

CHAPTER 2:

DISTRIBUTION OF DEVELOPMENT ASSISTANCE FOR HEALTH

In this chapter, we will explore how much development assistance for health (DAH) is allocated to different regions, countries, and health problems. As we have explained in previous *Financing Global Health* reports, we found that DAH generally goes to impoverished areas of the world and to countries with the largest disease burdens. However, there are countries that receive DAH for reasons driven by political, economic, and security interests. We were only able to analyze data through 2009 due to time lags in the publication of data from the majority of donors.

In 2009, sub-Saharan Africa received the largest amount of DAH (\$7.61 billion, or 30%) compared to other regions. The regions receiving the next largest amount of DAH were South Asia (\$1.85 billion, or 7.2%) and East Asia and the Pacific (\$1.48 billion, or 5.8%). North Africa/Middle East received the smallest amount among the regions, \$554.98 million, or 2.2% of DAH. Growth in DAH to sub-Saharan Africa, however, slowed to 8% from 2008 to 2009, its lowest rate of growth since 2001 to 2002. This slowdown is largely due to the reduced growth of HIV/AIDS funding. Other regions

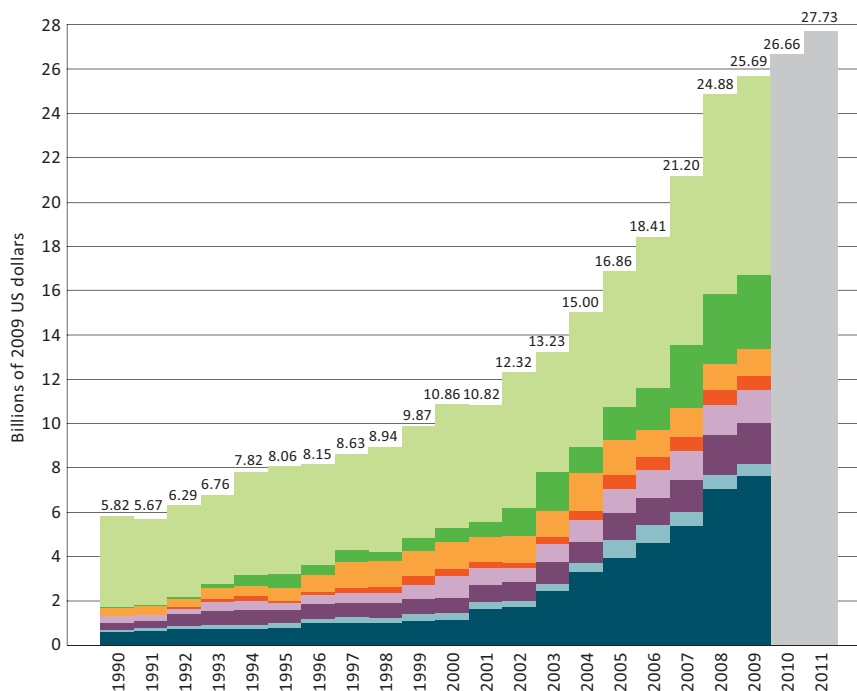
FIGURE 11:
DAH by focus region, 1990-2011

Health assistance for which we have no recipient country or region information is coded as “unallocable.”

- Unallocable
- Global
- Latin America and Caribbean
- Europe and Central Asia
- East Asia and Pacific
- South Asia
- North Africa / Middle East
- Sub-Saharan Africa
- Preliminary estimates

Sources: IHME DAH Database 2011 and IHME DAH Database (Country and Regional Recipient Level) 2011

Notes: 2010 and 2011 are preliminary estimates based on information from channels of assistance, including budgets, appropriations, and correspondence. Data were unavailable to show total DAH by focus region for 2010 and 2011.



BOX 4:**Non-governmental organizations' expenditures in developing countries**

How much do NGOs spend in total in Uganda? In El Salvador? The answer is very hard to determine. NGOs generally do not make country-specific expenditures publicly available. This limits researchers' ability to analyze the distribution of DAH and measure its impact. Policymakers and planners in developing countries are also interested in tracking these funds.⁵⁰ Donors do not require this type of reporting, and conversations between NGOs and IHME have revealed that few seem to have tracking systems in place that would make reporting country-specific expenditures feasible. Unless donors include requirements and provide additional funding to track and publicly report country-specific expenditures in grant agreements, NGOs will probably have little incentive to invest time and money into establishing more sophisticated tracking mechanisms and making these important data available.

experienced stagnating or declining DAH from 2008 to 2009 with the exception of East Asia and the Pacific and Latin America. DAH increased 10% in East Asia and the Pacific, while it increased 4% in Latin America during this period. DAH targeted toward improving health at a global level, such as HIV/AIDS vaccine research and the development of new drugs to treat multidrug-resistant tuberculosis (TB), represented 13% of DAH in 2009.

Next, we will examine spending by country and by health focus area. The figures and maps that present data at the country level only include DAH that can be traced to a specific recipient country. Most notably, they do not include DAH channeled through non-governmental organizations (NGOs) and the World Health Organization (WHO), since most of these organizations do not provide standardized and complete data on country-specific expenditure. For 2009, 35% of DAH could not be traced to recipient countries due to missing data.

Our analysis of the top 10 recipients of DAH shows the countries that are driving the regional trends seen in Figure 12. This figure only presents results through 2009 due to lack of data for years 2010 and 2011. Appearing on the list of top 10 recipients of aid are some of the world's most populous countries as well as those with high HIV/AIDS prevalence. Among the 10 largest recipients of DAH are eight sub-Saharan African countries, all of whom received a large fraction of their aid from the US through programs such as the US President's Emergency Plan for AIDS Relief (PEPFAR). All countries except India, South Africa, Nigeria, and China were focus countries of the US President's Malaria

Initiative (PMI) as of 2009.⁵¹ Among the top 10 are two countries that are foreign aid donors: China and India.⁵² Although these countries give away foreign aid, massive health disparities still exist within these nations. India received most of its aid (29%) in the form of loans and grants from development banks, primarily the World Bank, while the largest portion (29%) of China's DAH came from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). While each of the top 10 countries received DAH from GFATM, Ethiopia, Tanzania, and India are the top GFATM recipients on this list. Out of the 10 countries shown here, the GAVI Alliance (GAVI) granted nearly three times more DAH to Ethiopia than to the next largest recipient, Kenya. The influence of the Bill & Melinda Gates Foundation (BMGF) in India is also captured on this figure. One of BMGF's major initiatives in India is Avahan, a program designed to lower the transmission of HIV. In a study published in October 2011, Avahan was estimated to have averted over 100,000 HIV infections.^{53,54}

Figure 12 sheds light on ways that spending cuts and shifting priorities may impact these countries in years to come. For example, the UK was India's second-largest funder of DAH from 2004 to 2009, representing 23% (\$873.62 million) of total DAH received by India. In 2011, the UK decided it would only commit to sending aid to India until 2015,⁵⁵ and pressure is mounting on its government to cut off aid to India entirely.^{56,57} Other examples include the case of the African countries shown on this figure that receive the majority of their DAH from the US. The combined effects of budget cuts in the US and the uncertainty of PEPFAR funding after

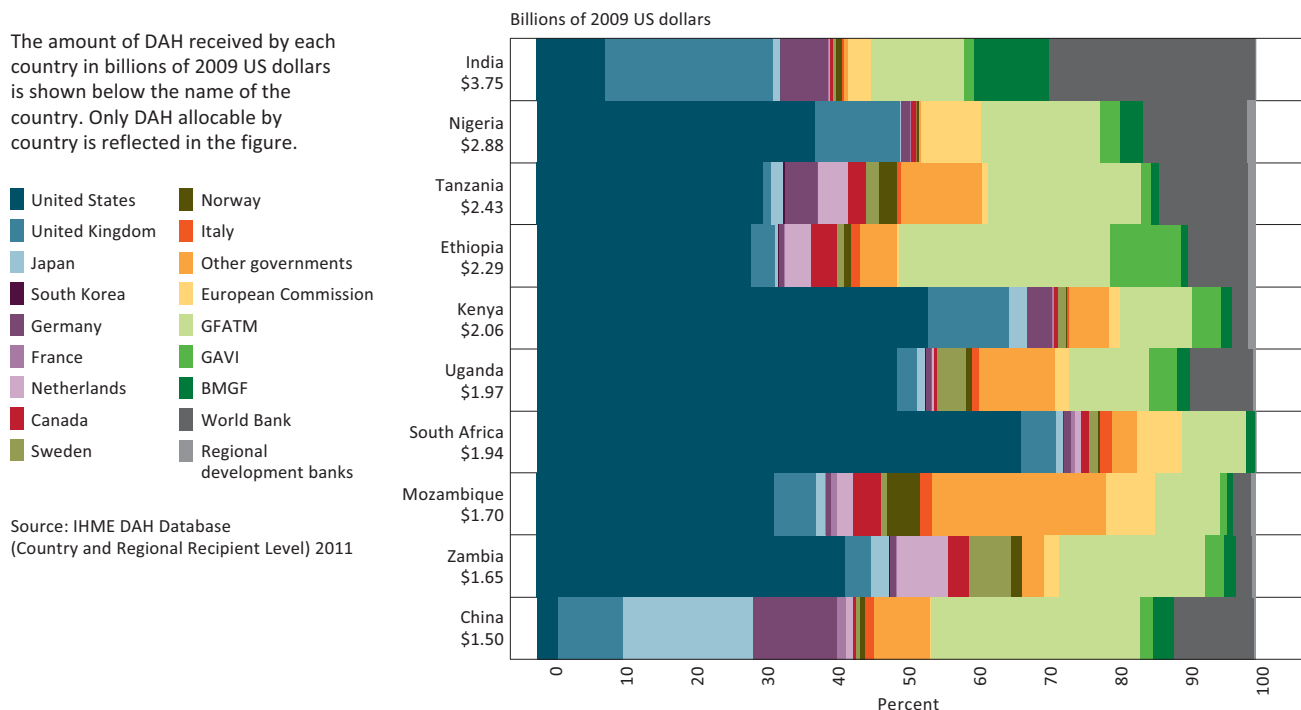
2013⁵⁸ could lead to large declines in DAH funding to these countries. Furthermore, the Dutch government announced in 2011 plans to stop providing foreign aid to Zambia and 12 other countries.⁵⁹ The Dutch contributed \$118.00 million to Zambia in 2009, or 7% of Zambia’s total DAH.

Calculating DAH per disability-adjusted life year (DALY), a measure of years lost due to premature death and disability, is one way to assess how much DAH a country is getting relative to its health needs. The map shown in Figure 13 puts into perspective the country rankings of Figure 12. We were unable to extend this analysis to years 2010 and 2011 due to incomplete data on transfers from channels to recipient countries during this period. While Ethiopia was the fourth-highest recipient of DAH, it only received \$8.93 of DAH per DALY from 2004 to 2009. Argentina, a more prosperous and healthier country and the thirteenth-largest recipient of DAH in 2010, received \$32.22 per DALY. Argentina obtained 84% of its DAH from the World Bank from 2004 to 2009. In response to the Argentinian financial crisis in 2001 to 2002, the World Bank issued a large

portfolio of loans, including health loans, to the country as part of an economic stimulus package.⁶⁰ Low-income countries in sub-Saharan Africa such as Chad and Sierra Leone received \$4.28 and \$6.21 dollars per DALY, respectively, while Botswana, an upper-middle-income country, received \$95.07 per DALY. Botswana is a PEPFAR Partnership Framework country and received 92% of its DAH from the US between 2004 and 2009, while Chad and Sierra Leone are not PEPFAR Partnership Framework countries.⁶¹

To further understand the relationship between DAH and DALYs, we compare the top 30 recipients of DAH from 2004 to 2009 to countries ranked by total DALYs for 2004 in Figure 14. We were unable to present estimates for more recent years due to lack of data. South Africa, an upper-middle-income country that ranks 11th for total DALYs, is the seventh-largest recipient of DAH largely thanks to US grants from PEPFAR. Niger, a low-income country, ranks 29th for disease burden but does not appear on the list of top 30 recipients of DAH. In addition to Botswana, other PEPFAR Partnership Framework countries are among the top 30 recipients

FIGURE 12:
Top 10 recipients of DAH by percentage received from channels of assistance, 2004-2009



of DAH, including Nigeria, Tanzania, and Ethiopia, which appear at the top of the list, and Rwanda, which ranks 22nd.⁶¹

While DAH tends to go to countries with higher disease burden, there are a number of examples where factors such as focus on particular diseases (HIV/AIDS and malaria), efforts to bolster a country experiencing a financial crisis, and security interests can also influence where DAH is allocated.

DAH by health focus area

This section includes the amount of DAH that channels of assistance earmarked for specific health issues. In addition, we quantify the amount of DAH for HIV/AIDS; maternal, newborn, and child health (MNCH); TB; and noncommunicable diseases (NCDs) that different countries received relative to each country's burden of disease caused by these conditions. Due to lack of data on the specific health focus areas that donors are funding, we were unable to identify the amount of DAH going to these different areas for years beyond 2009.

To identify the amount of DAH going to different health focus areas, we used project codes, titles, and descriptions reported by channels of funding. We also classified all DAH from the Joint United Nations Programme on HIV/AIDS (UNAIDS) as DAH for HIV/AIDS and expenditures by GAVI and the United Nations Population Fund (UNFPA) as going to MNCH. When showing the channels that are funding different focus areas, we subtract any transfers between channels to avoid double counting. For example, funds that the UK gave to GFATM appear in the figures as coming from GFATM, making the UK's contribution appear smaller than it actually was. Also, for those projects targeted toward multiple health focus areas (such as a project for both HIV/AIDS and TB), we assume those projects are divided equally among these areas. Another issue is that our estimates of the US's allocation of DAH by health focus area between 2002 and 2004 are likely underestimated due to missing and abbreviated project descriptions.

FIGURE 13:
Total DAH per all-cause DALY, 2004-2009

We used DALY data for 2004 as a proxy for burden in all subsequent years. Countries that received no DAH over the study period and countries with zero or missing burden data are not shown. DAH received is shown in real 2009 US dollars.

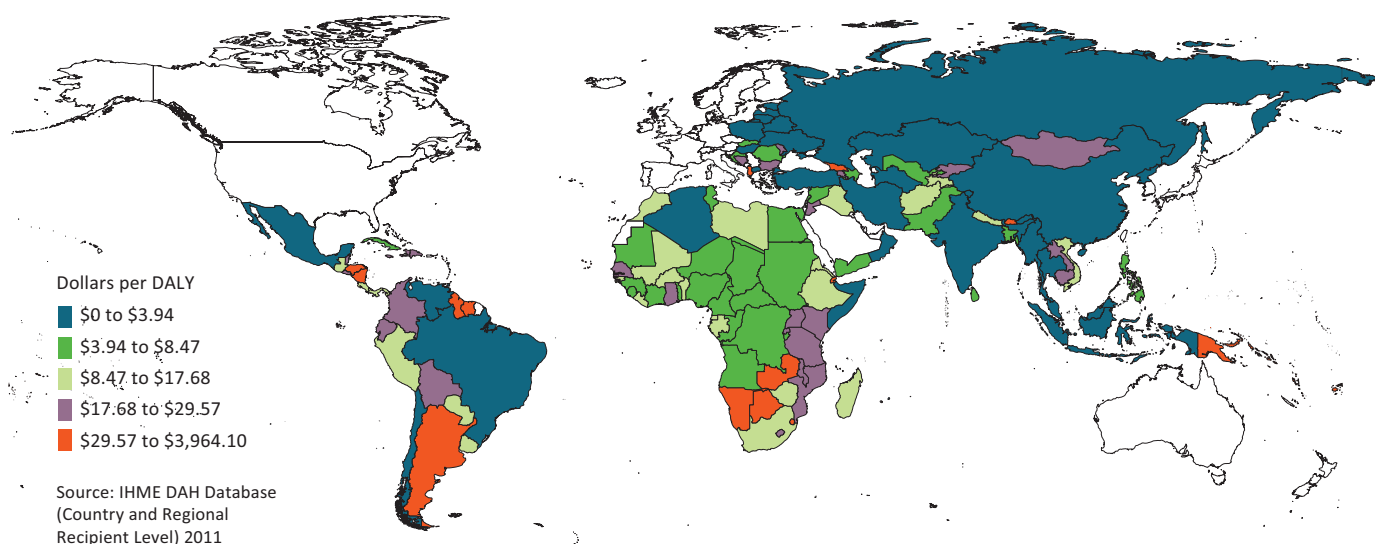
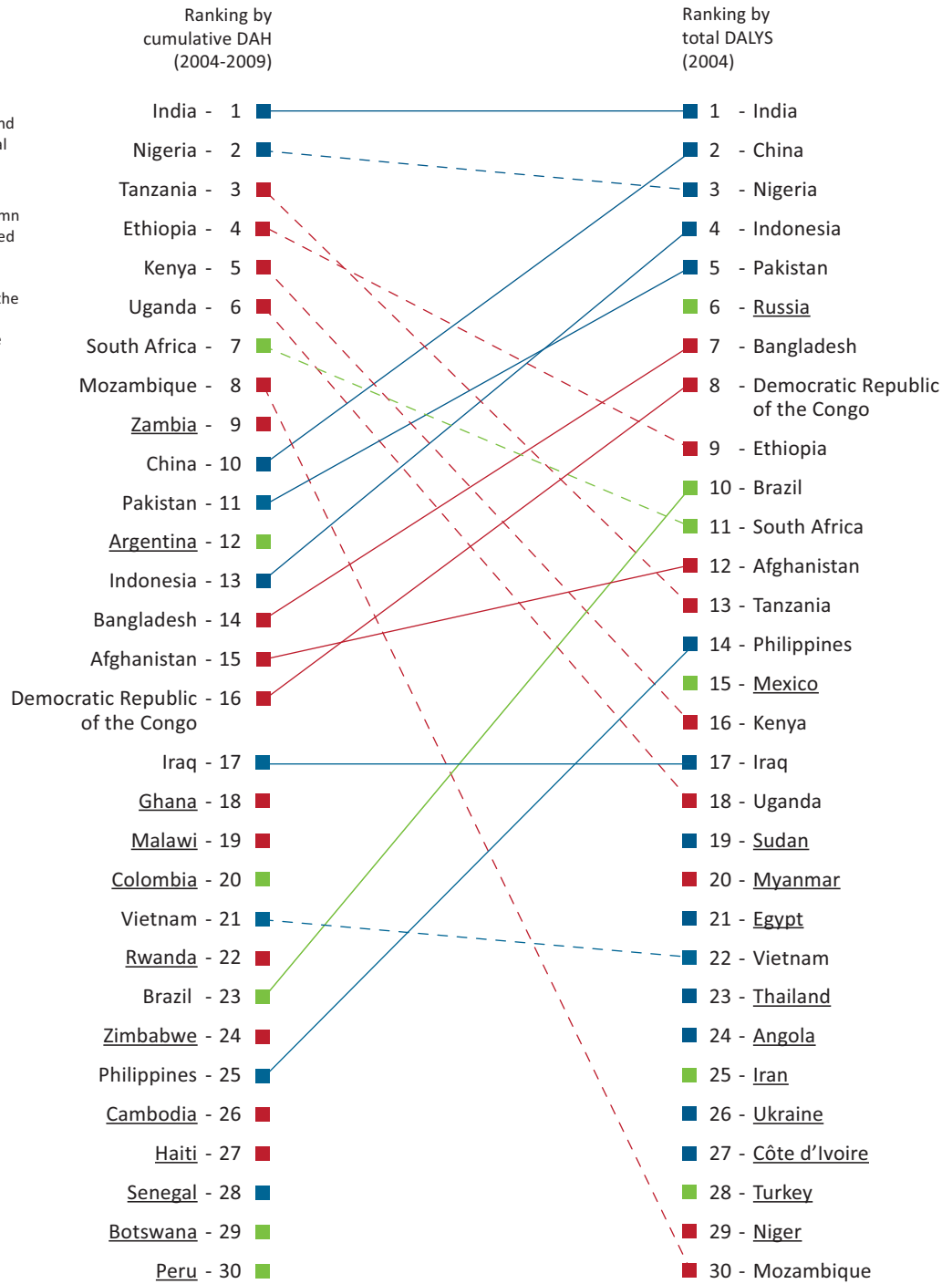


FIGURE 14:
Top 30 country recipients of DAH, 2004-2009, compared with top 30 countries by all-cause burden of disease, 2004

■ Upper-middle-income countries
 ■ Lower-middle-income countries
 ■ Low-income countries

Sources: IHME DAH Database (Country and Regional Recipient Level) 2011 and Global Burden of Disease 2004 Summary Tables 2009

Notes: Countries that appear in one column but not the other are underlined. A dashed line indicates the country ranks higher in the cumulative DAH column than in the total DALY column. A solid line indicates the country ranks the same or higher in the total DALY column than in the cumulative DAH column.



We have made changes that improved our estimates of DAH devoted to different health issues. We incorporated more detailed data from the World Bank (a variable called “theme codes”) into our analysis to gain further insight into the projects it is funding. Furthermore, we identified and solved two technical challenges. One challenge resulted in the underestimation of health sector support from bilateral donors prior to 1999. Another prevented us from completely identifying health focus areas for European Commission (EC) projects, which caused underestimation of the EC’s contribution to certain health issues. As a result of these subsequent changes, our research contains better information about how the World Bank and EC are allocating their DAH.

From 2008 to 2009, growth in DAH for some health issues slowed but sped up for others. Between 2008 and 2009, the growth rate of DAH for HIV/AIDS slowed to 5% from 21% between 2007 and 2008. Growth in DAH for TB and health sector support was also slower in comparison to the previous year. In contrast, DAH for malaria continued its rapid rise, increasing by around

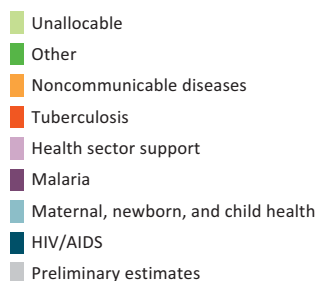
50% for the second year in a row. While DAH for MNCH and NCDs barely increased from 2007 to 2008, their growth rate sped up to 9% and 17%, respectively, between 2008 and 2009.

Funding for HIV/AIDS by channel of assistance

As shown in Figure 16, between 2001 and 2002, DAH for HIV/AIDS started to expand to levels never seen before. It grew by \$919.48 million between 2001 and 2003. Once PEPFAR began disbursing funds for HIV/AIDS in 2004, levels of funding shot up by \$3.76 billion between 2004 and 2008. Between 2008 and 2009, year-to-year growth slowed to its lowest rate since 1997 to 1998. This is largely due to trends in HIV/AIDS expenditures from the largest channels, GFATM and the US. Between 2008 and 2009, GFATM’s HIV/AIDS expenditure decreased by 4%, while disbursements from the US did not increase as much as they have in the past (14% growth from 2008 to 2009 compared to 41% from 2007 to 2008). Lack of data from most channels hindered us from estimating total DAH for HIV/AIDS past 2009. However, a recent study by the Kaiser

FIGURE 15:
DAH for HIV/AIDS; maternal, newborn, and child health; malaria; health sector support; tuberculosis; and noncommunicable diseases, 1990-2011

“Unallocable” corresponds to DAH for which we did not have information on disease focus. “Other” represents DAH for other health focus areas not yet tracked by IHME.



Sources: IHME DAH Database 2011 and IHME DAH Database (Country and Regional Recipient Level) 2011

Notes: 2010 and 2011 are preliminary estimates based on information from channels of assistance, including budgets, appropriations, and correspondence. Data were unavailable to show total DAH by health focus area for 2010 and 2011.

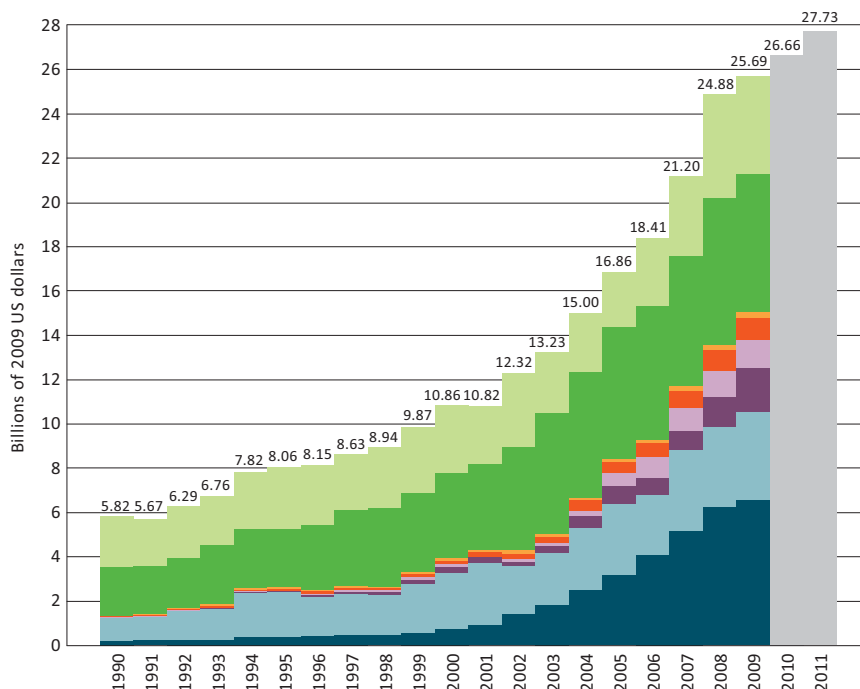


FIGURE 16:
DAH for HIV/AIDS by channel of assistance, 1990-2009

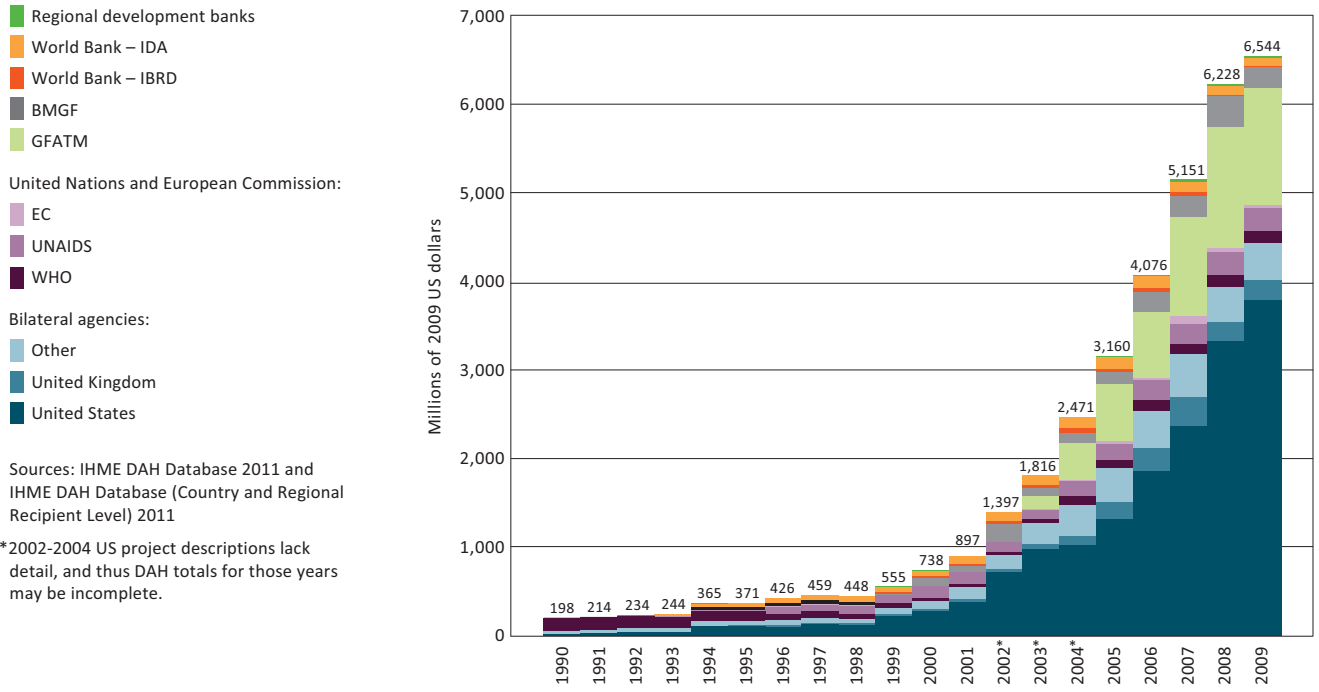
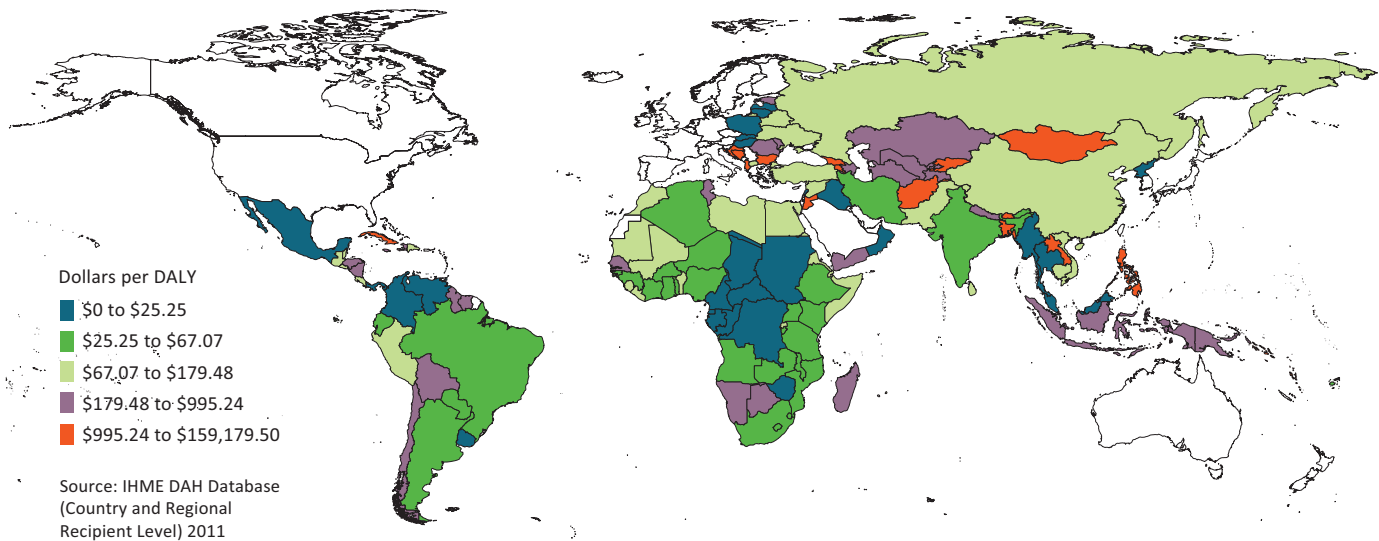


FIGURE 17:
DAH for HIV/AIDS per related DALY, 2004-2009

We used DALY data for 2004 as a proxy for burden in all subsequent years. Countries that received no DAH over the study period and countries with zero or missing burden data are not shown. DAH received is shown in real 2009 US dollars.



Family Foundation and UNAIDS estimated that PEPFAR funding to countries declined 10% between 2009 and 2010.⁶² Our analysis of GFATM's up-to-date financial data shows that its HIV/AIDS disbursements rose 20% from 2009 to 2010. For our 2012 *Financing Global Health* report, we will be able to use new data to evaluate overall trends in HIV/AIDS DAH up to 2010.

As seen in Figure 12, low-income countries such as Kenya, Uganda, and Zambia figured high on the list of top recipients of DAH, largely due to HIV/AIDS DAH that they received. However, the map in Figure 17 shows that the HIV/AIDS DAH they received per HIV/AIDS DALY between 2004 and 2009 was much smaller than that received by richer countries such as Botswana and Chile. Countries that are of strategic interest to the US and their NATO allies such as Afghanistan and Jordan received some of the highest amounts of HIV/AIDS DAH per HIV/AIDS DALY, amounting to \$5,172 and \$1,083 per DALY, respectively. Cuba, which receives the majority of its money from GFATM, received \$1,438 per HIV/AIDS DALY from 2004 to 2009. Small island nations in the South Pacific are outliers in this analysis and received the largest amounts of DAH for HIV/AIDS per HIV/AIDS DALY.

Funding for maternal, newborn, and child health by channel of assistance

MNCH has garnered much policy attention, given developing countries' efforts to reach Millennium Development Goals (MDGs) 4 and 5, which include the reduction of child and maternal mortality rates by two-thirds and three-quarters, respectively, between 1990 and 2015.⁶³

Our understanding of the amount of DAH allocated to MNCH has improved thanks to the use of additional data from the World Bank's International Bank for Reconstruction and Development (IBRD) and International Development Association (IDA). Last year, we did not track any DAH for MNCH coming from the World Bank. This year, we have a better understanding of contributions from this source. As a result, total DAH for MNCH is estimated to be greater than we reported last year (see Figure 18). The growth rate of DAH for MNCH has fluctuated greatly over time, increasing by 34% from 2006 to 2007, stagnating from 2007 to 2008, and then expanding again by 9% in 2009. From 2006 to

2009, GAVI's dominance in the field of MNCH grew as it controlled an increasing share of the total. In contrast, DAH for MNCH from the United Nations Children's Fund (UNICEF) as a share of total DAH has declined substantially. Also, the dominance of IBRD and IDA, measured by the percent of total DAH for MNCH that they spend, shrank from 24% of total DAH in 2006 to 8% in 2009. UNFPA's contribution to MNCH as a share of total DAH has maintained its share of the total DAH, which was 20% in both 2006 and 2009. This contrasts with other traditional institutions, whose dominance in MNCH has declined in recent years. US DAH for MNCH grew at the end of the George W. Bush administration, increasing by 50% from 2007 to 2008. The US contribution to MNCH also jumped by 51% from 2008 to 2009 under Barack Obama's administration. Future updates of this research will assess the impact of the current administration's continued prioritization of MNCH through the Global Health Initiative on funding levels.⁶⁴

DAH for MNCH is likely to increase in future years if donors honor commitments made in 2010. Donor governments at the Group of Eight summit in Muskoka, Canada, pledged to give \$5.6 billion to the cause. Developing and developed country governments, as well as donors from the private sector, pledged \$40 billion for the next five years to save mothers' and children's lives.^{65,66}

As was reported last year, the range of MNCH dollars received by countries per MNCH DALY as shown in Figure 19 is much smaller than the extreme values seen in the map of DAH for HIV/AIDS per HIV/AIDS DALY. The country that received the largest amount per DALY (\$314) is Argentina, whose largest donor was the World Bank. Overall, countries in South America receive some of the highest amounts of MNCH DAH per MNCH DALY, which contrasts starkly with poorer countries in sub-Saharan Africa, who receive lower amounts and have higher MNCH disease burden. A study by the Institute of Health Metrics and Evaluation (IHME) of progress toward MDGs 4 and 5² found that countries receiving more DAH for this health focus area such as Peru, Mongolia, and Egypt are on track to meet both MDGs, while other countries who are also expected to attain MDGs 4 and 5 (such as China, Libya, Maldives, Syria, and Tunisia) received around \$1 of MNCH DAH or less per MNCH DALY.

FIGURE 18:
DAH for maternal, newborn, and child health by channel of assistance, 1990-2009

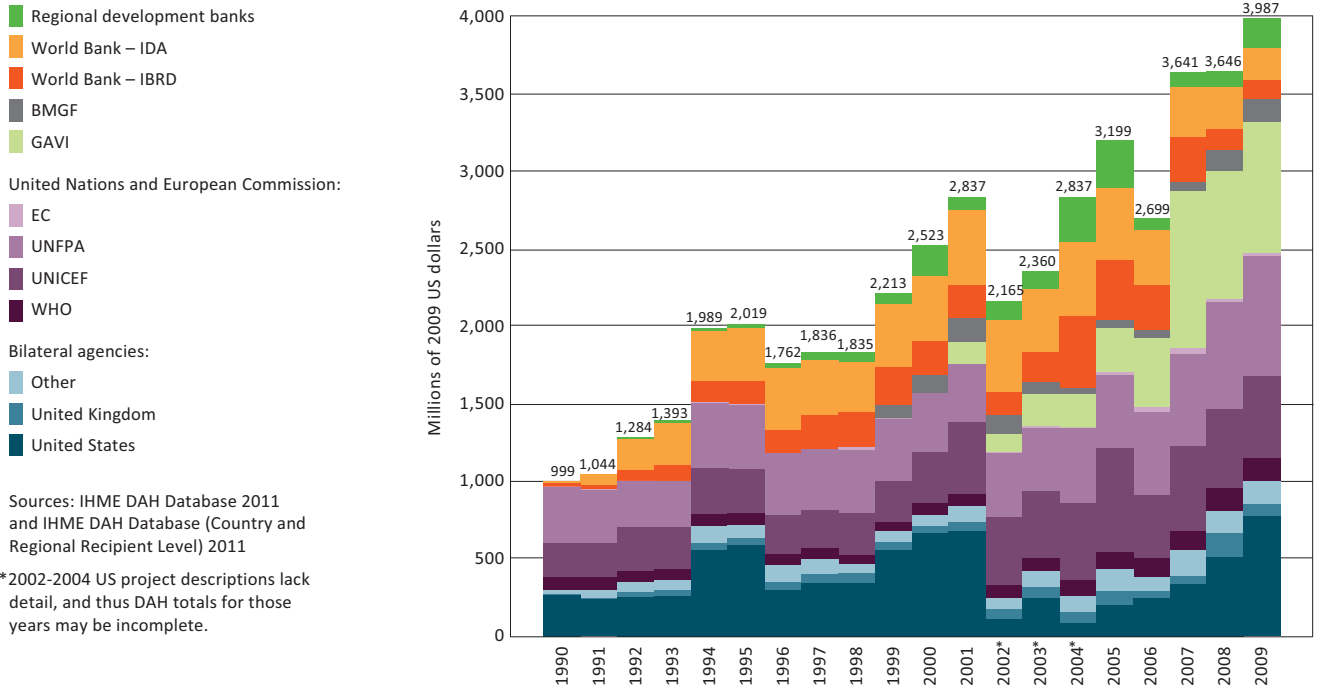
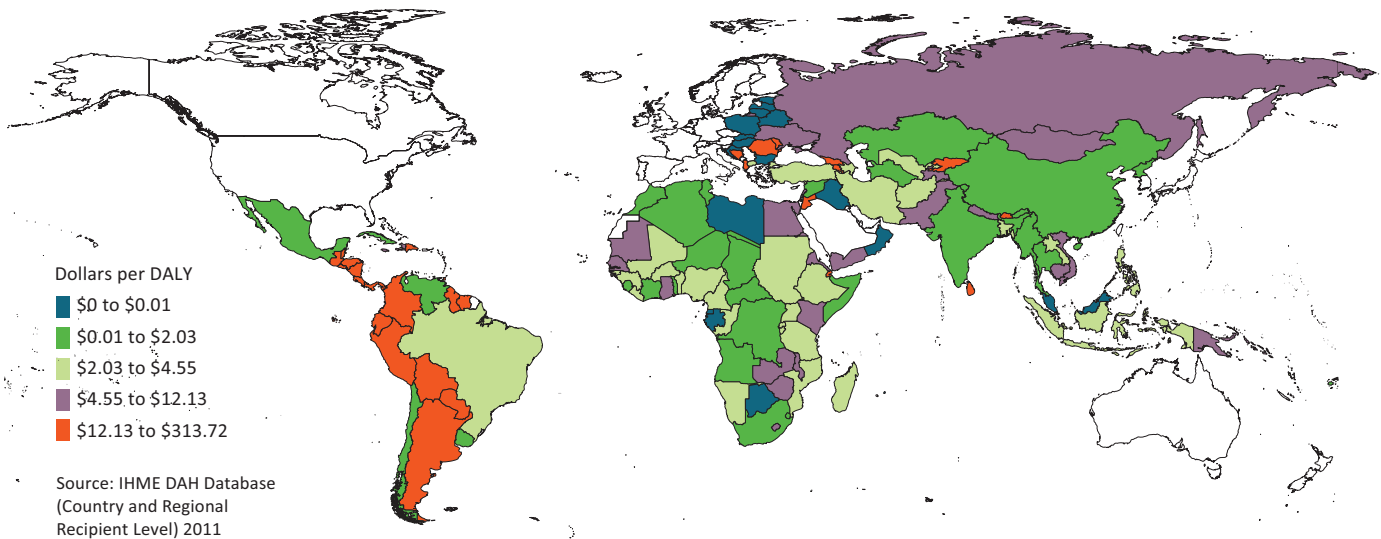


FIGURE 19:
DAH for maternal, newborn, and child health per related DALY, 2004-2009

We used DALY data for 2004 as a proxy for burden in all subsequent years. Countries that received no DAH over the study period and countries with zero or missing burden data are not shown. DAH received is shown in real 2009 US dollars.



Funding for malaria by channel of assistance

DAH for malaria experienced the fastest rate of growth from 2008 to 2009 (49%) among all the health focus areas that we tracked, and received nearly \$2 billion in 2009. This stunning growth trend in malaria DAH began between 2007 and 2008, driven largely by donations channeled through GFATM. Malaria DAH from GFATM increased by 44% from 2007 to 2008 and 96% between 2008 and 2009. It is important to keep in mind that channels such as the US and UK governments and BMGF actually contribute more to malaria than is shown in this figure since their contributions to GFATM are subtracted.

Following the Abuja Declaration in 2001 in Nigeria, where African leaders pledged to halve malaria deaths by 2010 and requested \$1 billion per year from donors, malaria DAH rose slowly.⁶⁷ In 2007, Bill and Melinda Gates held a meeting in Seattle and invited key global health players to join them in their quest to eradicate malaria, lending new energy to the cause.⁶⁸ BMGF's contributions to the fight against malaria have grown

over time. Excluding funds that it granted to other channels, shown in Figure 20, malaria DAH from BMGF grew 45% annually between 2006 and 2009. Funds from PMI, which started in 2005, and the 2008 Lantos-Hyde Act contributed to the growth of malaria DAH from the US.⁶⁹ According to our estimates, only in 2008 did malaria DAH finally reach the \$1 billion mark that African leaders originally requested in 2001 to meet the Abuja Declaration malaria mortality target.

The map of malaria DAH per related DALY in Figure 21 shows that the two countries that account for the largest number of malaria DALYs in the world, Nigeria and the Democratic Republic of the Congo, receive small sums of money per malaria DALY (\$6 and \$8 respectively) compared to other high-burden countries in Africa. For example, Ethiopia and Tanzania received \$29 and \$34 each per malaria DALY from 2004 to 2009. Nigeria and the Democratic Republic of the Congo became focus countries for PMI in 2011, joining other African countries such as Ethiopia, Tanzania, Madagascar, and Kenya. In general, PMI focus countries tended to receive larger sums of malaria DAH per DALY,

FIGURE 20:
DAH for malaria by channel of assistance, 1990-2009

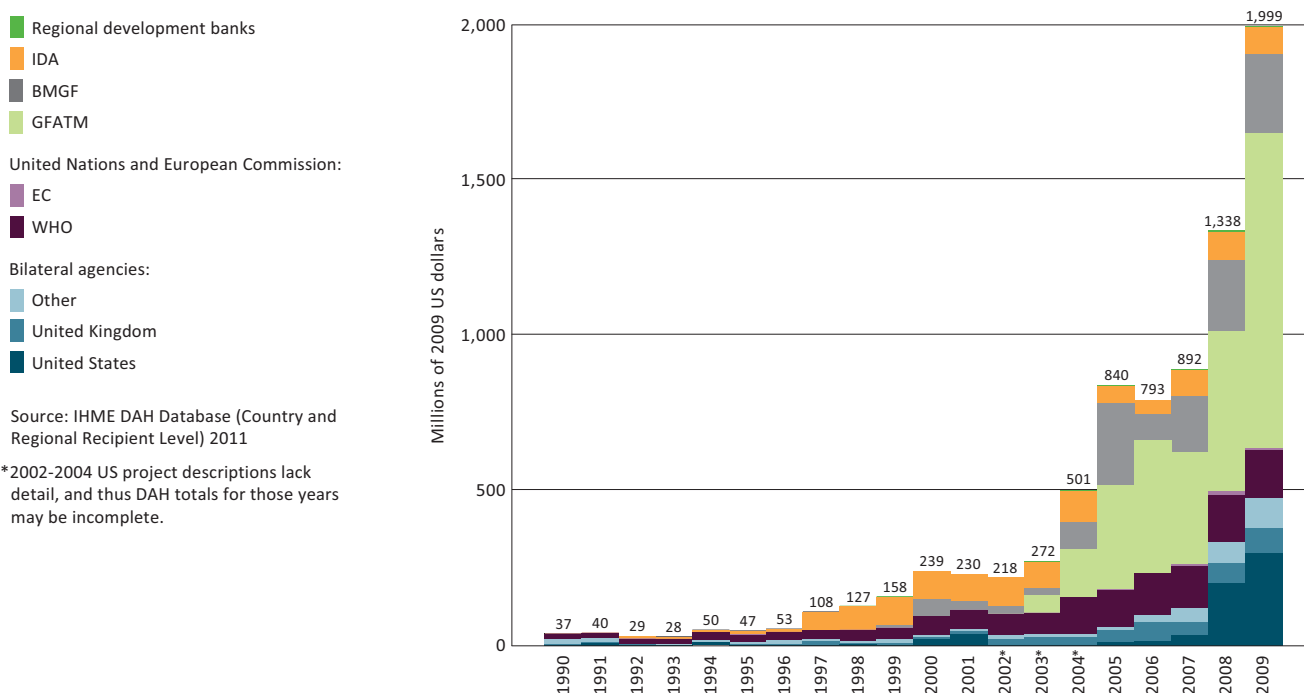


FIGURE 21:
DAH for malaria per related DALY, 2004-2009

We used DALY data for 2004 as a proxy for burden in all subsequent years. Countries that received no DAH over the study period and countries with zero or missing burden data are not shown. DAH received is shown in real 2009 US dollars.

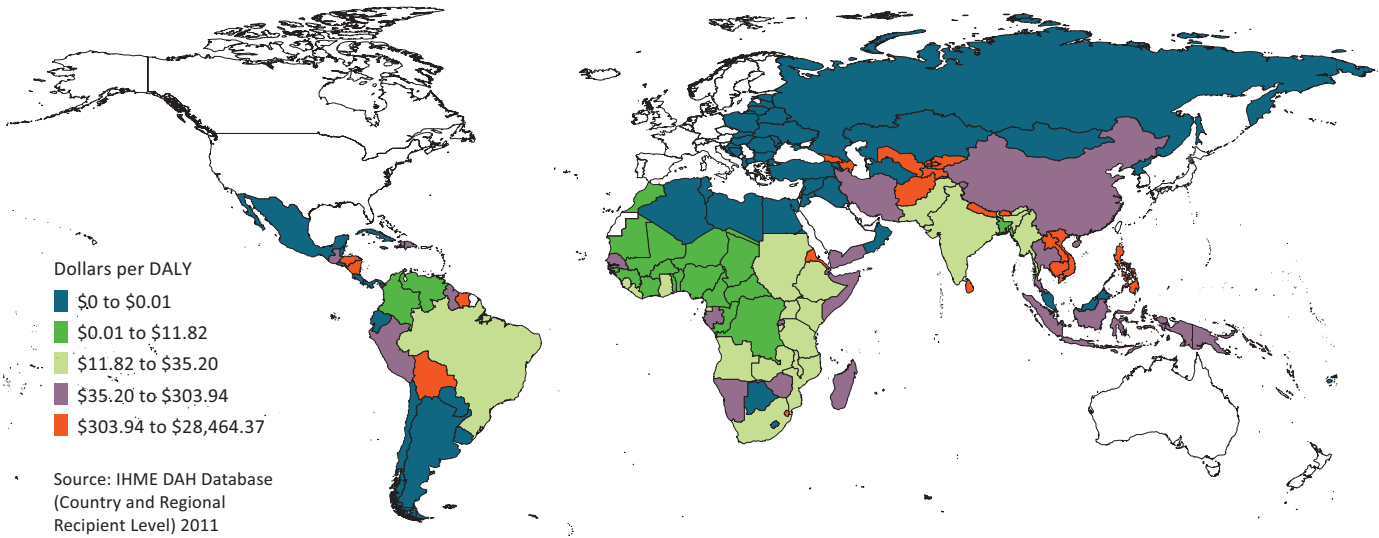


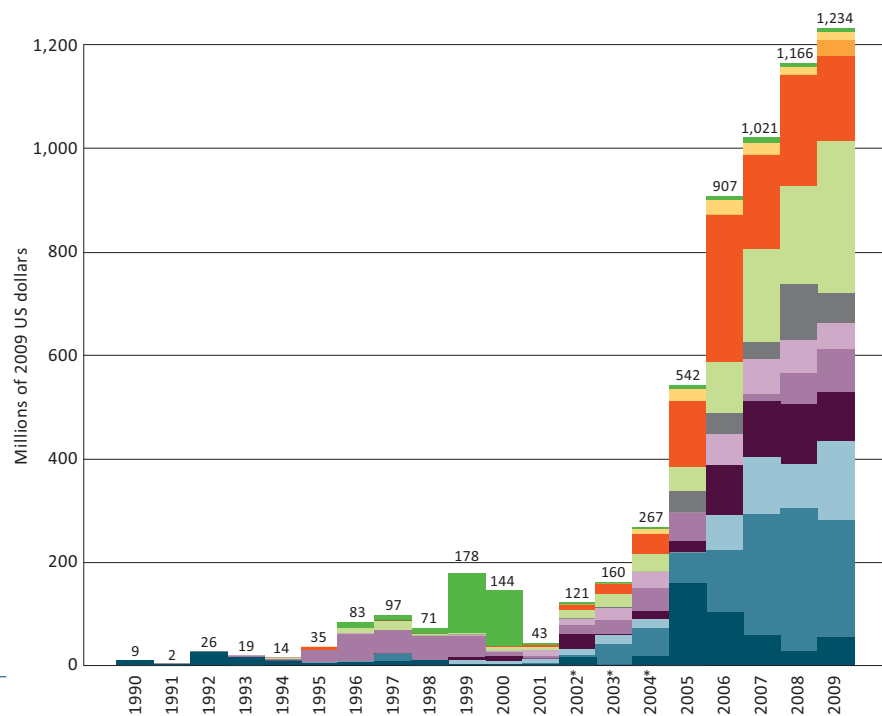
FIGURE 22:
DAH for health sector support by channel of assistance, 1990-2009

- Regional development banks
 - World Bank – IDA
 - World Bank – IBRD
 - EC
- Bilateral agencies:
- Other
 - Spain
 - Sweden
 - Denmark
 - Netherlands
 - Norway
 - United Kingdom
 - United States

Source: IHME DAH Database (Country and Regional Recipient Level) 2011

*2002-2004 US project descriptions lack detail, and thus DAH totals for those years may be incomplete.

Notes: For search terms used to define health sector support, please visit our online Methods Annex at: http://www.healthmetricsandevaluation.org/publications/financing_global_health_2011_methods_IHME.pdf



due in part to their inclusion in this program. In future updates of this research, the status of Nigeria and the Democratic Republic of the Congo as PMI focus countries may translate to higher levels of malaria funding per DALY. Overall, countries in Central and South-east Asia receive much larger sums of malaria DAH per malaria DALY than sub-Saharan Africa, where the greatest levels of malaria burden exist.

Funding for health sector support by channel of assistance

Health sector support includes grants that a recipient country government can use to fund any area of the health sector. Health sector support is related to the principle of alignment established by the Paris Declaration on Aid Effectiveness, in which donors pledged to provide aid that corresponds with countries' priorities and channel assistance through the treasuries of developing countries.⁴⁴ Tracking DAH for health sector support reveals that the Paris Declaration has fueled increases of DAH for this area since 2005, but it remains much smaller than DAH for HIV/AIDS and MNCH. Health sector support was 5% of total DAH in 2009 compared to 25% for HIV/AIDS and 16% for MNCH.

We have revised our estimates of DAH for health sector support due to some key improvements described earlier, resulting in slightly larger estimates of DAH for health sector support from the EC and of total DAH for health sector support prior to 1999. Also, methodological changes have led to better assessment of the World Bank's contribution to health sector support (see Methods Annex: http://www.healthmetricsandevaluation.org/publications/financing_global_health_2011_methods_IHME.pdf).

European bilateral agencies and the EC have been the main drivers of the increase in DAH for health sector support. Combined, the six largest bilateral donors of health sector support in Europe increased their contribution at a rate of 39% from 2005 to 2009, with the UK contributing the largest amount. Five of the six European donors are part of the International Health Partnership and Related Initiatives (IHP+), an organization that aims to work together to implement the Paris Declaration and Accra Agenda for Action, endorsed in Ghana in 2008.⁷⁰ DAH for health sector support from the EC peaked in 2006 at \$284.77 million and shrank to \$164.14 million in 2009. Although the US signed the Paris Declaration, the amount of DAH that it provides for health sector support has decreased from \$158.65 million in 2005 to \$54.36 million in 2009.

Funding for tuberculosis by channel of assistance

The global health community has recently paid more attention to TB since the HIV/AIDS epidemic caused a large increase in the number of cases. The likelihood of people with HIV/AIDS developing active TB is 50 times greater than those without HIV/AIDS.⁷¹ As some people being treated for TB have failed to complete the six-month antibiotic treatment regimen, strains of multidrug-resistant and extremely drug-resistant TB have developed.⁷² These conditions are more expensive to treat and require longer treatments.⁷² In addition to the growing number of TB cases and the emergence of drug-resistant strains of the disease, TB poses a threat across borders as increasing numbers of people emigrate or travel to other countries.

To address the challenge of fighting TB, the Stop TB Partnership led by WHO estimates that \$47 billion would be required from 2011 to 2015.⁷³ Our estimates show that TB funding surpassed \$1 billion for the first time in 2009 (see Figure 23). Furthermore, growth in DAH for TB began to slow between 2008 and 2009. While donors such as the US government and BMGF have pledged to expand TB funding,^{74,75} it seems unlikely that DAH for TB will attain the Stop TB target funding levels should the current pace of funding continue.

GFATM, BMGF, and WHO are the channels of assistance that have contributed the largest amounts of resources to TB. Since 2004, BMGF and GFATM have experienced some of the most rapid growth rates among the channels, growing by 34% and 24%, respectively, over each year from 2004 to 2009. DAH channeled through WHO grew 7% annually during this period. From 2004 to 2009, DAH from the World Bank IDA and IBRD shrank by 9% annually. DAH for TB from the UK expanded greatly (21%) from 2008 to 2009.

In Figure 24 the map of TB DAH per related DALY shows that some low-income countries with among the highest TB burdens such as Ethiopia, Kenya, and Uganda receive little DAH per TB DALY compared to wealthier countries such as Botswana and Peru. From a different perspective, it is interesting to examine DAH per DALY amounts flowing to countries that have some of the highest levels of multidrug-resistant TB, such as India, China, and Russia. Russia receives \$21 per TB DALY, while China and India receive \$9 and \$5 per DALY, respectively. Given that multidrug-resistant TB poses a serious threat to public health in these countries and other nations, it is surprising to see the substantially lower funding levels of DAH per TB DALY in India and China compared to Russia, a richer country.

Funding for noncommunicable diseases by channel of assistance

NCDs recently generated worldwide attention at the September 2011 UN High-Level Meeting on Noncommunicable Diseases. NCDs such as cancer, heart disease, and diabetes have long been viewed as health issues that plague rich countries. Research has shown, however, that NCDs disproportionately affect the developing world. According to Dr. Ala Alwan of the WHO, premature death (mortality before age 60) from NCDs in poor countries is three times higher than in rich countries.⁷⁶ New research from IHME reported that breast cancer deaths in developing regions are over two times higher than in developed regions.⁷⁷ For cervical cancer, IHME found that developing regions account for 76% of new cases.⁷⁷ While risk factors such as tobacco, harmful alcohol use, and overweight and obesity that drive increases in NCDs are similar across developed and developing countries, developing countries have fewer resources to treat and prevent them. In its 2010 Global Risks report, the World Economic Forum noted that NCDs pose a major threat to the world economy, as they will strain national budgets by

raising health care costs and reducing economic growth and worker productivity.⁷⁸

At the High-Level Meeting on Noncommunicable Diseases, the summit’s declaration noted that current levels of local, national, and international funding are insufficient to deal with the size of the problem posed by NCDs. The declaration called for increased and long-term funding for NCDs, but no specific funding target was announced at the summit. Future updates of this research will assess the amount of additional resources mobilized for NCDs as a result of this high-level meeting.⁷⁹

While NCDs represent 45% of the overall disease burden in developing regions,⁸⁰ DAH for NCDs was just 1% of total DAH in 2009. While NCDs represent the smallest amount of DAH compared to the other health focus areas we are tracking, our updated estimates show that it was slightly higher than we reported in last year’s *Financing Global Health* report.¹⁶ This is due to our new methods for estimating DAH from the World Bank as well as the addition of data from another channel, the Bloomberg Family Foundation. Bloomberg

FIGURE 23:
DAH for tuberculosis by channel of assistance, 1990-2009

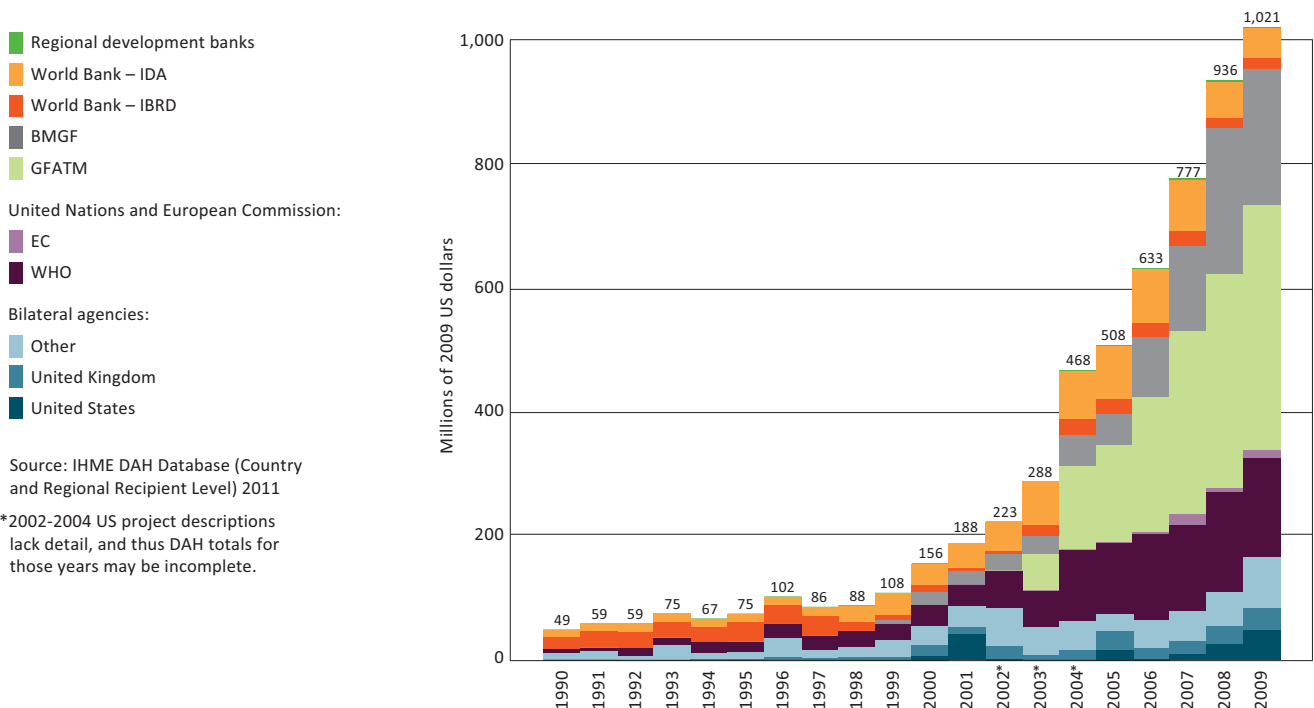


FIGURE 24:
DAH for tuberculosis per related DALY, 2004-2009

We used DALY data for 2004 as a proxy for burden in all subsequent years. Countries that received no DAH over the study period and countries with zero or missing burden data are not shown. DAH received is shown in real 2009 US dollars.

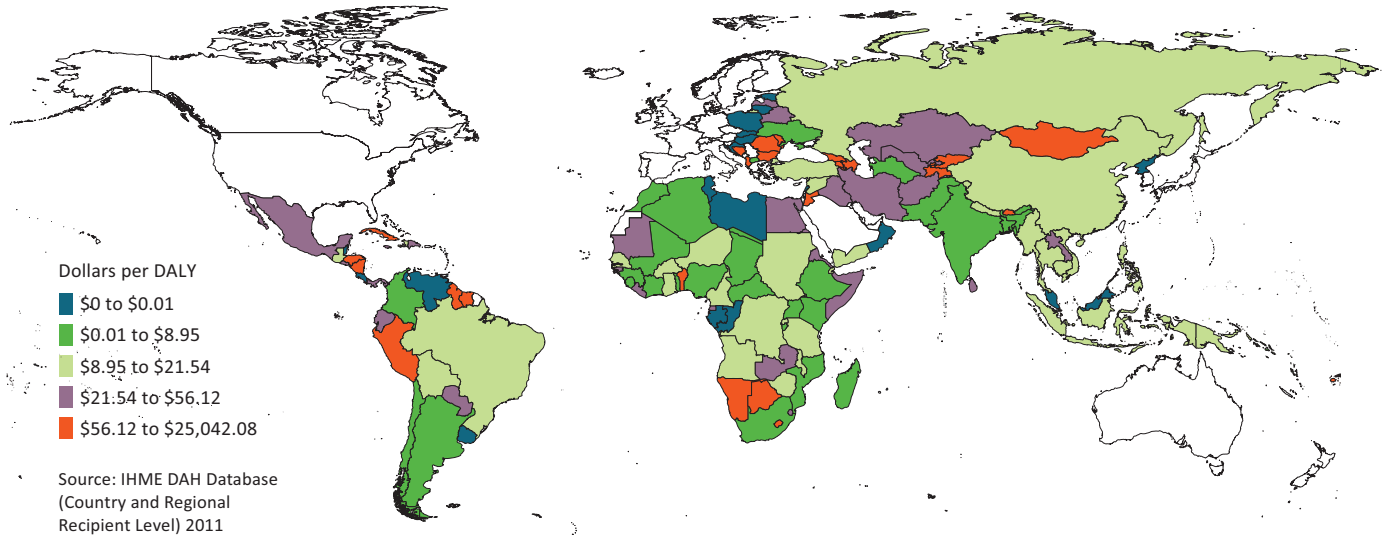


FIGURE 25:
DAH for noncommunicable diseases by channel of assistance, 1990-2009

- Regional development banks
- World Bank:
 - IDA
 - IBRD
- US foundations:
 - BMGF
 - Bloomberg Family Foundation
- United Nations and European Commission:
 - EC
 - WHO
- Bilateral agencies:
 - Other
 - United Kingdom
 - United States

Source: IHME DAH Database (Country and Regional Recipient Level) 2011

*2002-2004 US project descriptions lack detail, and thus DAH totals for those years may be incomplete.

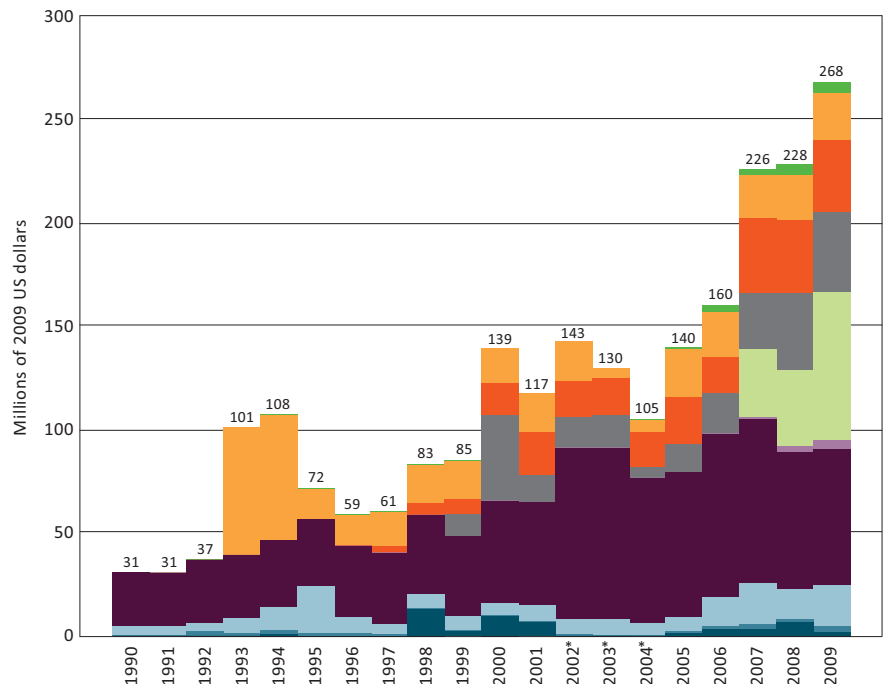
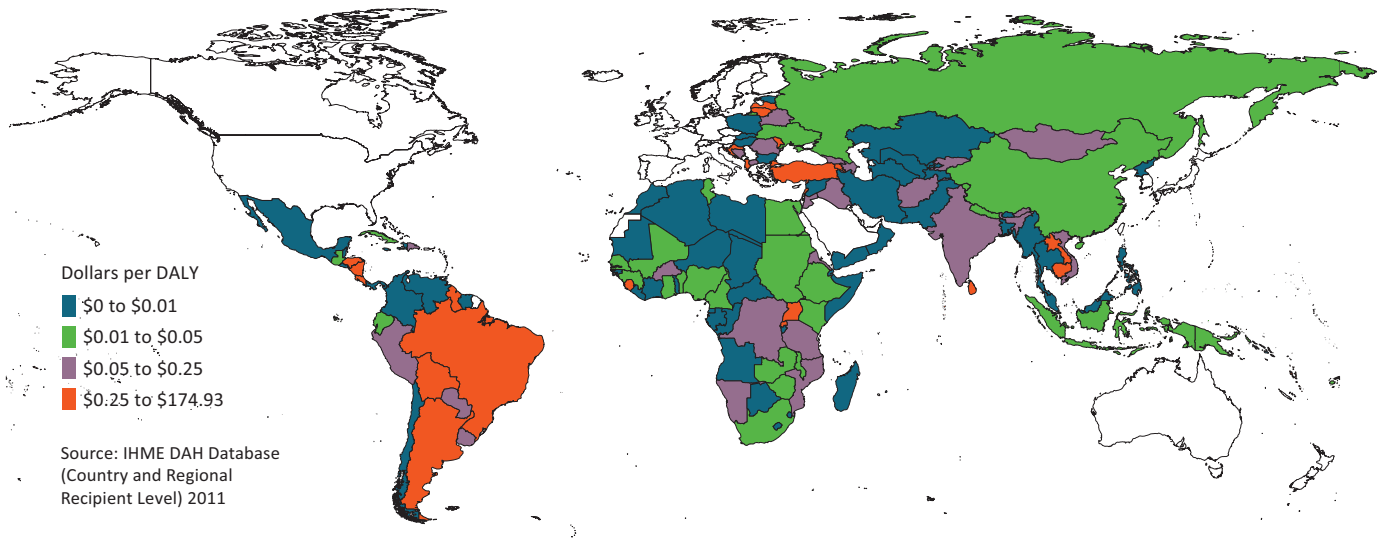


FIGURE 26:
DAH for noncommunicable diseases per related DALY, 2004-2009

We used DALY data for 2004 as a proxy for burden in all subsequent years. Countries that received no DAH over the study period and countries with zero or missing burden data are not shown. DAH received is shown in real 2009 US dollars.



Family Foundation, the largest donor to NCDs in 2009, funds tobacco reduction initiatives around the world. Other large contributors include WHO and the World Bank (IDA and IBRD). Between 2004 and 2009, the World Bank’s contribution to NCDs has grown by 21% annually, while DAH for NCDs channeled through WHO has decreased by 1% annually. BMGF’s funding of DAH for NCDs, which funds cervical cancer prevention as well as tobacco control, grew by 49% annually over this period.

Will the global health community’s efforts to increase both awareness and DAH for NCDs succeed in raising its funding to levels that other health focus areas have reached? Some experts, such as David Fidler from Indiana University, argue that NCDs generate less of a “human dignity pull” than communicable diseases such as malaria, since many cases can be linked to behavior such as poor diet and smoking.⁸¹ Devi Sridhar and colleagues noted the difficulty of garnering support for NCDs from donors in the current economic climate.⁸² Recent pledges to increase funding for breast and cervical cancer prevention, screening, and treatment

from the US government via PEPFAR may translate to more DAH for NCDs in future years, particularly among people living with HIV/AIDS.⁸³

It is difficult to trace all NCD-specific DAH to the country level, and we were unable to trace DAH flowing through WHO and the Bloomberg Family Foundation to countries, as country-specific disbursement data are not available. For DAH that we could trace to the country level, the map of DAH for NCDs per related DALY in Figure 26 shows that many countries receive relatively few dollars per NCD DALY. With the exception of Tonga, which receives nearly \$200 per NCD DALY, no country received more than \$7 per NCD DALY. In low-income countries that face the challenge of addressing both noncommunicable and communicable diseases, these extremely low levels of funding paint a picture of places where HIV-positive women may have access to antiretroviral therapy funded by foreign donors, while women with breast cancer likely have very few treatment options.⁸⁴