Financing Global Health 2014

Shifts in Funding as the MDG Era Closes

IHME

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INSTITUTE FOR HEALTH METRICS AND EVALUATION
UNIVERSITY OF WASHINGTON

IHME

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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.healthdata.org.

ABOUT *FINANCING GLOBAL HEALTH 2014*

Financing Global Health 2014 is the sixth 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 (GHE). 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 2014. 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. In cases where 2013 and 2014 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:** IHME uses data produced by the World Health Organization (WHO) to provide estimates of GHE as a source of funding. 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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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
DALY	Disability-adjusted life year
DFID	United Kingdom's Department for International Development
DRC	Democratic Republic of the Congo
EC	European Commission
GBD 2010	Global Burden of Diseases, Injuries, and Risk Factors Study 2010
GDP	Gross domestic product
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
HSS	Health sector support
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IHME	Institute for Health Metrics and Evaluation
IDB	Inter-American Development Bank
MDGs	Millennium Development Goals
MNCH	Maternal, newborn, and child health
NCD	Non-communicable disease
NGO	Non-governmental organization
NTDs	Neglected tropical diseases
OECD	Organisation for Economic Co-operation and Development
PAHO	Pan American Health Organization
PEPFAR	United States President's Emergency Plan for AIDS Relief
PPPs	Public-private partnerships
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

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Executive summary

In 2000, the international community put global health high on the development agenda. Three distinct Millennium Development Goals focused on health issues in the developing world. At the forefront was the fight against child mortality, maternal mortality, and three infectious diseases: HIV/AIDS, malaria, and tuberculosis (TB).

The formation of the MDGs was followed by major increases in global health financing flows, particularly for the health focus areas explicitly targeted. *Financing Global Health 2014* explores this mobilization of funds for health before and after the establishment of the MDGs. With the MDGs concluding in 2015, the financing trends that bolstered global health in the MDG era and the evolution in burden of disease hold lessons for future global health ambitions.

Financing Global Health 2014 depicts more than two decades of disbursements in development assistance for health (DAH), highlighting major shifts in growth. From 1990 to 2000, minor but stable increases were present in international financing for health, with 5.4% annualized growth over that time. Rapid growth took hold from 2000 to 2010, following the launch of the MDGs. Increases reached 11.3% annually during that period. Over the last four years, however, funding has plateaued. With $35.9 billion in DAH disbursed in 2014, total funding for global health has hovered around $35 billion for four consecutive years. From 2013 to 2014, DAH dropped 1.6%.

The cost of this recent stagnation is substantial. If the rapid rates of growth present over 2000-2010 had continued into 2014, $38.4 billion more in DAH would have been available for global health. Total DAH in 2014 alone would have been 45.3%, or $16.2 billion, higher.

Since 2000, the health focus areas targeted by the MDGs have benefited substantially from the rapid rates of growth, although certain areas increased more than others. DAH for HIV/AIDS increased substantially, with annual growth of 15.8% and $9.5 billion more provided for this health focus area in 2014 than in 2000. DAH for tuberculosis and malaria also rose considerably. TB DAH grew 17.7% annually over this period, and malaria DAH rose 17.4%. Funding for maternal, newborn, and child health (MNCH) grew least among MDG health focus areas. Annual rates of growth were 6.2%. However, in 2000 more funds targeted MNCH than any other health focus area. When broken down further, child health funding, in fact, grew substantially in annualized terms (8.3%), while rates of growth in funding for maternal health were not as sizeable, at 3.0% annually over 2000-2014.

In 2014, examining disaggregated trends reveals sluggishness among some sources and channels. Only Australian, Japanese, British, and private sources of DAH rose in 2014. Across channels, the DAH disbursed was also largely steady, although minor shifts did occur. The World Health Organization (WHO); the Bill & Melinda Gates Foundation (BMGF); Gavi, the Vaccine Alliance (Gavi); and Switzerland's bilateral aid agency all expended more resources in 2014. Of note, and largely tied to the Ebola epidemic in West Africa, financing for the African Development Bank (AfDB) and the United Nations Children's Fund (UNICEF) expanded considerably in 2014, rising 24.4% and 17.9%, respectively, relative to 2013 levels.

Trends in the DAH designated for specific health focus areas were mixed in 2014. Funds targeting malaria grew slightly (0.4%). DAH for other areas highlighted in the MDGs dropped, with decreases observed in the DAH provided for HIV/AIDS, which dropped 2.2%, as well as maternal, newborn, and child health and TB, which fell 2.2% and 9.2%, respectively. However, IHME parsed out funding for Ebola for the first time in 2014, estimating that $652 million was disbursed as development assistance for health to combat the epidemic in West Africa in 2014. On the whole, an estimated $1.1 billion, including humanitarian aid, was provided for the crisis in 2014.[1]

Finally, this year's report underlines the interconnectedness across development assistance partners and burden of disease. This edition visualizes funding flows as they are transferred from sources to channels to recipients and health focus areas. Furthermore, the granularity with which DAH estimates are produced allows for linkages with the Global Burden of Disease (GBD) 2013 study, shedding light on concurrent changes in burden. New to this year's report is the breakdown of funding for two health focus areas, maternal, newborn, and child health and non-communicable diseases, into more detailed subcategories, including vaccines, family planning, mental health, and anti-tobacco activities.

Key findings from *Financing Global Health 2014* include the following:

Development assistance for health

- In 2014, total DAH amounted to $35.9 billion, a drop of 1.6% over the all-time high in DAH reached in 2013.
- The United States continued to serve as the largest source of funds, providing $12.4 billion in 2014. Although the US transferred substantial sums of DAH to a number of other channels, it provided 71.6%, or $8.9 billion, through its own bilateral aid agencies.
- The contribution of the United Kingdom increased 1.6% in 2014, with DAH sourced from the UK amounting to $3.8 billion. UK government agencies received 46.9% of UK public funding, or $1.8 billion, in 2014, a 3.3% decrease over 2013 levels.
- In contrast to the other United Nations (UN) agencies active in global health, funding for WHO and UNICEF grew in 2014. Rising 17.9%, the DAH furnished by UNICEF rose to $1.4 billion. WHO increased its contributions 4.0%, providing $2.1 billion in 2014.
- Trends in the DAH provided to public-private partnerships were mixed. With expenditure of $1.8 billion in 2014, Gavi funding rose 8.2% relative to 2013 levels. In contrast, financing provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) dropped 6.9% to $4.1 billion in DAH in 2014.
- BMGF continued its steady rise in provision of DAH. In 2014, global health's largest private supporter supplied $2.9 billion of DAH. Of these funds, 55.8%, or $1.6 billion, was channeled directly through the foundation, a 5.1% rise over 2013.
- The DAH channeled by NGOs grew 3.8% in 2014, with total spending amounting to $5.4 billion in 2014.
- Funding for a number of health focus areas dropped from 2013 to 2014. HIV/AIDS DAH amounted to $10.9 billion, a 2.2% decrease from 2013. MNCH DAH also fell slightly, to $9.6 billion, a drop of 2.2% as well. Funding for malaria

remained steady at $2.4 billion, a 0.4% increase over 2013 levels. However, DAH for TB activities dropped considerably, with a 9.2% decrease observed and total funding for this area amounting to just $1.5 billion in 2014.

- Funding for other infectious diseases, which encapsulates financing disbursed in the fight against the Ebola epidemic in West Africa as well as neglected topical diseases (NTDs), rose precipitously in 2014. Total DAH for other infectious diseases reached $1.3 billion, with 102.5% in growth over 2013 levels. An estimated $652 million of this DAH was disbursed to combat Ebola in 2014.
- Sub-Saharan Africa continued to receive the largest share of DAH. In 2012, $11.8 billion was provided for health in the region, 35.7% of all DAH. This contrasts substantially with the share of DAH provided for South Asia (6.9%), East Asia and the Pacific (6.8%), Latin America and the Caribbean (5.6%), and North Africa and the Middle East (1.7%).

Government health expenditure as a source

- Government health expenditure as a source (GHE-S) in low- and middle-income countries (as defined by the World Bank) also continued to grow. In 2012, GHE-S reached an all-time high of $711.1 billion. GHE-S grew 9.7% between 2011 and 2012.
- On the whole, GHE-S is considerably larger than DAH, with $19.80 in GHE-S spent for each DAH dollar.

The contrast of stability in DAH and continued growth in GHE-S hints at new trends in global health financing. As the MDGs conclude and the next set of development goals takes form, up-to-date estimates like those found in *Financing Global Health 2014* will be important inputs to broad-based global health decisions.

BOX 1

Putting development assistance for health into context

- Three of the eight Millennium Development Goals focus on health outcomes in low- and middle-income countries. Since the formation of these goals in 2000, $227.9 billion in development assistance has targeted these health focus areas. This is 61.3% of all DAH disbursed from 2000 to 2014.

- 73.2% of development assistance for health was funded by the governments of high-income countries in 2012. This is 0.7% of domestic governmental spending on health in high-income countries.

- Development assistance for health increased annually by 11.3% between 2000 and 2010. Over 2010–2014, in the aftermath of the financial crisis, growth dwindled to 1.4%. Had DAH continued to climb over 2010–2014 as it had during the previous decade, $38.4 billion in additional resources would have been available for health between 2010 and 2014. DAH in 2014 alone would be 45.3%, or $16.2 billion, higher.

Introduction

As the Millennium Development Goals (MDGs) come to a close in 2015, it is an opportune moment for the international community to reflect on the last 15 years of efforts to improve health in low- and middle-income countries. *Financing Global Health 2014* depicts the trends in development assistance provided for health and the health-related MDGs from 1990 to 2014, highlighting global health priorities in the run-up to the MDGs and throughout their presence on the world stage. These findings make clear that a number of development assistance partners were important catalysts in the scale-up in funding that supported efforts to achieve the MDGs, although not all MDG targets benefited equally.

This report combines measurements of development assistance for health (DAH) with in-depth disease burden analyses to put the DAH disbursed across focus areas and recipients in context. Global Burden of Disease (GBD) 2013 estimates pinpoint which countries are on track to meet each of the three health MDGs, measuring the trends in child mortality, maternal mortality, and the rates of change in HIV/AIDS, malaria, and tuberculosis (TB) incidence.[2,3,4] Examining burden alongside 2014 DAH estimates emphasizes the tie between funding trends and progress toward the MDGs.

This report also highlights the persisting plateau in DAH, signaling that global health has entered a new era of financing. Since 2010, total DAH has hovered around $35 billion. The rapid rates of year-over-year growth present from 2000 to 2010 subsided in the aftermath of the global economic crisis. The latest DAH estimates reveal stability across the main categories of spending. With the exception of the international response to the Ebola crisis, spending for most health focus areas did not increase or decrease substantially from 2013 to 2014.

While this period of sluggish growth is likely underpinned by the ongoing economic and fiscal woes facing Europe and other high-income countries, it may also reflect international dialogue surrounding the role of government health expenditure. At the end of 2015, the international community, through a United Nations General Assembly vote, will inaugurate the next generation of targets, represented currently by the Sustainable Development Goals (SDGs). As the international community looks to the SDGs and health priorities more generally in the post-MDG era, the role developing country governments play in funding improvements in their own populations' health is increasingly emphasized. Development assistance partners are discontinuing DAH disbursements to some upper-middle-income countries with the expectation that government health expenditure (GHE) will fill the resulting funding gap. *Financing Global Health 2014* estimates of GHE highlight the major role – and ongoing growth – of domestically sourced government health expenditure.

Following this introduction, Chapter 2 discusses the overview of 2014 trends in development assistance for health, highlighting the flow of funds from source to channel to recipient region. Chapter 3 delves into health focus areas to explore the relationship between the MDGs and the associated development assistance. Finally, in the fourth chapter, government health expenditure as a source (GHE-S) is examined, underlining just how government spending continues to grow steadily despite the plateau in development assistance for health.

CHAPTER 1

Overview of development assistance for health

The Millennium Declaration reaffirmed the international community's commitment to improving the lives of billions across low- and middle-income countries. Eight global goals, each focused on a specific area of action, were established. The Millennium Development Goals (MDGs) focused on three global health issues: child health, maternal health, and infectious diseases including HIV/AIDS, tuberculosis (TB), and malaria. With these goals in mind, this chapter explores the trends in development assistance for health (DAH), highlighting the specific sources, channels, and recipients of DAH involved in the major increases that took place after the MDGs were launched in 2000. From the purchase of antiretroviral drugs and long-lasting insecticide-treated nets to support for disease-specific planning and programming, DAH has funded an array of activities in pursuit of MDGs 4, 5, and 6. *Financing Global Health 2014* also tracks the funds provided for combating the Ebola crisis in 2014 and other important health focus areas, underscoring the international response to the epidemic in West Africa and breadth of global health efforts.

A special highlight of this chapter is the Institute for Health Metrics and Evaluation's (IHME) investigation into the cost of the recent plateau in DAH. After the international response to the financial crisis subsided, growth in DAH stagnated. IHME has estimated that over $16 billion in additional resources would be available in 2014 if the slowdown had not occurred.

Development assistance for health consists of the financial and in-kind contributions that aim to improve health in developing countries. DAH captures contributions from high-income governments and a wide range of non-governmental actors, including public-private partnerships (PPPs), non-governmental organizations (NGOs), and private foundations. Figure 1 represents the conceptual framework IHME applies in order to track the flow of funds from high-income to low- and middle-income countries for health.

This framework is complicated by overlap in roles among sources, channels, and implementing institutions. In some instances, sources and channels are the same entity. An example of this is the Bill & Melinda Gates Foundation (BMGF). BMGF, as a source, draws resources from its endowment. With these funds, BMGF sponsors a variety of global health initiatives, including some channels of DAH such as Gavi, the Vaccine Alliance (Gavi), and the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund). BMGF also funds work it conducts through the activities of its staff (funds which are not disbursed through any other channel IHME tracks) and by transferring money directly to implementing institutions. In these cases, BMGF is designated as a channel. Similar to BMGF, many governments are also both sources and channels of development assistance. For example, the United States Treasury provides assistance to many global health organizations, including some

FIGURE 1

Sources, channels, implementing institutions

US government agencies that channel DAH to low- and middle-income countries. In addition, some organizations are both channels and implementing institutions. For example, the World Health Organization (WHO) plays both those roles by receiving funds from bilateral aid agencies and using those funds to deploy health workers to vaccinate children or provide technical assistance to developing country governments for health planning.

OVERVIEW OF SOURCES AND CHANNELS

The MDGs were supported by the mobilization of funds from a variety of sources, the direction of flows through channels, and the prevention and treatment activities led by implementing institutions across low- and middle-income countries. Because many sources favor a single or small set of channels, and certain channels specialize in MDG health focus areas, the DAH trends across sources and channels are intertwined with the expansion in support for maternal and child health and the core infectious disease areas of HIV/AIDS, TB, and malaria.

Capturing different perspectives on DAH in the MDG era as well as the 10 years leading up to the MDG launch, Figures 2 and 3 depict DAH disbursements between

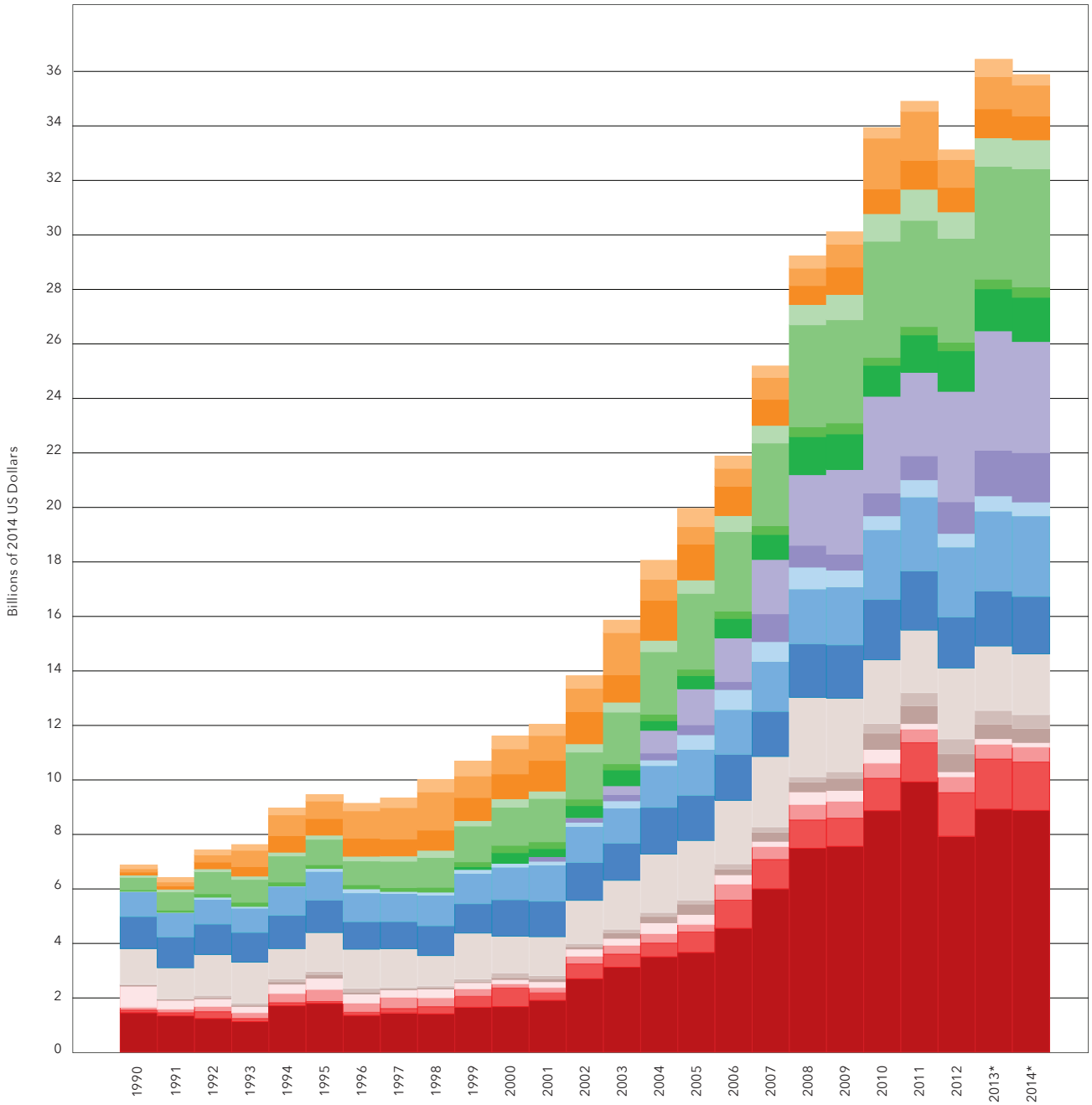
BOX 2

Definitions

- **Development assistance for health** is the financial and in-kind contributions provided by global health channels to improve health in developing countries. These contributions include grants as well as concessionary loans, provided with no interest or at a rate significantly lower than the current market rate. Because development assistance for health includes only funds with the primary intent to improve health, funding for humanitarian assistance, water and sanitation, and other allied sectors that do not primarily focus on health are not included in these estimates. Global health research funded by institutions whose primary purpose is not development assistance is also not captured by these estimates.
- **Sources** are defined as the origins of funding, which are generally government treasuries, the endowments of philanthropic entities, or other private pools, including direct contributions from private parties to non-governmental organizations (NGOs).
- **Channels** serve as the intermediaries in the flow of funds. Channels are composed of bilateral aid agencies, multilateral organizations, NGOs, UN agencies, public-private partnerships, and private foundations. These organizations play a major role in the global health landscape by directing funds to priority disease areas and other health focus areas and providing platforms for action and financing for implementing institutions.
- **Implementing institutions** are the actors working to promote health and prevent and treat diseases in low- and middle-income countries. Implementing institutions vary from governmental bodies, such as national disease programs and networks of public health facilities run by ministries of health, to non-governmental bodies consisting of NGOs, international organizations, and others active in health in low- and middle-income countries.

FIGURE 2

DAH by channel of assistance, 1990–2014



Regional development banks
World Bank – IBRD
World Bank – IDA
International NGOs
US NGOs
Other foundations
BMGF

Global Fund
Gavi
European Commission
UNICEF, UNFPA, UNAIDS, PAHO
WHO

BILATERAL AGENCIES

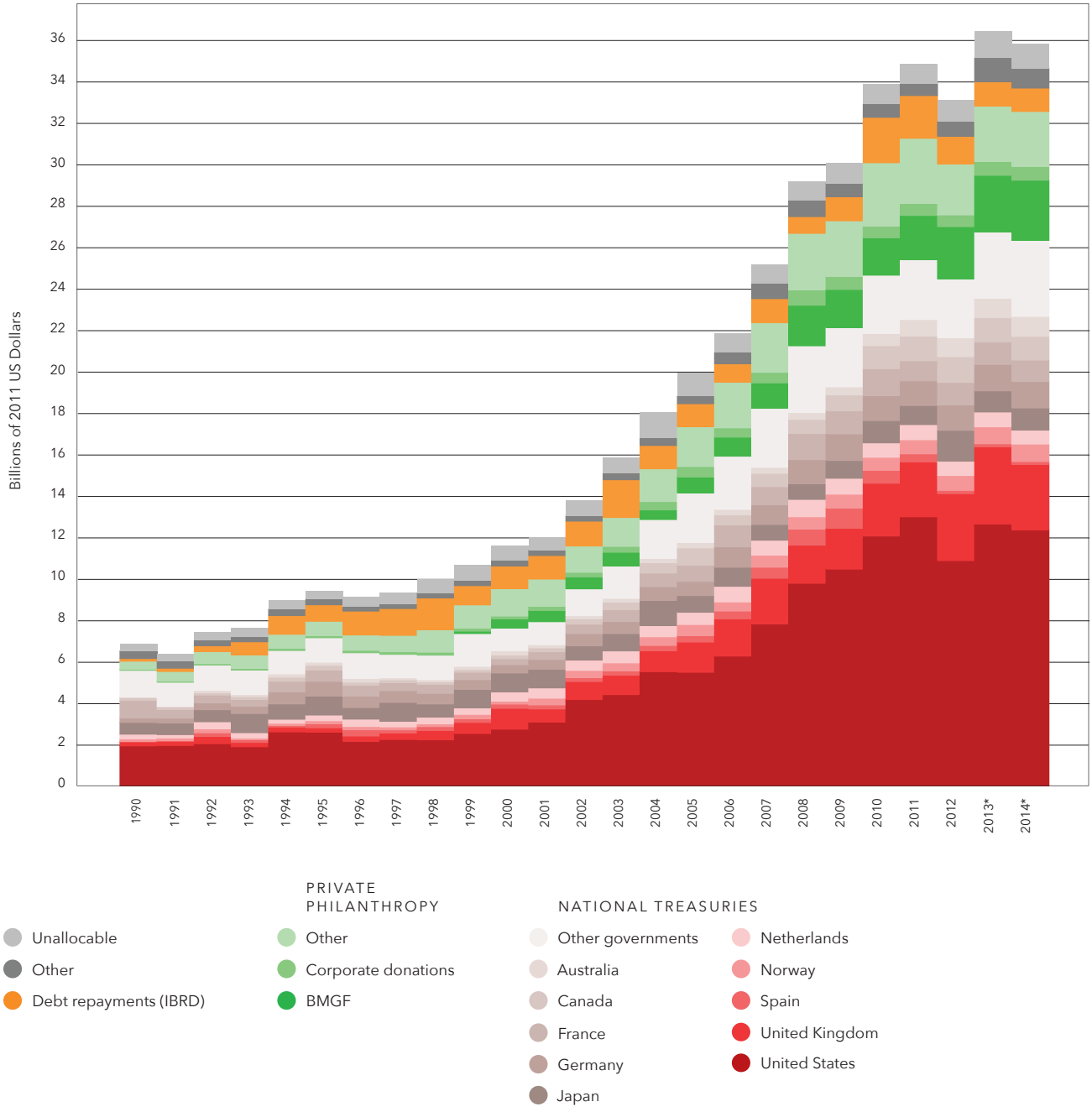
Other
Australia
Canada
France
Germany
UK
US

*2013 and 2014 are preliminary estimates.

Source: IHME DAH Database 2014

FIGURE 3

DAH by source of funding, 1990–2014



*2013 and 2014 are preliminary estimates.

Source: IHME DAH Database 2014

1990 and 2014, broken down by channel and source, respectively. The channels represented in Figure 2 are the development partners that together form the global health landscape. UN agencies, PPPs, bilateral aid agencies, multilateral organizations, NGOs, and private foundations all serve as channels. Figure 3 captures the high-income governments, private individuals, and corporations that constitute the origins of these funds. Governments in high-income countries are generally the

source of the majority of DAH. However, in recent years, the share furnished by private sources, including private philanthropic contributions and corporate donations, has grown substantially.

Both Figures 2 and 3 present trends in total DAH since 1990. In 2014, an estimated $35.9 billion in DAH was disbursed. The 2014 total is a minor 1.6% drop from 2013, when DAH reached an all-time high of $36.5 billion. While some changes were observed across foundations, public-private partnerships, and bilateral channels, growth and contraction were not substantial in 2014. Total DAH was buoyed by stability across major global health actors.

The lack of growth over 2010–2014 contrasts with previous eras. From 1990 to 2000, increases were steady, with annualized growth of 5.4% over that period. In the years directly following the MDG launch, rapid growth defined DAH. From 2000 to 2010, annualized rates of growth reached 11.3%. From 2010 on, DAH has steadied, hovering around $35 billion over the last four years.

BOX 3

The Millennium Development Goals

Subsequent to the Millennium Summit in New York in 2000, development assistance partners signed the Millennium Declaration, reaffirming their commitment to a number of global values, including human development and poverty eradication. Eight goals with 21 targets were established to improve lives across low- and middle-income countries. Health was prominent among the set of Millennium Development Goals; three distinct goals and four targets were set to improve health in the developing world:[5]

Goal 4: Reduce child mortality rates
Target: Reduce by two-thirds, between 1990 and 2015, the under-5 mortality rate

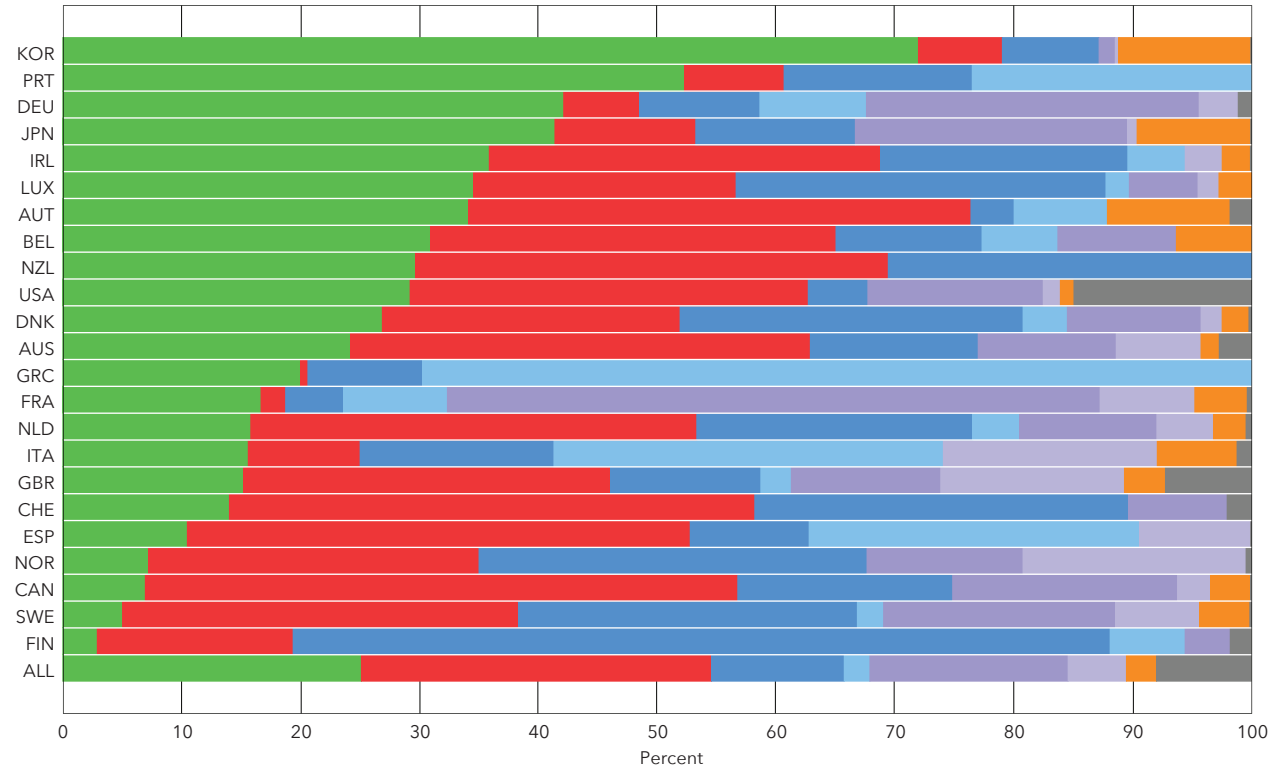
Goal 5: Improve maternal health
Target: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

Goal 6: Combat HIV/AIDS, malaria, and other diseases
Target: Have halted by 2015 and begun to reverse the spread of HIV/AIDS
Target: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

The international community will assess progress against these goals alongside the other MDGS throughout 2015. In September, with the first generation of global targets concluded, UN member states will consider a new set of global targets, as currently embodied by the Sustainable Development Goals.

FIGURE 4

Governmental sources of DAH by channel of assistance, 2012–2014



- Bilateral agencies
- NGOs, foundations, other
- UNAIDS, UNFPA, UNICEF, PAHO, & WHO
- European Commission
- Global Fund
- Gavi
- World Bank — IDA
- Unspecified

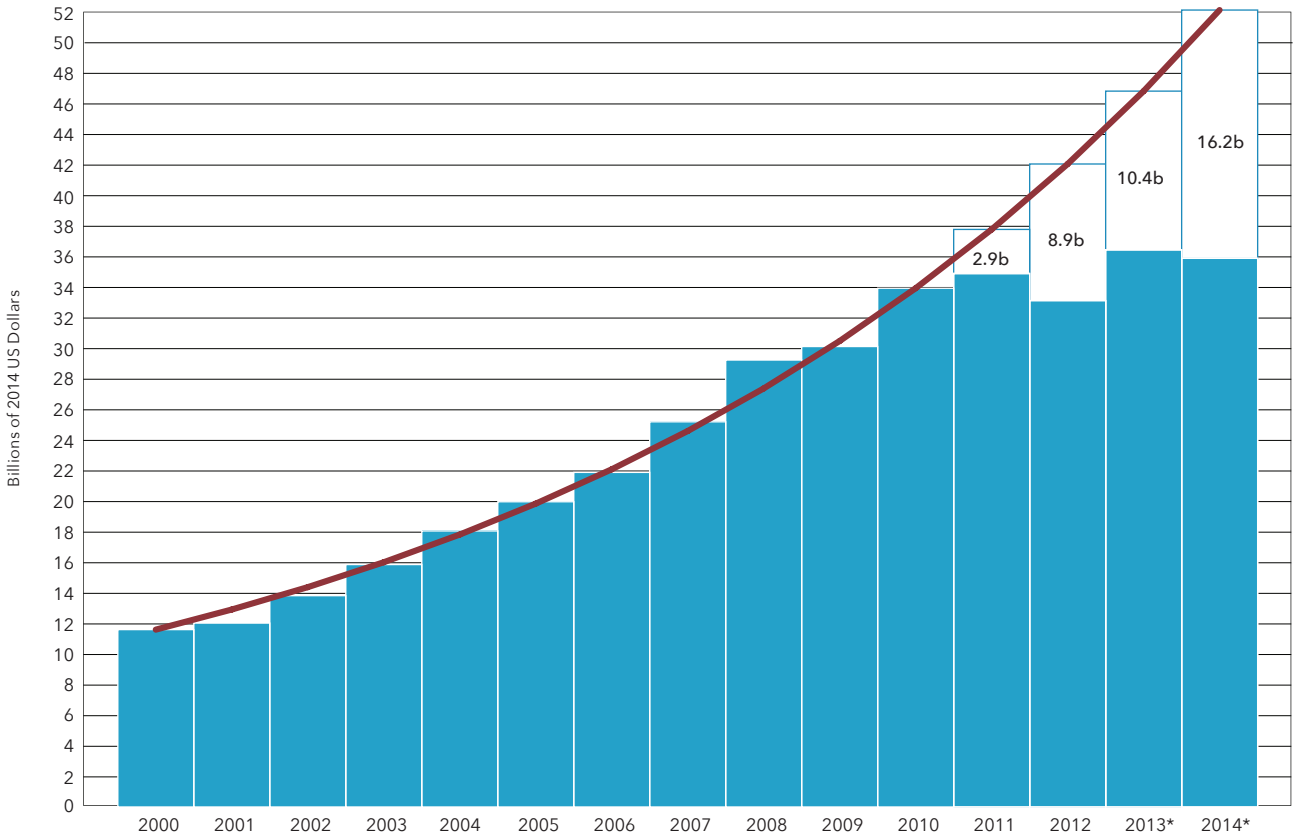
Source: IHME DAH Database 2014

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
NDL	Netherlands
NOR	Norway
NZL	New Zealand
PRT	Portugal
SWE	Sweden
USA	United States

The transfers of funds from sources to channels were not uniform in the MDG era. Some sources, such as Germany, Korea, and Portugal, favor their own bilateral channels above and beyond any multilateral organizations, as seen in Figure 4. In contrast, countries like Denmark, Finland, the Netherlands, and Norway tend to support UN agencies, including WHO, the United Nations Children's Fund (UNICEF), the Joint United Nations Programme on HIV/AIDS (UNAIDS), and the United Nations Population Fund (UNFPA), more than their own bilateral channels. Of note, France, Germany, and Portugal support the Global Fund most substantially across their allocation of DAH. The DAH for NGOs also varied substantially across sources, with the US, New Zealand, and Canada providing more to NGOs than to other channels, including their bilateral organizations, on average, over 2012–2014.

FIGURE 5

Total DAH, 2000–2014, observed versus potential



DAH disbursed

Forecast based on 2000–2010 trend

Trend

*2013 and 2014 are preliminary estimates.

Notes: Continued growth scenario for DAH is modeled from 2011 through 2014, in billions of 2014 US dollars, as based on the average annual percent increase from 2000 to 2010. The difference between DAH disbursed and DAH with continued growth is captured by the white boxes and funding levels reported therein.

Source: IHME DAH Database 2014

BOX 4

The cost of stagnation

From 2000 to 2010, DAH grew at a swift pace, with 11.3% in annualized rates of growth. This "golden age" of DAH receded as the economic crisis took hold and development assistance partners began to consider their domestic fiscal space alongside their global health contributions. Stagnation in DAH has ensued, with DAH hovering around $35 billion since 2010.

Figure 5 represents the cost of stagnation by extending 2000–2010 annualized growth to the subsequent period. Overall, if the 11.3% in annual growth present over 2000–2010 had continued on to 2010–2014, $38.4 billion more in DAH would have been available for global health activities. Total DAH in 2014 alone would have been 45.3%, or $16.2 billion, higher had this growth persisted.

OVERVIEW OF HEALTH FOCUS AREAS

Figure 6 breaks down the DAH total by each of the health focus areas estimated by IHME. This figure shows that, in line with MDG 6, HIV/AIDS funding has ranged from 12.0% to 31.2% of total DAH each year since 2000 and has been the largest area of focus since 2006. Fueled by the creation of the Global Fund and the United States President's Emergency Plan for AIDS Relief (PEPFAR), funding for HIV/AIDS DAH soared over the 2000–2010 period, with rates of growth amounting to 22.5% annually. Although in 2014 DAH for HIV/AIDS dropped 2.2%, DAH for HIV/AIDS has generally held steady at just under $11 billion in annual disbursements since 2010.

After HIV/AIDS, maternal, newborn, and child health (MNCH) received the second-highest absolute level of support in 2014, making up 26.9% of total DAH. Both MDGs 4 and 5, with their focus on child and maternal mortality, are targeted by MNCH DAH. Over 2000–2014, a cumulative $96.5 billion in DAH was made available for MNCH. In 2014, international financing for MNCH reached $9.6 billion, with $3.0 billion disbursed for maternal health and $6.6 billion provided for newborn and child health. Over 2000–2010, growth in this health focus area was less rapid than the growth in funding for HIV/AIDS, at 6.2% annually. These increases were mostly driven by the growth in child health DAH, with 8.8% in annual growth over 2000–2010. Maternal health financing rose approximately 2.6% over the same period.

Both malaria and TB were among the other infectious disease areas targeted in MDG 6. Financing to combat malaria grew substantially from 2000 on, with annual growth of 17.4% over 2000–2014. A total of $19.0 billion was provided across the board for malaria over that time. In 2014, malaria disbursements held steady. With a very slight 0.4% in growth, malaria funding reached $2.4 billion in DAH in 2014. Funding for malaria made up 6.6% of total DAH in 2014.

TB efforts, in contrast, received 3.8% of DAH in 2014. TB DAH dropped from an all-time high of $1.5 billion in 2013 to $1.4 billion in 2014. This 9.2% decrease followed rapid growth of 19.8% annually throughout 2000–2012.

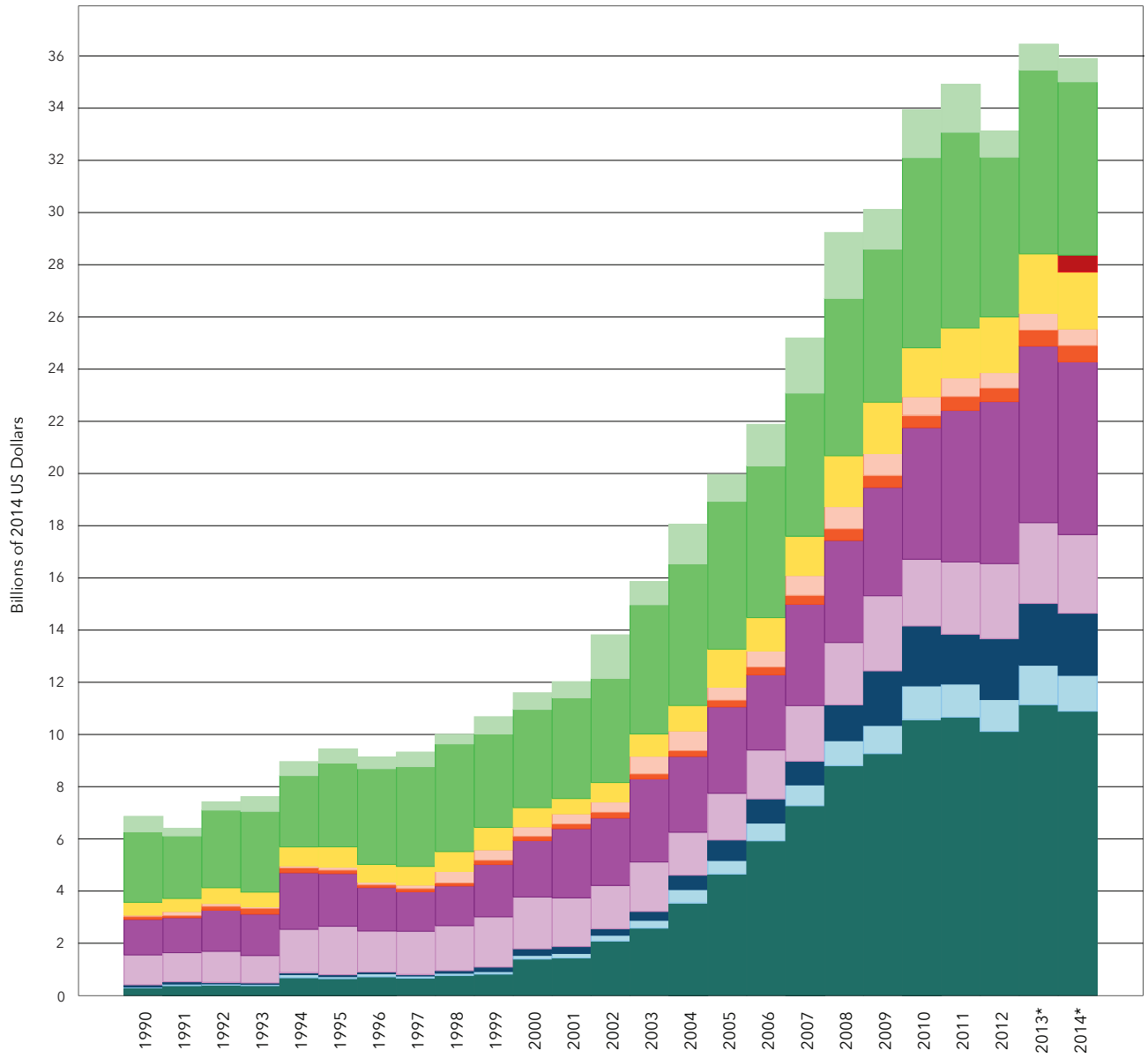
Changes in the DAH provided for health focus areas not included in the MDGs were mixed. DAH for non-communicable diseases (NCDs), at 1.7% of DAH, was flat from 2013 to 2014, amounting to $611 million in 2014. Financing for sector-wide approaches (SWAps) and health sector support (HSS) was also generally level across 2012–2014, with 2014 funding flows amounting to $2.2 billion. In contrast, DAH for other infectious diseases escalated sharply, largely due to the efforts to combat Ebola in West Africa in 2014. On the whole, this health focus area received $1.3 billion in DAH in 2014, growing 102.5% vis-à-vis 2013 levels. Of this, $652 million was provided to fight Ebola in 2014. The funding flows for Ebola are explored in more depth in Box 5 (Page 28).

While Figure 6 provides the trend in DAH over time, Figure 7 captures total flows among the sources, channels, and health focus areas prominent in global health since the onset of the MDGs. The United States, as both a source and a channel, and HIV/AIDS, as a health focus area, are clearly prominent. However, UN agencies and development banks, along with child and maternal health activities, are also notable across funding flows from 2000 to 2014.

In Figure 8, the health focus areas prioritized from 2012 to 2014 across different sources of DAH are presented. Among these sources, the US clearly provided the most to HIV/AIDS, with 62.7% furnished over the period of 2012–2014, although other private philanthropy, including BMGF, disbursed 9.2% and France 3.1% of their

FIGURE 6

DAH by health focus area, 1990–2014



- Unallocable
- Other
- Ebola
- SWAps/HSS
- Other infectious diseases
- Non-communicable diseases
- Newborn and child health
- Maternal health
- Malaria
- Tuberculosis
- HIV/AIDS

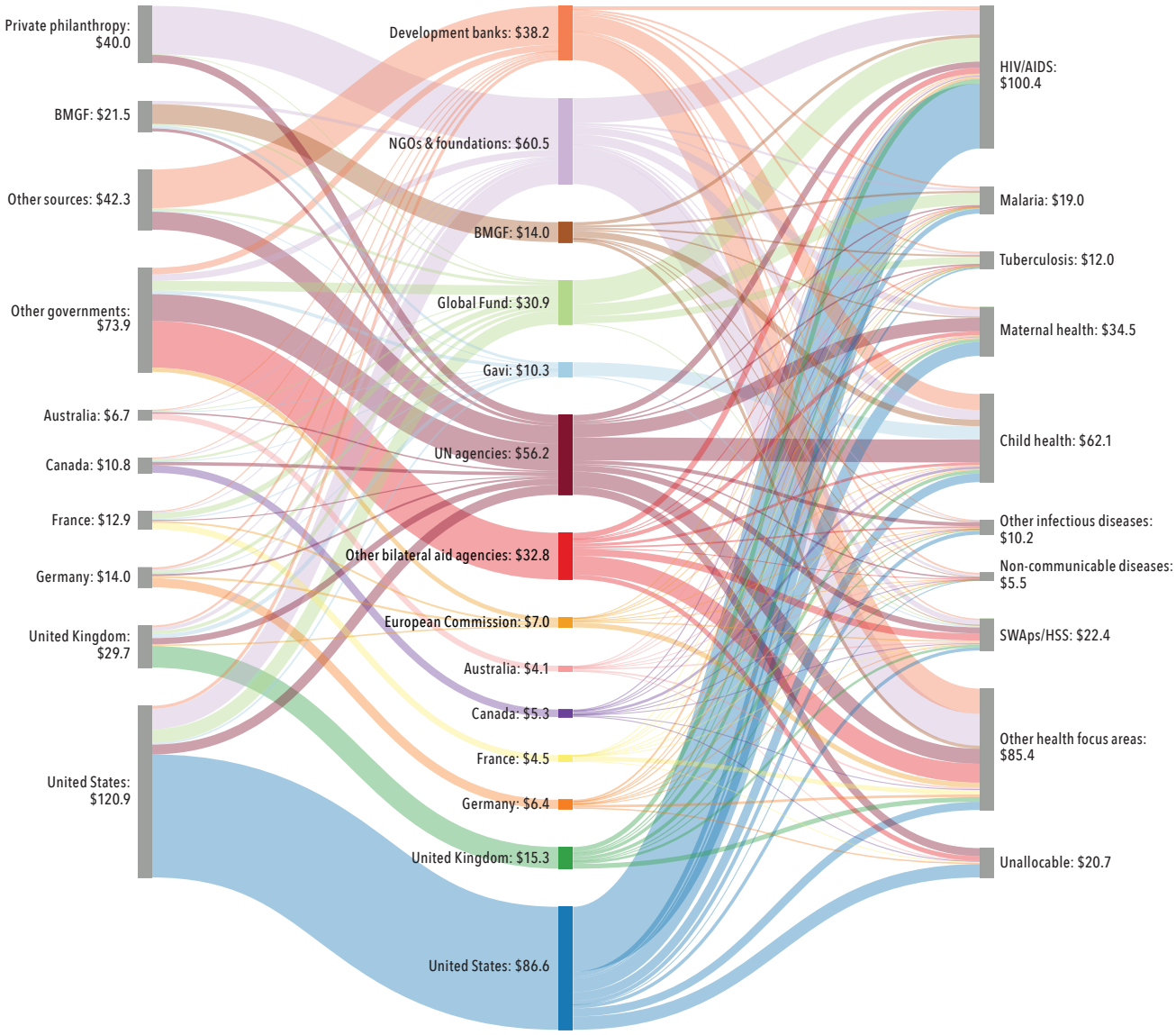
*2013 and 2014 are preliminary estimates.

Notes: Health assistance for which we have no health focus area information is designated as "unallocable." "Other" captures DAH for which we have project-level information but which is not identified as funding any of the health focus areas we track.

Source: IHME DAH Database 2014

FIGURE 7

Flows of DAH from source to channel to health focus area, 2000–2014



Notes: Cumulative DAH from 2000 through 2014 in billions of 2014 US dollars. Health assistance for which we have no health focus area information is designated as "unallocable." "Other" captures DAH for which we have project-level information but which is not identified as funding any of the health focus areas we track. 2013 and 2014 are preliminary estimates.

Source: IHME DAH Database 2014

DAH in the fight against this infectious disease. France also disbursed the most, as a share of its DAH, for malaria, at 15.8%, and TB, at 9.4% of average French DAH over 2012–2014. A number of sources prioritized maternal, newborn, and child health most prominently, including Norway (51.2%), Canada (46.6%), BMGF (46.9%), and the United Kingdom (41.9%). Across sources, Australia provided the largest share of its funds to SWAPS/HSS relative to other sources, disbursing 21% of its DAH to this health focus area across 2012–2014.

The health focus areas emphasized across major channels are depicted in Figure 9. The Global Fund focused resources on the fight against its three main disease areas: HIV/AIDS (51.8%), tuberculosis (16.9%), and malaria (28.8%). However, because the PPP is also committed to strengthening health systems

FIGURE 8

DAH for health focus areas by source, 2012–2014

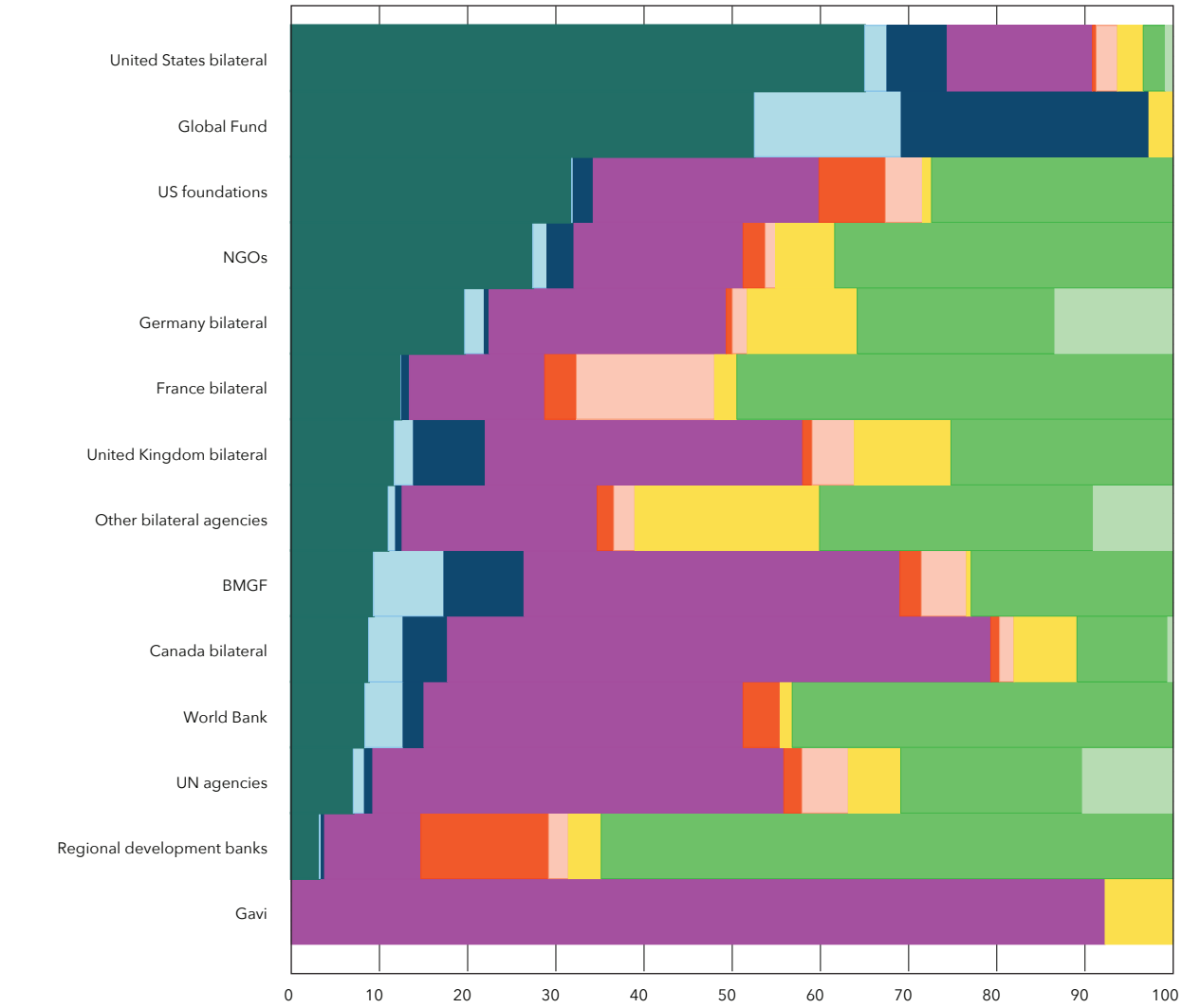
alongside disease-specific funding, the Global Fund provided 2.5% of its funds in support of SWAps/HSS. Funding for vaccines in global health focuses almost entirely on the diseases affecting children, and thus, over 2012–2014, Gavi's funds flowed almost entirely to the MNCH area of focus (92.3%), with a portion disbursed for HSS (7.7%). UN agencies, including UNICEF, WHO, and UNAIDS, concentrated most substantially on MNCH (43.6%), but also supported work on other infectious diseases (11.3%), HIV/AIDS (6.6%), and SWAps/HSS (5.3%), and to a minor extent NCDs (1.8%), tuberculosis (1.1%), and malaria (0.9%).

Notes: Health assistance for which we have no health focus area information is designated as "unallocable." "Other" captures DAH for which we have project-level information but which is not identified as funding any of the health focus areas we track.

Source: IHME DAH Database 2014

FIGURE 9

DAH for health focus areas by channel, 2012–2014



Notes: Health assistance for which we have no health focus area information is designated as "unallocable." "Other" captures DAH for which we have project-level information but which is not identified as funding any of the health focus areas we track.

Source: IHME DAH Database 2014

UNITED STATES

Since 1990, the US government has consistently served as both the largest source and channel of DAH. Furthermore, its share has grown over time, increasing substantially after the MDGs were established in 2000. In 1990, the US government as a source provided $1.9 billion in DAH, 28.2% of the total. By its peak in 2011, the US total was $13.0 billion, its share climbing to 37.3% of total DAH in that year. Growth was highest following the MDG launch, rising 16.0% annually from 2000 to 2010. Recently, however, the US's contribution has begun to decline, with 1.6% in annual decreases in financing from 2011 onward. In 2014, DAH from the US as a source was $12.4 billion. The US provided 32.5% of all DAH from 2000 to 2014.

In addition to the recent reductions, US budgetary proposals may be an indication of further decreases to come. The US President's initial fiscal year 2015 budget request for global health programs would have entailed a reduction of approximately 4% from the previous year's budget.[12] However, the US also moved recently to prioritize innovation in global health. In 2014, the United States Agency for International Development (USAID) unveiled its Global Development Lab, which will explore innovations focused on nutrition and maternal and child health in low- and middle-income countries.[13]

While the US provided more development assistance for health than any other source, US DAH was a relatively small share of the US economy. In 2014, DAH provided by the US government was 0.07% of the US gross domestic product (GDP). This is down from a peak of 0.08% in 2011.

US DAH supported the pursuit of the MDGs by largely funneling financing through US organizations dedicated to the core MDG areas, notably HIV/AIDS and malaria. Of the $12.4 billion the US government provided in 2014, 71.6% was allocated to the global health activities conducted by US bilateral aid agencies. The majority of these resources were disbursed through USAID, although other governmental agencies are active in global health as well, such as the Centers for Disease Control and Prevention (CDC). The US President's Malaria Initiative (PMI) and PEPFAR, both created after 2000, grew exponentially during this period with the aim of contributing to the pursuit of two major MDG targets. Other US funding flowed to channels such as UN agencies, the Global Fund, and NGOs. NGOs received $1.1 billion, while the Global Fund and UN agencies received $1.5 billion and $583 million, respectively, from the US government in 2014.

As a channel, US bilateral funding was relatively stable between 2013 and 2014. In 2014, $8.9 billion in DAH was provided through US bilateral aid agencies, encompassing 24.7% of total DAH. This was a very slight 0.5% decrease from 2013 US bilateral DAH. Similar to US source trends, funding for US channels also peaked in 2011, with $9.9 billion allocated in that year.

Figure 7 highlights the major role the United States plays in supporting the prevention and treatment of HIV/AIDS in low- and middle-income countries. From 2000 to 2014, 46.7% of total US funding went to HIV/AIDS, almost entirely through US bilateral sources. A smaller portion of US DAH as a source, 19.0%, flowed through other channels for HIV/AIDS. MNCH also received a substantial portion of funds from the US, with 19.1% of all US source funds flowing to maternal and child health, again, predominantly through US bilateral channels. Malaria, tuberculosis, and other infectious diseases received 5.6%, 2.7%, and 2.6% of total DAH originating with the US Treasury over 2000–2014.

Sub-Saharan Africa has received 37.4% of all US DAH since 2000, and a total of $35.8 billion was disbursed in 2014 alone. This financing for health in sub-Saharan Africa flows largely through US bilateral sources, much like US DAH for global health overall. Global initiatives were the second-largest recipient of US DAH as a source, as supported by $16.8 billion from the US in 2014. The US provided 4.3% of its DAH to Latin America and the Caribbean, and 1.7% and 4.1% to Europe and Central Asia and East Asia and the Pacific, respectively.

UNITED KINGDOM

The UK was also a consistent and growing source of DAH during the MDG era. Annualized growth from 2000 to 2014 in DAH sourced from the UK government amounted to 9.9%, with the total reaching $3.8 billion in 2014. At 10.6% of DAH overall in 2014, this is an increase from 2000, when DAH sourced from the UK amounted to $1.0 billion, 8.7% of total DAH. DAH from the UK government is 0.12% of the UK's GDP.

The UK marked a considerable achievement in official development assistance in 2013. After several years of ramping up development assistance, the United Kingdom reported achieving the Monterrey target of spending 0.7% of gross

BOX 5

DAH for the Ebola crisis

According to the UN Office for the Coordination of Humanitarian Affairs (OCHA), $1.1 billion in development assistance was disbursed in 2014 to combat the Ebola crisis in West Africa.[6] Of this, 59.4% was channeled as DAH (as opposed to humanitarian funding). The mobilization of funds of this magnitude for Ebola is testament to the international community's response, including a number of private donors, to the crisis that unfolded in West Africa in 2014.

Ebola epidemics have been on the global health community's radar several times since the disease was first discovered in 1976.[7] However, the most recent epidemic has been the most enduring and affected the most people. In 2014, more than 7,890 people died and 20,171 were infected in Guinea, Liberia, and Sierra Leone, where the heart of crisis was located.[8] Mortality rates, fortunately, were lower in 2014 than in previous epidemics.

A wide range of donors have come together to support efforts to quash the spread of Ebola and treat those infected. In total, IHME estimates that $652 million in DAH was disbursed in 2014 to fight the epidemic, with much more committed and likely to be disbursed. The US disbursed $96 million in 2014, has officially pledged $703 million, and reported that the Department of Defense is prepared to devote more than $1 billion to the Ebola response.[9] The UK, as well, has already contributed $100 million. The World Bank, in one of the most rapid disbursements in its history, mobilized an initial $69 million, which has since accumulated to a total of $213 million for the crisis. In their first contribution to global health, Mark Zuckerberg and his wife, Priscilla Chan, gave $25 million for the cause of Ebola.[10] Paul Allen committed $100 million.[11] BMGF has also been at the forefront, disbursing a total of $25 million in 2014 to fight Ebola.

national income on official development assistance, much of it on global health.[14] The UK joins Sweden, Denmark and just a few other high-income countries in reaching this target.[15]

In 2014, UK bilateral channels, most predominantly the United Kingdom's Department for International Development (DFID), disbursed $1.8 billion, 46.9% of the UK's governmental contributions to global health. This is a minor decrease of 3.3% over 2013 levels. Beyond the UK aid agencies, the UK government provided $438 million to UN agencies (11.6%) and $312 million to the Global Fund (8.2%). Of all UK-sourced DAH, 53.1% went to channels other than UK bilateral organizations

Unlike the US, the UK government, as a source, focused considerably more on maternal and child health, providing 34.8% of its funding to this health focus area in 2014. HIV/AIDS received 20.5% of UK DAH. The UK also provided funds to tuberculosis (3.3%) and malaria (7.0%). NCDs, other infectious diseases, and SWAPs/HSS received 1.2%, 3.9%, and 9.2%, respectively, of UK financing.

Finally, the United Kingdom also focused a major share of funding on sub-Saharan Africa, providing 35.8% of its total to this region from 2000 to 2012. Over this period, 8.5% of DAH for sub-Saharan Africa originated in the UK treasury. The United Kingdom also focused substantially on South Asia (18.9%) and global initiatives (12.8%).

GERMANY

After the US and the UK, Germany provided the next largest governmental contribution to global health in 2014. Germany supplied $1.3 billion as a source in 2014, dropping 0.4% from 2013 levels. This is 0.03% of German GDP. Across channels, 41.8% of German DAH flowed to its bilateral aid agencies, mostly Gesellschaft für Internationale Zusammenarbeit, rising 1.1% to $537 million in 2014. Germany supported other channels with a considerable share of its DAH as well, including the Global Fund (24.5%), UN agencies (10.8%), and Gavi (3.9%) in 2014. In terms of MDG health focus areas, Germany supplied 22.8% to HIV/AIDS, 6.5% of its funds to malaria, and 4.3% to TB between 2000 and 2014. Germany furnished 10.3% and 13.3% of all its funds over the same period to maternal health and child health, respectively. Across regional recipients, Germany supported sub-Saharan Africa most predominantly, furnishing 33.3% of its source funds for the subcontinent, a total of $3.8 billion over 2000–2012. South Asia, along with Latin America and the Caribbean, were also key beneficiaries, receiving $1.9 billion (16.6%), and $439.8 million (3.8%), respectively, in German development assistance for health.

CANADA

As provided through its Foreign Ministry, predominantly, Canada's DAH as a source fell slightly in 2014. DAH sourced from Canada underwent a 2.0% decrease from 2013, with $1.2 billion in DAH disbursed in 2014. This is 3.2% of all DAH and 0.06% of Canadian GDP. Canadian bilateral aid agencies received 44.9% of Canadian DAH in 2014, a sum of $516 million. Other substantial shares of Canadian DAH were provided to the Global Fund (18.3%) and UN agencies (19.0%). Canada focused predominantly on HIV/AIDS during the MDG era, furnishing $2.1 billion from 2000 to 2014. Canada also provided 7.9% and 28.9% of DAH over the same period to maternal health and child health, respectively. Another 7.1% and 5.1%, respectively,

of Canadian DAH flowed to malaria and TB activities. Much like many other sources, Canada tends to favor supporting health activities in sub-Saharan Africa, with disbursements of $2.9 billion (34.2%) to countries in the region.

FRANCE

DAH originating from the French government dropped 5.9% to $1.0 billion in 2014. DAH amounted to 0.03% of French GDP in 2014. Bilateral French spending also fell to $184 million in 2014, an 18.0% decrease relative to 2013. France financed the MDGs largely through the Global Fund, providing 60.4% of its DAH in 2014 solely to the PPP. Smaller portions, 7.0% and 4.8%, respectively, were supplied to Gavi and the collection of UN agencies working on health. Across MDG health focus areas, France furnished substantial shares of DAH to HIV/AIDS (22.2%), malaria (10.0%), and TB (5.7%), while MNCH activities received 15.1% of all French DAH between 2000 and 2014. With a history of development cooperation in West Africa, France focused its funding flows on sub-Saharan Africa, with $4.3 billion, or 39.9% of total DAH sourced from the government of France, provided to countries in the region. Other regions targeted included South Asia (8.3%), East Asia and the Pacific (8.8%), and North Africa and the Middle East (4.8%).

JAPAN

In contrast to many other development assistance partners, Japan's contribution to DAH grew in 2014. Japan's funding increased 4.7% in 2014 alone, providing just under $1.1 billion in DAH, but remains lower than the peak of Japanese health funding in 2012. The 2014 disbursement was 0.02% of Japanese GDP. Japan tends to channel DAH through its bilateral aid agencies, which received 40.9% of its DAH in 2014. Japanese bilateral DAH, as furnished predominantly through the Japan International Cooperation Agency, fell 0.1% to $43.8 million in 2014. Across regions, Japan supported the health of countries in its geographic region, the surrounding East Asia and the Pacific region, which benefited from $2.0 billion, or 16.2%, in DAH sourced from the Japanese government. Japan provided $1.4 billion to South Asia, 11.5% of Japanese DAH in 2014. Sub-Saharan Africa, as well, was a main beneficiary, receiving $2.7 billion from Japan in 2014, 22.4% of its DAH.

AUSTRALIA

Australia joined Japan and the UK in providing more DAH in 2014, supplying 3.0% more to global health activities in 2014 than in 2013. The Australian government directed a total of $964.3 million to global health, 0.06% of Australian GDP in 2014. Among the different channels these funds flowed to, financing for Australian bilateral activities, mostly directed by Australia's bilateral aid agency, were stable, growing just 0.2% and reaching $508 million in 2014. A wide array of global health partners were also beneficiaries. In 2014, Australia disbursed $121 million (12.6%) to UN agencies, while the Global Fund received $131 million (13.6%), and Gavi benefited from $73 million (7.6%) in Australian funding. From 2000 to 2014, Australia furnished 21.8% of its DAH to HIV/AIDS, 8.1% to maternal health, 17.3% to child health, and 4.3% to malaria. Sub-Saharan Africa was a key Australian beneficiary, receiving

$419.1 million, or 8.8% of Australian DAH, since 2000. East Asia and the Pacific was the recipient of $2.4 billion, or 51.4% of all Australian DAH, over the same period.

OTHER HIGH-INCOME GOVERNMENTS

An array of other high-income governments also stand out as major sources of the many billions of dollars in DAH provided annually. However, funding from most other major sources dropped in 2014. The DAH sourced from the treasuries of Spain and the Netherlands, for instance, fell 16.3% and 6.1%, respectively.

While many of these governments provided less DAH in absolute terms in 2014, some of them continued to provide significant funds relative to their own economies. Substantial portions of GDP were also provided as DAH by the governments of Norway (0.15%) and Luxembourg (0.07%) in 2014.

Among other governmental channels, bilateral DAH generally dropped as well. With austerity still in effect in a number of countries, high-income governments are funneling their financial portfolios away from development assistance. Switzerland, Norway, and New Zealand were exceptions, with financing growing 8.1%, 4.0%, and 3.0%, respectively, in 2014. The decreases across bilateral DAH contributions included Portugal (65.7%), Austria (34.5%), Italy (14.2%), the European Commission (9.5%), Belgium (6.2%), Luxembourg (6.2%), Korea (6.0%), Ireland (4.4%), Finland (1.9%), and Denmark (1.5%). Sweden's bilateral DAH was essentially unchanged.

UNITED NATIONS AGENCIES

UN agencies working on health include the WHO, UNAIDS, UNICEF, UNFPA, and the Pan-American Health Organization (PAHO). This collection of multilateral bodies continued to channel substantial resources to low- and middle-income countries in 2014. Support for these international organizations was provided by governments, and to a limited extent, private foundations and other private sources. The major sources of the DAH supplied to these UN agencies were the US ($410 million), the UK ($277 million), and Norway ($174 million).

In 2014, UN agencies expended $3.7 billion in DAH, 10.2% of the total disbursed in that year. Among these bodies, UNICEF underwent the most expansive growth, with an increase of 17.9% and total spending of $1.4 billion in 2014. WHO also grew, albeit less substantially. At $2.1 billion, total DAH from WHO almost regained its 2011 peak – WHO's DAH expanded 4.0% from 2013 to 2014, with 10.2% of its disbursement targeting the Ebola crisis in West Africa.

The DAH of other UN global health entities decreased from 2013 to 2014. UNAIDS and UNFPA both declined slightly, with reductions of 2.4% and 5.6%, respectively. UNAIDS spending was 0.8% of total DAH, a sum of $274 million in 2014, whereas UNFPA's share of the total was more substantial, at 2.4% and with $845 million in spending in 2014.

GAVI, THE VACCINE ALLIANCE

Gavi was created in 2000 to combat preventable child maladies and other infectious diseases that can be avoided with vaccination. These efforts, in line with MDG 4, have grown rapidly since Gavi was established. Total Gavi spending reached $1.8

billion in 2014, a rise of $137 million or 8.2% over 2013. From 2000 to 2014, Gavi furnished a total of $10.3 billion in the fight to reduce child mortality and other death and disability.

The sources of Gavi funding have varied across the years, with BMGF playing a key role in starting the vaccine-focused international entity. In 2014, BMGF supplied $401 million or 22.1% of total funding for Gavi. However, increasingly, high-income governments furnish the bulk of Gavi support. In 2014, the US contributed 10.8%, or $195 million. Substantial funding was also provided by the UK ($624 million, or 34.5%), France ($72 million, or 4.0%), and Germany ($50 million, or 2.8%) in 2014.

Also in 2014, Gavi embarked on a new replenishment round, aiming to raise $7.5 billion for vaccinations in the developing world, twice the amount requested in the previous round of pledges.[16] These funds will be used to support the International Finance Facility for Immunisation and scale immunization efforts, with a target of vaccinating 300 million more children over 2016–2020. Increased pledge targets are also tied to Gavi's plans to support 150 new vaccine introductions, including 11 distinct vaccines in 68 countries.

THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

The other major public-private partnership in global health is the Global Fund. The Global Fund contributes to reducing the burden of the three diseases encapsulated

BOX 6

Tracking development assistance for health

IHME collects budget, revenue, and expenditure data for 39 global health channels in order to construct a comprehensive picture of how DAH flows from sources to channels to implementing institutions. In total, more than 60 data sources are utilized. Disbursements, rather than commitments, are measured and reported, because disbursements provide the most accurate account of the resources made available. All estimates are adjusted for inflation and reported in 2014 US dollars. Because global health channels routinely transfer DAH among themselves, IHME credits the last tracked channel with the funds.

Many channels do not provide the necessary data for accurate and timely accounting of DAH in the most recent years (2013 and 2014). When this is the case, estimates are modeled using time trends and budget data. These estimates are considered preliminary. Data limitations prevent IHME from tracking DAH to recipient countries and regions for 2013 and 2014. Additional information about IHME's DAH tracking methodology is available in Annex A of this report. A comprehensive methods annex is available online at http://www.healthdata.org/sites/default/files/files/policy_report/2015/FGH2014/IHME_fgh2014_methods_annex.pdf.

Each year, IHME improves its DAH estimation methods. This year, IHME focused on improving its methodology for dividing DAH into health focus areas. DAH is now disaggregated into 15 health focus areas and estimated through 2014. Furthermore, this report more completely traces resources from source to channel to health focus area and recipient country. A myriad of other more minor improvements have also led to more accurate and comprehensive tracking of DAH.

by MDG 6. Launched in 2002, the Global Fund has provided $16.8 billion to HIV/AIDS, $8.6 billion to malaria, and $5.0 billion to TB from its inception to 2014. In 2014, the Global Fund channeled $4.1 billion of DAH, 11.4% of total DAH. This is a 6.9% decrease from 2013 levels.

However, in 2013, the Global Fund garnered pledges of $12 billion over three years from a wide variety of development partners.[17] The US, which provided $3.0 billion or 37.1% of all funds in 2014, pledged $4 billion over the subsequent three years; it also committed an additional $1 for every $2 in further pledges.[18] The UK committed $1.5 billion, doubling its previous contribution of $755 million or 18.3% of funding. Historically, France has been the second-largest donor to the Global Fund, and the country maintained its support with a commitment of $1.4 billion in the most recent round of pledges. The Nordic countries also increased their pledges to $750 million. If these commitments are realized, this DAH contribution would be an increase over previous disbursements.

DEVELOPMENT BANKS

In 2014, the DAH provided by development banks fell vis-à-vis 2013 levels. Drops were observed in the DAH provided both by the World Bank's International Development Association (IDA), which primarily provides grants to low-income countries, and the International Bank for Reconstruction and Development (IBRD), which primarily provides loans to middle-income countries. Funding from IDA, with disbursements of $876 million in 2014, dropped 16.7%, while IBRD financing fell 4.3% to $1.1 billion. Decreases were also observed in the DAH provided by the Asian Development Bank (33.5%) and Inter-American Development Bank (50.9%). The DAH distributed by the African Development Bank, however, jumped 24.4%, with $101 million in spending in 2014.

Despite these recent reductions, disbursements from development banks are expected to rise, particularly funding from IDA and IBRD. In 2014, the World Bank announced plans to boost funding for the 10 countries with 80% of the world's extreme poor, including Bangladesh, China, the Democratic Republic of the Congo, and India.[19] This follows a commitment from World Bank members to provide an additional $52 billion to IDA for low-income countries. The World Bank also announced that it would increase lending to middle-income countries to up to $28 billion annually, a rise over the $15 billion lent on an annual basis in previous years.[20] Japan, the US, and the UK provided 13.5%, 12.3%, and 11.3%, respectively, of the resources that funded IDA in 2014. Germany and France, as well, contributed 1.7% and 3.3%.

THE BILL & MELINDA GATES FOUNDATION

Also established relatively recently, BMGF is the largest single source of private funding for global health. Created in 1999, BMGF has provided $21.6 billion to global health from its launch to 2014. BMGF has targeted MDG health focus areas broadly, furnishing 6.5% or $1.4 billion to maternal health and 35.7% or $7.7 billion to child health over this time. Through a number of channels, including the foundation itself, BMGF provided $3.3 billion to HIV/AIDS, $2.1 billion to malaria, and $1.7 billion to TB from 1999 to 2014.

In 2014, BMGF provided $2.9 billion, 8.1% of total DAH, and 46.6% of private funding flows for global health. That same year, 55.8% of BMGF funding was channeled directly through its foundation, with the remaining funds disbursed to Gavi (13.8%), NGOs (13.7%), UN agencies (10.0%), and the Global Fund (6.7%). As a channel, BMGF disbursed $1.6 billion for global health causes in 2014, a 5.1% increase over 2013 levels.

Among private sources, BMGF also directed the majority of its funding to maternal, newborn, and child health, with 46.3% of all financing sourced from the foundation provided to these causes in 2014. Shares for other health focus areas from BMGF varied from 10.7% for HIV/AIDS, to 7.9% for malaria and 5.9% for TB. BMGF also provided 4.2% of its funds for other infectious diseases, 2.8% for SWAPs/HSS, and 1.7% for NCDs.

Across recipient regions, BMGF also focused predominantly on sub-Saharan Africa, which received 25.3% of all BMGF funds as a source in 2012. Sub-Saharan Africa benefited from $266 million in support from BMGF. Following sub-Saharan Africa, East Asia and the Pacific received the next-highest share of BMGF funds, with 3.6% or $38 million in BMGF funds provided to the region.

NON-GOVERNMENTAL ORGANIZATIONS, OTHER FOUNDATIONS, AND OTHER PRIVATE ENTITIES

Corporate donations and other private philanthropic sources make up the rest of private financing of DAH. In 2014, corporate donations made up $662 million or 1.9% of DAH. Other private sources amounted to $2.7 billion or 7.4% of DAH. Of the resources from other private philanthropy (excluding BMGF), 74.8% was provided to NGOs in 2014 ($2.5 billion), while a more minor share went to UN agencies (12.6%, or $418 million) and the Global Fund (1.2%, or $41 million).

Among the many other private sources are the endowments of a number of major foundations, including entities such as Bloomberg Philanthropies and the Clinton Foundation. Donations from numerous individuals also make up a major source of DAH. In 2014, 11.4% of these resources, or $378 million, were channeled through foundations.

NGOs disbursed 15.1% of all DAH in 2014, amounting to $5.4 billion, a 3.8% rise over 2013. In 2014, these organizations benefited substantially from corporate donations, with 12.3% of NGO DAH sourced from these private, corporate funders. The contributions of thousands of private individuals were also key to the global health activities implemented by NGOs, with other private philanthropic sources making up 33.7% of total NGO spending in 2014. Substantial funding was also received from the US government (20.6%, or $1.1 billion), BMGF (7.3%, or $393 million), and other high-income country governments (25.0%, or $1.4 billion).

RECIPIENTS OF DEVELOPMENT ASSISTANCE FOR HEALTH

The MDGs focus on low- and middle-income countries, as does DAH. Figure 10 depicts DAH by developing country region and presents the trends in allocations over time. This highlights the prominence of sub-Saharan Africa as a recipient and the growth in its share of DAH over time.

Figure 11 embodies the financing pathway from source to channel to developing world region. The weight of the US as a source and the sub-Saharan Africa region as the key regional recipient of DAH is clear, underscoring the important role these development partners played in working toward the MDGs. Other sources of funding, such as the UK and BMGF, are also prominent in this depiction of 15 years of funding flows.

Focusing on the country level, Figure 12 provides estimates of DAH per the disability-adjusted life years (DALYs) present in 2011 in each low- and middle-income country. DALYs are the combination of years of life lost to disability and years of life lost to early death. Bringing DALYs and DAH together captures how much DAH is provided in terms of each country's disease burden. As shown in Figure 12, the vast majority of countries received less than $20 per DALY between 2010 and 2012. However, certain countries were beneficiaries of much more, an indication of the concentration of funds in certain countries and causes of disease burden.

SUB-SAHARAN AFRICA

Sub-Saharan Africa, as Figure 10 shows, received the most substantial amount of funds during the MDG era. From 2003 on, this region consistently received the largest share of DAH, accounting for more than 24.5% of total international expenditure on health, on average, from 2000 to 2012. With annual growth rates of 17.7% in absolute DAH from 2000 to 2012, DAH for sub-Saharan Africa rose to $11.8 billion in 2012. DAH for sub-Saharan Africa was sourced most prominently from the US government, with 49.7% of DAH for the region flowing from the US. US DAH for the region amounted to $5.9 billion in 2012. Following the US, other major sources of DAH for sub-Saharan Africa included the UK, which provided 12.1% of all DAH for the region, followed by Canada (5.1%) and BMGF (2.3%).

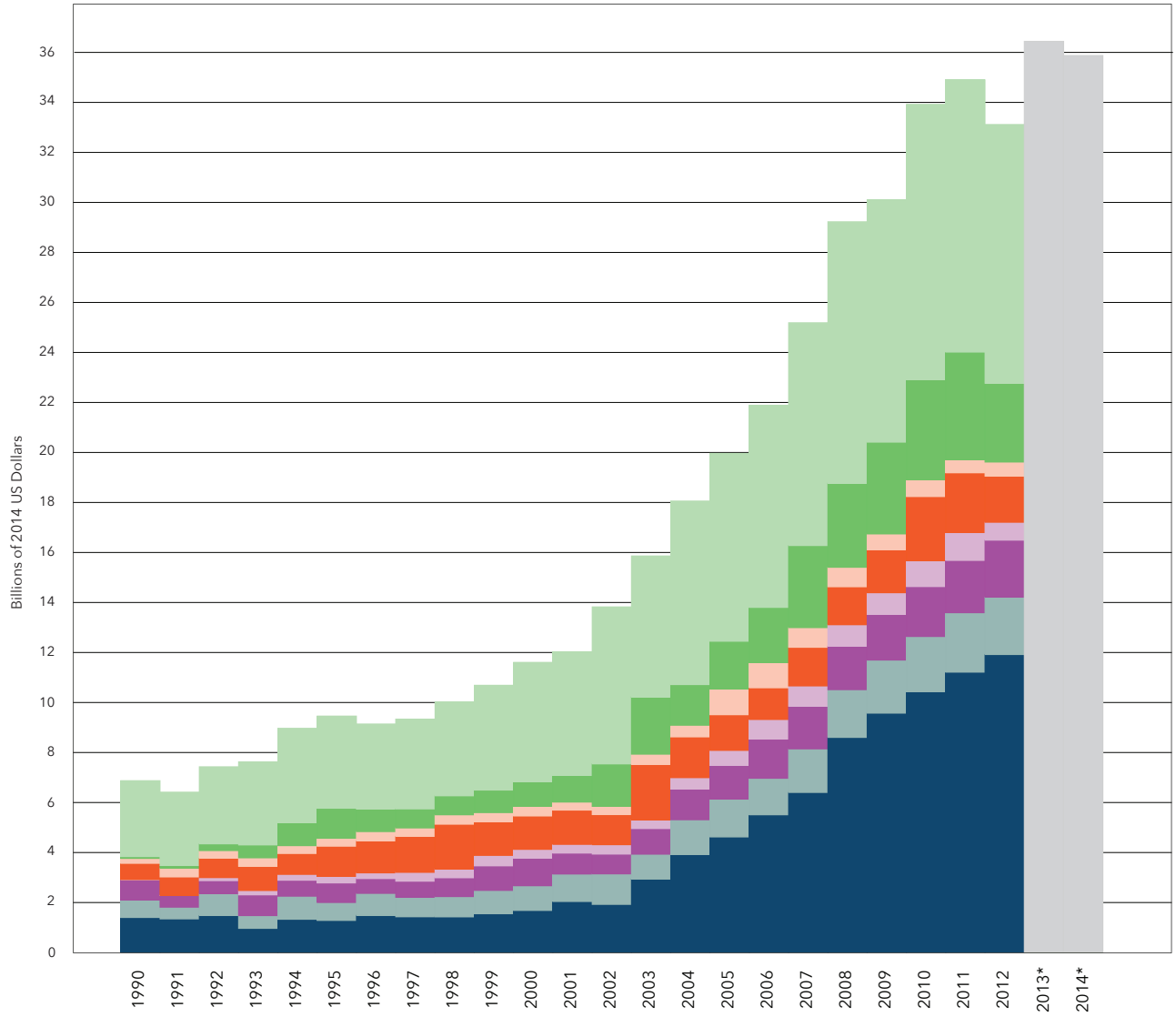
When compared to domestic burden, most countries in the region received dollar figures ranging from less than a dollar to close to $10 per DALY. However, in a number of countries, particularly in the corridor that spans Eastern and Southern Africa, where HIV/AIDS prevalence is high, upward of $40 per DALY was received. Botswana and Namibia, of note, received more than $70 per DALY from 2010 to 2012.

SOUTH ASIA

The GBD region of South Asia covers a collection of highly populated countries, including India, with a population of more than one billion, as well as Pakistan and Bangladesh, each with more than 100 million people. This region accounts for 23.1% of the world's population and 30.4% of global all-cause DALYs. Burden is driven largely by the prevalence of major infectious diseases, but a rising

FIGURE 10

DAH by recipient region, 1990–2014



- Unallocable
- Global initiatives
- Middle East & North Africa
- Latin America & Caribbean
- Europe & Central Asia
- East Asia & Pacific
- South Asia
- Sub-Saharan Africa

*2013 and 2014 are preliminary estimates.

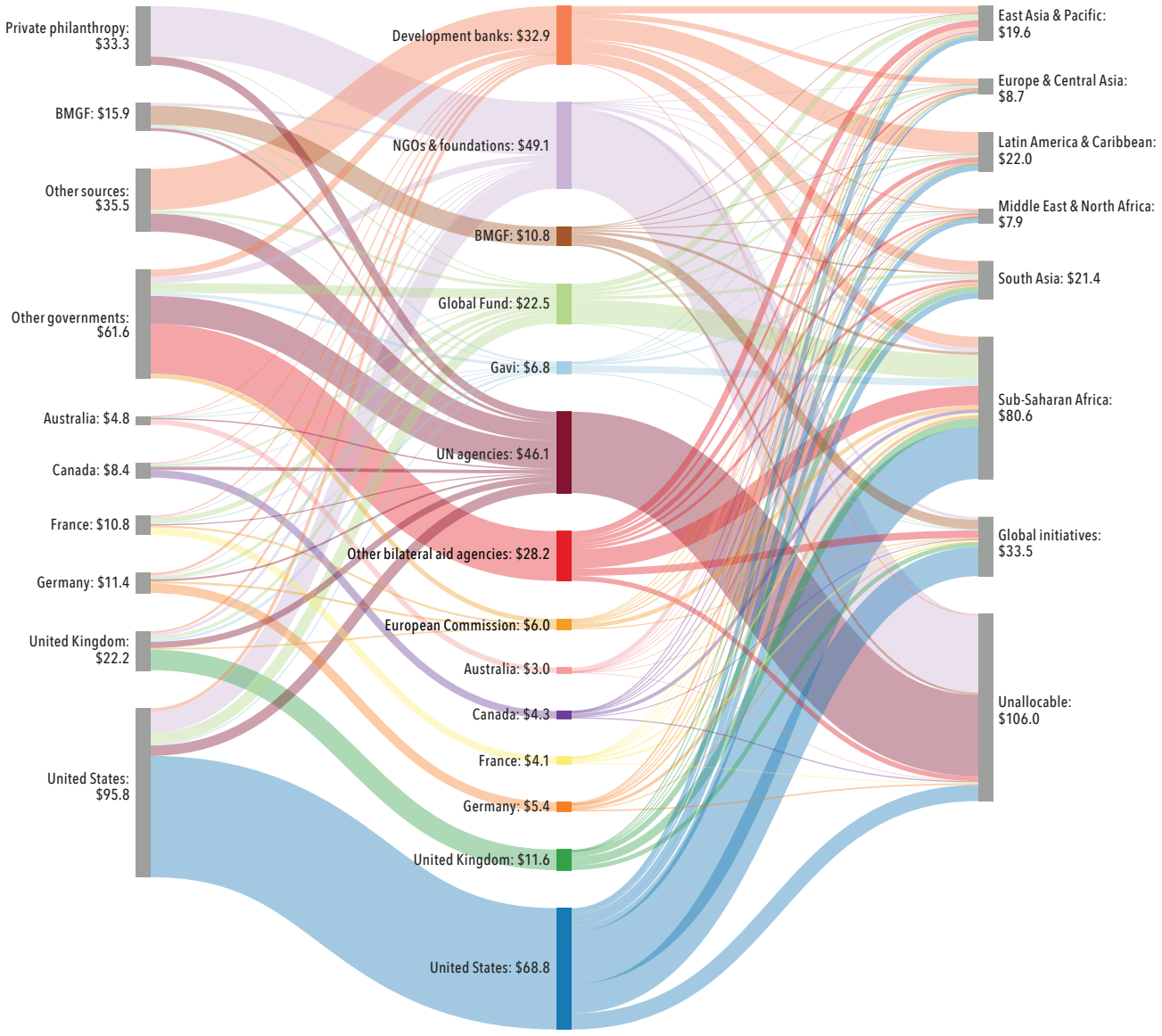
Notes: Health assistance for which no recipient country or region information is available is coded as "unallocable." Due to data limitations, estimates are unavailable for DAH by focus region for 2013 and 2014.

Source: IHME DAH Database 2014

non-communicable disease burden contributes to premature death and disability in the region. In 2012, South Asia received 6.9% of all DAH, dropping 3.0% between 2011 and 2012. This decrease is notable and in line with the announcement that UK aid will be phased out to India because it attained middle-income status in 2007.[21] In 2012 alone, the UK provided 19.7%, or $453 million, of total estimated DAH for South Asia. Other major sources were the United States, contributing $544 million, or 23.6% of total DAH for South Asia, followed by Germany ($121 million, or 5.3%), France ($117 million, or 5.1%), and BMGF ($73 million, or 3.2%).

FIGURE 11

Flows of DAH from source to channel to recipient region, 2000–2012



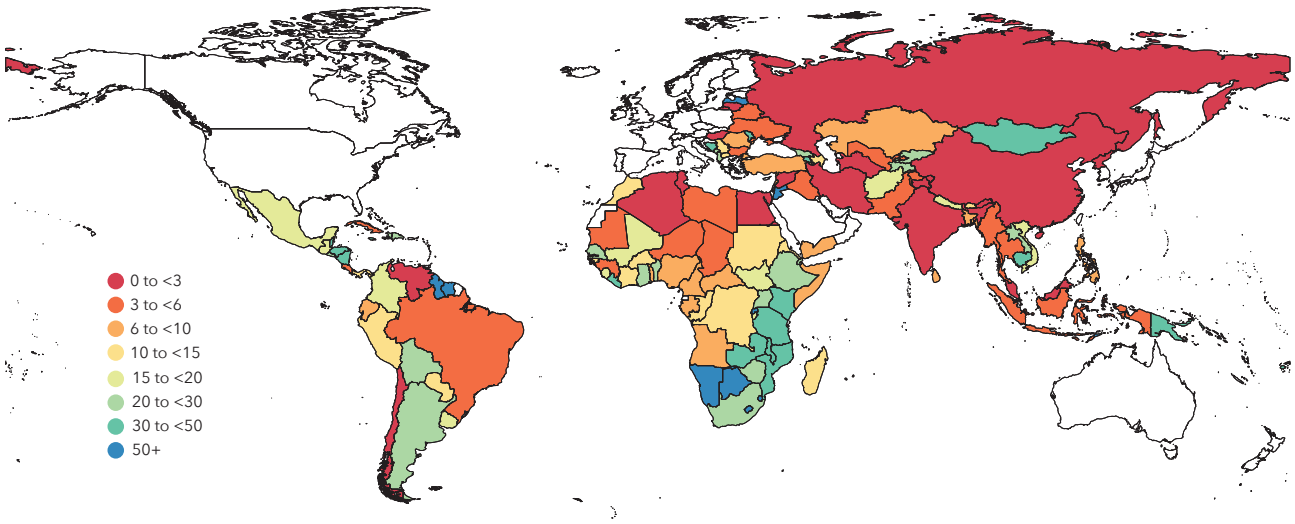
Looking at DAH per DALY, most countries in the region generally benefited from lower rates of DAH per DALY than sub-Saharan African nations. Major, populous countries, such as India, Pakistan, and Bangladesh, received a lower-range sum of between less than a dollar and $10 per DALY. Afghanistan, however, was an exception, benefitting from an estimated $19.97 in average DAH per DALY.

Notes: Cumulative DAH from 1990 through 2014 in billions of 2014 US dollars. Health assistance for which we have no health focus area information is designated as "unallocable."

Source: IHME DAH Database 2014

FIGURE 12

Total DAH per all-cause DALY, 2010–2012



Notes: 2011 DALYs are estimated using Global Burden of Disease Study 2010 and 2013. Countries that were ineligible for DAH based on their World Bank classifications are shown in white. Average annual DAH received over 2010-2012 is shown in real 2014 US dollars.

Sources: IHME DAH Database 2014, Global Burden of Disease Study 2010, 2013

EAST ASIA AND THE PACIFIC

East Asia and the Pacific encompasses China, Indonesia, North Korea, and a wide range of low- and middle-income countries. Numerous small island developing states, with unique health and development issues associated with their particular geographic and economic conditions, are also grouped into this region. DAH in 2012 amounted to $2.3 billion in East Asia and the Pacific, with growth of 8.7% in 2012. DAH per DALY was typically between less than a dollar and $10. However, some island nations attracted more than $70 per DALY. Major sources of funds were the US government, providing $480 million or 21.3% of total DAH for East Asia and the Pacific, as well as the UK government ($162 million or 7.2%), and an amalgamation of other high-income countries ($918 million or 40.7%).

NORTH AFRICA AND THE MIDDLE EAST

North Africa and the Middle East spans Morocco to Iran, inclusive of Turkey. This region is more typically afflicted with non-communicable diseases, which made up 69.1% of the region's DALYs in 2011. DAH flowing to North Africa and the Middle East amounted to $561 million in 2012, with growth of 6.3% from 2011 to 2012. DAH per DALY was generally similar across countries in the region, with the exceptions of the DAH per DALY of Palestine ($79.98) and Jordan ($50.55). The development assistance partners most active in providing DAH for this region were the United States, the Global Fund, and the development banks.

LATIN AMERICA AND THE CARIBBEAN

Distinct among regions, as represented in Figure 11, was Latin America and the Caribbean. In contrast to other areas, this region received a substantial chunk of investment funds from development banks. Over 2000–2012, Latin America and

the Caribbean received 54.8% of its DAH from development banks. At $12.1 billion over this period, this was substantially higher than the contributions of development bank funds to other regions, including sub-Saharan Africa, which received just $6.3 billion from these channels. Overall, however, DAH targeting Latin America and the Caribbean fell in 2012 to 22.5%, totaling just over $1.8 billion. DAH per DALY in the region ranged from just over zero, such as in Brazil and Chile, to more than $40 per DALY in Costa Rica, Guyana, Honduras, and Suriname.

EUROPE AND CENTRAL ASIA

Europe and Central Asia received a substantial share of its DAH from other sources (32.3%) over 2000–2012 but also benefited from DAH from other high-income governments (23.7%), the US (19.2%), and the UK (4.6%). In 2012, DAH provided for the Europe and Central Asia region fell 36% to $714 million in 2012. DAH per DALY in the region ranges from close to $0 to more than $40 in certain countries. Latvia, notably, received more than $50 per DALY between 2010 and 2012.

GLOBAL

Some DAH is not designated for any particular region but flows to international programs, conferences, and other globally focused health activities. In 2012, $3.1 billion was provided for these activities. While globally focused DAH dropped by 26.6% from 2011 to 2012, this DAH generally grew substantially from 2000 onward. Rates of growth from 2000 to 2012 topped 10.1% in annual terms. Across sources, the United States contributed more to global activities than any other source, providing 66.6% of all global DAH in 2012. Other major contributors were the UK (13.6%, or $426 million) and other high-income governments (13.1%, or $412 million).

EXPLORING CHANGE IN DAH, 2000-2014

Assessing DAH growth is important to understanding how global health activities have scaled up rapidly since 2000. Figures 13-16 visualize these trends, highlighting absolute and annual percent change for sources, channels, recipient regions, and health focus areas.

From 2000 to 2014, the United States and the United Kingdom's growth outpaced other sources. Over this period, UK source funding grew more than 12.0% on an annual basis. The US was not far behind, with increases of 10.0% annually over the same time span. BMGF posted increases of close to 15.0% annually.

Figure 13 provides the growth rates observed among channels during the same time period. Annual percentage growth rates were highest among public-private partnerships (57.2%), but significant increases were also observed in the DAH channeled by US bilaterals (12.7%), NGOs and foundations (7.9%), and UK bilaterals (7.1%). Development banks grew least of all channels, at 0.04% annually during this period, although this reflects the major injection of funds provided by the World Bank in response to the financial crisis and its scale-back as the financial crisis subsided.

The region to receive the most substantial boost in DAH was sub-Saharan Africa. With 17.7% in annual growth and an absolute increase of $10.2 billion, countries in sub-Saharan Africa were core beneficiaries of the major growth in global health

FIGURE 13

Change in DAH by source, 2000–2014

Source: IHME DAH Database 2014

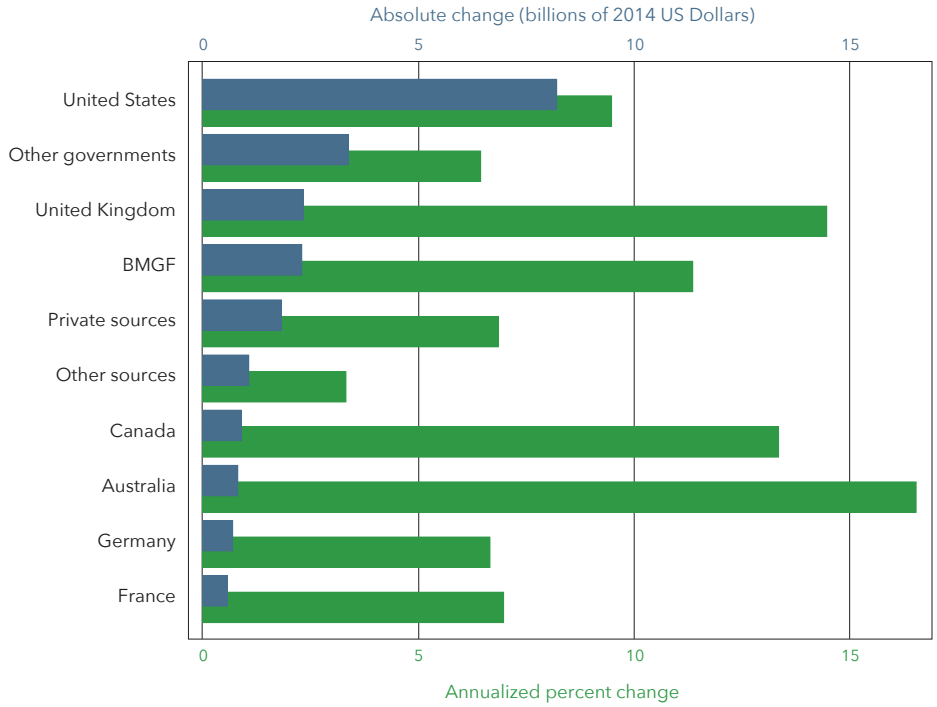


FIGURE 14

Change in DAH by channel, 2000–2014

Source: IHME DAH Database 2014

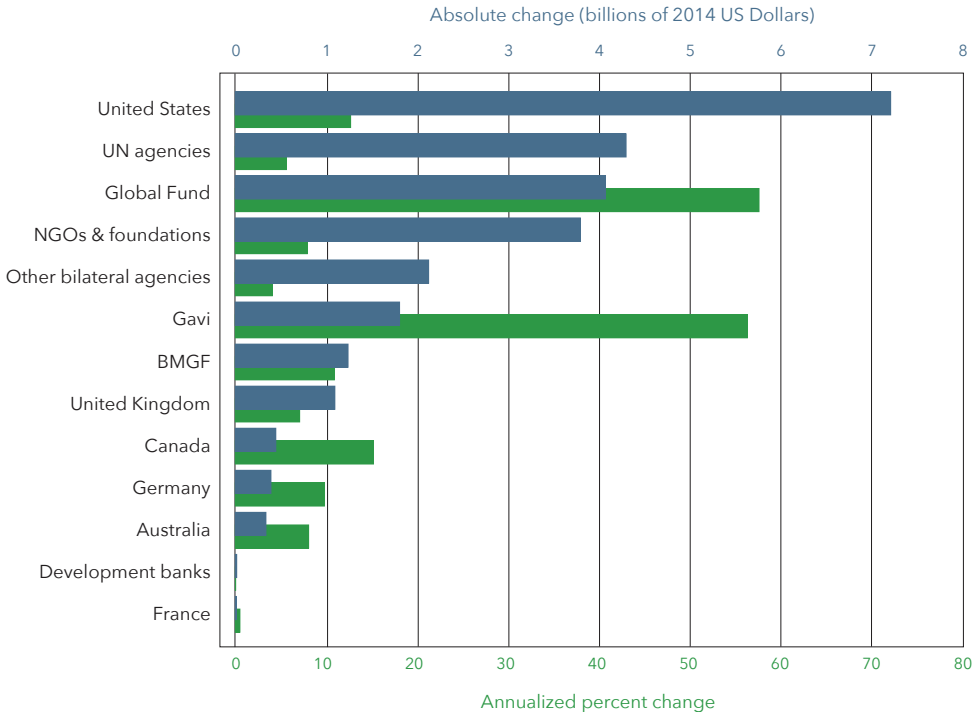


FIGURE 15

Change in DAH by recipient region, 2000–2012

Source: IHME DAH Database 2014

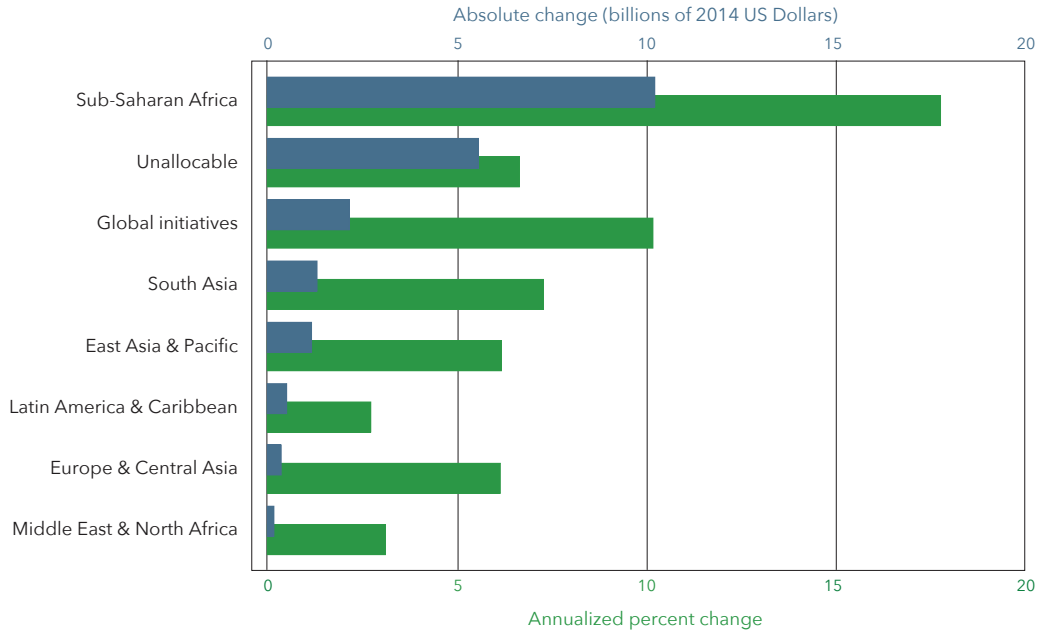
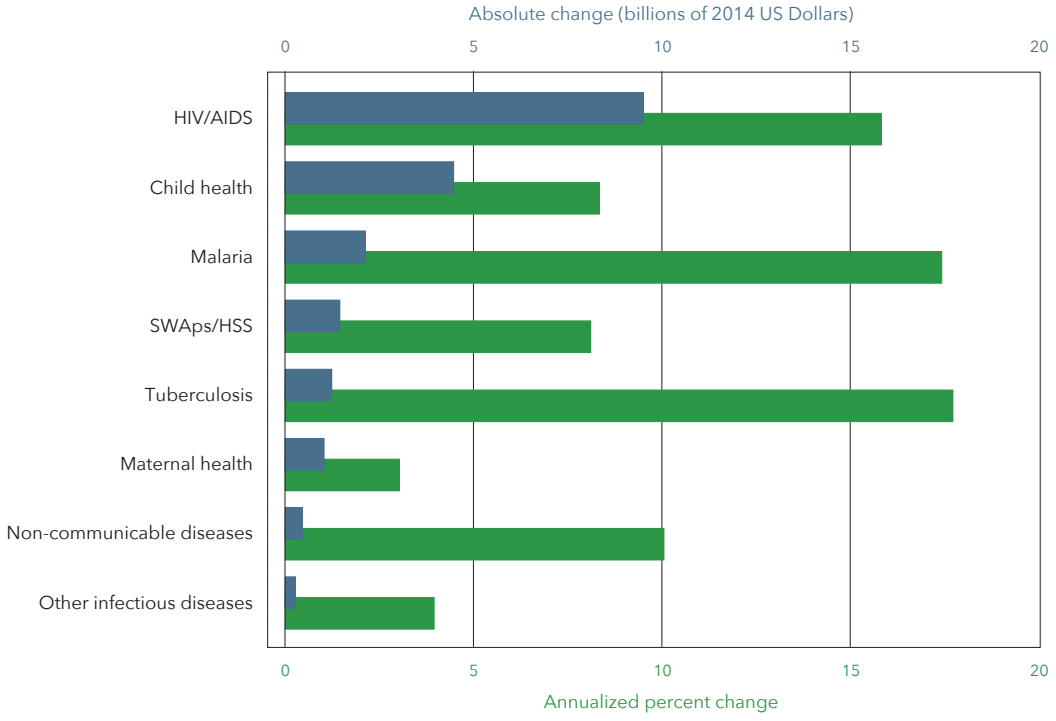


FIGURE 16

Change in DAH by health focus area, 2000–2014

Source: IHME DAH Database 2014



financing that has occurred since 2000. After sub-Saharan Africa, other regional categories with predominant growth patterns were global initiatives (10.1%), South Asia (7.3%), and Europe and Central Asia (6.1%).

Finally, among health focus areas, the causes that attracted the most substantial increases were associated with the MDGs: funding for HIV/AIDS, TB, and malaria grew more than DAH for other health focus areas. Financing for TB grew the most in percentage terms, rising 17.7% from 2000 to 2014. However in absolute terms, funding for HIV/AIDS increased much more, rising $9.5 billion over the period, as compared to the $1.2 billion in increases observed for TB. Malaria DAH was also a major target of growth, with 17.4% in average annual growth and $2.1 billion in increases from 2000 to 2014. Child health, as the area targeted by MDG 4, was also affected by great increases, with growth of 8.3% annually and $4.5 billion absolutely over the same period. Maternal health benefited least of the MDG health focus areas, growing just $1.0 billion absolutely and 3.0% in percentage terms over 2000-2014. Finally, while funding for NCDs did not increase substantially in absolute terms vis-à-vis other health focus areas, growing $451 million over the same period, this area of health expenditure did rise 10.0% annually over 2000–2014.

CHAPTER 2

Health focus areas

This section is dedicated to exploring health focus areas, or the expenditure categories most prominent in global health. By breaking down development assistance for health (DAH) by these different areas of focus, we can better assess trends in the interventions funded and maladies fought by the wide range of actors in global health.

IHME distinguishes seven core health focus areas: HIV/AIDS, tuberculosis, malaria, other infectious diseases, non-communicable diseases, health sector support and sector-wide approaches, and maternal, newborn, and child health. This year, additional effort was dedicated to splitting funding for maternal, newborn, and child health (MNCH) into DAH for newborn and child health and DAH for maternal health. Furthermore, in this year's report, we present subcategories for MNCH as well as non-communicable disease expenditure.

MATERNAL, NEWBORN, AND CHILD HEALTH

In global health, MNCH activities focus on some of the most vulnerable populations: children and pregnant women in need of health services in low-income settings. The Millennium Development Goals (MDGs) stressed maternal and child health with two distinct goals. MDG 4 aimed to reduce the under-5 mortality rate by two-thirds between 1990 and 2015. MDG 5 set out to reduce maternal mortality by three-fourths over the same time span.

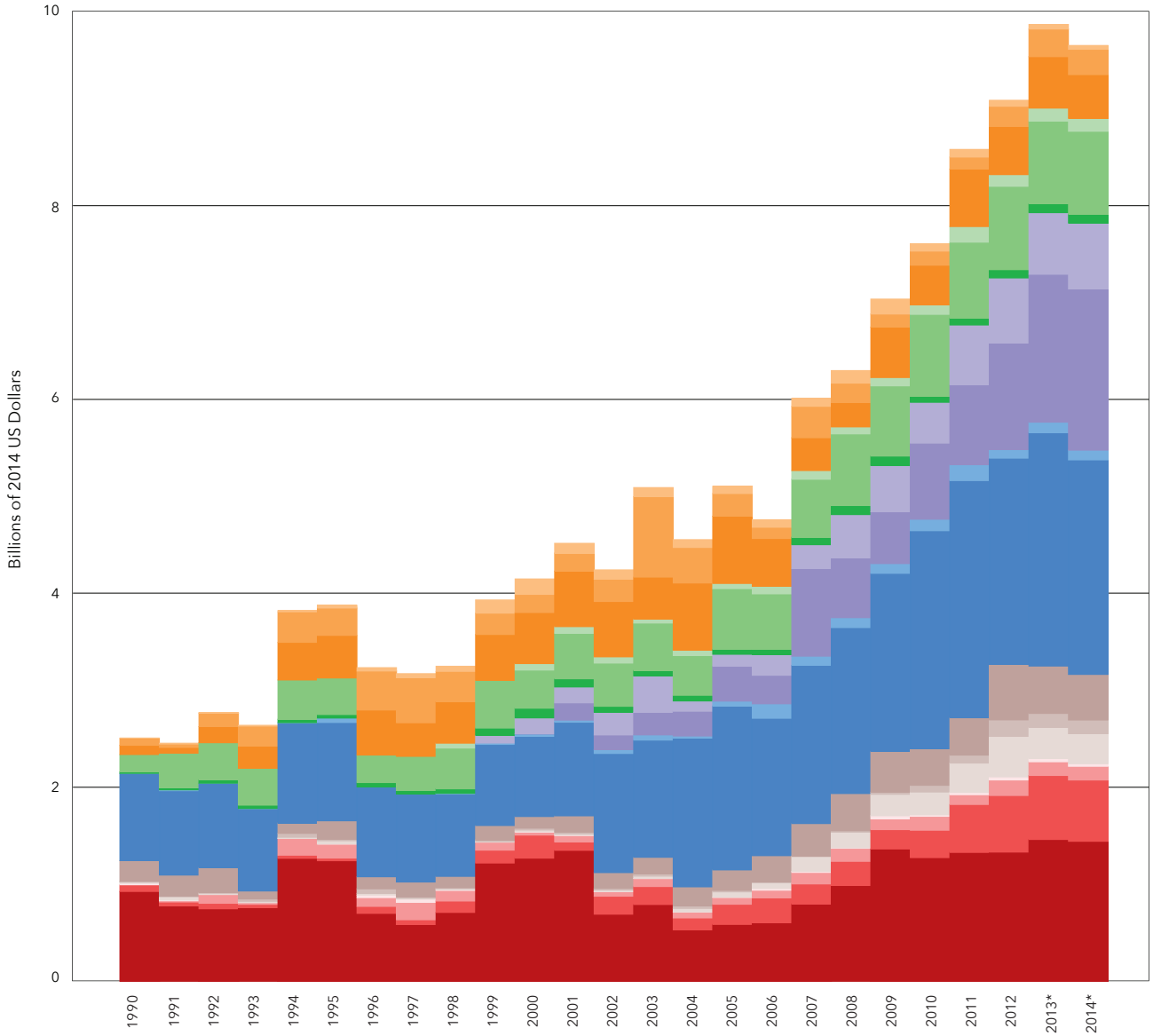
Figure 17 displays the overall trend in combined DAH for maternal, newborn, and child health. In 2014, total DAH for MNCH activities dropped 2.2% to $9.6 billion, around $1 billion less than the DAH provided for HIV/AIDS. Of this total, $3.0 billion was allocated to maternal health. The other $6.6 billion focused on child health activities. Since 1990, MNCH has benefited from a substantial share of DAH, ranging from 21.5% in 2008 to 42.6% in 1994 of DAH overall. Growth amounted to 4.1% annually from 1990 to 2006, although absolute spending dipped in 1996. On the whole, MNCH's share of total DAH has decreased as HIV/AIDS DAH picked up steam. However, annual growth rates were high from 2006 to 2013, at 11.0%, as a series of international calls for action pushed the area up the list of global health priorities.

While IHME's MNCH estimates begin in 1990, maternal and child health has been high on the global health agenda for more than three decades.[22] As early as 1987, the Safe Motherhood movement was launched to address maternal mortality and other issues related to maternal care. A flurry of initiatives followed, albeit some almost 20 years later. In view of bolstering efforts to attain MDGs 4 and 5, as well as improve maternal and child health more generally, the Partnership for Maternal, Newborn and Child Health and the Countdown to 2015 collaboration were both initiated in 2005, followed by Every Woman Every Child in 2010.[23,24,25,26]

Future growth is anticipated. An unprecedented $1.2 billion was committed by the World Bank, the United Nations Children's Fund (UNICEF), the United States

FIGURE 17

DAH for maternal, newborn, and child health by channel of assistance, 1990–2014

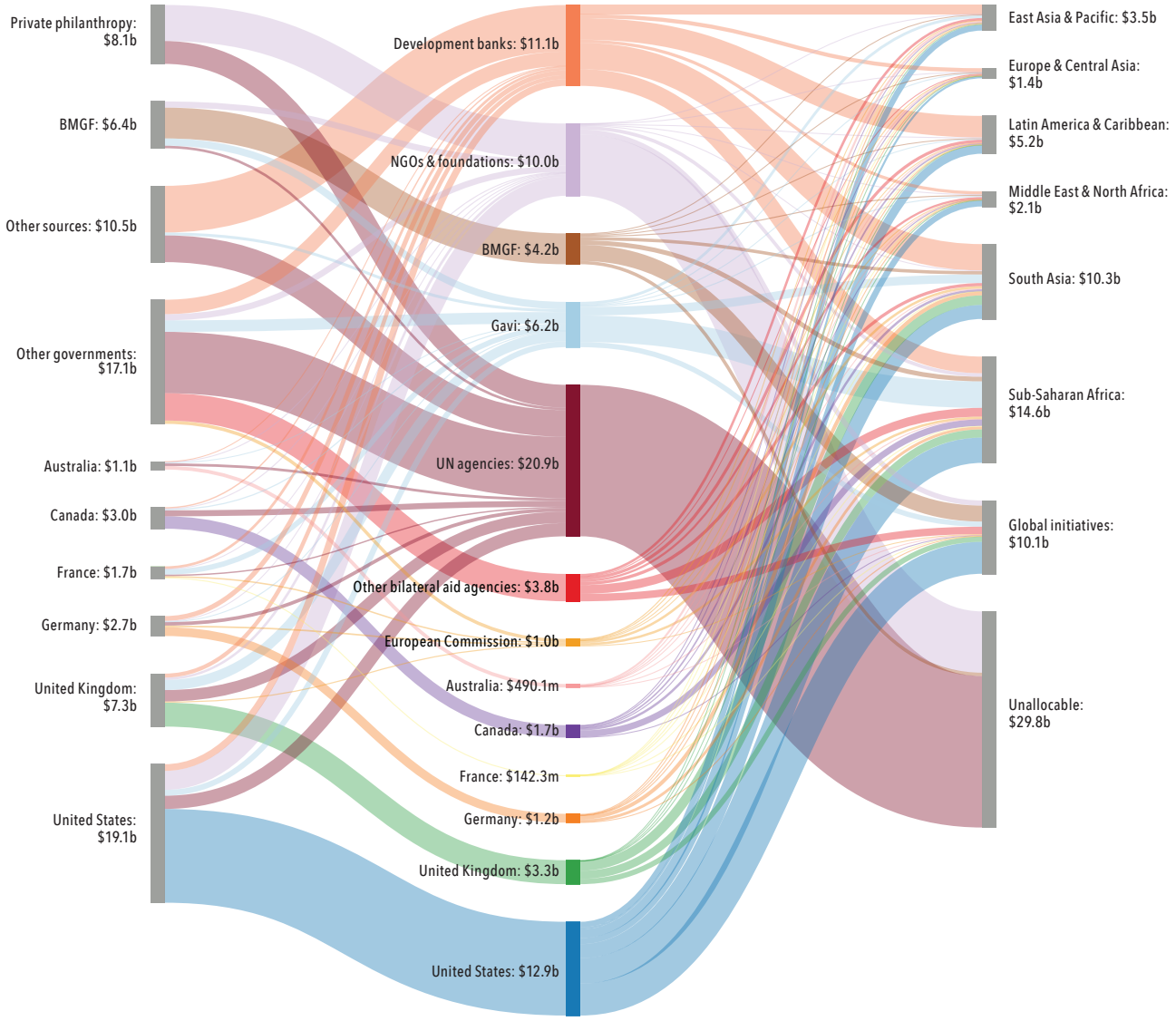


*2013 and 2014 are preliminary estimates.

Source: IHME DAH Database 2014

FIGURE 18

Flows of maternal, newborn, and child health DAH from source to channel to recipient region, 2000–2012



Agency for International Development (USAID), and Norway to MNCH causes in September 2013.[27] Furthermore, in 2014, at a high-level summit on maternal, newborn, and child health in Toronto, the Saving Every Woman Every Child Summit, an additional $3.5 billion was pledged for maternal and child health activities.[28,29,30]

Figure 18 shows that MNCH is distinct from other MDG health focus areas because multilateral institutions, namely UN agencies, channel the largest share of DAH for this area of action. Together these agencies channeled $2.2 billion, 22.9% of the MNCH DAH in 2014. While still large in relative terms, this is an 8.1% decrease from 2013 funding levels.

Notes: Cumulative maternal, newborn, and child health DAH from 1990 through 2012 in 2014 US dollars. Health assistance for which we have no recipient region information is designated as "unallocable."

Source: IHME DAH Database 2014

In 2014, Gavi provided $1.7 billion to maternal and child health activities, just under the sum furnished by the collection of UN agencies working on MNCH. Gavi financing continued to grow into 2014, with a 9.0% increase over 2013 levels. Gavi's DAH amounted to 17.2% of all funding for MNCH in 2014. An array of sources have supported Gavi in its launch and scale-up, including numerous other high-income governments. The US and UK have furnished 12.0% and 20.6%, respectively, while a number of other sources were also important contributors, including the Bill & Melinda Gates Foundation (BMGF), which provided 18.0% of Gavi's resources from its inception to 2014.

Across MNCH sources, the United States was the origin of 20.8% of all MNCH funding in 2014, 72.1% of which was channeled through US bilateral aid agencies. US bilateral DAH for MNCH was steady into 2014, at $1.4 billion, with just a minor drop of 1.3% in 2014. Other channels in receipt of substantial US government support for MNCH were UN agencies (8.8%, or $177 million), NGOs and foundations (7.4%, or $148 million), and Gavi (8.9%, or $179 million).

The UK sourced $1.5 billion, or 15.0%, of total DAH for MNCH. The UK's contribution has increased rapidly, growing 23.1% annually from 2009 to 2014, with a peak of $1.5 billion in contributions in 2014. Of these funds, 42.0% was channeled through UK bilateral institutions, but the UK also provided considerable sums to Gavi (38.1%, or $573 million) and UN agencies (11.0%, or $173 million).

In 2014, 13.9% of total DAH for MNCH activities flowed from the endowment of the Bill & Melinda Gates Foundation. MNCH support from BMGF reached $1.3 billion in 2014, a 5.4% increase over 2013. Of these funds, 50.6% was channeled through the foundation itself. BMGF also supported NGOs, other foundations, Gavi, and UN agencies, all targeting MNCH.

Other high-income governments were also important sources of assistance intended to improve the health of children and mothers. In 2014, Canada furnished $481 million as a source, while Germany provided $282 million. France and Australia were the sources of $145 million and $287 million, respectively.

Among other prominent channels, both expansion and contraction were observed. NGOs and foundations, excluding BMGF, provided $1.1 billion to the cause in 2014, a 0.2% increase over 2013 levels. In contrast, the DAH provided by the World Bank's IDA and IBRD dropped to $450 million and $261 million, respectively, in 2014. IBRD funding fell 15.1% and IDA funding decreased by 8.1%, relative to 2013 levels.

Figure 19 highlights the alignment between burden of disease and DAH for MNCH. At the top of both lists are four of the most populous – and highest-burden – developing countries, demonstrating fairly good alignment between burden and DAH. India is found in the first slot on both lists, and Nigeria and Pakistan, both very populous countries, are among the top four. China, with the sixth-largest burden of maternal and child conditions, was not among the top 20 recipients of MNCH. However, as highlighted in purple, China is also categorized as an upper-middle-income country by the World Bank.

Figure 20 showcases more specific subcategories of international expenditure on MNCH. The subcategories divide child and newborn health spending into vaccines, nutrition, and other child and newborn health DAH. Maternal health is parsed between family planning and non-family-planning funding.

The child and newborn area of DAH highlights the rapid and substantial growth in vaccine expenditure, which increased from $1.2 billion in 2006 to more than $3.2 billion in 2014. This nearly three-fold increase was fueled by the creation and growth

of Gavi. Major increases were also observed in the DAH provided for nutrition, which reached $1.1 billion in 2014, having grown 11.0% annually from 2006 to 2014.

The maternal portion of MNCH funding did not exhibit the growth rates seen in child and newborn health DAH. DAH for maternal health grew from 2006 onward at 6.1% annually. Encompassing both family planning and non-family-planning activities, maternal health DAH amounted to $3.0 billion in 2014, which was 8.4% of total DAH. Family planning funding dipped from 2000 to 2004 and crept upward thereafter. In 2014, family planning DAH stood at $778 million, $185 million lower than 2013 levels.

CHILD HEALTH

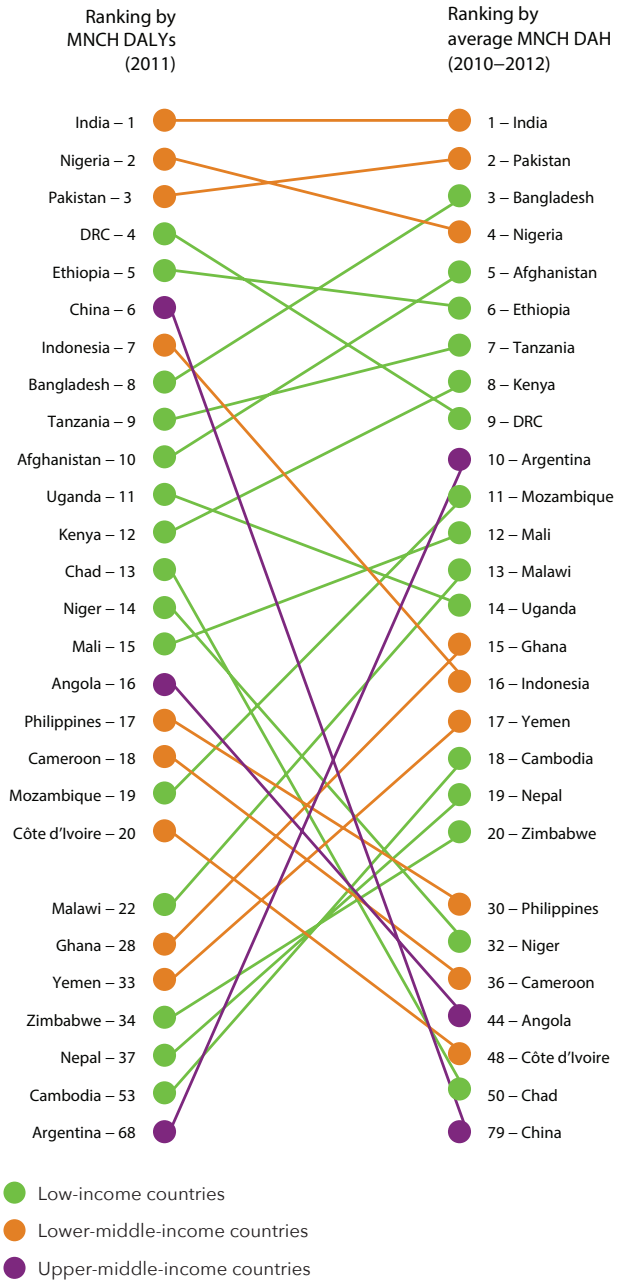
MDG 4 focused on reducing under-5 mortality in low- and middle-income countries. Children are at risk for a wide range of ailments in the developing world. Many of these, including diarrhea, pneumonia, and malaria, are largely preventable or treatable with low-cost interventions.[31] In view of reducing the more than 6.3 million preventable child deaths that occurred in 2013 in low- and middle-income countries, the DAH for child health rose substantially in the MDG era.

Figure 21 depicts that growth, over 8.3% annually since 2000, and the channels most prominent in providing this aid. Figure 21 also shows how child health DAH differs from the aid directed toward maternal health issues. Child health DAH is fueled primarily by UN agencies, which provided 21.3% of these funds, and US bilateral agencies, which provided 9.8%, in 2014. The major increases in funding for child health, however, were driven largely by the creation and scale-up of Gavi. From 2000 to 2014, Gavi channeled $9.4 billion cumulatively in DAH. These resources have supported the immunization of an additional 500 million children throughout Gavi's tenure in global health.[32]

Figure 22 represents child health DAH disbursed over 2010–2012 as compared to the disability-adjusted life years (DALYs) that capture the ailments of children under 5. This map shows that very few countries in sub-Saharan Africa rose above $11 per DALY. In contrast, a number of countries in South America, including Argentina, Bolivia, Paraguay, and others, received more than $17 in DAH per DALY.

FIGURE 19

Top 20 countries by 2011 maternal, newborn, and child health burden of disease versus average 2010–2012 DAH

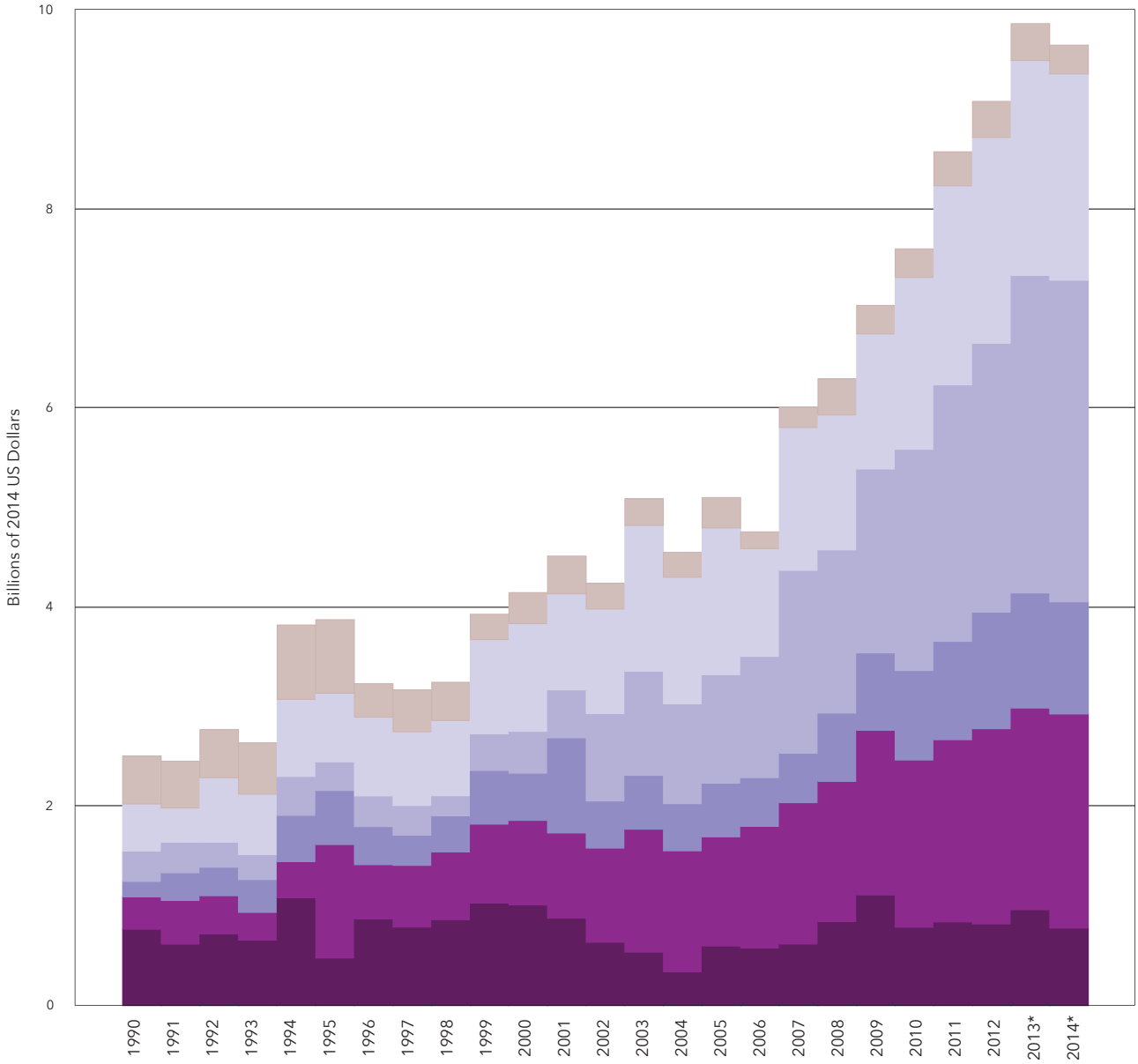


Notes: 2011 DALYs are estimated using Global Burden of Disease Study 2010 and 2013.

Sources: IHME DAH Database 2014, Global Burden of Disease Study 2010, 2013

FIGURE 20

DAH for maternal, newborn, and child health by health focus subcategory, 1990–2014



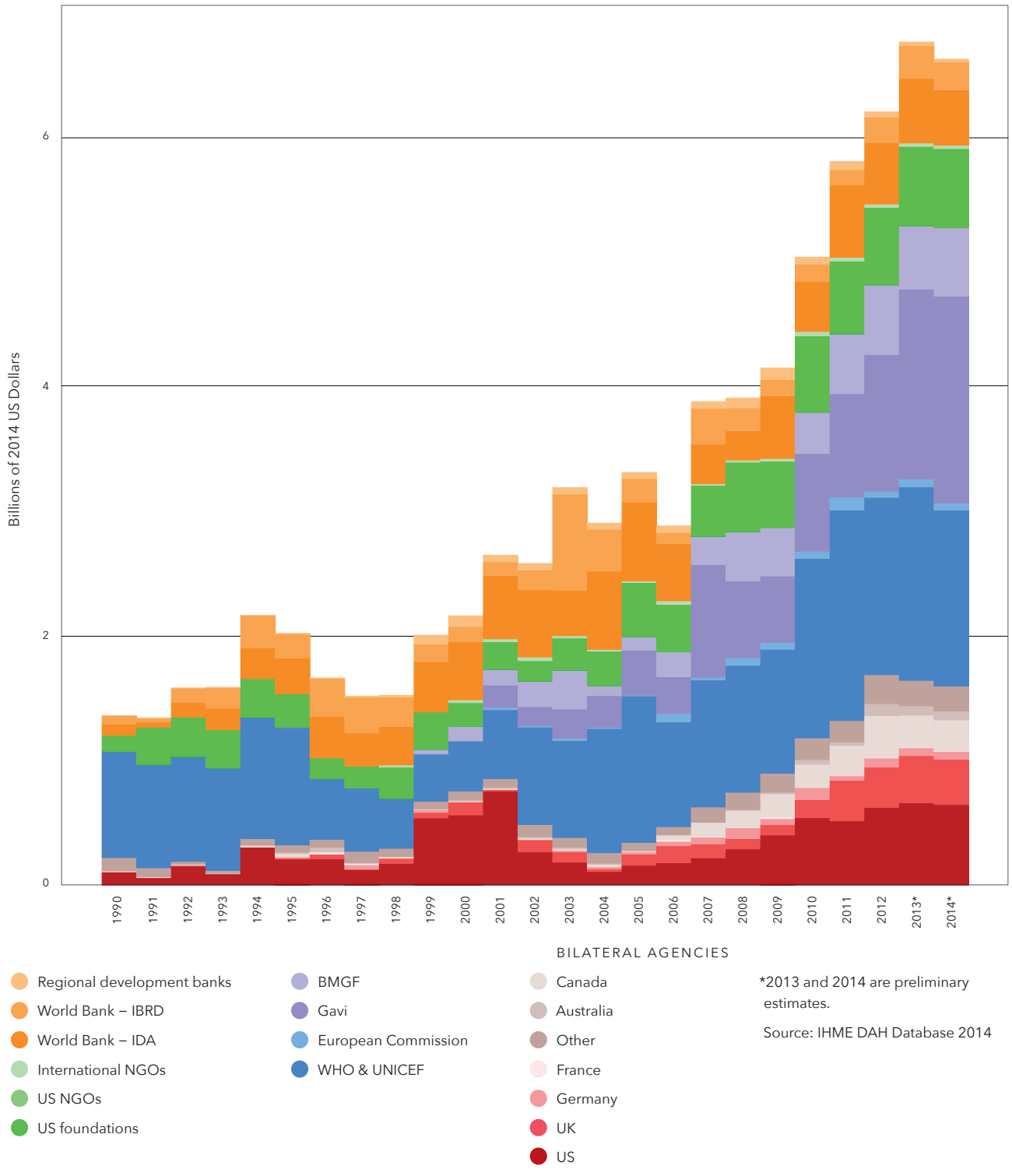
*2013 and 2014 are preliminary estimates.

Notes: Maternal, newborn, and child health DAH for which we have no health focus subcategory information is designated as "unidentifiable."

Source: IHME DAH Database 2014

FIGURE 21

DAH for newborn and child health by channel of assistance, 1990–2014

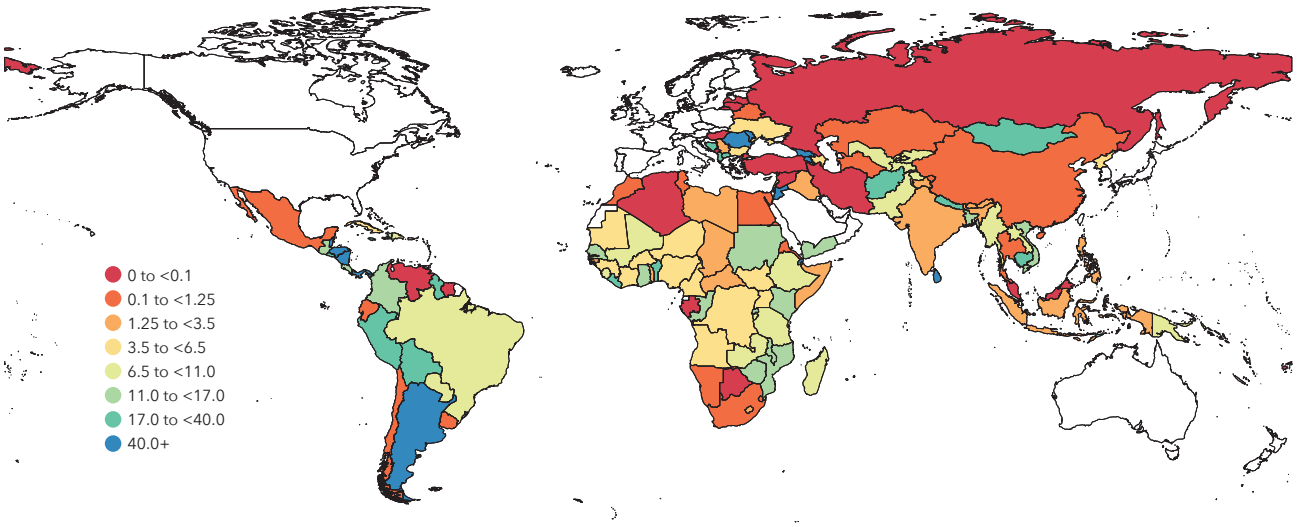


*2013 and 2014 are preliminary estimates.

Source: IHME DAH Database 2014

FIGURE 22

Newborn and child health DAH, 2010–2012, per related DALY, 2011



Notes: 2011 DALYs are estimated using Global Burden of Disease Study 2010 and 2013. Countries that were ineligible for DAH based on their World Bank classifications are shown in white. DAH received is shown in real 2014 US dollars.

Sources: IHME DAH Database 2014, Global Burden of Disease Study 2010, 2013

BOX 7

Child health and MDG 4

With the end of 2015 in sight, 27 developing countries are on track to achieve MDG 4.[33] According to the GBD study, more than 10 million fewer children died in 2013 as compared to 1970. Between 1970 and 2013, under-5 mortality decreased from 143 per 1,000 live births to 44 per 1,000 worldwide, a more than two-thirds decrease. The annualized rates of decrease changed drastically after 2000, with rates of decline accelerating from 2000 onward. Worldwide, 99 of 188 countries saw faster rates of decline in 2000-2013 than over 1990-2000.

While declines in under-5 mortality have accelerated since 2000, particularly in sub-Saharan Africa, many countries in West and Central Africa still have high levels of under-5 mortality. The 10 countries with the highest under-5 mortality in 2013 were all in sub-Saharan Africa. If current trends persist, mortality rates will stay high until 2030 in these regions. However, around 90% of sub-Saharan African countries had faster rates of decline from 2000 to 2013 than from 1990 to 2000.

MATERNAL HEALTH

The MDGs also emphasized maternal health, focusing particularly on women with complicated pregnancies or with limited access to health services in low- and middle-income countries. Women across low- and middle-income countries use antenatal care, delivery facilities, and family planning services at a wide range of rates, whether for cultural and contextual reasons or because of factors affecting access and availability. By encouraging development assistance partners to support increasing utilization rates, improve quality of care, and address other factors affecting pregnant women, MDG 5 aimed to reduce maternal mortality by three-fourths.

The international community has launched a number of initiatives to work toward this objective. However, until recently, maternal health disbursements have not grown as rapidly as the DAH provided for child health activities. Figure 23 shows the overall trend and the channels active in funding maternal health DAH. Maternal health financing in 2014, at $3.0 billion, was just 45.5% of funding for child health in the same year. Furthermore, growth rates have been less substantial, at 3.0% annually since 2000. Relative to child health, the US channel is more prominent in this health focus area, contributing 26.4% of the total. US bilateral agencies disbursed $796 million for maternal health in 2014. United Nations agencies contributed a similar share, providing $799 million, or 26.5% of maternal health DAH, in 2014.

Some evidence suggests that DAH for maternal health, notably family planning activities, might benefit from increased funding flows in the future. The London Summit on Family Planning, in July 2012, mobilized major commitments to financing family planning activities from a wide range of stakeholders. A major share of pledges was committed by more than 70 NGOs (27%), 62 low- and middle-income countries (22%), and an array of private sector actors (15%).[34]

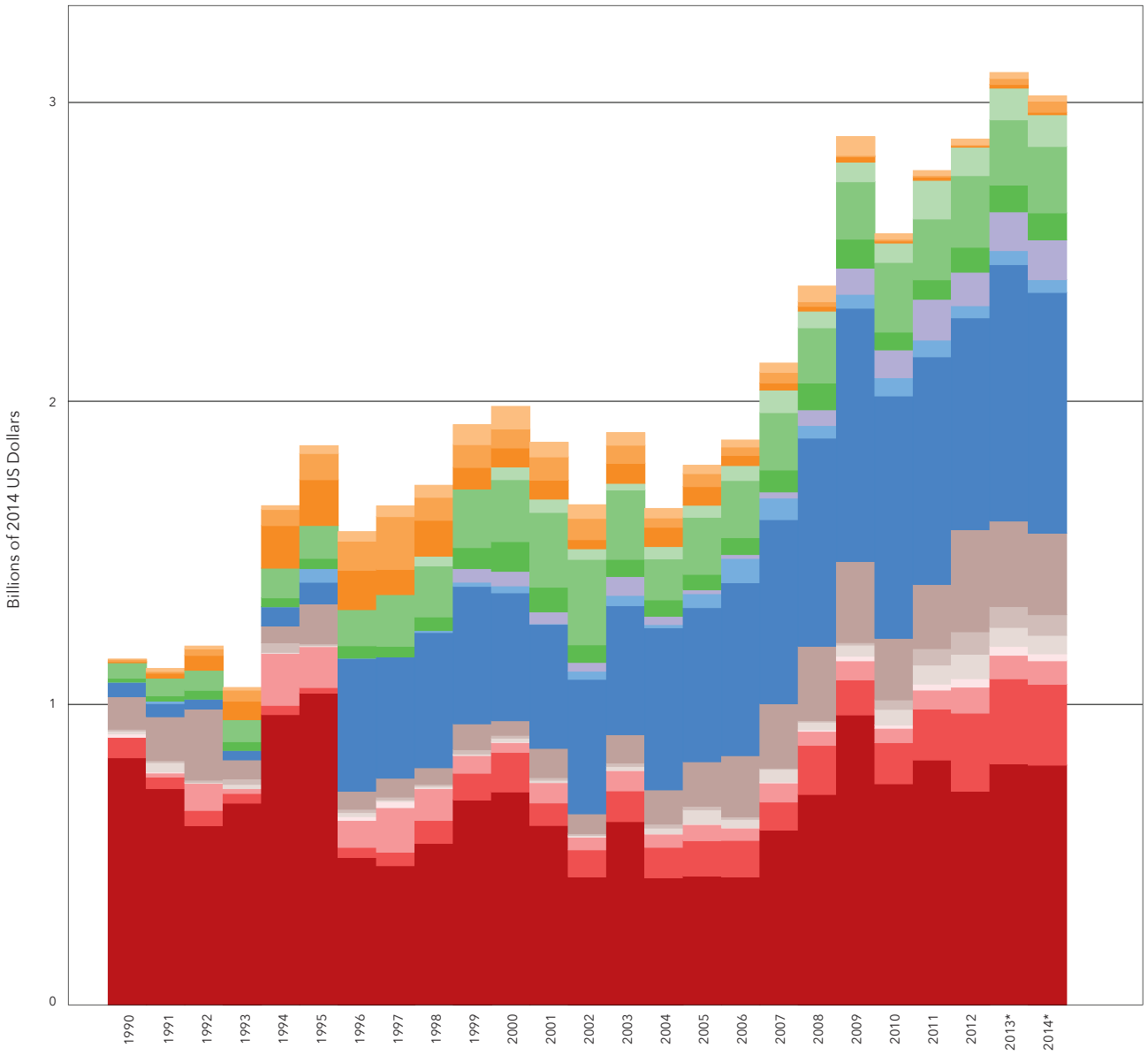
BOX 8

Maternal health and MDG 5

Millennium Development Goal 5 aimed to reduce the maternal mortality ratio (MMR), or the number of maternal deaths per 100,000 live births, by three-fourths between 1990 and 2015. From 1990 to 2013, MMR dropped by approximately 1.3% annually on a global level.[35] With minimal decreases in many countries, only 16 countries will likely achieve the MDG 5 target by 2015. However, 137 countries had higher annualized rates of change in MMR between 2003 and 2013 as compared to 1990 to 2003. In Asia, MMR reductions accelerated from 2003 to 2013, and in some countries, notably China, decreases in maternal mortality exceeded 8% in the past decade. In contrast, MMR in sub-Saharan Africa increased, largely related to the prevalence of HIV/AIDS. However, Eastern sub-Saharan Africa bucks the regional trend: MMR decreased at 4.5% annually since 2005.

FIGURE 23

DAH for maternal health by channel of assistance, 1990–2014



Regional development banks
World Bank – IBRD
World Bank – IDA
International NGOs
US NGOs
US foundations
BMGF
European Commission
WHO & UNFPA

BILATERAL AGENCIES

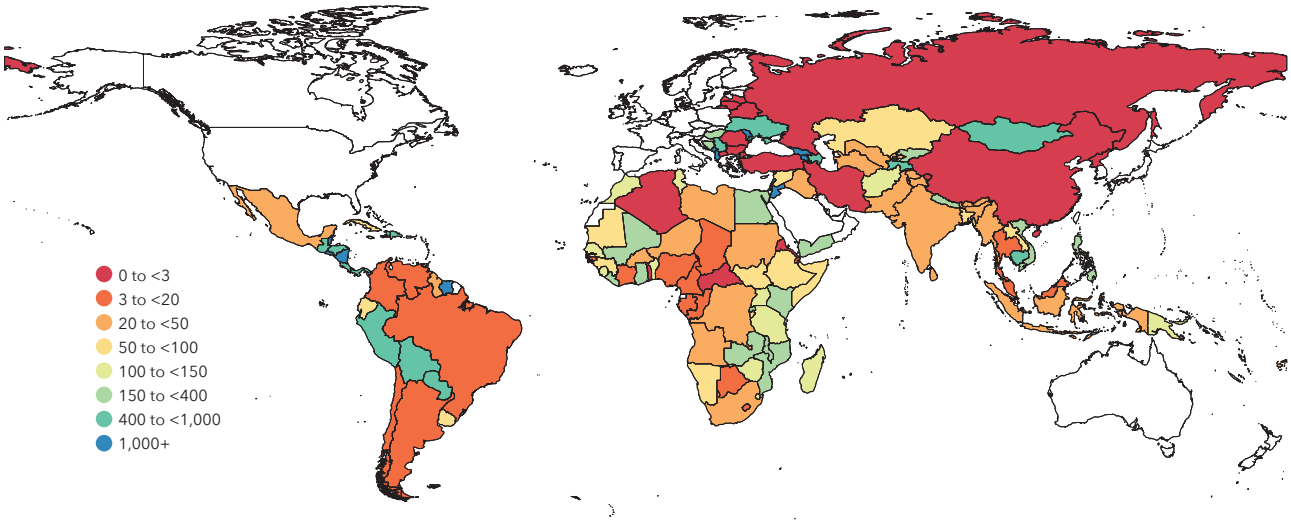
Other
Australia
Canada
France
Germany
UK
US

*2013 and 2014 are preliminary estimates based on information from the organizations listed, including budgets, appropriations, and correspondence.

Source: IHME DAH Database 2014

FIGURE 24

Maternal health DAH, 2010–2012, per related DALY, 2011



Notes: 2011 DALYs are estimated using the Global Burden of Disease Study 2010 and 2013. Countries that were ineligible for DAH based on their World Bank classifications are shown in white. DAH received is shown in real 2014 US dollars.

Sources: IHME DAH Database 2014, Global Burden of Disease 2010, 2013

The map provided in Figure 24 represents average maternal DAH over 2010 to 2012, as related to 2011 maternal DALYs. Substantial variation across geographies and income levels is present in Figure 24. Across sub-Saharan Africa, some countries, such as Madagascar and Tanzania, received more than $100 per DALY. Others, such as Botswana and Côte d'Ivoire, received less than $20 per DALY. Finally, some of the countries that received very high levels of child health DAH per DALY, notably Argentina, did not benefit from sizeable maternal DAH per DALY rates.

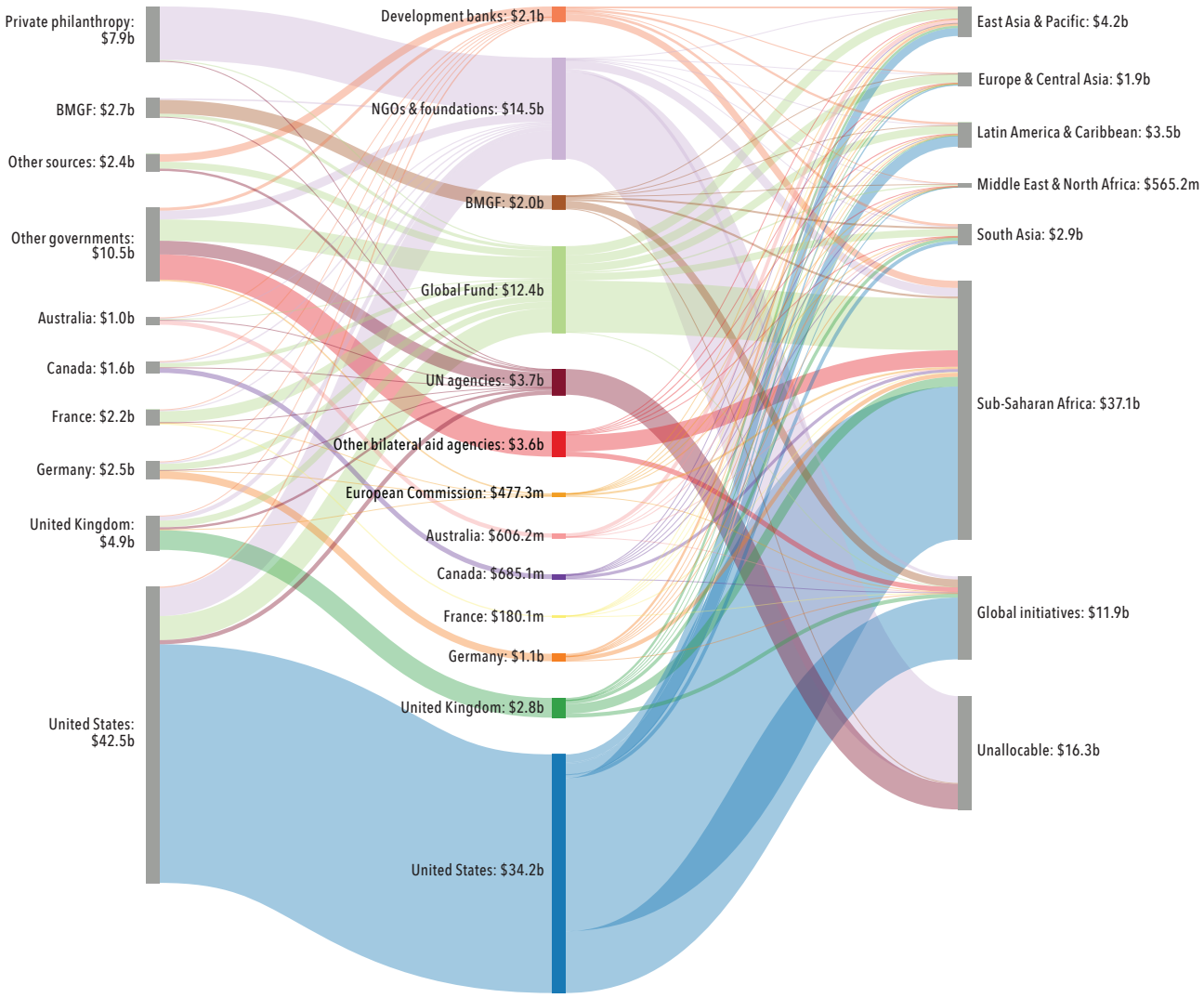
HIV/AIDS

During the MDG era, HIV/AIDS was brought to the forefront of international efforts to combat infectious disease. A multitude of new organizations were created, and existing organizations grew precipitously as part of efforts to prevent or treat HIV/AIDS. Increases in the DAH for HIV/AIDS, both in percentage and absolute terms, outpaced all other health focus areas during the height of DAH growth over 2000–2010. During this period, HIV/AIDS DAH rates of growth were 22.5% annually, and $57.5 billion cumulatively was disbursed to combat HIV/AIDS.

Since 2010, however, international funding for HIV/AIDS has leveled off at just under $11 billion annually, mirroring the slowdown observed in total development assistance for health. In 2014, total DAH for HIV/AIDS amounted to $10.9 billion, dropping 2.2% relative to 2013 disbursements. As HIV/AIDS DAH levels have stabilized, the Joint United Nations Programme on HIV/AIDS (UNAIDS) reports that domestic spending on HIV in low- and middle-income countries has increased. According to UNAIDS, 53% of total resources available for HIV originated in domestic sources in 2012.[36]

FIGURE 25

Flows of HIV/AIDS DAH from source to channel to recipient region, 2000–2012



Notes: Cumulative HIV/AIDS DAH from 1990 through 2012 in 2014 US dollars. Health assistance for which we have no recipient region information is designated as "unallocable."

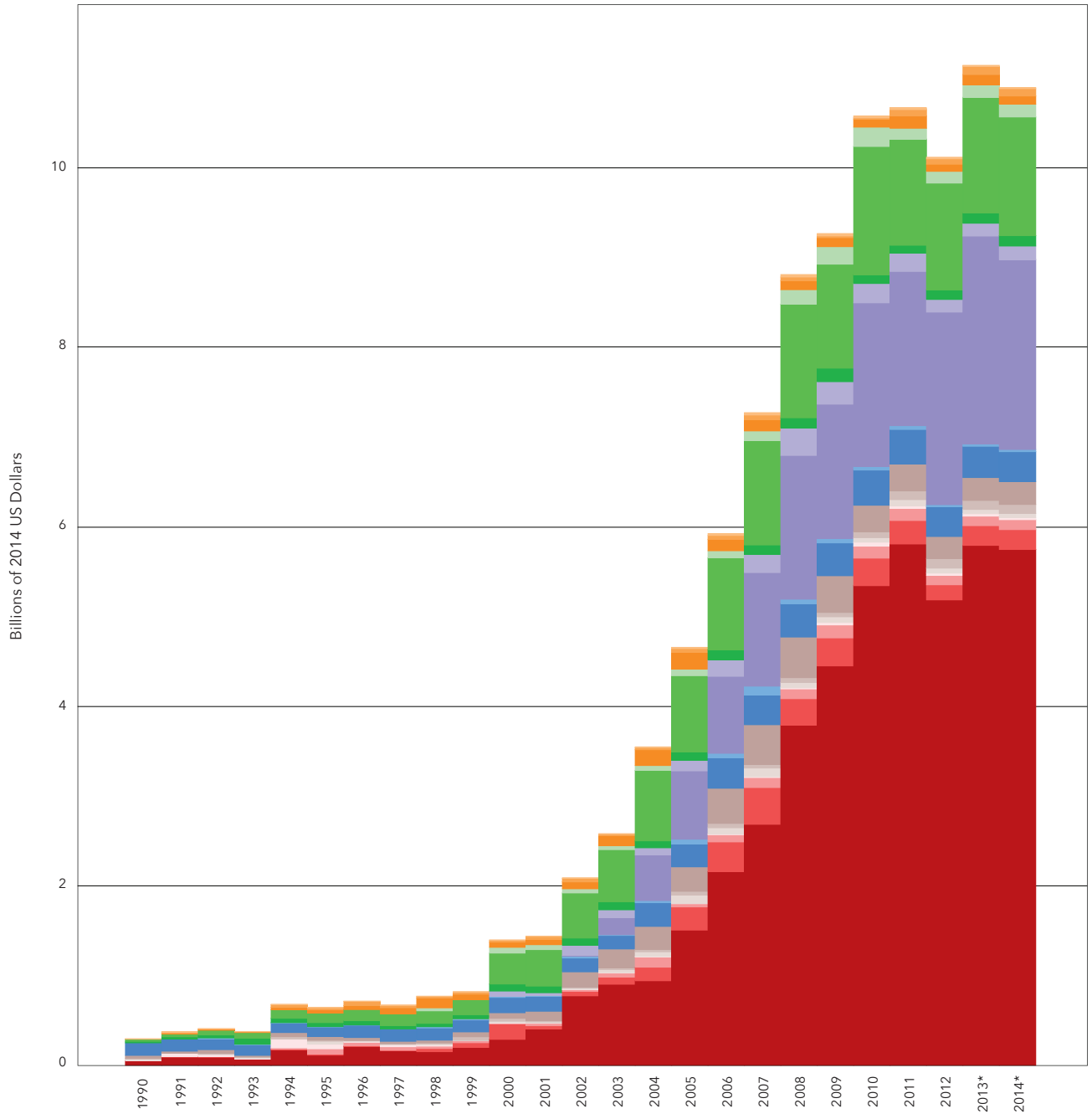
Source: IHME DAH Database 2014

Figure 25 illustrates the pivotal role the United States has played in fueling the fight against HIV/AIDS. In 2014, DAH for HIV/AIDS sourced from the US government amounted to $6.9 billion, with 83.6% of financing flowing through US bilateral channels. US-sourced funds were also channeled through the Global Fund and NGOs and foundations, which received 11.4% and 4.0%, respectively, of US-source DAH for HIV/AIDS. Over 2000–2012, an estimated $34.2 billion was disbursed for the health focus area by US bilaterals, and annual growth rates during this time were a substantial 27.2%. Furthermore, as represented in Figure 26, the US remains the single-largest funder of DAH for HIV/AIDS across all regions as well as global initiatives.

The United States President's Emergency Plan for AIDS Relief (PEPFAR) has been the US institution most active in this scale-up. Established in 2003 to combat rising HIV/AIDS prevalence and mortality, PEPFAR's goal was to distribute $15 billion in aid over five years to the 15 countries with the highest burdens of HIV/AIDS. With

FIGURE 26

DAH for HIV/AIDS by channel of assistance, 1990–2014



*2013 and 2014 are preliminary estimates.

Source: IHME DAH Database 2014

disbursement levels now surpassing that mark, PEPFAR has funded training for over 140,000 health care workers and other personnel to address HIV-related needs.[37,38]

However, in August 2012, the US government announced a scale-back in funding for HIV/AIDS. Figure 25 confirms this slow-down, showing US DAH for HIV/AIDS stable at around $5.6 billion per year between 2010 and 2014. Regardless, US President Barack Obama's 2013 State of the Union address reiterated the US's commitment to "realizing the promise of an AIDS-free generation."[39]

After the US, the UK was the next biggest single source of development assistance for health for HIV/AIDS, contributing $610 million, or 5.6% of the total in 2014. At 36.4% of total UK DAH, UK contributions also largely went through UK bilateral channels, such as its Department for International Development (DFID). The Global Fund was also a major beneficiary, with 26.5% of UK source funds flowing to the organization's HIV/AIDS work.

Private philanthropic sources (excluding BMGF) made up 6.4% of all HIV/AIDS contributions in 2014. Of the $692 million disbursed, 95.2% flowed to NGOs and foundations. Another 3.1% was provided to the Global Fund, totaling $21 million in 2014.

The Bill & Melinda Gates Foundation disbursed $310 million to HIV/AIDS as a source in 2014, making up 2.9% of all HIV/AIDS DAH. These funds were provided largely through the foundation itself (48.6%), although the Global Fund also benefited from $101 million, or 32.5% of total HIV/AIDS funding from the Gates Foundation.

Alongside PEPFAR, the establishment of the Global Fund was another key global response to the HIV/AIDS epidemic. Figure 25 shows the Global Fund's swift rise from its launch in 2002 to providing 19.4% of total DAH for HIV/AIDS in 2014. Total DAH for HIV/AIDS from the Global Fund was $2.1 billion in 2014, amounting cumulatively to $16.8 billion from 2002 to 2014. Growth in Global Fund DAH for HIV/AIDS has been high, standing at 58.6% annually since 2002. A diversity of funding sources supported

BOX 9

HIV/AIDS and MDG 6

MDG 6 aimed to halt the spread of HIV/AIDS by 2015, and on a global scale, trends indicate that incidence and mortality are slowing. In 2013, an estimated 29.2 million individuals were HIV-positive. However, with decreases in incidence of 1.6% annually since 2005, only 1.8 million new HIV infections were recorded in 2013. This compares markedly with 1997, when incidence rates peaked with 2.8 million people contracting the virus on an annual basis. The age-specific death rate from HIV/AIDS has also decreased, at an annual rate of 2.0% for developing countries between 2000 and 2013.

Decreases in mortality and incidence are related to the massive scale-up of HIV/AIDS treatment and prevention activities. Since the launch of the MDGs in 2000, the reach of prevention of mother-to-child transmission (PMTCT), co-trimoxazole prophylaxis, and antiretroviral (ART) treatment has expanded substantially. This has contributed to saving an estimated 19.1 million life-years – the years lived by all people who might have contracted and died from HIV without these and other interventions. Approximately 13.7 million, or 71.8% of these life-years, are concentrated in the period of 2009–2013 when these treatments were rapidly scaled.

the Global Fund's work on HIV/AIDS in 2014, including a substantial amount from governments besides the United States and the United Kingdom. The United States provided $785 million in DAH to the Global Fund for HIV/AIDS, while the UK was the source of $162 million. However, funds sourced from France ($284 million), Germany ($163 million), and Japan ($110 million) also considerably supported the HIV/AIDS work of the public-private partnership.

NGOs and foundations also figure prominently in the fight against HIV/AIDS. Among the NGOs that IHME is able to track, including some internationally based NGOs, $1.6 billion in DAH was collectively provided in 2014, or 14.5% of HIV/AIDS DAH. Annualized growth rates for DAH for HIV/AIDS from NGOs and foundations have amounted to 8.8% from 2000 to 2014. Most of these funds are sourced from private philanthropic efforts, including private individual and corporate donations and other types of fundraising, at $660 million, or 41.8% of the total for NGOs and foundations working on the cause of HIV/AIDS. The US was the second-largest source of funds, with 17.4%, or $275 million, provided to these entities.

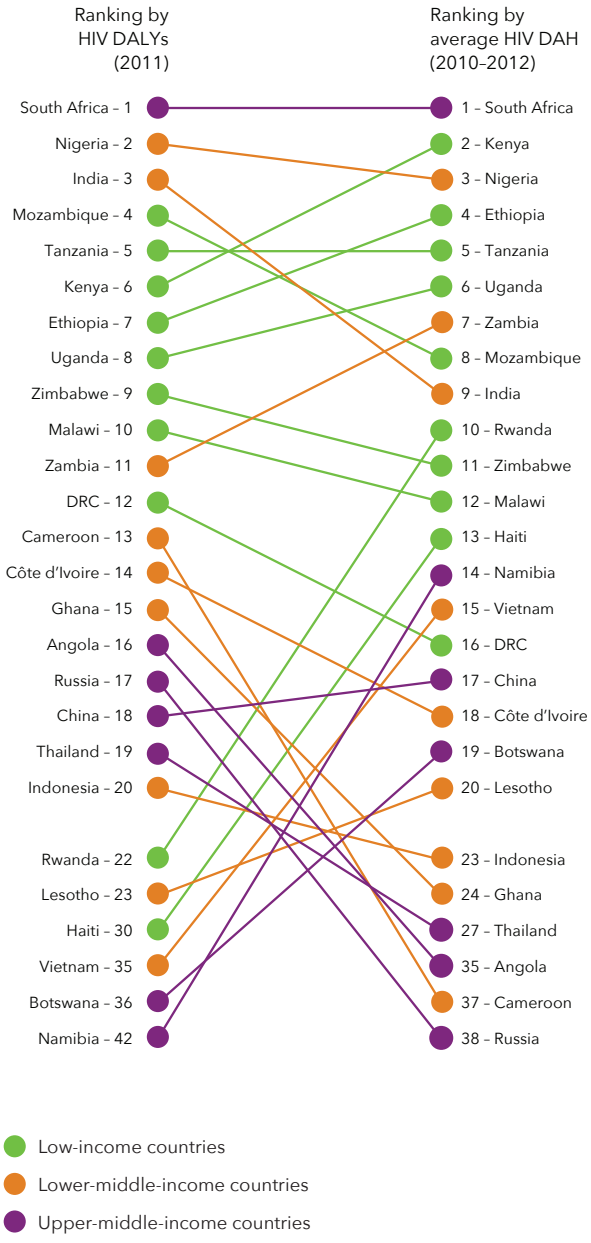
UN agencies and development banks are less prominent than other channels in HIV/AIDS funding. UNAIDS, with WHO, UNICEF, the United Nations Population Fund (UNFPA), and the Pan American Health Organization (PAHO), channeled $333 million in DAH for HIV/AIDS in 2014. Since its establishment in 1996, UNAIDS has alone channeled $3.8 billion, with growth of 4.9% annually since 2000. Development banks provided $185 million, 1.7% of HIV/AIDS funding, in 2014.

Figure 26 represents the flow of HIV/AIDS DAH from source to channel to low- and middle-income countries, as distinguished by region, from 2000 to 2012. Sub-Saharan Africa, which has suffered from the largest share of burden, at 82.7% of all HIV/AIDS DALYs in 2011, received the most DAH. At $1.9 billion in 2012, 39.0% of all HIV/AIDS DAH flowed to sub-Saharan Africa. The US provided 21.9% of all HIV/AIDS DAH for sub-Saharan Africa, which totaled $414 million. The UK sourced $256 million, or 13.5% of funds for sub-Saharan Africa. The majority of the Global Fund DAH for HIV/AIDS, $1.4 billion or 65.4%, was also provided for activities in sub-Saharan Africa in 2014.

Global initiatives, which include international AIDS conferences, the development of global treatment guidelines, and other international activities, also drew

FIGURE 27

Top 20 countries by 2011 HIV/AIDS burden of disease versus average 2010-2012 DAH

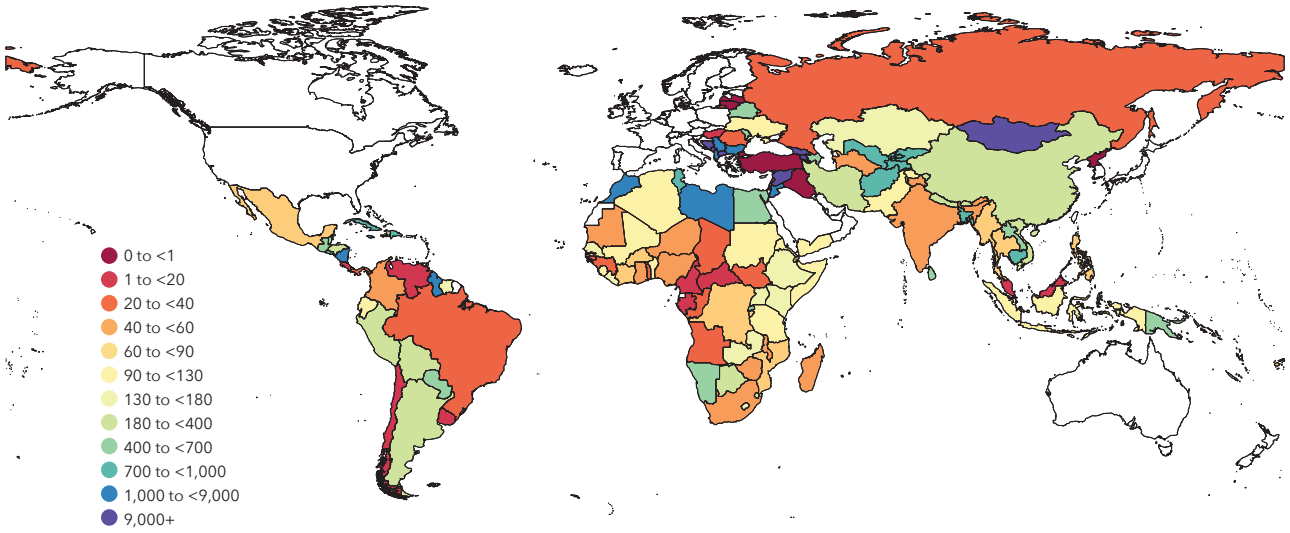


Notes: 2011 DALYs are estimated using Global Burden of Disease Study 2010 and 2013.

Sources: IHME DAH Database 2014, Global Burden of Disease Study 2010, 2013

FIGURE 28

HIV/AIDS DAH, 2010–2012, per related DALY, 2011



Notes: 2011 DALYs are estimated using the Global Burden of Disease Study 2010 and 2013. Countries that were ineligible for DAH based on their World Bank classifications are shown in white. DAH received is shown in real 2014 US dollars.

Sources: IHME DAH Database 2014, Global Burden of Disease Study 2010, 2013

a substantial portion of HIV/AIDS funds, amounting to 32.1%, or $1.6 billion in 2012. The US contributed the lion's share, at 89.9%, or $1.4 billion in 2012, to global HIV/AIDS activities.

Figure 27 provides rankings of countries by the DALYs attributed to HIV in 2011 and the average DAH disbursed from 2010 to 2012. South Africa is at the top of both lists, with 6.2 million HIV-positive people in 2013 and approximately $791 million in DAH provided to the country from 2010 to 2012. In terms of prevalence, the presence of HIV/AIDS is highest in Botswana, Lesotho, and Swaziland, at more than 12,000 cases per 100,000 people. Because both Lesotho and Botswana have very small populations, they did not rise to the top 20 in DALY rankings, but were among the 20 highest DAH recipients. Botswana, China, Namibia, and South Africa were the only four countries designated as upper-middle-income on the HIV/AIDS DAH list, which for the most part was made up of low- and lower-middle-income countries. The HIV/AIDS DAH disbursed for Malawi, Nigeria, Tanzania, Uganda, and Zimbabwe was all fairly well-aligned, standing just one or two slots above or below their DALY ranking. Many of the other countries on the DALY list fall much farther from their DAH ranking.

In Figure 28, the HIV/AIDS DAH per DALY is depicted for all low- and middle-income countries. There is diversity in funding flows per unit of burden of HIV/AIDS. Rates of disbursement per DALY are also the highest in this health focus area. Where the HIV/AIDS epidemic is most prominent, in many countries in Southern and Eastern Africa, DAH has reached approximately $170 per disability-adjusted life year, on average, as was true in Kenya over 2010–2012. Libya, Morocco, Namibia, and Tunisia also stand out, where more than $500 per HIV/AIDS DALY was received. Mongolia and a few countries in Eastern Europe and Central Asia also received substantial sums relative to the nations' HIV/AIDS burden. Argentina, Bolivia, and Paraguay, each with lower than 0.2% prevalence of HIV/AIDS, also received approximately $300 in DAH per DALY.

MALARIA

Malaria, a mosquito-borne disease most prevalent in sub-Saharan Africa, predominantly affects children under 5, although research shows that malaria also has an impact on adults.[40] Reducing malaria incidence over 2000–2015 was another key global target embodied in MDG 6. Development assistance partners responded in turn, establishing a number of initiatives and ramping up funding for this health focus area after 2000.

As shown in Figure 29, development assistance for malaria reached an all-time high of $2.4 billion in 2014, climbing 0.4% over 2013 levels. From the launch of the MDGs in 2000 to 2014, $19.0 billion in cumulative malaria DAH has been disbursed. DAH for malaria increased rapidly from 2000 to 2010, with 24.8% in growth annually. However, much like HIV/AIDS, malaria DAH has slowed since 2010, hovering around $2 billion annually over those four years.

Also similar to HIV/AIDS, malaria funding flows are not extensively diversified, with one key organization, the Global Fund, channeling 49.5% of all malaria DAH in 2014. In 2014, the Global Fund provided $1.2 billion to malaria control and prevention. Concurrently, the organization embarked on improvements to its procurement system, including instituting structures to pool orders from countries.[41] With this capacity in place, the Global Fund announced the single largest order for mosquito nets in history in 2014, purchasing around 90 million nets for protection against malaria's central vector, the mosquito. While the Global Fund received 37.1% and 7.6%, respectively, from the US and the UK as sources, the vast majority of funds flowed from other high-income governmental sources, at $532 million, or 45.1% of total Global Fund receipts in 2014.

The United States government is the largest source of DAH for malaria, contributing $1.1 billion, or 44.5% of malaria DAH, in 2014. Similar to the DAH the US provides for HIV/AIDS, 41.3% of its malaria dollars are deployed in support of the Global Fund. US bilateral aid agencies were supplied with 56.6% of US source DAH. US bilateral channels, primarily USAID and the President's Malaria Initiative (PMI), channel the most substantial amount of DAH to malaria activities sourced from the US. US DAH for malaria climbed from 2007 to 2011, growing 54.9% annually during that time. Over the last four years, however, US bilateral DAH for malaria has stagnated at around $600 million. In 2014, US bilateral agencies spent just under $600 million on malaria, an amount essentially unchanged from 2013 levels.

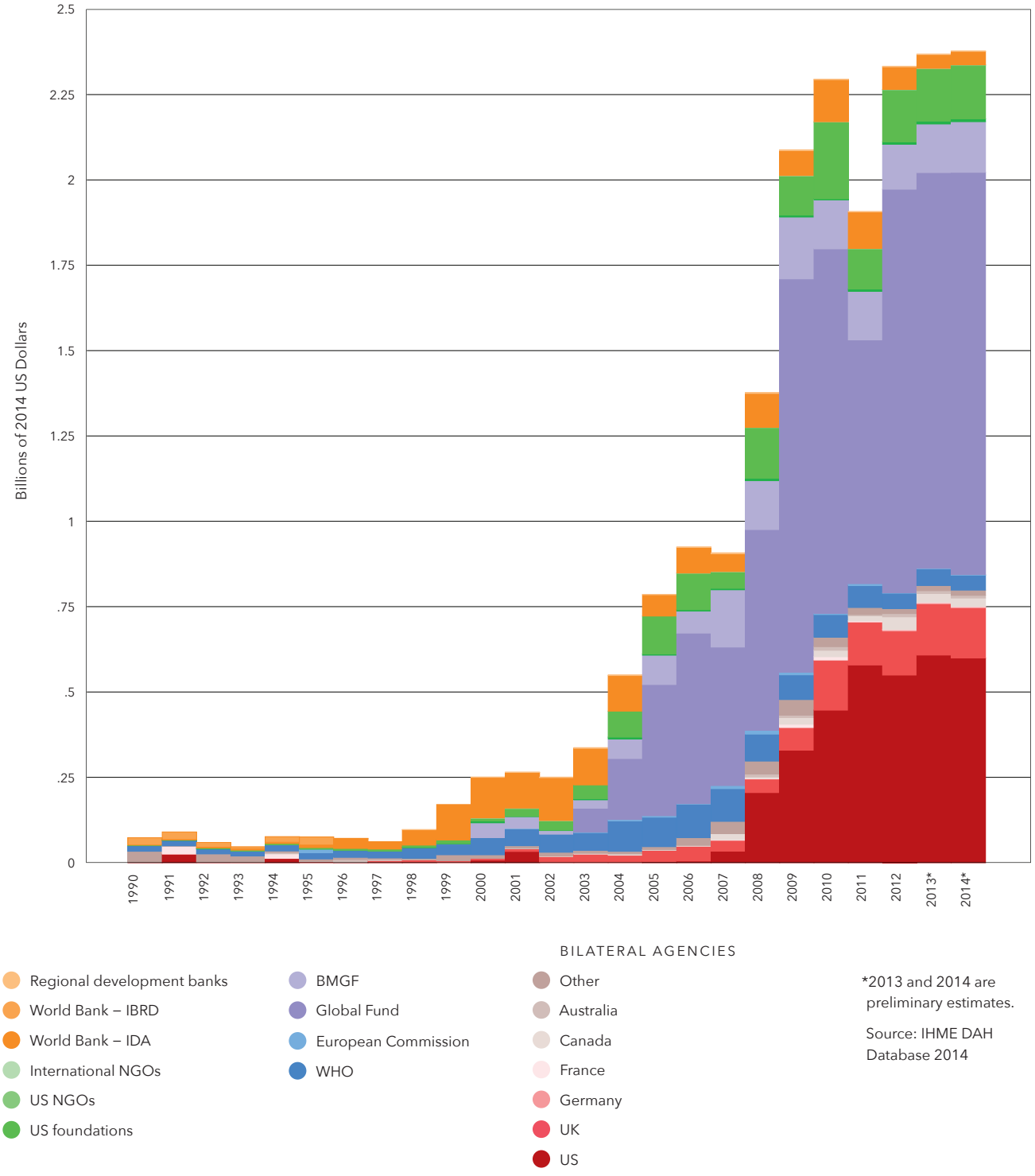
The United Kingdom also provided $279 million for malaria in 2014. UK bilateral DAH, at a total of $147 million in 2014, dropped 2.0% over 2013. Other channels in receipt of UK government source funds included the Global Fund (32.2%) and development banks (1.6%).

Across health focus areas, the contribution provided by an array of other high-income governments was also substantial for malaria. Germany, for instance, provided $106 million, or 4.5%, and France provided $166 million, or 7.0%, to malaria activities in 2014. Canada and Australia channeled less DAH for malaria in 2014, disbursing $24 million and $8 million, respectively.

Private actors complete the set of sources active in funding DAH targeting malaria. Private philanthropic sources (other than BMGF) provided $12 million to the Global Fund in 2014 but disbursed more to NGOs and foundations, which received $31 million from other private philanthropic sources. NGOs play a range of roles in preventing and treating malaria in the developing world, from distributing

FIGURE 29

DAH for malaria by channel of assistance, 1990–2014

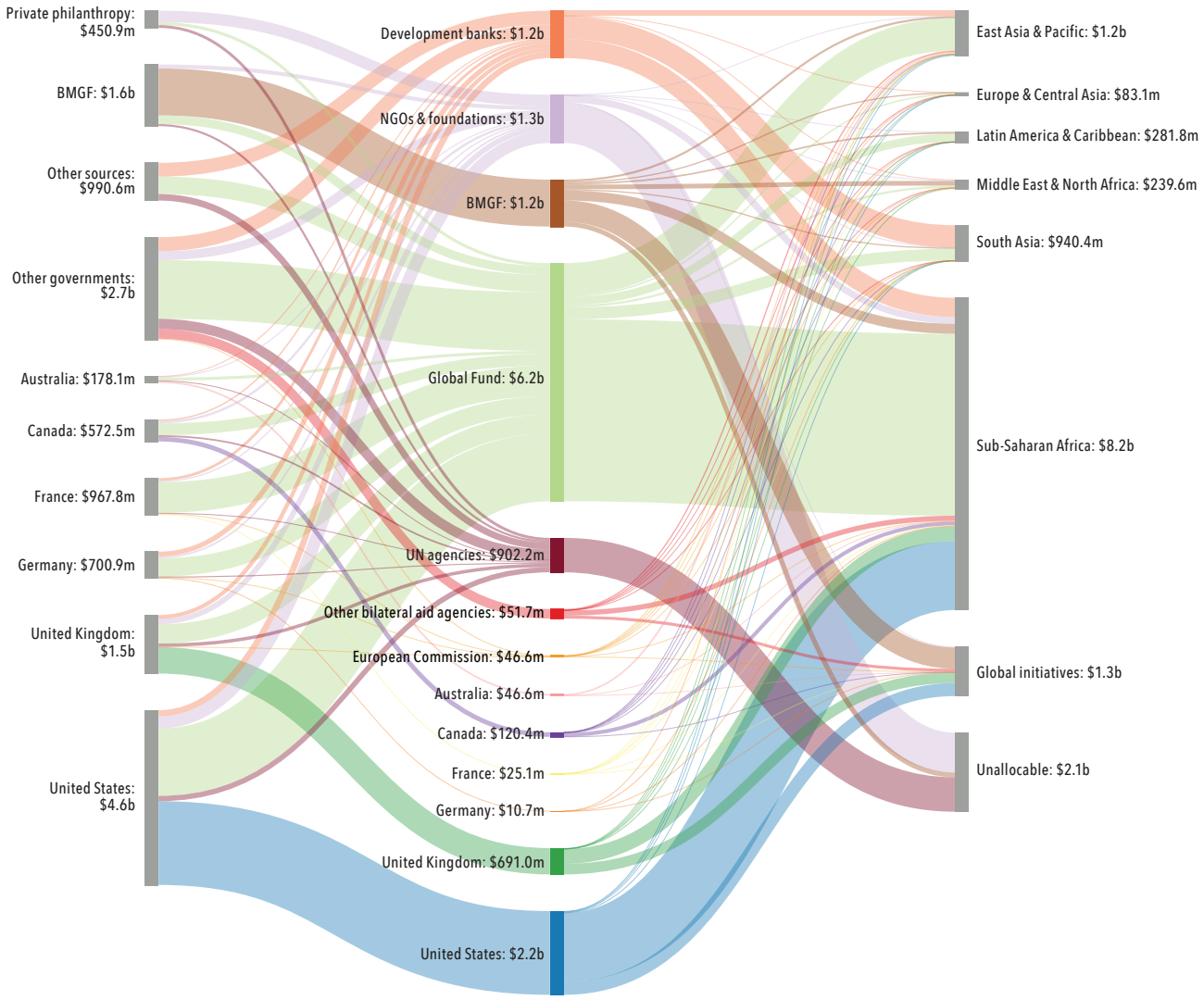


*2013 and 2014 are preliminary estimates.

Source: IHME DAH Database 2014

FIGURE 30

Flows of malaria DAH from source to channel to recipient region, 2000–2012



Notes: Cumulative malaria DAH from 1990 through 2012 in 2014 US dollars. Health assistance for which we have no recipient region information is designated as "unallocable."

Source: IHME DAH Database 2014

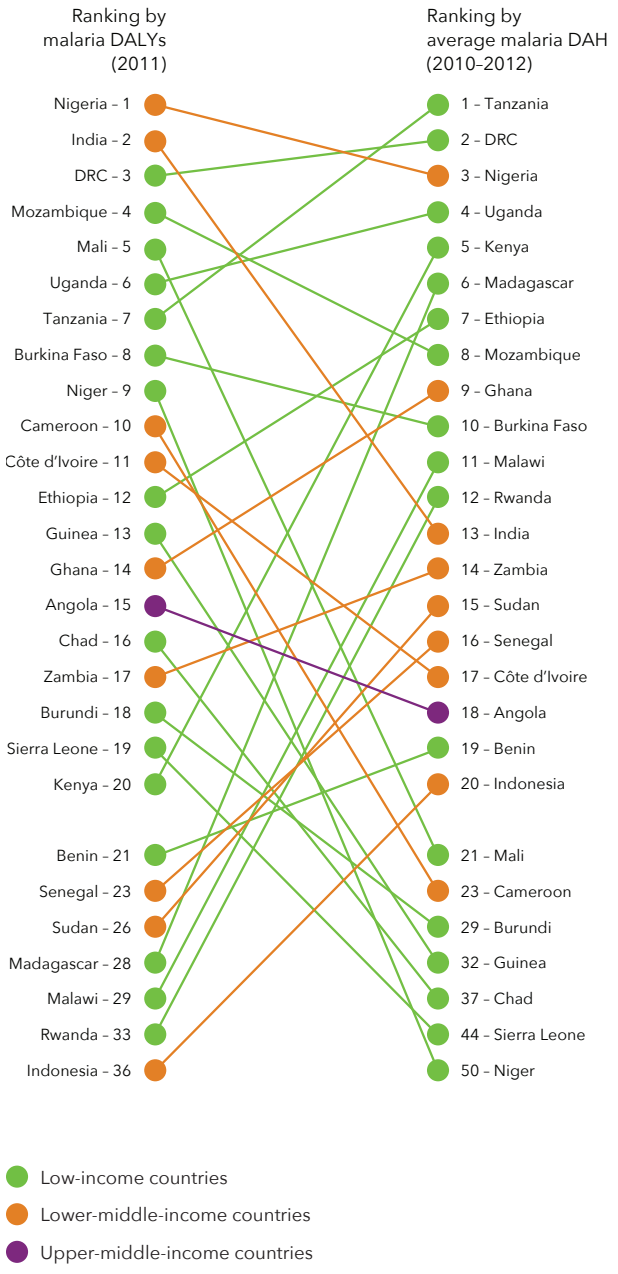
bed nets to directly treating adults and children who contract the acute febrile illness. NGOs provided 7.0% of DAH to malaria in 2014 and have expended a cumulative $1.6 billion from the launch of MDG 6 in 2000 to 2014, growing 19.1% annually during that period.

The Bill & Melinda Gates Foundation, which supports new treatments, vaccines, diagnostic tools, and other activities in the fight against malaria, was the source of 9.7% of DAH for this health focus area.[42] BMGF was the source of $230 million in DAH for malaria activities in 2014. Of this total, 64.5% flowed through the foundation as a channel, growing 4.2% over 2013 levels. The Global Fund is also a key beneficiary of BMGF malaria funding, with 24.4% of total BMGF DAH for malaria flowing to the PPP in 2014.

Figure 30 depicts the monetary flows from sources of malaria DAH to channels and to the regions of the world where malaria DAH is expended. As shown in Figure 30, sub-Saharan Africa received the largest portion of DAH. Between 2000

FIGURE 31

Top 20 countries by 2011 malaria burden of disease versus average 2010–2012 DAH



Notes: 2011 DALYs are estimated using Global Burden of Disease Study 2010 and 2013.

Source: IHME DAH Database 2014

and 2012, 57.3% of malaria DAH, a total of $8.2 billion, was provided to the subcontinent to combat malaria. This aligns relatively well with burden, as malaria is most prevalent in sub-Saharan Africa, where the disease contributed to 17.6% of child deaths in 2013. Funding was channeled most prominently by the Global Fund, which provided a total of $4.8 billion to sub-Saharan African countries, 76.4% of its malaria spending from 2000 to 2012. The US channel provided DAH of $1.8 billion, or 82.2% of its funds for malaria, to sub-Saharan Africa over 2000 to 2012.

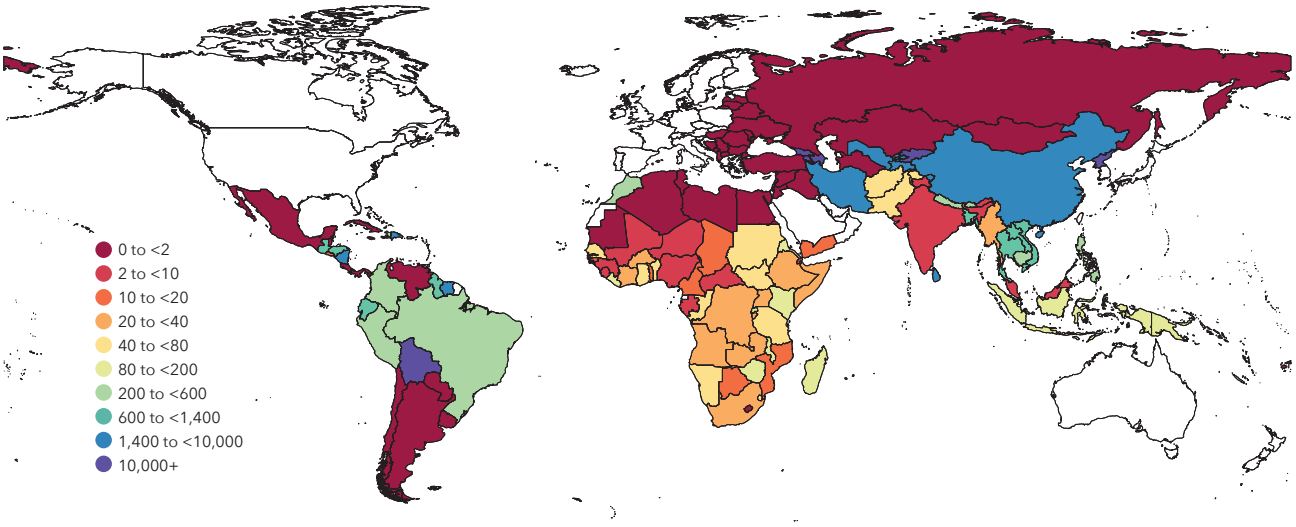
Among the remaining DAH regional recipients, channels and sources of support for malaria are mixed. Global malaria initiatives received $138 million in support in 2012, 5.9% of the total. South Asia, with 9.3% of malaria DALYs in 2013, was the recipient of development assistance for malaria amounting to $98 million in 2012, or 4.2% of total DAH for malaria. South Asia's malaria DAH was channeled predominantly through development banks, with $29 million received from these entities. East Asia and the Pacific, with 1.7% of malaria DALYs in 2013, received 7.4% of total malaria DAH, amounting to $173 million in 2012. The Global Fund provided a great deal of funds to these two regions as well, with $67 million provided to South Asia and $134 million provided to East Asia and the Pacific for malaria activities in 2012.

As shown by Figure 31, upper-middle-income countries do not feature prominently among the countries with the highest burden of malaria. This underlines the relationship between income level and prevalence of the disease. Angola is the only upper-middle-income country on both lists. Nigeria, as the most populous country in sub-Saharan Africa, tops the list of DALYs but received only the third-highest level of DAH. Tanzania and the Democratic Republic of the Congo (DRC), which have lower per-person income than Nigeria, received the most DAH targeting malaria. India, the second-largest country in the world, has the second-highest number of malaria DALYs. India is the only non-sub-Saharan African country to rank in the top 20 countries with the highest malaria burden. However, India did not receive substantial DAH over 2010–2012, on average, and is ranked 13th on the list of malaria DAH recipients.

Among countries with prevalence of malaria in 2011, the average 2010–2012 malaria DAH per 2011 malaria DALY is represented in Figure 32. This figure shows that where malaria is most prevalent, across sub-Saharan

FIGURE 32

Malaria DAH, 2010–2012, per related DALY, 2011



Notes: 2011 DALYs are estimated using Global Burden of Disease Study 2010 and 2013. Countries that were ineligible for DAH based on their World Bank classifications are shown in white. DAH received is shown in real 2014 US dollars.

Sources: IHME DAH Database 2014, Global Burden of Disease Study 2010, 2013

Africa, DAH per DALY rates tend to be low. Because of the high level of burden, rates generally stood below $40 per DALY. Countries such as Kenya, Madagascar, South Sudan, Sudan, and Zimbabwe benefited from more DAH per unit of burden, however, with upward of $40 per DALY provided on average between 2010 and 2012.

Thirty-four low-burden countries have been designated as on the verge of malaria elimination.[43] As these countries approach elimination and malaria persists in hard-to-reach populations, efforts to stamp out the disease tend to become more costly. For some of these countries, primarily outside of sub-Saharan Africa, DAH per DALY disbursements are much higher, and burden of malaria is less pronounced. China, for instance, and a number of other low- and middle-income countries were provided with more than $200 per DALY for malaria. The low level of burden, combined with fairly modest absolute levels of DAH, drives these rates.

BOX 10

Malaria and MDG 6

Malaria, a mosquito-borne infectious disease prevalent in low- and middle-income countries, is another core focus of Millennium Development Goal 6, which called for the halt of malaria's spread and the reversal of its rate of incidence by 2015. Global Burden of Disease 2013 estimates indicate that there were 232 million malaria cases and 1.2 million deaths attributed to malaria in 2003.[44] Since then, decreases in incidence and mortality have been observed. From 2003 to 2013, malaria incidence fell by 28.9%, with just 165 million new cases in 2013. The number of annual malaria deaths also declined to approximately 855,000 in 2013, a 30.1% decrease in mortality since 2003.

TUBERCULOSIS

Of the three infectious diseases mentioned explicitly in MDG 6, TB received the least development assistance for health. As shown in Figure 33, in 2014, $1.4 billion in DAH was disbursed for TB. This is a 9.2% drop from 2013, when international funding for the infectious disease reached a peak of $1.5 billion. Over 2000–2014, DAH for TB increased substantially, with growth rates of 17.7% annually. A total of $12.0 billion was disbursed overall for the health focus area over that period. Even so, the Global Tuberculosis Report 2014 highlighted a $2 billion gap in financing for tuberculosis prevention, diagnosis, and treatment.[45]

Figure 34 depicts transfers of DAH for TB from sources to channels and from channels to regional groupings. As with malaria, the Global Fund is the key channel in the fight against tuberculosis. In 2014, the Global Fund accounted for 50.2% of international funding for the disease, channeling $690 million in TB DAH. This includes resources for multi-drug-resistant TB (MDR-TB), which is of growing concern because it is more difficult and more costly to treat. The DAH channeled by the Global Fund bumped up considerably in 2013, and thus the decrease in 2014 sets contributions at $690 million, still a $100 million increase over 2012.

Unlike the distinct US efforts for malaria and HIV/AIDS, the United States has not established a separate entity focused solely on TB. However, the largest single source of TB DAH in 2014 was still the United States, which provided $501 million, or 36.5% of TB DAH. Of this total, 51.1% flowed through the Global Fund, and 42.8% was provided through US bilateral channels. US aid agencies provided $214 million to TB in 2014, the second-highest among channels. In 2014, US bilateral DAH for TB remained steady relative to the previous two years; the US sustained aid agencies' efforts at around $215 million annually over 2012-2014.

The Bill & Melinda Gates Foundation, from its inception, has provided support for tuberculosis prevention and treatment. With total, cumulative TB DAH at $1.7 billion over 1999-2014, this contribution has grown 29.9% annually. In 2014, BMGF provided $173 million, 12.6% of total DAH for TB.

BOX 11

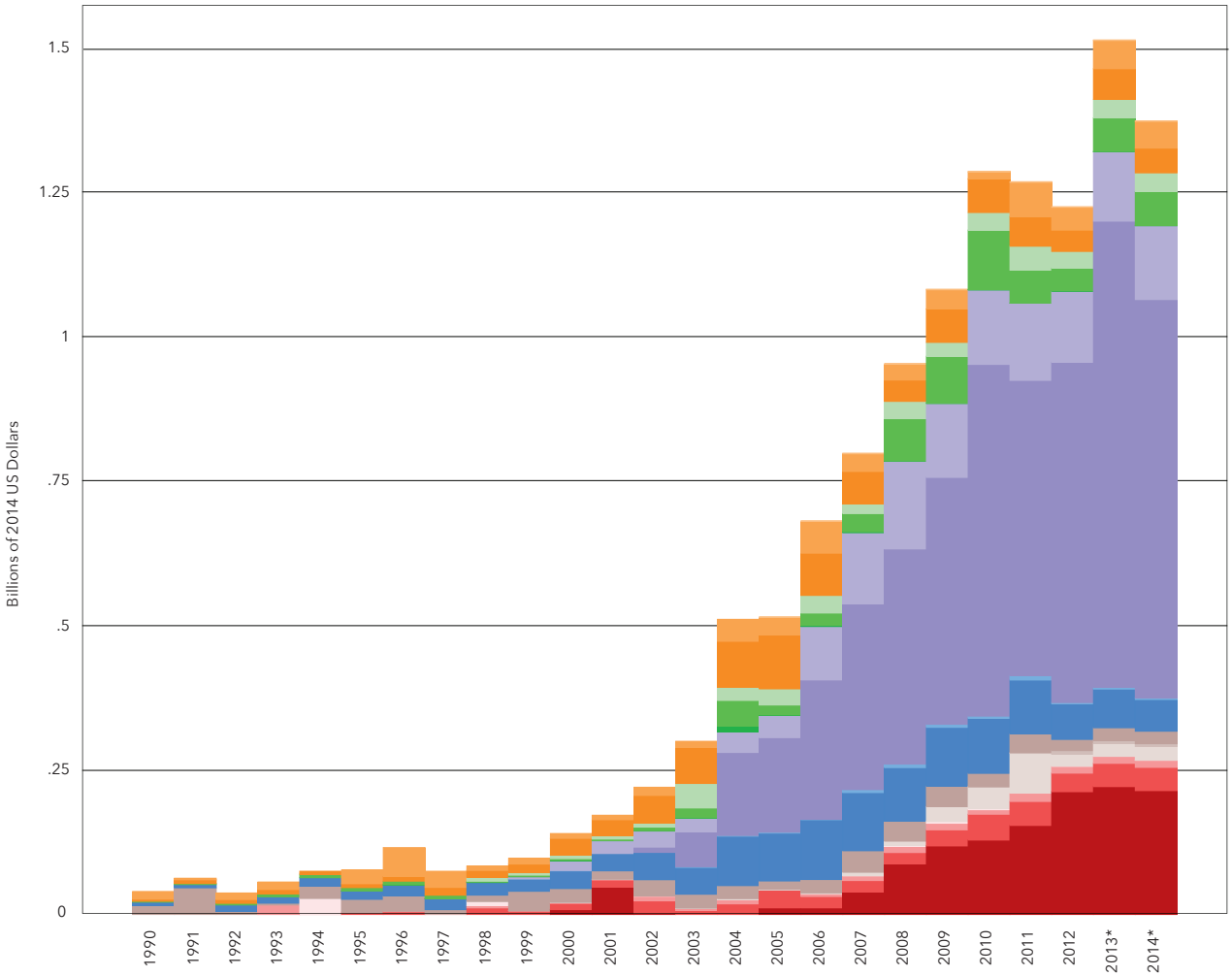
Tuberculosis and MDG 6

TB is a third pillar of MDG 6, encompassed under "other infectious diseases." While TB deaths have decreased globally since 1990, incidence of tuberculosis rose with the spread of HIV/AIDS. In 2013, inclusive of tuberculosis in HIV-positive individuals, all-form tuberculosis incidence was 7.5 million, prevalence was 11.9 million, and 1.4 million deaths occurred. After 2000, annualized rates of change for all three metrics, incidence, prevalence, and deaths, began declining. Prevalence dropped 1.3% annually from 2000 to 2013, driven largely by decreases observed in East and South Asia.

With TB incidence dropping, WHO and other TB stakeholders have begun to set their sights on more ambitious targets in the fight against the disease. In May 2014, the World Health Assembly approved the post-2015 global TB plan, known as the End TB Strategy, which establishes a target of a 95% reduction in TB deaths and a 90% reduction in TB incidence by 2035.[49]

FIGURE 33

DAH for tuberculosis by channel of assistance, 1990–2014



- Regional development banks
- World Bank – IBRD
- World Bank – IDA
- International NGOs
- US NGOs
- US foundations
- BMGF
- Global Fund
- European Commission
- WHO

BILATERAL AGENCIES

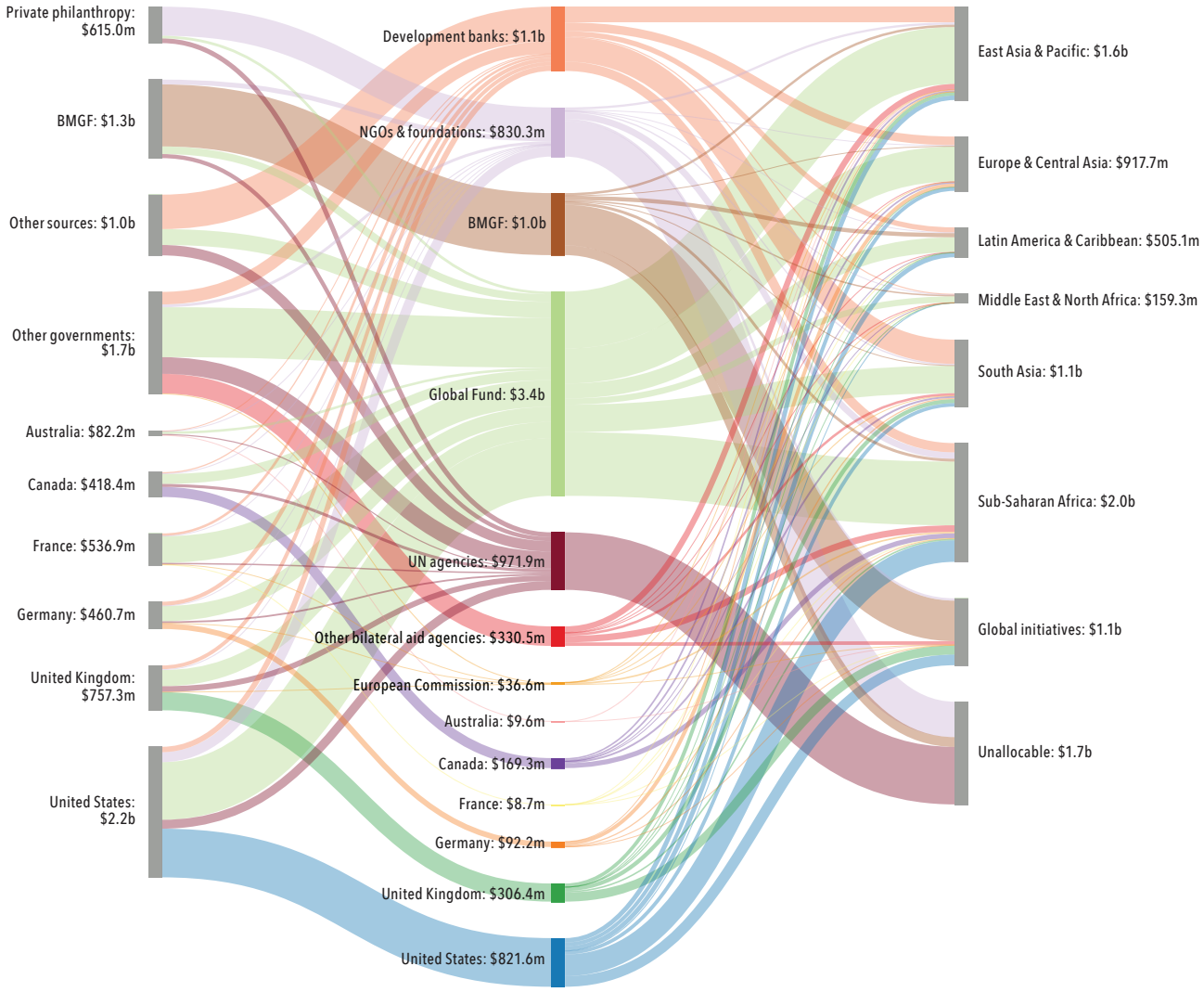
- Other
- Australia
- Canada
- France
- Germany
- UK
- US

*2013 and 2014 are preliminary estimates.

Source: IHME DAH Database 2014

FIGURE 34

Flows of tuberculosis DAH from source to channel to recipient region, 2000–2012



Notes: Cumulative tuberculosis DAH from 1990 through 2012 in 2014 US dollars. Health assistance for which we have no recipient region information is designated as "unallocable."

Source: IHME DAH Database 2014

Among other sources, the UK and other private philanthropic funds have also supported TB activities generously. The UK government was the source of $107 million, or 7.7% of TB DAH in 2014. Of this, 49.2% flowed through the Global Fund. Another 37.6%, or $40 million, was provided through UK bilateral channels, which remained steady relative to 2013 levels. At 5.2% of all DAH for TB, or $72 million, private philanthropic funding (other than BMGF) was directed mainly through NGOs and other foundations (84.4%). These organizations (not including BMGF) were supplied with $92 million for their TB activities in 2014, a 0.9% increase over 2013 expenditure.

In 2014, other high-income governments were also a major source of TB DAH. High-income countries prominent in sourcing DAH for TB were France (7.0%, or $96 million), Germany (5.1%, or $70 million), Japan (3.4%, or $47 million), Australia (2.2%, or $30 million), and Canada (4.7%, or $65 million). More than 77.7% of this collective source DAH was provided to the Global Fund, while

significantly less of these governmental funds were provided through bilateral channels (14.3%).

The WHO and other UN agencies have long played a role in supporting developing countries to prevent and treat TB. In 1990, UN agencies furnished 14.7% of total DAH for TB. Many other channels have grown exponentially since then, but UN agencies have increased at a steady 9.8% annually since that year. Total support for TB through the UN in 2014 amounted to $55 million.

In terms of the regional distribution, TB DAH flows predominantly to sub-Saharan African countries. The region received $402 million, 32.8% of the total DAH for tuberculosis in 2012. East Asia and the Pacific, with 80.3% of its funding provided by the Global Fund, received $239 million in 2012, 19.5% of total TB DAH. South Asia was funded with lower levels of DAH from the Global Fund but still received 67.3% of its total TB DAH from the PPP. South Asia benefited from $101 million, 8.2% of total DAH for TB.

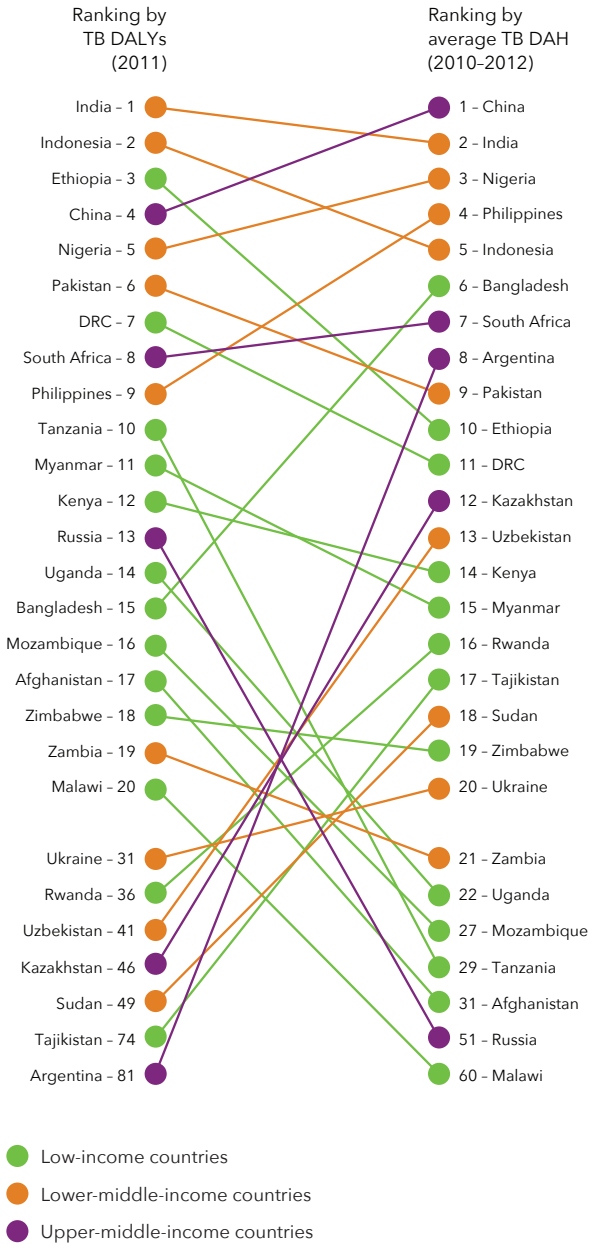
Global initiatives for TB received $88 million in support in 2012. A multitude of international efforts focus on combating the spread and impact of TB, including the TB Alliance, the TB Drug Accelerator initiative, and the Critical Path to TB Drug Regimens, which are collaborating to develop new treatments for TB, including MDR-TB.[46,47,48] These types of global efforts are funded principally by BMGF, which provided $685 million, or 60.1% of the total for global initiatives from 2000 to 2012. After BMGF, the US directed $181 million, or 16.0% of DAH, for global initiatives to combat TB.

Figure 35 highlights the countries suffering from the highest TB burden, as measured by DALYs. Three upper-middle-income countries – China, Russia, and South Africa – are present among those countries with top DALYs. Because of the range of income levels, the alignment of 2011 TB DALYs with highest average TB DAH levels over 2010–2012 is poor relative to malaria and HIV/AIDS.

Finally, Figure 36 displays the average, country-specific levels of TB DAH, from 2010 to 2012, per TB DALY in 2011. Most countries did not receive substantial amounts of TB DAH per DALY. This is particularly true in sub-Saharan Africa, where most countries received less than 25 cents per TB DALY. However, Argentina, as well Cuba, Guyana, Paraguay, Tunisia, and a few countries in Eastern Europe, the Middle East, and Central Asia, were recipients of more than $200 per DALY for TB.

FIGURE 35

Top 20 countries by 2011 tuberculosis burden of disease versus average 2010–2012 DAH

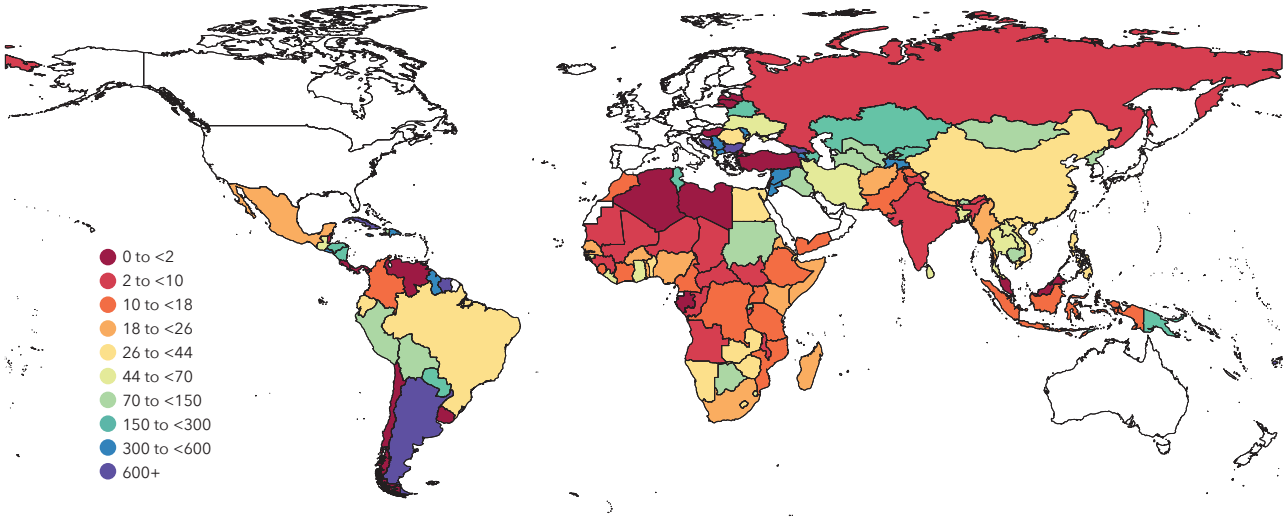


Notes: 2011 DALYs are estimated using Global Burden of Disease Study 2010 and 2013.

Sources: IHME DAH Database 2014, Global Burden of Disease Study 2010, 2013

FIGURE 36

Tuberculosis DAH, 2010–2012, per related DALY, 2011



Notes: 2011 DALYs are estimated using Global Burden of Disease Study 2010 and 2013. Countries that were ineligible for DAH based on their World Bank classifications are shown in white. DAH received is shown in real 2014 US dollars.

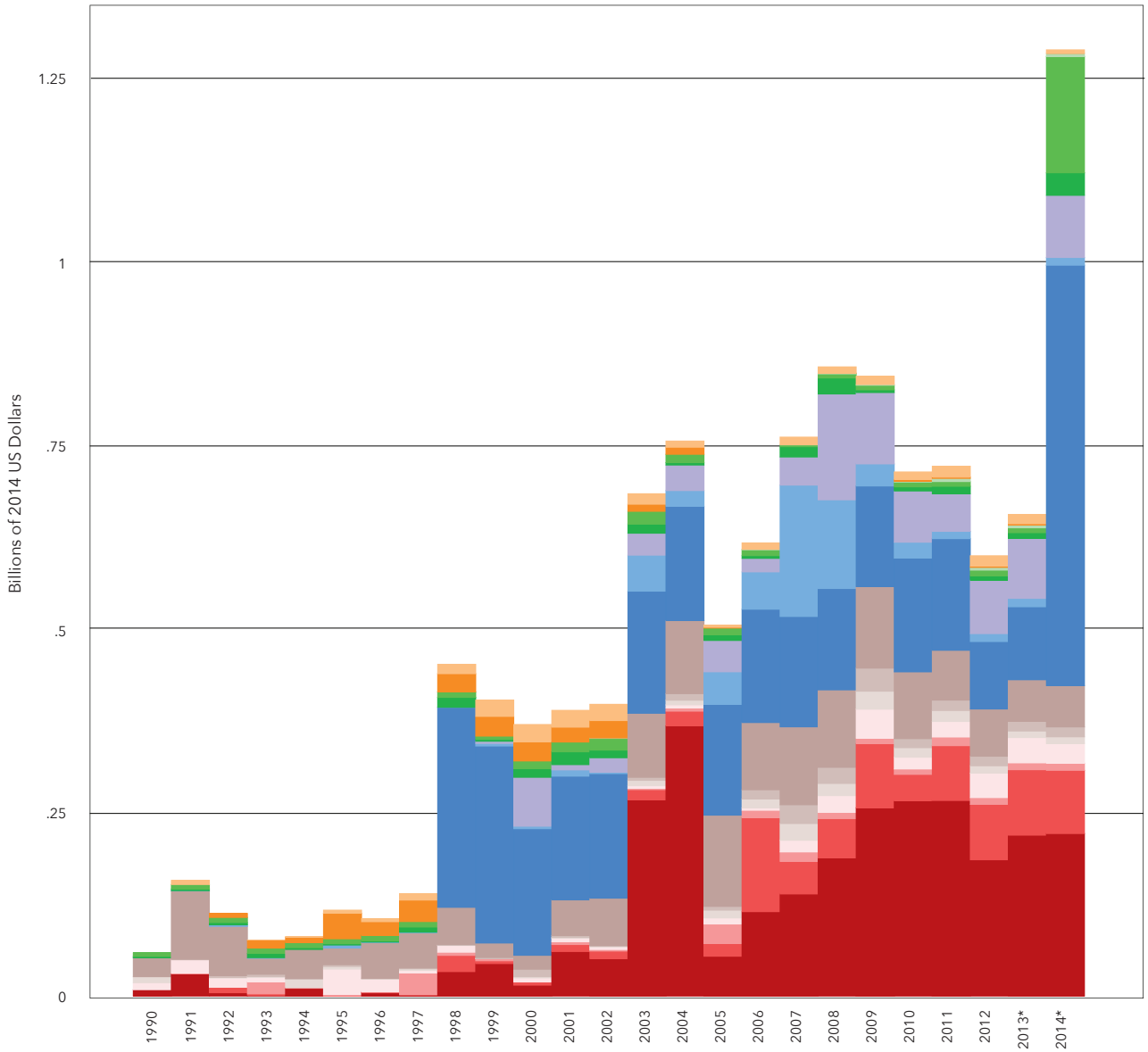
OTHER INFECTIOUS DISEASES

MDG 6 mobilized collective action to combat three major infectious diseases, HIV/AIDS, malaria, and tuberculosis, but a number of other infectious diseases are a threat to populations across the developing world. A host of other infectious diseases are responsible for a major share of health problems in low- and middle-income countries. Nonetheless, funding to combat these health problems makes up a very small proportion of the DAH total: just 3.6%, or $1.3 billion, was provided for this health focus area in 2014, as shown in Figure 37.

Based on these insights, neglected tropical diseases (NTDs) have begun to rise up the global health agenda in recent years. First coined as a unified disease area in the 1980s,[50] NTDs are the 17 maladies that together contribute to 4.9% of burden in low- and middle-income countries, among them dengue, rabies, Chagas, guinea worm, river blindness, and trachoma.[51] NTDs have attracted support after a number of international gatherings and other efforts highlighted the impact of this disease area. In 2003, the Drugs for Neglected Diseases initiative and the Foundation for Innovative Diagnostics were established, and in 2006, the Global Network for Neglected Tropical Diseases was formed.[52] The WHO released its *First Report on the NTDs* in 2010.[53] By 2012, a global roadmap and the London Declaration on Neglected Tropical Diseases had mobilized a wide array of stakeholders behind the cause of the 17 NTDs.[54,55] Also launched in 2012, the END7 campaign focuses on controlling and eliminating the seven most common neglected tropical diseases by 2020: elephantiasis, river blindness, snail fever, trachoma, roundworm, whipworm, and hookworm.[56] It has been argued that, given the number of DALYs caused by this disease group and the low cost of treatment (an estimated $0.50-$0.79 per person per year), NTDs are one of the "best buys" in global health.[57,58]

FIGURE 37

DAH for other infectious diseases by channel of assistance, 1990–2014



- Regional development banks
- World Bank – IBRD
- World Bank – IDA
- International NGOs
- US NGOs
- US foundations
- BMGF
- European Commission
- WHO, UNICEF, & UNFPA

BILATERAL AGENCIES

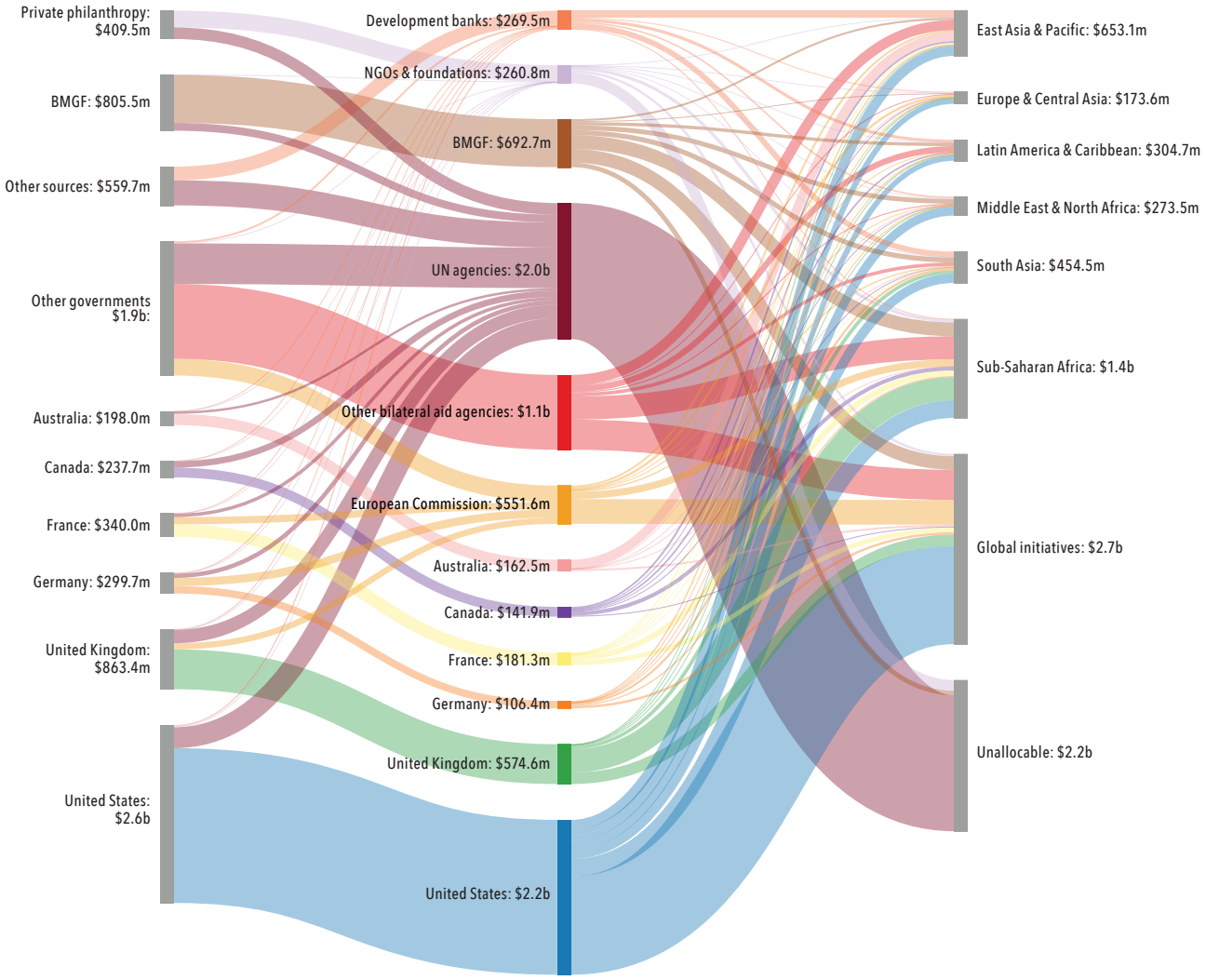
- Other
- Australia
- Canada
- France
- Germany
- UK
- US

*2013 and 2014 are preliminary estimates.

Source: IHME DAH Database 2014

FIGURE 38

Flows of other infectious disease DAH from source to channel to recipient region, 2000–2012



Notes: Cumulative other infectious disease DAH from 1990 through 2012 in 2014 US dollars. Health assistance for which we have no recipient region information is designated as "unallocable."

Source: IHME DAH Database 2014

During the MDG era (2000–2014), development assistance for health for other infectious diseases amounted cumulatively to $10.2 billion. Data for this health focus area are somewhat unreliable before 1998 because project-level descriptions are not very detailed. However, from 1998 on, DAH for other infectious diseases grew 6.8% annually. This funding stream dropped from 2009 to 2013, but major disbursements in the fight against the Ebola epidemic in West Africa propelled DAH for other infectious diseases to an all-time high of $1.3 billion in 2014, 50.4% higher than its former peak of $857 million in 2008.

Support for this collection of diseases is expected to continue to grow in coming years. In 2012, BMGF convened "Uniting to Combat Neglected Tropical Diseases: Ending the Neglect and Reaching 2020 Goals" at the Royal College of Physicians in London. The event brought together WHO, major pharmaceutical companies, and government officials from donor and recipient countries. Across partners, $785 million was pledged to support research and development efforts as well as improve

drug distribution and implementation programs.[59] Between the pledges in London and previous commitments, the 13 pharmaceutical companies attending the event committed to providing 1.4 billion treatments annually to address NTDs in low- and middle-income countries.[60]

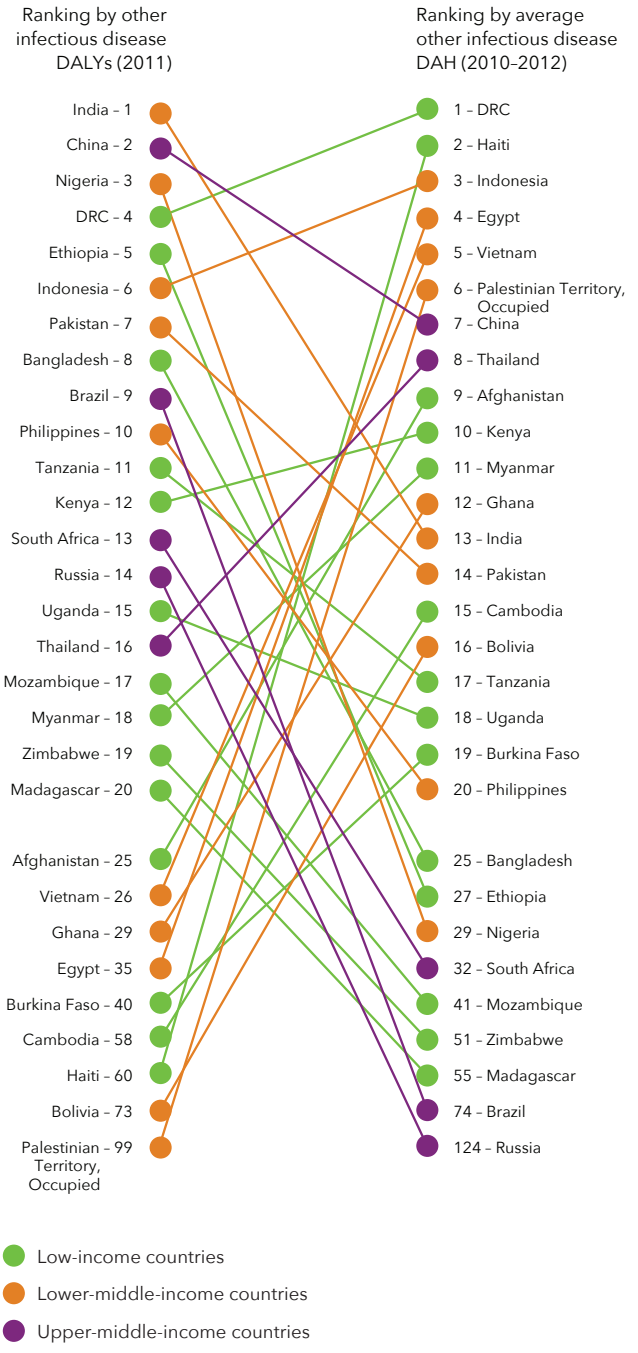
WHO has been the largest single channel in this area of global health since 1998, with its share of contributions reaching $311 million, or 24.1%, in 2014. From 1998 on, DAH expended by WHO for other infectious diseases has grown 0.8% annually. In 2014, WHO played a major role in coordinating, channeling funds, and carrying out the response to the Ebola crisis. In addition to this crisis response, WHO also recently launched efforts to expand its work on other infectious diseases, including WHO and the World Meteorological Organization's Joint Office for Climate and Health, an effort to understand and combat diseases linked to climate change, such as cholera and dengue fever.[61]

The United States is the largest source of other infectious disease funding, with 25.6% or $331 million provided in 2014. In receipt of 67.0% of all US source financing for the health focus area, bilateral US support also served as the second-biggest channel of DAH for other infectious diseases. In 2014, the US channeled $221 million of expenditure toward these causes, 17.2% of total DAH for this health focus area. Similar to WHO funding, US DAH for other infectious diseases has ranged widely from year to year, with a low of $54 million in 2005 as compared to a peak of $368 million in the DAH provided in the previous year (2004). However, the US bilateral agencies' contribution over 2000–2014 was substantial, amounting cumulatively to $2.7 billion. From 2006 to 2014, USAID, in fact, provided $1 billion in NTD treatments that reached 465 million people in 25 countries.[62] In coming years, NTDs may continue to receive increasing support from US bilateral channels, as the US fiscal year 2014 budget was approved to quadruple funding for USAID's NTD Program.[63]

The United Kingdom has also been a consistent source of other infectious disease DAH, providing on average 11.5% of DAH for these causes from 2000 to 2014 and amounting to $199 million in 2014. UK bilateral funding for these diseases has also expanded since 2000, with annual growth of

FIGURE 39

Top 20 countries by 2011 other infectious disease burden versus average 2010–2012 DAH

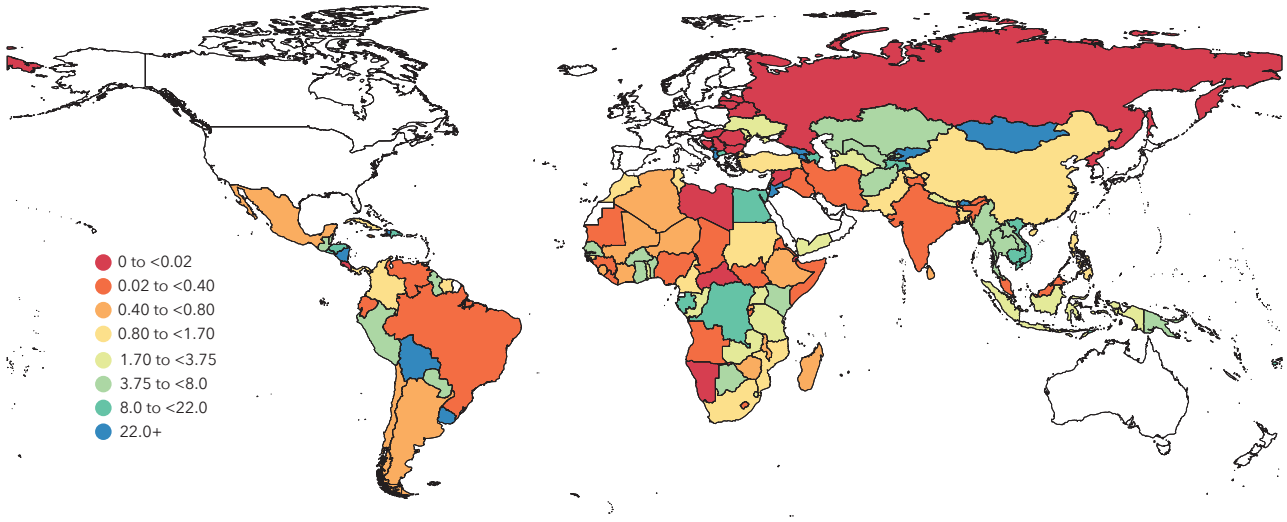


Notes: 2011 DALYs are estimated using Global Burden of Disease Study 2010 and 2013.

Sources: IHME DAH Database 2014, Global Burden of Disease Study 2010, 2013

FIGURE 40

Other infectious disease DAH, 2010–2012, per related DALY, 2011



Notes: 2011 DALYs are estimated using Global Burden of Disease Study 2010 and 2013. Countries that were ineligible for DAH based on their World Bank classifications are shown in white. DAH received is shown in real 2014 US dollars.

Sources: IHME DAH Database 2014, Global Burden of Disease Study 2010, 2013

23.9% over 2000–2014 and a total of $86 million provided through UK bilaterals in 2014. UK funding for this disease area is also expected to rise. In early 2012, DFID announced a five-fold increase in development assistance in the fight against NTDs. The UK Coalition against Neglected Tropical Diseases also leverages the strengths of actors across different sectors to support NTD treatment and prevention.[64]

The Bill & Melinda Gates Foundation has also been a major supporter of work on other infectious diseases. In 2014, BMGF provided an estimated $123 million as a source to these causes, 69.0% of which flowed through the foundation as a channel, amounting to $85 million in 2014. Growth in the BMGF funding channel for this area of health has grown a consistent 1.7% annually from 2000 to 2014. This is expected to continue to rise; early in 2012, BMGF pledged $363 million over five years for NTDs.[65]

Germany initiated a recent push on NTDs by bringing attention to this disease area with international meetings on NTDs in 2003 and 2004 in Berlin.[66] German bilateral contributions to other infectious diseases, provided through its bilateral aid agency Deutsche Gesellschaft für Internationale Zusammenarbeit, amounted to just under $10 million in 2014.

Figure 39 represents average DAH over 2010–2012 for other infectious diseases side-by-side with the DALYs for this disease set in 2011. Burden and development assistance for health are not clearly aligned: many countries with the largest burdens for these causes did not receive the largest amount of DAH for other infectious diseases. Among the top 20 countries on either list, a few upper-middle-income countries are present, namely China, Brazil, Russia, South Africa, and Thailand. The Democratic Republic of the Congo received the most DAH, on average, for these causes over 2010–2012, despite standing fourth among countries with the highest disease burden. Haiti received the second-largest sum of DAH over the same period but ranked 60th in disease burden across low- and middle-income countries.

DAH per DALY for other infectious diseases for each low- and middle-income country is presented in Figure 40. Some countries received less than 40 cents per DALY related to these diseases. Many of these were large middle-income countries,

such as Brazil, India, and Russia, with similarly large infectious disease burdens. A number of countries in sub-Saharan Africa, Central Asia, and South America received more than $1.70 per DALY. Nonetheless, the DAH disbursements per DALY remained much lower than other disease areas, notably HIV/AIDS, where DAH per DALY is higher than $500 in some countries.

NON-COMMUNICABLE DISEASES

Non-communicable diseases (NCDs) were not included among the Millennium Development Goals. However, they are of rising concern in the developing world. The Global Burden of Disease Study 2013 estimates that the burden of disease associated with NCDs grew 1.2% annually from 2000 to 2013 in developing countries and represents 53.9% of the total burden in 2013. As these trends evolve, ischemic heart disease, diabetes, cancer, and other NCDs will require additional resources for treatment and prevention in low- and middle-income countries.

DAH for NCDs is one of the smallest health focus areas estimated by IHME. In 2014, $611 million in DAH was disbursed for NCDs. This was just under 2% of total DAH. DAH for NCDs has grown 10.8% annually from 2000 to 2013, but remained steady from 2013 to 2014, with a small year-over-year increase of 0.5%.

However, the world's attention is beginning to turn to this disease area. In the US, a task force convened by the Council on Foreign Relations emphasized the urgency of addressing NCDs, pressing the US to examine spending on the health focus area as well as bring together other global health stakeholders to plan for collective action.[67] A global action plan for the prevention and control of NCDs, 2013–2020, has also generated attention on the global stage, leading to the establishment of nine international NCD targets for 2025.[68] The United Nations Interagency Task Force on the Prevention and Control of NCDs was established in July 2013 and, along with the WHO Global Coordination Mechanism on the Prevention and Control of NCDs, will facilitate action across global stakeholders.

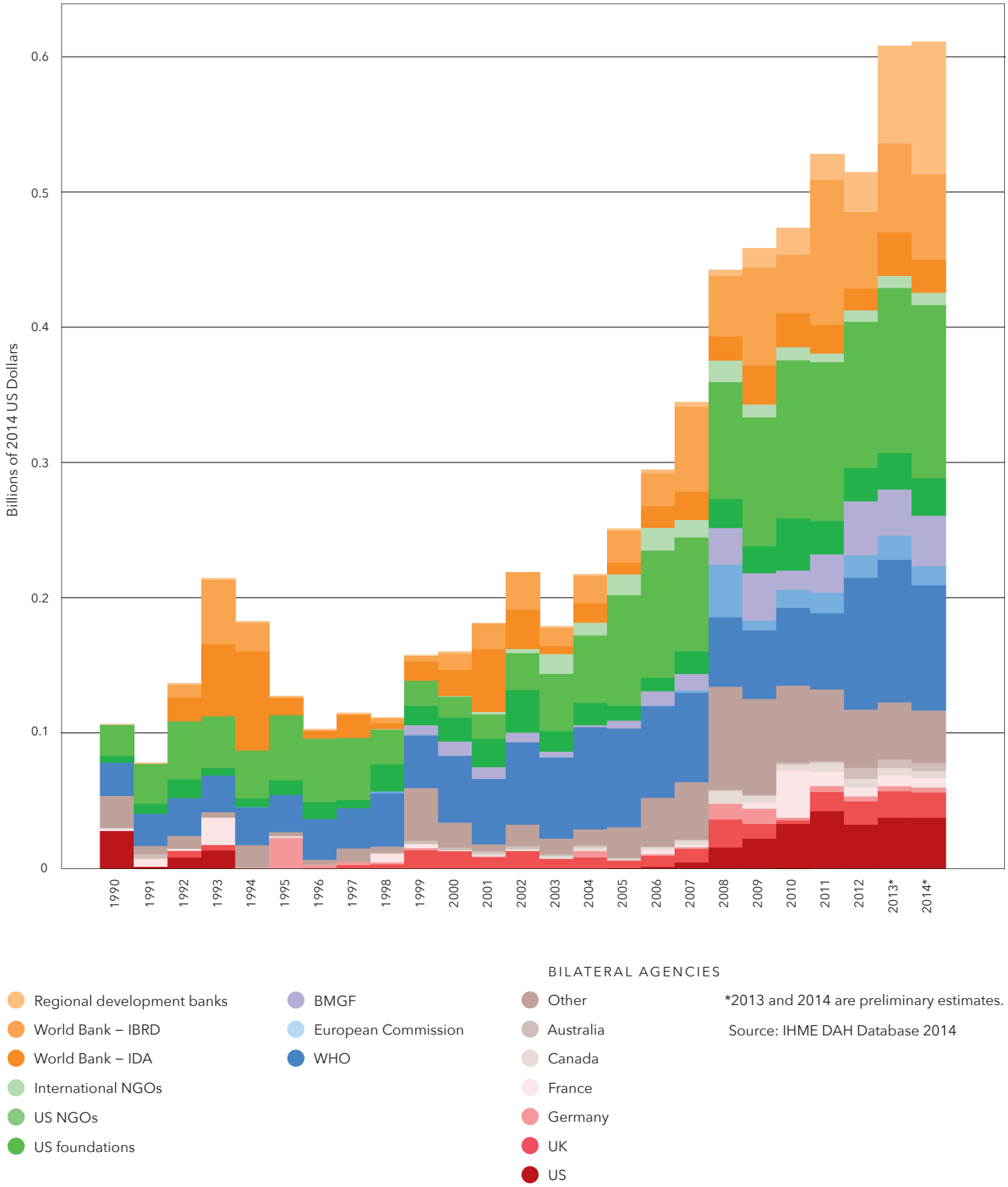
Across disease areas, private philanthropic sources, including BMGF, are most prominent in NCDs, providing 32.1% of all funding across 2000–2014. These funds predominantly flowed to NGOs and foundations (75.0%) (excluding BMGF), which channeled $165 million in 2014, a 4.4% increase over 2013 levels. BMGF alone provided $37 million to the cause in 2014.

Bloomberg Philanthropies also stands out as a private foundation championing the importance of funding this health focus area. Bloomberg Philanthropies invests heavily in combating non-communicable diseases in the developing world, as evidenced by its $274 million in contributions from 2007 to 2012. The bulk of these funds concentrated on anti-smoking campaigns, but the organization is also beginning to focus on obesity, including a $10 million pilot project in Mexico announced in 2013 to reduce the prevalence of this major risk factor.[69]

The World Bank's IDA and IBRD, as well as the regional development banks, are also active in addressing NCDs. Sourced mainly from debt repayments and other resources managed by the development banks, these entities channeled the largest sum of DAH to NCDs in 2014. In 2014, they collectively channeled $185 million, 30.3% of all DAH provided to this disease area. The regional banks provided $98 million, while IDA and IBRD provided $24 million and $63 million, respectively, to this cause in 2014.

FIGURE 41

DAH for non-communicable diseases by channel of assistance, 1990–2014

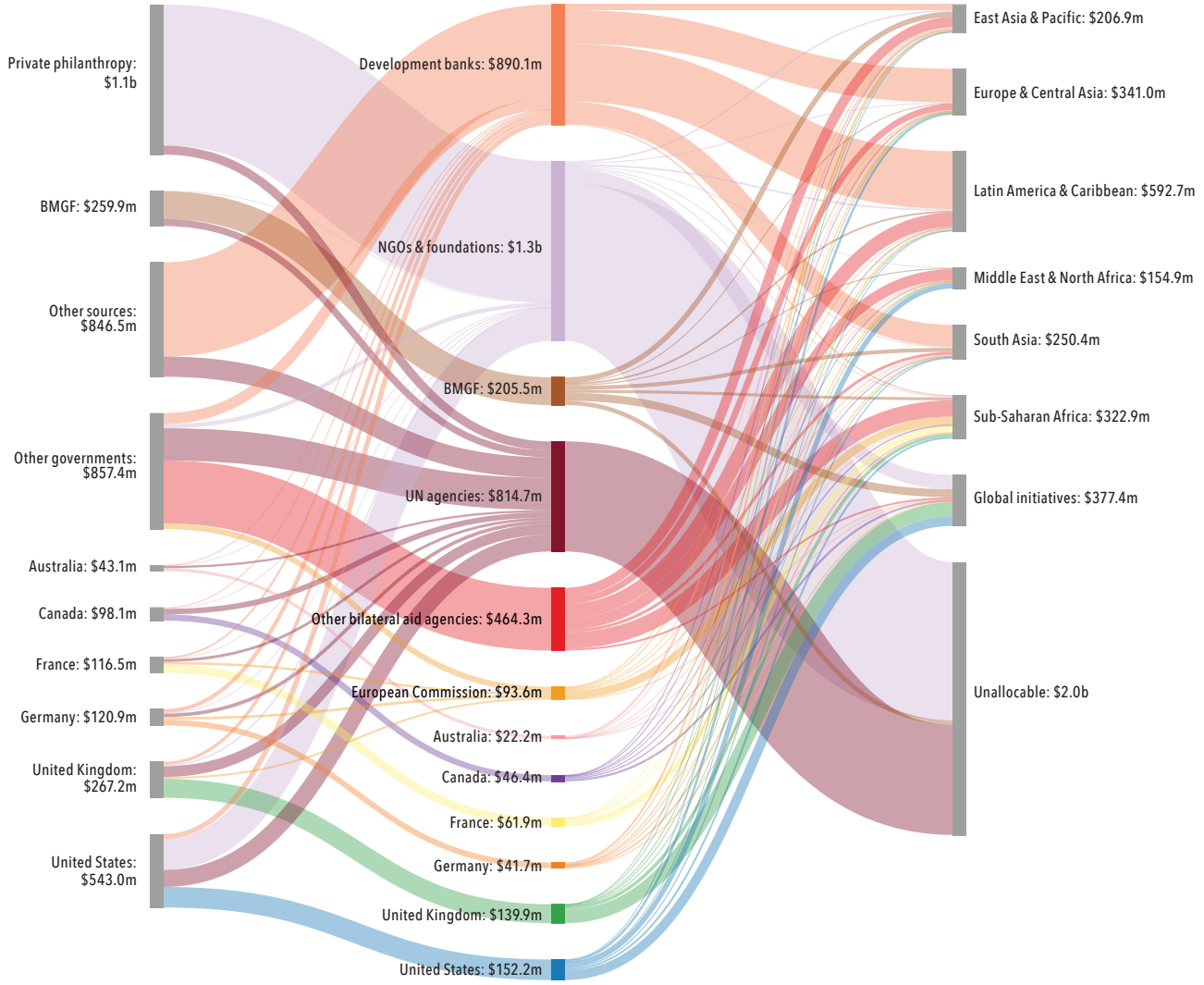


*2013 and 2014 are preliminary estimates.

Source: IHME DAH Database 2014

FIGURE 42

Flows of non-communicable disease DAH from source to channel to recipient region, 2000–2012



WHO leads a number of efforts in this area of global health,[70,71] and, following the development banks, channeled the third-largest amount of DAH to NCDs in 2014. $93 million was disbursed through WHO in 2014 for NCDs. Of these funds, 12.9% were sourced from the US, while 11.7% and 41.3% were sourced from the UK and other high-income governments, respectively. Growth in WHO's NCD portfolio has been considerable, with 4.6% in increases annually from 2000 to 2014.

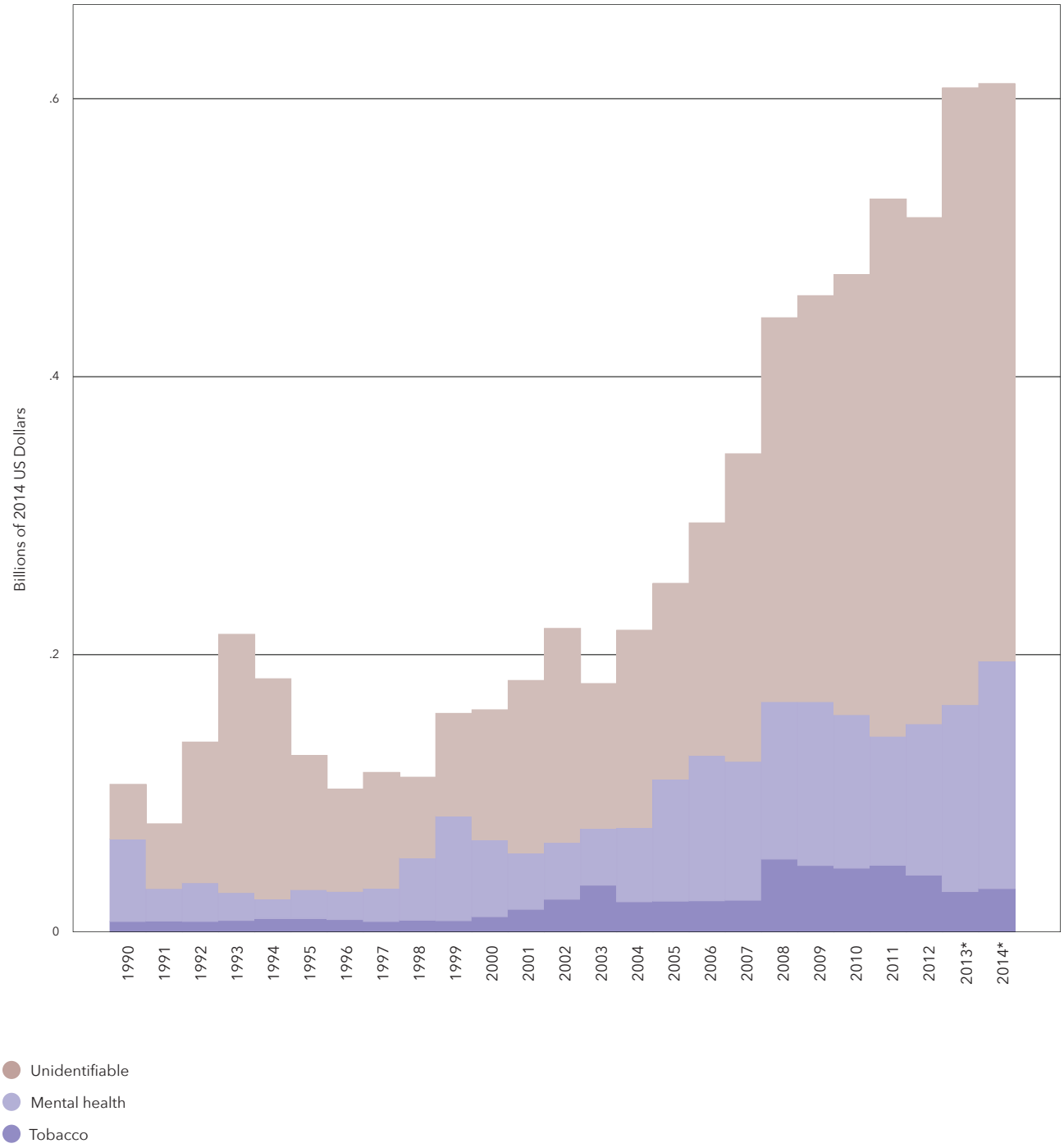
Figure 43 breaks down these funding flows to a more granular level, highlighting the DAH provided for mental health and anti-tobacco activities in low- and middle-income countries. The substantial amount of DAH not specified in this figure is indicative of the assortment of disease areas encompassed by NCDs, as well as some data limitations.

Notes: Cumulative non-communicable disease DAH from 1990 through 2012 in 2014 US dollars. Health assistance for which we have no recipient region information is designated as "unallocable."

Source: IHME DAH Database 2014

FIGURE 43

DAH for non-communicable diseases by health focus subcategory, 1990–2014



*2013 and 2014 are preliminary estimates.

Note: Non-communicable diseases health assistance for which we have no health focus subcategory information is designated as "unidentifiable."

Source: IHME DAH Database 2014

International funding for anti-tobacco campaigns and other preventive measures was $31 million in 2014. Tobacco, as a risk factor, is responsible for 5.7% of DALYs in low- and middle-income countries. Largely due to the efforts of Bloomberg Philanthropies, which provided $45 million on average from 2007 to 2014 for anti-tobacco activities, tobacco DAH has ranged between $23 million and $52 million annually from 2007 to 2014,

representing between 4.8% and 18.8% of the DAH for NCDs over this period. Growth from 1990 onward has amounted to 6.1% annually.

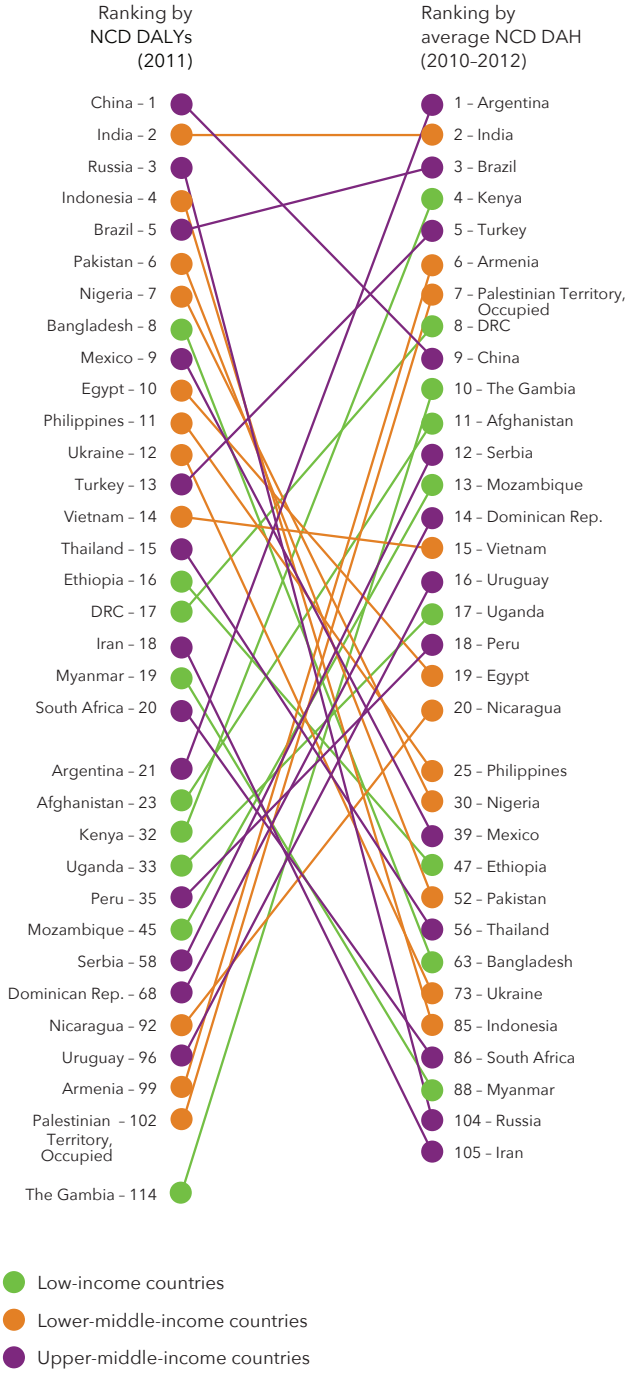
Mental health is also highlighted in Figure 43. Mental health receives less attention but is still a major cause of disease burden throughout the developing world, as highlighted by the 1993 World Development Report.[72] Mental health issues amounted to almost 6.9% of DALYs in these low- and middle-income countries, with rates of prevalence similar to those found in developed countries. Furthermore, according to the World Health Organization, there is only one psychiatrist per 200,000 people or more for about half of the world's population, and other mental health care providers are even rarer.[73] DAH for this cause of burden was $164 million in 2014. At 26.8% of total NCD DAH, mental health DAH amounts to five times the funds allocated to tobacco prevention and control in 2014.

Figure 44 highlights that NCD burden is present in a range of low- and middle-income countries, with some of the most populous low- and middle-income countries harboring the largest amount of DALYs. All but one of the 10 countries with the largest NCD burden in 2011 rank within the 10 most populous low- and middle-income countries. Topping the list of NCD DALYs in 2013 is China, as the most populous country in the world. Argentina, another upper-middle-income country, received the highest DAH figure, on average, over 2010–2012.

Average NCD DAH, 2010–2012, per 2011 DALY, is represented in Figure 45. DAH disbursements per DALY are relatively low across countries, ranging from close to zero to $0.75. However, a few key countries, including notably Argentina, Kenya, Mongolia, and Zambia, received more. The highest DAH per DALY related to NCDs, at $21.60, was received by Tonga over this period. Gambia, as well, benefited from $18.52 in average 2010–2012 DAH per 2011 DALY.

FIGURE 44

Top 20 countries by 2011 non-communicable disease burden versus average 2010–2012 DAH

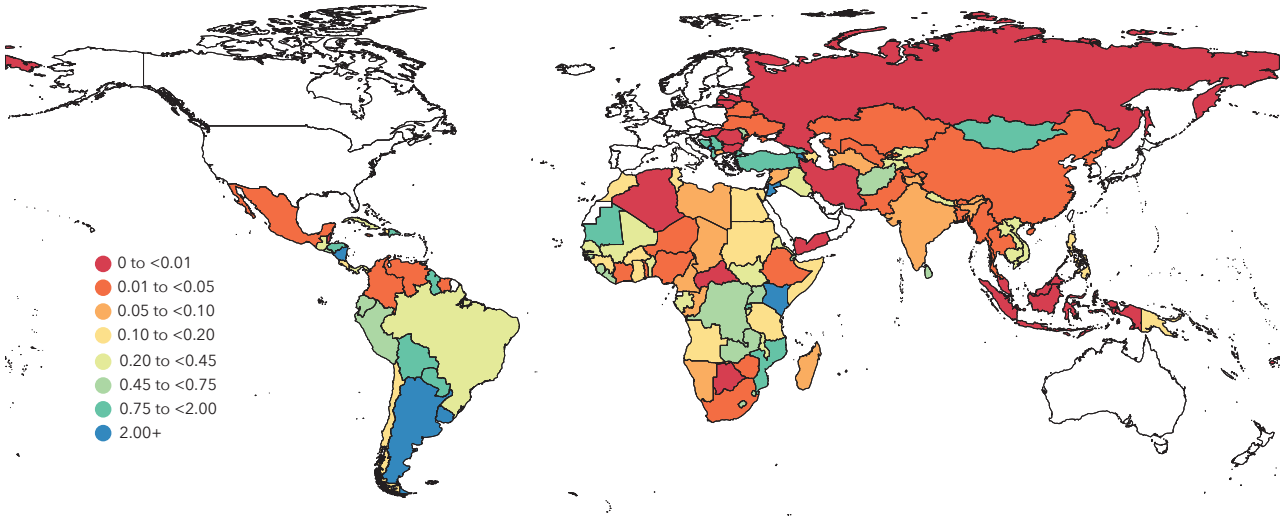


Notes: 2011 DALYs are estimated using Global Burden of Disease Study 2010 and 2013.

Sources: IHME DAH Database 2014, Global Burden of Disease Study 2010, 2013

FIGURE 45

Non-communicable disease DAH, 2010–2012, per related DALY, 2011



Notes: 2011 DALYs are estimated using Global Burden of Disease Study 2010 and 2013. Countries that were ineligible for DAH based on their World Bank classifications are shown in white. DAH received is shown in real 2014 US dollars.

Sources: IHME DAH Database 2014, Global Burden of Disease Study 2010, 2013

HEALTH SECTOR SUPPORT AND SECTOR-WIDE APPROACHES

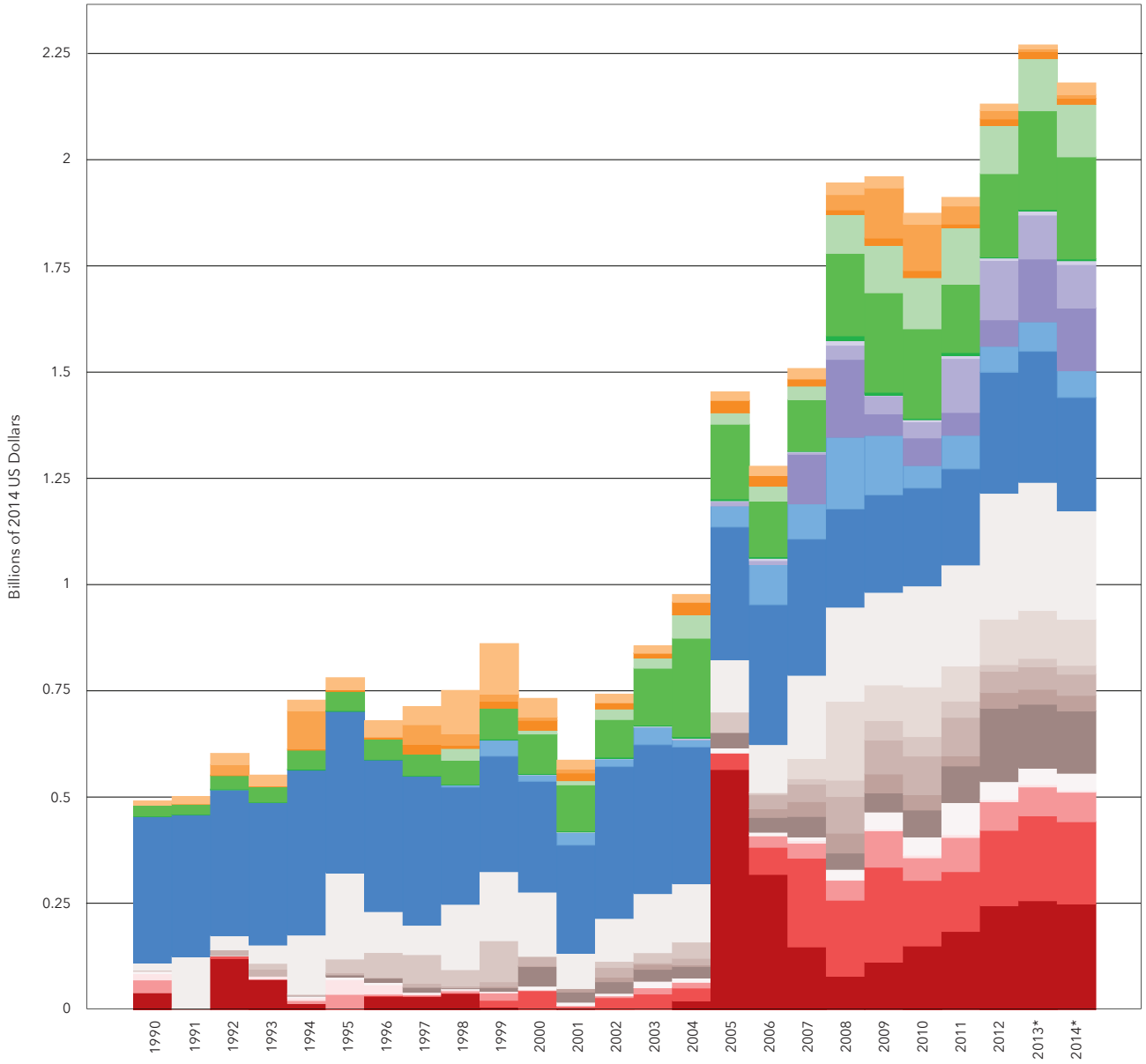
Health sector support (HSS) and sector-wide approaches (SWAPS) align with the aim to catalyze a global partnership for development by working to improve health systems in a broad fashion. SWAPS and HSS were both born of the recognition that much development assistance for health focuses on specific disease areas, such as HIV/AIDS, malaria, or TB, rather than the more basic operations of the health system. In contrast to the other health focus areas highlighted in *Financing Global Health 2014,* these types of DAH concentrate on enhancing health systems in a more general manner.

SWAPS work to strengthen health systems by better aligning DAH with recipient governments' health objectives. Through SWAPS, development assistance partners provide direct budgetary support for governments to invest in the health sector. This support is oftentimes related to a health sector policy, but funds remain under the government's authority.[74] SWAPS emerged as the donor community recognized that fragmentation and duplication in the aid sector were undermining the effectiveness of development assistance. SWAPS are an effort to reduce this type of misalignment and ineffectiveness. Disbursements of this kind are intended to be in line with the 2005 Paris Declaration on Aid Effectiveness, which emphasized ownership, alignment, harmonization, managing for results, and mutual accountability as key components of effective development assistance.[75]

HSS-focused support assists health systems directly through initiatives and strategies that improve the functioning of health systems. HSS projects may aim to enhance access, coverage, quality, or efficiency.[76] In 2007, WHO highlighted six basic building blocks of health systems: service delivery; health workforce; information; medical products, vaccines, and technologies; financing; and leadership and governance (stewardship).[77] As part of a recognition of these six areas as vital to

FIGURE 46

DAH for sector-wide approaches and health sector support by channel of assistance, 1990–2014



Regional development banks
World Bank – IBRD
World Bank – IDA
International NGOs
US NGOs
US foundations
BMGF
Global Fund
Gavi
European Commission
WHO

BILATERAL AGENCIES

Other
South Korea
Denmark
The Netherlands
Norway
Australia
France
Canada
Germany
UK
US

*2013 and 2014 are preliminary estimates.

Source: IHME DAH Database 2014

disease-specific efforts, even organizations that focus exclusively on specific disease areas, such as PEPFAR, Gavi, and the Global Fund, increasingly provide DAH for health sector support.[78,79]

In Figure 46, DAH for both SWAPs and HSS is represented from 1990 to 2014. In 2014, total DAH for this health focus area dropped to $2.2 billion. This is a 3.9% decrease from 2013, when DAH amounted to $2.3 billion for HSS and SWAPs. Since 2001, DAH focused on HSS and SWAPs has grown 10.6% annually.

The United States provided the largest sum of DAH to this health focus area, disbursing $425 million in 2014. However, Denmark, Norway, and Sweden have been big proponents of this area of development assistance. In 2014, these sources provided $23 million, $66 million, and $31 million, respectively, for HSS and SWAPs. In recent years, Australia has also focused DAH on this area of support, with $171 million furnished in 2014.

Additionally, WHO is active in this type of support for developing countries. From the beginning of the DAH series in 1990, WHO has contributed in a major way to this health focus area. Although some contraction occurred over 2008–2010, support never dropped lower than $226 million on an annual basis. By 2014, WHO spending on SWAPs and HSS had risen to $267 million, 12.2% of the total DAH envelope for this health focus area.

The Global Fund, through its HSS portfolio, also contributes to this health focus area. In 2014, the Global Fund provided $102 million. Among all contributions for these activities, the Global Fund's support for HSS is 4.7%.

CHAPTER 3

Government health expenditure

The Millennium Development Goals (MDGs) focused on mobilizing aid to attain eight goals by 2015. However, as the international community considers a new set of global goals, the focus is increasingly turning to the role of national governments in financing health. The gross domestic product of many middle-income countries continued to grow substantially during the financial crisis. Furthermore, as Brazil, Ghana, Indonesia, and other countries roll out more comprehensive health insurance schemes – and the taxation plans to fund them – turning to these sources may contribute to a more sustainable and accountable funding environment for health in developing countries.[80]

Government health expenditure (GHE) was also a key factor in the progress made in reducing disease burden during the MDG era. This chapter highlights just how much governments in the developing world contribute to health in their own countries. The vast majority of financing to address the burden of disease in the developing world is sourced from low- and middle-income country governments.

To explore trends in government spending, and how governmental financing complements development assistance for health, IHME produces an annual series on government health expenditure as a source (GHE-S). These estimates capture the funds provided by national governments with domestic resources sourced from their own treasuries. IHME combines its development assistance for health (DAH) estimates with the GHE estimates developed by WHO to produce trends in the provision of funding from governments for their populations' health needs.

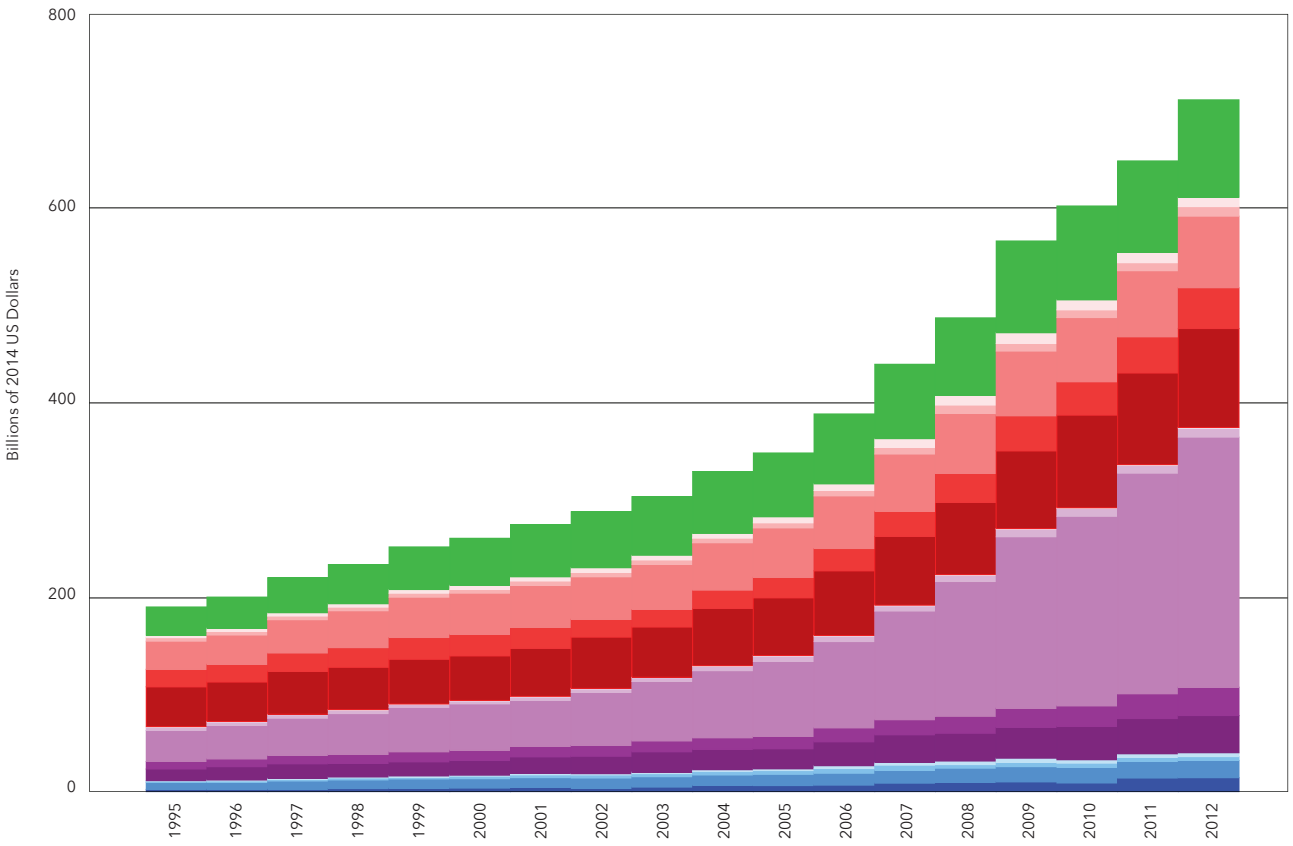
Figure 47 captures total government health expenditure for all low- and middle-income countries from 1995 to 2012. In 1995, GHE-S was $189.8 billion. In the 17 years since, GHE-S has risen 8.1% annually, reaching a historic high of $711.1 billion in 2012. This is 19.8 times higher than the DAH provided in 2012. As growth in DAH has diminished since 2010, GHE-S has continued to rise, with annual growth of 8.7% over 2010-2012.

Figure 47 represents GHE-S funding flows by Global Burden of Disease regions, which have been designed to encompass geographic, economic, and epidemiological similarities. By a wide margin, government health expenditure in East Asia is the highest among all regions. This region also has the largest population (1.4 billion people) and the largest share of disability-adjusted life years (DALYS) across the developing world (16.7%). In 2012, GHE-S in East Asia reached $257.0 billion, 36.1% of total GHE-S; this equated to $183.35 per person. Spending on health by governments in this region has also grown the most rapidly in recent years. From 2005 to 2012, East Asia GHE-S increased 18.7% on an annual basis.

While Latin America suffers from 7.4% of the total burden of disease for developing countries and hosts 554 million people, governments in the region provided the second-highest amount of funds for health from their own tax base in 2012. GHE-S

FIGURE 47

GHE-S by Global Burden of Disease developing region, 1995–2012



Source: IHME Government Health Spending Database 2014

in Latin America, including Andean, Central, Southern, and Tropical Latin America, amounted to $227.0 billion in 2012, or $400.96 per person. Latin America's share of the total GHE-S provided across all low- and middle-income countries was 31.9% in 2012. From 1995 to 2012, GHE-S in Latin America grew 5.5% annually.

After Latin America, governments in North Africa and the Middle East, which are home to 507 million people and 6.1% of the total burden of disease for developing countries, provided 14.1% of total GHE-S. In 2012, $100.1 billion in GHE-S was expended in this region.

In contrast to other regions, GHE-S from all areas of sub-Saharan Africa (Central, Eastern, Southern, and Western) is relatively low, amounting to just 5.6% of the total in 2012. Although the region is the home of 902 million people, with 27.1% of all DALYS, only $40.0 billion was provided by governments, from their own sources of revenue, to health activities across the region in 2012. In sub-Saharan Africa, governments provided $43.74 per person in 2012. Furthermore, this region also has the poorest populations, with average gross domestic product (GDP) per capita of $1,222 annually. This is substantially lower than East Asia, which boasts per capita GDP of $4,187, as well as Latin America and North Africa and the Middle East, with GDP per capita rates of $6,689 and $5,995, respectively, in 2012.

FIGURE 48

Change in GHE-S by region, 2001–2012

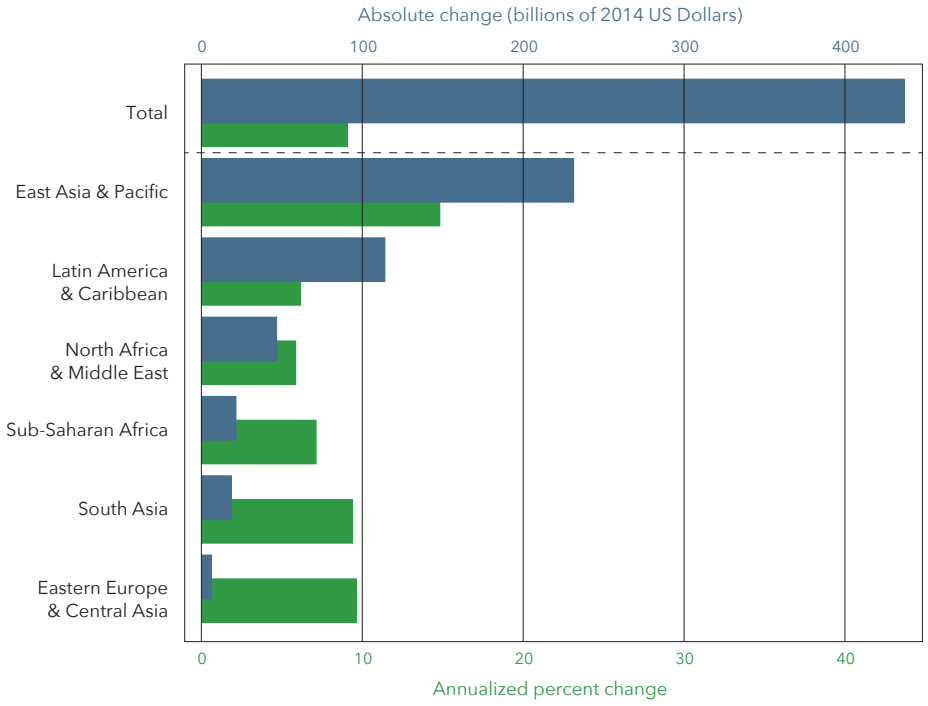


Figure 48 shows absolute and percentage growth in GHE-S by region, from 2001 to 2012. Across all low- and middle-income countries, total GHE-S grew more than $400 billion over this time, with annual percentage growth of 9.0%.

Among all regions, the GHE-S expended in East Asia and the Pacific grew the most in absolute terms, rising by $231.2 billion from 2001 to 2012. Its annualized growth reached 14.8% over the same period. The percentage growth in South Asia, at 9.4% annually over 2001–2012, was less than the increases in East Asia and the Pacific. Absolute growth in South Asia amounted to $18.3 billion, substantially less than East Asia and the Pacific.

Other regions did not encounter such massive absolute and percentage increases. The GHE-S provided by governments in Latin America and the Caribbean increased over 2001–2012 by 6.1%, or $113.8 billion. In North Africa and the Middle East, GHE-S rose $46.5 billion, which was higher than the total increases in sub-Saharan Africa ($21.2 billion) and Eastern Europe and Central Asia ($5.8 billion). Percentage growth, however, was higher in Eastern Europe and Central Asia (9.6%) and sub-Saharan Africa (7.1%) than in North Africa and the Middle East (5.8%).

Notes: The bars represent changes in GHE-S in absolute and annualized percentage terms from 2001 to 2012. On the vertical axis, recipient regions are ordered by the magnitude of absolute change in GHE-S over this period.

Source: IHME Government Health Spending Database 2014

Conclusion

Financing Global Health 2014 highlights how funding for child health, HIV/AIDS, tuberculosis (TB), and malaria expanded tremendously in the decade following the launch of the Millennium Development Goals (MDGs). Rates of growth for these health focus areas are larger than those for non-MDG health issues. Funding for HIV/AIDS, notably, with substantial US support, climbed dramatically from 2000 to 2010. Other issues, such as maternal health, did not benefit from such concentrated and rapidly expanded funding flows, although development assistance for health (DAH) for these areas has also grown. Sub-Saharan Africa, also, clearly received more than any other region from funding directed to the MDGs.

The absence of DAH growth between 2010 and 2014, however, denotes a shift to a new era in DAH. Not only does total DAH appear to be plateauing, trends in spending across different health issues also seem to indicate stability. Only minor increases and decreases were observed across the many different perspectives on the data IHME provides, with the exception of the major response to the Ebola epidemic that swept West Africa in 2014.

As the deadline for the MDGs quickly approaches, Global Burden of Disease 2013 estimates pinpoint the countries that will meet targets. Across low- and middle-income countries, 72 will meet MDG 6 targets for HIV/AIDS, and another 86 and 100 will meet the targets for malaria and TB, respectively. With regard to the target set in MDG 4, 27 countries are on track to reduce child mortality by two-thirds. Only seven countries will meet MDG 5, having reduced their maternal mortality by three-fourths.

Although success in achieving these targets is mixed, the substantial growth in DAH leaves little doubt that more prevention and treatment activities were launched and sustained since the MDGs were established. GBD 2013 estimates 4.1 million deaths were averted in 2013 alone due to the scale-up in HIV/AIDS treatment and prevention. The growth in provision of insecticide-treated bed nets, directly observed treatment, short-course (DOTS), vaccines, and other important health interventions is also unprecedented.

The historic increases in DAH should be considered as the international community moves to finalize the Sustainable Development Goals (SDGs). However, it should be recognized that the SDGs are being put in place in a very different political and financial environment than when the MDGs were formed. An additional major distinction is that these new goals are being designed to target all countries. While it remains unclear which health focus areas the SDGs will prioritize, the discourse surrounding the SDGs focuses much more on government financing than development assistance.[81]

The specifics of the SDGs remain to be determined, but it is clear that the measurability of these targets should be considered as they are defined. The sparseness of data in many low-income countries, particularly in a large number of sub-Saharan African countries, is a major roadblock to informing governments and catalyzing evidence-based decision-making in view of attaining targets. Without appropriate metrics, it is difficult to hold stakeholders accountable for progress. Setting aside

sufficient funds to properly monitor progress on the SDGs may be a key building block for the success of these goals. Building this aspect into any post-2015 agreement could make data transparency a boon to the achievement of new global goals.

The DAH estimates produced and annually provided in *Financing Global Health* will continue to build out the foundation of global health knowledge. With timely, up-to-date estimates in hand, decision-makers the world over will be equipped to react to the rapidly evolving epidemiological and financial landscape. Capturing gaps in financing and opportunities to invest across the developing world will continue to provide insights for evidence-based decision-making across global health.

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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.healthdata.org/sites/default/files/files/policy_report/2015/FGH2014/IHME_fgh2014_methods_annex.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 2014. 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

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 the Creditor Reporting System (CRS), budget documents, annual reports, and correspondence
UN Agencies: PAHO, 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
Global Fund	Online grant database, pledges, and correspondence
NGOs registered in the US	USAID Report of Voluntary Agencies, tax filings, financial statements, annual reports, RED BOOK Drug Reference, and WHO's Model List of Essential Medicines
BMGF and other private US foundations*	Foundation Center's grants database, BMGF online grants database, and tax filings

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. One to three of the most recent years of data are missing for some channels. In these cases we rely on budgets, revenues, commitments, appropriations, and macroeconomic data to estimate these most recent disbursements. 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 Gavi, the Vaccine Alliance (Gavi) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund). Yet, in this report, funds from BMGF to those channels are assigned to Gavi and the Global Fund, respectively. BMGF remains the source of those funds, and is assigned as the channel only for funds it distributes directly to recipients. Thus, it is of interest to track both the sources and channels of DAH. 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 divide funding for those projects across health focus areas through weights based on the number of keywords attributed to each health focus area, as found in project descriptions.

In *Financing Global Health 2013: Transition in an Age of Austerity,* our preliminary estimates of total DAH for 2012 and 2013 were $31.1 and $32.3 billion, respectively (measured in 2014 US dollars). This year, we report $33.1 billion and $36.5 billion of DAH for 2012 and 2013, respectively (measured in 2014 US dollars). 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 estimate government health spending through 2012 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 Government Health Observatory database. 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.

ANNEX B

Tabulated data

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TABLE B1

DAH by channel of assistance, 1990–2014

Channel	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
BILATERAL DEVELOPMENT AGENCIES											
United States	1,445.54	1,345.28	1,233.37	1,117.21	1,706.82	1,788.15	1,344.45	1,436.91	1,402.35	1,646.15	1,669.18
United Kingdom	97.07	97.16	249.84	113.93	105.67	68.76	117.39	161.03	264.46	400.74	682.57
Germany	106.73	120.82	184.78	204.65	327.75	433.83	328.40	403.67	319.04	262.16	144.95
France	776.43	342.49	292.31	243.92	359.19	424.07	349.32	288.01	334.23	244.80	171.16
Canada	49.11	40.07	40.25	47.83	83.52	136.25	64.29	35.13	49.89	31.56	71.30
Australia	13.78	16.09	82.33	74.31	109.05	116.61	140.87	57.91	61.18	101.84	171.74
Other bilaterals	1,319.33	1,133.04	1,502.23	1,503.52	1,105.73	1,419.54	1,434.51	1,417.34	1,113.42	1,683.61	1,346.51
UNITED NATIONS											
Joint United Nations Programme on HIV/AIDS (UNAIDS)	–	–	–	–	–	–	83.36	81.96	92.45	91.06	141.22
United Nations Population Fund (UNFPA)	384.63	372.23	321.15	313.68	454.39	445.11	424.35	417.21	440.03	433.40	408.03
United Nations Children's Fund (UNICEF)	239.06	231.36	298.39	291.45	310.56	304.22	274.15	269.53	284.73	280.44	343.49
World Health Organization (WHO)	1,170.05	1,132.35	1,114.74	1,088.84	1,224.43	1,199.42	1,008.01	991.05	1,093.97	1,077.48	1,336.03
Pan American Health Organization (PAHO)	294.44	284.95	292.91	286.10	303.44	297.24	281.05	276.32	314.77	310.03	305.41
European Commission (EC)[1]	7.99	16.85	76.23	65.97	20.22	111.43	144.17	63.27	104.24	144.35	145.03
PUBLIC-PRIVATE PARTNERSHIPS											
Gavi, the Vaccine Alliance	–	–	–	–	–	–	–	–	–	–	3.49
Global Fund to Fight AIDS, Tuberculosis and Malaria	–	–	–	·	–	–	–	–	–	–	–
Bill & Melinda Gates Foundation (BMGF)	–	–	–	–	–	–	–	–	–	102.42	380.78
Other foundations[2]	57.86	81.32	127.35	151.05	132.82	135.69	150.17	140.96	176.65	177.87	271.23
Non-governmental organizations (NGOs)	542.28	769.74	917.14	961.38	1,097.58	1,088.86	1,048.95	1,163.54	1,360.17	1,516.76	1,718.60
WORLD BANK											
International Bank for Reconstruction and Development (IBRD)	121.18	145.68	263.87	595.51	760.06	643.61	998.95	1,156.58	1,401.95	793.00	918.82
International Development Association (IDA)	107.73	117.36	242.86	351.56	609.49	604.82	668.02	617.15	738.70	842.58	903.73
REGIONAL DEVELOPMENT BANKS											
African Development Bank (AfDB)	70.44	68.17	66.65	65.10	101.41	78.34	80.02	99.91	67.10	66.09	48.30
Asian Development Bank (ADB)	26.59	40.08	55.10	60.14	57.80	53.70	56.93	80.33	196.11	292.47	220.02
Inter-American Development Bank (IDB)	34.52	52.46	60.48	82.68	92.55	101.83	136.22	170.81	193.49	185.15	199.66
TOTAL	6,864.74	6,407.52	7,422.00	7,618.83	8,962.48	9,451.48	9,133.57	9,328.60	10,008.94	10,683.96	11,601.25

2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
1,897.78	2,693.07	3,117.08	3,497.98	3,659.49	4,545.38	5,994.45	7,484.19	7,554.09	8,864.63	9,922.86	7,924.34	8,921.94	8,873.94
272.71	543.46	478.26	505.02	750.17	1,033.63	1,075.67	1,037.08	1,034.19	1,187.79	1,437.31	1,600.60	1,837.38	1,777.11
188.76	276.58	317.37	334.16	282.57	579.41	461.33	560.21	609.63	548.46	487.79	576.89	530.84	536.59
229.16	276.27	269.11	417.66	373.00	356.71	210.35	477.65	421.69	521.98	220.08	196.01	224.04	183.68
107.14	83.44	196.16	230.11	372.88	209.98	339.73	355.54	432.41	593.79	653.74	657.57	526.18	516.49
113.73	115.36	136.44	144.85	147.34	191.63	191.23	197.31	247.44	351.37	479.85	549.37	507.29	508.30
1,426.15	1,585.11	1,794.82	2,144.31	2,183.31	2,331.50	2,583.58	2,913.72	2,695.18	2,338.40	2,292.92	2,598.69	2,365.13	2,227.14
138.08	120.51	118.15	191.87	185.89	252.17	245.63	285.98	283.82	314.42	308.07	272.39	281.12	274.40
398.94	443.63	434.96	517.62	501.49	568.28	641.56	767.50	868.28	883.20	866.18	829.21	895.05	844.68
492.49	464.51	459.21	535.03	719.33	430.40	583.25	542.61	569.71	910.78	1,134.88	992.93	1,181.60	1,393.48
1,306.27	1,390.38	1,363.19	1,711.77	1,658.42	1,695.40	1,651.45	1,972.19	1,957.32	2,212.93	2,171.72	1,874.29	2,027.66	2,107.88
298.61	292.03	286.32	290.79	281.73	383.68	373.74	412.27	409.16	453.63	409.88	475.66	566.25	447.61
138.17	155.89	258.30	206.16	539.11	733.07	722.50	803.07	616.06	511.51	630.58	499.48	562.50	509.14
177.80	151.82	231.78	255.51	362.35	294.33	1,020.09	799.23	584.89	849.58	879.93	1,160.61	1,672.29	1,809.40
–	17.44	321.05	833.16	1,319.98	1,606.68	1,995.81	2,594.57	3,118.73	3,539.02	3,069.65	4,055.47	4,385.76	4,085.19
286.40	439.96	577.54	349.52	489.49	709.01	914.82	1,393.04	1,297.32	1,135.64	1,369.03	1,488.75	1,542.25	1,620.19
249.86	241.06	227.51	240.52	232.11	272.29	325.17	363.43	402.38	292.42	308.90	317.33	353.29	382.80
1,861.76	2,030.82	2,264.21	2,713.78	3,277.14	3,506.80	3,685.59	4,496.90	4,719.25	5,279.97	5,040.67	4,784.40	5,203.64	5,400.53
911.80	856.40	1,544.10	767.88	641.30	658.62	810.81	639.15	848.70	1,868.71	1,791.44	1,021.81	1,183.13	1,132.34
1,129.54	1,181.12	1,005.82	1,471.49	1,318.41	1,075.62	953.45	691.14	1,003.89	904.07	1,069.39	897.58	1,052.69	876.43
45.34	87.21	45.50	97.16	160.33	98.01	95.27	115.56	93.86	121.17	116.08	121.00	81.09	100.85
153.87	155.75	148.05	130.87	194.12	200.05	152.86	160.32	185.92	108.74	101.89	85.78	52.16	34.69
202.07	219.15	263.87	469.84	314.77	153.22	165.71	172.84	166.28	142.70	148.71	148.43	502.55	246.93
12,026.42	13,820.94	15,858.79	18,057.08	19,964.71	21,885.90	25,194.06	29,235.51	30,120.21	33,934.92	34,911.55	33,128.57	36,455.82	35,889.79

Source: IHME DAH Database 2014

In millions of 2014 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. Dashes indicate inapplicable.

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, 1990–2014

Funding source	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
NATIONAL TREASURIES											
Australia	35.32	35.11	106.03	100.53	161.42	152.31	192.17	97.82	89.56	155.11	213.78
Austria	44.06	17.41	17.88	43.80	45.10	33.84	22.80	81.23	36.55	143.27	57.70
Belgium	139.19	107.45	132.69	132.47	110.57	122.77	133.72	115.75	120.58	126.35	139.21
Canada	132.15	120.99	119.01	128.94	196.79	224.20	146.71	130.56	128.98	128.83	169.31
Denmark	105.18	161.94	215.36	181.91	141.03	128.06	233.72	229.26	142.36	167.36	95.23
Finland	123.47	99.62	57.94	46.09	49.52	39.40	53.13	42.91	44.89	49.41	49.51
France	843.65	414.62	377.91	333.17	513.24	555.92	523.28	386.60	445.15	359.09	292.10
Germany	219.43	237.00	328.97	354.77	579.51	696.16	556.14	574.09	509.24	471.95	401.91
Greece	1.70	1.65	1.60	1.56	2.28	10.40	15.35	14.62	16.51	9.89	11.46
Ireland	4.25	4.63	6.63	2.12	13.00	32.77	34.58	5.36	32.26	30.36	44.40
Italy	253.91	298.47	248.81	201.06	154.96	169.09	233.76	88.76	117.37	164.51	154.98
Japan	565.35	563.21	580.32	924.84	738.52	928.06	555.85	901.24	638.20	894.17	908.91
Luxembourg	1.46	1.44	10.46	10.34	4.29	20.15	21.31	32.39	35.18	26.84	38.32
Netherlands	224.92	160.53	344.69	250.53	196.42	275.45	357.64	282.37	321.70	312.81	449.20
New Zealand	1.60	5.97	5.13	4.56	59.87	57.22	2.90	2.79	10.89	12.42	9.75
Norway	129.26	122.26	189.83	90.10	106.78	141.11	157.66	139.85	134.19	205.01	144.49
Portugal	1.01	1.17	5.55	2.11	10.61	14.40	17.51	21.18	15.05	17.85	16.33
South Korea	1.13	3.32	6.22	7.99	7.58	14.37	11.94	64.69	55.79	170.60	107.67
Spain	18.61	46.34	165.99	132.04	77.96	201.72	303.93	154.01	189.69	184.52	202.95
Sweden	368.92	242.25	278.39	312.29	203.29	244.81	245.75	205.47	144.77	174.27	185.82
Switzerland	100.24	78.94	60.94	59.95	102.80	69.30	76.79	103.33	54.14	139.37	67.36
United Kingdom	193.88	195.55	363.95	211.05	232.25	204.42	250.54	315.87	448.32	534.39	1,010.19
United States	1,937.02	1,954.65	2,039.81	1,890.42	2,612.73	2,604.28	2,161.40	2,243.09	2,231.47	2,534.35	2,743.74
Other	142.66	138.06	181.88	177.65	226.92	222.28	129.94	127.76	359.05	353.60	113.16
PRIVATE PHILANTHROPY											
Bill & Melinda Gates Foundation (BMGF)	–	–	–	–	–	–	–	–	–	114.44	445.83
Corporate donations	47.39	51.71	65.10	82.59	107.13	101.63	117.94	128.55	142.72	150.37	138.25
Other[1]	396.54	468.98	592.29	650.51	676.48	694.35	743.28	790.30	1,084.82	1,121.87	1,335.10
Debt repayments (IBRD)	127.40	158.53	285.01	636.62	909.27	798.33	1,151.68	1,295.62	1,539.18	930.60	1,099.66
Other	368.76	356.88	245.42	239.72	296.48	290.42	198.54	195.20	234.44	230.90	249.08
Unallocable	336.28	358.84	388.19	409.10	425.69	404.25	483.59	557.94	685.91	769.47	705.87
Total	6,864.74	6,407.52	7,422.00	7,618.83	8,962.48	9,451.48	9,133.57	9,328.60	10,008.95	10,683.96	11,601.25

2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
154.81	153.48	176.30	202.79	270.97	268.45	291.70	329.98	387.14	598.27	790.36	913.72	935.12	964.30
25.45	34.42	42.96	56.97	71.39	62.50	75.02	95.03	85.77	107.61	133.33	169.07	187.84	121.96
149.16	158.89	172.29	222.46	197.86	236.44	250.43	365.15	374.64	358.93	374.67	308.08	256.01	206.04
188.40	255.45	376.90	504.21	819.34	483.05	645.34	670.02	771.07	1,102.64	1,202.81	1,248.33	1,173.13	1,150.10
103.73	114.27	151.98	191.02	219.56	228.76	246.59	245.13	302.78	355.29	332.17	307.23	278.97	192.68
60.71	66.73	73.32	68.45	84.84	102.65	107.77	116.74	115.80	167.17	140.36	129.04	107.65	35.13
373.64	457.41	568.33	662.02	799.04	1,058.78	873.94	1,275.89	1,105.03	1,314.56	967.23	1,080.39	1,088.43	1,027.72
469.24	592.62	586.32	657.99	684.98	986.06	956.09	1,168.28	1,292.29	1,205.74	1,196.07	1,231.70	1,279.53	1,284.94
14.25	12.50	39.07	40.16	58.93	64.17	65.01	39.43	46.18	21.30	15.76	12.42	1.74	0.28
56.24	127.85	162.86	180.31	200.09	293.44	314.94	248.35	195.76	176.53	153.13	139.41	111.33	93.08
180.88	231.98	291.46	229.98	496.28	451.82	494.81	553.45	326.33	289.64	273.29	207.10	154.96	110.49
904.98	688.62	833.43	1,221.41	805.71	923.69	759.07	752.09	858.54	1,072.68	922.07	1,492.78	1,020.75	1,071.22
48.68	55.41	53.77	64.26	59.76	77.45	87.07	89.99	88.78	98.93	81.71	72.96	73.97	51.46
495.72	496.79	580.54	539.07	594.04	756.92	714.91	840.21	768.79	698.33	732.17	691.31	716.86	675.41
10.24	12.43	18.69	22.48	32.11	30.37	28.74	30.96	32.54	49.86	45.07	48.43	40.72	35.41
327.06	349.61	376.84	419.71	534.65	439.44	588.72	599.39	673.84	627.03	680.51	721.72	820.23	845.14
16.83	20.73	21.68	23.74	28.27	29.00	30.73	25.89	29.17	31.56	34.58	29.25	25.16	7.93
80.93	84.41	45.98	120.55	140.35	86.00	184.94	367.19	250.47	206.43	217.80	311.43	312.12	272.22
194.10	190.59	220.03	258.15	310.68	377.06	535.50	772.05	977.18	628.72	385.95	158.59	150.18	129.11
186.11	202.80	235.58	412.60	541.39	587.57	635.12	654.37	562.30	563.48	620.61	680.48	615.47	313.73
64.41	83.14	157.28	95.33	100.75	125.33	93.83	118.16	201.77	138.63	198.21	156.54	159.81	130.88
635.96	869.60	937.13	1,009.22	1,462.03	1,799.85	2,192.95	1,844.18	1,972.46	2,551.21	2,657.88	3,234.50	3,728.72	3,789.27
3,086.19	4,175.53	4,415.05	5,523.97	5,493.76	6,277.06	7,846.17	9,796.69	10,481.76	12,081.47	13,011.15	10,892.42	12,661.49	12,385.93
112.12	92.73	95.17	152.16	163.96	195.01	238.91	278.91	262.57	244.79	280.28	270.32	877.35	1,483.47
540.55	573.22	663.49	466.35	776.62	920.39	1,224.07	1,960.67	1,835.11	1,805.55	2,129.14	2,531.18	2,739.39	2,903.38
201.70	226.61	282.51	401.76	490.77	447.00	511.56	754.10	640.45	564.25	591.12	564.54	671.03	662.38
1,317.10	1,272.76	1,399.06	1,584.11	1,934.03	2,204.79	2,399.24	2,720.36	2,680.41	3,064.95	3,141.63	2,469.79	2,680.67	2,660.11
1,139.85	1,202.09	1,825.00	1,127.17	1,105.32	902.12	1,162.97	810.40	1,165.55	2,197.61	2,065.13	1,347.38	1,183.13	1,132.34
250.05	273.10	304.33	359.22	363.29	545.94	730.60	780.82	650.09	663.17	584.02	690.23	1,141.08	965.70
637.31	745.18	751.45	1,239.44	1,123.91	924.80	907.30	931.66	985.63	948.58	953.38	1,018.23	1,262.99	1,187.96
12,026.42	13,820.94	15,858.79	18,057.08	19,964.71	21,885.89	25,194.05	29,235.51	30,120.21	33,934.91	34,911.55	33,128.57	36,455.82	35,889.79

Source: IHME DAH Database 2014

Notes: In millions of 2014 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. Dashes indicate inapplicable.

1 Includes private contributions through foundations and NGOs.

TABLE B3

DAH by focus region, 1990–2012

Year	Sub-Saharan Africa	Middle East and North Africa	South Asia	East Asia and Pacific
1990	1,386.81	198.59	703.74	813.11
1991	1,329.98	347.98	469.69	466.72
1992	1,464.80	305.73	875.91	520.21
1993	951.86	340.50	511.57	829.48
1994	1,314.68	315.06	924.79	637.50
1995	1,269.04	318.24	717.96	782.85
1996	1,472.27	370.90	881.87	590.70
1997	1,416.50	337.84	783.61	639.94
1998	1,412.49	377.12	812.04	751.87
1999	1,537.43	369.31	934.76	980.68
2000	1,668.73	390.18	989.01	1,107.05
2001	2,028.09	321.87	1,099.52	836.91
2002	1,912.54	328.34	1,221.26	792.31
2003	2,922.74	408.08	999.12	1,024.66
2004	3,904.30	465.10	1,394.38	1,229.20
2005	4,611.31	1,046.14	1,520.44	1,353.04
2006	5,497.13	1,011.24	1,463.32	1,580.92
2007	6,392.52	787.00	1,743.61	1,707.93
2008	8,594.73	780.71	1,910.70	1,737.31
2009	9,565.84	627.86	2,125.43	1,828.06
2010	10,426.66	670.23	2,207.28	1,997.13
2011	11,206.30	531.40	2,379.94	2,092.52
2012	11,910.35	564.14	2,303.31	2,275.62

Europe and Central Asia	Latin America and Caribbean	Global[1]	Unallocable by region	Total
2.79	648.33	68.92	3,042.45	6,864.74
6.56	737.42	107.87	2,941.32	6,407.52
122.85	775.24	269.37	3,087.90	7,422.00
173.02	969.03	515.21	3,328.16	7,618.83
236.36	834.16	917.65	3,782.29	8,962.48
266.78	1,203.93	1,199.59	3,693.09	9,451.48
228.30	1,280.32	900.73	3,408.48	9,133.57
355.04	1,438.46	760.89	3,596.32	9,328.60
356.00	1,788.23	758.68	3,752.51	10,008.94
420.41	1,342.65	900.71	4,198.01	10,683.96
350.40	1,335.51	984.16	4,776.20	11,601.25
349.46	1,371.73	1,065.69	4,953.15	12,026.42
373.62	1,206.32	1,699.07	6,287.48	13,820.94
347.94	2,222.07	2,289.65	5,644.54	15,858.79
456.16	1,631.93	1,626.46	7,349.56	18,057.08
590.91	1,425.23	1,896.71	7,520.94	19,964.71
771.48	1,267.48	2,206.04	8,088.28	21,885.90
810.61	1,546.93	3,285.10	8,920.34	25,194.06
860.86	1,520.05	3,361.62	10,469.53	29,235.51
864.80	1,727.09	3,672.84	9,708.29	30,120.21
1,041.78	2,561.92	4,003.29	11,026.63	33,934.91
1,120.57	2,385.46	4,301.35	10,894.01	34,911.55
716.27	1,846.12	3,154.27	10,358.49	33,128.57

Source: IHME DAH Database 2014

Notes: In millions of 2014 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 World Bank regional groups intended to benefit from the assistance. For preliminary estimates of DAH for 2013 and 2014, 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, 1990–2012

Recipient country	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Afghanistan	71.35	46.65	19.25	14.08	1.62	3.25	5.07	6.21	3.85	4.88
Albania	0.00	0.00	18.42	0.00	5.74	15.94	12.55	3.47	11.17	22.88
Algeria	0.00	0.00	6.28	4.14	0.01	0.04	0.01	0.36	1.41	2.02
Angola	12.30	21.45	21.46	11.60	7.86	48.55	96.12	44.82	23.58	31.08
Antigua and Barbuda	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.13	1.72
Argentina	11.91	22.15	105.59	18.77	25.25	191.24	275.11	284.59	292.51	132.15
Armenia	0.00	0.00	0.01	0.43	28.54	0.68	4.17	1.28	5.86	8.60
Azerbaijan	0.00	0.00	0.00	0.00	11.91	0.00	0.45	0.00	0.65	14.75
Bahrain	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.06	0.03
Bangladesh	97.64	143.55	421.75	125.39	208.56	113.57	100.03	136.82	273.47	285.06
Barbados	3.27	3.31	1.85	0.14	0.14	0.19	0.13	0.13	0.13	0.13
Belarus	0.00	0.00	0.00	0.00	0.00	0.04	0.00	0.03	0.02	0.00
Belize	6.91	4.53	4.18	8.31	0.08	0.44	0.43	0.57	0.45	0.78
Benin	12.00	8.78	39.37	15.59	37.28	13.77	18.93	12.06	33.98	21.09
Bhutan	15.65	0.79	0.00	0.00	1.26	0.77	0.22	9.30	7.49	0.68
Bolivia	49.06	41.29	73.84	65.55	57.20	45.06	57.27	52.09	76.00	63.45
Bosnia and Herzegovina	0.00	0.00	0.00	1.51	10.84	0.00	19.85	4.41	29.51	79.70
Botswana	11.15	0.00	6.98	4.91	5.17	22.15	0.26	0.87	0.57	0.19
Brazil	49.60	83.42	49.61	47.78	184.73	157.12	197.66	208.80	120.05	229.07
Bulgaria	0.00	0.00	0.00	0.03	0.00	0.06	0.03	1.61	21.93	2.15
Burkina Faso	18.93	15.50	19.24	17.55	75.35	32.43	13.03	34.44	36.73	27.07
Burundi	6.71	6.49	20.67	47.17	12.17	12.83	5.16	5.05	5.75	7.49
Cambodia	0.00	2.52	28.79	24.25	87.46	143.16	83.94	67.65	43.37	37.48
Cameroon	14.61	66.10	29.91	32.46	21.33	2.23	54.81	21.46	25.52	16.79
Cape Verde	0.00	0.00	0.00	0.96	1.63	0.32	0.00	3.91	0.94	2.90
Central African Republic	8.76	8.22	8.43	6.29	4.59	12.42	0.57	5.57	23.22	14.25
Chad	25.71	3.11	16.50	20.87	5.81	36.18	13.27	25.01	23.89	32.92
Chile	37.99	142.00	37.09	82.28	34.78	31.26	31.08	53.05	5.24	3.07
China	39.47	36.84	73.48	96.73	87.08	152.23	155.39	139.47	161.66	138.63
Colombia	5.65	9.61	5.96	57.66	9.74	13.01	64.62	50.79	30.41	59.80
Comoros	0.00	0.30	0.03	0.00	2.07	10.26	3.20	5.88	8.10	1.69
Congo	19.67	0.31	0.51	4.12	10.64	12.21	0.23	4.50	5.90	1.45
Congo, Democratic Republic of the	37.93	29.66	3.54	1.43	16.46	15.48	35.63	22.77	22.54	24.68
Costa Rica	2.21	0.20	3.47	8.47	6.47	8.82	9.64	12.39	16.03	20.53
Croatia	0.00	0.00	0.00	0.00	7.93	20.40	23.72	17.70	8.97	0.93
Cuba	0.00	0.00	0.94	0.96	0.02	1.32	0.24	1.72	1.00	5.87
Czech Republic	0.00	0.00	0.10	0.16	0.00	0.00	0.00	0.00	0.08	0.11
Côte d'Ivoire	35.54	50.03	82.06	27.03	120.60	103.30	68.81	37.59	43.21	41.25
Djibouti	9.01	8.17	17.00	0.79	0.32	7.95	2.07	13.55	15.72	5.45
Dominica	0.00	0.00	0.27	4.79	0.00	0.00	0.00	1.06	0.81	0.00

2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
3.94	11.14	20.84	42.51	118.50	155.14	160.26	197.42	227.63	328.53	340.91	451.75	350.27
22.33	22.48	19.16	24.39	24.54	28.67	33.04	17.55	23.47	20.30	16.28	33.10	12.74
1.25	2.11	1.42	0.43	3.11	2.40	3.58	3.99	5.50	2.28	2.27	5.25	2.69
31.37	41.22	37.34	40.86	53.03	128.04	60.06	77.85	101.32	91.99	92.90	73.70	114.22
1.13	0.11	NA	0.27	0.28	NA	NA	NA	NA	0.12	0.07	0.11	NA
73.46	216.84	84.66	796.45	226.83	82.45	72.85	318.29	171.91	164.63	171.75	313.70	268.03
16.05	9.22	15.40	6.04	9.45	19.01	28.38	31.63	24.35	44.70	29.32	31.12	34.26
19.09	3.36	6.31	3.80	3.46	11.37	15.66	14.85	16.40	23.60	27.84	43.81	23.31
0.02	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
247.43	216.04	161.12	167.92	182.71	228.16	282.09	198.20	300.18	300.71	308.26	315.68	427.32
NA	0.12	NA	4.67	6.18	2.30	NA	NA	NA	NA	NA	NA	NA
0.00	0.00	0.00	0.00	1.65	5.39	5.43	8.50	15.57	16.11	19.66	16.05	16.58
2.20	2.86	2.43	2.88	2.40	2.37	2.81	1.82	0.53	2.54	4.02	2.50	4.48
26.18	25.24	23.20	39.04	59.07	66.99	65.21	60.88	79.06	105.85	122.26	122.68	92.03
5.63	4.66	4.65	7.77	6.54	10.12	8.58	6.62	4.64	3.30	2.63	2.66	4.19
94.52	77.48	61.80	100.87	96.21	67.10	86.55	75.47	77.25	64.49	70.11	72.51	58.35
19.16	14.10	15.43	18.30	9.52	12.26	14.47	16.83	76.30	31.33	56.77	35.78	32.17
0.10	0.80	12.72	28.11	40.79	25.39	50.68	59.14	295.67	302.50	120.72	130.39	87.64
160.64	261.52	182.88	442.90	118.31	150.67	126.19	105.33	128.54	192.05	343.05	203.77	189.48
12.89	10.68	14.13	8.63	29.36	39.33	12.06	79.54	27.09	137.51	15.84	13.42	6.10
26.40	41.76	34.99	62.71	76.40	87.31	87.36	90.23	123.79	128.07	171.50	92.48	146.69
8.71	8.61	12.93	18.29	28.87	41.31	48.89	43.58	62.93	78.78	108.51	114.60	99.49
44.71	60.46	46.25	88.00	96.47	132.25	128.84	139.59	151.90	182.72	225.07	206.88	174.73
10.76	20.89	13.71	30.41	53.65	55.82	70.91	71.87	71.40	81.12	59.69	144.41	104.72
1.27	8.73	2.79	9.30	10.93	14.50	14.06	12.64	13.54	5.89	12.47	22.44	14.48
4.88	7.11	10.92	7.60	13.03	16.74	19.59	9.35	32.64	13.00	21.64	23.43	23.78
23.84	19.48	25.10	36.66	38.59	44.51	31.29	22.04	30.71	28.43	54.19	45.96	38.78
3.18	3.73	1.43	9.28	28.63	16.59	5.92	7.38	4.04	2.09	3.24	1.73	NA
191.51	106.74	148.92	163.56	274.27	231.62	303.11	385.11	313.76	399.94	322.54	288.05	395.25
17.45	76.29	143.90	179.28	433.14	244.02	120.18	121.49	55.68	195.93	307.09	267.12	90.76
1.82	1.92	4.45	6.29	4.51	2.70	1.71	1.93	1.45	3.89	9.31	7.43	8.40
0.38	0.75	2.38	1.74	8.01	7.34	8.56	8.31	16.34	11.45	31.79	30.12	20.78
28.39	39.89	42.72	74.00	88.40	163.99	163.02	167.93	396.79	431.05	439.53	500.97	596.05
28.63	11.31	12.96	13.02	8.15	2.73	6.70	6.40	10.52	9.79	6.55	2.79	2.47
4.16	5.92	7.21	10.74	4.98	17.42	25.20	0.69	NA	NA	NA	NA	NA
4.18	4.64	5.62	14.94	14.65	8.97	9.45	16.46	11.37	20.87	19.59	14.94	12.66
0.00	0.00	0.00	0.00	0.00	0.00	NA	NA	NA	NA	NA	NA	NA
13.30	18.61	47.68	40.00	54.28	53.06	78.69	75.09	150.88	122.45	211.88	136.11	152.48
4.23	0.83	2.72	2.22	8.28	15.51	16.33	19.93	16.10	14.16	7.65	9.38	17.29
0.00	0.00	0.00	0.25	0.18	0.19	0.20	0.13	0.17	0.23	0.25	0.53	0.15

TABLE B4

DAH by target country, 1990–2012, continued

Recipient country	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Dominican Republic	19.30	5.13	15.31	15.38	9.07	9.13	46.22	19.04	51.25	66.26
Ecuador	32.49	14.95	27.43	19.28	62.45	19.49	23.92	26.40	47.60	26.56
Egypt	57.44	152.47	149.36	155.37	158.62	138.90	134.14	85.04	129.09	91.32
El Salvador	45.95	81.19	80.45	56.94	23.22	44.29	50.36	26.71	37.53	32.02
Equatorial Guinea	0.00	0.00	0.48	1.47	6.45	0.86	6.71	1.38	1.30	2.65
Eritrea	0.00	0.00	0.00	0.00	11.08	11.89	15.95	5.25	15.98	22.00
Estonia	0.00	0.00	0.00	0.00	0.00	0.00	0.04	0.12	0.58	1.99
Ethiopia	73.18	17.17	49.14	18.97	38.32	65.21	84.71	56.68	50.40	98.58
Fiji	0.00	34.69	23.41	10.60	0.00	0.51	0.06	0.45	10.87	14.02
Gabon	1.61	0.00	3.72	17.93	0.04	0.03	2.68	6.84	10.00	2.35
Gambia	0.15	2.65	13.51	19.53	3.31	2.24	2.07	2.25	3.62	6.01
Georgia	0.00	0.00	0.00	0.00	16.04	0.54	3.19	3.47	8.71	20.21
Ghana	4.78	139.39	29.33	76.89	21.97	21.30	23.25	82.52	27.63	64.87
Grenada	12.30	0.00	0.00	0.00	0.00	0.00	0.00	0.43	0.36	0.00
Guatemala	25.48	14.31	28.77	48.31	17.12	24.79	25.62	141.26	35.78	70.70
Guinea	1.38	28.92	11.21	11.89	17.26	45.01	19.49	39.19	32.11	22.03
Guinea-Bissau	6.66	10.67	6.00	8.01	3.93	29.05	4.35	5.70	6.93	0.68
Guyana	4.38	4.24	4.15	5.32	5.21	5.14	4.98	5.88	4.47	4.13
Haiti	54.56	68.46	37.06	61.31	48.64	157.18	30.59	30.90	76.85	53.25
Honduras	52.28	40.15	65.70	28.97	26.43	23.63	49.87	54.32	28.62	68.83
Hungary	0.00	0.00	0.00	6.47	2.43	1.89	14.52	13.91	7.09	3.51
India	278.79	95.24	320.44	230.47	461.17	435.35	602.06	411.77	346.03	488.64
Indonesia	406.25	97.82	83.71	242.01	159.98	221.31	117.14	138.34	153.40	256.97
Iran	0.00	2.01	0.00	0.00	0.00	4.56	40.76	38.64	23.11	12.02
Iraq	1.12	0.00	0.12	0.73	0.69	6.28	3.78	0.07	0.62	2.23
Jamaica	26.50	30.71	31.76	23.38	24.94	36.15	24.54	20.61	22.26	18.96
Jordan	1.35	12.09	1.46	13.50	29.46	24.70	12.99	20.46	31.15	58.74
Kazakhstan	0.00	0.00	0.00	0.00	9.53	6.37	8.64	7.36	14.53	23.58
Kenya	212.81	54.67	122.60	38.73	46.50	83.01	120.70	71.79	105.34	89.87
Kiribati	13.05	0.00	4.29	0.05	0.11	0.44	0.28	0.27	0.18	0.00
Kyrgyzstan	0.00	0.00	0.00	0.15	3.01	15.58	14.20	12.49	22.54	7.81
Laos	0.00	0.00	2.30	1.39	3.90	10.26	6.55	6.54	9.72	14.44
Latvia	0.00	0.00	0.00	10.42	9.24	0.78	0.01	0.00	0.49	0.89
Lebanon	2.08	7.72	1.85	0.60	1.46	24.81	2.35	4.58	7.32	11.70
Lesotho	3.52	6.13	4.73	1.61	7.57	10.43	9.96	4.31	1.19	0.30
Liberia	0.00	0.00	0.85	2.43	0.08	0.04	0.38	2.98	5.44	6.98
Libya	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.02	0.00
Lithuania	0.00	0.00	0.00	16.75	1.66	4.59	0.07	0.00	0.01	0.01
Macedonia, FYR	0.00	0.00	0.00	0.00	0.00	10.40	8.06	6.11	9.42	22.22
Madagascar	8.68	37.02	35.84	21.73	45.64	35.53	38.17	30.18	50.43	27.83

2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
36.18	33.38	30.93	35.77	54.77	72.31	46.28	51.36	54.65	127.33	113.29	54.64	78.45
26.63	26.46	13.68	33.67	32.50	37.14	46.42	59.78	57.98	44.45	37.79	35.85	17.73
104.10	94.35	73.39	58.33	90.55	113.18	163.18	112.23	146.67	65.55	76.24	57.70	25.88
27.71	46.03	28.85	24.54	30.72	36.26	33.44	34.21	35.62	39.20	77.10	39.20	36.60
5.01	4.26	2.54	3.70	5.53	9.87	13.00	NA	NA	NA	NA	NA	NA
29.53	15.82	26.68	44.10	42.70	39.77	18.87	23.44	28.05	20.04	53.97	21.72	34.54
0.15	0.00	0.00	1.43	2.36	3.17	NA	NA	NA	NA	NA	NA	NA
81.54	98.32	115.10	216.33	208.84	265.10	438.33	621.12	624.47	686.74	872.13	1,012.40	889.25
9.73	4.94	6.42	16.41	7.45	3.44	7.50	9.92	6.66	7.19	11.94	10.86	6.55
2.43	2.87	2.67	3.95	8.20	7.45	12.59	8.71	6.53	11.67	5.62	6.99	5.93
6.15	6.68	7.94	9.82	19.59	25.43	11.75	15.22	15.02	18.77	28.78	35.23	38.22
19.13	20.17	22.11	12.17	15.52	35.55	41.90	43.78	28.64	44.95	39.63	48.49	48.92
54.98	99.76	95.25	146.45	233.79	227.82	201.84	206.59	254.68	279.07	260.75	285.43	363.81
0.00	0.00	0.00	0.35	0.32	0.10	0.27	0.56	0.34	0.35	0.00	0.02	0.08
37.80	54.61	38.44	56.94	36.85	37.35	43.20	59.62	93.71	77.84	69.50	94.15	61.12
25.89	38.93	25.48	24.05	29.83	27.61	35.20	24.22	32.37	29.54	44.69	33.09	54.91
4.61	8.96	9.00	9.41	12.49	13.65	12.42	17.71	13.80	16.60	29.16	16.47	7.40
1.05	2.22	3.12	14.60	30.25	24.79	35.22	31.43	40.56	37.10	33.53	25.76	19.75
43.18	39.98	27.13	64.89	71.42	80.64	140.58	160.76	177.10	177.29	216.88	273.00	253.31
47.43	34.78	27.49	44.78	68.41	75.25	47.75	55.89	62.87	68.22	62.83	71.97	90.70
3.34	0.09	0.00	0.00	0.00	0.00	0.00	NA	NA	NA	NA	NA	0.14
587.72	613.97	729.11	538.28	759.44	788.23	572.85	781.80	815.14	916.57	953.92	1,073.25	854.51
392.92	249.73	189.65	232.55	243.26	222.48	318.34	272.53	372.05	310.44	275.23	308.03	429.29
7.49	13.99	3.90	0.63	6.29	73.80	13.42	8.20	15.91	17.41	10.08	13.12	20.56
1.45	2.90	0.51	28.99	86.69	527.71	424.37	257.73	96.16	96.05	101.32	34.77	25.10
21.11	53.00	7.89	9.87	12.69	12.71	16.96	16.86	17.55	14.95	37.39	23.96	12.17
49.43	44.94	50.10	52.56	43.94	21.43	17.30	12.34	33.33	39.42	48.64	56.77	105.73
23.14	24.40	11.57	21.51	16.02	12.34	18.59	11.67	22.43	23.93	41.99	39.06	42.39
105.33	131.38	122.60	189.66	257.16	257.63	398.21	409.88	546.43	702.25	852.65	952.31	1,025.73
0.04	0.22	0.17	0.21	6.47	2.49	3.31	5.21	8.91	5.33	6.23	5.36	6.50
17.67	7.43	15.52	30.60	20.42	34.04	34.27	43.36	51.49	39.51	43.17	54.26	43.38
29.86	18.91	16.81	39.99	29.39	43.89	39.35	45.94	48.92	45.78	61.21	68.94	64.03
1.91	2.59	4.75	0.90	1.99	0.00	0.00	0.00	0.00	NA	42.42	48.34	NA
8.79	9.77	12.13	17.37	10.89	3.44	4.54	12.71	10.32	8.03	10.55	7.18	7.08
3.17	5.90	5.34	11.58	14.92	14.72	16.19	24.78	49.62	41.59	87.08	125.93	120.08
10.39	5.51	4.75	7.39	15.27	17.74	18.78	21.67	59.36	91.73	95.47	94.94	116.68
0.00	0.00	0.00	0.00	0.00	0.27	0.59	1.81	37.72	22.69	0.85	13.19	1.43
1.15	0.71	5.03	5.11	8.31	2.44	2.21	0.00	0.00	0.00	0.00	0.00	NA
9.08	17.23	4.30	5.82	9.02	11.35	8.31	23.88	9.68	3.78	13.16	8.64	2.25
27.05	37.31	32.80	62.25	86.56	99.75	69.82	90.60	94.53	75.02	164.22	104.34	101.18

TABLE B4

DAH by target country, 1990–2012, continued

Recipient country	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Malawi	89.25	21.76	57.37	39.54	48.95	48.50	59.06	68.39	52.42	104.17
Malaysia	44.18	67.37	24.95	140.65	18.39	29.09	49.38	36.19	17.91	19.91
Maldives	0.00	0.00	18.32	8.11	0.00	0.00	0.00	1.11	0.00	0.28
Mali	26.38	39.59	48.65	30.94	44.07	39.99	27.91	33.69	9.97	29.80
Malta	0.00	0.00	0.00	0.00	0.04	0.00	0.00	0.00	NA	0.00
Marshall Islands	0.00	0.00	0.13	0.13	0.62	1.32	1.21	1.16	1.02	6.14
Mauritania	73.90	0.05	19.60	6.22	36.63	2.92	19.35	9.68	10.91	9.09
Mauritius	0.00	0.00	0.00	0.00	2.83	0.05	2.68	0.51	0.31	0.19
Mexico	47.82	33.10	21.50	105.67	57.24	144.89	134.49	160.64	584.79	113.02
Micronesia, Federated States of	0.00	0.00	13.44	0.00	0.00	0.00	0.00	0.00	0.00	11.19
Moldova	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.02	2.19	17.98
Mongolia	12.01	1.52	10.98	13.74	4.20	5.80	4.94	3.27	12.25	14.56
Montenegro	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Morocco	22.23	28.89	47.61	75.97	51.36	45.58	58.55	26.64	52.93	41.38
Mozambique	133.66	175.58	138.07	29.61	119.39	79.11	115.40	90.54	81.53	101.67
Myanmar	2.67	0.00	0.00	0.23	0.29	0.21	0.50	0.82	2.24	6.30
Namibia	7.05	10.40	6.41	23.32	5.19	10.77	6.94	13.26	8.09	7.92
Nepal	52.82	71.70	22.61	45.20	22.00	17.50	18.99	41.01	50.94	45.49
Nicaragua	29.13	29.57	61.05	36.93	58.15	40.47	65.81	55.32	49.99	118.59
Niger	8.36	29.15	52.62	19.70	19.10	18.98	23.12	19.33	22.58	12.77
Nigeria	41.63	30.72	21.92	72.07	26.68	20.30	19.55	20.98	33.83	60.83
North Korea	0.00	0.00	0.00	0.00	0.03	0.00	0.00	0.00	0.80	0.73
Occupied Palestinian Territory	0.06	0.05	0.02	0.06	19.54	14.05	34.42	52.00	40.24	39.13
Oman	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.04	0.04
Pakistan	168.20	54.83	43.57	62.32	216.28	129.20	142.62	128.39	82.37	75.84
Panama	0.12	13.68	9.82	0.86	8.82	8.73	31.25	20.96	15.57	14.91
Papua New Guinea	53.13	65.79	41.64	10.68	17.60	5.12	54.24	26.50	51.35	93.38
Paraguay	0.67	0.14	0.15	4.60	0.06	0.04	0.17	4.84	26.83	34.68
Peru	40.62	26.12	32.20	93.70	94.16	134.23	74.87	68.57	100.16	87.12
Philippines	133.41	123.88	87.77	117.15	74.68	152.08	64.86	68.88	99.83	109.40
Poland	0.00	0.00	0.24	4.36	9.83	10.45	22.53	37.53	0.91	3.05
Romania	0.00	0.00	28.21	20.27	13.65	46.50	28.21	13.77	40.63	25.02
Russia	0.00	0.00	0.55	99.95	61.17	0.94	0.36	147.52	98.98	58.29
Rwanda	23.35	27.06	23.25	7.70	7.46	18.62	17.75	33.21	32.97	29.73
Samoa	0.00	0.00	0.00	14.13	2.06	0.52	0.29	0.13	0.26	0.38
Sao Tome and Principe	7.87	0.50	0.42	2.35	12.15	3.17	2.80	1.35	1.73	8.90
Saudi Arabia	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.50	0.29
Senegal	25.73	35.16	45.76	43.50	38.49	38.14	25.39	45.80	58.72	57.14
Serbia	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.53	19.12
Seychelles	0.00	0.00	1.99	0.00	0.23	2.94	0.00	1.29	1.63	0.63

2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
90.32	78.60	71.34	92.38	125.66	136.33	196.14	263.75	312.86	295.31	254.08	366.90	428.36
16.16	11.03	1.56	3.35	1.79	1.83	1.06	0.92	0.85	0.65	0.33	1.98	3.12
0.46	0.15	0.13	0.11	0.19	0.57	0.17	1.85	0.73	1.49	0.88	0.60	1.23
30.75	55.68	23.20	61.15	61.60	93.95	94.78	112.36	143.61	143.56	205.55	209.18	176.74
NA	0.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
2.46	2.45	1.95	4.62	12.76	18.74	9.41	9.88	10.49	12.53	0.25	0.36	11.79
11.74	10.97	10.60	12.73	14.77	6.12	8.23	16.25	16.09	11.89	9.37	11.93	7.99
0.24	0.20	0.00	0.20	0.23	0.23	0.68	1.01	0.01	0.94	2.56	1.87	2.54
417.33	134.32	218.74	32.16	34.00	81.87	128.91	103.54	106.45	47.04	597.82	565.12	317.15
0.00	0.08	0.00	5.55	21.82	23.74	22.27	22.91	23.11	31.80	0.53	1.18	30.27
20.72	7.41	6.22	7.12	16.77	19.45	12.66	19.70	19.04	47.84	53.92	38.67	41.48
8.46	20.51	6.54	9.84	7.26	10.16	8.70	18.64	18.60	22.66	32.52	32.09	34.52
0.00	0.00	0.00	0.00	2.86	0.00	8.86	8.44	10.38	2.94	3.34	4.59	3.54
65.96	29.55	32.30	50.90	28.06	58.90	89.70	57.81	52.71	87.40	116.00	97.63	77.06
116.87	125.72	157.51	174.73	235.41	233.22	260.50	380.80	505.41	475.12	567.62	587.60	590.81
7.31	5.45	15.94	33.03	31.86	48.44	23.71	43.29	52.88	58.71	99.96	71.76	167.77
7.55	11.47	12.13	18.63	36.14	40.64	92.53	112.98	102.42	167.61	173.06	129.45	160.20
40.73	60.01	50.51	76.03	66.04	75.63	90.51	81.14	128.86	111.19	158.94	135.05	130.59
60.77	50.95	56.77	68.40	74.77	79.88	82.46	90.76	97.53	98.24	72.85	66.55	65.62
18.91	25.74	27.59	45.53	44.59	44.30	75.85	64.26	103.83	80.39	61.55	80.72	43.66
173.58	100.48	98.05	154.46	274.28	349.98	477.05	511.08	754.70	1,068.08	877.75	942.49	1,108.75
0.00	0.35	1.71	1.68	2.77	5.62	3.16	2.59	3.11	7.81	27.80	18.13	18.83
48.70	36.39	34.12	73.47	76.98	68.50	61.74	84.74	79.67	54.53	74.11	84.43	66.03
0.01	0.01	0.01	0.06	0.06	0.02	0.00	NA	NA	NA	NA	NA	NA
63.66	153.67	206.12	116.47	225.68	197.46	274.19	376.12	355.67	372.90	329.09	311.09	464.05
12.76	14.59	17.80	9.35	9.66	7.82	7.17	6.79	7.18	38.56	12.20	10.98	14.72
98.59	49.26	64.03	62.51	64.29	68.48	68.89	62.82	76.05	102.37	113.22	171.53	152.81
24.09	15.29	11.33	13.60	12.52	12.09	12.47	18.81	26.99	25.76	32.77	18.99	21.87
105.78	82.82	98.79	111.39	127.28	100.80	72.84	65.11	149.70	144.20	105.49	54.41	74.43
92.27	104.94	52.36	96.54	103.20	184.34	191.15	163.18	102.02	111.51	209.30	205.64	182.83
1.97	23.26	16.15	0.00	0.00	0.00	0.01	0.01	0.00	NA	NA	NA	NA
0.32	17.17	21.81	11.48	30.91	13.28	8.31	33.65	30.50	14.09	9.46	166.41	13.42
49.97	54.27	33.27	10.34	21.28	46.69	112.53	143.79	145.09	75.57	40.31	16.03	NA
30.29	38.74	44.06	53.06	108.25	123.40	168.88	195.95	290.61	319.80	383.90	406.73	379.23
4.13	1.84	0.41	3.74	4.11	4.25	6.43	4.34	3.96	3.44	9.62	2.79	12.62
6.21	6.59	5.09	4.31	5.40	5.22	4.91	3.93	6.61	4.59	5.20	9.67	5.30
0.05	0.08	0.15	0.32	NA	NA	NA	NA	NA	NA	NA	NA	NA
43.00	72.48	51.47	110.15	132.98	128.43	148.35	82.29	113.84	143.11	124.83	148.78	176.67
22.68	19.31	32.73	49.11	34.63	21.84	32.86	20.57	19.36	31.37	16.49	53.92	37.20
0.11	0.29	0.43	1.41	1.41	1.33	0.20	0.10	0.07	0.18	0.60	0.06	0.17

TABLE B4

DAH by target country, 1990–2012, continued

Recipient country	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Sierra Leone	0.28	0.00	8.88	2.94	3.33	3.24	5.91	0.78	6.26	5.29
Slovakia	0.00	0.00	0.00	0.06	0.00	0.00	0.00	0.00	0.02	0.00
Slovenia	0.00	0.00	0.00	0.00	0.00	0.00	0.00	NA	NA	NA
Solomon Islands	3.08	0.12	5.04	1.26	2.62	1.11	1.85	1.75	1.06	2.27
Somalia	13.92	10.63	3.76	6.85	5.76	3.74	4.25	2.84	3.63	4.53
South Africa	0.83	0.00	5.80	3.64	24.52	13.00	36.31	34.05	49.57	40.84
South Korea	58.57	0.00	9.71	54.98	33.33	NA	NA	NA	0.01	0.07
South Sudan	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Sri Lanka	16.70	52.11	27.98	24.18	11.37	14.98	10.99	26.07	41.40	16.60
St. Lucia	5.31	3.49	0.00	0.10	4.17	0.01	4.73	1.23	0.87	0.05
St. Vincent and the Grenadines	0.00	0.00	0.00	0.04	0.12	0.37	0.58	0.06	0.09	0.07
Sudan	11.27	2.43	19.91	3.98	2.41	17.30	13.15	7.36	12.33	12.06
Suriname	18.01	17.08	30.70	4.22	5.71	23.39	8.34	3.40	20.45	12.75
Swaziland	4.59	5.98	2.48	0.26	9.38	2.44	1.48	1.82	5.37	2.22
Syria	0.00	0.46	0.00	26.12	0.00	0.00	0.00	5.46	3.25	0.12
Tajikistan	0.00	0.00	0.00	0.00	10.72	1.96	2.11	2.60	3.15	3.63
Tanzania	85.53	61.27	104.80	54.08	48.30	53.79	105.12	122.85	110.87	208.62
Thailand	2.56	0.96	28.12	22.04	4.05	2.29	12.59	9.17	85.10	123.18
Timor-Leste	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.33
Togo	3.27	14.82	27.35	0.79	7.78	3.04	28.95	4.89	13.18	2.57
Tonga	0.00	0.02	0.00	0.19	0.66	0.60	0.00	2.12	0.00	0.10
Trinidad and Tobago	0.01	0.98	1.16	1.46	1.10	1.11	8.02	15.32	14.89	14.51
Tunisia	1.88	0.00	9.00	6.13	15.07	12.19	15.24	10.41	16.86	22.23
Turkey	0.20	1.74	71.70	9.45	13.31	92.10	47.21	44.63	35.79	28.52
Turkmenistan	0.00	0.00	0.00	0.00	2.78	3.49	1.90	1.48	8.17	4.32
Uganda	78.64	126.68	87.48	52.25	44.26	71.18	93.90	100.18	92.84	99.38
Ukraine	0.00	0.00	0.00	0.00	0.02	0.00	0.02	0.00	0.01	0.00
Uruguay	0.09	0.18	1.50	91.66	22.19	0.41	1.64	0.61	2.57	2.13
Uzbekistan	0.00	0.00	0.00	0.00	2.98	27.24	13.21	7.68	11.02	27.29
Vanuatu	0.19	1.31	0.00	0.26	15.79	0.28	0.06	0.92	5.90	1.83
Venezuela	0.00	1.24	1.56	3.82	11.30	53.30	27.54	46.52	89.65	51.08
Vietnam	28.28	15.38	54.36	48.79	92.55	34.90	27.27	94.80	68.09	88.95
Yemen	4.27	33.49	25.03	34.62	7.96	21.91	30.47	25.19	18.62	25.82
Zambia	42.25	5.61	51.64	68.85	52.25	62.87	59.01	56.46	33.05	41.05
Zimbabwe	40.13	43.72	95.04	41.75	52.60	56.28	61.49	79.23	63.94	52.09

2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
21.72	15.13	12.73	18.99	24.59	36.03	34.28	39.52	51.15	47.80	65.90	72.68	66.96
0.00	0.00	0.00	0.00	19.50	21.19	2.12	NA	NA	NA	NA	NA	NA
NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
5.77	6.86	8.30	12.69	15.65	12.94	12.43	14.36	20.10	22.56	29.53	43.48	21.39
3.24	4.24	5.67	5.07	16.91	18.84	23.52	25.52	27.34	23.83	43.03	42.33	95.14
43.42	73.25	64.00	141.83	163.01	216.40	251.34	412.49	602.55	806.96	835.85	937.54	856.06
0.05	NA	NA	NA	NA	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	124.20	209.10
15.62	13.74	19.44	27.55	10.25	18.75	40.36	26.49	36.23	39.67	58.65	40.59	33.48
0.00	0.05	0.12	0.40	0.26	0.28	0.67	0.40	1.24	1.66	1.53	16.72	12.98
0.03	0.02	0.00	0.13	0.14	0.12	0.47	0.41	0.42	0.66	0.71	0.22	0.59
8.98	9.32	20.48	18.04	39.83	72.74	84.01	84.74	137.14	181.80	208.70	131.04	147.75
6.16	8.21	9.77	11.18	11.56	12.91	5.23	8.25	9.73	21.38	15.07	15.05	4.39
2.32	2.04	2.23	10.72	5.35	28.55	16.33	24.57	25.05	42.10	77.45	96.17	66.08
0.31	0.08	17.88	2.96	6.61	17.00	4.76	7.67	17.86	32.57	18.58	2.80	4.24
4.57	4.13	7.71	12.92	23.20	20.60	24.81	29.94	41.74	55.88	52.69	42.75	59.37
94.73	194.95	140.79	153.80	271.52	328.27	415.15	517.78	731.82	681.85	918.80	914.32	932.00
71.01	21.66	23.67	37.23	59.04	43.52	96.35	69.83	75.63	56.85	72.94	107.57	50.40
0.86	3.17	16.50	3.33	8.53	10.67	19.06	21.12	27.81	23.26	30.28	28.13	34.37
4.99	3.47	2.78	13.71	16.41	20.21	16.05	26.70	31.30	37.18	30.19	46.99	20.01
0.26	1.12	1.15	2.47	3.63	15.87	5.44	5.49	2.19	3.46	6.27	19.52	8.99
13.86	13.57	13.36	13.03	18.81	13.84	NA	NA	NA	NA	NA	NA	NA
9.38	18.05	21.12	23.39	9.03	4.93	33.79	8.33	38.92	5.60	11.00	4.71	5.99
26.93	8.71	31.03	27.02	26.89	30.07	147.75	53.85	88.40	30.22	314.70	190.44	22.71
2.89	2.22	2.48	2.62	2.08	2.50	2.16	2.29	2.50	2.36	2.39	7.28	3.38
112.01	180.90	84.51	224.93	321.28	349.37	371.09	452.77	431.18	532.93	600.56	577.46	774.32
0.00	0.00	2.02	3.16	24.53	45.87	75.81	79.90	78.75	78.97	62.80	88.25	108.97
0.06	13.82	48.05	61.24	0.79	39.39	0.84	3.46	1.27	1.15	6.05	23.14	NA
17.11	29.25	35.79	29.45	48.87	34.44	36.08	42.41	41.05	48.17	36.43	44.05	75.01
1.85	3.48	2.81	4.23	4.37	4.25	3.47	3.74	6.06	10.02	6.85	8.78	11.22
17.36	19.51	14.01	8.78	8.68	11.98	2.19	1.96	1.89	3.35	3.11	1.25	1.27
84.63	97.48	114.34	144.62	154.29	179.61	213.65	276.55	319.28	293.27	351.66	375.32	351.43
19.27	25.08	21.56	42.58	21.75	49.62	51.94	58.34	65.73	50.93	69.38	52.24	99.51
68.15	86.47	104.57	171.77	226.97	274.95	238.06	352.39	480.27	425.69	370.56	541.06	539.61
43.82	49.08	43.24	49.38	52.48	123.47	119.94	176.59	129.21	246.90	237.78	191.19	427.42

Source: IHME DAH Database 2014

Notes: Development assistance for health (DAH) is in millions of 2014 US dollars. DAH includes both financial and in-kind contributions for activities aimed at improving health in low- and middle-income countries.This table disaggregates financial DAH transfers by the country receiving funds or intended to benefit from research or technical assistance activities. 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, the Global Fund, Gavi, and BMGF. Years in which a country was classified as high-income by the World Bank are marked as "NA."

TABLE B5

DAH per capita by target country, 1990–2012

Recipient country	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Afghanistan	5.66	3.47	1.32	0.89	0.10	0.18	0.27	0.31	0.19	0.23
Albania	0.00	0.00	5.16	0.00	1.63	4.56	3.61	1.00	3.23	6.65
Algeria	0.00	0.00	0.22	0.14	0.00	0.00	0.00	0.01	0.04	0.06
Angola	1.11	1.88	1.82	0.96	0.63	3.76	7.23	3.28	1.68	2.15
Antigua and Barbuda	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	14.78	21.83
Argentina	0.35	0.65	3.04	0.53	0.71	5.29	7.52	7.68	7.80	3.49
Armenia	0.00	0.00	0.00	0.12	8.38	0.20	1.27	0.40	1.82	2.69
Azerbaijan	0.00	0.00	0.00	0.00	1.51	0.00	0.06	0.00	0.08	1.79
Bahrain	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.10	0.05
Bangladesh	0.88	1.26	3.62	1.05	1.72	0.92	0.79	1.06	2.08	2.12
Barbados	12.16	12.26	6.81	0.51	0.50	0.70	0.48	0.47	0.46	0.45
Belarus	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Belize	35.11	22.55	20.44	39.84	0.38	2.03	1.95	2.48	1.91	3.27
Benin	2.29	1.62	7.00	2.67	6.16	2.20	2.93	1.81	4.97	3.00
Bhutan	28.26	1.43	0.00	0.00	2.37	1.44	0.42	17.20	13.56	1.20
Bolivia	6.94	5.70	9.97	8.65	7.38	5.69	7.07	6.29	8.99	7.35
Bosnia and Herzegovina	0.00	0.00	0.00	0.37	2.83	0.00	5.44	1.20	7.86	20.78
Botswana	7.75	0.00	4.59	3.15	3.23	13.52	0.15	0.51	0.32	0.11
Brazil	0.32	0.53	0.31	0.30	1.12	0.94	1.17	1.21	0.69	1.29
Bulgaria	0.00	0.00	0.00	0.00	0.00	0.01	0.00	0.19	2.61	0.26
Burkina Faso	2.05	1.64	1.98	1.76	7.34	3.07	1.20	3.09	3.20	2.29
Burundi	1.14	1.07	3.34	7.48	1.90	1.97	0.78	0.76	0.85	1.09
Cambodia	0.00	0.26	2.86	2.33	8.14	12.92	7.35	5.76	3.59	3.02
Cameroon	1.15	5.08	2.23	2.36	1.51	0.15	3.67	1.40	1.62	1.04
Cape Verde	0.00	0.00	0.00	2.42	3.99	0.77	0.00	8.98	2.11	6.43
Central African Republic	2.88	2.65	2.65	1.93	1.37	3.63	0.16	1.56	6.36	3.83
Chad	4.12	0.48	2.48	3.04	0.82	4.93	1.75	3.19	2.95	3.92
Chile	2.78	10.21	2.62	5.71	2.37	2.10	2.06	3.46	0.34	0.19
China	0.03	0.03	0.06	0.08	0.07	0.12	0.12	0.11	0.12	0.11
Colombia	0.16	0.27	0.17	1.58	0.26	0.34	1.68	1.30	0.76	1.48
Comoros	0.00	0.68	0.06	0.00	4.37	21.12	6.42	11.51	15.47	3.13
Congo	7.90	0.12	0.19	1.53	3.84	4.29	0.08	1.50	1.91	0.46
Congo, Democratic Republic of the	1.03	0.78	0.09	0.03	0.39	0.35	0.79	0.49	0.48	0.51
Costa Rica	0.70	0.06	1.04	2.48	1.84	2.45	2.62	3.28	4.14	5.18
Croatia	0.00	0.00	0.00	0.00	1.62	4.20	4.93	3.72	1.91	0.20
Cuba	0.00	0.00	0.08	0.09	0.00	0.12	0.02	0.15	0.09	0.51
Czech Republic	0.00	0.00	0.01	0.01	0.00	0.00	0.00	0.00	0.01	0.01
Côte d'Ivoire	2.82	3.84	6.10	1.94	8.41	7.00	4.53	2.41	2.70	2.52
Djibouti	15.05	13.10	26.40	1.19	0.47	11.54	2.94	18.93	21.59	7.37
Dominica	0.00	0.00	3.81	67.47	0.00	0.00	0.00	14.99	11.53	0.00

2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
0.18	0.50	0.89	1.76	4.72	5.97	5.99	7.19	8.09	11.40	11.56	14.96	11.33
6.52	6.60	5.66	7.25	7.35	8.64	10.01	5.35	7.18	6.23	5.00	10.15	3.90
0.04	0.06	0.04	0.01	0.09	0.07	0.10	0.11	0.15	0.06	0.06	0.13	0.07
2.11	2.69	2.35	2.49	3.12	7.29	3.30	4.14	5.22	4.59	4.49	3.45	5.19
14.04	1.37	NA	3.18	3.26	NA	NA	NA	NA	1.39	0.76	1.25	NA
1.92	5.60	2.16	20.17	5.69	2.05	1.79	7.76	4.16	3.94	4.08	7.38	6.25
5.06	2.92	4.90	1.93	3.03	6.11	9.16	10.24	7.92	14.57	9.56	10.14	11.13
2.29	0.40	0.74	0.44	0.40	1.29	1.75	1.64	1.78	2.54	2.96	4.60	2.42
0.04	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
1.81	1.55	1.14	1.17	1.26	1.55	1.89	1.32	1.97	1.96	1.98	2.01	2.69
NA	0.43	NA	16.63	21.87	8.11	NA	NA	NA	NA	NA	NA	NA
0.00	0.00	0.00	0.00	0.16	0.54	0.54	0.86	1.57	1.63	1.99	1.62	1.67
8.91	11.30	9.35	10.82	8.79	8.44	9.78	6.19	1.76	8.19	12.67	7.67	13.43
3.61	3.37	3.00	4.89	7.16	7.86	7.41	6.71	8.46	11.00	12.35	12.05	8.80
9.68	7.79	7.55	12.26	10.04	15.15	12.55	9.49	6.53	4.56	3.57	3.55	5.50
10.72	8.62	6.74	10.80	10.12	6.93	8.79	7.54	7.59	6.24	6.67	6.79	5.38
4.91	3.59	3.91	4.64	2.41	3.11	3.67	4.27	19.34	7.94	14.38	9.05	8.13
0.06	0.44	6.82	14.88	21.34	13.13	25.93	29.96	148.40	150.46	59.51	63.72	42.46
0.89	1.43	0.99	2.37	0.62	0.79	0.65	0.54	0.65	0.96	1.70	1.00	0.92
1.56	1.30	1.74	1.07	3.65	4.92	1.52	10.06	3.45	17.62	2.04	1.74	0.79
2.18	3.34	2.72	4.74	5.61	6.22	6.04	6.06	8.07	8.11	10.54	5.53	8.52
1.25	1.20	1.76	2.41	3.67	5.07	5.79	4.98	6.94	8.38	11.16	11.40	9.59
3.52	4.66	3.50	6.55	7.06	9.53	9.14	9.74	10.44	12.36	14.98	13.54	11.24
0.65	1.22	0.78	1.69	2.91	2.95	3.65	3.61	3.49	3.87	2.77	6.54	4.63
2.77	18.66	5.86	19.23	22.32	29.31	28.23	25.26	27.00	11.71	24.66	44.11	28.25
1.29	1.84	2.78	1.90	3.21	4.06	4.66	2.19	7.49	2.92	4.78	5.07	5.05
2.74	2.16	2.67	3.76	3.81	4.24	2.88	1.97	2.66	2.38	4.41	3.63	2.97
0.20	0.23	0.09	0.56	1.72	0.98	0.35	0.43	0.23	0.12	0.18	0.10	NA
0.15	0.08	0.11	0.12	0.20	0.17	0.22	0.28	0.23	0.29	0.23	0.20	0.28
0.42	1.82	3.39	4.15	9.88	5.48	2.66	2.65	1.20	4.15	6.42	5.51	1.85
3.29	3.38	7.66	10.54	7.35	4.29	2.65	2.92	2.14	5.57	13.03	10.15	11.21
0.12	0.22	0.69	0.50	2.22	1.98	2.24	2.11	4.02	2.74	7.38	6.81	4.58
0.57	0.78	0.82	1.38	1.60	2.88	2.78	2.79	6.41	6.77	6.72	7.45	8.63
7.06	2.73	3.07	3.03	1.86	0.61	1.48	1.39	2.25	2.06	1.36	0.57	0.50
0.90	1.29	1.58	2.36	1.09	3.82	5.54	0.15	NA	NA	NA	NA	NA
0.36	0.40	0.48	1.28	1.25	0.77	0.81	1.40	0.97	1.78	1.67	1.27	1.08
0.00	0.00	0.00	0.00	0.00	0.00	NA	NA	NA	NA	NA	NA	NA
0.80	1.09	2.76	2.28	3.05	2.94	4.29	4.02	7.94	6.32	10.72	6.74	7.39
5.63	1.09	3.52	2.83	10.42	19.25	19.98	24.05	19.15	16.60	8.84	10.69	19.41
0.00	0.00	0.00	3.48	2.55	2.72	2.79	1.84	2.42	3.24	3.51	7.40	2.02

TABLE B5

DAH per capita by target country, 1990–2012, continued

Recipient country	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Dominican Republic	2.57	0.67	1.96	1.93	1.12	1.11	5.51	2.23	5.90	7.51
Ecuador	3.09	1.39	2.49	1.71	5.44	1.66	2.00	2.16	3.82	2.09
Egypt	0.98	2.57	2.47	2.53	2.54	2.19	2.09	1.30	1.95	1.36
El Salvador	8.24	14.35	14.01	9.78	3.93	7.42	8.35	4.40	6.14	5.22
Equatorial Guinea	0.00	0.00	1.14	3.36	14.32	1.84	13.98	2.79	2.54	5.04
Eritrea	0.00	0.00	0.00	0.00	3.14	3.33	4.38	1.41	4.16	5.54
Estonia	0.00	0.00	0.00	0.00	0.00	0.00	0.03	0.08	0.40	1.39
Ethiopia	1.46	0.33	0.91	0.34	0.66	1.09	1.38	0.90	0.77	1.47
Fiji	0.00	45.42	30.30	13.54	0.00	0.64	0.07	0.56	13.17	16.88
Gabon	1.63	0.00	3.57	16.77	0.04	0.02	2.32	5.77	8.22	1.88
Gambia	0.16	2.68	13.19	18.52	3.05	2.01	1.80	1.90	2.98	4.80
Georgia	0.00	0.00	0.00	0.00	3.01	0.10	0.62	0.68	1.73	4.07
Ghana	0.31	8.91	1.82	4.66	1.30	1.23	1.31	4.53	1.48	3.40
Grenada	122.87	0.00	0.00	0.00	0.00	0.00	0.00	4.12	3.42	0.00
Guatemala	2.73	1.50	2.95	4.85	1.68	2.38	2.40	12.94	3.20	6.18
Guinea	0.22	4.37	1.60	1.61	2.22	5.55	2.33	4.55	3.65	2.46
Guinea-Bissau	6.26	9.80	5.39	7.05	3.38	24.43	3.58	4.58	5.45	0.52
Guyana	5.89	5.71	5.59	7.15	6.99	6.89	6.65	7.83	5.94	5.46
Haiti	7.39	9.09	4.83	7.84	6.10	19.36	3.70	3.67	8.97	6.11
Honduras	10.20	7.62	12.14	5.22	4.65	4.06	8.37	8.92	4.60	10.84
Hungary	0.00	0.00	0.00	0.60	0.23	0.18	1.36	1.30	0.67	0.33
India	0.31	0.10	0.34	0.24	0.48	0.44	0.60	0.40	0.33	0.46
Indonesia	2.21	0.52	0.44	1.25	0.82	1.11	0.58	0.67	0.74	1.22
Iran	0.00	0.03	0.00	0.00	0.00	0.07	0.64	0.60	0.35	0.18
Iraq	0.06	0.00	0.01	0.04	0.03	0.30	0.17	0.00	0.03	0.09
Jamaica	10.68	12.31	12.64	9.24	9.78	14.07	9.47	7.89	8.44	7.13
Jordan	0.39	3.31	0.38	3.30	6.86	5.52	2.82	4.33	6.49	12.05
Kazakhstan	0.00	0.00	0.00	0.00	0.58	0.39	0.54	0.47	0.94	1.55
Kenya	8.70	2.16	4.70	1.44	1.68	2.91	4.11	2.38	3.40	2.83
Kiribati	176.31	0.00	56.06	0.64	1.39	5.56	3.42	3.30	2.21	0.00
Kyrgyzstan	0.00	0.00	0.00	0.03	0.64	3.26	2.94	2.55	4.53	1.55
Laos	0.00	0.00	0.49	0.29	0.80	2.04	1.27	1.25	1.82	2.65
Latvia	0.00	0.00	0.00	3.90	3.51	0.30	0.00	0.00	0.20	0.36
Lebanon	0.74	2.69	0.63	0.20	0.48	7.94	0.74	1.44	2.28	3.59
Lesotho	2.11	3.61	2.74	0.92	4.23	5.73	5.39	2.30	0.63	0.16
Liberia	0.00	0.00	0.40	1.13	0.04	0.02	0.16	1.20	2.05	2.47
Libya	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Lithuania	0.00	0.00	0.00	4.39	0.44	1.22	0.02	0.00	0.00	0.00
Macedonia, FYR	0.00	0.00	0.00	0.00	0.00	5.12	3.95	2.97	4.54	10.61
Madagascar	0.72	2.97	2.79	1.64	3.34	2.52	2.63	2.01	3.26	1.75

2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
4.03	3.66	3.34	3.81	5.75	7.48	4.72	5.16	5.42	12.45	10.93	5.20	7.37
2.05	2.00	1.01	2.45	2.32	2.61	3.20	4.05	3.86	2.91	2.44	2.27	1.11
1.53	1.36	1.04	0.81	1.24	1.53	2.16	1.46	1.88	0.83	0.95	0.70	0.31
4.49	7.43	4.64	3.93	4.89	5.75	5.28	5.39	5.58	6.11	11.96	6.04	5.60
9.23	7.61	4.39	6.20	9.00	15.59	19.96	NA	NA	NA	NA	NA	NA
7.19	3.71	6.00	9.51	8.83	7.90	3.61	4.34	5.02	3.47	9.06	3.53	5.43
0.11	0.00	0.00	1.02	1.68	2.26	NA	NA	NA	NA	NA	NA	NA
1.18	1.39	1.58	2.89	2.71	3.35	5.39	7.44	7.28	7.80	9.65	10.92	9.36
11.65	5.88	7.62	19.44	8.80	4.04	8.76	11.50	7.65	8.19	13.49	12.18	7.29
1.90	2.19	1.99	2.87	5.84	5.17	8.54	5.76	4.22	7.36	3.46	4.21	3.49
4.77	5.02	5.79	6.94	13.43	16.90	7.56	9.49	9.08	10.99	16.32	19.36	20.35
3.89	4.16	4.61	2.57	3.30	7.62	9.03	9.47	6.22	9.78	8.64	10.60	10.73
2.82	4.99	4.64	6.96	10.83	10.28	8.87	8.85	10.63	11.36	10.37	11.10	13.85
0.00	0.00	0.00	3.27	2.99	0.91	2.47	5.25	3.17	3.21	0.04	0.17	0.71
3.23	4.56	3.13	4.52	2.86	2.83	3.19	4.30	6.59	5.34	4.65	6.15	3.89
2.84	4.19	2.69	2.50	3.04	2.76	3.44	2.31	3.01	2.68	3.95	2.85	4.62
3.47	6.60	6.49	6.64	8.63	9.22	8.22	11.47	8.75	10.30	17.68	9.76	4.29
1.38	2.92	4.09	19.09	39.44	32.20	45.54	40.45	51.93	47.19	42.33	32.23	24.46
4.87	4.44	2.96	6.98	7.58	8.44	14.51	16.39	17.83	17.62	21.29	26.45	24.20
7.32	5.26	4.07	6.50	9.74	10.50	6.53	7.50	8.27	8.80	7.95	8.92	11.03
0.32	0.01	0.00	0.00	0.00	0.00	0.00	NA	NA	NA	NA	NA	0.01
0.55	0.56	0.66	0.48	0.67	0.68	0.49	0.66	0.67	0.75	0.77	0.85	0.67
1.83	1.15	0.86	1.04	1.07	0.97	1.36	1.15	1.55	1.28	1.12	1.24	1.70
0.11	0.20	0.06	0.01	0.09	1.02	0.18	0.11	0.21	0.23	0.13	0.17	0.26
0.06	0.11	0.02	1.07	3.13	18.56	14.56	8.64	3.15	3.07	3.16	1.05	0.74
7.86	19.56	2.89	3.58	4.56	4.54	6.03	5.97	6.19	5.26	13.10	8.36	4.22
9.99	8.95	9.82	10.13	8.28	3.92	3.06	2.10	5.45	6.17	7.31	8.19	14.67
1.54	1.62	0.77	1.42	1.04	0.80	1.18	0.73	1.40	1.47	2.56	2.35	2.52
3.23	3.92	3.56	5.37	7.08	6.91	10.39	10.42	13.52	16.93	20.01	21.76	22.82
0.46	2.48	1.97	2.30	70.64	26.77	34.96	54.25	91.33	53.75	61.91	52.50	62.68
3.47	1.45	3.02	5.93	3.94	6.53	6.52	8.16	9.57	7.25	7.81	9.69	7.65
5.40	3.37	2.95	6.91	5.00	7.35	6.47	7.42	7.75	7.11	9.32	10.29	9.37
0.77	1.06	1.96	0.37	0.83	0.00	0.00	0.00	0.00	NA	18.06	20.66	NA
2.63	2.83	3.37	4.62	2.78	0.85	1.10	3.02	2.42	1.85	2.37	1.56	1.49
1.65	3.04	2.74	5.88	7.52	7.37	8.06	12.25	24.34	20.23	41.99	60.14	56.75
3.49	1.79	1.50	2.28	4.61	5.20	5.32	5.90	15.55	23.14	23.29	22.49	26.92
0.00	0.00	0.00	0.00	0.00	0.05	0.10	0.30	6.24	3.70	0.14	2.10	0.23
0.32	0.20	1.40	1.43	2.33	0.69	0.62	0.00	0.00	0.00	0.00	0.00	NA
4.30	8.11	2.02	2.72	4.21	5.28	3.86	11.07	4.48	1.75	6.08	3.98	1.04
1.65	2.20	1.88	3.47	4.68	5.25	3.57	4.50	4.57	3.53	7.51	4.64	4.38

TABLE B5

DAH per capita by target country, 1990–2012, continued

Recipient country	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Malawi	8.93	2.13	5.54	3.79	4.66	4.56	5.45	6.17	4.61	8.92
Malaysia	2.36	3.49	1.26	6.92	0.88	1.36	2.25	1.61	0.78	0.85
Maldives	0.00	0.00	77.11	33.29	0.00	0.00	0.00	4.19	0.00	1.03
Mali	3.16	4.65	5.58	3.46	4.80	4.25	2.89	3.40	0.98	2.86
Malta	0.00	0.00	0.00	0.00	0.10	0.00	0.00	0.00	NA	0.00
Marshall Islands	0.00	0.00	2.63	2.55	12.32	26.10	23.79	22.35	19.23	113.36
Mauritania	34.97	0.02	8.77	2.71	15.49	1.20	7.72	3.75	4.11	3.32
Mauritius	0.00	0.00	0.00	0.00	2.47	0.05	2.29	0.43	0.26	0.16
Mexico	0.54	0.36	0.23	1.11	0.59	1.47	1.34	1.57	5.62	1.07
Micronesia, Federated States of	0.00	0.00	127.81	0.00	0.00	0.00	0.00	0.00	0.00	99.29
Moldova	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.23	0.51	4.21
Mongolia	5.31	0.66	4.74	5.88	1.78	2.45	2.07	1.36	5.07	5.98
Montenegro	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Morocco	0.87	1.11	1.80	2.83	1.89	1.65	2.09	0.94	1.84	1.42
Mozambique	9.38	12.06	9.22	1.91	7.44	4.77	6.75	5.14	4.50	5.46
Myanmar	0.06	0.00	0.00	0.01	0.01	0.00	0.01	0.02	0.05	0.13
Namibia	4.78	6.82	4.07	14.38	3.11	6.26	3.92	7.27	4.31	4.11
Nepal	2.81	3.73	1.14	2.23	1.06	0.82	0.87	1.83	2.22	1.94
Nicaragua	6.74	6.69	13.50	7.98	12.30	8.38	13.36	11.03	9.79	22.84
Niger	1.02	3.46	6.04	2.19	2.05	1.96	2.31	1.86	2.10	1.15
Nigeria	0.42	0.30	0.21	0.67	0.24	0.18	0.17	0.18	0.28	0.49
North Korea	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.03	0.03
Occupied Palestinian Territory	0.03	0.02	0.01	0.02	7.56	5.20	12.17	17.57	13.02	12.18
Oman	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.02	0.02
Pakistan	1.45	0.46	0.36	0.50	1.68	0.98	1.05	0.92	0.58	0.52
Panama	0.05	5.20	3.66	0.32	3.15	3.06	10.72	7.04	5.13	4.81
Papua New Guinea	12.32	14.88	9.19	2.30	3.69	1.05	10.80	5.14	9.71	17.20
Paraguay	0.15	0.03	0.03	0.97	0.01	0.01	0.03	0.93	5.04	6.38
Peru	1.80	1.14	1.37	3.92	3.87	5.42	2.97	2.68	3.84	3.29
Philippines	2.08	1.89	1.30	1.70	1.06	2.11	0.88	0.91	1.30	1.39
Poland	0.00	0.00	0.01	0.11	0.25	0.26	0.57	0.95	0.02	0.08
Romania	0.00	0.00	1.17	0.84	0.57	1.95	1.19	0.59	1.75	1.08
Russia	0.00	0.00	0.00	0.66	0.40	0.01	0.00	0.98	0.66	0.39
Rwanda	3.11	3.66	3.26	1.13	1.14	2.88	2.68	4.77	4.44	3.75
Samoa	0.00	0.00	0.00	80.42	11.68	2.92	1.61	0.75	1.47	2.11
Sao Tome and Principe	64.45	4.01	3.27	18.04	91.62	23.47	20.43	9.66	12.23	61.94
Saudi Arabia	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.02	0.01
Senegal	3.29	4.36	5.50	5.08	4.36	4.21	2.73	4.80	6.01	5.70
Serbia	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.14	1.80
Seychelles	0.00	0.00	26.82	0.00	2.95	37.63	0.00	16.09	20.17	7.75

2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
7.53	6.39	5.66	7.15	9.48	10.02	14.04	18.38	21.21	19.47	16.27	22.82	25.85
0.67	0.45	0.06	0.13	0.07	0.07	0.04	0.03	0.03	0.02	0.01	0.07	0.10
1.65	0.53	0.44	0.38	0.62	1.87	0.54	5.85	2.27	4.52	2.61	1.77	3.53
2.86	5.04	2.04	5.20	5.08	7.50	7.32	8.40	10.39	10.07	13.98	13.81	11.33
NA	0.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
44.67	43.88	34.23	79.44	214.93	308.79	151.59	155.73	162.02	189.75	3.77	5.24	169.24
4.16	3.77	3.54	4.12	4.65	1.87	2.44	4.69	4.52	3.25	2.49	3.09	2.02
0.19	0.17	0.00	0.16	0.18	0.19	0.54	0.81	0.01	0.75	2.03	1.47	1.99
3.89	1.23	1.98	0.29	0.30	0.72	1.11	0.88	0.90	0.39	4.91	4.59	2.54
0.01	0.69	0.00	49.43	195.08	213.25	201.34	208.73	212.18	294.06	4.88	10.97	282.43
4.92	1.78	1.52	1.77	4.22	4.97	3.28	5.16	5.05	12.80	14.57	10.54	11.40
3.45	8.28	2.61	3.89	2.84	3.92	3.31	7.00	6.89	8.27	11.69	11.36	12.04
0.00	0.00	0.00	0.00	4.52	0.00	13.92	13.25	16.28	4.61	5.22	7.18	5.53
2.24	0.99	1.07	1.68	0.92	1.90	2.87	1.83	1.65	2.71	3.55	2.95	2.30
6.10	6.38	7.77	8.39	11.00	10.60	11.52	16.40	21.20	19.41	22.61	22.84	22.41
0.15	0.11	0.32	0.65	0.62	0.94	0.46	0.83	1.01	1.11	1.87	1.34	3.10
3.84	5.73	5.98	9.08	17.43	19.37	43.58	52.52	46.95	75.70	76.91	56.55	68.72
1.70	2.45	2.03	3.00	2.57	2.90	3.43	3.04	4.77	4.07	5.76	4.84	4.63
11.52	9.52	10.47	12.44	13.43	14.16	14.44	15.69	16.66	16.56	12.12	10.91	10.61
1.64	2.15	2.23	3.55	3.35	3.20	5.29	4.31	6.71	5.00	3.69	4.66	2.43
1.35	0.76	0.73	1.12	1.93	2.40	3.19	3.33	4.79	6.60	5.28	5.51	6.31
0.00	0.01	0.07	0.07	0.11	0.23	0.13	0.10	0.13	0.31	1.11	0.72	0.74
14.66	10.66	9.77	20.63	21.21	18.50	16.32	21.89	20.10	13.43	17.82	19.81	15.12
0.01	0.00	0.00	0.02	0.02	0.01	0.00	NA	NA	NA	NA	NA	NA
0.43	1.01	1.33	0.74	1.40	1.21	1.65	2.22	2.06	2.13	1.84	1.71	2.51
4.04	4.52	5.41	2.79	2.83	2.24	2.02	1.88	1.95	10.30	3.20	2.83	3.74
17.71	8.63	10.94	10.41	10.45	10.86	10.67	9.50	11.24	14.78	15.98	23.68	20.64
4.34	2.70	1.96	2.31	2.09	1.98	2.00	2.96	4.18	3.92	4.90	2.79	3.16
3.94	3.04	3.58	3.99	4.50	3.52	2.52	2.23	5.07	4.83	3.49	1.78	2.40
1.15	1.28	0.63	1.13	1.19	2.08	2.12	1.78	1.10	1.18	2.17	2.10	1.84
0.05	0.59	0.41	0.00	0.00	0.00	0.00	0.00	0.00	NA	NA	NA	NA
0.01	0.75	0.95	0.50	1.35	0.58	0.36	1.47	1.34	0.62	0.42	7.32	0.59
0.33	0.36	0.22	0.07	0.14	0.32	0.76	0.98	0.98	0.51	0.27	0.11	NA
3.62	4.44	4.88	5.70	11.31	12.53	16.67	18.82	27.17	29.12	34.03	35.10	31.85
22.71	10.06	2.25	20.21	22.01	22.63	34.05	22.89	20.76	17.90	49.77	14.32	64.29
42.49	44.30	33.56	27.87	34.09	32.19	29.50	22.98	37.57	25.39	28.00	50.63	27.06
0.00	0.00	0.01	0.01	NA	NA	NA	NA	NA	NA	NA	NA	NA
4.19	6.88	4.76	9.91	11.64	10.94	12.30	6.63	8.93	10.91	9.25	10.71	12.36
2.15	1.83	3.12	4.71	3.34	2.12	3.21	2.02	1.91	3.11	1.64	5.40	3.74
1.30	3.40	4.99	16.11	15.82	14.68	2.15	1.03	0.74	1.87	6.20	0.67	1.71

TABLE B5

DAH per capita by target country, 1990–2012, continued

Recipient country	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Sierra Leone	0.07	0.00	2.10	0.70	0.80	0.78	1.42	0.19	1.49	1.24
Slovakia	0.00	0.00	0.00	0.01	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	NA	NA	NA
Solomon Islands	9.37	0.35	14.49	3.53	7.12	2.95	4.77	4.40	2.59	5.41
Somalia	2.08	1.58	0.56	1.02	0.86	0.55	0.61	0.40	0.50	0.60
South Africa	0.02	0.00	0.14	0.09	0.59	0.30	0.84	0.77	1.10	0.90
South Korea	1.33	0.00	0.22	1.22	0.73	NA	NA	NA	0.00	0.00
South Sudan	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Sri Lanka	0.94	2.89	1.53	1.31	0.61	0.80	0.58	1.37	2.16	0.86
St. Lucia	36.54	23.73	0.00	0.67	27.52	0.05	30.45	7.79	5.45	0.32
St. Vincent and the Grenadines	0.00	0.00	0.00	0.39	1.11	3.26	5.16	0.51	0.81	0.64
Sudan	0.54	0.11	0.88	0.17	0.10	0.68	0.50	0.27	0.45	0.43
Suriname	42.86	40.11	71.15	9.66	12.89	52.09	18.32	7.36	43.70	26.89
Swaziland	5.10	6.46	2.61	0.27	9.52	2.43	1.44	1.74	5.02	2.04
Syria	0.00	0.03	0.00	1.86	0.00	0.00	0.00	0.35	0.20	0.01
Tajikistan	0.00	0.00	0.00	0.00	1.79	0.32	0.34	0.42	0.50	0.57
Tanzania	3.21	2.23	3.69	1.84	1.59	1.72	3.27	3.73	3.28	6.02
Thailand	0.04	0.02	0.48	0.37	0.07	0.04	0.21	0.15	1.36	1.95
Timor-Leste	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.37
Togo	0.83	3.66	6.59	0.19	1.79	0.68	6.33	1.04	2.74	0.52
Tonga	0.00	0.21	0.00	1.93	6.57	5.97	0.00	21.05	0.00	1.02
Trinidad and Tobago	0.01	0.77	0.91	1.13	0.85	0.86	6.19	11.80	11.45	11.14
Tunisia	0.22	0.00	1.03	0.69	1.66	1.32	1.63	1.10	1.76	2.29
Turkey	0.00	0.03	1.24	0.16	0.22	1.52	0.77	0.72	0.57	0.45
Turkmenistan	0.00	0.00	0.00	0.00	0.66	0.81	0.43	0.33	1.80	0.94
Uganda	4.27	6.64	4.43	2.56	2.10	3.27	4.18	4.32	3.88	4.02
Ukraine	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Uruguay	0.03	0.06	0.46	27.66	6.64	0.12	0.48	0.18	0.75	0.62
Uzbekistan	0.00	0.00	0.00	0.00	0.13	1.15	0.55	0.31	0.44	1.08
Vanuatu	1.23	8.29	0.00	1.57	91.93	1.57	0.35	5.03	31.76	9.69
Venezuela	0.00	0.06	0.07	0.17	0.51	2.34	1.18	1.96	3.70	2.07
Vietnam	0.39	0.21	0.73	0.64	1.20	0.44	0.34	1.17	0.83	1.07
Yemen	0.34	2.57	1.83	2.40	0.53	1.40	1.87	1.50	1.08	1.45
Zambia	5.15	0.67	6.00	7.80	5.78	6.78	6.20	5.77	3.29	3.98
Zimbabwe	3.68	3.91	8.31	3.58	4.43	4.65	4.99	6.33	5.03	4.05

2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
4.98	3.36	2.71	3.87	4.81	6.79	6.26	7.02	8.88	8.12	10.97	11.87	10.74
0.00	0.00	0.00	0.00	3.51	3.80	0.38	NA	NA	NA	NA	NA	NA
NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
13.38	15.48	18.26	27.20	32.72	26.39	24.76	27.94	38.27	42.02	53.82	77.61	37.39
0.42	0.53	0.69	0.60	1.95	2.11	2.57	2.72	2.84	2.41	4.25	4.07	8.89
0.94	1.56	1.34	2.93	3.32	4.35	4.98	8.06	11.61	15.34	15.68	17.46	15.77
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	0.00	0.00	0.00	0.00	0.00	0.00	0.00
0.80	0.70	0.98	1.37	0.50	0.91	1.94	1.26	1.72	1.87	2.74	1.88	1.54
0.00	0.30	0.74	2.36	1.53	1.62	3.85	2.23	6.88	9.14	8.31	89.80	69.10
0.30	0.19	0.00	1.12	1.22	1.05	4.16	3.63	3.74	5.90	6.29	1.94	5.21
0.31	0.31	0.67	0.57	1.24	2.20	2.48	2.44	3.86	5.00	5.61	3.45	3.81
12.82	16.87	19.82	22.41	22.89	25.28	10.12	15.79	18.41	40.00	27.91	27.60	7.97
2.10	1.83	1.99	9.51	4.72	24.97	14.12	20.93	21.00	34.72	62.82	76.76	51.91
0.02	0.00	1.02	0.17	0.36	0.91	0.25	0.38	0.86	1.51	0.84	0.13	0.19
0.71	0.63	1.16	1.90	3.34	2.90	3.41	4.03	5.49	7.17	6.60	5.23	7.09
2.66	5.34	3.76	4.00	6.87	8.08	9.93	12.04	16.53	14.96	19.58	18.92	18.72
1.11	0.34	0.36	0.56	0.89	0.65	1.43	1.03	1.12	0.84	1.07	1.57	0.73
0.96	3.49	17.60	3.42	8.46	10.28	17.97	19.58	25.46	21.03	26.99	24.69	29.66
0.99	0.67	0.52	2.51	2.92	3.51	2.72	4.40	5.03	5.82	4.61	6.99	2.90
2.59	10.98	11.18	23.83	34.85	151.26	51.49	51.62	20.42	32.06	57.74	179.06	82.17
10.61	10.36	10.15	9.86	14.16	10.36	NA	NA	NA	NA	NA	NA	NA
0.96	1.82	2.11	2.31	0.88	0.48	3.24	0.79	3.64	0.52	1.00	0.43	0.53
0.41	0.13	0.46	0.40	0.39	0.43	2.09	0.75	1.22	0.41	4.24	2.53	0.30
0.62	0.47	0.52	0.55	0.43	0.51	0.44	0.46	0.49	0.46	0.46	1.38	0.63
4.39	6.87	3.10	7.99	11.04	11.60	11.92	14.06	12.95	15.47	16.86	15.69	20.35
0.00	0.00	0.04	0.06	0.50	0.94	1.57	1.66	1.64	1.65	1.31	1.84	2.26
0.02	3.97	13.80	17.58	0.23	11.29	0.24	0.99	0.36	0.33	1.70	6.49	NA
0.67	1.13	1.37	1.12	1.83	1.28	1.32	1.54	1.47	1.70	1.27	1.52	2.55
9.59	17.70	13.95	20.50	20.65	19.63	15.72	16.60	26.35	42.67	28.50	35.65	44.43
0.69	0.76	0.54	0.33	0.32	0.43	0.08	0.07	0.07	0.11	0.10	0.04	0.04
1.01	1.15	1.34	1.68	1.78	2.05	2.41	3.09	3.54	3.22	3.82	4.04	3.74
1.05	1.33	1.11	2.14	1.07	2.37	2.42	2.65	2.92	2.21	2.94	2.16	4.03
6.43	7.96	9.39	15.05	19.39	22.88	19.29	27.77	36.78	31.65	26.74	37.85	36.58
3.37	3.75	3.29	3.74	3.97	9.33	9.05	13.31	9.71	18.42	17.51	13.79	30.05

Source: IHME DAH Database 2014; IHME Population Data

Notes: Development assistance for health (DAH) per capita is in 2014 US dollars. DAH includes both financial and in-kind contributions for activities aimed at improving health in low- and middle-income countries. 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 IHME population estimates. 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, the Global Fund, Gavi, and BMGF. Years in which a country was classified as high-income by the World Bank are marked as "NA."

TABLE B6

DAH by health focus area, 1990–2014

Year	HIV/AIDS	Maternal health	Newborn and child health	Malaria	Health sector support
1990	294.05	1,147.61	1,359.53	73.30	491.28
1991	372.62	1,115.97	1,338.78	90.23	501.53
1992	407.32	1,191.33	1,580.44	59.46	603.13
1993	375.70	1,053.81	1,585.45	47.07	552.07
1994	678.24	1,657.52	2,164.55	76.58	728.49
1995	643.83	1,856.79	2,018.63	75.78	781.25
1996	714.60	1,571.60	1,661.52	71.50	679.95
1997	669.58	1,656.39	1,515.39	61.77	713.35
1998	769.69	1,725.26	1,522.30	97.46	751.36
1999	819.12	1,926.41	2,004.78	171.52	861.55
2000	1,395.20	1,987.32	2,160.57	251.21	732.63
2001	1,437.96	1,867.79	2,646.93	265.56	587.16
2002	2,087.53	1,660.66	2,580.32	250.88	742.66
2003	2,580.29	1,899.44	3,189.97	337.14	856.33
2004	3,546.81	1,648.22	2,904.17	550.42	977.22
2005	4,655.96	1,791.38	3,310.87	785.98	1,454.04
2006	5,923.32	1,875.60	2,882.14	924.68	1,279.05
2007	7,270.17	2,131.11	3,879.41	907.73	1,509.08
2008	8,808.55	2,386.98	3,908.37	1,376.85	1,945.78
2009	9,265.23	2,882.52	4,149.76	2,087.75	1,960.45
2010	10,575.64	2,560.41	5,039.61	2,294.60	1,874.45
2011	10,665.89	2,770.29	5,804.57	1,907.30	1,911.79
2012	10,115.82	2,874.90	6,206.11	2,332.20	2,131.44
2013	11,139.58	3,095.84	6,766.13	2,368.03	2,270.62
2014	10,892.51	3,018.48	6,627.54	2,377.34	2,181.21

Tuberculosis	Other infectious diseases	Non-communicable diseases	Other	Unallocable	Total
39.80	59.03	106.31	2,706.31	587.52	6,864.74
62.81	157.66	77.88	2,392.98	297.07	6,407.52
37.27	112.57	136.76	2,972.51	321.23	7,422.00
56.22	76.41	214.39	3,092.36	565.35	7,618.83
125.19	80.85	182.37	2,730.31	538.38	8,962.48
76.86	117.14	127.11	3,206.38	547.72	9,451.48
115.82	105.51	102.87	3,664.40	445.80	9,133.57
74.82	139.66	114.90	3,826.45	556.31	9,328.60
83.84	451.95	111.44	4,125.46	370.19	10,008.94
97.36	403.21	157.42	3,583.68	658.90	10,683.96
140.20	369.97	160.02	3,763.28	640.86	11,601.25
171.90	389.23	181.12	3,868.55	610.22	12,026.42
220.30	397.45	218.66	4,005.38	1,657.10	13,820.94
299.92	684.25	178.89	4,943.78	888.77	15,858.79
511.14	755.98	217.34	5,426.15	1,519.62	18,057.08
514.90	505.37	251.11	5,664.29	1,030.79	19,964.71
681.40	617.29	294.68	5,812.28	1,595.46	21,885.90
798.95	761.32	344.47	5,476.88	2,114.94	25,194.06
954.13	857.02	442.47	6,031.70	2,523.66	29,235.51
1,082.85	844.11	458.38	5,865.94	1,523.22	30,120.21
1,287.00	713.94	473.52	7,284.17	1,831.57	33,934.91
1,269.06	721.70	528.02	7,495.42	1,837.52	34,911.55
1,225.75	599.80	514.63	6,120.78	1,007.14	33,128.57
1,514.54	655.47	608.14	7,037.47	999.99	36,455.82
1,374.50	1,288.73	611.20	6,635.82	882.46	35,889.79

Source: IHME DAH Database 2014

Notes: In millions of 2014 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 other infectious diseases. We were able to allocate flows from the following channels of assistance by their health focus areas: bilateral development agencies, the World Bank (IDA and IBRD), ADB, AfDB, IDB, the Global Fund, Gavi, WHO, UNICEF, UNAIDS, UNFPA, BMGF, and NGOs. Contributions from remaining channels are shown as unallocable by disease. For preliminary estimates of DAH for 2013 and 2014, refer to Table B1.

TABLE B7

Bilateral commitments and disbursements, 1990–2012

Donor	Observed/estimated[1]	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
	Observed Committments	14.32	18.99	30.29	67.81	85.21	37.72	180.52	81.93	84.86	153.95
Australia	Estimated Disbursements	13.78	16.09	80.60	65.43	92.64	150.35	143.83	65.35	70.81	119.47
	Observed Disbursements	0.00	0.00	0.00	0.00	0.00	0.00	-0.00	0.00	41.36	50.45
	Observed Committments	18.58	3.17	0.00	0.00	0.00	0.00	9.56	5.18	9.22	7.11
Austria	Estimated Disbursements	37.96	11.52	9.42	3.09	0.29	0.00	12.06	63.53	25.64	107.38
	Observed Disbursements	1.38	0.19	0.00	0.68	13.23	1.20	6.91	5.65	5.41	5.76
	Observed Committments	4.08	2.58	0.00	0.00	63.84	69.89	82.56	73.08	78.88	85.75
Belgium	Estimated Disbursements	120.23	86.41	92.04	112.87	76.55	81.69	92.94	91.46	91.30	96.51
	Observed Disbursements	0.00	2.58	0.00	0.00	0.00	0.00	0.00	0.00	0.00	85.75
	Observed Committments	60.49	58.29	29.37	21.71	85.48	140.87	67.12	39.81	45.14	51.59
Canada	Estimated Disbursements	53.72	40.07	42.04	48.14	81.02	116.19	65.13	39.62	39.91	22.24
	Observed Disbursements	0.00	0.00	33.08	30.41	39.31	42.09	58.27	35.63	35.55	19.89
	Observed Committments	52.43	117.22	152.84	143.40	49.16	119.66	333.10	40.62	8.37	148.34
Denmark	Estimated Disbursements	41.57	97.17	145.34	113.13	48.77	43.03	113.60	120.41	63.71	98.83
	Observed Disbursements	0.00	0.00	0.00	0.00	0.00	0.00	0.00	101.15	76.14	-0.05
	Observed Committments	17.46	47.17	243.71	243.91	72.39	293.50	372.74	259.05	426.09	432.80
European Commission	Estimated Disbursements	7.36	15.53	70.25	60.80	18.63	102.87	132.85	58.30	97.83	133.02
	Observed Disbursements	0.00	0.05	0.00	0.00	0.00	0.13	82.69	64.79	86.46	68.85
	Observed Committments	34.51	56.44	36.49	7.08	22.67	30.44	16.41	9.82	28.89	17.31
Finland	Estimated Disbursements	64.33	40.99	31.79	20.81	19.58	12.14	17.41	11.37	15.09	18.18
	Observed Disbursements	43.16	44.85	32.30	22.34	22.96	0.00	18.52	14.72	10.87	12.11
	Observed Committments	155.87	82.14	101.03	80.99	91.47	112.15	110.08	152.94	156.16	82.93
France	Estimated Disbursements	537.34	341.34	283.93	243.92	350.29	424.07	349.32	288.01	334.23	97.11
	Observed Disbursements	44.77	27.97	31.81	64.83	32.59	37.74	21.77	25.51	41.50	86.05
	Observed Committments	55.72	32.14	88.61	88.40	227.60	196.72	97.51	337.47	242.80	204.40
Germany	Estimated Disbursements	106.73	116.22	184.78	189.81	323.08	429.16	319.72	403.67	319.04	262.16
	Observed Disbursements	7.35	7.57	58.13	14.16	126.31	89.97	88.81	86.10	120.89	99.83
	Observed Committments	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Greece	Estimated Disbursements	0.00	0.00	0.00	0.00	0.00	7.80	7.66	10.28	11.62	5.22
	Observed Disbursements	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Observed Committments	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Ireland	Estimated Disbursements	3.06	3.27	4.29	0.00	8.51	26.87	26.39	0.00	25.30	22.99
	Observed Disbursements	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Observed Committments	159.50	174.94	107.91	76.80	10.10	48.70	58.92	32.58	18.51	51.57
Italy	Estimated Disbursements	196.37	224.29	167.87	121.47	51.31	70.15	89.48	36.46	20.88	58.08
	Observed Disbursements	5.30	1.26	5.81	12.25	4.22	0.93	0.29	0.48	0.00	0.00
	Observed Committments	163.14	136.42	204.84	400.79	244.13	231.50	415.34	297.78	302.09	248.02
Japan	Estimated Disbursements	330.65	372.34	369.43	556.89	369.58	353.91	252.00	301.69	326.31	390.29
	Observed Disbursements	0.00	0.00	139.40	332.67	100.39	23.98	223.31	267.35	289.17	345.87

2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
210.41	125.80	86.64	153.30	68.65	162.93	184.29	173.60	539.31	291.09	356.57	498.69	543.36
177.87	110.59	116.85	136.48	146.04	159.06	227.87	224.43	249.39	273.60	397.54	553.31	605.89
84.71	98.73	104.50	122.24	131.54	143.24	206.12	202.68	226.93	245.44	357.54	498.69	543.36
5.29	4.57	10.69	17.94	29.00	35.13	25.00	34.76	54.65	36.40	59.74	77.97	102.80
41.84	10.63	16.28	21.58	31.47	40.62	26.30	37.77	59.46	42.07	65.90	87.72	117.74
3.42	39.11	6.76	7.79	9.53	9.60	15.95	15.60	15.33	12.80	10.55	15.74	10.60
87.84	86.02	159.56	107.70	125.20	143.84	147.97	206.70	214.87	227.28	202.47	221.48	111.83
97.73	99.63	101.96	120.55	110.34	124.95	150.27	182.39	181.85	190.65	195.84	199.36	177.64
87.83	88.62	90.69	106.83	98.60	111.46	134.86	163.35	162.68	169.88	174.08	178.17	158.00
111.09	111.91	152.58	269.56	303.65	213.76	299.18	698.20	467.17	725.83	637.64	1,240.28	557.66
64.65	59.18	91.16	141.23	223.33	215.07	265.09	499.35	485.82	524.78	530.83	771.07	783.75
57.63	53.25	84.91	129.53	208.36	193.35	244.35	460.68	445.42	475.57	481.24	702.41	708.91
35.22	42.89	83.72	107.01	176.38	124.93	154.17	155.44	49.04	219.61	76.90	148.90	195.79
19.98	27.17	30.70	70.37	86.67	100.95	87.46	100.73	109.22	159.48	202.13	173.00	132.32
22.72	39.16	0.00	62.50	76.86	89.52	77.57	89.29	96.98	143.03	181.85	155.94	117.75
460.50	379.49	271.52	292.34	636.96	789.75	664.05	618.26	649.32	687.76	852.80	420.02	852.36
133.65	127.33	143.65	238.26	190.01	496.84	693.13	736.15	791.85	620.62	506.05	691.83	559.84
60.71	90.70	92.86	118.78	240.46	496.84	693.13	736.15	791.85	620.62	506.05	691.83	559.84
15.33	30.85	46.90	45.36	29.13	36.93	64.32	36.83	54.28	53.84	47.89	21.20	33.45
15.58	24.77	25.11	34.21	12.37	27.34	47.15	49.32	54.93	42.95	43.07	37.99	38.84
12.86	21.51	20.69	27.71	0.00	0.00	43.02	44.93	50.56	39.10	39.63	35.12	35.77
91.78	185.02	195.05	240.71	364.14	228.55	363.37	168.19	424.80	366.63	517.94	188.32	193.80
61.59	186.79	189.60	251.58	327.30	333.98	356.71	123.10	431.77	421.69	521.98	249.19	221.21
54.58	165.53	168.02	222.94	290.05	296.26	316.11	109.09	382.63	373.70	462.57	224.14	198.90
135.88	158.69	218.68	268.12	281.36	236.10	542.69	423.74	524.70	562.42	383.00	451.18	527.85
80.52	188.75	141.83	253.59	318.71	282.98	320.47	439.12	498.04	518.63	571.96	479.13	494.35
71.35	167.26	125.68	224.73	282.44	250.77	284.02	390.41	443.52	460.81	509.54	426.43	438.80
0.00	0.00	4.59	14.88	27.10	33.09	36.42	37.90	14.84	23.27	6.65	2.83	2.29
5.94	7.98	5.18	16.79	30.58	37.34	41.08	42.76	16.47	26.26	7.50	3.20	2.59
0.00	0.00	4.59	14.88	27.10	33.09	36.42	37.90	14.84	23.27	6.65	2.83	2.29
20.24	33.49	81.69	112.25	120.25	124.08	178.05	202.00	166.72	134.28	105.86	101.10	87.32
32.80	41.41	92.02	126.66	135.69	140.01	200.91	224.63	181.90	146.51	115.41	112.43	96.08
2.23	3.09	81.69	112.25	120.25	124.08	178.05	200.47	166.72	134.28	105.86	101.10	87.32
68.83	31.09	94.18	97.68	76.24	98.98	112.62	118.40	144.66	128.87	100.33	75.62	50.15
76.66	35.08	99.10	61.55	69.57	84.99	93.09	134.64	148.44	124.75	101.61	102.82	55.41
0.00	0.00	10.87	55.13	61.99	76.93	82.49	119.32	131.57	110.95	90.35	91.83	49.61
187.29	172.51	192.37	393.30	691.75	282.75	342.17	362.53	295.85	384.56	475.34	410.87	987.91
355.68	230.99	169.54	391.84	363.59	351.22	449.30	488.12	420.45	424.06	460.75	507.32	574.66
315.20	204.70	150.24	347.24	322.20	311.25	404.72	441.68	379.91	388.81	419.20	458.11	522.45

TABLE B7

Bilateral commitments and disbursements, 1990–2012, continued

Donor	Observed/estimated[1]	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
	Observed Committments	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Luxembourg	Estimated Disbursements	0.00	0.00	7.60	7.61	0.00	15.01	14.74	25.95	29.80	22.04
	Observed Disbursements	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Observed Committments	67.29	73.72	144.61	119.52	125.68	182.11	250.35	154.56	179.84	211.51
Netherlands	Estimated Disbursements	128.55	66.47	225.87	107.76	113.31	169.34	212.72	125.82	156.14	162.25
	Observed Disbursements	2.14	0.00	0.00	0.00	0.00	0.00	0.00	0.00	64.87	0.00
	Observed Committments	0.00	0.00	0.00	0.00	0.00	2.67	0.00	0.00	0.00	0.00
New Zealand	Estimated Disbursements	0.00	3.42	3.26	2.56	3.22	3.32	0.07	0.00	5.72	7.66
	Observed Disbursements	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Observed Committments	30.38	26.15	94.46	10.15	56.73	97.65	69.30	54.85	52.30	124.31
Norway	Estimated Disbursements	34.30	29.50	106.60	11.46	62.64	108.16	74.78	59.60	58.56	117.82
	Observed Disbursements	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-0.02
	Observed Committments	0.00	0.00	0.00	0.00	0.03	0.29	1.06	0.16	0.68	11.67
Portugal	Estimated Disbursements	0.00	0.00	3.35	0.07	7.10	10.96	13.55	16.48	11.15	13.41
	Observed Disbursements	0.00	0.00	0.00	0.00	0.00	0.04	0.43	0.68	0.61	0.39
	Observed Committments	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
South Korea	Estimated Disbursements	0.00	1.65	3.51	5.26	1.24	6.46	1.42	43.34	38.73	126.43
	Observed Disbursements	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Observed Committments	7.46	20.24	92.55	68.09	25.94	166.30	193.68	158.66	137.10	177.78
Spain	Estimated Disbursements	8.42	34.01	145.33	114.07	54.62	168.74	255.77	124.89	109.50	140.24
	Observed Disbursements	0.00	0.00	0.00	23.15	13.33	50.58	0.00	110.67	97.04	124.28
	Observed Committments	301.96	107.84	317.62	64.74	130.84	226.15	86.82	77.06	142.92	128.51
Sweden	Estimated Disbursements	280.56	156.85	213.41	132.94	119.92	151.87	135.79	119.61	80.16	107.46
	Observed Disbursements	142.94	143.92	196.94	122.38	109.38	136.08	123.64	108.01	72.87	97.28
	Observed Committments	69.92	46.57	30.36	21.26	44.36	20.01	33.20	59.70	33.86	52.90
Switzerland	Estimated Disbursements	63.13	42.04	27.24	20.00	40.04	18.07	29.97	53.90	30.56	40.77
	Observed Disbursements	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Observed Committments	107.14	69.33	497.85	140.84	162.38	163.86	298.69	284.65	483.98	627.45
United Kingdom	Estimated Disbursements	97.07	97.16	259.54	76.59	84.12	69.09	110.37	146.72	270.85	406.77
	Observed Disbursements	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	224.73	228.66
	Observed Committments	547.50	679.97	585.64	751.71	1,413.46	1,351.15	706.57	1,248.13	1,102.18	1,395.79
United States	Estimated Disbursements	1,463.21	1,345.28	1,254.87	1,143.13	1,760.28	1,788.15	1,352.71	1,436.91	1,402.35	1,646.15
	Observed Disbursements	12.72	10.11	11.11	1.87	0.00	0.00	0.00	0.00	0.00	0.00

2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
0.00	31.28	32.54	30.92	35.97	45.47	48.73	60.36	62.22	50.86	61.91	42.98	40.82
26.57	35.30	36.71	34.89	39.93	48.91	53.63	65.65	68.00	56.26	68.29	47.60	45.21
0.00	0.00	0.00	0.00	35.97	45.47	48.73	60.36	62.22	50.86	61.91	42.98	40.82
190.07	178.64	280.60	180.46	315.72	285.79	866.10	207.32	718.19	271.34	280.32	162.09	618.40
148.35	189.18	224.24	306.43	314.38	277.81	314.33	379.18	449.03	425.24	359.07	355.10	307.66
0.00	167.65	199.40	272.98	284.93	246.19	285.25	341.61	407.45	388.47	331.04	324.87	278.52
0.00	0.00	4.79	14.15	12.53	23.30	33.06	16.84	51.62	27.35	13.99	28.79	10.93
5.97	5.94	4.83	11.29	13.56	21.23	22.46	15.54	23.04	21.23	31.48	30.91	32.12
0.00	0.00	4.28	10.01	12.22	18.94	20.32	13.77	20.92	19.16	28.30	28.36	28.75
48.20	190.71	157.48	163.61	121.57	255.93	406.45	434.26	303.26	538.49	205.81	192.75	271.51
47.63	198.33	121.42	107.48	157.61	266.32	295.76	259.60	305.00	314.44	240.12	251.95	244.73
0.00	43.52	109.82	96.42	140.47	236.01	273.70	233.81	275.82	280.72	217.01	228.28	221.33
7.85	10.06	9.54	10.07	12.02	12.00	11.89	12.44	8.98	10.11	13.28	18.24	15.05
9.09	11.34	10.77	11.36	13.56	13.40	13.42	14.03	10.13	11.41	14.95	20.56	16.96
0.24	10.05	9.54	10.07	12.02	11.88	11.89	12.44	8.98	10.11	13.28	18.24	15.05
0.00	0.00	0.00	0.00	0.00	0.00	44.71	126.63	285.42	168.41	146.20	169.98	204.90
88.14	61.16	54.80	28.10	64.42	105.55	49.46	118.19	282.64	121.72	169.99	121.17	156.92
0.00	0.00	0.00	0.00	0.00	0.00	46.65	57.86	70.95	108.32	151.14	108.24	139.32
100.98	94.36	107.83	107.36	150.57	143.91	183.63	286.39	360.59	283.73	281.78	200.49	85.79
158.05	130.97	88.42	127.66	158.72	193.78	186.33	284.16	466.23	392.48	286.94	188.93	87.73
140.06	116.06	78.35	113.13	140.65	171.84	167.13	255.83	423.04	355.06	259.63	169.63	79.18
113.36	57.43	144.71	150.19	168.84	353.75	361.36	174.78	192.59	152.77	188.99	180.70	227.92
75.57	115.61	105.44	136.72	207.93	255.23	267.21	371.29	329.83	262.37	236.24	217.23	308.85
67.66	103.72	93.49	121.20	184.56	226.18	236.94	333.73	294.39	237.83	213.94	199.30	279.51
44.32	36.71	69.74	39.62	71.71	44.92	39.64	76.03	73.11	58.20	89.10	70.83	95.65
32.80	32.86	47.68	54.60	58.07	61.73	49.42	55.49	73.21	81.87	68.20	93.56	90.59
0.00	0.00	42.51	48.42	51.58	54.77	44.02	49.31	65.27	73.34	60.98	83.59	80.63
1,058.88	419.79	822.19	738.93	735.81	1,364.61	1,859.19	1,974.81	1,036.37	1,671.83	357.84	405.30	648.64
688.09	289.64	566.48	515.64	594.56	829.62	1,093.69	1,308.65	1,166.73	1,261.26	1,368.62	1,667.49	1,845.00
247.22	271.92	532.76	473.05	552.28	764.71	1,006.91	1,225.76	1,096.75	1,181.32	1,301.18	1,596.89	1,765.29
1,405.27	1,599.01	2,200.99	2,730.85	3,158.75	4,067.25	4,794.10	6,257.77	7,651.88	7,314.81	7,948.67	8,750.98	6,789.30
1,669.18	1,897.78	2,063.96	2,875.86	2,869.30	4,037.83	4,669.20	5,339.74	6,549.49	7,870.36	8,900.85	10,000.20	8,995.32
0.00	0.00	1,784.81	2,489.64	2,500.59	3,642.99	4,101.07	4,701.10	5,816.97	6,597.84	6,834.53	7,525.87	7,182.44

Source: IHME DAH Database 2014

Notes: In millions 2014 US dollars. This table presents commitments from bilateral development agencies net of identifiable contributions through multilateral channels of assistance (Global Fund, Gavi, United Nations agencies, etc.) but does not exclude transfers to NGOs. In-kind donations also are not reflected in this table. Commitment estimates have been corrected for missingness using the DAC/CRS coverage ratio. Disbursement estimates were obtained by computing donor-specific disbursement schedules using information from complete projects where disbursements could be linked over time.

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

TABLE B8

World Bank financial and in-kind DAH, 1990–2012

	International Bank for Reconstruction and Development		International Development Association	
Year	Financial	In-kind	Financial	In-kind
1990	117.06	4.12	98.76	8.97
1991	138.80	6.88	109.41	7.96
1992	250.73	13.15	224.19	18.67
1993	566.12	29.39	321.05	30.52
1994	710.60	49.46	554.72	54.77
1995	603.90	39.72	549.75	55.07
1996	946.85	52.10	614.92	53.09
1997	1,104.77	51.81	576.09	41.06
1998	1,348.59	53.36	709.69	29.01
1999	757.69	35.32	792.66	49.92
2000	858.14	60.68	829.38	74.35
2001	849.47	62.33	1,048.05	81.49
2002	794.04	62.36	1,087.53	93.58
2003	1,436.79	107.31	895.94	109.88
2004	702.43	65.45	1,283.12	188.37
2005	580.10	61.19	1,182.46	135.95
2006	604.72	53.90	956.80	118.82
2007	739.48	71.34	840.87	112.58
2008	579.33	59.82	609.53	81.62
2009	795.30	53.40	883.79	120.11
2010	1,780.77	87.94	804.92	99.15
2011	1,679.40	112.04	926.80	142.59
2012	943.80	78.01	792.50	105.09

Source: IHME DAH Database 2014

Notes: In millions of 2014 US dollars. For preliminary estimates of DAH for 2013 and 2014, refer to Table B1.

TABLE B9

Regional development banks' financial and in-kind DAH, 1990–2012

	African Development Bank		Asian Development Bank		Inter-American Development Bank	
Year	Financial	In-kind	Financial	In-kind	Financial	In-kind
1990	65.01	5.43	24.54	2.05	31.86	2.66
1991	62.91	5.25	36.99	3.09	48.41	4.04
1992	61.51	5.14	50.85	4.25	55.82	4.66
1993	60.08	5.02	55.50	4.63	76.31	6.37
1994	93.59	7.82	53.35	4.45	85.41	7.13
1995	72.30	6.04	49.56	4.14	93.98	7.85
1996	73.85	6.17	52.54	4.39	125.72	10.50
1997	92.21	7.70	74.14	6.19	157.65	13.16
1998	61.93	5.17	181.00	15.11	178.57	14.91
1999	60.99	5.09	269.93	22.54	170.88	14.27
2000	44.58	3.72	203.06	16.96	184.27	15.39
2001	41.85	3.49	142.01	11.86	186.49	15.57
2002	80.49	6.72	143.75	12.00	202.26	16.89
2003	42.00	3.51	136.64	11.41	243.53	20.34
2004	89.67	7.49	120.79	10.09	433.63	36.21
2005	147.97	12.36	179.16	14.96	290.51	24.26
2006	90.46	7.55	184.64	15.42	141.41	11.81
2007	87.93	7.34	141.08	11.78	152.94	12.77
2008	106.66	8.91	147.97	12.36	159.52	13.32
2009	86.63	7.23	171.59	14.33	153.47	12.81
2010	111.84	9.34	100.36	8.38	131.70	11.00
2011	107.13	8.95	94.04	7.85	137.25	11.46
2012	111.68	9.33	79.17	6.61	137.00	11.44

Source: IHME DAH Database 2014

Notes: In millions of 2014 US dollars. For preliminary estimates of DAH for 2013 and 2014, refer to Table B1.

TABLE B10

Financial and in-kind contributions by the Global Fund and Gavi, 2000-2012

	Gavi		Global Fund	
Year	Financial	In-kind	Financial	In-kind
2000	3.08	0.40	–	–
2001	173.19	4.61	–	–
2002	140.59	11.23	1.15	16.29
2003	226.53	5.25	281.43	39.63
2004	199.10	56.41	770.82	62.34
2005	322.17	40.18	1,233.58	86.40
2006	283.57	10.75	1,507.66	99.02
2007	999.12	20.97	1,909.13	86.67
2008	774.07	25.16	2,425.06	169.51
2009	541.18	43.71	2,950.29	168.45
2010	817.83	31.75	3,272.10	266.93
2011	854.34	25.59	2,762.50	307.15
2012	1,113.44	47.17	3,456.17	599.29

Source: IHME DAH Database 2014

Notes: In millions of 2014 US dollars. For preliminary estimates of DAH for 2013 and 2014, refer to Table B1. Dashes indicate inapplicable.

TABLE B11

WHO, regular and extrabudgetary income and expenditure, 1990–2012

Year	Regular budget income	Regular budget expenditure	Extrabudgetary income	Extrabudgetary expenditure[1]	Total income	Total expenditure	Development assistance for health[2]
1990	572.56	481.08	708.88	740.47	1,281.44	1,221.55	1,170.05
1991	554.11	465.58	686.04	716.61	1,240.15	1,182.20	1,132.35
1992	576.19	458.05	659.00	689.19	1,235.19	1,147.25	1,114.74
1993	562.80	447.41	643.69	673.18	1,206.49	1,120.59	1,088.84
1994	510.28	562.21	680.92	696.09	1,191.20	1,258.30	1,224.43
1995	499.85	550.73	667.01	681.87	1,166.86	1,232.59	1,199.42
1996	637.88	492.71	609.42	540.93	1,247.30	1,033.64	1,008.01
1997	627.14	484.42	599.16	531.83	1,226.31	1,016.24	991.05
1998	586.45	491.11	743.11	617.34	1,329.56	1,108.45	1,093.97
1999	577.61	483.70	731.91	608.04	1,309.52	1,091.74	1,077.48
2000	572.68	480.07	1,028.80	874.45	1,601.48	1,354.52	1,336.03
2001	559.92	469.37	1,005.88	854.97	1,565.80	1,324.34	1,306.27
2002	513.08	474.64	973.69	941.49	1,486.77	1,416.13	1,390.38
2003	503.05	465.36	954.65	923.08	1,457.70	1,388.44	1,363.19
2004	518.87	471.42	1,392.10	1,277.16	1,910.97	1,748.57	1,711.77
2005	502.70	456.72	1,348.71	1,237.35	1,851.41	1,694.07	1,658.42
2006	518.62	445.72	1,759.66	1,397.55	2,278.28	1,843.26	1,695.40
2007	505.18	434.16	1,714.05	1,361.32	2,219.23	1,795.49	1,651.45
2008	466.35	442.06	1,557.15	1,592.52	2,023.50	2,034.58	1,972.19
2009	462.83	438.72	1,545.41	1,580.51	2,008.25	2,019.24	1,957.32
2010	577.16	416.58	1,942.36	1,886.91	2,519.53	2,303.49	2,212.93
2011	505.37	411.70	1,903.09	1,848.76	2,408.46	2,260.45	2,171.72
2012	426.77	406.95	1,688.76	1,582.12	2,115.53	1,989.06	1,874.29

Source: IHME DAH Database 2014

Notes: In millions of 2014 US dollars. For preliminary estimates of DAH for 2013 and 2014, 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 B12

Bill & Melinda Gates Foundation global health disbursements and in-kind contributions, 1999–2012

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
COMMITMENTS	1,612.44	795.16	650.80	466.41	1,040.07	1,125.29	1,215.08	1,487.98	2,080.44	2,995.24	2,097.50	869.59	2,868.58	1,792.33
DISBURSEMENTS	113.45	406.09	487.96	534.22	616.27	428.78	681.41	813.01	1,117.71	1,764.17	1,562.27	1,534.61	1,913.52	2,159.06
BMGF	101.43	341.43	237.47	401.80	532.50	315.47	408.37	606.21	813.50	1,204.60	1,034.70	876.18	1,175.42	1,153.44
Gavi	–	2.91	137.72	0.00	5.67	5.38	113.02	0.00	87.83	94.12	54.46	78.44	222.13	224.30
Global Fund	–	–	–	0.06	14.58	24.68	0.00	69.84	70.47	71.60	101.99	103.50	138.10	157.46
NGOs[1]	12.02	52.68	103.91	101.33	33.09	42.50	120.53	66.87	77.64	202.46	181.17	156.75	64.59	334.00
UN agencies	0.00	9.07	8.87	31.04	30.43	40.75	39.48	70.09	68.27	191.39	189.95	319.74	313.28	289.86
IN-KIND	0.99	39.73	52.59	39.00	47.22	37.57	95.21	107.39	106.36	196.50	272.84	270.94	215.62	372.11

Source: IHME DAH Database 2014

Notes: In millions of 2014 US dollars. For preliminary estimates of DAH for 2013 and 2014, refer to Table B1.

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

TABLE B13

US and international NGO expenditures, 1990–2013

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
TOTAL OVERSEAS HEALTH EXPENDITURE	333.48	489.16	596.20	639.86	745.95	755.47	741.34	836.73	988.56	1,121.06
BMGF grants	–	–	–	–	–	–	–	–	–	8.87
Private in-kind revenue	29.16	32.87	42.33	54.98	72.81	70.52	83.38	92.44	103.75	111.00
Private financial revenue	152.67	190.70	212.15	242.34	267.38	285.49	315.86	363.76	480.69	518.66
Revenue from other governments	152.67	65.16	72.99	76.11	88.56	82.61	100.69	100.33	116.28	136.38
Revenue from US government	116.40	200.43	268.73	266.42	317.19	316.85	241.42	280.20	287.84	346.15
AVERAGE PERCENT REVENUE FROM										
Private in-kind contributions	15.28	14.21	15.38	15.88	16.77	15.98	18.44	18.73	18.25	18.15
Private financial contributions	60.37	63.43	61.50	59.58	57.84	57.86	55.44	55.65	56.85	57.59
US government	19.78	17.24	18.01	19.42	19.93	20.13	19.77	19.37	17.16	16.79
NUMBER OF NGOs IN SAMPLE	268	340	391	419	439	430	434	441	496	494

2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
1,297.02	1,437.27	1,591.35	1,809.20	2,227.11	2,777.64	3,063.49	3,305.83	4,112.68	4,349.01	4,924.64	4,798.47	4,659.35	5,143.95	5,288.37
39.75	80.19	79.40	26.45	34.90	102.17	58.42	69.64	185.16	166.94	146.21	61.49	324.00	341.72	390.05
104.33	155.68	177.57	225.66	329.75	415.99	390.51	458.84	689.66	590.46	526.24	562.72	548.01	662.59	666.86
580.54	561.54	628.56	754.97	867.98	1,140.38	1,387.64	1,455.57	1,711.87	1,662.60	2,087.28	2,117.76	1,708.02	1,804.37	1,781.35
168.96	191.77	205.73	238.43	263.22	348.06	429.46	507.11	555.58	735.76	886.28	860.57	1,097.88	1,253.38	1,340.02
403.45	448.09	500.09	563.70	731.25	771.04	797.46	814.66	970.41	1,193.25	1,278.63	1,195.93	981.44	1,081.89	1,110.10
18.45	19.15	18.33	18.90	18.50	17.06	18.60	17.45	17.04	16.80	15.77	15.02	17.53	18.37	18.91
55.60	55.81	56.36	56.76	57.50	60.59	59.20	60.21	60.45	58.50	59.57	61.68	55.75	53.83	52.42
16.84	16.06	16.36	16.35	16.19	13.88	13.56	13.09	12.23	13.35	12.74	10.75	12.77	13.04	13.35
510	531	570	596	603	596	632	653	702	725	719	796	796	796	796

Source: IHME DAH Database 2014

Notes: In millions of 2014 US dollars. Includes both US and international NGOs.

TABLE B14

Government health expenditure by source, 1995–2012

Global Burden of Disease region	1995	1996	1997	1998	1999	2000	2001
ASIA							
Central	3.46	3.43	3.72	3.65	3.04	3.12	3.34
East	31.88	34.68	38.21	41.91	45.66	47.50	47.42
South	7.79	7.97	8.65	9.39	10.30	10.72	10.89
Southeast	11.92	13.66	14.75	13.82	14.46	15.07	16.94
CARIBBEAN	2.67	3.08	3.42	3.53	3.78	4.22	4.27
LATIN AMERICA							
Andean	3.60	3.90	3.76	3.70	4.10	3.93	4.15
Central	28.90	30.14	34.22	37.90	41.44	42.36	43.61
Southern	17.98	18.05	18.68	20.12	22.32	22.01	21.59
Tropical	40.97	40.69	44.26	43.56	46.03	45.81	49.26
NORTH AFRICA AND MIDDLE EAST	28.88	32.00	36.07	40.30	43.86	48.31	53.65
OCEANIA	0.46	0.44	0.42	0.46	0.45	0.48	0.54
SUB-SAHARAN AFRICA							
Central	0.32	0.94	1.17	1.00	1.19	1.00	1.54
East	1.44	1.31	1.69	2.06	1.87	2.61	2.87
South	7.23	7.37	8.44	8.91	9.62	9.67	10.08
West	2.33	2.33	2.50	3.11	3.44	3.63	4.30

2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
3.50	3.94	4.66	5.42	5.74	5.39	6.45	7.83	8.14	8.13	9.17
54.61	61.12	69.00	77.29	88.73	111.75	138.60	176.32	194.88	226.74	257.02
11.21	11.19	11.82	12.70	14.35	15.54	17.43	19.75	21.06	25.50	29.18
17.91	20.80	20.91	20.57	24.49	28.34	28.50	31.55	34.26	36.14	38.20
4.62	4.80	4.83	6.23	6.79	9.04	9.88	10.95	10.27	10.53	9.68
4.67	4.53	4.74	5.22	5.55	6.74	8.29	7.89	7.93	8.24	9.84
43.56	46.40	48.72	50.82	54.13	58.73	61.75	66.56	66.02	67.97	73.58
18.35	17.91	18.81	20.99	22.84	25.94	29.87	35.93	34.10	37.05	41.91
52.76	51.74	58.83	59.36	66.57	70.74	74.40	79.99	95.42	94.35	101.64
57.61	60.33	63.69	65.61	71.89	76.51	79.78	94.37	96.55	94.12	100.11
0.52	0.46	0.50	0.50	0.51	0.59	0.62	0.54	0.61	0.64	0.84
1.25	1.57	1.89	1.77	2.87	2.81	3.65	4.27	3.50	3.76	3.99
3.17	3.17	3.54	3.88	4.90	5.41	3.71	4.40	4.31	4.18	3.89
10.28	10.66	10.62	11.56	12.21	13.13	14.46	15.68	16.08	16.98	17.79
3.72	4.68	6.50	6.21	6.66	8.67	9.63	10.00	8.88	13.99	14.29

Source: IHME Government Health Spending Database (Developing Countries), 2014

Notes: In billions of 2014 US dollars. Government health expenditure as source (GHE-S) includes funds raised by recipient country governments from internal sources. This table disaggregates GHE-S by Global Burden of Disease developing region from data produced by the WHO and National Health Accounts.

TABLE B15

DAH allocated to government and non-government recipients, 1995–2012

Global Burden of Disease region	1995		1996		1997		1998		1999		2000		2001		2002	
	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
ASIA																
Central	0.16	60.73	2.17	46.37	0.23	25.99	1.55	64.02	0.14	99.42	14.10	92.15	1.87	76.32	8.73	81.07
East	5.01	38.70	2.41	19.43	3.94	32.30	5.72	61.05	9.17	60.07	42.48	45.19	23.17	21.46	19.69	65.84
South	20.61	223.65	24.50	399.17	22.56	401.27	24.22	405.23	28.56	404.34	163.17	279.42	39.99	337.29	60.42	346.89
Southeast	21.44	420.99	12.70	189.10	25.75	235.16	30.51	222.27	36.57	269.93	49.49	252.23	58.85	258.06	53.49	236.44
CARIBBEAN	0.60	185.58	1.08	56.34	1.90	44.01	1.99	81.46	8.27	109.17	12.12	66.74	23.37	70.41	19.28	42.75
LATIN AMERICA																
Andean	1.12	61.27	3.46	49.27	2.58	82.42	5.07	129.57	2.61	117.79	2.77	172.67	26.11	108.32	33.96	58.60
Central	3.32	82.73	4.82	101.52	5.52	227.43	9.39	119.22	20.80	224.39	14.09	119.55	18.07	151.45	40.04	107.35
Southern	0.15	2.55	0.14	1.19	0.19	14.88	0.12	1.57	0.56	2.35	0.61	1.75	0.63	2.44	1.48	5.33
Tropical	1.43	5.94	0.76	0.42	0.90	6.40	3.34	21.97	13.00	19.81	5.17	15.34	0.54	25.10	2.18	18.82
NORTH AFRICA AND MIDDLE EAST	24.97	224.65	6.19	201.91	21.72	147.82	9.64	210.15	14.84	235.90	21.94	230.06	30.52	187.38	42.56	177.48
OCEANIA	0.00	2.25	0.00	51.52	0.00	20.80	0.71	31.47	5.10	86.83	44.13	69.22	17.86	40.38	22.66	58.26
SUB-SAHARAN AFRICA																
Central	1.93	84.42	1.71	63.12	10.19	55.06	2.00	75.78	13.03	55.95	4.54	66.11	19.79	75.11	29.60	62.44
East	35.20	474.84	37.95	622.83	37.78	486.30	24.10	495.54	37.79	676.65	105.54	555.45	163.62	667.65	160.73	634.67
South	12.09	72.24	2.01	79.17	14.61	76.95	8.75	87.23	3.49	80.29	13.99	84.95	32.39	107.11	19.19	120.69
West	4.42	332.03	23.28	195.20	11.09	292.54	11.60	286.70	29.49	297.24	43.41	349.95	56.62	370.53	65.43	332.21

2003		2004		2005		2006		2007		2008		2009		2010		2011		2012	
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
3.06	98.57	7.93	98.35	68.58	85.52	85.10	74.36	54.65	136.48	55.22	162.96	61.06	151.93	80.69	149.69	92.90	176.59	117.11	159.73
11.90	105.36	16.67	143.46	20.32	168.30	35.05	146.73	42.56	202.07	70.22	175.83	80.86	207.23	132.22	177.15	116.28	139.57	145.97	203.43
64.16	470.81	115.51	462.89	284.74	567.28	484.46	499.88	430.41	818.14	564.95	947.46	543.71	816.29	555.44	929.86	739.38	818.86	644.98	879.69
46.89	446.44	76.36	486.10	229.62	441.10	299.06	526.43	292.33	559.55	294.30	632.63	342.38	602.33	453.95	696.82	436.06	726.88	631.27	594.58
23.81	111.71	44.09	96.67	90.51	89.03	142.09	83.15	169.33	102.09	152.74	151.41	219.37	138.44	212.57	110.68	281.92	132.22	291.04	117.50
25.39	115.64	26.14	132.37	51.49	104.83	59.86	111.79	57.38	114.84	63.14	124.34	83.04	132.62	91.38	82.75	68.72	74.34	84.11	57.57
24.76	164.40	54.83	150.46	85.63	113.08	93.40	118.16	116.93	146.34	154.45	168.50	141.06	143.66	150.81	113.46	169.46	111.15	166.56	95.20
9.82	11.70	18.04	9.25	13.43	12.50	3.84	14.31	7.90	14.48	4.20	18.79	2.34	10.03	5.57	3.00	4.50	3.52	1.86	1.01
0.93	35.98	5.09	34.36	20.84	23.26	12.09	25.87	15.69	25.96	33.21	27.20	38.16	19.55	55.01	18.20	38.46	17.02	25.82	12.14
30.64	287.95	47.41	400.68	666.48	326.43	557.59	456.31	315.25	577.38	283.43	570.22	341.60	469.98	327.95	488.85	409.75	406.46	370.91	360.97
19.53	88.98	26.13	113.26	36.98	115.86	62.63	77.65	44.37	89.95	49.19	108.28	31.94	161.20	39.56	139.40	98.21	173.95	79.86	215.02
30.32	95.02	64.20	106.21	181.98	132.57	181.09	110.81	180.51	107.24	300.04	273.98	359.53	191.10	369.98	217.24	352.93	228.18	520.49	260.54
145.36	1,072.57	343.63	1,057.53	716.91	1,274.39	1,136.49	1,371.51	1,450.18	1,791.98	1,922.91	2,097.49	2,545.44	1,842.02	2,666.53	2,172.80	3,012.77	2,308.56	3,795.06	2,604.89
60.97	202.56	91.39	143.77	201.54	255.40	307.26	247.86	443.05	338.57	577.33	358.11	912.16	389.89	912.64	416.55	1,004.58	451.14	1,297.05	569.60
74.30	512.64	143.85	600.98	334.65	621.61	418.39	802.34	584.14	727.53	874.22	1,024.13	1,075.36	1,273.92	1,450.28	1,074.39	1,176.23	1,097.37	1,442.94	1,332.72

Source: IHME DAH Database 2014

Notes: In millions of 2014 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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