

CHAPTER 1:

TRACKING DEVELOPMENT ASSISTANCE FOR HEALTH

Since 2009, the Institute for Health Metrics and Evaluation (IHME) has published an annual report containing high-quality estimates of development assistance for health (DAH) for policymakers, researchers, and the global health community. This report provides a picture of donations and spending and the intricate relationship between the two. Figure 1 shows how DAH comes from sources such as national treasuries, private donors in multiple countries, and from loan repayments by governments in developing countries. These funds flow through channels of assistance such as United Nations agencies, bilateral development agencies, non-govern-

mental organizations, and development banks. DAH's final destinations are institutions in the governmental or non-governmental sectors of developing countries that implement programs to improve health. In reality, tracking DAH is much more complex than this diagram indicates. Measurement of DAH is complicated by the fact that channels of assistance often transfer DAH to each other. Also, these channels sometimes implement programs directly. For example, the World Bank transfers DAH in the form of loans and grants to implementing institutions in developing countries, but it also provides technical assistance to these countries.

FIGURE 1:
Resource flows for DAH



BOX 1:**Financing Global Health 2010 main findings for development assistance for health**

- The global recession appeared to be contributing to a slowdown in the growth rate of DAH, which was cut by more than half from an annual average of 13% between 2004 and 2008 to 6% annually between 2008 and 2010.
- Declines in private donations led to a decrease in DAH flowing through non-governmental organizations, which dropped to their lowest level since 2004.
- Improved transparency among donor governments allows for more accurate estimation of DAH. Of public sector DAH, 65% could not be traced to its primary recipients in 1990, but this percentage dropped to 1% in 2008.
- Different health focus areas received dramatically different amounts of funding. DAH for HIV/AIDS experienced strong growth and received the most money of any health focus area. The area of maternal, newborn, and child health obtained half as much funding as HIV/AIDS in 2008. Tuberculosis DAH grew steadily, while malaria spending exhibited the fastest growth rate of any health focus area between 2007 and 2008. Health sector support grew slowly since 2006 despite substantial focus on the need for increased funding in this area. Noncommunicable diseases received less funding than any of the other focus areas.

The full 2010 report can be accessed online at: http://www.healthmetricsandevaluation.org/publications/policy-report/financing_global_health_2010_IHME

For last year's report, *Financing Global Health 2010: Development Assistance and Country Spending in Economic Uncertainty*, we developed methods to estimate DAH in a timely manner. Prior to this, estimates of DAH suffered from a two-year time lag. Key findings from last year's report are outlined in Box 1.¹⁶

This year, as we updated estimates of DAH for 1990 through 2011, we incorporated new data and refined our methodological approaches to improve the quality of the estimates.

- We collected new data on health expenditure from some of the largest non-governmental organizations (NGOs) in the US, which allowed us to improve our estimates of DAH flowing through these channels.
- To identify how much DAH flows to different health issues, we incorporated additional data from the World Bank. As a result, we have a better understanding of how this channel invests its money.
- Our estimates of DAH for noncommunicable diseases (NCDs) are more complete now that we have begun tracking efforts by the Bloomberg Family Foundation to fight tobacco use.

The sources we used to estimate DAH are summarized in Table 1.

Part One examines DAH by channel of assistance, by source, by country of origin, as a percentage of gross domestic product (GDP), by region and country, and by health focus area. All estimates in this report are presented in 2009 US dollars. Growth rates reported in this publication are compound annual growth rates.

By channel of assistance

Many experts have predicted that foreign assistance would shrink in the wake of the global financial crisis that occurred in 2008.^{17,18} Despite these forecasts, we found that DAH continued to rise through 2011. Funding is growing at a much slower rate than it did prior to the recession, however. DAH from some channels of assistance has dropped or stagnated, but other channels showed encouraging signs of faster growth. While more money is flowing into developing countries to help them attain the Millennium Development Goals (MDGs) by 2015, it is unclear if the current growth rate of DAH is sufficient to meet these targets.

In last year's *Financing Global Health* report, we noted that DAH is driven largely by financial contributions from governments that are spread over multiple years and committed in the past.¹⁶

BOX 2:
Methods

- We tracked, where possible, all health-related contributions to developing countries made through public and private channels of assistance for each year between 1990 and 2009.
- We reviewed both the income and expenditure data for each of these channels. The data came from annual reports, government documents, audited financial statements, tax forms, and datasets provided by public and private donors.
- To make sure we did not double-count the same DAH dollars flowing through several channels, we subtracted transfers between channels tracked by our study.
- We separated total DAH into subtotals for sources, channels, and types of funding.
- We collected data from sources such as budget documents and correspondence and used it to construct preliminary estimates of DAH by channel of assistance for years 2010 and 2011.
- For a subset of total DAH, we were able to gather project-level or activity-level information. Using these data, we analyzed the composition of DAH by health focus area and by recipient country.
- For more information about our methods and key definitions, please visit our online Methods Annex at: http://www.healthmetricsandevaluation.org/publications/financing_global_health_2011_methods_IHME.pdf

TABLE 1:
Sources of DAH data

Source	Data
Bilateral agencies in 23 OECD-DAC member countries and the EC	OECD-DAC aggregate database and the Creditor Reporting System (CRS), budget documents, annual reports, and correspondence
UN agencies: PAHO, UNAIDS, UNFPA, UNICEF, WHO	Financial reports and audited financial statements, annual reports, budget documents, and correspondence
World Bank, ADB, AfDB, IDB	Online project databases and compendium of statistics
GAVI	GAVI annual reports, country fact sheets, OECD-CRS, and correspondence
GFATM	Online grant database and pledges
NGOs registered in the US*	USAID Report of Voluntary Agencies, tax filings, financial statements, annual reports, RED BOOK Drug Reference, WHO's Model List of Essential Medicines, and correspondence
BMGF	Online grant database, tax filings, and correspondence
Other private US foundations*	Foundation Center's grants database and tax filings

*Non-US private foundations and NGOs were not included due to lack of comprehensive data.

Notes: For more information about these sources, please visit our online Methods Annex at: http://www.healthmetricsandevaluation.org/publications/financing_global_health_2011_methods_IHME.pdf

For this reason, we concluded that it was perhaps not surprising that DAH continued to rise.¹⁶ Our findings that DAH continued to grow after the economic crisis occurred are not without historical precedent. Some researchers have found that health assistance did not drop during previous recessions.^{19,20} While this may be good news for global health advocates, economic troubles and looming budget cuts in donor countries such as the US threaten to make these gains short lived.²¹ The impact of the unfolding European financial crisis on other major donors such as France and Germany adds to the uncertainty surrounding future levels of DAH.^{22,23}

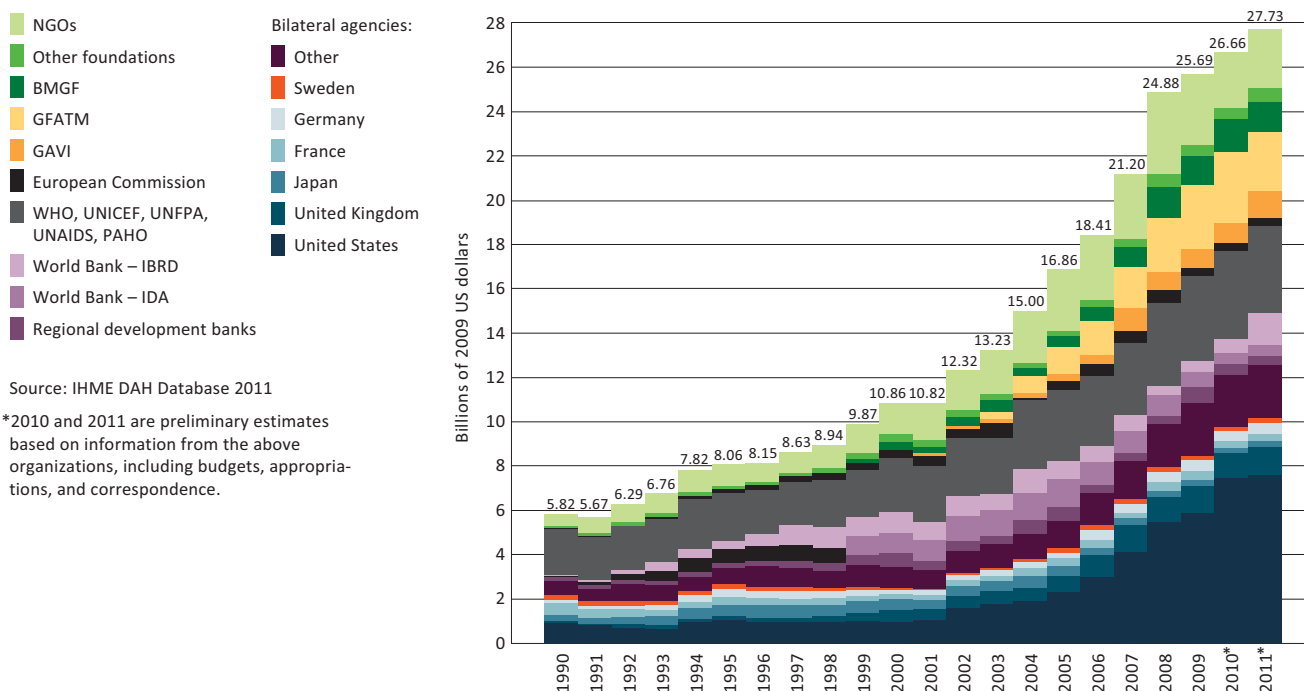
The growth rate of DAH seems to have been affected by the recession. Between 1990 and 2000, DAH increased gradually, but more than doubled in size between 2001 and 2008. From 2007 to 2008 – immediately before the world felt the full impact of the recession – DAH’s growth rate was 17%. In the aftermath of the recession, its rate of growth was much slower. DAH increased only 3% from 2008 to 2009 and 4% each year between 2009 and 2011. Another hypothesis is that the exceptional

era of growth in DAH that began in 2002 has ended, and growth patterns in DAH are returning closer to historic levels. The annual growth rate of DAH was 7% between 1990 and 1995, and 6% between 1995 and 2000. It is important to keep in mind that, in order to avoid double counting, the estimates of DAH by channel exclude any transfers to other channels that we also track.

DAH from many channels of assistance continued to grow despite the recession, although some other channels experienced declines or stagnation. The World Bank’s International Bank for Reconstruction and Development (IBRD) stands out as a channel that experienced dramatic growth between 2010 and 2011.

IBRD has played a key role in the continued growth of DAH in recent years. Over the period of 1997 to 2004, DAH from IBRD fluctuated around \$1 billion, then declined steadily starting in 2005 and continued to drop through 2008. However, IBRD’s growth rate began to rise in 2009 and increased through 2011 according to our preliminary estimates of DAH, described in Box 3. This channel accounted for the largest share (\$796.77 million) of the expansion in total DAH between 2010

FIGURE 2:
DAH by channel of assistance, 1990-2011



BOX 3:

Preliminary estimates of DAH

A major challenge in tracking DAH comes from the significant time lag between disbursements of funds and publication of data about these disbursements. Few channels of assistance that we track provided disbursement data for the years 2010 and 2011.

We overcame this challenge by using data sources, such as budget documents and correspondence with donors, to produce preliminary estimates of DAH for these years. Despite an inevitable margin of error, our previous preliminary estimate of DAH for 2009 from last year's *Financing Global Health* report was quite close to our updated analysis of the actual DAH estimate for 2009 based on reported disbursement data (our preliminary estimate was 0.6% lower than our actual estimate). IHME's preliminary estimates of DAH are valuable, as they supply policy-makers with access to timely data.

Improvements to this year's preliminary estimates include the incorporation of budget data on foreign assistance from South Korea and the Netherlands into our dataset, which were not included in our estimates last year. In addition, IHME strengthened its preliminary estimates of DAH for 2010 by incorporating revised expenditure data from channels such as the GAVI Alliance and the Bill & Melinda Gates Foundation.

and 2011. This scale-up in IBRD financing appears to be part of the World Bank's response to the global economic crisis, in the effort to help developing countries stimulate their economies and provide social safety nets to their citizens.^{24,25}

The large increase in IBRD from 2010 to 2011 indicates that the global health landscape is changing with respect to the purpose and beneficiaries of funds. This type of DAH differs from other forms of DAH that we are also tracking, as IBRD provides DAH in the form of loans instead of grants, which many other channels tend to provide. There is debate in the global health community about whether IBRD loans should be counted as development assistance. While IHME includes loans in its definition of DAH, other researchers have excluded them.²⁶ National Health Accounts of the World Health Organization (WHO) do not count loans to developing countries as external resources for health, since these countries' governments are required to pay them back.²⁷ Furthermore, IBRD loans are primarily targeted toward middle-income instead of low-income countries for the purpose of not only health improvement but also economic stimulus.²⁸

The trend in DAH from the other lending arm of the World Bank, the International Development Association (IDA), differs greatly from IBRD. In contrast to IBRD, IDA primarily provides zero- or low-interest loans and grants to the poorest countries.²⁹ Since 2006, DAH

from IDA has been shrinking. Given IDA's fundraising success at its 16th replenishment in 2010,³⁰ however, it will be important to follow the replenishment's impact on DAH from IDA in future iterations of this research.

Over the past decade, bilateral agencies have been the main drivers of increases in total DAH, but their rate of growth slowed in the aftermath of the recession. In 2002, bilateral agencies' DAH began to rise quickly and continued to expand dramatically through 2008. As rich countries saw their GDP decline between 2008 and 2009, however, growth slowed. From 2010 to 2011, DAH from bilateral agencies grew by only 4% (\$444.08 million). The last time DAH increased at a rate this low was prior to 2002 when the scale-up began. In spite of reduced growth, bilateral channels were the second-largest contributors to growth in total DAH from 2010 to 2011.

Many bilateral agencies in Figure 2 appear smaller than they would if transfers to other channels such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the GAVI Alliance (GAVI), and multilateral agencies were not subtracted.

A massive expansion in DAH from the US since 2002 has fueled the trend in overall DAH, but its growth slowed to just 2% between 2010 and 2011. This slow growth reflects the difficulties of expanding DAH in a country that is facing persistent unemployment, rising

foreclosure rates, and a ballooning national debt.³¹⁻³³ Furthermore, foreign aid is a popular target for cuts as many Americans believe that it makes up around 25% of the total US budget, while in reality it is just 1% of the total.³⁴

Slow growth in US DAH has been somewhat mitigated by increasing generosity from other bilateral agencies. The UK, whose DAH has grown substantially over the last decade, increased its DAH by 14% between 2010 and 2011. The UK has continued to expand its levels of foreign assistance despite cutting other areas of government spending.³⁵ Its decision to protect foreign aid spending from cuts has proved highly controversial.³⁶ The UK's approach differs starkly from other countries such as the Netherlands, Spain, and Italy that have cut foreign assistance along with other parts of the budget. During a period of time where the UK government's cuts to domestic spending have inspired much opposition, increasing its DAH is a continual struggle.³⁷

Germany's DAH began to expand in 2006, and then shrank amid concerns about the impact of the financial crisis. Over the last year, however, DAH from Germany started to grow once again.

Private channels of assistance have played an increasingly important role in channeling DAH over the last decade. Last year, we noted that they suffered more than any other channel as a result of the recession. This year, private channels showed signs of recovering from the negative impact of the economic downturn.

NGOs experienced sustained growth over the period 1997 to 2008. Their growth became especially pronounced in 2004 when the US President's Emergency Plan for AIDS Relief (PEPFAR) began disbursing funds and channeling large amounts of DAH through these organizations. From 2008 to 2010, however, NGOs were one of the channels most adversely impacted by the recession, in part due to declining contributions from private sources. DAH flowing through NGOs expanded by 25% from 2007 to 2008, but their DAH declined by 15% and 22% in the following two years. The period 2010 to 2011 seemingly marked a change in fortunes for NGOs, which rebounded and grew 8%.

US foundations, excluding the Bill & Melinda Gates Foundation (BMGF), experienced negative growth rates in the early 2000s but began to grow again in 2005. This growth continued until the period of 2008 to 2009, when DAH from this channel dropped by 4%. Our preliminary estimates show that DAH from US

foundations (excluding BMGF) started to increase again from 2009 to 2010 and grew 11% between 2010 and 2011.

Our estimates of DAH channeled through NGOs and private foundations do not include private donations from countries outside of the US due to the lack of standardized and complete data. Studies of philanthropic contributions from countries in the Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD-DAC), excluding the US, have indicated that these funds were 60% smaller than private DAH from the US in 2008.³⁸ As the quality, comparability, and availability of data for private DAH outside of the US improves, IHME aspires to track these important yet little understood contributions aimed at addressing health problems in developing countries.

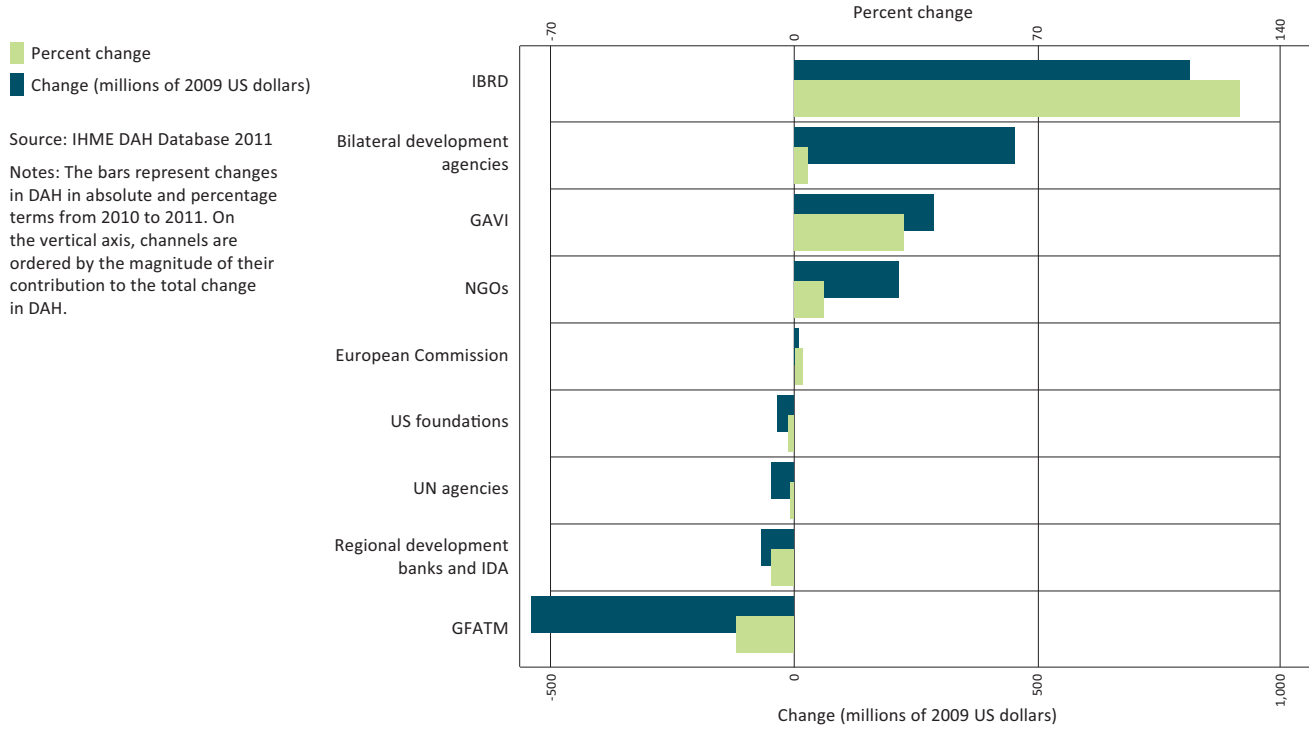
DAH from BMGF, the largest foundation involved in global health, increased over time. Its rate of growth was particularly fast between 2007 and 2008 (61%). At this time, BMGF's DAH expanded at the fastest rate since it first began disbursing money. Its DAH has fluctuated up and down since 2008, however. Historically, DAH from BMGF rose and fell due to peaks from large grants.

GAVI, a newer channel of assistance compared to more traditional institutions such as UN agencies, experienced sustained growth since its establishment early in the last decade. The amount of DAH flowing through GAVI became especially pronounced starting in 2007. Despite the recession, DAH from GAVI continued to grow. Our preliminary estimates indicate that its growth rate increased 31% between 2010 and 2011, rising from \$893.84 million to \$1.17 billion.

As seen in Figure 3, the growth rate of DAH from UN agencies has been slower than less traditional channels such as GAVI. Since 2002, the growth rate of DAH from UN agencies was 5%. From 2010 to 2011, their DAH decreased by 1%. Among these different agencies, the only one that did not experience a decline in DAH was the Pan American Health Organization.

Declines in the value of the US dollar pose challenges to UN agencies such as WHO. WHO receives its revenue in US dollars but pays its headquarters staff in Swiss francs.³⁹ One US dollar was worth 1.20 Swiss francs in 2007 but was worth only 0.92 Swiss francs in 2011. Therefore, the number of headquarter staff hours that WHO can purchase with its revenue has declined over time.

FIGURE 3:
Change in DAH by channel of assistance, 2010-2011



Source: IHME DAH Database 2011
 Notes: The bars represent changes in DAH in absolute and percentage terms from 2010 to 2011. On the vertical axis, channels are ordered by the magnitude of their contribution to the total change in DAH.

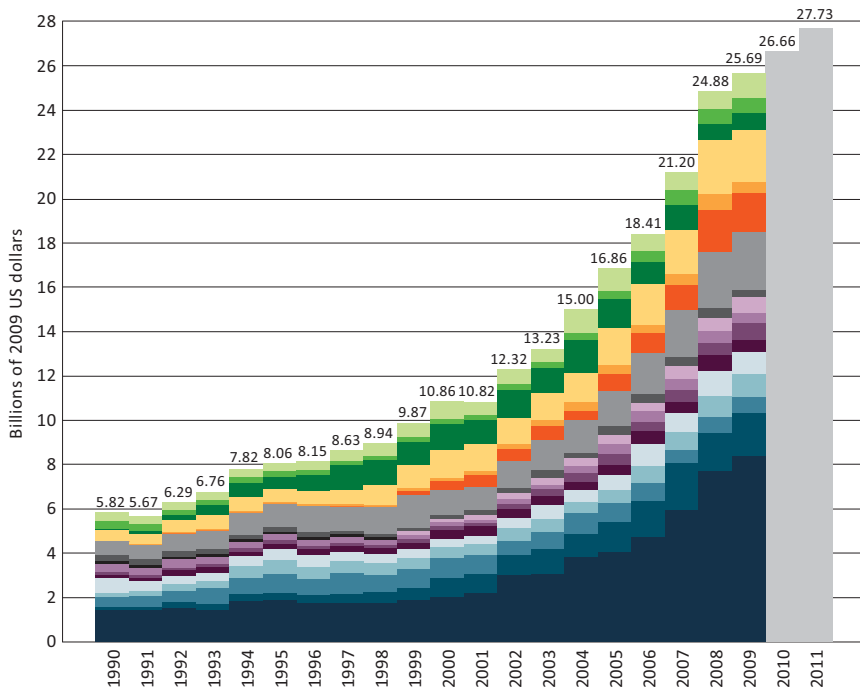
FIGURE 4:
DAH by source of funding, 1990-2011

Funds from channels for which we were unable to find disaggregated revenue information as well as interagency transfers from non-DAH institutions are included in "unallocable." "Other" refers to interest income, currency exchange adjustments, and other miscellaneous income.

- Unallocable
- Other
- Debt repayments (IBRD)
- Private philanthropy:
 - Other
 - Corporate donations
 - BMGF
- National treasuries:
 - Other governments
 - Italy
- Norway
- Sweden
- Canada
- Netherlands
- France
- Germany
- Japan
- United Kingdom
- United States
- Preliminary estimates

Source: IHME DAH Database 2011

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



Since its beginning in 2002, DAH from GFATM exhibited double-digit or greater yearly growth rates, increasing from \$16.28 million in its first year to \$3.22 billion in 2010. Between 2010 and 2011, however, our preliminary estimates show that GFATM's DAH declined by 16% (\$529.33 million).

In the wake of the economic crisis, donors did not give GFATM as much money as they had pledged. Prior to the recession, donors' disbursements to GFATM were approximately the same as commitments. By 2009, however, donors disbursed 94% of commitments, and this percentage decreased to just 78% of commitments in 2010. Preliminary data from GFATM, current as of August 2011, seem to indicate that donors' commitments and disbursements decreased again.

Declines in GFATM's revenue may partially explain why its disbursements also shrank in 2011. This may also reflect an institutional shift in focus from prioritizing the speed and volume of disbursements to ensuring the accountability for and effectiveness of these disbursements.⁴⁰

Figure 3 provides a detailed look at changes in DAH among different channels of assistance over the past year. Each green bar represents a channel's change in percentage, while the blue bars capture changes in volume. On the vertical axis, channels are ordered by the magnitude of their contribution to the total change in DAH. For example, the percentage change from bilateral channels was relatively small, but its contribution was the second largest in absolute terms.

As we have noted in previous studies, the arrival of less-traditional organizations such as GAVI and GFATM in the last decade as well as slower DAH growth led to increased competition between channels of assistance for public and private funds. In this environment, the newer global health actors GAVI and GFATM acquired a growing share of DAH. GAVI's share of total DAH grew from 1% in 2002 to 3% in 2010 to 4% in 2011. GFATM's share of total DAH grew from 2% of total DAH in 2003, the first year of its existence, to 12% in 2010 and 10% in 2011.

As GAVI and GFATM's influence expanded, more traditional institutions such as the UN, World Bank IDA, and the regional development banks controlled less of total DAH. For example, the UN saw its share of overall DAH decline from 21% in 2002 to 14% in 2011. Likewise, the World Bank IDA and regional development banks' shares have declined from 9% to 2% and from 4% to

2%, respectively, over the same period. The World Bank's IBRD is an exception to this trend as its DAH has grown in recent years.

As a larger number of players compete for uncertain DAH support, fundraising efforts have greatly expanded. Examples of this include the proliferation of calls for disease-specific funding, such as HIV/AIDS, tuberculosis, malaria, NCDs, and swine flu.⁴¹⁻⁴³

Alternative perspectives on DAH

To view the different sources that have contributed money to channels of assistance, please see Figure 4. Some channels of assistance, such as BMGF, are also sources of funding. In the source figure, the amount of DAH from BMGF reflects all of the funds that it disburses as a channel as well as the money that it transferred to other channels. Figures 5 and 6 provide alternative assessments of the amount of DAH donated by different countries. We were unable to produce estimates past 2009 due to lack of data.

Public sector DAH

Donors have very different preferences when it comes to the channels they choose to fund. This is shown in Figure 7. The donors who provide the largest amount of DAH tend to dominate the global health landscape through their choices about which channels to finance, as can be seen in Figure 8. Over time, public donors' funding decisions led to greater amounts of DAH flowing to NGOs, other private channels, and public-private partnerships (PPPs) than to UN agencies. Time lags in the publication of DAH data from bilateral agencies prevented us from including data from years 2010 and 2011.

The US, the largest public donor, channeled 55% of its DAH through NGOs and other private actors in 2009. As a result, this sector has become the dominant recipient of DAH. The US PEPFAR program is a prime example of a publicly funded program that relies mainly on NGOs as implementing partners. Many members of the international community have tried to promote the use of recipient countries' financial systems to channel aid according to the principles of the Paris Declaration for Aid Effectiveness.⁴⁴ Despite their efforts, a large portion of US DAH continues to be channeled through NGOs.

When it comes to giving money to multilaterals, the US government's preferences differed greatly from smaller donors such as the Netherlands, Finland, and

FIGURE 5:
DAH by country of origin, 1990-2011

“Unallocable” includes funds such as interagency transfers from non-DAH institutions, interest income, and miscellaneous income that could not be attributed to countries. Channels for which we had no revenue information are included under “unspecified.”

- Unspecified
- Unallocable
- Other
- Australia and New Zealand
- Canada
- South Korea
- Japan
- United Kingdom
- Europe, excluding UK
- United States
- Preliminary estimates

Source: IHME DAH Database 2011

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

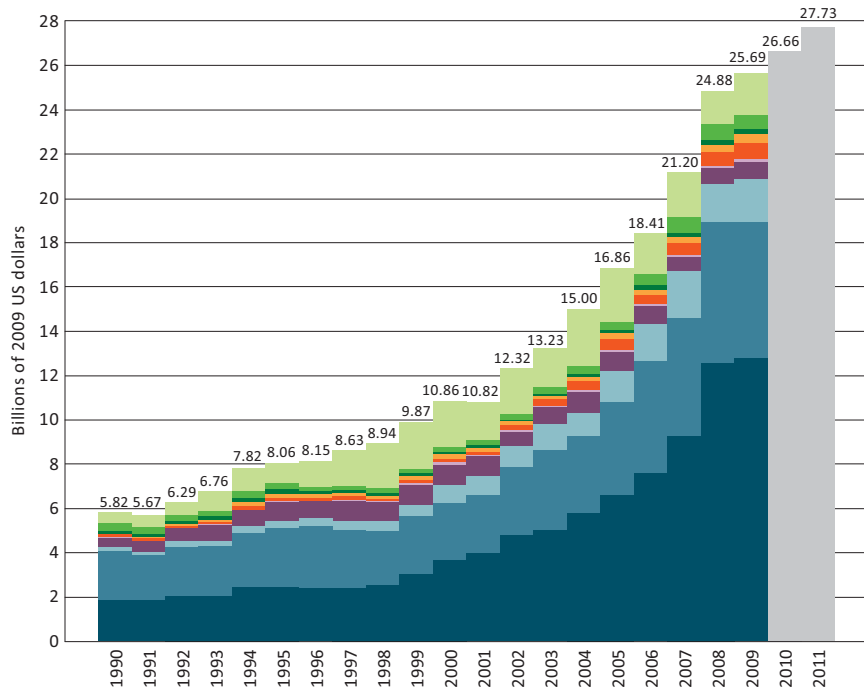
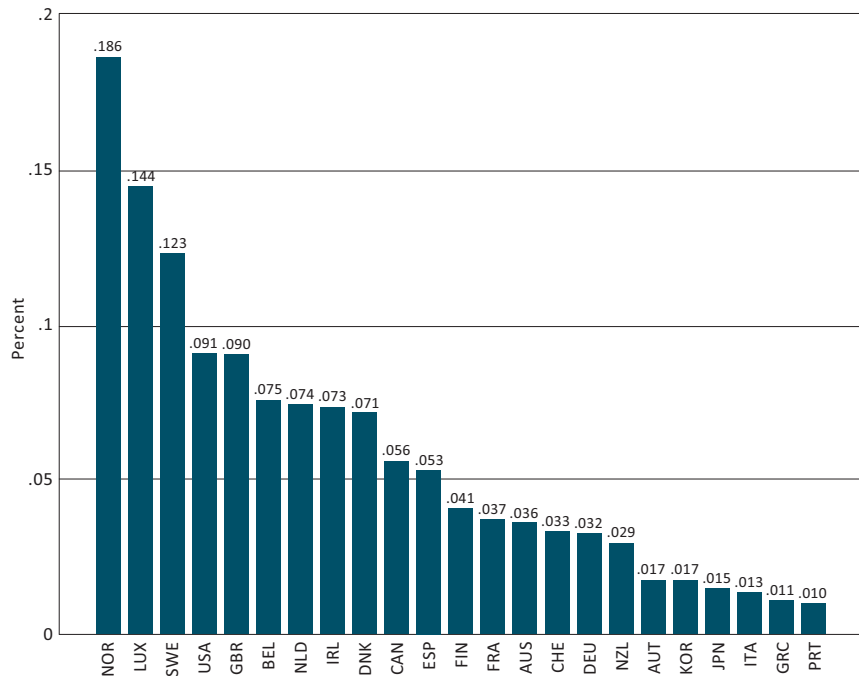


FIGURE 6:
DAH as a percentage of gross domestic product, 2009

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

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



Sources: IHME DAH Database 2011 and World Bank World Development Indicators

Denmark, who tend to favor multilateral mechanisms. The US government gave only 5% of its aid to multilateral institutions in 2009, while these three European nations gave amounts ranging from 36% to 65% of their DAH to multilaterals.

Many public donors choose to channel their funding through bilateral mechanisms. In Figure 7, these flows include direct transfers to recipient country governments as well as to other governmental agencies located in the donor's country.⁴⁵ Starting in reporting year 2010, the OECD-DAC issued directives for donor countries to use a new coding scheme that will differentiate between these two types of government-to-government transfers. This will allow us to better understand how DAC countries are channeling their aid, and will be discussed in the 2012 edition of *Financing Global Health*.⁴⁶ The governments of the UK, Japan, and Germany channel more than 35% of their DAH through bilateral channels, while South Korea directs 60% of its DAH via government-to-government transfers. Previous studies have suggested that channeling

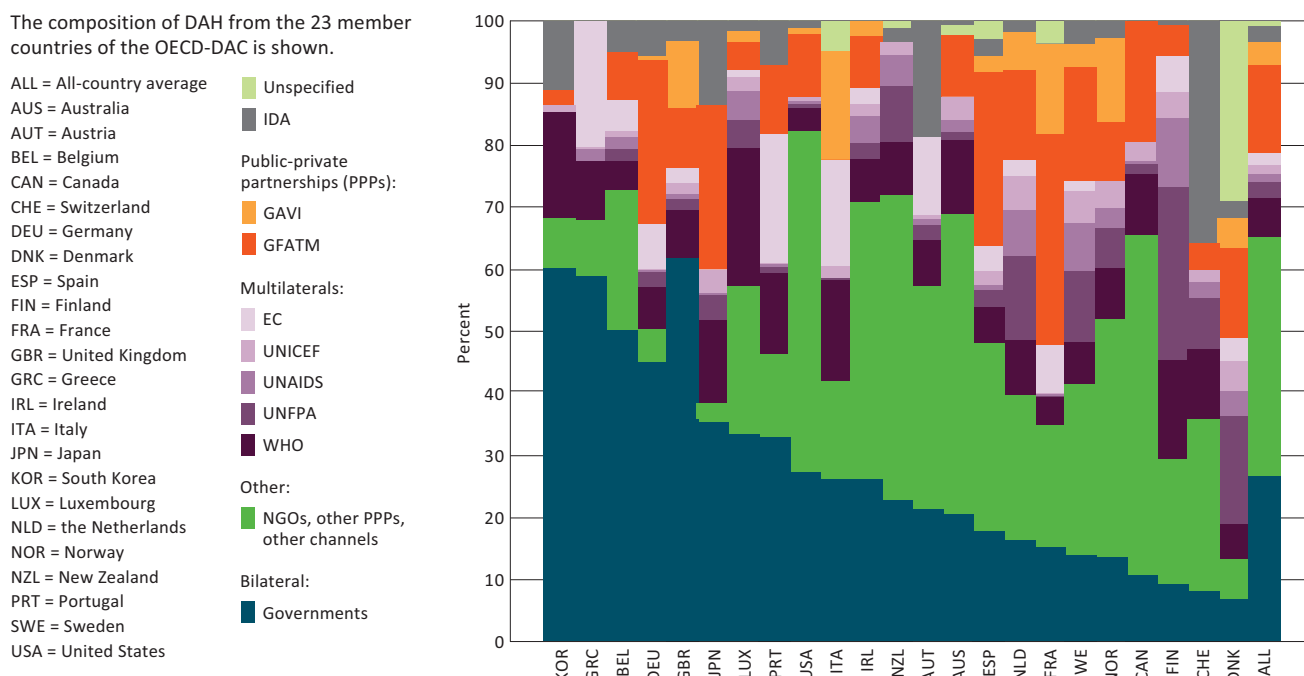
assistance bilaterally may indicate a preference for more control over the use of funds than if this support was routed through other channels.⁴⁷

This analysis also reveals how public donors as a whole increasingly preferred to direct their funds through the PPPs GFATM and GAVI instead of through UN agencies. Figure 8 shows that the total amount of public DAH given to GFATM and GAVI combined was \$3.24 billion in 2009, while UN agencies received \$2.11 billion.

Until its drop in 2011, GFATM continued to fare relatively well through 2009 and 2010 compared to more traditional institutions. Part of this was due to continued support from donors such as France, which is GFATM's second-largest donor after the US.⁴⁸ GFATM was France's preferred channel of assistance in 2009, indicated by the fact that it directed the largest portion of its DAH (34%) through this PPP.

Both GFATM and GAVI count another major donor, the UK, as one of their primary supporters. The UK plans to cut back on HIV/AIDS funding to expand its support

FIGURE 7:
Public sector DAH (donor country specific) by channels of assistance, 2009



Source: IHME DAH Database 2011

Notes: "Unspecified" indicates donor country did not report the specific channel that would first receive its DAH.

for maternal, newborn, and child health, which could affect the amount the UK contributes to GFATM in the future.⁴⁹

Our discussion about the different channels of assistance that donors decide to fund underscores the importance of transparent DAH data. Public donors have made major improvements in the transparency of DAH data, such as the progress made by the US in releasing data on all of the primary recipients of US DAH, as we noted in last year’s report.¹⁶ Since the US is the largest DAH donor, this progress led to profound changes in the transparency of DAH data as a whole.

When sources of funding and channels of assistance fail to provide information about the recipients of their aid, it impairs our ability to analyze DAH. In 2009, for example, 29% of Denmark’s DAH could not be traced to the primary recipients, which is indicated by the “unspecified” category in Figure 7. In 2008, Denmark reported primary recipients for 100% of its aid.¹⁶

In contrast, Canada and Japan both improved the transparency of their DAH data in 2009 compared to

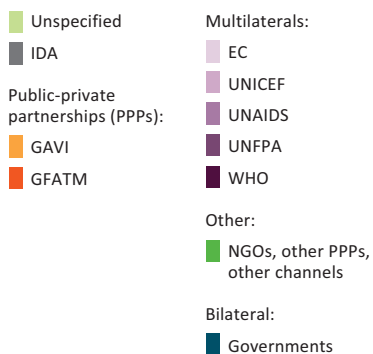
2008 and now report primary recipients for 100% of their DAH. Countries such as France, Italy, and Spain still have room for improving the completeness of their DAH data. Since last year’s *Financing Global Health* report, the other nations listed in Figure 7 consistently reported aid flows in a transparent manner. This information is crucial for researchers, policymakers and planners, and advocacy organizations.

Private philanthropy and DAH

Next, we examine the largest private donor of DAH, BMGF, and the ways in which this foundation channels its funding. BMGF’s giving patterns make it unique among the other major donors in global health. It has helped reshape the global health architecture by funding new global health institutions and the development of technology. Research institutions and universities were the largest beneficiaries of grants from BMGF in 2010 (\$448.61 million, or 30%). These funds go to projects such as efforts to develop HIV vaccines and other types of drugs as well as public health research studies. The second-largest share (\$418.93 million, or 28%) went to

FIGURE 8:
Public sector DAH by channels of assistance, 1990-2009

Bilateral assistance from the 23 member countries of the OECD-DAC are further disaggregated into aid going to recipient governments and flows to NGOs, PPPs excluding GAVI and GFATM, and other miscellaneous channels. Disbursements for which the channel was not specified in OECD-DAC’s database are labeled “unspecified.”



Source: IHME DAH Database 2011

Notes: See Figure 6 for list of OECD-DAC countries.

FIGURE 9:
Bill & Melinda Gates Foundation global health disbursements and commitments, 1999-2011

The multicolored bars represent disbursements, and the blue bars show commitments. “Universities and research institutions” include universities, NGOs, foundations, and government institutions in low-, middle-, and high-income countries with a research focus. “Country governments” include all nonresearch-oriented government agencies.

- Country governments and IGOs (excluding UN)
- United Nations
- World Bank
- GAVI
- GFATM
- PPPs (excluding GAVI and GFATM)
- Universities and research institutions
- NGOs, foundations, and corporations
- Commitments
- Preliminary disbursements

Source: IHME DAH Database (BMGF) 2011

Notes: 2011 data are based on preliminary estimates obtained from BMGF. Final data were unavailable to show BMGF's commitments and recipients of disbursements for 2011.

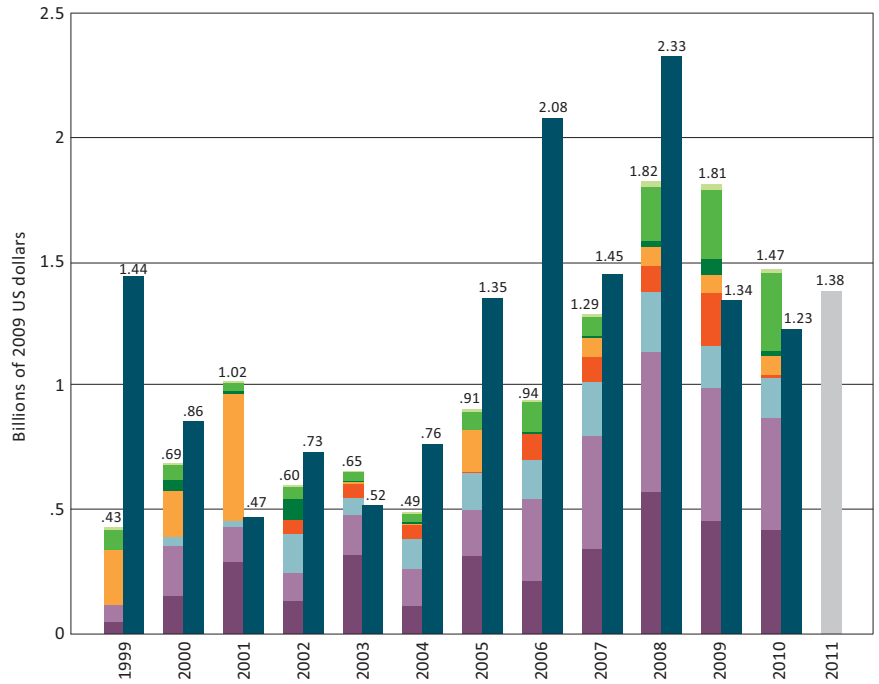


FIGURE 10:
Total overseas health expenditure channeled through US NGOs, 1990-2011

Total health spending is disaggregated by shares of revenue received from the US government, other public sources of funding and international organizations, BMGF, financial donations from private sources, and in-kind donations from private sources.

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

Source: IHME DAH Database (NGOs) 2011

*Data for 2009 to 2011 are based on preliminary estimates.

Notes: Data reflect US-based NGOs registered with USAID.

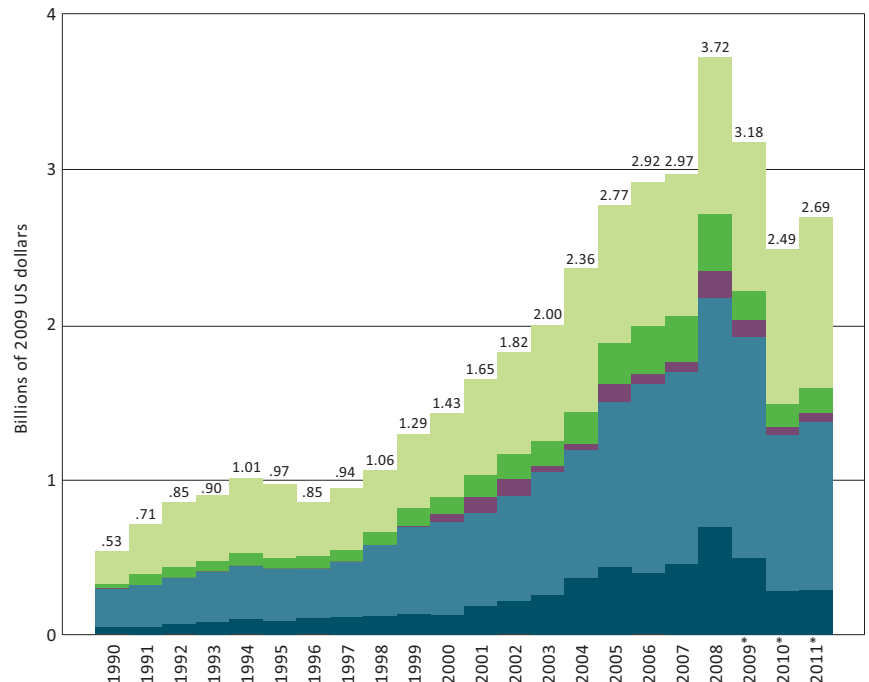


TABLE 2:
US NGOs with the highest cumulative overseas health expenditures, 2005-2008

Expenditures shown in millions of 2009 US dollars.

Rank	NGO	Overseas health expenditure, adjusted	Overseas health expenditure, unadjusted	Overseas expenditure, unadjusted	Percent of revenue from private sources	Percent of revenue from in-kind contributions
1	Population Services International	1,265.14	1,265.21	1,347.93	14	0
2	Food For The Poor	706.83	2,557.64	4,196.77	97	89
3	Catholic Relief Services	665.51	670.36	2,306.70	40	1
4	Management Sciences for Health	581.94	581.94	585.98	0	0
5	PATH	501.23	505.97	518.54	90	1
6	United Nations Foundation	466.08	497.42	637.84	91	8
7	World Vision	355.80	472.89	3,178.42	76	30
8	Pathfinder International	324.45	325.97	325.99	23	1
9	Elizabeth Glaser Pediatric AIDS Foundation	318.02	319.47	322.54	18	1
10	MAP International	293.96	1,398.24	1,398.67	100	97
11	Brother's Brother Foundation	274.88	1,460.07	2,011.33	100	99
12	Academy for Educational Development	265.03	267.44	1,060.58	12	1
13	Save the Children	246.24	254.86	1,428.72	53	4
14	CARE	241.20	241.92	2,370.40	27	0
15	Project HOPE	229.16	547.28	595.38	91	71
16	The Clinton Foundation	216.72	222.57	347.91	100	3
17	The Carter Center	205.17	328.35	476.38	95	46
18	Catholic Medical Mission Board	184.42	766.43	789.68	100	93
19	Population Council	180.71	191.14	257.03	37	7
20	ChildFund International	180.24	180.59	700.15	90	0

Source: IHME DAH Database (NGOs) 2011

Notes: Overseas health expenditure for 2009-2011 is not included because of data limitations. Data reflect NGOs registered with USAID. Adjusted overseas health expenditure reflects deflated overseas health expenditure from private in-kind donations plus unadjusted overseas health expenditure from all other revenue sources (private financial contributions, BMGF, US public, and other public). Unadjusted overseas health expenditure differs from adjusted overseas health expenditure due to the fact that overseas health expenditure from private in-kind donations is not deflated for this quantity.

NGOs, foundations, and corporations. The third-largest portion (\$315.49 million, or 21%) of BMGF's grants in 2010 went to UN agencies. PPPs, including GFATM and GAVI, accounted for 17% of BMGF's grants. Only 1% (\$16.08 million) of BMGF's disbursements went to intergovernmental institutions (IGOs) and developing-country governments in 2010.

Non-governmental organizations

Examining the revenue sources of US-based NGOs provides additional insight into the ways that private and public donors are influencing how DAH is channeled to

developing countries, as seen in Figure 10. Both public and private donors play key roles in financing NGOs. This year, we enhanced the quality of our estimates of DAH from US NGOs by collecting more information about health expenditures than we have in previous years.

According to our preliminary estimates for 2011, 40% of NGOs' expenditure came from cash donations from corporations, individuals, and foundations other than BMGF (labeled as "private financial contributions" in the figure). Our estimates of the top 20 NGOs ranked by overseas health expenditure from 2005 to 2008

TABLE 3:
Summary of health spending by non-US NGOs, 1998-2009

Year	Number of non-US NGOs in USAID report	Number of non-US NGOs for which we found health expenditure data	Combined health expenditures by largest non-US NGOs* (millions of 2009 US\$)
Prior to 1998	0	–	–
1998	44	3	–
1999	0	–	–
2000	50	6	150.32
2001	51	7	153.93
2002	58	7	151.35
2003	54	7	205.52
2004	55	9	212.35
2005	59	9	229.30
2006	67	8	239.22
2007	68	10	422.15
2008	78	11	503.17
2009	–	12	524.94

*Ranking determined by amount of overseas expenditure.

Notes: Data reflect non-US-based NGOs registered with USAID. USAID data for 2009 were not available at the time of the analysis, so we used rankings from 2008. Dashes indicate inapplicable.

include NGOs whose work is financed by these private donors (see Table 2). We were unable to extend the analysis of the top 20 NGOs past 2008 due to lack of data. Donations from individuals and groups wishing to sponsor a child are an important source of revenue for World Vision and ChildFund International. Donations from a single individual, media mogul Ted Turner, are the major funding source of the United Nations Foundation. The United Nations Foundation is recognized by the US Internal Revenue Service as a tax-exempt organization, not a private foundation, and is thus included in our NGO database. Private in-kind donations of pharmaceuticals and medical supplies represented 11% of NGOs' overseas health expenditure in 2011. These donations are the primary source of revenue for many NGOs among the top 20, such as Food For The Poor, MAP International, and Brother's Brother Foundation.

According to our preliminary estimates for 2011, US government funding to NGOs eclipsed non-BMGF private funding as the largest source of revenue for the US NGOs tracked in our study. Major recipients

of US government funds such as Population Services International, Management Sciences for Health, and the Academy for Educational Development appear on the list of top 20 NGOs ranked by overseas health expenditure. Since US government DAH is a key source of revenue for many of the top NGOs, budget cuts made by lawmakers in the US could cause the rankings shown here to change substantially.

Due to lack of comparable and complete data, US-based NGOs that do not appear in the data from USAID's annual Report of Voluntary Agencies and those based outside of the US were not included in our DAH estimates. Table 3 shows that 12 of the top international NGOs ranked by overseas spending for which we could find data spent \$524.94 million on health in 2009, whereas a single US NGO, Management Sciences for Health, spent a greater amount (\$581.94 million) over a period of four years. This table does not include data past 2009 due to significant time lags in the publication of these data.