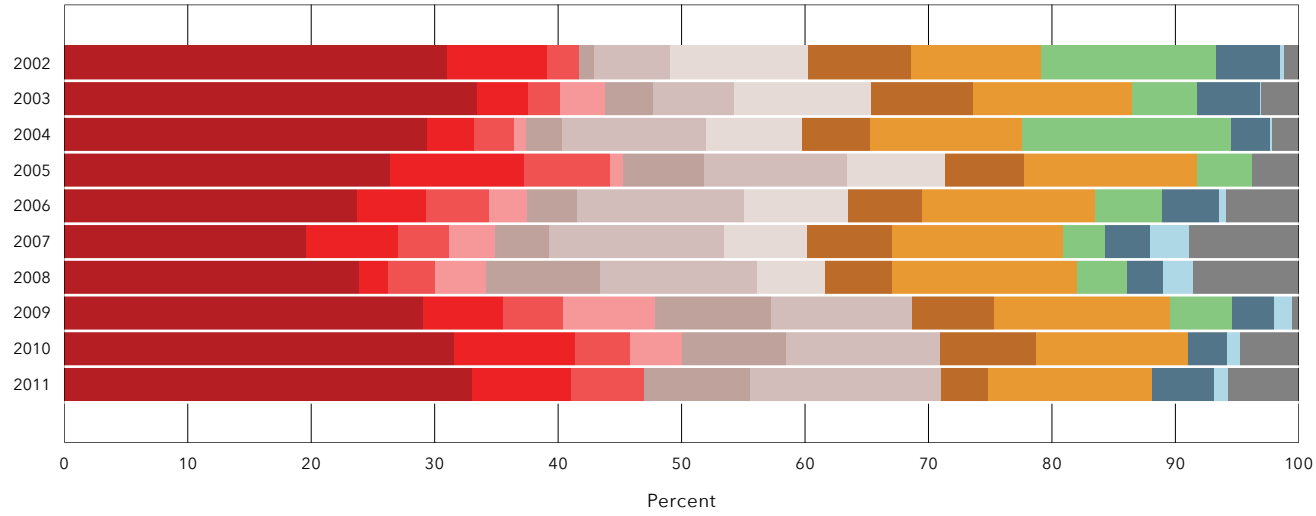
The trends underpinning GAVI support are substantially different. Figure 42 shows that BMGF played a crucial role in launching GAVI. In 2000 and 2001, BMGF provided the vast majority of funds, upward of 98.6% and 82%, respectively. By 2002, other development assistance partners had stepped in, with major funding from the US (49.2%), Norway (19.8%), UK (13.9%), and Netherlands (12.4%). By 2011, GAVI received financial support from a wide range of partners. BMGF regained its slot as top donor, providing 26.5% in 2011. The UK followed, contributing 18.1%. Substantial support was also provided by other development assistance partners in 2011, including the US (9%), France (9.4%), Norway (8.6%), Sweden (9.4%), and the Netherlands (2.9%).

NON-GOVERNMENTAL ORGANIZATIONS

NGOs play a key role in the delivery of DAH. NGOs act as channels, facilitating the transfer of funds from OECD countries to low- and middle-income countries. NGOs also contribute to the direct delivery of health services, serving as health facilities, vaccinating children, and running public health campaigns. The global health landscape would operate very differently in the absence of NGOs. While NGOs act independently to mobilize funding from public and private donors, many also join forces to strengthen fundraising efforts and bolster their influence. NGO alliance

FIGURE 41

GFATM revenue by source, 2002–2011



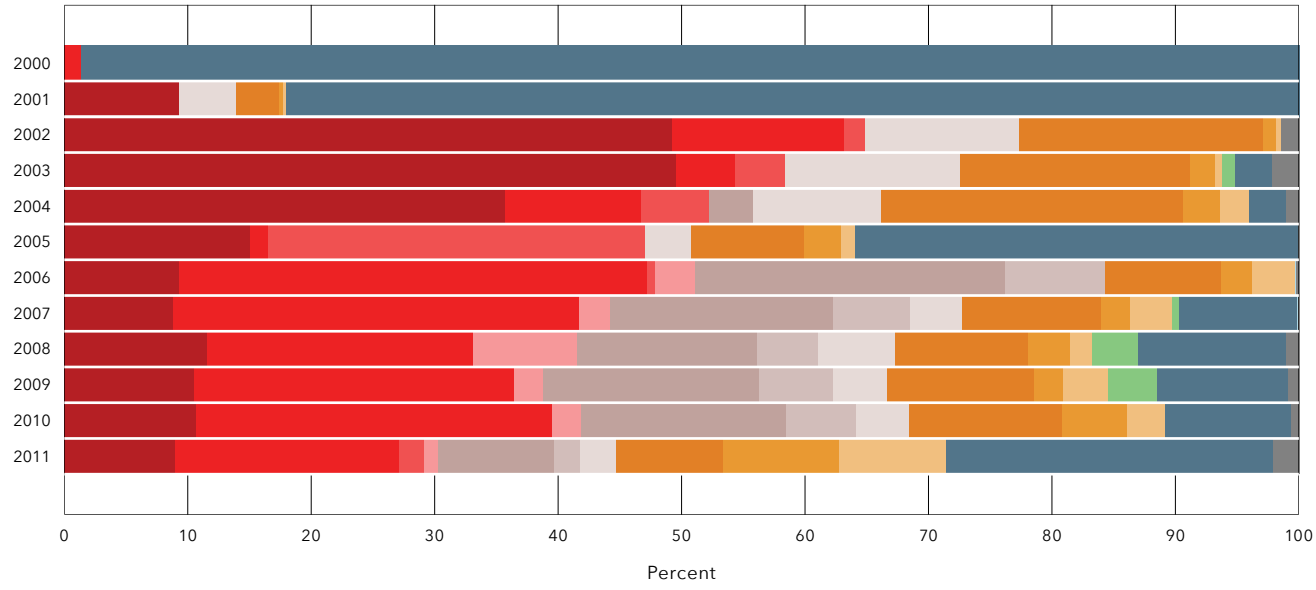
United States
United Kingdom
Canada
Spain
Germany
France
Italy
Japan
Other bilaterals
European Commission
BMGF
Other private
Unspecified

Source: IHME DAH Database 2013

Note: "Other private" refers to contributions from the private sector, less funds from BMGF.

FIGURE 42

GAVI Alliance revenue by source, 2000–2011



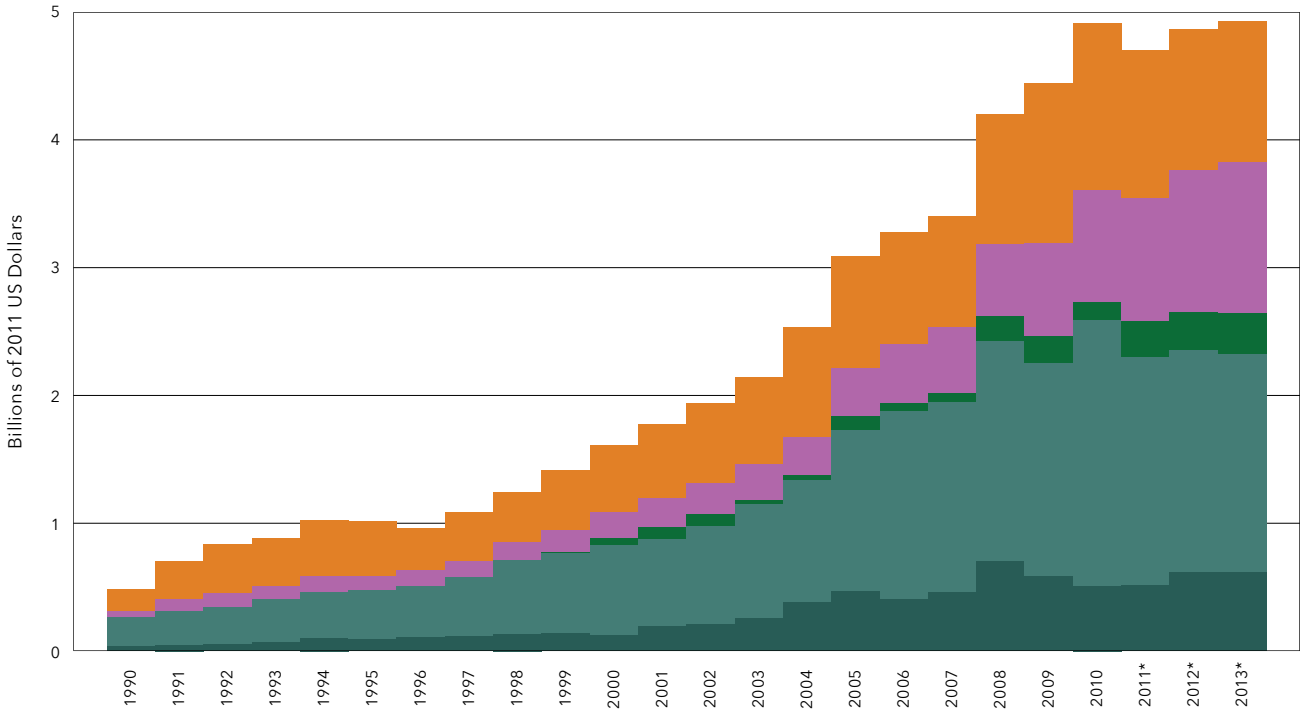
United States
United Kingdom
Canada
Spain
France
Italy
Netherlands
Norway
Sweden
Other bilaterals
European Commission
BMGF
World Bank
Other private

Source: IHME DAH Database 2013

Note: "Other private" refers to contributions from the private sector, less funds from BMGF.

FIGURE 43

Total overseas health expenditure by NGOs, 1990–2013



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

Source: IHME DAH Database 2013

Notes: Total health spending is disaggregated by shares of revenue received from the US government, other public sources of funding, international organizations, BMGF, financial donations from private sources, and in-kind donations from private sources. Data cover NGOs registered with USAID.

*Data from 2011–2013 are based on preliminary estimates.

organizations, such as InterAction and CONCORD, have been conceived or have grown dramatically since the launch of the Millennium Development Goals.

Overall, the NGO growth trend is similar to total DAH. As depicted in Figure 43, the 1990–2000 period is marked by steady but slow growth, while DAH grew rapidly in the 2001–2010 era. From 2011 onward, growth has slowed according to preliminary estimates. Total NGO spending was an estimated $4.9 billion in 2013, providing 15.7% of total DAH in 2013.

Figure 43 also provides the origin of support for NGOs. Funding originates in both public and private sources, with the bulk of funds provided by other public and international organizations (23.9%). This source of funds grew slightly by 6.2% from 2012 to 2013, with total contributions amounting to $1.2 billion in 2013. The US public, which comprises the US government's financial contributions, also provided 22.3%, or $1.1 billion, in 2013.

In recent years, private sources, including financial and in-kind contributions from private companies, philanthropies (excluding BMGF), and individuals, have supplied more in NGO DAH than combined public funding. NGOs' ability to mobilize private funding to improve health in developing countries may help explain why they have succeeded in increasing their spending in contrast to other channels that have relied primarily on a shrinking pool of public funding. In 2013, private financial contributions alone were responsible for $1.7 billion in NGO DAH. Private in-kind contributions, such as donations of drugs or vaccines, were also substantial in 2013. This source provides 12.5% of funds, a total of $617 million. BMGF supported NGOs with $327 million in 2013, an 11.1% rise over 2012.

Table 1 displays the top 20 US-based NGOs by cumulative spending over 2007–2010. Leading this group is Population Services International, spending $1.4 billion

TABLE 1

US-based NGOs with highest cumulative overseas health expenditure, 2007–2010

Rank	Organization	Overseas health expenditure, adjusted	Overseas health expenditure, unadjusted	Overseas expenditure, unadjusted	Percent of revenue from private sources	Percent of revenue from in-kind contributions
1	Population Services International	1392.35	1392.36	1784.37	17.72	0.00
2	Catholic Relief Services	910.90	916.74	2750.85	32.11	0.85
3	Food for the Poor	793.18	3009.92	4709.03	98.55	90.08
4	PATH	667.75	683.20	799.46	78.67	2.91
5	Clinton Health Access Initiative	626.77	631.74	709.96	55.57	1.11
6	Management Sciences for Health, Inc.	577.22	577.22	609.58	0.77	0.00
7	Elizabeth Glaser Pediatric AIDS Foundation	411.98	413.23	434.94	15.60	0.37
8	CARE	355.95	358.28	2418.42	29.20	0.79
9	Save the Children	319.19	334.16	1701.05	50.34	5.70
10	World Vision	312.68	418.08	3440.61	78.01	30.81
11	Pathfinder International	307.76	310.04	354.37	22.83	0.85
12	MAP International	292.88	1384.72	1509.19	99.51	96.67
13	International Medical Corps	276.74	397.24	414.48	49.65	37.05
14	Rotary Foundation of Rotary International	271.83	271.83	587.14	99.99	0.00
15	Brother's Brother Foundation	239.60	1277.34	1919.16	99.96	99.36
16	Academy for Educational Development	232.72	233.93	943.28	11.21	0.62
17	Project HOPE	230.00	593.09	643.90	94.00	75.02
18	United Nations Foundation	219.47	230.85	342.12	88.30	8.63
19	Catholic Medical Mission Board	217.70	877.54	928.34	99.37	91.99
20	Feed the Children	212.60	738.36	2114.31	99.64	87.13

Source: IHME DAH Database 2013

Notes: Expenditures shown in millions of 2011 US dollars. Overseas health expenditure for 2011–2013 is not included because of data limitations. Data reflect NGOs registered with USAID. Adjusted overseas health expenditure reflects deflated private in-kind donations plus unadjusted financial assistance.

TABLE 2

Internationally based NGOs with highest cumulative overseas health expenditure, 2007–2010

Rank	NGO	Overseas health expenditure	Overseas expenditure	Percent of revenue from private sources
1	Save the Children Fund, United Kingdom	281.54	1307.32	62.37
2	Marie Stopes International	273.47	388.54	92.31
3	Handicap International	227.51	316.13	84.39
4	Medical Emergency Relief International	222.45	286.23	40.00
5	International Union Against Tuberculosis and Lung Disease	146.27	189.78	76.38

Source: IHME DAH Database 2013

Note: Expenditures shown in millions of 2011 US dollars.

over the period, followed by Catholic Relief Services, with $911 million in expenditure. The increase in spending by World Vision boosted the organization in the list of NGOs. World Vision spent $313 million from 2007 to 2011. No new organizations appeared on the top 20 list in *Financing Global Health 2013*, reflecting an emerging stability among major NGOs.

To better quantify non-governmental spending on global health, IHME took special care to estimate the DAH provided by internationally based NGOs in this year's report. NGOs are considered "internationally based" if their headquarters and tax base are located outside the US. The top five internationally based NGOs are displayed in Table 2. Topping the list was Save the Children Fund, UK, which provided $282 million in DAH. Marie Stopes International was a close second, with $273 million in expenditure across 2007–2010.

BOX 3

Non-governmental organization estimates

This year, the Institute for Health Metrics and Evaluation (IHME) made a special effort to include NGOs based outside as well as inside the US, a substantial improvement on previous estimates. Tracking focuses on NGOs that receive funding from the US government because systematic reporting of worldwide NGO spending is not currently available. By combining data provided by the US government on total NGO expenditure with a series of estimation methods, IHME developed updated, expanded estimates of the DAH provided by NGOs in *Financing Global Health 2013*.

OTHER SOURCES

Increasingly, middle-income countries, such as China, Turkey, South Africa, Brazil, and India provide health-related support to low-income countries. While some official development assistance is provided, transfer of technology, private investments, and other types of south-south cooperation are also part of this support. Middle-income countries have been involved in global health by working to improve access to medicines, supporting HIV/AIDS and malaria interventions, augmenting disease surveillance, and other capacity-building efforts.[53]

Unfortunately, although data are available on the contributions made by OECD countries, little is still known about the magnitude and scope of DAH provided by some of the emerging development assistance partners. In 2013, some initial forays into estimating these sums were made by AidData, which estimated the development assistance provided by China.[54,55] Even so, because of data quality issues, *Financing Global Health 2013* cannot provide estimates of middle-income countries' DAH. IHME looks forward to integrating these contributions in the future as better data become available.

CHAPTER 5

Government health expenditure as a source

To complement its development assistance for health (DAH) time series, the Institute for Health Metrics and Evaluation (IHME) also annually produces estimates of government health expenditure as a source (GHE-S). The GHE-S series is estimated with use of the DAH data. The funds provided directly to developing country governments by development assistance partners are removed from GHE estimates. GHE-S thereby captures the funds governments in low- and middle-income countries contribute to health, as sourced directly from their tax base and other revenues. These estimates emphasize the fundamental role government financing plays in the provision of health services and public health intervention strategies in the developing world.

Examining GHE-S and DAH side by side reveals the current and growing prominence of GHE-S in health. GHE-S is consistently bigger than DAH by a wide margin. In 2011, GHE-S topped $613.5 billion, which was 20 times greater than DAH in the same year. Furthermore, GHE-S growth is outpacing DAH, as the stagnation seen in DAH has not been present in GHE-S trends. Since 2008, annualized growth in GHE-S has amounted to 9.8%, while DAH's annualized rate over the same period was 6.4%.

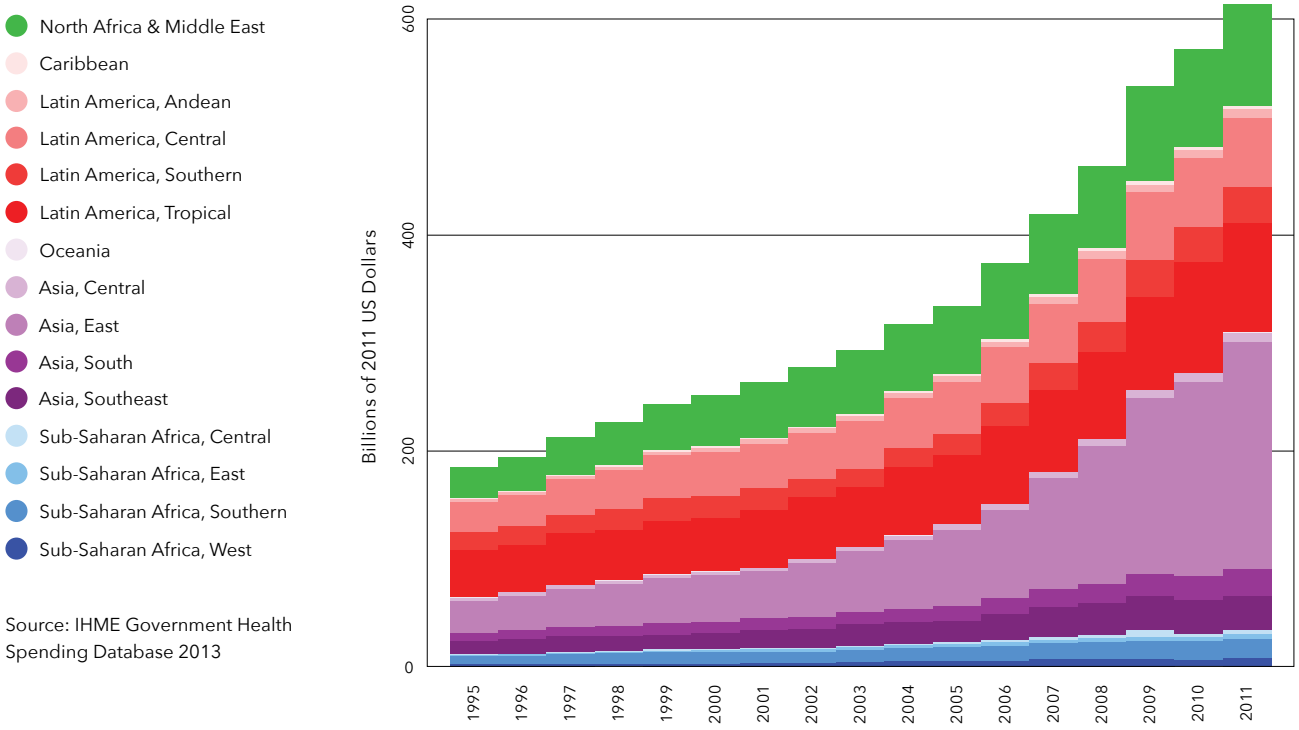
Looking to regional trends, Figure 44 shows that governments in East Asia spend the most, absolutely, on health. In 2011, driven largely by the spending of the Chinese government, $210.5 billion was spent in East Asia alone. Following East Asia was Latin America, where $206.8 billion in GHE-S was spent in 2011. GHE-S in North Africa and the Middle East topped $93.7 billion in 2011, a 3.5% increase over 2010. Despite the substantial disease burden afflicting most countries in sub-Saharan Africa, governments across all four Global Burden of Disease (GBD) regions spent just $33.5 billion.

The change in governmental investments in health varies across regions. As shown in Figure 45, GHE-S either grew or held steady in all regions. East Asia grew the most in absolute ($82.6 billion) and annualized (18.1%) terms between 2008 and 2011. Although GHE-S growth in most parts of sub-Saharan Africa was not as high as in other regions, annualized growth rates of more than 3% in West, East, and Southern sub-Saharan Africa amount to major increases in government spending. Andean Latin America showed almost no change during this period, with annualized growth of 0.1%.

Boosting governmental investments in health in sub-Saharan Africa has been on the global health agenda of late. Sub-Saharan African governments committed to health financing targets in Abuja in 2001, agreeing to provide 15% of general government expenditure for health. These targets were reiterated in Kampala in 2010 and in Addis Ababa in 2011 in an effort to further catalyze government investments in

FIGURE 44

GHE-S by Global Burden of Disease developing region, 1995–2011



Source: IHME Government Health Spending Database 2013

FIGURE 45

Change in GHE-S by Global Burden of Disease developing region, 2008–2011

Source: IHME Government Health Spending Database 2013

Notes: The bars represent changes in DAH in absolute and percentage terms from 2008 to 2011. On the vertical axis, channels are ordered by the magnitude of their contribution to the total change in government health spending over this period.

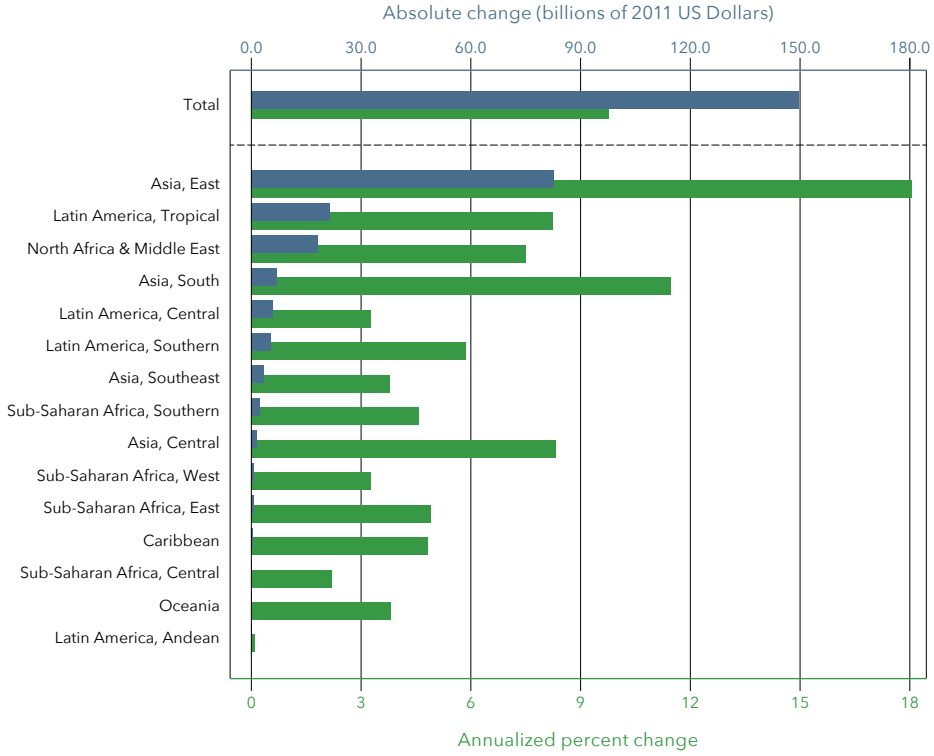
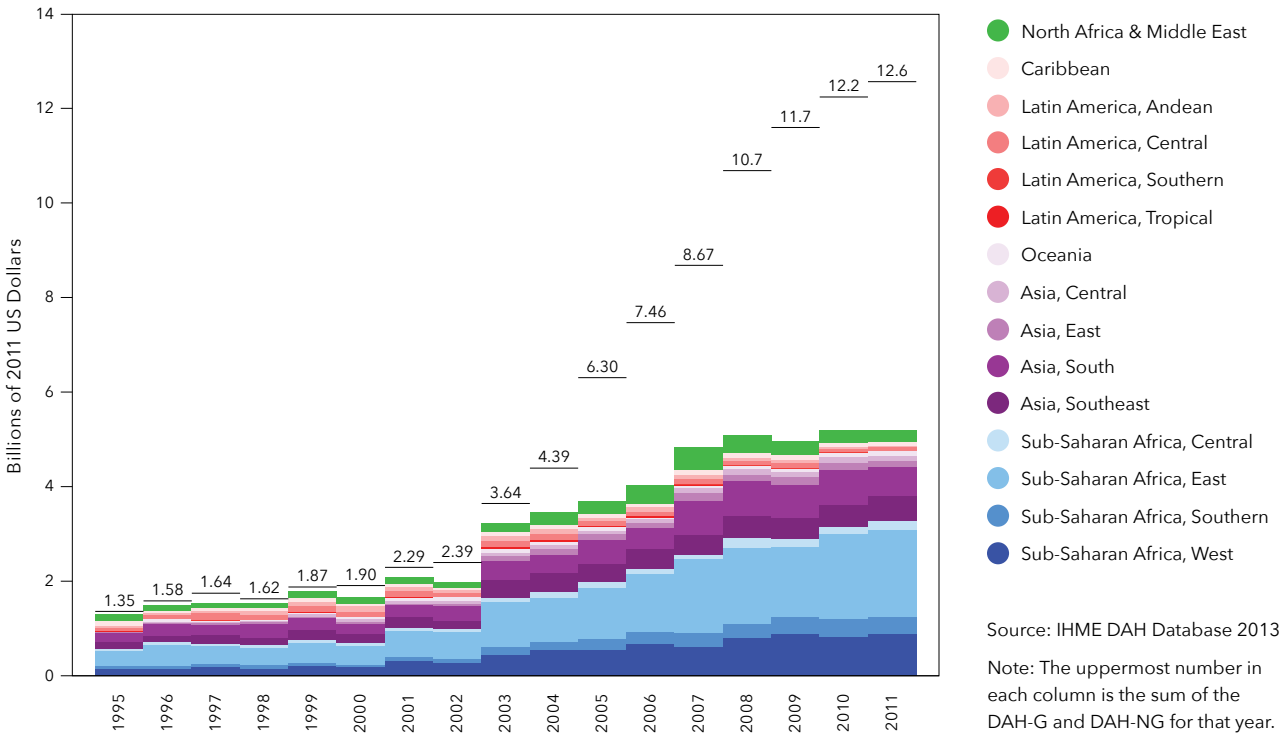


FIGURE 46

DAH-G by Global Burden of Disease developing region, 1995–2011



Source: IHME DAH Database 2013

Note: The uppermost number in each column is the sum of the DAH-G and DAH-NG for that year.

health.[56-58] However, GHE as a share of total health expenditure reportedly grew in just 31 sub-Saharan African countries, while contracting in 13 across the region.[59]

DAH FOR GOVERNMENTAL VERSUS NON-GOVERNMENTAL ENTITIES

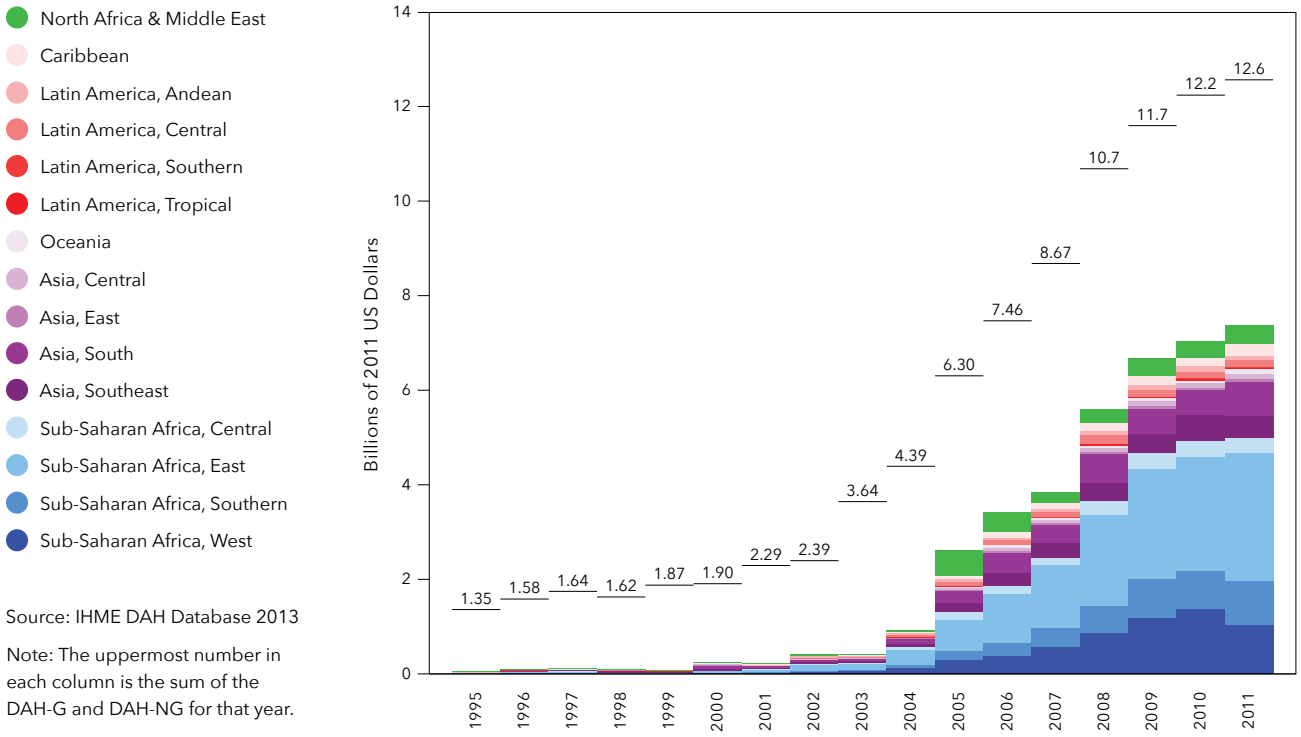
Governmental and non-governmental entities play different roles in delivering health services and managing health systems. The split of DAH between governments and non-governmental entities (including private sector actors) has been shown to have an impact on government expenditure, as does the consistency of these flows over time.[60-62] For these reasons, IHME parses out the DAH provided to the non-governmental sector (DAH-NG) as compared to the DAH channeled to governments (DAH-G).

Governments have historically been the main recipients of DAH, as shown in Figure 46. From 1995 to 2001, 90% of DAH was funneled to governments. Since 2002, however, the share of DAH channeled to a recipient country's government has diminished. From 2007 onward, in fact, DAH-G appears to have reached a stagnation phase. By 2011, DAH-G totaled $5.2 billion.

Governments in sub-Saharan Africa received the largest share of DAH-G funds. In 2011, $3.3 billion was provided to governmental agencies to spend on health. East sub-Saharan Africa alone received $1.8 billion, while $884 million was provided to West sub-Saharan African governments. The next-largest recipient was South Asia, which benefited from $619 million in DAH-G in 2011. Southeast Asia, as well, received a substantial $536 million in DAH-G.

FIGURE 47

DAH-NG by Global Burden of Disease developing region, 1995–2011

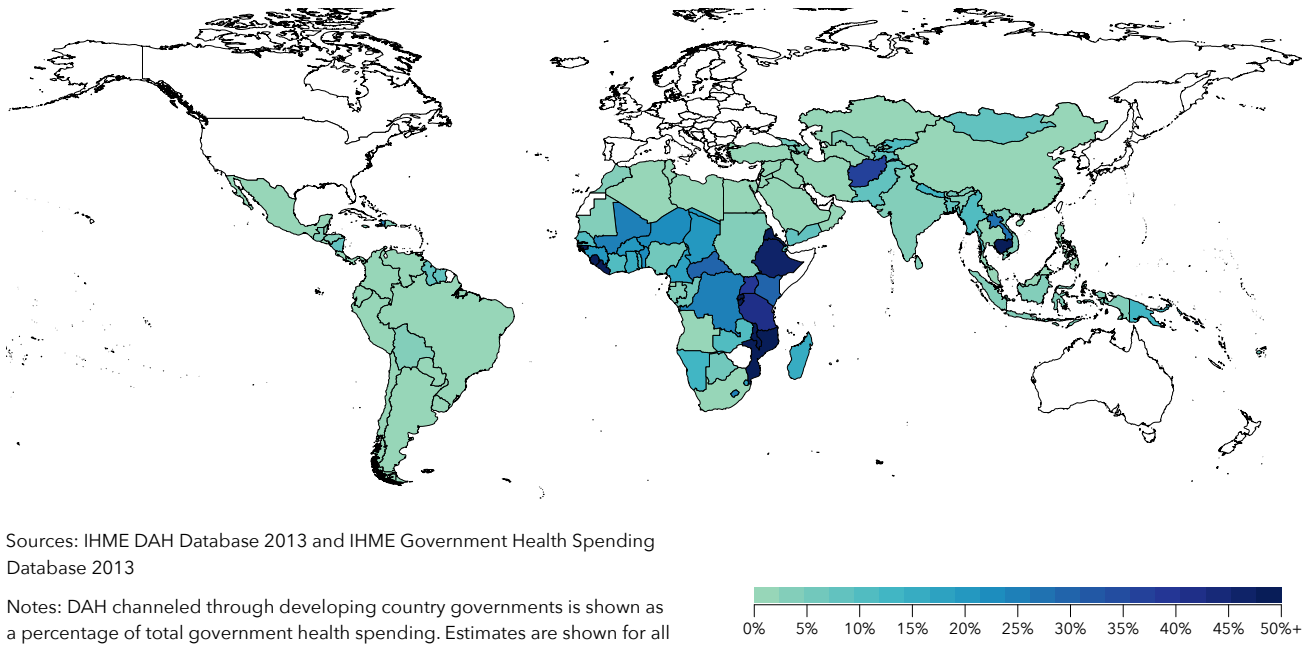


Source: IHME DAH Database 2013

Note: The uppermost number in each column is the sum of the DAH-G and DAH-NG for that year.

FIGURE 48

DAH-G as a percentage of government health expenditure, 2009–2011



Sources: IHME DAH Database 2013 and IHME Government Health Spending Database 2013

Notes: DAH channeled through developing country governments is shown as a percentage of total government health spending. Estimates are shown for all Global Burden of Disease developing countries with the exception of Zimbabwe and Somalia, which were not included due to missing GHE data.

In contrast, DAH-NG has risen sharply since 2003. Figure 47 shows that from 2003 to 2011, the rate of growth for DAH-NG was 43.5%. By 2011, total DAH-NG was $7.4 billion. As a share of total DAH, DAH-NG was considerably higher than DAH-G. In 2011, DAH-NG accounted for 58.7% of total DAH.

Examining the regional distribution of funds shows that sub-Saharan Africa receives the majority of both DAH-NG and DAH-G. The region received 67.8% of DAH-NG and 63.2% of DAH-G in 2011. This is considerably larger than any other region's share of the two categories. Asia received 26.6% of DAH-G, or $1.4 billion, and 18.3% of DAH-NG, a sum of $1.3 billion, in 2011.

Across regions, the ratio of DAH-G to total GHE varies. Total GHE includes health spending from domestic and external sources. As Figure 48 shows, the DAH-G to GHE ratio is highest in select countries in sub-Saharan Africa. Among countries in this region, Mozambique, Malawi, Uganda, Guinea-Bissau, Sierra Leone, and Liberia receive some of the highest DAH-G as a share of GHE, amounting to upward of 50% in 2011. Looking to other regions, Cambodia also sources a large share of GHE from DAH to its government. Across South America and most parts of the Middle East, North Africa, and Asia, however, DAH-G's share of GHE is less than 5%.

Conclusion

Updated estimates of development assistance for health (DAH) confirm that global health continues along a path of transition. At $31.3 billion in 2013, DAH climbed slightly over 2012. This is in line with recent trends, with DAH hovering just above $30 billion since 2010. Despite abounding reports of contractions in official development assistance, levels of DAH were maintained into 2013.

Underneath the bolstered total, emerging trends signal a pivot to different priorities. This year's edition of *Financing Global Health* highlighted the shifting role of income status, health focus areas, and delivery mechanisms in DAH. These changes emphasize the evolving and adaptable nature of the global health field.

Pairing Global Burden of Diseases, Injuries, and Risk Factors Study 2010 data with 2013 DAH estimates reveals an imbalance between DAH and disability-adjusted life years (DALYs). While the vast majority of DAH concentrates on communicable diseases, the leading causes of premature death and disability are shifting to non-communicable diseases (NCDs) in all regions with the exception of sub-Saharan Africa. The NCD burden is also rising quickly around the world. At the same time, a large burden of communicable, maternal, nutritional, and newborn diseases persists, especially in the poorest countries.

However, there are signs that DAH's substantial focus on HIV/AIDS, TB, and malaria may be shifting. The most rapidly growing health focus area from 2010 to 2011 was maternal, newborn, and child health (MNCH). MNCH posted a major rise in 2011, fueled by the push to address health issues faced by women and family planning efforts, as led by the Bill & Melinda Gates Foundation and the United Kingdom. NCD funding, while still a fragment of total DAH, also climbed. Reported increases by the World Health Organization and the attention brought to NCDs by consortiums of non-governmental organizations may fuel future expansion. Across the main infectious diseases, HIV/AIDS DAH increased slightly, while malaria and TB DAH fell.

Financing Global Health 2013 also showed that the prominence of certain organizational types has shifted. Public-private partnerships have enjoyed a persistent, rapid expansion. These bodies are characterized by specialization in specific health focus areas and the influence of both public and private actors. Their rise has coincided with a decline in the share of DAH maintained by development banks.

The economic expansion of middle-income countries is also driving change in the DAH landscape. DAH to middle-income countries is being phased out by some Organisation for Economic Co-operation and Development governments. At the same time, these countries, including South Africa, China, India, and Mexico, are playing a growing role in DAH activities, in the form of technical cooperation, private investment flows, and the provision of development assistance.

As the developing world prepares for the post-2015 era, epidemiological, organizational, and economic transitions will continue to catalyze change in DAH disbursements. Improved information, such as the estimates produced by *Financing Global Health 2013*, will prove vital to development assistance partners as they make decisions about the causes and mechanisms to fund. With timely and comprehensive evidence in hand, stakeholders can work to improve population health in the developing world for generations to come.

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ANNEX A

Methods

The Institute for Health Metrics and Evaluation (IHME) relies on a variety of data sources and methods to produce the *Financing Global Health* report. Accounting methods and statistical models are used to generate our annual database and to estimate the most up-to-date financing figures and trends. In this section, we briefly describe those data and methods. For further information about the sources and methods used in this report, please refer to our online Methods Annex, available at http://www.healthmetricsandevaluation.org/sites/default/files/policy_report/2014/FGH_2013_methods_annex_IHME.pdf

Data compilation and collation is a yearlong effort. Our objective is to track all health-related contributions to developing countries made through public and private channels for the period of 1990 to 2013. IHME analysts collect government documents, annual reports, audited financial statements, datasets from public and private organizations, and tax forms. For several channels, publicly available information is supplemented by private correspondence.

These data allow IHME to generate estimates of development assistance for health (DAH) by channel, source, recipient country, and health focus area. Two significant hurdles overcome in the process relate to the availability and timeliness of disbursement data. For some channels, the most recent or earliest years of DAH reported are commitments or appropriations but not disbursements. Few organizations publish comprehensive financial data concurrent with the disbursement of funds, thus one to three of the most recent years of data are missing for some channels. Regardless, in most cases we have sufficient channel-level data to estimate disbursements. These data include budgets, revenues, commitments, appropriations, and macroeconomic data. While IHME's estimates of DAH for the most recent years are preliminary and based on estimation rather than accounting, they are important to supplying timely, otherwise-unavailable information to decision-makers.

Our estimates account for transfers between the channels to avoid double counting. For example, the Bill & Melinda Gates Foundation (BMGF) is a large funder of both the GAVI Alliance (GAVI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Yet, in this report, funds from BMGF to those channels are assigned to GAVI and GFATM, respectively. BMGF remains the source of those funds, but it is assigned as the channel only for funds it distributes directly to recipients. We do not comprehensively track private donations from countries outside the US except for non-governmental organizations (NGOs) that receive some support from the US government. This is due to the lack of standardized and complete reporting. As the quality, comparability, and availability of data for private DAH outside the US improve, IHME aspires to track these contributions as well.

To identify the amount of DAH allocated to different health focus areas, IHME uses project-level sector and theme codes as well as keyword searches of project titles and descriptions reported by each channel. We classified all DAH from the Joint United Nations Programme on HIV/AIDS (UNAIDS) as DAH for HIV/AIDS. All expenditures by GAVI, the United Nations Children's Fund (UNICEF), and the United

Nations Population Fund (UNFPA) are categorized as maternal, newborn, and child health. For those projects that targeted multiple health focus areas (such as a project for both HIV/AIDS and tuberculosis), we assume that funding for those projects is divided equally among the targeted health focus areas.

In *Financing Global Health 2012: The End of the Golden Age?*, our preliminary estimates of total DAH for 2011 and 2012 were $28.0 and $28.1 billion, respectively (measured in 2011 US dollars). This year, we report $30.6 billion and $30.1 billion of DAH for 2011 and 2012, respectively. These differences are caused by primary data revisions and changes to preliminary estimation methods. Moreover, large projects can be disbursed over many years, and there are lags in obtaining project-level disbursement data. We typically rely on statistical modeling to determine which fraction of a project's budget is disbursed in the most recent years. In response to the financial crisis, organizations like the World Bank altered their operating practices to "front-load" disbursements (prioritizing projects that released funds quickly). Last year, our models did not incorporate some of that change.

We estimate government health spending through 2011 as data for more recent years are incomplete. The World Health Organization (WHO) is the only organization to regularly publish estimates of government health expenditure (GHE) in their National Health Accounts (NHA) database. However, a large quantity of data was either missing or created by WHO using modeling techniques that could not easily be replicated by others. Furthermore, the WHO data report government health expenditure as an agent (GHE-A), which is government health spending financed by both domestic taxpayers and foreign donors. In order to obtain government health expenditure as source (domestically generated expenditure, or GHE-S) from the WHO data, IHME subtracts its estimates of DAH channeled to governments (DAH-G) from GHE-A provided by WHO.

TABLE A1

Sources of DAH data

*Non-US private foundations were not comprehensively tracked due to lack of data

Source	Data
Bilateral agencies in the 23 OECD Development Assistance Committee member countries and the European Commission	OECD-DAC aggregate database and Creditor Reporting System (CRS), budget documents, annual reports, and correspondence
UN agencies: Pan American Health Organization, UNAIDS, UNFPA, UNICEF, and WHO	Financial reports and audited financial statements, annual reports, budget documents, and correspondence
World Bank, Asian Development Bank, African Development Bank, and Inter-American Development bank	Online project databases, compendium of statistics, and correspondence
GAVI	Online project database, cash received database, annual reports, International Finance Facility for Immunisation annual reports, and OECD-CRS
GFATM	Online grant database and pledges
NGOs registered in the US	USAID Report of Voluntary Agencies, tax filings, financial statements, annual reports, RED BOOK Drug Reference, WHO's Model List of Essential Medicines, and correspondence
BMGF and other private US foundations*	Foundation Center's grants database, BMGF online grants database, tax filings, and correspondence

ANNEX B

Tabulated data

TABLE B1

DAH by channel of assistance, 1990–2013

Channel	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
BILATERAL DEVELOPMENT AGENCIES										
United States	983.35	847.89	746.19	709.22	1,019.95	1,128.27	995.54	993.13	980.54	1,052.62
United Kingdom	63.38	75.50	209.64	190.71	164.58	168.92	203.36	230.21	289.81	395.28
Germany	105.27	116.41	162.72	188.45	296.30	393.58	302.12	337.99	268.39	249.00
France	465.30	306.97	271.71	229.18	321.46	402.13	327.15	258.47	295.35	243.62
Canada	58.19	56.73	42.60	40.53	62.33	98.30	70.23	49.74	50.96	51.21
Australia	11.32	14.73	49.19	55.52	76.61	88.13	138.55	97.12	83.61	115.30
Other bilaterals	1,125.13	1,051.69	1,311.75	1,262.93	1,143.17	1,344.02	1,583.89	1,453.75	1,281.24	1,539.87
UNITED NATIONS										
Joint United Nations Programme on HIV/AIDS (UNAIDS)	–	–	–	–	–	–	80.31	78.92	88.99	87.69
United Nations Population Fund (UNFPA)	371.25	358.55	309.06	302.38	438.10	429.16	408.83	401.74	423.54	417.39
United Nations Children's Fund (UNICEF)	230.75	222.85	287.16	280.95	299.43	293.32	264.12	259.54	274.06	270.08
World Health Organization (WHO)	1,129.79	1,091.12	1,072.87	1,049.68	1,180.73	1,156.64	971.17	954.33	1,052.96	1,037.69
Pan American Health Organization (PAHO)	284.20	274.47	281.88	275.79	292.56	286.60	270.78	266.08	302.97	298.57
European Commission (EC)[1]	53.70	40.80	29.33	104.34	179.97	185.96	204.64	250.05	312.90	357.00
PUBLIC-PRIVATE PARTNERSHIPS										
GAVI Alliance (GAVI)	–	–	–	–	–	–	–	–	–	–
Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)	–	–	–	–	–	–	–	–	–	–
Bill & Melinda Gates Foundation (BMGF)	–	–	–	–	–	–	–	–	–	98.64
Other foundations[2]	121.57	118.13	144.13	177.72	154.75	144.65	178.32	171.50	218.89	279.99
Non-governmental organizations (NGOs)	488.43	704.41	835.38	886.30	1,024.73	1,013.77	963.80	1,081.97	1,241.45	1,416.22
WORLD BANK										
International Bank for Reconstruction and Development (IBRD)	79.14	136.81	270.42	409.26	438.49	460.40	762.58	890.64	960.09	602.36
International Development Association (IDA)	73.39	164.00	338.95	579.61	670.03	642.38	732.04	726.31	747.41	815.47
REGIONAL DEVELOPMENT BANKS										
African Development Bank (AfDB)	67.99	65.66	64.14	62.75	97.77	75.53	77.10	96.21	64.58	63.64
Asian Development Bank (ADB)	24.60	37.31	51.04	55.94	60.17	53.55	54.00	79.46	192.36	287.39
Inter-American Development Bank (IDB)	42.31	53.15	67.32	87.43	91.40	98.48	131.07	164.15	156.47	182.42
TOTAL	5,779.05	5,737.18	6,545.48	6,948.71	8,012.55	8,463.80	8,719.62	8,841.29	9,286.56	9,861.45

2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
1,026.95	1,126.46	1,677.40	1,878.03	2,034.32	2,395.62	3,161.92	4,323.95	5,382.46	5,783.80	7,144.69	8,283.46	7,689.43	7,426.85
593.78	495.06	537.72	586.12	582.69	774.85	1,019.97	1,237.39	1,075.83	1,062.39	943.69	985.71	975.71	1,216.52
180.29	174.55	240.03	256.85	271.76	228.45	434.41	369.04	439.93	473.23	344.60	392.97	353.75	346.73
174.00	206.14	248.91	231.08	362.86	321.71	335.81	201.33	395.70	338.13	434.35	160.91	231.33	206.52
82.87	86.25	87.95	130.53	150.11	126.08	174.74	291.75	309.09	468.07	398.57	663.18	542.36	490.53
164.46	129.99	109.63	107.64	110.65	114.64	137.54	146.59	174.78	190.64	271.53	380.11	332.03	338.97
1,284.12	1,221.10	1,468.85	1,453.77	1,718.05	1,841.62	1,989.15	2,103.53	2,197.69	2,166.43	1,789.59	1,617.74	1,493.61	1,556.56
136.16	133.15	116.11	113.71	184.55	178.62	241.93	235.11	273.04	270.68	299.53	293.28	273.51	274.22
393.39	384.70	427.43	418.63	498.02	482.02	545.21	614.08	732.77	828.08	841.36	824.60	796.45	842.82
331.16	474.90	447.56	441.97	514.62	691.19	412.93	558.26	518.06	543.34	867.76	1,080.56	985.83	1,072.24
1,288.10	1,259.63	1,340.03	1,312.43	1,646.53	1,593.61	1,626.64	1,580.77	1,882.99	1,866.73	2,165.54	2,123.71	2,174.23	2,154.99
294.45	287.94	281.37	275.58	279.69	270.70	368.11	357.73	393.62	390.22	432.14	390.20	458.85	414.69
375.27	439.86	451.92	683.04	105.67	456.61	544.56	556.34	676.07	408.37	366.92	522.72	615.99	630.12
3.39	173.23	147.88	240.01	253.09	334.37	287.33	999.92	774.88	532.59	803.73	841.09	1,173.55	1,549.42
–	–	16.80	317.62	794.39	1,276.44	1,543.87	1,920.67	2,508.87	3,009.15	3,363.04	2,928.08	3,435.86	4,014.79
367.12	276.17	423.90	555.86	336.19	470.45	680.32	875.79	1,337.67	1,237.91	1,086.80	1,301.34	1,291.31	1,331.00
355.74	334.70	295.16	258.40	249.41	263.97	303.10	384.32	565.87	546.16	463.83	586.57	566.44	595.45
1,607.31	1,770.02	1,940.63	2,140.29	2,534.27	3,088.94	3,279.52	3,404.06	4,204.86	4,444.31	4,914.76	4,698.57	4,860.33	4,929.49
888.18	817.43	703.43	1,042.40	638.07	576.16	546.37	489.70	539.07	662.90	1,294.12	1,221.31	893.34	883.38
850.60	1,017.27	924.75	869.71	1,334.99	1,177.71	914.35	758.41	650.79	963.06	862.33	1,010.91	709.35	861.22
46.57	43.72	84.02	43.80	93.46	154.05	94.04	91.19	97.07	96.87	122.69	117.55	122.30	76.93
215.37	147.82	149.82	150.17	124.53	186.96	190.64	146.93	154.52	174.80	97.82	83.24	67.31	41.52
196.54	198.67	214.91	257.57	455.27	304.68	145.41	153.47	152.26	142.29	112.39	102.72	76.78	53.37
10,855.82	11,198.76	12,336.22	13,765.19	15,273.20	17,309.44	18,977.89	21,800.31	25,437.87	26,600.15	29,421.77	30,610.51	30,119.66	31,308.33

Source: IHME DAH Database 2013

Notes: In millions of 2011 US dollars. Development assistance for health (DAH) includes both financial and in-kind contributions for activities aimed at improving health in low- and middle-income countries. This table disaggregates DAH by the institutional channel through which DAH flowed to low- and middle-income countries.

1 Includes funds from the European Development Fund and the European Commission budget.

2 Only includes organizations incorporated in the United States.

TABLE B2

DAH by source of funding, 1990–2011

Funding source	1990	1991	1992	1993	1994	1995	1996	1997	1998
NATIONAL TREASURIES									
Australia	30.84	33.76	71.48	83.33	126.95	121.26	188.96	139.73	112.47
Austria	42.49	14.46	10.12	14.74	18.18	15.08	19.86	80.38	33.58
Belgium	105.83	121.38	127.39	123.03	114.28	119.35	125.80	115.01	117.82
Canada	137.07	137.88	122.92	127.47	174.81	182.35	152.89	151.26	128.21
Denmark	107.56	117.26	155.08	169.38	167.15	152.95	256.58	222.82	125.76
Finland	108.19	107.72	69.89	56.91	55.17	49.35	53.00	46.31	48.37
France	533.91	383.99	352.81	341.48	508.34	546.93	514.34	392.21	432.90
Germany	221.95	240.18	299.84	367.40	600.24	678.35	546.42	557.59	502.22
Greece	1.64	1.59	1.54	1.50	2.20	9.68	16.29	17.93	18.95
Ireland	4.33	4.51	6.01	2.57	13.31	31.08	32.57	6.86	31.42
Italy	246.15	278.11	235.68	210.16	182.82	169.96	233.29	115.73	146.72
Japan	461.66	510.19	554.11	771.38	726.88	885.41	783.08	944.96	835.23
Luxembourg	1.49	1.43	9.67	9.69	4.14	18.94	20.02	30.43	32.63
Netherlands	187.63	157.37	273.98	274.29	190.76	242.00	317.73	302.39	313.61
New Zealand	1.51	4.73	4.93	4.60	57.51	55.09	3.46	2.76	8.64
Norway	124.05	117.69	160.17	106.67	97.55	120.49	158.36	138.24	123.33
Portugal	1.37	1.38	4.74	2.72	12.19	14.25	16.88	22.15	17.09
South Korea	1.09	2.50	4.97	6.43	7.02	11.52	11.82	44.76	47.56
Spain	20.26	41.85	138.11	125.10	93.52	198.55	286.34	207.31	196.19
Sweden	362.36	271.18	304.16	308.64	262.25	270.79	227.48	209.85	194.52
Switzerland	89.34	78.34	62.05	62.68	93.64	72.42	71.13	92.62	55.61
United Kingdom	162.28	176.42	314.75	295.81	315.08	316.83	344.61	417.32	504.56
United States	1,439.85	1,433.78	1,539.97	1,486.62	1,896.72	1,909.34	1,796.22	1,788.87	1,788.50
Other	137.70	135.26	175.03	171.25	218.78	214.32	125.19	123.02	345.62
PRIVATE PHILANTHROPY									
Bill & Melinda Gates Foundation (BMGF)	–	–	–	–	–	–	–	–	–
Corporate donations	43.18	47.07	59.69	77.19	101.92	95.73	110.56	120.18	133.61
Other[1]	432.70	471.13	569.58	639.54	665.70	665.20	720.62	769.32	1,032.81
Debt repayments (IBRD)	93.78	166.55	313.98	492.92	621.75	642.27	950.15	1,080.46	1,130.80
Other	355.94	343.76	236.18	231.08	285.85	280.02	191.28	187.96	225.65
Unallocable	322.89	335.69	366.65	384.17	397.82	374.30	444.70	512.85	602.18
Total	5,779.05	5,737.18	6,545.48	6,948.71	8,012.55	8,463.80	8,719.62	8,841.29	9,286.56

1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
167.22	204.50	170.29	146.23	144.72	165.03	228.38	205.65	232.69	302.12	323.66	513.47	693.66
116.00	66.52	31.08	40.40	48.89	47.32	58.72	51.76	62.66	81.27	71.69	87.64	109.14
123.92	135.71	143.55	211.72	183.55	211.97	180.74	219.34	252.24	319.10	328.57	320.33	329.95
145.87	177.45	161.89	246.77	296.93	406.04	526.53	431.32	575.30	604.14	810.76	879.15	1,256.75
124.02	133.62	114.32	121.07	143.33	181.79	200.15	190.93	207.63	193.17	222.27	216.43	220.15
50.20	50.70	54.43	65.03	71.52	78.52	79.13	89.46	87.88	98.01	99.94	146.31	125.71
387.88	327.08	403.13	475.72	584.77	578.52	716.46	965.62	821.52	1,166.80	954.86	1,188.92	870.22
507.06	485.13	502.99	576.59	605.05	554.29	595.55	779.75	794.18	1,014.29	1,092.19	942.07	1,077.93
13.12	15.21	18.68	18.02	43.52	34.69	52.23	54.38	55.18	35.15	37.36	17.02	13.43
30.23	42.41	53.71	118.54	149.42	160.65	178.11	259.36	280.91	228.32	161.98	153.80	127.94
178.63	171.66	210.07	243.91	343.91	217.98	441.74	404.36	443.91	506.50	273.88	263.29	247.63
857.93	870.64	854.73	650.59	763.99	980.05	867.58	797.82	607.28	628.62	760.80	896.47	775.58
25.11	35.32	44.07	50.77	49.81	58.03	52.22	69.74	78.58	82.07	78.44	86.81	72.66
312.10	444.30	436.37	436.52	434.91	426.60	471.06	673.61	537.36	758.03	595.43	550.93	527.56
11.11	8.98	9.14	11.56	17.82	20.68	26.00	37.19	30.09	44.62	40.76	43.11	45.15
173.59	148.95	261.63	308.21	318.02	380.50	405.45	391.05	675.79	556.52	788.66	637.50	624.72
18.72	17.82	19.34	22.54	25.22	20.43	25.17	24.58	26.24	23.14	24.20	26.60	29.48
120.22	87.00	63.44	67.36	37.44	92.36	101.70	73.49	85.27	95.00	149.17	157.60	114.95
238.92	164.72	192.59	195.94	231.64	234.89	270.78	348.11	473.26	742.37	815.47	571.70	376.41
198.08	181.74	152.18	196.68	226.20	351.00	503.44	514.33	525.67	539.81	479.07	470.87	571.03
127.07	65.90	66.42	84.37	128.24	85.79	76.23	105.66	89.46	101.15	163.45	128.48	153.05
558.06	946.01	907.98	901.58	1,098.76	1,060.21	1,457.31	1,736.45	2,283.59	1,839.82	1,932.09	2,232.31	2,132.47
1,924.51	2,064.51	2,273.33	3,047.92	3,133.11	3,960.72	4,146.71	4,816.06	6,076.95	7,606.33	8,595.13	10,202.18	11,183.41
348.87	119.51	109.55	89.83	92.90	145.39	150.09	176.58	219.24	251.65	239.65	366.33	396.41
109.32	434.09	519.33	551.95	640.42	448.18	741.40	883.61	1,171.08	1,887.28	1,787.38	1,722.14	2,237.13
140.39	128.67	194.71	213.93	261.95	380.73	468.94	409.48	465.09	709.94	589.62	509.19	519.90
1,145.86	1,343.38	1,348.33	1,281.97	1,369.30	1,485.54	1,864.59	2,106.73	2,305.23	2,718.16	2,634.38	3,024.59	2,923.84
775.28	1,091.64	1,052.59	1,008.51	1,319.75	1,015.73	1,040.26	786.42	799.49	731.38	998.77	1,633.50	1,503.42
222.37	240.14	241.17	265.07	299.82	348.32	349.42	524.65	703.27	733.15	651.83	636.11	572.80
709.76	652.50	587.74	686.91	700.29	1,141.24	1,033.35	850.41	833.28	839.64	898.33	796.90	778.00
9,861.45	10,855.82	11,198.76	12,336.22	13,765.19	15,273.20	17,309.44	18,977.89	21,800.31	25,437.53	26,599.80	29,421.77	30,610.51

Source: IHME DAH Database 2013

Notes: In millions of 2011 US dollars. Development assistance for health (DAH) includes both financial and in-kind contributions for activities aimed at improving health in low- and middle-income countries. This table disaggregates DAH by primary funding source. For preliminary estimates of DAH for 2012 and 2013, refer to Table B1.

1 Includes private contributions through foundations and NGOs.

TABLE B3

DAH by focus region, 1990–2011

Year	Sub-Saharan Africa	Middle East and North Africa	South Asia	East Asia and Pacific
1990	588.44	115.80	302.03	319.24
1991	611.99	176.70	354.77	262.09
1992	769.89	183.87	576.03	263.63
1993	770.84	216.63	631.63	442.78
1994	804.62	206.40	665.30	408.81
1995	817.04	219.16	563.20	367.11
1996	1,058.11	222.88	649.47	446.10
1997	1,034.94	264.09	653.10	497.33
1998	1,000.77	246.00	701.86	558.08
1999	1,092.20	277.11	710.19	725.28
2000	1,123.28	289.16	751.61	855.13
2001	1,585.68	290.67	861.67	686.58
2002	1,614.55	258.84	887.92	609.20
2003	2,434.62	317.50	812.17	862.39
2004	3,417.51	373.08	1,094.19	992.52
2005	3,874.45	875.99	1,292.15	1,132.90
2006	4,662.54	852.80	1,154.88	1,364.30
2007	5,380.30	642.93	1,424.30	1,354.06
2008	7,257.67	647.45	1,671.34	1,402.07
2009	7,886.53	514.14	1,795.69	1,528.94
2010	8,248.27	540.76	1,859.96	1,607.17
2011	8,751.70	429.00	2,012.18	1,640.96

Europe and Central Asia	Latin America and Caribbean	Global[1]	Unallocable by region	Total
13.99	325.21	46.24	4,068.10	5,779.05
21.85	378.54	61.63	3,869.61	5,737.18
105.42	448.82	89.35	4,108.47	6,545.48
144.02	539.87	195.89	4,007.04	6,948.71
181.73	499.06	505.37	4,741.27	8,012.55
133.13	686.66	659.40	5,018.10	8,463.80
202.39	955.45	485.07	4,700.16	8,719.62
215.39	1,165.26	545.86	4,465.33	8,841.29
249.36	1,176.54	467.06	4,886.89	9,286.56
298.21	991.56	568.70	5,198.20	9,861.45
255.60	1,166.53	608.44	5,806.08	10,855.82
297.39	1,159.36	648.53	5,668.88	11,198.76
282.97	967.60	1,300.15	6,415.00	12,336.22
288.80	1,562.57	1,789.28	5,697.87	13,765.19
360.99	1,403.93	1,192.83	6,438.16	15,273.20
647.64	1,246.31	1,406.54	6,833.47	17,309.44
655.78	1,078.95	1,693.20	7,515.45	18,977.89
660.99	1,177.66	2,238.79	8,921.30	21,800.31
695.54	1,255.76	2,904.51	9,603.53	25,437.87
626.48	1,457.01	3,022.13	9,769.23	26,600.15
618.04	1,987.42	3,169.82	11,390.34	29,421.77
655.92	1,829.93	3,511.69	11,779.13	30,610.51

Source: IHME DAH Database 2013

Notes: In millions of 2011 US dollars. Development assistance for health (DAH) includes both financial and in-kind contributions for activities aimed at improving health in low- and middle-income countries. This table disaggregates DAH by region intended to benefit from the assistance. World Bank regional groupings are used. For preliminary estimates of DAH for 2012 and 2013, refer to Table B1.

1 Global denotes contributions made toward health research or the creation of public goods for multiple regions or projects that donors categorized as benefiting the world on the whole.

TABLE B4

DAH by target country, 1990–2011

Region/country	1990		1991		1992		1993		1994		1995		1996		1997		1998		1999	
	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita
EAST ASIA AND PACIFIC																				
Cambodia	0.00	0.00	1.88	0.19	7.99	0.78	11.66	1.10	39.33	3.62	61.05	5.48	61.34	5.36	48.59	4.15	34.16	2.85	31.10	2.54
China	37.72	0.03	31.25	0.03	55.24	0.05	59.78	0.05	70.75	0.06	94.08	0.08	110.56	0.09	106.33	0.09	115.02	0.09	84.22	0.07
Fiji	0.28	0.38	5.98	8.07	12.08	16.11	20.54	27.05	1.74	2.26	1.08	1.39	0.63	0.80	0.87	1.09	0.62	0.77	12.01	14.87
Indonesia	123.17	0.67	59.01	0.31	40.89	0.21	77.44	0.40	56.30	0.29	59.54	0.30	64.12	0.32	114.40	0.56	116.22	0.56	198.76	0.94
Kiribati	6.40	91.56	3.00	42.10	0.01	0.08	2.58	35.32	0.13	1.77	0.37	4.93	0.25	3.24	0.20	2.64	0.14	1.81	0.00	0.00
Laos	0.00	0.00	0.00	0.00	1.85	0.42	1.09	0.24	2.32	0.50	7.36	1.54	7.44	1.52	5.88	1.17	6.67	1.30	11.53	2.21
Malaysia	35.77	1.97	37.29	2.00	29.80	1.55	25.94	1.32	31.28	1.55	34.71	1.68	43.96	2.07	33.05	1.52	12.30	0.55	17.73	0.77
Marshall Islands	0.00	0.00	0.00	0.00	0.09	1.73	0.08	1.67	0.47	9.36	1.12	21.88	1.04	20.08	1.01	19.43	0.90	17.12	3.79	71.11
Micronesia, Federated States of	0.00	0.00	0.00	0.00	3.99	39.39	0.65	6.27	0.48	4.52	0.35	3.27	0.26	2.39	0.19	1.76	0.00	0.00	6.06	55.91
Mongolia	2.30	1.05	2.62	1.18	3.88	1.72	2.24	0.99	3.09	1.35	4.14	1.79	3.12	1.34	3.99	1.70	6.77	2.86	12.65	5.30
Myanmar	2.03	0.05	2.04	0.05	0.08	0.00	0.22	0.01	0.15	0.00	0.22	0.01	0.30	0.01	0.30	0.01	0.61	0.01	2.15	0.05
North Korea	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.27	0.01	0.26	0.01
Papua New Guinea	20.26	4.87	26.29	6.16	23.78	5.44	28.29	6.31	13.50	2.93	7.62	1.61	49.19	10.15	34.78	6.99	41.27	8.08	42.65	8.14
Philippines	44.31	0.72	48.19	0.76	44.61	0.69	39.69	0.60	43.90	0.65	56.96	0.82	50.97	0.72	52.61	0.73	81.54	1.10	88.96	1.17
Samoa	0.00	0.02	0.00	0.00	0.00	0.00	0.40	2.42	0.84	4.99	0.54	3.21	0.33	1.92	0.23	1.31	1.09	6.22	0.64	3.64
Solomon Islands	2.11	6.72	1.23	3.81	3.35	10.10	2.80	8.21	2.72	7.74	1.72	4.76	2.09	5.65	1.51	3.97	1.12	2.85	2.89	7.20
South Korea	30.24	0.70	18.31	0.42	3.40	0.08	108.06	2.45	99.34	2.24	NA	NA	NA	NA	NA	NA	0.00	0.00	0.06	0.00
Thailand	2.06	0.04	1.10	0.02	0.95	0.02	14.81	0.25	4.98	0.08	2.84	0.05	10.59	0.18	23.08	0.38	77.25	1.25	111.54	1.79
Timor-Leste	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.29	0.35
Tonga	0.05	0.54	0.04	0.43	0.05	0.47	0.17	1.73	0.42	4.33	0.48	4.93	0.15	1.57	1.78	18.28	0.00	0.01	0.09	0.88
Vanuatu	0.38	2.55	0.83	5.50	0.30	1.89	0.40	2.48	0.70	4.25	0.59	3.49	0.34	1.99	0.88	5.02	1.18	6.58	1.75	9.63
Vietnam	4.39	0.07	12.79	0.19	21.48	0.31	29.52	0.41	18.15	0.25	16.55	0.22	33.53	0.45	49.59	0.65	53.27	0.69	76.82	0.98
EUROPE AND CENTRAL ASIA																				
Albania	0.00	0.00	0.00	0.00	2.98	0.91	0.72	0.22	3.67	1.15	3.35	1.06	5.09	1.63	3.80	1.22	8.94	2.89	15.23	4.94
Armenia	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	14.56	4.41	2.76	0.85	3.39	1.06	3.29	1.04	5.50	1.76	6.60	2.12
Azerbaijan	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	6.08	0.80	0.99	0.13	0.99	0.13	0.60	0.08	0.74	0.09	9.93	1.23
Belarus	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Bosnia and Herzegovina	0.00	0.00	0.00	0.00	0.00	0.00	0.77	0.21	1.72	0.49	0.28	0.08	17.19	5.13	4.07	1.20	21.26	6.08	49.75	13.81
Bulgaria	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.32	0.40	4.45	0.54	5.45	0.67	1.98	0.24
Croatia	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.42	0.31	16.94	3.64	12.14	2.62	11.54	2.50	11.50	2.51	1.35	0.30
Czech Republic	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Estonia	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.49	0.34	0.51	0.36	0.50	0.35	0.49	0.35	1.82	1.32
Georgia	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8.18	1.59	1.65	0.32	3.97	0.79	4.21	0.85	7.32	1.50	16.32	3.38
Hungary	0.00	0.00	0.00	0.00	0.00	0.00	5.04	0.49	7.03	0.68	6.89	0.67	6.78	0.66	6.64	0.65	6.57	0.64	3.23	0.31
Kazakhstan	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	5.01	0.31	4.66	0.29	4.62	0.29	5.32	0.34	8.09	0.53	18.90	1.24
Kyrgyzstan	0.00	0.00	0.00	0.00	0.00	0.00	0.14	0.03	1.63	0.36	0.30	0.07	11.17	2.39	8.68	1.83	9.30	1.93	9.33	1.90
Latvia	0.00	0.00	0.00	0.00	1.71	0.65	8.58	3.34	8.40	3.33	0.00	0.00	0.00	0.00	0.00	0.00	0.31	0.13	0.33	0.14
Lithuania	0.00	0.00	0.00	0.00	1.33	0.36	6.67	1.81	6.53	1.79	6.40	1.76	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Macedonia, FYR	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8.08	4.10	6.93	3.50	7.46	3.74	18.89	9.43
Malta	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.02	0.06	0.01	0.01	0.00	0.00	0.00	0.00	NA	NA	0.00	0.00

2000		2001		2002		2003		2004		2005		2006		2007		2008		2009		2010		2011	
DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita
38.85	3.12	45.57	3.60	38.67	3.01	74.77	5.73	80.51	6.09	114.37	8.54	111.61	8.24	123.52	9.01	138.04	9.96	159.23	11.37	190.84	13.47	171.69	11.98
143.66	0.11	94.66	0.07	105.93	0.08	134.74	0.10	225.04	0.17	187.38	0.14	251.95	0.19	296.87	0.22	247.59	0.19	321.03	0.24	228.95	0.17	206.66	0.15
8.37	10.29	4.22	5.17	5.48	6.69	14.00	17.04	6.35	7.70	2.93	3.54	6.38	7.64	7.93	9.44	6.12	7.22	6.08	7.11	10.22	11.84	9.19	10.56
333.58	1.56	215.47	1.00	151.81	0.69	209.52	0.94	207.36	0.92	192.73	0.85	283.13	1.23	234.44	1.01	265.86	1.13	264.07	1.11	233.15	0.97	223.07	0.92
0.15	1.82	0.18	2.11	0.21	2.45	0.20	2.35	0.16	1.80	2.12	24.08	2.86	31.98	4.54	50.03	7.77	84.36	4.57	48.93	5.28	55.76	4.53	47.08
22.74	4.28	16.11	2.98	14.53	2.64	33.44	5.99	26.45	4.67	35.40	6.16	33.86	5.80	39.16	6.61	41.64	6.92	39.12	6.41	52.90	8.54	55.88	8.90
14.10	0.60	2.34	0.10	1.17	0.05	2.86	0.11	1.46	0.06	1.55	0.06	0.90	0.03	0.78	0.03	0.72	0.03	0.55	0.02	0.23	0.01	1.70	0.06
2.70	50.12	2.48	45.37	1.72	31.01	3.93	69.40	10.74	185.99	15.88	269.95	7.71	128.68	8.11	132.88	8.72	140.52	9.75	154.35	0.21	3.33	0.30	4.63
1.09	10.08	0.79	7.27	0.00	0.00	4.62	42.06	18.24	165.31	20.03	180.98	18.22	164.21	18.73	168.61	18.82	169.13	24.72	221.79	0.41	3.68	1.02	9.06
7.36	3.05	17.71	7.27	5.85	2.37	8.58	3.44	6.35	2.51	8.63	3.37	7.70	2.97	16.14	6.13	16.58	6.21	19.74	7.29	26.66	9.69	25.24	9.03
3.23	0.07	3.58	0.08	10.69	0.23	28.42	0.62	26.95	0.58	43.83	0.94	22.89	0.49	35.11	0.75	45.29	0.96	50.21	1.05	85.97	1.79	62.23	1.29
0.06	0.00	0.00	0.00	1.44	0.06	1.58	0.07	2.21	0.09	4.75	0.20	2.93	0.12	2.25	0.09	2.86	0.12	6.78	0.28	21.97	0.90	15.40	0.63
36.27	6.74	42.62	7.72	55.05	9.72	53.73	9.25	55.75	9.36	58.54	9.59	64.09	10.24	46.40	7.24	70.00	10.67	73.12	10.89	81.00	11.80	137.87	19.63
78.80	1.02	79.31	1.00	42.80	0.53	82.26	1.00	89.23	1.06	160.16	1.87	166.17	1.91	141.65	1.60	88.02	0.98	107.99	1.18	162.08	1.74	167.01	1.76
0.48	2.70	1.58	8.86	0.36	1.99	3.19	17.72	3.49	19.29	3.63	20.01	5.47	30.09	2.87	15.74	3.25	17.78	2.91	15.84	8.13	44.18	2.34	12.66
1.73	4.20	6.10	14.39	7.14	16.39	10.82	24.19	13.32	28.98	11.03	23.35	10.65	21.96	12.09	24.25	17.03	33.26	19.05	36.24	25.02	46.36	36.71	66.28
0.00	0.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
60.66	0.96	18.75	0.29	15.50	0.24	29.77	0.46	50.76	0.77	37.48	0.56	83.58	1.25	61.54	0.91	70.90	1.04	53.12	0.77	64.63	0.94	85.69	1.23
0.54	0.65	2.65	3.09	0.75	0.84	2.83	3.03	3.74	3.81	8.35	8.20	16.50	15.78	18.12	16.98	23.82	21.95	19.31	17.49	24.46	21.67	22.85	19.72
0.94	9.61	0.96	9.73	0.98	9.89	2.10	21.08	3.08	30.72	13.56	134.14	4.63	45.53	4.61	44.95	1.85	17.92	2.91	28.06	5.30	50.78	16.47	157.01
1.66	8.91	2.98	15.66	2.41	12.37	3.62	18.08	3.73	18.14	3.62	17.15	2.95	13.61	3.10	13.94	5.14	22.52	8.45	36.14	5.79	24.16	7.41	30.15
72.92	0.92	84.56	1.06	98.30	1.22	121.96	1.50	109.55	1.33	146.63	1.76	180.20	2.14	166.10	1.95	241.36	2.81	236.31	2.72	288.27	3.28	294.70	3.32
16.96	5.51	18.45	5.98	16.27	5.26	20.74	6.67	20.63	6.60	23.59	7.50	28.29	8.96	18.25	5.76	20.65	6.50	12.57	3.94	10.53	3.29	25.63	7.98
12.49	4.03	8.60	2.79	13.32	4.34	5.10	1.66	7.86	2.56	16.26	5.30	24.00	7.82	23.00	7.48	20.62	6.69	37.61	12.18	23.32	7.54	20.62	6.64
12.02	1.48	4.10	0.50	5.45	0.66	3.27	0.39	2.66	0.31	9.72	1.13	11.50	1.31	12.83	1.45	14.06	1.57	19.79	2.17	22.25	2.41	35.91	3.85
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.47	0.15	4.66	0.48	4.81	0.49	8.11	0.83	14.71	1.52	14.53	1.51	15.83	1.65	13.85	1.45
11.13	3.02	12.60	3.37	11.51	3.05	15.72	4.16	7.50	1.98	10.51	2.78	26.62	7.03	23.06	6.10	19.41	5.14	26.71	7.09	42.27	11.24	28.62	7.62
11.60	1.45	9.60	1.21	12.62	1.60	7.69	0.98	25.86	3.32	34.13	4.41	10.88	1.41	20.88	2.72	23.51	3.08	15.18	2.00	12.95	1.71	11.79	1.57
1.13	0.25	4.71	1.05	6.43	1.44	9.51	2.13	4.36	0.98	14.89	3.35	2.04	0.46	0.58	0.13	NA	NA	NA	NA	NA	NA	NA	NA
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0.00	0.00	0.00	0.00	0.00	0.00	1.21	0.89	2.10	1.56	2.62	1.94	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
14.52	3.04	17.12	3.63	19.19	4.12	9.51	2.07	11.79	2.59	30.51	6.76	35.22	7.87	37.00	8.33	24.72	5.61	38.21	8.72	35.12	8.06	37.28	8.61
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
18.82	1.25	21.34	1.42	9.63	0.64	18.14	1.21	13.69	0.91	10.65	0.70	15.85	1.03	10.13	0.65	19.80	1.27	20.96	1.33	37.40	2.34	32.97	2.04
15.08	3.04	5.47	1.10	13.29	2.65	26.23	5.22	17.60	3.49	29.04	5.73	28.73	5.62	37.38	7.25	43.82	8.41	32.80	6.23	37.40	7.02	45.63	8.47
1.72	0.72	2.30	0.98	4.24	1.81	0.81	0.35	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	NA	NA	38.50	17.12	43.14	19.21
1.03	0.29	0.62	0.18	4.50	1.30	4.57	1.33	7.31	2.13	2.12	0.62	2.01	0.59	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3.10	1.54	14.90	7.38	1.93	0.96	2.29	1.13	7.88	3.87	5.74	2.82	7.26	3.55	18.88	9.22	8.74	4.26	3.33	1.62	6.97	3.38	7.00	3.39
NA	NA	0.00	0.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

TABLE B4

DAH by target country, 1990–2011, continued

Region/country	1990		1991		1992		1993		1994		1995		1996		1997		1998		1999	
	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita
Moldova	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.56	0.13	1.25	0.30	11.43	2.74
Montenegro	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Poland	0.00	0.00	0.00	0.00	8.69	0.23	12.98	0.34	12.71	0.33	12.45	0.32	12.26	0.32	12.01	0.31	11.88	0.31	2.80	0.07
Romania	0.00	0.00	7.05	0.31	27.39	1.19	26.72	1.16	26.17	1.14	25.64	1.12	25.23	1.11	24.72	1.10	24.44	1.09	0.00	0.00
Russia	0.00	0.00	0.00	0.00	28.46	0.19	68.67	0.47	50.30	0.34	0.00	0.00	38.43	0.26	67.46	0.46	69.37	0.47	53.43	0.37
Serbia	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.86	0.08	14.98	1.47
Slovakia	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Slovenia	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	NA	NA	NA	NA	NA	NA
Tajikistan	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	5.52	0.97	2.05	0.35	1.81	0.31	2.21	0.37	2.20	0.36	3.36	0.55
Turkey	11.78	0.22	11.69	0.21	32.24	0.57	11.67	0.20	14.76	0.25	37.93	0.64	31.84	0.53	24.36	0.40	23.41	0.38	18.69	0.30
Turkmenistan	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.42	0.35	1.92	0.46	1.08	0.25	1.40	0.32	6.66	1.51	2.83	0.63
Ukraine	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Uzbekistan	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.52	0.07	2.89	0.13	11.96	0.51	7.82	0.33	9.13	0.38	18.81	0.77
LATIN AMERICA AND CARIBBEAN																				
Antigua and Barbuda	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.18	2.46
Argentina	13.59	0.42	23.20	0.70	67.45	2.01	23.00	0.68	33.32	0.97	86.53	2.48	189.84	5.38	278.74	7.80	292.00	8.08	119.67	3.27
Barbados	2.68	10.33	2.72	10.43	2.66	10.19	1.11	4.25	0.12	0.46	0.12	0.45	0.12	0.44	0.11	0.43	0.11	0.43	0.11	0.42
Belize	3.20	16.78	3.31	16.83	3.72	18.41	2.41	11.60	0.99	4.63	0.79	3.59	0.79	3.52	0.97	4.19	0.86	3.60	0.71	2.93
Bolivia	19.51	2.92	22.15	3.24	37.71	5.40	39.40	5.52	37.61	5.15	34.72	4.65	42.87	5.61	45.05	5.77	53.94	6.76	48.62	5.96
Brazil	47.47	0.32	43.94	0.29	48.69	0.31	50.15	0.32	84.00	0.53	83.77	0.52	112.21	0.68	154.19	0.92	127.00	0.75	129.41	0.75
Chile	12.30	0.93	39.88	2.97	28.24	2.10	43.02	3.15	30.80	2.22	33.53	2.38	27.91	1.95	27.16	1.88	7.39	0.50	6.47	0.44
Colombia	5.28	0.16	7.94	0.23	5.12	0.15	25.05	0.71	14.80	0.41	14.71	0.40	49.25	1.33	43.31	1.15	24.91	0.65	52.43	1.34
Costa Rica	1.71	0.56	0.98	0.31	2.05	0.64	7.15	2.16	9.24	2.73	9.05	2.61	9.37	2.63	8.70	2.38	9.56	2.56	18.38	4.80
Cuba	0.04	0.00	0.02	0.00	0.50	0.05	0.55	0.05	0.10	0.01	0.73	0.07	0.22	0.02	1.18	0.11	0.63	0.06	4.93	0.44
Dominica	3.98	58.79	1.17	17.22	0.12	1.73	1.46	21.38	0.10	1.44	0.06	0.90	0.03	0.49	0.54	7.91	0.36	5.33	0.00	0.00
Dominican Republic	6.00	0.83	4.98	0.68	4.57	0.61	13.21	1.73	8.41	1.08	6.93	0.88	24.86	3.09	17.36	2.12	40.65	4.88	50.18	5.92
Ecuador	10.76	1.05	7.79	0.74	12.62	1.17	18.50	1.68	17.99	1.61	16.69	1.46	16.74	1.44	20.44	1.73	31.84	2.66	21.90	1.80
El Salvador	26.47	4.94	36.09	6.65	42.39	7.69	25.92	4.63	19.91	3.51	19.06	3.32	11.60	2.00	16.73	2.87	28.18	4.80	22.69	3.84
Grenada	3.39	35.39	2.05	21.33	0.34	3.54	0.00	0.03	0.00	0.01	0.00	0.00	0.00	0.00	0.21	2.07	0.16	1.57	0.00	0.00
Guatemala	10.85	1.21	8.57	0.93	10.83	1.15	28.24	2.94	14.79	1.51	21.10	2.10	20.01	1.95	89.33	8.50	35.54	3.30	50.65	4.60
Guyana	4.82	6.58	4.62	6.34	4.48	6.15	4.75	6.54	4.66	6.42	4.57	6.31	4.49	6.20	4.38	6.04	3.99	5.51	3.62	5.01
Haiti	24.20	3.39	27.92	3.84	20.40	2.75	34.55	4.56	36.01	4.66	86.77	11.02	32.24	4.02	29.87	3.65	37.27	4.47	46.55	5.49
Honduras	24.23	4.94	20.90	4.14	19.16	3.70	33.97	6.39	20.07	3.68	17.42	3.12	34.46	6.03	45.62	7.81	23.70	3.97	49.15	8.06
Jamaica	16.01	6.73	18.38	7.68	17.62	7.32	15.81	6.52	15.67	6.41	12.06	4.89	15.55	6.25	16.00	6.37	16.25	6.42	19.40	7.59
Mexico	19.48	0.23	15.01	0.17	15.72	0.18	8.97	0.10	1.04	0.01	69.53	0.75	163.77	1.75	153.48	1.61	207.95	2.14	77.87	0.79
Nicaragua	8.54	2.06	18.62	4.40	19.41	4.48	34.30	7.73	34.44	7.59	27.35	5.90	32.81	6.93	37.05	7.68	37.24	7.58	64.83	12.98
Panama	0.26	0.11	4.56	1.85	3.85	1.53	4.41	1.72	11.61	4.42	12.56	4.69	24.36	8.90	14.93	5.35	14.43	5.07	13.15	4.54
Paraguay	0.54	0.13	0.17	0.04	0.11	0.02	0.08	0.02	0.05	0.01	0.04	0.01	1.17	0.24	6.26	1.24	22.44	4.37	29.24	5.57
Peru	14.05	0.65	12.79	0.58	30.48	1.35	49.94	2.17	46.85	2.00	55.15	2.31	62.27	2.57	51.52	2.09	62.80	2.50	58.06	2.28
St. Lucia	1.33	9.51	0.80	5.68	0.08	0.56	0.16	1.11	1.01	6.96	0.08	0.52	1.34	8.97	0.64	4.25	0.63	4.11	0.08	0.48
St. Vincent and the Grenadines	0.08	0.73	0.04	0.35	0.03	0.25	0.02	0.23	0.08	0.78	0.47	4.33	0.06	0.53	0.68	6.31	1.24	11.51	0.73	6.73

2000		2001		2002		2003		2004		2005		2006		2007		2008		2009		2010		2011	
DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita
15.64	3.81	7.85	1.94	5.32	1.33	6.04	1.54	14.20	3.68	16.68	4.38	11.23	2.99	17.33	4.68	17.86	4.89	40.40	11.18	46.63	13.03	33.42	9.42
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	7.93	12.64	6.97	11.10	5.46	8.68	2.53	4.01	2.83	4.49	4.02	6.35
1.54	0.04	20.68	0.54	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	NA	NA	NA	NA	NA	NA
0.00	0.00	15.23	0.69	19.37	0.88	9.43	0.43	18.50	0.85	11.82	0.54	7.44	0.34	29.91	1.38	27.50	1.27	12.31	0.57	8.41	0.39	17.60	0.82
42.35	0.29	48.66	0.34	29.71	0.21	9.79	0.07	16.92	0.12	40.89	0.29	99.47	0.70	129.45	0.91	127.29	0.90	63.62	0.45	35.04	0.25	12.95	0.09
11.81	1.16	12.69	1.26	7.76	0.77	28.60	2.87	23.34	2.36	19.63	1.99	28.29	2.87	16.90	1.72	17.01	1.73	27.74	2.81	14.33	1.45	46.85	4.75
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	17.16	3.19	18.41	3.42	1.87	0.35	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
3.58	0.58	3.41	0.55	6.19	0.98	10.89	1.71	19.75	3.08	16.94	2.61	21.18	3.23	26.77	4.04	35.62	5.30	46.19	6.78	45.63	6.61	35.72	5.10
12.72	0.20	7.89	0.12	27.68	0.42	24.08	0.36	23.67	0.35	21.74	0.32	130.34	1.89	47.81	0.68	76.10	1.07	27.23	0.38	28.13	0.39	23.32	0.32
2.25	0.50	2.18	0.48	2.09	0.45	2.20	0.47	1.73	0.37	2.11	0.44	1.79	0.37	1.88	0.38	2.08	0.42	1.83	0.37	2.10	0.42	5.95	1.16
0.00	0.00	0.00	0.00	1.80	0.04	10.26	0.22	14.33	0.30	38.94	0.83	63.25	1.36	70.43	1.52	68.21	1.48	70.74	1.54	51.50	1.13	71.44	1.57
12.80	0.52	24.22	0.96	30.25	1.19	24.86	0.97	42.10	1.63	28.45	1.09	30.94	1.18	34.63	1.30	37.50	1.40	43.03	1.58	31.43	1.14	36.36	1.31
1.32	17.99	0.10	1.34	NA	NA	0.02	0.31	0.09	1.18	NA	NA	NA	NA	NA	NA	NA	NA	0.02	0.29	0.03	0.40	0.00	0.00
66.12	1.79	194.47	5.21	46.75	1.24	592.27	15.57	199.61	5.20	71.16	1.84	62.64	1.60	127.50	3.24	141.24	3.55	137.54	3.43	145.15	3.59	271.41	6.66
NA	NA	0.11	0.40	NA	NA	4.20	15.62	2.27	8.41	2.01	7.42	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
2.12	8.50	2.99	11.66	2.05	7.82	1.58	5.89	2.00	7.26	1.96	6.98	2.26	7.86	2.05	6.99	0.78	2.61	2.25	7.35	3.31	10.60	2.06	6.46
73.67	8.85	65.89	7.76	51.00	5.89	85.17	9.65	81.68	9.08	57.75	6.31	73.77	7.92	64.08	6.76	63.24	6.57	53.79	5.50	56.30	5.66	57.42	5.68
142.43	0.82	231.37	1.31	161.95	0.90	136.61	0.75	95.83	0.52	134.36	0.72	111.15	0.59	74.71	0.39	94.33	0.49	167.15	0.86	247.37	1.27	175.17	0.89
2.59	0.17	3.18	0.21	1.19	0.08	7.84	0.51	13.36	0.86	14.66	0.93	5.09	0.32	6.62	0.41	3.42	0.21	1.76	0.11	2.55	0.16	1.43	0.09
14.74	0.37	67.40	1.67	128.32	3.12	140.98	3.38	381.15	8.99	214.61	4.98	100.24	2.29	101.83	2.30	46.88	1.04	139.78	3.06	172.53	3.73	114.47	2.44
21.69	5.54	9.95	2.49	7.84	1.92	8.98	2.16	9.01	2.13	3.98	0.92	5.57	1.27	5.71	1.28	8.92	1.97	8.47	1.84	3.78	0.81	2.39	0.50
3.29	0.30	3.91	0.35	4.57	0.41	12.65	1.13	12.80	1.14	7.86	0.70	8.26	0.73	14.74	1.31	9.83	0.87	18.54	1.64	17.01	1.51	12.75	1.13
0.00	0.00	0.00	0.00	0.00	0.00	0.16	2.37	0.11	1.53	0.17	2.45	0.17	2.48	0.11	1.63	0.13	1.95	0.20	2.93	0.21	3.07	0.45	6.46
33.15	3.85	28.65	3.28	28.82	3.25	32.19	3.57	50.08	5.48	62.84	6.78	39.73	4.23	44.22	4.64	45.98	4.76	175.50	17.92	95.81	9.65	42.30	4.21
20.84	1.69	16.99	1.35	11.92	0.93	29.31	2.26	19.79	1.50	32.56	2.42	43.31	3.18	52.42	3.78	50.25	3.57	38.11	2.67	31.70	2.19	26.77	1.82
22.13	3.73	36.33	6.10	24.70	4.13	20.88	3.47	26.38	4.36	31.51	5.19	27.86	4.57	28.96	4.74	28.49	4.64	33.27	5.39	63.14	10.19	24.74	3.97
0.00	0.00	0.00	0.00	0.00	0.00	0.20	1.99	0.24	2.36	0.09	0.83	0.23	2.26	0.49	4.76	0.30	2.86	0.07	0.66	0.00	0.04	0.02	0.15
35.19	3.12	49.14	4.25	31.60	2.67	46.64	3.85	31.69	2.55	31.99	2.51	36.71	2.81	49.09	3.67	76.55	5.58	63.56	4.52	54.92	3.81	73.52	4.97
0.69	0.95	1.60	2.21	2.64	3.65	12.37	17.13	25.52	35.29	21.13	29.10	29.19	39.93	26.09	35.37	34.08	45.74	30.39	40.41	25.23	33.31	21.87	28.73
41.19	4.77	33.29	3.79	26.20	2.93	52.61	5.79	66.58	7.22	72.53	7.75	118.58	12.49	135.11	14.04	149.97	15.39	143.66	14.55	156.64	15.67	197.32	19.49
42.04	6.75	30.36	4.78	23.11	3.56	36.88	5.57	58.47	8.65	65.48	9.49	40.90	5.81	67.68	9.43	62.49	8.54	56.15	7.52	51.03	6.70	50.14	6.45
17.31	6.71	14.99	5.75	6.56	2.49	8.39	3.16	10.96	4.09	10.71	3.97	14.85	5.48	14.63	5.37	14.37	5.26	13.30	4.85	16.47	5.99	18.74	6.79
393.53	3.93	112.91	1.11	128.73	1.25	25.05	0.24	23.27	0.22	68.47	0.64	110.37	1.02	87.89	0.80	90.86	0.82	11.78	0.11	538.27	4.74	499.50	4.35
53.48	10.54	44.64	8.67	47.58	9.11	58.67	11.08	65.01	12.12	64.94	11.96	68.00	12.37	78.00	14.01	81.79	14.51	77.67	13.61	61.92	10.71	52.59	8.97
11.30	3.82	13.07	4.34	16.01	5.22	8.45	2.70	8.48	2.67	6.84	2.11	6.30	1.91	5.94	1.77	6.27	1.84	33.99	9.81	10.77	3.06	8.65	2.42
20.62	3.85	13.03	2.39	10.09	1.81	11.80	2.08	10.15	1.75	9.80	1.66	10.57	1.76	16.13	2.63	21.04	3.37	22.02	3.46	26.34	4.07	14.77	2.24
68.62	2.65	75.25	2.86	86.62	3.25	97.48	3.62	110.65	4.06	86.22	3.12	63.37	2.27	54.01	1.92	126.68	4.45	123.13	4.28	85.74	2.95	42.70	1.45
0.00	0.00	0.13	0.81	0.14	0.85	0.30	1.85	0.16	0.99	0.24	1.45	0.59	3.51	0.34	2.02	1.04	6.09	1.44	8.35	0.78	4.51	14.66	83.39
0.12	1.11	0.00	0.00	0.00	0.00	0.00	0.00	0.05	0.49	0.10	0.94	0.41	3.78	0.35	3.24	0.35	3.16	0.54	4.94	0.68	6.25	0.02	0.16

TABLE B4

DAH by target country, 1990–2011, continued

Region/country	1990		1991		1992		1993		1994		1995		1996		1997		1998		1999	
	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita
Suriname	5.90	14.47	11.36	27.48	13.50	32.24	6.21	14.64	5.49	12.77	14.96	34.33	8.67	19.62	4.91	10.96	16.41	36.12	10.76	23.37
Trinidad and Tobago	0.01	0.01	0.87	0.71	1.01	0.82	1.18	0.95	1.10	0.88	1.04	0.83	7.14	5.62	13.60	10.64	13.22	10.30	12.90	10.01
Uruguay	0.15	0.05	0.18	0.06	0.61	0.19	18.10	5.70	3.68	1.15	0.96	0.30	1.58	0.49	0.89	0.27	0.89	0.27	1.81	0.55
Venezuela	1.02	0.05	10.89	0.54	11.59	0.56	23.88	1.13	23.99	1.11	39.89	1.81	39.06	1.74	38.17	1.66	37.76	1.61	39.71	1.66
MIDDLE EAST AND NORTH AFRICA																				
Algeria	0.00	0.00	0.00	0.00	3.33	0.13	2.68	0.10	0.42	0.02	0.08	0.00	0.03	0.00	0.02	0.00	0.72	0.02	1.69	0.06
Bahrain	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.03	0.04	0.03	0.04
Djibouti	2.03	3.63	2.22	3.84	8.00	13.50	0.95	1.57	0.80	1.30	2.11	3.35	1.86	2.87	8.54	12.75	8.53	12.32	8.44	11.81
Egypt	40.22	0.71	61.65	1.06	61.22	1.04	88.17	1.46	83.48	1.36	86.35	1.39	76.60	1.21	73.41	1.14	70.18	1.07	71.00	1.07
Iran	0.00	0.00	2.32	0.04	1.37	0.02	12.67	0.22	15.60	0.26	15.21	0.25	14.88	0.24	14.58	0.23	14.64	0.23	11.03	0.17
Iraq	1.06	0.06	0.00	0.00	0.11	0.01	0.43	0.02	0.69	0.04	3.60	0.18	3.07	0.15	0.91	0.04	0.42	0.02	1.94	0.08
Jordan	2.45	0.73	4.93	1.38	2.42	0.64	9.13	2.28	19.64	4.66	10.78	2.46	15.42	3.41	13.80	2.99	19.15	4.08	46.10	9.68
Lebanon	2.52	0.85	3.41	1.12	1.98	0.63	0.64	0.20	1.13	0.33	15.18	4.38	6.38	1.80	6.89	1.92	7.02	1.93	7.87	2.13
Libya	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.00	0.00	0.00
Morocco	23.22	0.93	25.35	1.00	38.95	1.51	49.50	1.89	29.78	1.12	35.46	1.32	31.41	1.15	34.98	1.26	44.40	1.58	33.35	1.17
Occupied Palestinian Territory	0.08	0.04	0.04	0.02	0.02	0.01	0.05	0.02	9.64	3.90	8.00	3.10	16.36	6.04	36.15	12.75	27.80	9.38	26.27	8.52
Oman	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.02	0.01	0.01	0.00
Saudi Arabia	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.21	0.01	0.25	0.01
Syria	0.01	0.00	0.28	0.02	0.05	0.00	1.19	0.09	0.12	0.01	0.01	0.00	0.00	0.00	4.66	0.31	2.65	0.17	0.11	0.01
Tunisia	1.12	0.14	8.61	1.03	11.69	1.37	10.83	1.25	10.46	1.19	10.15	1.13	10.29	1.13	9.73	1.06	14.73	1.59	7.96	0.85
Yemen	5.22	0.44	14.43	1.15	18.54	1.40	20.38	1.47	12.79	0.88	18.13	1.20	26.89	1.72	24.82	1.53	9.33	0.56	17.58	1.02
SOUTH ASIA																				
Afghanistan	30.82	2.28	24.80	1.72	14.29	0.91	11.68	0.68	5.50	0.30	3.85	0.20	4.55	0.22	4.68	0.22	2.31	0.11	4.24	0.19
Bangladesh	54.94	0.52	112.92	1.05	211.62	1.92	129.77	1.15	168.21	1.46	117.72	1.00	109.99	0.92	137.07	1.12	140.65	1.13	198.46	1.56
Bhutan	5.36	9.62	5.17	9.30	1.56	2.84	0.43	0.80	0.51	0.97	0.49	0.95	0.20	0.39	2.04	3.85	5.09	9.37	2.24	4.01
India	109.67	0.13	127.18	0.14	248.40	0.27	382.31	0.41	384.08	0.41	317.47	0.33	384.96	0.39	343.13	0.34	395.28	0.39	368.47	0.36
Maldives	0.00	0.00	0.00	0.00	0.27	1.16	9.65	40.53	0.00	0.00	0.00	0.00	0.00	0.00	0.91	3.48	0.00	0.00	0.20	0.75
Nepal	17.33	0.91	21.71	1.11	20.83	1.04	13.92	0.68	11.92	0.57	15.06	0.70	20.79	0.94	23.67	1.04	31.27	1.34	33.39	1.40
Pakistan	62.54	0.56	38.64	0.34	53.08	0.45	58.84	0.48	79.86	0.64	95.10	0.74	116.88	0.89	103.28	0.77	86.34	0.63	76.01	0.54
Sri Lanka	19.16	1.10	21.25	1.21	24.28	1.37	23.56	1.31	13.03	0.72	10.21	0.56	10.34	0.56	25.11	1.36	36.04	1.94	13.62	0.73
SUB-SAHARAN AFRICA																				
Angola	19.13	1.83	16.09	1.50	17.48	1.57	15.77	1.38	12.11	1.02	23.85	1.96	69.17	5.51	39.40	3.05	13.93	1.05	28.54	2.09
Benin	7.96	1.67	1.99	0.40	17.10	3.35	10.90	2.06	8.22	1.50	8.67	1.53	13.33	2.29	12.75	2.13	17.09	2.77	19.81	3.13
Botswana	5.37	3.87	1.00	0.70	4.23	2.88	3.96	2.63	4.93	3.18	14.36	9.04	3.61	2.22	2.38	1.43	1.09	0.64	0.46	0.27
Burkina Faso	9.31	1.00	8.90	0.93	7.89	0.80	9.15	0.90	35.38	3.40	33.58	3.14	18.09	1.65	23.26	2.06	20.78	1.79	21.11	1.77
Burundi	1.18	0.21	0.62	0.11	11.23	1.92	19.38	3.26	9.91	1.64	13.78	2.25	8.64	1.40	5.73	0.92	5.46	0.87	7.02	1.11
Cameroon	5.09	0.42	17.17	1.37	14.60	1.13	14.40	1.09	8.90	0.66	6.52	0.47	11.95	0.84	12.88	0.88	13.43	0.90	15.27	0.99
Cape Verde	0.29	0.84	0.11	0.32	0.05	0.14	0.57	1.51	0.72	1.86	0.42	1.05	0.55	1.36	2.47	5.95	1.00	2.36	1.83	4.24
Central African Republic	2.48	0.84	2.33	0.77	2.91	0.94	3.31	1.04	3.32	1.02	5.43	1.63	1.49	0.44	3.50	1.00	3.76	1.06	11.80	3.25
Chad	13.31	2.21	5.56	0.90	12.64	1.98	13.99	2.12	7.56	1.11	13.14	1.87	16.44	2.27	17.95	2.40	20.99	2.72	21.03	2.64
Comoros	0.07	0.15	0.20	0.45	0.13	0.29	0.13	0.27	1.66	3.43	3.37	6.78	1.56	3.06	3.29	6.29	7.01	13.07	1.44	2.61

2000		2001		2002		2003		2004		2005		2006		2007		2008		2009		2010		2011	
DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita
5.43	11.64	7.13	15.08	8.13	16.98	9.57	19.74	10.15	20.70	11.23	22.62	4.62	9.21	7.32	14.41	8.37	16.30	18.37	35.39	13.09	24.97	12.52	23.64
12.33	9.54	12.06	9.29	11.88	9.12	11.54	8.83	12.19	9.29	11.83	8.99	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0.04	0.01	12.29	3.69	41.94	12.60	54.51	16.38	0.67	0.20	34.22	10.28	0.72	0.22	2.68	0.80	1.08	0.32	0.97	0.29	4.99	1.48	6.43	1.90
13.37	0.55	17.44	0.70	7.91	0.31	7.77	0.30	7.69	0.29	10.54	0.40	2.44	0.09	1.68	0.06	1.60	0.06	2.80	0.10	2.63	0.09	1.13	0.04
1.04	0.03	1.74	0.06	0.81	0.03	0.37	0.01	2.73	0.08	2.11	0.06	3.16	0.09	3.44	0.10	4.83	0.14	1.93	0.06	1.91	0.05	4.49	0.12
0.02	0.03	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
3.71	5.04	0.74	0.99	2.16	2.82	1.88	2.39	6.98	8.75	13.45	16.55	14.03	16.94	17.23	20.40	14.13	16.42	12.02	13.70	6.17	6.90	7.96	8.75
76.96	1.14	73.73	1.07	60.67	0.86	48.85	0.68	75.61	1.04	96.98	1.31	139.51	1.84	96.24	1.25	128.93	1.64	54.77	0.69	61.90	0.76	46.89	0.57
6.72	0.10	12.56	0.19	2.55	0.04	0.55	0.01	5.34	0.08	64.04	0.91	11.73	0.17	7.26	0.10	13.87	0.19	12.59	0.17	8.95	0.12	11.24	0.15
1.35	0.06	0.46	0.02	0.39	0.02	24.18	0.93	69.13	2.59	445.23	16.25	344.19	12.22	218.90	7.55	78.14	2.62	76.54	2.49	75.83	2.40	27.39	0.84
34.49	7.13	35.08	7.12	48.69	9.69	44.64	8.70	36.82	7.02	13.17	2.45	14.62	2.65	11.17	1.98	25.57	4.41	31.43	5.27	35.70	5.84	39.76	6.35
7.94	2.12	7.37	1.94	8.93	2.31	15.45	3.92	3.97	0.99	2.97	0.73	3.88	0.95	8.94	2.16	8.59	2.06	6.73	1.60	8.67	2.05	5.83	1.37
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.23	0.04	0.52	0.09	1.62	0.27	32.08	5.22	19.27	3.08	0.75	0.12	11.55	1.80
46.53	1.61	25.58	0.88	27.31	0.93	43.95	1.47	24.16	0.80	49.11	1.61	66.38	2.16	38.00	1.22	45.59	1.46	75.72	2.39	100.51	3.15	84.21	2.61
30.74	9.64	28.31	8.63	23.61	7.03	42.78	12.49	64.97	18.59	57.41	16.08	52.41	14.34	71.44	19.08	65.21	16.98	45.45	11.53	58.71	14.51	71.81	17.27
0.01	0.01	0.01	0.00	0.01	0.00	0.05	0.02	0.05	0.02	0.02	0.01	0.00	0.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0.04	0.00	0.07	0.00	0.13	0.01	0.27	0.01	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
0.13	0.01	0.07	0.00	3.27	0.19	2.42	0.14	5.62	0.32	14.96	0.82	4.10	0.22	6.45	0.34	15.26	0.79	28.00	1.41	15.90	0.79	2.42	0.12
8.37	0.88	15.85	1.66	18.72	1.94	20.65	2.12	4.84	0.49	4.21	0.42	29.77	2.97	8.03	0.79	34.17	3.33	4.93	0.48	9.64	0.92	4.03	0.38
9.92	0.56	40.50	2.21	19.04	1.01	26.76	1.38	18.49	0.92	44.31	2.14	44.60	2.09	50.61	2.30	57.57	2.54	44.59	1.91	60.32	2.50	46.15	1.86
3.84	0.17	3.98	0.17	18.94	0.76	27.51	1.06	89.20	3.31	131.96	4.73	134.66	4.69	166.70	5.65	188.35	6.22	276.80	8.91	275.54	8.63	361.52	10.99
185.22	1.43	185.58	1.41	132.23	0.98	144.69	1.06	153.00	1.10	175.02	1.25	250.10	1.76	170.91	1.19	264.51	1.82	255.37	1.73	265.68	1.78	271.59	1.80
7.41	12.93	3.75	6.37	2.35	3.88	6.62	10.60	5.54	8.63	9.20	13.97	5.09	7.55	3.79	5.50	4.06	5.79	2.91	4.08	2.31	3.18	2.27	3.08
447.12	0.42	523.09	0.49	565.23	0.52	445.17	0.40	589.34	0.52	659.36	0.58	415.95	0.36	674.45	0.57	716.09	0.60	782.84	0.65	810.43	0.66	933.28	0.75
0.43	1.58	0.15	0.53	0.11	0.39	0.10	0.34	0.02	0.08	0.35	1.17	0.14	0.48	1.67	5.50	0.62	2.01	1.33	4.25	0.76	2.42	0.29	0.92
33.53	1.37	45.59	1.82	44.54	1.74	64.54	2.47	55.74	2.09	65.09	2.39	76.76	2.76	70.94	2.50	113.35	3.92	93.97	3.19	136.89	4.57	111.65	3.66
40.43	0.28	65.95	0.45	86.52	0.57	96.52	0.63	169.16	1.08	193.98	1.22	217.47	1.34	248.59	1.51	317.82	1.90	307.77	1.80	275.64	1.59	261.28	1.48
11.01	0.59	11.76	0.62	14.75	0.77	10.79	0.56	11.71	0.60	17.85	0.90	27.33	1.36	24.00	1.18	31.74	1.55	33.30	1.61	50.52	2.42	34.60	1.64
20.65	1.47	27.29	1.88	30.20	2.01	39.52	2.54	52.50	3.26	109.88	6.61	52.32	3.05	63.68	3.60	90.71	4.97	77.19	4.11	78.80	4.08	59.35	2.99
19.84	3.04	23.84	3.54	22.58	3.25	31.93	4.45	50.91	6.87	58.30	7.62	59.99	7.60	53.94	6.62	63.25	7.54	87.79	10.16	99.11	11.15	94.10	10.29
0.38	0.22	2.21	1.24	10.56	5.83	14.37	7.84	35.69	19.23	21.25	11.31	31.71	16.65	48.68	25.21	245.99	125.67	230.72	116.32	81.50	40.57	87.12	42.86
22.53	1.83	36.50	2.89	28.94	2.22	52.73	3.93	64.25	4.66	73.98	5.21	77.26	5.29	80.97	5.38	110.44	7.13	112.63	7.06	144.31	8.79	77.59	4.59
7.30	1.14	6.80	1.04	11.34	1.70	21.36	3.11	27.56	3.90	33.14	4.55	42.12	5.61	38.14	4.93	54.45	6.83	68.82	8.38	85.72	10.17	95.45	11.07
8.39	0.53	11.30	0.70	12.18	0.74	28.37	1.69	49.89	2.90	48.60	2.76	62.09	3.45	62.05	3.37	63.53	3.37	71.82	3.73	51.17	2.60	129.51	6.44
1.12	2.55	7.26	16.25	2.41	5.29	7.44	16.10	9.55	20.39	9.11	19.20	11.97	24.95	10.72	22.12	11.60	23.72	4.33	8.78	10.40	20.91	19.05	37.94
4.26	1.15	6.05	1.61	10.11	2.64	6.03	1.55	17.99	4.55	14.78	3.67	17.56	4.29	8.36	2.00	31.60	7.44	11.31	2.61	18.82	4.26	20.59	4.57
17.43	2.11	16.47	1.93	20.33	2.30	23.63	2.57	37.94	3.99	38.69	3.94	27.30	2.70	19.50	1.87	27.53	2.57	25.08	2.28	69.83	6.18	40.81	3.51
1.29	2.29	1.62	2.79	3.89	6.53	4.70	7.67	2.73	4.35	2.33	3.61	1.51	2.27	1.68	2.46	1.30	1.85	3.42	4.75	7.85	10.63	6.31	8.32

TABLE B4

DAH by target country, 1990–2011, continued

Region/country	1990		1991		1992		1993		1994		1995		1996		1997		1998		1999	
	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita
Congo	9.60	4.01	1.11	0.45	0.63	0.25	4.76	1.83	5.24	1.97	4.02	1.47	3.58	1.27	4.08	1.41	3.00	1.01	0.44	0.14
Congo, the Democratic Republic of the	17.25	0.47	13.77	0.36	6.24	0.16	3.33	0.08	14.21	0.33	13.45	0.31	18.39	0.41	19.66	0.42	23.21	0.49	21.81	0.45
Côte d'Ivoire	13.85	1.11	15.23	1.18	65.87	4.93	48.98	3.55	39.61	2.79	17.08	1.17	63.69	4.23	33.50	2.17	24.59	1.55	21.43	1.32
Equatorial Guinea	0.04	0.11	0.03	0.07	0.66	1.65	0.75	1.81	1.78	4.15	0.61	1.38	2.26	4.93	1.07	2.26	1.02	2.08	2.12	4.21
Eritrea	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	5.52	1.73	5.59	1.73	8.70	2.65	5.66	1.69	13.90	4.03	17.24	4.84
Ethiopia	32.53	0.67	18.54	0.37	26.01	0.50	12.37	0.23	26.73	0.49	39.62	0.70	49.97	0.85	40.22	0.67	33.36	0.54	52.31	0.82
Gabon	0.72	0.77	0.19	0.20	1.35	1.36	9.27	9.09	3.33	3.16	1.26	1.16	2.50	2.24	4.46	3.90	5.51	4.68	2.79	2.31
Gambia	2.35	2.43	2.48	2.47	4.83	4.67	6.94	6.51	3.30	3.01	2.78	2.46	2.20	1.89	1.99	1.66	4.36	3.54	5.12	4.04
Ghana	5.42	0.37	24.02	1.58	16.09	1.03	36.60	2.27	32.72	1.98	24.90	1.47	22.56	1.29	45.36	2.54	26.53	1.45	49.80	2.66
Guinea	2.66	0.46	8.49	1.40	5.41	0.84	6.88	1.01	11.59	1.62	9.09	1.21	13.00	1.68	18.78	2.37	15.78	1.95	19.94	2.42
Guinea-Bissau	4.75	4.65	4.58	4.40	4.51	4.24	4.52	4.18	4.96	4.48	11.00	9.75	3.99	3.47	3.68	3.13	4.93	4.12	1.21	0.99
Kenya	55.47	2.37	45.20	1.87	56.01	2.24	49.47	1.91	43.88	1.65	67.26	2.45	91.79	3.25	78.63	2.71	75.93	2.55	77.39	2.54
Lesotho	6.08	3.70	5.04	3.01	4.71	2.77	3.10	1.79	8.17	4.63	9.43	5.25	8.87	4.84	3.92	2.10	0.92	0.48	0.31	0.16
Liberia	2.73	1.27	1.25	0.59	1.10	0.53	1.59	0.77	1.01	0.49	0.33	0.15	0.23	0.10	1.95	0.82	1.72	0.68	3.62	1.35
Madagascar	6.26	0.55	12.45	1.07	15.53	1.29	15.60	1.26	21.01	1.65	18.43	1.40	21.52	1.59	22.92	1.64	26.77	1.85	25.04	1.68
Malawi	30.33	3.24	18.56	1.94	29.15	3.00	37.23	3.81	28.03	2.85	33.32	3.34	44.86	4.41	50.62	4.86	35.83	3.35	50.93	4.64
Mali	14.09	1.62	20.97	2.36	15.67	1.72	21.04	2.26	27.15	2.84	30.51	3.10	20.50	2.03	26.23	2.53	19.77	1.85	26.04	2.38
Mauritania	20.84	10.40	1.40	0.68	6.65	3.15	10.98	5.05	4.99	2.24	3.80	1.65	10.30	4.36	6.81	2.80	9.20	3.68	7.80	3.03
Mauritius	0.06	0.06	0.02	0.02	0.01	0.01	0.01	0.01	0.79	0.70	0.17	0.15	0.79	0.69	0.39	0.34	0.25	0.21	0.56	0.47
Mozambique	43.09	3.17	73.78	5.32	75.63	5.30	40.18	2.72	72.04	4.72	63.10	4.00	89.07	5.47	71.42	4.26	61.42	3.57	78.56	4.44
Namibia	2.66	1.88	4.44	3.03	5.99	3.95	18.40	11.80	16.42	10.22	9.33	5.64	14.23	8.35	10.18	5.80	6.43	3.56	11.71	6.32
Niger	7.57	0.97	12.11	1.51	24.97	3.01	13.76	1.60	13.48	1.52	14.23	1.55	17.48	1.84	23.86	2.42	18.21	1.78	12.61	1.19
Nigeria	29.11	0.30	25.75	0.26	21.70	0.21	37.32	0.36	22.99	0.21	21.38	0.19	19.76	0.18	15.43	0.13	14.29	0.12	23.57	0.19
Rwanda	8.22	1.16	10.24	1.48	11.55	1.76	8.01	1.30	8.83	1.51	12.17	2.13	13.91	2.36	17.69	2.80	21.40	3.11	24.96	3.35
Sao Tome and Principe	1.83	15.66	0.12	0.98	1.21	9.97	2.23	18.04	2.58	20.50	1.45	11.34	1.44	11.01	1.63	12.26	1.50	11.05	7.52	54.41
Senegal	12.77	1.76	14.46	1.93	15.01	1.95	16.43	2.07	15.03	1.84	16.19	1.93	9.88	1.15	26.97	3.06	33.46	3.70	41.30	4.46
Seychelles	0.08	1.25	0.01	0.14	0.70	10.80	0.49	7.46	0.41	6.12	0.87	12.94	0.16	2.42	0.86	12.62	0.74	10.76	0.54	7.80
Sierra Leone	0.37	0.09	0.02	0.01	0.84	0.21	5.16	1.30	1.47	0.37	1.19	0.30	4.40	1.11	4.18	1.05	3.68	0.92	5.16	1.27
Somalia	11.67	1.75	2.53	0.38	2.23	0.34	4.56	0.69	3.87	0.58	2.99	0.45	2.93	0.43	2.58	0.37	3.17	0.45	4.08	0.56
South Africa	1.45	0.04	0.00	0.00	4.11	0.11	5.25	0.13	13.96	0.34	12.33	0.30	20.53	0.49	25.14	0.59	39.69	0.91	24.29	0.55
South Sudan	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Sudan	8.26	0.31	4.01	0.15	1.90	0.07	13.47	0.47	2.09	0.07	4.97	0.16	9.20	0.30	5.58	0.17	7.73	0.24	7.97	0.24
Swaziland	3.23	3.75	3.64	4.09	1.74	1.91	0.81	0.87	7.45	7.85	3.11	3.21	1.26	1.27	1.71	1.69	5.05	4.88	1.35	1.29
Tanzania	55.36	2.17	47.99	1.82	57.07	2.10	62.85	2.23	40.11	1.38	38.24	1.28	64.56	2.10	77.24	2.44	95.87	2.96	103.81	3.12
Togo	1.88	0.51	5.39	1.44	7.83	2.04	2.56	0.65	3.68	0.92	3.80	0.93	5.80	1.38	6.61	1.52	7.76	1.72	2.58	0.56
Uganda	27.21	1.54	47.08	2.57	46.41	2.45	52.56	2.68	55.71	2.75	57.09	2.73	87.84	4.07	69.64	3.13	79.23	3.46	84.67	3.59
Zambia	8.68	1.11	4.70	0.58	21.38	2.59	34.29	4.04	42.48	4.88	56.84	6.36	64.67	7.05	46.31	4.91	30.98	3.19	34.40	3.45
Zimbabwe	9.47	0.90	17.69	1.64	55.98	5.08	53.38	4.74	51.99	4.53	52.22	4.46	50.14	4.21	52.09	4.30	57.27	4.66	46.76	3.76

2000		2001		2002		2003		2004		2005		2006		2007		2008		2009		2010		2011	
DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita	DAH	DAH per capita
0.55	0.18	0.70	0.22	2.35	0.71	3.50	1.04	8.15	2.37	6.36	1.80	7.63	2.10	7.58	2.03	14.45	3.76	10.07	2.55	26.93	6.65	26.00	6.26
26.91	0.54	35.38	0.69	45.45	0.86	69.78	1.28	85.45	1.52	127.21	2.20	141.95	2.38	152.39	2.49	349.18	5.54	371.40	5.74	374.60	5.63	426.43	6.25
12.75	0.77	17.35	1.03	42.12	2.45	34.57	1.98	46.78	2.63	46.06	2.55	67.36	3.67	68.30	3.66	127.74	6.73	97.41	5.04	168.21	8.53	101.80	5.06
4.34	8.35	3.90	7.27	2.24	4.04	3.15	5.51	4.10	6.94	8.13	13.36	11.04	17.59	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
22.51	6.11	15.86	4.15	23.07	5.80	34.70	8.37	36.16	8.39	32.31	7.22	13.99	3.02	20.84	4.35	24.66	5.00	17.80	3.50	46.71	8.91	18.80	3.48
58.73	0.90	88.78	1.32	83.74	1.21	183.54	2.59	165.77	2.28	225.71	3.04	370.98	4.87	541.46	6.95	533.00	6.69	574.73	7.06	704.47	8.47	815.64	9.60
4.34	3.51	5.10	4.04	2.82	2.19	3.37	2.56	7.13	5.30	6.52	4.76	10.86	7.77	7.89	5.54	6.15	4.24	10.76	7.28	4.92	3.26	5.89	3.84
5.53	4.24	6.04	4.50	7.09	5.13	8.62	6.06	16.65	11.36	18.26	12.11	10.67	6.87	13.61	8.53	13.77	8.39	16.73	9.91	25.05	14.45	30.46	17.09
43.86	2.29	87.92	4.47	69.76	3.46	95.23	4.62	197.26	9.34	198.31	9.16	150.89	6.81	160.96	7.09	193.57	8.32	226.75	9.52	214.87	8.80	224.19	8.97
20.85	2.49	32.45	3.82	17.83	2.06	22.47	2.56	27.35	3.06	26.65	2.93	27.83	3.00	20.90	2.22	27.94	2.91	24.54	2.50	38.13	3.80	26.44	2.58
4.12	3.30	7.42	5.84	7.95	6.14	8.28	6.28	8.82	6.56	12.01	8.76	10.87	7.76	15.24	10.65	11.70	8.01	14.90	9.98	25.49	16.72	14.59	9.38
51.03	1.63	104.24	3.25	110.87	3.36	164.82	4.87	218.31	6.28	219.76	6.16	337.94	9.22	345.06	9.17	458.12	11.87	561.38	14.16	647.51	15.91	721.34	17.26
2.13	1.09	4.38	2.20	4.58	2.27	9.44	4.64	13.33	6.49	12.34	5.95	13.89	6.64	21.55	10.21	42.83	20.11	37.69	17.53	64.12	29.54	91.15	41.58
7.28	2.58	4.62	1.59	4.04	1.35	5.74	1.89	13.15	4.24	15.68	4.91	17.51	5.27	19.44	5.58	51.85	14.19	77.16	20.19	75.82	19.08	74.65	18.17
22.25	1.45	30.51	1.92	31.05	1.90	54.91	3.26	76.23	4.39	87.19	4.87	60.95	3.30	80.11	4.22	82.01	4.19	63.43	3.15	136.44	6.58	86.27	4.05
61.56	5.46	73.76	6.37	71.40	6.01	89.91	7.37	118.32	9.43	117.83	9.13	169.55	12.77	232.21	16.98	277.05	19.66	255.82	17.61	208.82	13.94	303.00	19.60
22.71	2.01	41.44	3.56	22.02	1.84	52.41	4.23	52.88	4.14	81.29	6.16	82.61	6.06	96.57	6.86	115.06	7.92	119.87	7.99	168.36	10.89	167.55	10.51
10.04	3.79	9.59	3.52	9.25	3.30	10.07	3.49	12.56	4.23	4.89	1.60	7.11	2.26	13.84	4.29	17.67	5.35	10.60	3.13	7.78	2.24	10.97	3.09
0.94	0.78	0.26	0.21	0.00	0.00	0.17	0.14	0.19	0.15	0.20	0.16	0.58	0.46	0.86	0.67	0.01	0.00	0.89	0.69	2.13	1.64	1.60	1.22
85.07	4.68	102.75	5.50	122.91	6.41	136.67	6.94	214.62	10.62	196.47	9.48	224.97	10.59	318.74	14.63	397.96	17.82	394.58	17.25	455.89	19.46	445.49	18.59
12.83	6.76	10.47	5.40	10.43	5.28	19.12	9.51	30.86	15.09	35.24	16.94	79.28	37.42	96.70	44.80	86.38	39.27	136.48	60.90	129.27	56.64	91.73	39.48
17.08	1.56	22.37	1.97	23.87	2.04	39.42	3.25	38.07	3.03	38.79	2.97	65.29	4.83	50.81	3.63	82.22	5.67	68.25	4.55	53.02	3.41	65.10	4.04
46.86	0.38	74.84	0.59	72.27	0.56	122.75	0.92	266.97	1.96	300.97	2.15	407.24	2.84	428.65	2.91	650.76	4.31	902.62	5.83	656.22	4.13	757.00	4.65
22.47	2.84	32.44	3.92	36.94	4.32	45.36	5.17	93.17	10.38	103.89	11.28	144.13	15.20	151.14	15.47	240.77	23.90	255.94	24.64	311.19	29.07	315.27	28.59
5.29	37.62	3.83	26.71	4.26	29.18	3.70	24.94	4.37	28.93	4.51	29.41	4.24	27.16	3.38	21.30	5.74	35.64	3.96	24.17	4.47	26.83	8.22	48.45
34.11	3.59	59.63	6.11	45.32	4.52	99.56	9.66	106.24	10.03	87.83	8.06	126.33	11.29	71.42	6.21	99.92	8.46	120.55	9.93	98.02	7.86	118.00	9.22
0.09	1.32	0.23	3.26	0.37	5.10	1.20	16.58	1.20	16.39	1.13	15.30	0.17	2.25	0.08	1.08	0.06	0.78	0.15	1.96	0.48	6.18	0.00	0.02
11.44	2.73	12.74	2.94	7.62	1.69	17.76	3.76	23.81	4.83	31.44	6.13	30.04	5.66	35.18	6.44	45.01	8.02	43.26	7.52	56.10	9.52	61.54	10.20
3.20	0.43	3.44	0.45	4.45	0.57	4.23	0.53	14.50	1.76	16.46	1.95	21.06	2.44	23.71	2.68	24.46	2.71	21.48	2.32	41.35	4.37	37.98	3.92
27.64	0.62	53.11	1.17	48.68	1.06	113.77	2.43	127.21	2.69	183.91	3.84	208.84	4.31	344.04	7.03	506.64	10.25	636.88	12.78	601.63	11.98	666.32	13.18
–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	0.00	79.82	0.00
7.58	0.22	6.59	0.19	17.38	0.48	15.72	0.43	34.36	0.91	63.21	1.64	74.15	1.88	71.20	1.76	120.56	2.90	159.10	3.73	174.37	3.99	119.06	2.66
2.20	2.06	1.13	1.04	0.89	0.82	9.79	8.97	5.48	5.00	25.53	23.06	14.55	13.00	21.72	19.15	22.41	19.46	34.05	29.10	62.10	52.23	72.10	59.72
59.58	1.75	95.64	2.73	126.46	3.52	132.68	3.60	228.67	6.03	283.16	7.27	345.85	8.63	440.06	10.68	637.12	15.02	556.43	12.74	719.22	15.99	696.87	15.04
2.14	0.45	3.05	0.62	2.03	0.40	9.50	1.84	15.10	2.86	17.91	3.31	14.28	2.58	24.81	4.39	28.08	4.86	33.94	5.75	28.38	4.71	41.26	6.71
88.48	3.64	144.51	5.76	82.18	3.17	156.85	5.87	251.90	9.12	264.17	9.26	283.19	9.60	357.91	11.74	363.77	11.55	429.19	13.18	452.84	13.45	429.86	12.36
52.44	5.13	71.91	6.87	84.72	7.90	159.04	14.49	208.69	18.56	246.78	21.40	219.07	18.52	280.84	23.12	391.30	31.35	337.49	26.30	285.71	21.64	418.79	30.82
20.61	1.64	29.74	2.35	34.65	2.73	49.24	3.88	63.32	5.00	107.74	8.53	104.85	8.33	156.20	12.46	101.74	8.14	206.25	16.48	188.49	14.95	157.55	12.33

Source: IHME DAH Database 2013

Notes: Development assistance for health (DAH) is in millions of 2011 US dollars, and DAH per capita is in 2011 US dollars. DAH includes both financial and in-kind contributions for activities aimed at improving health in low- and middle-income countries. Years in which a country was classified as high-income by the World Bank are marked as "NA." This table disaggregates financial DAH transfers by the country receiving funds or intended to benefit from research or technical assistance activities. Population data were obtained from the United Nations Population Division. This table reflects financial DAH only from channels of assistance providing project-level detail, specifically bilateral development agencies, the World Bank (IDA and IBRD), ADB, AfDB, IDB, GFATM, GAVI, and BMGF.

TABLE B5

DAH by health focus area, 1990–2011

Year	HIV/AIDS	Maternal, newborn, and child health	Malaria	Health sector support
1990	218.13	1,070.69	39.86	8.94
1991	217.72	1,168.08	45.33	1.73
1992	254.61	1,373.87	28.39	29.05
1993	259.62	1,474.71	27.19	20.70
1994	402.07	2,044.02	47.56	17.67
1995	401.71	2,083.83	48.19	55.03
1996	436.00	1,887.82	91.24	97.79
1997	487.63	2,019.50	126.25	85.13
1998	487.20	2,109.76	134.36	144.51
1999	593.48	2,371.04	166.35	167.72
2000	867.18	2,657.76	236.02	67.28
2001	991.88	2,963.56	241.39	47.29
2002	1,564.12	2,426.48	247.92	149.96
2003	2,024.79	3,268.63	324.57	172.32
2004	2,778.48	2,758.21	554.56	289.32
2005	3,665.07	3,060.14	715.10	525.96
2006	4,595.37	2,739.78	834.80	924.04
2007	5,720.73	3,903.07	869.35	1,016.59
2008	6,878.12	4,215.08	1,369.65	1,213.46
2009	7,246.98	4,499.23	1,999.25	1,256.77
2010	7,602.48	5,209.31	2,076.14	1,293.88
2011	7,696.11	6,129.77	1,787.85	1,314.74

Tuberculosis	Non-communicable diseases	Tobacco	Other	Unallocable	Total
67.84	30.92	7.40	2,366.47	1,976.20	5,779.05
70.73	31.02	7.15	2,405.79	1,796.79	5,737.18
65.38	41.14	6.90	2,713.13	2,039.92	6,545.48
73.23	115.73	6.75	3,039.91	1,937.63	6,948.71
91.66	104.09	7.56	2,959.96	2,345.54	8,012.55
80.97	69.44	7.40	3,073.41	2,651.22	8,463.80
107.90	57.12	6.33	3,557.09	2,484.64	8,719.62
103.74	69.01	7.76	3,726.72	2,223.31	8,841.29
94.10	84.33	8.81	3,842.10	2,390.21	9,286.56
106.39	75.48	6.99	3,736.36	2,644.63	9,861.45
157.47	128.86	8.43	4,008.45	2,732.81	10,855.82
191.37	135.10	10.32	4,138.90	2,489.26	11,198.76
251.03	144.86	17.86	4,478.17	3,073.68	12,336.22
321.27	152.53	38.44	5,143.42	2,357.65	13,765.19
528.08	118.07	22.61	5,862.90	2,383.59	15,273.20
539.31	194.04	23.94	6,345.92	2,263.91	17,309.44
682.85	210.02	24.57	6,209.53	2,781.51	18,977.89
797.96	323.40	55.20	5,676.34	3,492.87	21,800.31
1,015.87	279.71	71.04	6,370.11	4,095.88	25,437.87
1,141.92	370.38	107.71	5,937.06	4,148.57	26,600.15
1,403.59	360.98	101.37	6,702.29	4,773.10	29,421.77
1,265.78	377.48	67.76	6,475.06	5,563.72	30,610.51

Source: IHME DAH Database 2013

Notes: In millions of 2011 US dollars. Development assistance for health (DAH) includes both financial and in-kind contributions for activities aimed at improving health in low- and middle-income countries. This table dissagregates financial DAH earmarked for HIV/AIDS; maternal, newborn, and child health; malaria; health sector support; tuberculosis; non-communicable diseases; and tobacco. We were able to allocate flows from the following channels of assistance by their health focus areas: bilateral development agencies, World Bank (IDA and IBRD), regional development banks, GFATM, GAVI, WHO, UNICEF, UNAIDS, UNFPA, BMGF, and NGOs. Contributions from remaining channels are shown as unallocable by disease. For preliminary estimates of DAH for 2012 and 2013, refer to Table B1.

TABLE B6

Bilateral commitments and disbursements, 1990–2011

Donor	1990		1991		1992		1993		1994		1995		1996		1997		1998		1999	
Observed/ estimated[1]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]
AUSTRALIA																				
Observed	13.82	0.00	18.29	0.00	29.15	0.00	63.67	0.00	77.12	0.00	25.90	0.00	171.32	0.00	72.23	0.00	71.85	30.39	126.23	43.92
Estimated	13.82	10.31	18.29	13.81	71.13	45.76	65.24	51.81	94.52	71.82	97.58	81.53	171.32	128.71	76.08	90.49	72.17	78.91	126.23	108.65
AUSTRIA																				
Observed	17.94	1.33	3.06	0.18	0.00	0.00	0.00	0.66	0.00	12.75	0.00	1.16	8.51	5.96	4.99	5.40	8.88	5.20	6.83	5.52
Estimated	42.09	33.43	4.82	8.00	0.00	1.40	0.00	2.96	0.00	0.58	0.00	0.03	11.53	9.16	66.81	54.23	14.85	18.84	111.43	92.32
BELGIUM																				
Observed	3.94	0.00	2.48	2.48	0.00	0.00	0.00	0.00	59.73	0.00	66.11	0.00	78.23	0.00	69.15	0.00	74.64	0.00	80.71	80.71
Estimated	102.85	79.01	94.17	92.32	100.22	97.75	95.97	96.02	74.85	79.30	66.11	68.36	78.23	75.49	76.93	76.61	78.24	77.66	80.71	79.77
CANADA																				
Observed	51.67	0.00	56.15	0.00	28.27	29.23	20.93	25.92	72.03	28.18	120.51	38.58	63.48	51.45	38.32	29.97	43.45	32.70	48.14	17.64
Estimated	56.41	52.98	56.15	53.22	35.56	39.63	37.75	37.83	72.75	58.43	122.29	90.93	63.48	65.24	38.32	46.34	47.71	48.09	48.14	48.25
DENMARK																				
Observed	50.61	0.00	112.91	0.00	147.09	0.00	137.62	0.00	47.39	0.00	115.38	0.00	320.92	0.00	39.11	97.50	8.06	73.57	142.86	0.00
Estimated	50.61	41.34	118.58	53.08	177.21	83.05	137.62	92.16	59.58	67.82	115.38	62.54	327.31	127.37	42.07	105.58	8.45	43.64	142.86	53.51
EUROPEAN COMMISSION																				
Observed	16.86	0.00	45.44	0.00	234.54	0.00	235.13	0.00	69.80	0.00	282.55	0.00	359.11	79.84	249.45	62.54	405.87	83.32	416.82	66.43
Estimated	16.86	49.48	45.44	37.60	234.54	27.03	235.13	96.15	69.80	165.85	282.55	171.37	359.11	188.57	249.45	230.42	405.87	288.34	416.82	328.98
FINLAND																				
Observed	57.82	41.66	54.37	43.20	35.12	31.09	6.82	21.53	21.86	22.14	28.91	0.00	15.66	17.85	9.46	14.18	27.80	10.46	16.67	11.66
Estimated	58.67	46.85	54.37	46.96	35.12	40.93	7.12	29.68	21.92	23.77	28.91	19.79	15.66	16.21	9.58	12.82	34.81	15.87	23.52	16.70
FRANCE																				
Observed	150.45	43.21	79.12	26.94	97.22	30.61	78.08	62.49	88.19	31.43	108.14	36.39	106.06	20.98	147.27	24.56	150.30	39.94	79.87	82.88
Estimated	459.76	423.66	292.48	287.94	250.21	252.76	208.37	213.88	307.87	301.36	383.87	371.99	303.25	303.92	233.69	240.82	279.22	278.74	225.12	229.57
GERMANY																				
Observed	53.78	7.10	30.96	7.29	85.27	55.95	85.21	13.65	219.44	121.79	189.68	86.75	93.95	85.56	324.96	82.91	233.70	116.35	196.85	96.15
Estimated	122.75	95.85	130.28	109.19	179.38	151.38	204.94	175.87	334.69	277.77	433.56	364.08	284.61	280.67	324.96	314.92	233.70	253.30	208.37	234.64
GREECE																				
Observed	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Estimated	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	6.67	6.67	6.54	6.54	8.77	8.77	9.91	9.91	4.45	4.45
IRELAND																				
Observed	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Estimated	2.62	2.62	2.79	2.79	3.66	3.66	0.00	0.00	7.27	7.27	22.96	22.96	22.53	22.53	0.00	0.00	21.58	21.58	19.62	19.62
ITALY																				
Observed	153.95	5.11	168.51	1.22	103.85	5.59	74.03	11.81	9.74	4.07	40.79	0.90	56.77	0.28	29.03	0.46	17.80	0.00	48.81	0.00
Estimated	167.34	171.95	195.62	191.20	139.31	147.51	103.44	109.82	47.21	57.12	50.18	50.88	76.39	72.20	29.03	36.19	17.80	20.39	48.81	44.08
JAPAN																				
Observed	157.47	0.00	131.41	0.00	197.13	134.15	386.35	320.68	235.38	96.79	223.20	23.12	400.15	215.15	286.74	257.44	290.76	278.33	238.86	333.09
Estimated	335.80	265.31	321.61	299.94	318.80	308.94	580.75	433.00	443.11	463.57	491.39	464.51	617.40	533.18	488.87	523.32	484.47	490.03	455.37	463.63

2000		2001		2002		2003		2004		2005		2006		2007		2008		2009		2010		2011	
Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]
199.35	75.77	117.56	89.63	78.55	92.53	105.07	106.30	48.98	108.56	116.14	118.45	143.89	167.30	142.15	151.79	386.87	174.01	152.38	195.24	285.81	291.07	413.93	413.93
199.35	157.39	117.56	126.20	101.73	105.78	105.07	104.92	107.22	107.04	116.14	112.74	162.09	135.50	166.10	145.19	386.87	277.64	152.38	182.74	288.24	240.74	421.57	337.82
5.00	3.19	4.30	37.52	9.85	6.26	17.26	7.50	27.17	8.64	32.62	7.95	20.36	11.96	30.01	11.66	50.67	13.25	33.49	10.55	55.45	8.58	73.72	14.44
35.34	44.36	4.35	10.91	11.08	17.82	17.26	18.04	27.17	24.06	32.62	29.76	20.36	21.23	30.01	28.50	50.67	46.07	33.49	34.03	55.45	50.81	73.72	68.62
74.35	74.34	82.95	82.68	153.74	84.51	103.66	102.82	98.20	87.90	120.70	100.93	131.82	115.10	186.50	142.53	190.48	147.34	212.43	155.38	191.45	161.42	201.50	159.23
78.19	78.26	82.95	81.44	153.74	136.83	103.66	112.32	98.20	99.68	120.70	115.01	131.82	127.72	186.50	172.35	206.98	199.38	212.43	209.55	191.45	195.13	201.50	198.68
101.91	52.73	96.80	44.56	98.04	46.93	165.80	88.82	166.97	112.57	120.12	313.86	215.71	156.74	393.74	296.70	368.82	318.77	636.53	365.84	464.51	356.43	966.76	486.96
101.91	79.30	101.18	83.73	98.04	84.86	165.80	127.23	177.62	145.21	128.40	123.99	215.71	172.15	393.80	288.96	370.55	307.74	639.03	479.36	470.20	427.24	967.52	722.17
33.01	20.47	41.33	35.55	78.94	0.00	101.09	59.02	169.65	73.42	120.05	85.49	147.36	74.20	148.78	85.14	35.87	92.03	204.80	121.48	71.44	167.02	131.87	143.17
33.01	51.42	41.33	34.05	80.51	38.02	106.24	54.39	169.65	80.13	127.89	86.09	147.36	87.32	148.79	91.38	35.88	63.66	204.80	82.27	71.72	79.23	131.87	73.55
443.98	58.92	365.94	86.98	261.60	89.24	281.10	114.32	612.52	231.28	702.50	476.53	569.26	648.15	535.97	633.34	582.81	702.37	652.31	539.11	706.06	442.75	315.23	545.32
443.98	345.81	436.45	405.33	424.60	416.45	590.08	629.43	612.52	97.38	702.50	420.77	569.26	501.82	535.97	512.68	582.81	623.01	652.31	376.32	706.06	338.13	315.23	481.69
13.59	11.21	28.28	19.28	41.48	16.97	40.85	21.56	27.43	0.00	25.48	0.00	55.89	30.87	25.04	33.39	37.51	34.43	35.34	29.65	22.40	29.74	17.19	23.59
13.59	14.79	28.28	16.48	44.60	21.23	41.26	24.90	29.36	24.14	28.13	22.98	55.90	28.43	25.04	25.61	37.51	25.89	35.34	26.14	22.40	22.66	17.19	19.94
88.49	52.62	178.42	159.62	187.93	161.88	226.88	214.58	350.24	278.98	217.10	282.17	334.84	289.50	160.99	104.42	405.58	365.32	349.66	356.40	479.94	432.92	152.16	183.63
158.25	166.53	200.40	200.12	245.33	240.17	226.88	225.25	365.85	351.01	320.96	316.38	334.84	330.82	187.92	199.41	409.10	393.97	349.66	346.28	479.94	465.59	152.17	175.22
131.00	68.81	153.02	161.27	210.70	121.10	258.06	216.29	270.62	271.66	226.87	240.96	514.85	266.83	393.09	362.92	478.75	409.83	529.77	429.30	347.44	468.83	425.69	396.75
131.00	172.55	153.02	169.45	250.94	231.60	277.68	250.36	286.52	262.88	226.87	224.67	514.85	427.96	393.10	365.52	478.75	438.00	529.77	484.65	347.44	369.38	425.70	427.93
0.00	0.00	0.00	0.00	4.42	4.42	14.21	14.21	26.06	26.06	31.76	31.76	34.84	34.84	36.27	36.27	12.09	12.09	22.18	22.18	6.33	6.33	2.70	2.70
5.07	5.07	6.82	6.82	4.42	4.42	26.10	26.10	26.06	26.06	36.33	36.33	34.84	34.84	36.27	36.27	12.10	12.10	22.19	22.19	6.33	6.33	2.72	2.72
19.17	2.15	32.07	2.98	78.12	78.12	107.35	107.35	114.90	114.90	119.20	119.20	170.82	170.82	184.48	183.02	133.84	133.84	100.40	100.40	88.28	88.28	83.89	83.89
27.58	27.58	35.17	35.17	84.24	84.24	107.35	107.35	114.90	114.90	120.48	120.48	170.82	170.82	184.48	184.48	137.98	137.98	100.40	100.40	88.28	88.28	83.89	83.89
58.77	0.00	29.95	0.00	90.74	10.47	89.03	48.08	66.85	56.74	79.57	60.31	108.05	79.14	113.33	114.02	138.11	125.30	118.67	102.43	91.82	84.24	94.64	107.69
58.77	56.44	29.95	34.14	90.74	81.01	89.03	87.92	66.85	69.79	106.44	99.82	108.05	106.50	113.46	111.73	138.34	133.55	118.67	121.11	91.82	96.21	94.64	94.43
180.57	303.88	166.35	197.39	185.35	144.76	378.54	334.21	665.35	309.91	271.68	299.07	268.33	333.02	272.67	346.11	221.37	301.39	255.07	261.71	363.85	320.53	346.01	374.97
411.27	428.55	385.49	395.57	401.30	389.18	378.55	379.50	665.35	505.78	271.68	418.61	276.90	309.35	272.67	275.04	221.37	245.14	255.08	240.87	363.85	298.12	346.01	330.40

TABLE B6

Bilateral commitments and disbursements, 1990–2011

Donor	1990		1991		1992		1993		1994		1995		1996		1997		1998		1999	
Observed/ estimated[1]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]
LUXEMBOURG																				
Observed	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Estimated	0.00	0.00	0.00	0.00	6.48	6.48	6.50	6.50	0.00	0.00	12.82	12.82	12.58	12.58	22.14	22.14	25.42	25.42	18.81	18.81
NETHERLANDS																				
Observed	64.95	2.07	71.01	0.00	137.69	0.00	115.21	0.00	121.17	0.00	175.57	0.00	239.93	0.00	143.77	0.00	167.29	59.57	199.83	0.00
Estimated	137.62	85.15	71.01	60.06	238.82	147.93	115.21	100.91	121.17	95.63	181.08	126.57	239.93	164.50	143.77	122.46	167.29	127.60	199.83	145.06
NEW ZEALAND																				
Observed	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.51	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Estimated	0.00	0.00	3.67	2.80	2.71	2.80	2.09	2.21	2.94	2.72	2.88	2.83	0.00	0.64	0.00	0.07	6.12	4.68	6.89	6.50
NORWAY																				
Observed	29.33	0.00	25.18	0.00	90.91	0.00	9.79	0.00	44.36	0.00	78.86	0.00	41.05	0.00	35.71	0.00	46.92	0.00	105.83	0.00
Estimated	29.34	29.86	25.18	25.99	90.91	74.10	9.79	24.97	44.36	40.76	78.86	68.08	41.05	47.13	35.71	39.30	46.92	44.81	105.83	89.64
PORTUGAL																				
Observed	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.03	0.00	0.28	0.03	1.02	0.41	0.15	0.65	0.66	0.58	11.24	0.38
Estimated	0.00	0.00	0.00	0.00	2.93	2.88	0.00	0.04	6.23	6.12	9.45	9.38	11.63	11.58	14.16	14.11	9.43	9.50	11.24	11.22
SOUTH KOREA																				
Observed	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Estimated	0.00	0.00	1.85	1.45	3.49	3.05	4.95	4.55	0.00	0.98	6.88	5.60	0.00	1.16	47.91	37.89	32.11	33.37	130.39	109.79
SPAIN																				
Observed	7.20	0.00	19.49	0.00	89.07	0.00	65.63	22.32	25.01	12.85	160.35	48.77	186.60	0.00	151.64	106.57	131.96	93.40	171.21	118.90
Estimated	7.20	6.52	29.03	26.68	123.94	113.79	97.45	98.13	51.43	55.73	160.35	149.93	242.86	232.58	151.64	158.44	132.87	135.46	171.21	167.84
SWEDEN																				
Observed	207.17	98.56	32.48	96.96	218.88	123.37	57.47	79.26	104.07	79.11	187.18	122.87	42.15	101.31	64.73	87.10	112.24	54.73	121.28	76.34
Estimated	207.17	213.66	61.58	135.34	218.88	160.15	174.25	159.48	139.00	141.26	187.18	152.80	87.31	115.77	110.61	107.40	112.24	103.16	121.28	104.87
SWITZERLAND																				
Observed	67.49	0.00	44.86	0.00	27.69	0.00	20.49	0.00	42.77	0.00	19.30	0.00	31.98	0.00	57.49	0.00	32.59	0.00	49.20	0.00
Estimated	67.50	48.74	44.86	40.03	27.69	26.22	21.36	18.69	42.77	29.13	19.30	20.18	31.98	22.91	57.49	39.49	32.59	31.05	49.24	35.75
UNITED KINGDOM																				
Observed	103.42	0.00	66.79	0.00	460.84	0.00	133.53	0.00	156.34	0.00	155.31	0.00	285.40	0.00	262.84	0.00	455.57	206.43	598.60	212.21
Estimated	143.79	60.08	96.64	73.74	460.84	203.07	144.63	185.31	156.34	160.65	176.91	162.69	285.40	196.70	262.84	223.34	455.57	284.79	598.60	387.84
UNITED STATES																				
Observed	520.42	12.28	654.97	9.73	558.42	10.70	719.56	1.81	1,313.52	0.00	1,302.75	0.00	675.97	0.00	1,201.86	0.00	1,060.86	0.00	1,344.23	0.00
Estimated	1,103.24	912.57	1,081.96	952.93	997.02	936.56	919.91	906.10	1,374.02	1,216.74	1,496.08	1,352.19	1,128.23	1,150.26	1,201.86	1,190.67	1,149.45	1,162.05	1,344.23	1,290.23

2000		2001		2002		2003		2004		2005		2006		2007		2008		2009		2010		2011	
Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]	Comm[2]	Disb[3]
0.00	0.00	30.16	0.00	31.35	0.00	29.76	0.00	29.59	29.59	25.73	25.73	36.62	36.62	41.26	41.26	42.94	42.94	40.14	40.14	47.37	47.37	34.26	34.26
22.70	22.70	30.16	30.16	31.35	31.35	29.76	29.76	34.83	34.83	28.60	28.60	36.62	36.62	41.26	41.26	42.95	42.95	40.14	40.14	47.37	47.37	34.27	34.27
183.09	0.00	172.26	161.62	264.71	189.90	161.03	253.48	227.44	226.00	237.24	236.56	578.17	227.76	187.72	290.57	493.47	331.33	235.62	300.30	212.51	249.85	154.31	241.12
183.09	138.97	172.26	132.65	264.71	181.95	176.32	144.68	227.44	165.30	237.24	174.51	578.17	362.80	187.72	194.78	493.47	329.86	235.62	218.00	212.51	179.54	154.31	136.85
0.00	0.00	0.00	0.00	4.62	3.08	12.32	9.63	9.90	9.98	16.43	16.98	27.95	16.79	15.53	13.18	35.30	16.17	25.38	16.47	12.15	25.88	27.16	23.87
4.79	5.17	5.19	5.08	4.62	4.69	12.32	10.46	9.90	10.12	16.43	14.78	27.95	24.84	15.53	17.78	35.30	30.70	25.38	26.93	24.84	24.91	27.16	26.34
39.55	0.00	158.72	41.72	115.81	86.48	113.68	82.62	104.79	128.60	169.13	226.63	162.71	169.52	376.47	197.21	203.73	228.21	478.08	246.64	184.16	177.17	169.57	189.31
39.55	51.17	158.72	132.07	115.81	117.55	117.35	117.89	120.87	119.37	169.13	155.13	162.71	158.84	376.47	319.68	203.73	228.86	478.08	417.19	189.75	242.62	169.58	192.23
7.57	0.23	9.70	9.69	9.20	9.20	9.69	9.69	11.56	11.56	11.48	11.36	11.41	11.41	11.90	11.90	8.57	8.57	9.64	9.64	12.44	12.44	17.16	17.16
7.76	7.81	9.70	9.67	9.76	9.76	9.69	9.68	11.56	11.52	11.48	11.47	11.41	11.40	11.90	11.89	8.57	8.63	9.64	9.63	12.44	12.39	17.16	17.07
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	42.28	44.14	118.12	52.30	269.30	64.53	156.70	99.53	135.72	140.43	157.34	96.32
66.30	75.37	44.11	51.12	46.22	46.48	17.57	23.41	64.58	55.51	101.68	91.30	42.28	44.14	118.12	52.30	269.30	64.53	156.70	99.53	135.72	140.43	157.34	96.32
97.36	135.04	90.99	111.91	103.89	75.49	103.33	108.88	144.83	135.29	137.33	164.15	159.27	143.44	240.91	211.65	318.82	323.76	210.95	279.02	227.50	204.49	181.27	151.75
97.36	104.03	113.65	112.73	116.16	115.79	127.12	125.64	144.83	142.40	163.88	161.03	159.27	158.69	240.91	231.96	378.41	362.39	377.25	374.08	227.82	241.56	187.81	193.68
84.21	59.35	52.96	90.27	139.43	88.96	144.55	113.72	152.68	167.44	339.91	217.33	302.01	259.28	151.97	265.65	157.62	245.53	107.96	172.60	140.40	145.29	161.80	150.56
84.21	91.04	52.96	68.36	139.43	94.49	144.55	111.75	183.23	137.22	339.91	217.42	302.01	244.67	266.98	243.39	192.93	209.41	126.23	162.39	155.82	150.03	171.44	149.44
42.37	0.00	35.38	0.00	66.73	40.50	37.58	46.22	67.99	48.37	39.86	51.95	37.48	45.99	71.71	45.79	68.26	57.28	49.41	60.95	81.93	55.34	64.04	75.35
42.37	34.78	44.49	34.86	66.73	47.78	37.58	35.92	67.99	47.43	41.62	38.16	47.11	36.44	71.71	50.99	68.26	54.30	52.82	45.57	81.93	58.68	64.04	54.18
1,011.62	232.68	373.22	244.18	736.16	485.61	688.14	414.83	651.76	437.19	1,234.44	655.19	1,640.40	910.00	1,801.92	981.52	963.84	982.32	1,323.99	934.81	284.63	1,089.18	367.54	1,353.44
1,011.62	591.68	373.22	507.10	736.16	549.16	688.14	587.29	651.76	582.80	1,234.44	785.47	1,640.40	1,038.81	1,801.92	1,276.29	983.56	1,127.12	1,323.99	1,132.86	1,034.99	1,076.68	1,440.25	1,151.77
1,354.83	0.00	1,541.90	0.00	2,031.50	1,630.51	2,510.56	2,396.19	2,834.15	2,405.15	3,212.57	2,788.44	3,909.43	3,237.89	5,189.24	3,737.30	6,519.60	4,799.11	6,240.69	5,529.58	6,647.57	5,728.87	7,234.49	6,286.95
1,354.85	1,304.06	1,541.90	1,430.97	2,313.51	1,976.37	2,510.57	2,211.52	2,834.15	2,521.12	3,213.24	2,868.85	3,910.15	3,442.21	5,189.28	4,444.99	6,519.62	5,568.74	6,240.72	5,721.64	6,647.57	6,195.18	7,234.70	6,754.15

Source: IHME DAH Database 2013

Notes: In millions of 2011 US dollars. This table presents commitments from bilateral development agencies net of identifiable contributions through multilateral channels of assistance (GFATM, GAVI, United Nations agencies, etc.) but does not exclude transfers to NGOs. In-kind donations also are not reflected in this table.

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

2 Commitment estimates (Comm) have been corrected for missingness using the DAC/CRS coverage ratio.

3 Disbursement estimates (Disb) were obtained by computing donor-specific disbursement schedules using information from complete projects where disbursements could be linked over time.

TABLE B7

World Bank financial and in-kind DAH, 1990–2011

	International Bank for Reconstruction and Development		International Development Association	
Year	Financial	In-kind	Financial	In-kind
1990	76.45	2.69	67.28	6.11
1991	130.35	6.46	152.88	11.12
1992	256.94	13.47	312.89	26.06
1993	389.06	20.20	529.30	50.31
1994	409.96	28.54	609.82	60.21
1995	431.99	28.41	583.89	58.49
1996	722.81	39.78	673.86	58.18
1997	850.74	39.90	677.99	48.33
1998	923.55	36.54	718.06	29.35
1999	575.54	26.83	767.16	48.32
2000	829.52	58.66	780.63	69.98
2001	761.56	55.88	943.89	73.39
2002	652.20	51.22	851.48	73.27
2003	969.95	72.45	774.70	95.01
2004	583.68	54.39	1,164.09	170.90
2005	521.18	54.98	1,056.27	121.44
2006	501.66	44.71	813.35	101.01
2007	446.60	43.10	668.86	89.55
2008	488.59	50.47	573.94	76.85
2009	621.20	41.71	847.84	115.22
2010	1,233.22	60.90	767.76	94.57
2011	1,144.94	76.37	876.12	134.79

Source: IHME DAH Database 2013

Notes: In millions of 2011 US dollars. For preliminary estimates of DAH for 2012 and 2013, refer to Table B1.

TABLE B8

Regional development banks' financial and in-kind DAH, 1990–2011

	African Development Bank		Asian Development Bank		Inter-American Development Bank	
Year	Financial	In-kind	Financial	In-kind	Financial	In-kind
1990	62.75	5.24	22.71	1.90	39.05	3.26
1991	60.60	5.06	34.43	2.88	49.06	4.10
1992	59.20	4.94	47.10	3.93	62.13	5.19
1993	57.92	4.84	51.63	4.31	80.69	6.74
1994	90.24	7.54	55.53	4.64	84.35	7.04
1995	69.71	5.82	49.43	4.13	90.89	7.59
1996	71.15	5.94	49.84	4.16	120.97	10.10
1997	88.79	7.41	73.33	6.12	151.50	12.65
1998	59.60	4.98	177.54	14.83	144.41	12.06
1999	58.74	4.90	265.24	22.15	168.36	14.06
2000	42.98	3.59	198.78	16.60	181.39	15.15
2001	40.35	3.37	136.42	11.39	183.36	15.31
2002	77.55	6.48	138.27	11.55	198.35	16.56
2003	40.42	3.38	138.59	11.57	237.72	19.85
2004	86.25	7.20	114.93	9.60	420.19	35.09
2005	142.18	11.87	172.55	14.41	281.20	23.48
2006	86.79	7.25	175.95	14.69	134.20	11.21
2007	84.17	7.03	135.61	11.32	141.64	11.83
2008	89.59	7.48	142.61	11.91	140.53	11.73
2009	89.40	7.47	161.33	13.47	131.33	10.97
2010	113.24	9.46	90.28	7.54	103.72	8.66
2011	108.49	9.06	76.82	6.41	94.80	7.92

Source: IHME DAH Database 2013

Notes: In millions of 2011 US dollars. For preliminary estimates of DAH for 2012 and 2013, refer to Table B1.

TABLE B9

Financial and in-kind contributions by GFATM and GAVI, 2000-2011

	GAVI		GFATM	
Year	Financial	In-kind	Financial	In-kind
2000	3.00	0.39	–	–
2001	168.74	4.49	–	–
2002	136.94	10.94	1.10	15.70
2003	234.57	5.44	278.42	39.20
2004	197.21	55.88	734.96	59.44
2005	297.29	37.08	1,192.89	83.55
2006	276.83	10.50	1,448.72	95.15
2007	979.36	20.55	1,837.26	83.41
2008	750.49	24.40	2,344.96	163.91
2009	492.78	39.80	2,846.62	162.53
2010	773.69	30.03	3,109.38	253.65
2011	816.63	24.46	2,635.09	292.99

Source: IHME DAH Database 2013

Notes: In millions of 2011 US dollars. For preliminary estimates of DAH for 2012 and 2013, refer to Table B1.

TABLE B10

WHO, regular and extrabudgetary income and expenditure, 1990–2011

Year	Regular budget income	Regular budget expenditure	Extrabudgetary income	Extrabudgetary expenditure[1]	Total income	Total expenditure	Development assistance for health[2]
1990	552.65	464.36	684.24	714.73	1,236.89	1,179.09	1,129.79
1991	533.74	448.47	660.82	690.26	1,194.55	1,138.73	1,091.12
1992	554.50	440.81	634.20	663.26	1,188.70	1,104.07	1,072.87
1993	542.52	431.29	620.49	648.92	1,163.01	1,080.21	1,049.68
1994	491.99	542.06	656.51	671.14	1,148.50	1,213.20	1,180.73
1995	481.95	531.00	643.12	657.44	1,125.07	1,188.44	1,156.64
1996	614.56	474.69	587.14	521.15	1,201.69	995.85	971.17
1997	603.90	466.46	576.95	512.11	1,180.85	978.57	954.33
1998	564.46	472.70	715.26	594.20	1,279.72	1,066.90	1,052.96
1999	556.27	465.84	704.88	585.58	1,261.15	1,051.42	1,037.69
2000	552.13	462.84	991.87	843.07	1,544.00	1,305.91	1,288.10
2001	539.92	452.61	969.95	824.43	1,509.88	1,277.05	1,259.63
2002	494.35	457.31	938.14	907.12	1,432.49	1,364.43	1,340.03
2003	484.17	447.89	918.82	888.43	1,402.98	1,336.32	1,312.43
2004	499.07	453.43	1,338.99	1,228.43	1,838.06	1,681.85	1,646.53
2005	483.03	438.86	1,295.95	1,188.94	1,778.98	1,627.80	1,593.61
2006	497.57	427.63	1,688.23	1,340.82	2,185.81	1,768.45	1,626.64
2007	483.54	415.57	1,640.62	1,303.00	2,124.16	1,718.57	1,580.77
2008	445.25	422.06	1,486.71	1,520.47	1,931.96	1,942.53	1,882.99
2009	441.40	418.41	1,473.87	1,507.34	1,915.27	1,925.75	1,866.73
2010	549.82	396.85	1,850.34	1,797.52	2,400.16	2,194.36	2,165.54
2011	481.10	391.93	1,811.72	1,760.00	2,292.83	2,151.93	2,123.71

Source: IHME DAH Database 2013

Notes: In millions of 2011 US dollars. For preliminary estimates of DAH for 2012 and 2013, refer to Table B1.

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

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

TABLE B11

Bill & Melinda Gates Foundation global health disbursements and in-kind contributions, 1999–2011

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
COMMITMENTS	1,552.89	766.62	627.56	449.38	1,001.03	1,082.35	1,167.55	1,427.59	1,991.32	2,859.73	2,000.39	828.40	2,730.86
DISBURSEMENTS	444.20	699.07	1,048.90	616.22	672.44	504.12	934.63	971.73	1,328.12	1,882.63	1,877.90	1,512.99	2,048.44
Country governments and inter-government organizations (excluding UN)	13.05	8.94	7.50	6.54	0.21	6.42	11.66	7.49	11.56	24.21	40.19	30.84	40.06
UN agencies	83.70	60.52	31.51	49.54	40.97	35.31	77.35	124.11	79.01	227.32	286.31	324.44	397.87
World Bank	0.00	46.64	13.19	86.07	4.82	4.68	0.11	6.78	6.46	23.71	54.37	9.05	18.72
GAVI	228.43	191.65	531.02	0.00	4.21	5.86	174.96	0.00	80.04	78.30	77.62	76.60	264.10
GFATM	–	–	–	61.48	60.21	58.56	0.00	110.96	106.71	104.64	216.86	10.92	150.00
Public-private partnerships (excluding GAVI and GFATM)	2.09	37.05	22.26	162.20	68.65	126.90	155.48	160.85	222.02	252.30	178.36	167.46	144.64
Universities and research institutions	48.93	155.47	100.07	93.53	112.52	95.80	152.47	207.82	291.25	356.18	332.33	294.10	324.28
Corporations and NGOs[1]	67.34	197.78	342.72	156.04	135.18	166.77	357.52	332.31	509.97	636.17	542.28	461.03	612.59
Foundations	0.65	1.02	0.62	0.82	245.67	3.83	5.08	21.41	21.11	179.81	149.58	138.56	96.18
IN-KIND	0.95	37.94	47.18	36.76	43.34	32.76	78.06	98.71	97.09	181.81	251.00	251.01	184.15

Source: IHME DAH Database 2013

Notes: In millions of 2011 US dollars. For preliminary estimates of DAH for 2012 and 2013, refer to Table B1.

1 Includes non-research-focused NGOs based in low-, middle-, and high-income countries.

TABLE B12

US and international NGO expenditures, 1990–2013

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
TOTAL OVERSEAS HEALTH EXPENDITURE	489.45	705.56	836.68	887.76	1,026.29	1,015.19	965.66	1,084.17	1,245.25	1,421.29
BMGF grants	–	–	–	–	–	–	–	–	–	10.69
Private in-kind revenue	44.37	48.41	61.21	78.89	103.86	97.99	113.05	122.96	137.59	145.75
Private financial revenue	224.25	269.41	293.35	331.64	366.77	381.52	404.59	462.93	580.52	641.88
Revenue from other governments	50.06	94.67	101.75	104.24	119.23	109.18	126.67	124.45	147.47	166.68
Revenue from US government	170.76	293.06	380.37	373.00	436.43	426.51	321.35	373.83	379.67	456.29
AVERAGE PERCENT REVENUE FROM										
Private in-kind contributions	15.28	14.25	15.38	15.99	16.77	15.98	18.44	18.74	18.16	18.14
Private financial contributions	75.65	77.57	76.88	75.46	74.61	73.84	73.88	74.32	75.06	75.75
US government	19.78	17.29	18.00	19.42	19.93	20.13	19.77	19.41	17.25	16.96
NUMBER OF NGOS IN SAMPLE	268	340	391	419	439	430	434	441	496	493

2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
1,613.17	1,771.92	1,946.79	2,149.24	2,546.46	3,096.45	3,287.22	3,410.22	4,210.87	4,456.86	4,925.06	4,704.53	4,869.85	4,938.67
55.02	96.86	97.28	32.94	40.58	115.84	64.53	71.27	193.44	211.19	147.80	277.00	294.63	327.31
134.81	197.60	220.14	271.43	392.93	476.73	417.70	471.28	716.48	604.64	519.50	533.35	632.43	631.07
709.43	687.58	766.36	893.26	961.99	1,261.62	1,473.26	1,488.93	1,719.82	1,666.49	2,079.46	1,775.34	1,727.88	1,689.34
198.22	221.26	239.22	276.60	292.75	374.32	457.11	511.86	567.24	732.31	877.93	953.81	1,100.39	1,166.83
515.68	568.61	623.79	675.00	858.21	867.94	874.61	866.88	1,013.89	1,242.23	1,300.37	1,165.03	1,114.53	1,124.14
18.40	19.11	18.26	18.86	18.66	17.15	18.52	17.29	16.89	16.66	15.66	17.87	18.85	20.10
74.56	75.23	74.79	75.72	75.98	77.66	77.64	77.85	78.03	75.56	75.52	72.62	70.28	67.69
17.18	16.49	16.65	16.66	16.65	14.39	13.96	13.38	12.29	13.40	12.83	14.73	15.66	17.14
510	530	569	595	601	596	629	650	699	722	714	714	714	714

Source: IHME DAH Database 2013

Notes: In millions of 2011 US dollars. Includes both US and international NGOs.

TABLE B13

Government health expenditure as source, 1995–2011

Global Burden of Disease region	1995	1996	1997	1998	1999	2000	2001
ASIA							
Central	3.27	3.21	3.45	3.44	2.86	2.90	3.10
East	29.17	31.78	35.07	38.47	41.95	43.61	43.52
South	8.08	8.57	9.09	9.80	10.66	11.00	11.15
Southeast	11.89	13.42	14.11	13.23	13.82	14.40	16.20
CARIBBEAN	1.13	1.31	1.51	1.57	1.60	1.84	1.73
LATIN AMERICA							
Andean	3.24	3.49	3.39	3.38	3.72	3.59	3.76
Central	27.54	28.58	32.55	36.24	39.63	40.48	41.68
Southern	16.80	16.87	17.45	18.78	20.86	20.60	20.20
Tropical	44.15	43.84	47.69	46.95	49.60	49.36	53.09
NORTH AFRICA AND MIDDLE EAST	28.07	30.74	34.43	39.24	42.34	46.55	51.51
OCEANIA	0.33	0.32	0.30	0.36	0.38	0.37	0.39
SUB-SAHARAN AFRICA							
Central	0.33	0.90	1.10	0.94	1.09	0.90	1.43
East	1.11	1.11	1.36	1.61	1.52	1.97	2.07
South	7.71	7.85	9.00	9.52	10.29	10.38	10.81
West	2.21	2.17	2.33	2.75	2.87	2.98	3.32

2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
3.25	3.62	4.28	4.96	5.26	4.98	5.93	7.31	7.54	7.54
50.17	56.20	63.49	71.16	81.75	103.07	127.91	163.26	180.43	210.49
11.51	11.50	12.23	13.12	14.88	16.11	18.27	20.58	21.33	25.30
17.19	19.96	20.20	20.28	24.01	28.19	28.87	31.51	31.84	32.27
2.00	2.12	2.09	2.25	2.60	2.61	2.93	3.09	3.48	3.37
4.21	4.09	4.27	4.72	5.00	6.06	7.56	7.26	7.30	7.58
42.45	44.53	46.44	48.40	51.50	55.43	58.42	62.93	63.59	64.31
17.21	16.79	17.65	19.70	21.44	24.36	28.06	33.65	32.46	33.28
56.86	55.76	63.41	63.98	71.75	76.24	80.20	86.20	102.83	101.67
54.99	59.07	61.57	62.42	69.55	73.98	75.42	87.88	90.52	93.70
0.37	0.33	0.38	0.38	0.39	0.45	0.49	0.47	0.46	0.54
1.30	1.46	1.73	1.66	2.66	2.60	3.45	5.75	3.16	3.68
2.28	2.19	2.33	2.67	3.29	3.36	3.63	4.15	3.93	4.19
11.01	11.60	11.79	12.66	13.34	14.50	15.42	16.69	17.11	17.64
2.93	4.03	5.38	5.42	5.64	7.16	7.23	7.16	6.41	7.96

Source: IHME Government Health Spending Database (Developing Countries), 2013

Notes: In billions of 2011 US dollars. Government health expenditure as source (GHE-S) includes funds raised by recipient country governments from internal resources. This table disaggregates GHE-S by Global Burden of Disease developing region from data produced by the World Health Organization and National Health Accounts.

TABLE B14

DAH allocated to government and non-government recipients, 1995–2011

Global Burden of Disease region	1995		1996		1997		1998		1999		2000		2001	
	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov
ASIA														
Central	0.11	20.23	0.78	35.15	0.32	27.46	0.53	38.15	0.17	75.78	11.88	67.61	1.74	63.57
East	0.47	12.19	1.01	18.60	1.10	27.41	1.34	38.02	4.53	15.36	22.77	28.99	11.71	23.38
South	7.20	186.41	22.28	250.75	20.04	227.05	13.53	281.12	13.73	248.84	72.25	212.67	26.95	273.81
Southeast	4.46	147.77	9.12	138.75	20.66	173.36	23.97	165.48	7.12	213.44	24.51	204.96	29.41	222.22
CARIBBEAN	0.20	109.30	0.57	53.60	0.46	50.38	1.02	67.03	4.79	80.10	6.15	59.67	3.35	56.05
LATIN AMERICA														
Andean	0.52	45.24	1.68	40.38	1.51	61.15	3.20	88.57	1.54	80.17	1.68	116.63	22.19	90.05
Central	1.01	71.05	1.72	78.22	3.38	148.49	4.94	89.73	5.46	132.39	3.23	105.67	6.01	128.49
Southern	0.02	3.39	0.23	1.84	0.16	0.85	0.11	1.35	0.03	2.72	0.01	1.37	0.34	2.11
Tropical	0.22	3.12	0.31	1.69	0.37	2.67	2.14	12.43	10.99	13.25	4.12	12.80	0.28	19.94
NORTH AFRICA AND MIDDLE EAST	0.71	131.83	1.45	112.58	13.11	91.27	3.31	91.92	10.26	135.15	4.54	131.73	8.43	126.69
OCEANIA	0.00	5.77	0.00	47.14	0.00	27.08	0.26	11.55	0.14	26.28	6.63	34.29	0.00	46.45
SUB-SAHARAN AFRICA														
Central	0.66	43.74	0.76	44.60	6.91	45.37	2.67	43.73	4.56	56.06	4.26	57.50	15.34	62.10
East	20.24	316.55	30.65	444.73	29.87	387.26	21.72	375.98	16.25	431.45	48.77	387.65	43.56	559.11
South	2.81	68.80	1.82	72.32	8.03	69.38	2.82	83.94	2.13	66.99	6.66	57.91	25.27	74.84
West	2.74	140.63	15.43	149.68	8.97	185.60	7.87	143.63	5.59	205.41	18.12	186.36	22.54	320.83

2002		2003		2004		2005		2006		2007		2008		2009		2010		2011	
DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov	DAH to non-gov	DAH to gov
7.31	68.79	4.20	82.24	7.74	83.39	62.81	71.73	72.34	65.92	52.18	115.22	81.78	114.82	101.16	114.06	92.68	122.99	116.07	110.85
5.08	57.49	6.52	87.52	8.86	122.16	10.08	138.73	28.53	119.58	37.32	167.05	58.54	142.54	64.08	163.16	51.51	149.96	48.52	113.86
47.79	298.37	51.22	411.63	113.18	394.79	251.86	502.08	424.05	440.87	397.36	708.45	604.87	738.01	523.05	703.95	530.13	738.93	719.30	619.13
38.08	183.63	39.58	368.79	75.31	395.83	204.84	383.07	288.41	439.40	304.80	423.22	363.59	453.74	408.94	445.41	547.06	454.04	464.07	536.09
12.63	36.93	8.33	90.49	22.63	85.57	76.73	76.07	116.37	77.99	134.55	96.56	154.32	107.40	192.82	111.48	175.44	84.19	254.54	77.93
29.23	47.21	26.04	93.73	29.21	99.12	60.92	76.38	63.09	87.20	55.66	90.07	104.47	55.22	108.34	78.29	110.05	31.04	84.07	30.35
26.83	86.23	14.86	137.72	44.95	127.92	74.41	92.84	87.56	94.68	111.65	109.40	177.28	91.98	141.50	95.49	144.37	74.81	154.03	71.93
1.02	2.27	7.63	10.22	15.92	7.88	14.77	8.28	5.06	10.96	12.69	6.63	10.43	10.36	2.02	9.09	4.02	2.41	5.16	1.51
1.57	16.83	0.22	31.46	4.45	30.05	18.08	19.67	10.12	21.64	12.49	21.75	32.31	17.07	34.97	13.63	47.18	12.11	38.08	7.46
23.56	124.26	17.51	174.52	32.77	267.25	533.45	256.14	423.34	389.15	224.03	478.44	289.77	369.49	370.13	284.26	344.59	273.96	383.49	238.83
1.89	64.46	0.57	79.85	3.86	76.23	6.25	73.00	51.94	35.99	41.52	46.87	42.32	57.77	60.30	55.13	49.53	89.59	99.25	102.69
24.84	63.08	24.96	95.11	50.42	123.06	154.24	121.02	158.83	100.26	158.50	100.93	307.52	212.86	332.95	153.90	342.09	166.56	1,878.80	957.63
127.14	560.68	120.00	934.60	312.82	933.31	671.90	1,073.01	1,044.90	1,226.07	1,322.55	1,546.12	1,927.60	1,604.12	2,334.47	1,481.08	2,407.68	1,790.07	2,702.11	1,832.27
12.76	97.45	36.47	183.22	64.43	153.72	170.51	244.00	261.95	236.21	406.95	310.46	558.62	299.26	818.94	367.96	812.92	371.03	928.17	372.05
55.20	266.39	54.01	444.00	136.59	562.07	306.96	544.19	391.03	688.16	570.83	609.51	881.28	807.64	1,184.75	889.75	1,371.87	834.26	1,373.18	1,038.11

Source: IHME DAH Database 2013

Notes: In millions of 2011 US dollars. Development assistance for health (DAH) includes both financial and in-kind contributions, excluding loans, for activities aimed at improving health in low- and middle-income countries. This table disaggregates financial DAH transfers by recipient sector and Global Burden of Disease developing region.

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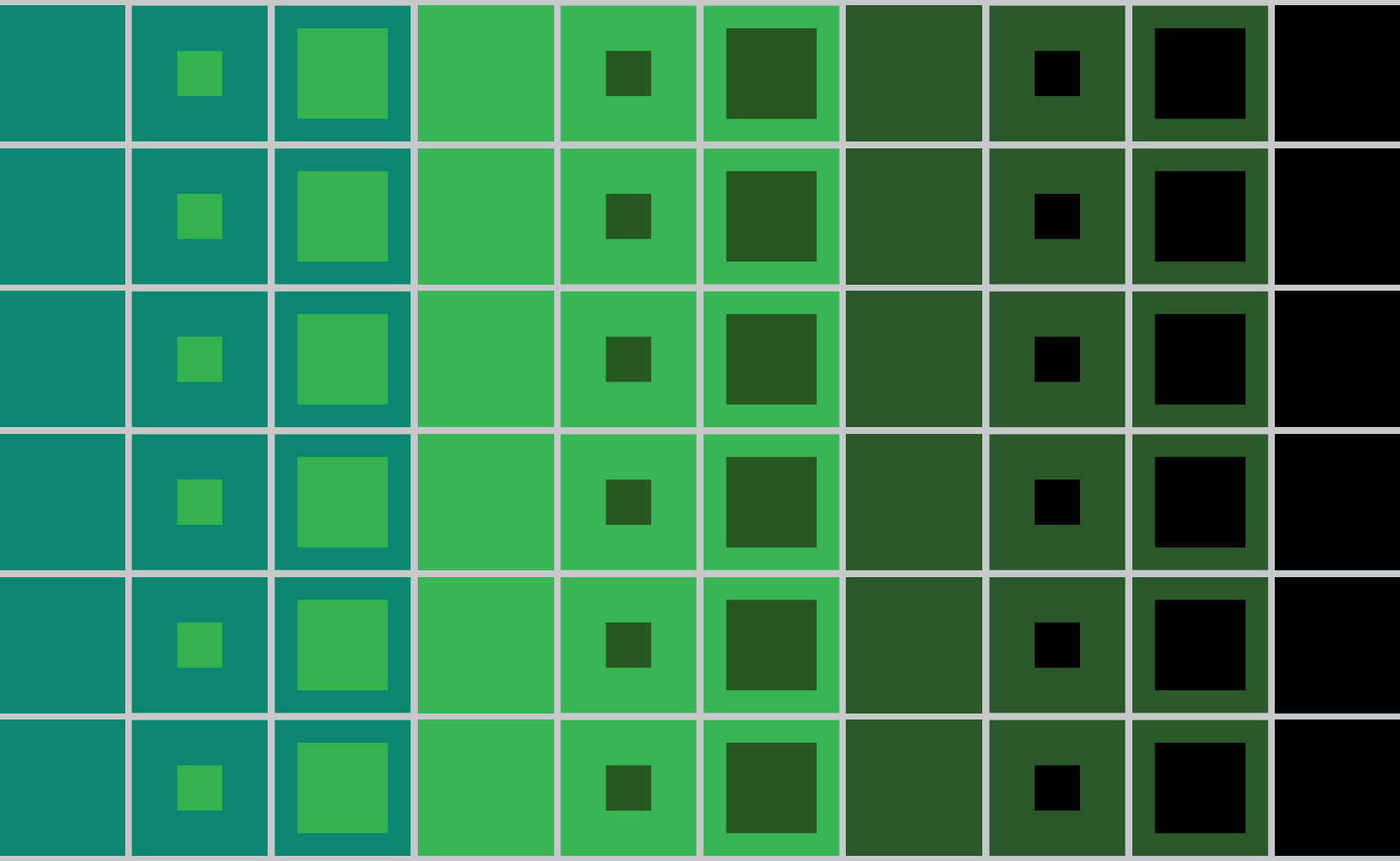

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