CHAPTER 2:

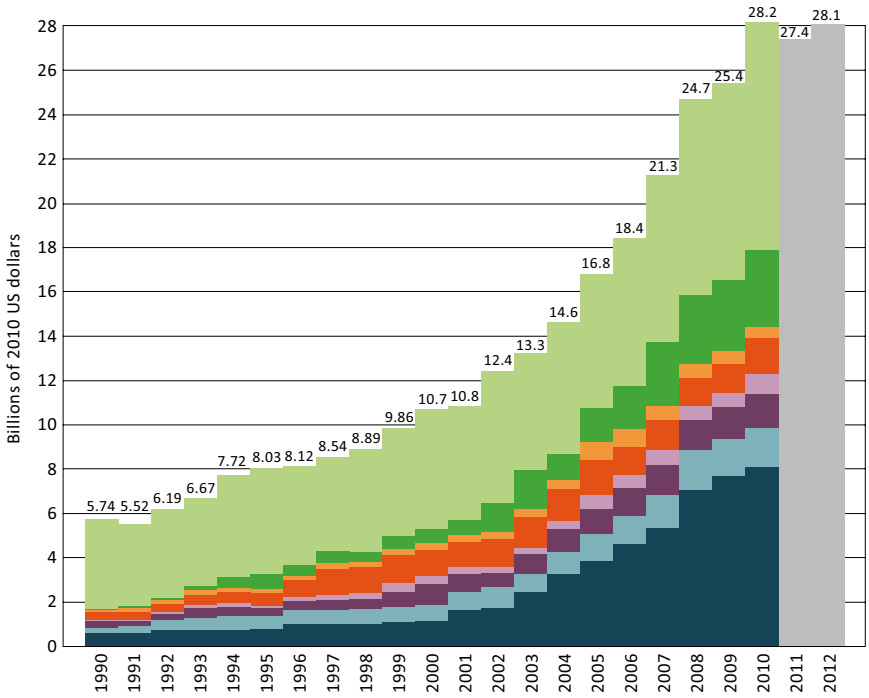
RECIPIENTS OF DEVELOPMENT ASSISTANCE FOR HEALTH

Recipients of DAH span regions and, to a certain extent, income levels; both low- and middle-income countries receive DAH. In recent years, more and more countries have attained middle-income status. From 1999 to 2012, 33 low-income countries graduated to middle-income or lower-middle-income status.[21,22] As these transitions proceed, bilaterals and public-private partnerships are considering whether and when development aid may be phased out.[23] Even so, our 2010 estimates do not reveal drastic drops of DAH in these countries. This may become apparent in future years, however, as this chapter does not feature 2012 estimates because of the lag between spending and reporting. The most recent year for which recipient-level estimates are available is 2010.

This chapter explores the current state of regional, economic, and burden-based variation in recipients of DAH, including the shifting regional focus of DAH during the 2001 to 2010 rapid-growth period. Among the regions highlighted, sub-Saharan Africa received a substantial share of increased funding over this period. Other regions' levels of DAH also expanded during this time.

FIGURE 6:
DAH by focus region, 1990-2010

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



Sources: IHME DAH Database 2012 and IHME DAH Database (Country and Regional Recipient Level) 2012

Notes: 2011 and 2012 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 2011 and 2012.

DAH by region

Regional variation in DAH flows is displayed in Figure 6 (on page 19). From 1990 to 2001, sub-Saharan Africa received a modest but still substantial proportion of DAH. Among the DAH allocable regionally in 1999, sub-Saharan Africa received 24.4% of the total.

As DAH entered its rapid-growth phase, sub-Saharan Africa's receipt of DAH grew at a similarly rapid pace, growing 19.6% in annualized terms from 2001 to 2010. Since the turn of the century, this region has consistently received a larger proportion of spending, and, by 2010, DAH flowed predominantly to sub-Saharan Africa. In 2010, the proportion of DAH disbursed to sub-Saharan Africa had risen to 56% of the total allocable to regions. IHME estimates that $8.1 billion in DAH was allotted to sub-Saharan Africa in 2010, a 5.5% increase from 2009.

As the sub-Saharan African region has the most numerous low-income countries, the economic status of the region clearly plays a role in the large share of DAH expended in sub-Saharan Africa. Epidemiological trends provide another explanation for the region's receipt of the highest share of DAH over the last two decades. In most other regions, communicable diseases have decreased considerably as a share of burden. While these ailments have also diminished in sub-Saharan Africa, communicable, maternal, neonatal, and nutritional disorders continue to account for 67% to 71% of DALYs.[12] These conditions account for 76% of deaths in this area of the world.[24] These types of health issues are more prominently favored in DAH spending, as Chapter 3 shows.

The second-highest amount of DAH is spent at the global level. The global DAH category includes research and development, such as the advancement of a malaria vaccine and drugs for multidrug resistant TB, as well as other health-related activities that cannot be directly tied to a specific country or region, including the creation of public goods or projects for multiple regions. From 2009 to 2010, spending in this category rose 7.2% to a total of $3.5 billion.

In almost all regions, DAH increased on the whole from 2009 to 2010. The North Africa/Middle East region was the exception; the DAH disbursed in this region decreased 8.1% from 2009 to 2010. Nonetheless, $519 million was spent in North Africa/Middle East in 2010. In contrast, in South Asia, DAH increased 4.4% to $1.8 billion. Growth in East Asia and the Pacific was 8%, amounting to $1.6 billion in total DAH in 2010. With a rate of growth of 38.8% in 2009, the DAH allocated to Europe and Central Asia jumped considerably; total DAH spending in the region was $900 million. Growth in Latin America and the Caribbean was similarly strong at 23%. In that region, $1.6 billion of DAH was expended in 2010.

Unfortunately, due to the manner in which DAH is reported, IHME is unable to assign a substantial amount of expenditure to specific countries or regions. In 2010, 36.4% of DAH could not be allocated to either a particular region or the global category. Even so, as Figure 6 illustrates, the proportion of funding categorized as unallocable has diminished over time. In 1990, 70.8% of DAH was designated as unallocable. The decline in unallocable DAH is evidence of better reporting and improved transparency of development assistance disbursements.

DAH by country

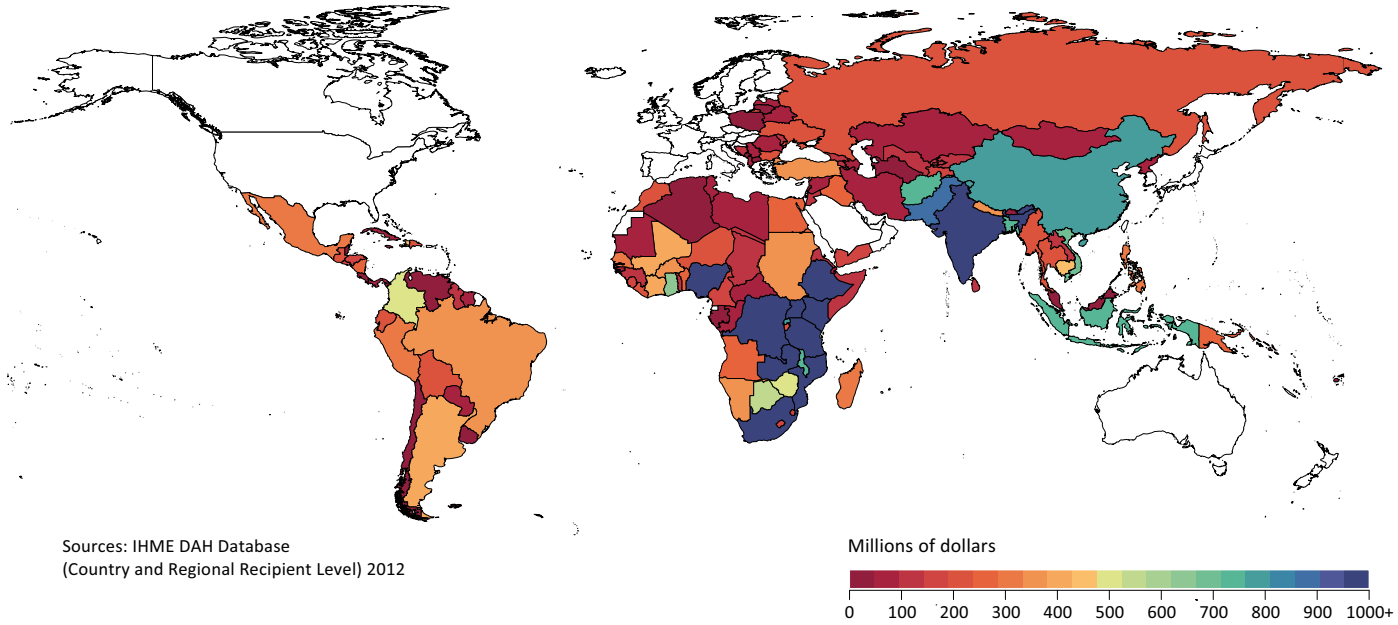
The total amount of DAH allocated at the country level is subject to a number of considerations. Population, disease burden, income, and geopolitical factors all play a part to varying degrees in different countries. This section features country-level estimates of DAH for 2010 that can be used to explore these factors.

Figure 7 illustrates the total DAH disbursed from 2008 to 2010 by country. In terms of total volume, India and a number of countries in sub-Saharan Africa received upwards of a billion dollars of DAH between 2008 and 2010. A few countries in Southeast Asia, China, and select countries in sub-Saharan Africa received below the billion-dollar mark but received between $600 and $800 million over those three years. The majority of countries, even populous countries such as Brazil, Mexico, and Russia, received less than $500 million in total DAH. It is notable that middle-income countries were represented across the spectrum of spending. Despite questions about whether too much aid is being disbursed to middle-income countries,[25] DAH to countries such as China and India remained substantial in 2010.

Figure 8 displays the top 10 recipients of total DAH from 2008 to 2010, in order of the amount of funds received. Excluding India, the top recipients were sub-Saharan African countries, reflecting the high burden and low income levels of that region. Nigeria, with the biggest population in sub-Saharan Africa, received the second highest levels of DAH. Uganda and Kenya received significant levels of aid due to their HIV/AIDS burden, as well as a high number of DALYs overall.

FIGURE 7:
Total DAH, 2008-2010

Countries that were ineligible for DAH based on their World Bank income classification are shown in white. DAH received is shown in millions of real 2010 US dollars.



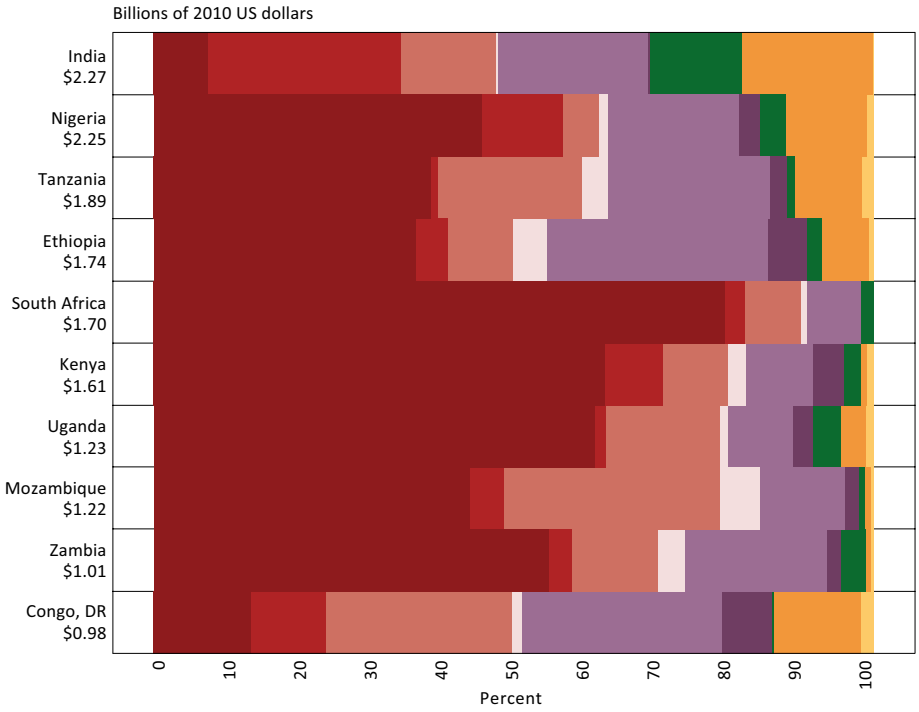
Sources: IHME DAH Database
(Country and Regional Recipient Level) 2012

FIGURE 8:
Top 10 country recipients of DAH by channel of assistance, 2008-2010

The amount of DAH received by each country in billions of 2010 US dollars is shown below the name of the country. Only DAH allocable by country is reflected in the figure.

- United States
- United Kingdom
- Other European bilaterals / EC
- Other bilaterals
- GFATM
- GAVI
- BMGF
- World Bank
- Regional development banks

Source: IHME DAH Database
(Country and Regional Recipient Level) 2012



That two middle-income countries, India and South Africa, received enough DAH to be among the top 10 recipients highlights the contradictions informing discussions about continued aid to middle-income countries. India reportedly allocated $547 million to foreign aid in 2008.[26] South Africa also provided approximately 0.03% of its gross national income as foreign assistance in 2010.[27]

With the exceptions of India and the Democratic Republic of the Congo (DRC), US bilateral assistance, through the United States Agency for International Development (USAID), PEPFAR, the President's Malaria Initiative, and other initiatives, played the prominent role in funding the top 10 recipients of DAH. In South Africa, US bilateral assistance comprised close to 80% of DAH expenditure, mostly due to the active role of PEPFAR. In India, the UK contributed the biggest proportion of funds. India has been the single largest recipient of UK aid historically.[28] However, the UK Department for International Development (DFID) announced in November 2012 that it will be phasing out its aid to India; existing programs should be completed by 2015.[29] A mix of bilaterals and GFATM made up the bulk of spending in the DRC. Across recipients, GFATM spent the second highest proportion of DAH in these countries after the US.

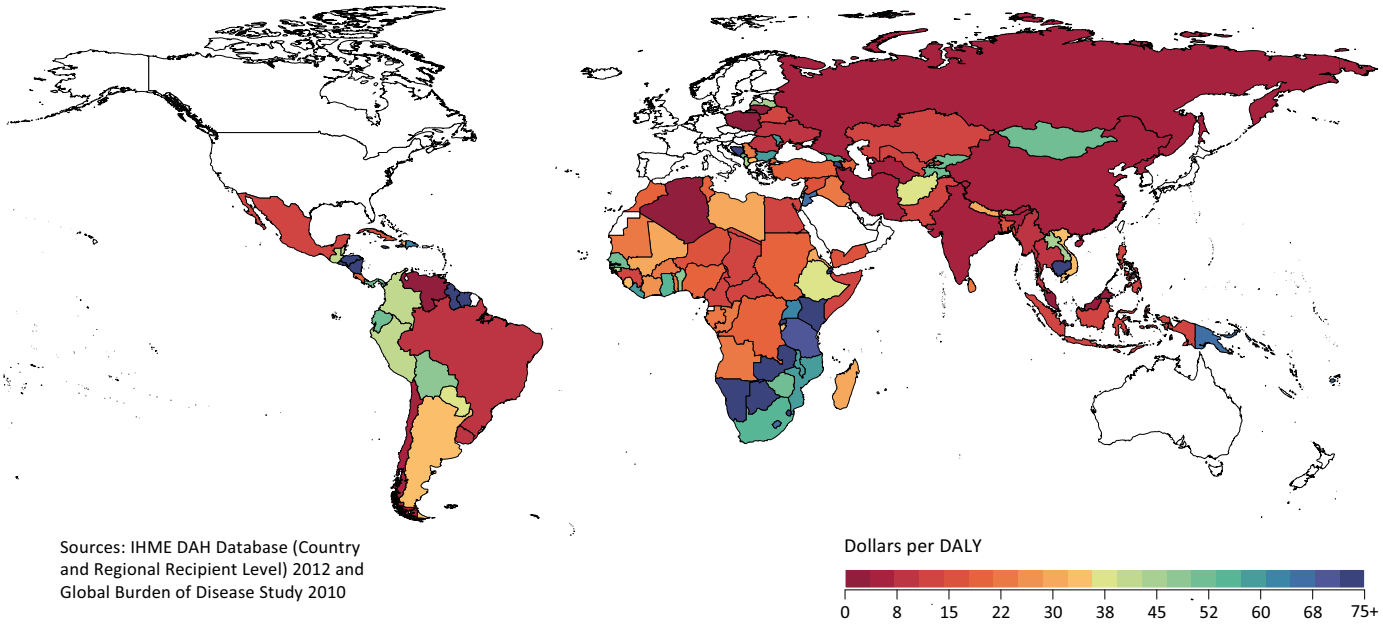
With respect to the recipients of the highest absolute DAH from 2004 to 2009, the 2008 to 2010 assessment exposed changes in the recipient countries. The top recipients over 2004 to 2009 included China as 10th, but in the period from 2008 to 2010, the DRC replaced China in that slot. South Africa also moved from seventh to fifth, with a significant amount of support from PEPFAR. The mix of sources of DAH did not vary significantly across the two periods. US bilateral and GFATM DAH constituted the highest proportion of spending in the top 10 recipients of DAH over 2004 to 2009 and 2008 to 2010.

DAH and burden of disease

Representing DAH in terms of volume falls short of accounting for factors such as population size and disease burden, which are important for assessing DAH at the country level. In contrast to the total DAH map, Figure 9 presents DAH across the globe in terms of DAH per all-cause DALY, exposing the relationship between burden and DAH. DALYs quantify a population's health relative to the normative goal of living a full life in good health. As more members of the population suffer from

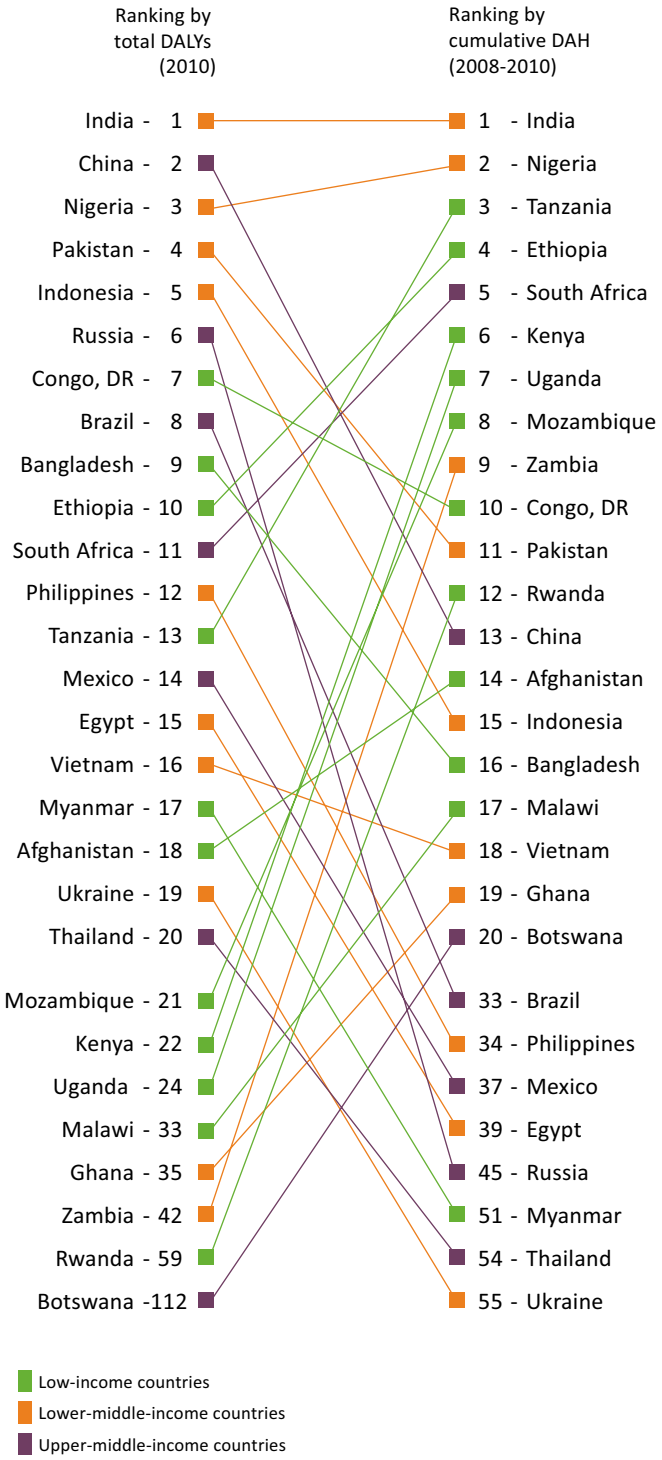
FIGURE 9:
Total DAH per all-cause DALY, 2008-2010

DALY estimates for 2010 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 2010 US dollars.



Sources: IHME DAH Database (Country and Regional Recipient Level) 2012 and Global Burden of Disease Study 2010

FIGURE 10:
Top 20 countries by 2010 all-cause burden of disease versus cumulative 2008-2010 DAH



Sources: IHME DAH Database (Country and Regional Recipient Level) 2012 and Global Burden of Disease Study 2010

illness or disability, or die prematurely, a country's DALYs increase. The level of DALYs at the country level is influenced by the composition of injuries and illnesses as well as population size. DALYS are one of the main summary measures of population health produced by GBD 2010. A key component of GBD 2010 is the aspect of comparability between DALYs across countries, diseases, and injuries. The dollar of DAH per DALY metric likewise provides a comparable assessment of how DAH aligns with a country's burden of disease.

In general, DAH per DALY ranged from less than a dollar to approximately $25 per DALY across regions. This includes regions with higher per capita income, such as North Africa/Middle East, Europe, and Central Asia, as well as regions with lower GDP per capita, such as South Asia. Most countries in sub-Saharan Africa received more than $10 per DALY, however, and countries in Southern Africa received some of the highest DAH per DALY, with some values exceeding $75 per DALY. A number of countries in South America and a few in Central Asia and Europe received more than $40 per DALY as well.

Furthermore, relative to the total DAH map, Figure 9 shows that the DAH received by most middle-income countries in terms of their DALYs was low. Whereas China and India were at the higher end of the spectrum in terms of total DAH, they received some of the lowest DAH per DALY, as they harbor the two largest populations in the world and high disease burdens. Mexico, Brazil, and Russia also received less than $15 per DALY. An exception is South Africa, where DAH per DALY was above $50.

This map does not present disease-specific DALYs, such as those for HIV/AIDS, although that disease burden is included in the final tally. HIV/AIDS DAH per HIV/AIDS DALY as well as other disease-specific spending is explored in Chapter 3, which covers DAH by health focus area.

The relationship between all-cause DALYs and DAH is represented in Figure 10. In the left-hand column, countries are listed in order according to their disease burden, as represented by 2010 DALYs. On the right, countries are ordered based on the total amount of DAH received between 2008 and 2010. The lines connect the countries on the lists, displaying the misalignment that exists more often than not between DALYs and DAH. This is true across income groups and regions. Only India, Nigeria, and Vietnam had comparable DAH and DALY levels, relative to other countries on the list. A number of upper-middle-income countries – Russia, Brazil, Mexico, and Thailand – received particularly low DAH relative to burden.