

CHAPTER 2:

DISTRIBUTION OF DEVELOPMENT ASSISTANCE FOR HEALTH

Measuring the scope of development assistance for health (DAH) from its various sources is important for understanding the overall trends in public and private funding of health programs. In this chapter, we explore how funding through various channels and from different sources has created the current landscape of DAH for regions, countries, and health focus areas.

Following DAH to its recipient country and then to the specific health program it funds can illuminate the effects of national-level policy decisions on global health priorities. At the regional level, our DAH estimates indicate that the areas with the greatest need tend to receive the most DAH. This assumption is challenged, though, when taking a close look at the countries within those regions. The proportion of DAH spent on different health focus areas also raises important questions when viewed in the context of the disease burden attributed to those diseases and conditions.

Funding by focus region

To the extent possible, we separated DAH by focus region in Figure 12. When we were unable to identify the final recipient of DAH, we marked the funding as “unallocable.” As shown in Figure 12, a large share of DAH is unallocable because of limitations in the data. NGOs, for example, do not uniformly report the regions where their funds are targeted. The term “global” includes contributions made toward health research or the creation of public goods for multiple regions as well as projects that donors categorized as benefiting the entire world. Even with the data limitations, the figure shows an increase in funding across all regions. The relative share of DAH for sub-Saharan Africa has grown to the point where that region now receives

more funding than all other regions combined. In 1990, sub-Saharan Africa received 10% of DAH, and from 1997 to 2000, sub-Saharan Africa actually received a smaller share of DAH than Latin America. By 2008, though, its share had grown to 29%, representing \$6.92 billion. This growth primarily reflects the continued rise in funding for HIV/AIDS.

The other regions that received the largest shares of funding in 2008 were: South Asia, East Asia and the Pacific, and Latin America and the Caribbean. There were three regions that lost ground in DAH between 2005 and 2008: Europe and Central Asia; the Middle East and North Africa; and Latin America and the Caribbean. The figure also shows striking growth in DAH for research and product development that is global in nature, from \$688.44 million in 2001 to \$3.13 billion in 2008.

Funding by recipient country

Looking more closely at each region, we were able to pinpoint the recipient country for the majority of DAH, although 35%, or \$8.30 billion, remained unallocable in 2008 because of limitations in the data.

Figure 13 shows the top 10 health aid recipients, comprised mainly of the most populous developing countries. Here, we see the wide variety in the makeup of DAH for countries that received the most DAH from 2003 to 2008. Both India, the top recipient of DAH, and Pakistan, the 10th highest recipient, received 35% of their DAH funding through the World Bank. Ethiopia, the fourth largest recipient of DAH, received a much smaller share of its funding through the World Bank.

The figure also reveals how ongoing commitments from individual donor governments can have a large impact on a recipient government’s funding picture.

FIGURE 12:
DAH by focus region, 1990-2010

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

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

Sources: IHME DAH Database 2010 and IHME DAH Database (Country and Regional Recipient Level) 2010

Notes: 2009 and 2010 data are preliminary estimates based on information from channels of assistance, including budgets, appropriations, and correspondence. Data were unavailable to show total DAH by focus region for 2009 and 2010.

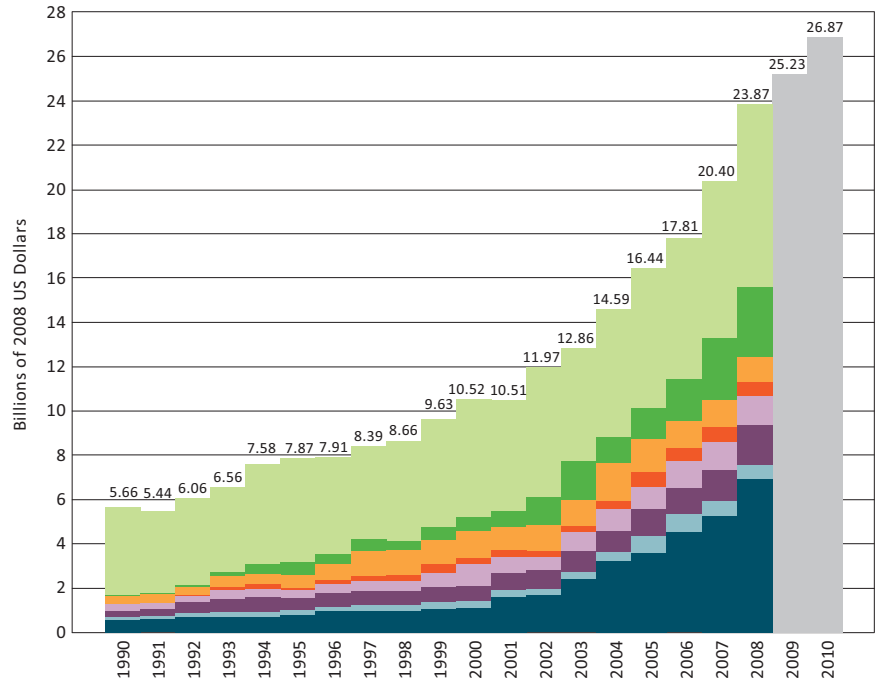
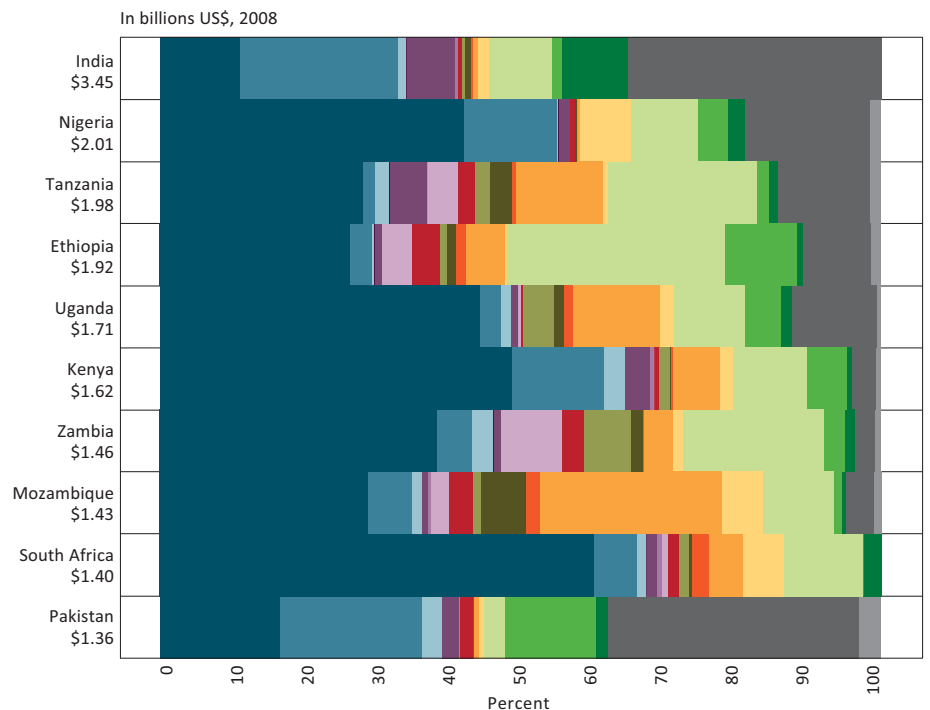


FIGURE 13:
Top 10 recipients of DAH by percentage received from channels of assistance, 2003-2008

The amount of DAH received by each country in real 2008 US\$ is shown below the name of the country. Only DAH allocable by country is reflected in the figure.

- United States
- Great Britain
- Japan
- South Korea
- Germany
- France
- Netherlands
- Canada
- Sweden
- Norway
- Italy
- Other governments
- EC
- GFATM
- GAVI
- BMGF
- World Bank
- Regional development banks

Source: IHME DAH Database (Country and Regional Recipient Level) 2010



The US government is the biggest channel for seven of the top 10 recipient countries, which are all US President’s Emergency Plan for AIDS Relief (PEPFAR) focus countries.²⁵ In South Africa, 60% of all DAH comes from the US. Contributions funneled through the UK account for more than 10% of all DAH received by India, Nigeria, Kenya, and Pakistan, reflecting historical ties established during British colonial rule. Norway’s role in DAH funding for Mozambique is more significant than its role in other countries shown in Figure 13. The Netherlands contributes a large portion of all DAH received by Zambia.

The importance of funding from the Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM) also can be seen in the figure. Funding from GFATM comprises 30% of DAH to Ethiopia, 21% to Tanzania, 20% to Zambia, and significant sums to other countries in the top 10 with the exception of Pakistan.

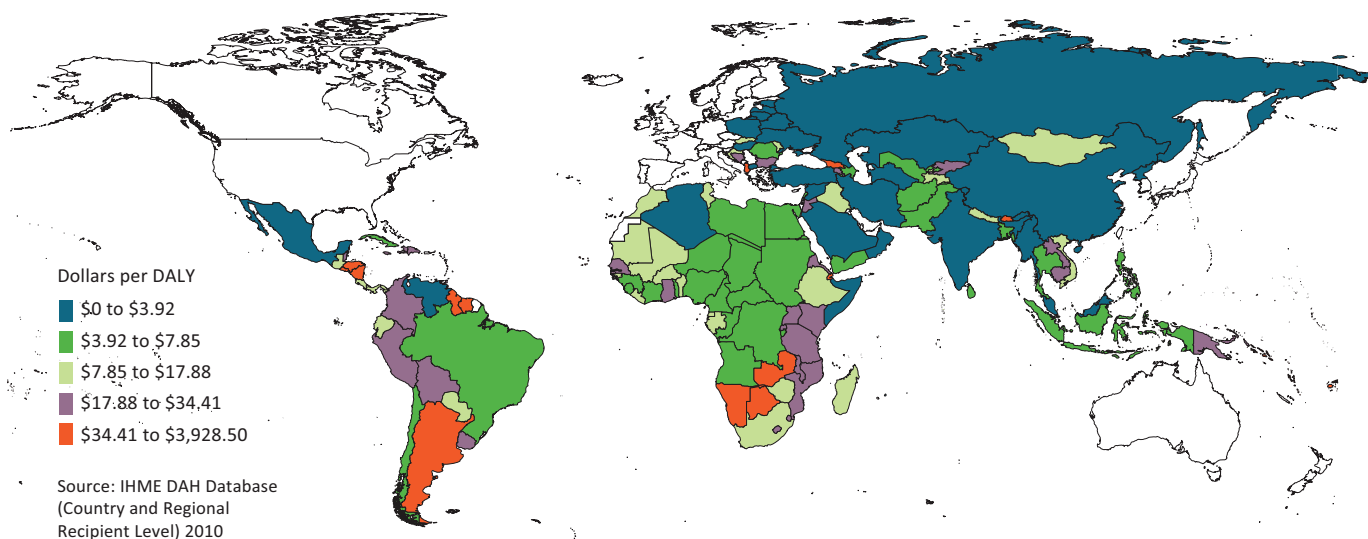
Overall, the distribution of DAH across countries continues to correspond with need as measured

by disease burden, but there remain strong exceptions to this trend. In Figure 14, we have mapped the amount of DAH given to each developing country for every disability-adjusted life year (DALY). A disability-adjusted life year measures overall disease burden by calculating the years of healthy life lost due to illness, disability, or early death.²⁶ We found that more than half of countries in sub-Saharan Africa received less than \$12 per DALY between 2003 and 2008, while all but three South American countries, which have both smaller populations and lower DALYs, received more than \$13 per DALY. Most countries in Asia and the Middle East received less than \$4 per DALY in this time period.

As we noted in last year’s report, allocation of DAH by country appears to be driven by many considerations beyond the burden of disease. Among those considerations are historical, political, and economic relationships between certain donors and recipient countries. The countries with the highest amount of

FIGURE 14:
Total DAH per all-cause DALY, 2003-2008

We used DALY data for 2004 as a proxy for burden in all subsequent years. Countries that received no DAH over the study period and countries with zero or missing burden data are not shown. DAH received is shown in real 2008 US\$.



DAH per DALY are small island nations with longtime ties to larger, more economically prosperous countries, including a cluster of islands in the South Pacific with ties to Australia, New Zealand, and the US: Niue, Micronesia, the Marshall Islands, Nauru, the Cook Islands, Tonga, Palau, Tuvalu, the Solomon Islands, Kiribati, and Samoa. All of these countries received more than \$100 per DALY – 20 times the amount that some African countries received. Sierra Leone, Central African Republic, and Niger each received less than \$7 per DALY.

Figure 15 ranks the top 30 recipients of DAH on the left and ranks countries by decreasing order of disease burden, as measured in total DALYs, on the right. In general, countries with higher disease burden receive greater external aid, as evidenced by India, which ranks first in both, and Nigeria, which ranks near the top in both. However, at similar levels of disease burden, there can be large variations in DAH.

Some countries, such as Bangladesh, the Democratic Republic of the Congo, and Brazil, had a much higher rank on the burden list than on the health aid list. They received much less assistance than would be expected based purely on disease burden. At the same time, countries such as Tanzania, Ethiopia, Uganda, Kenya, and Mozambique received more funds in proportion to their disease burden, in part because all received health aid from PEPFAR from 2004 to 2008 to help combat the high incidence of HIV/AIDS in these countries.

When viewed in the context of specific health focus areas, the contrast between need and funding can be even more apparent. For example, 16 of the 20 countries with the highest maternal mortality ratios in 2008 do not appear among the 20 countries that received the most DAH between 2003 and 2008.²⁷

To highlight countries in Figure 15 that appear on one list but not the other, we have underlined those countries' names. There are 11 countries that appear in the top 30 for DAH but not in the list of countries with the highest disease burdens: Zambia, Argentina, Colombia, Ghana, Malawi, Rwanda, Cambodia, Senegal, Haiti, Zimbabwe, and Peru. With the exception of Argentina, Colombia, and Peru, all of the countries were low- or lower-middle-income countries in 2008, as classified by the World Bank.²⁸

There are 11 countries with high disease burdens that are not among the top recipients of DAH: Russia, Mexico, Sudan, Myanmar, Thailand, Angola, Iran, Ukraine, Côte d'Ivoire, Turkey, and Niger. With the exception of Russia, Mexico, and Turkey, these are low- or lower-middle-income countries.

Funding by health focus

Over the past decade, the top health priorities for global health leaders have been HIV/AIDS, tuberculosis, and malaria,³¹ and this has been reflected in DAH funding patterns.¹ Beginning with events such as the first Women Deliver conference in 2007, though, there has been a move to increase funding for maternal, newborn, and child health (MNCH) programs.³² More recently, the United Nations (UN) and other organizations have raised concerns about the emergence of noncommunicable diseases (NCDs), such as cancer, heart disease, and diabetes, as a more prominent issue in the developing world.³³ This is partly the result of economic improvements^{34,35} and reductions in the mortality of children and adults. As people live longer, their likelihood of developing a chronic disease increases.

We analyzed the volume of DAH earmarked for these five priority areas as well as support for the health sector as a whole. This analysis was only possible for the channels where we were able to isolate a channel's total health contributions by disease. For GFATM, we were able to obtain data coded by disease focus. In all other cases, we used the descriptive fields in the data, such as the project title and project description, to distinguish a channel's total DAH by disease. In 2008, we identified the health focus areas for \$12.47 billion out of \$23.87 billion of total DAH.

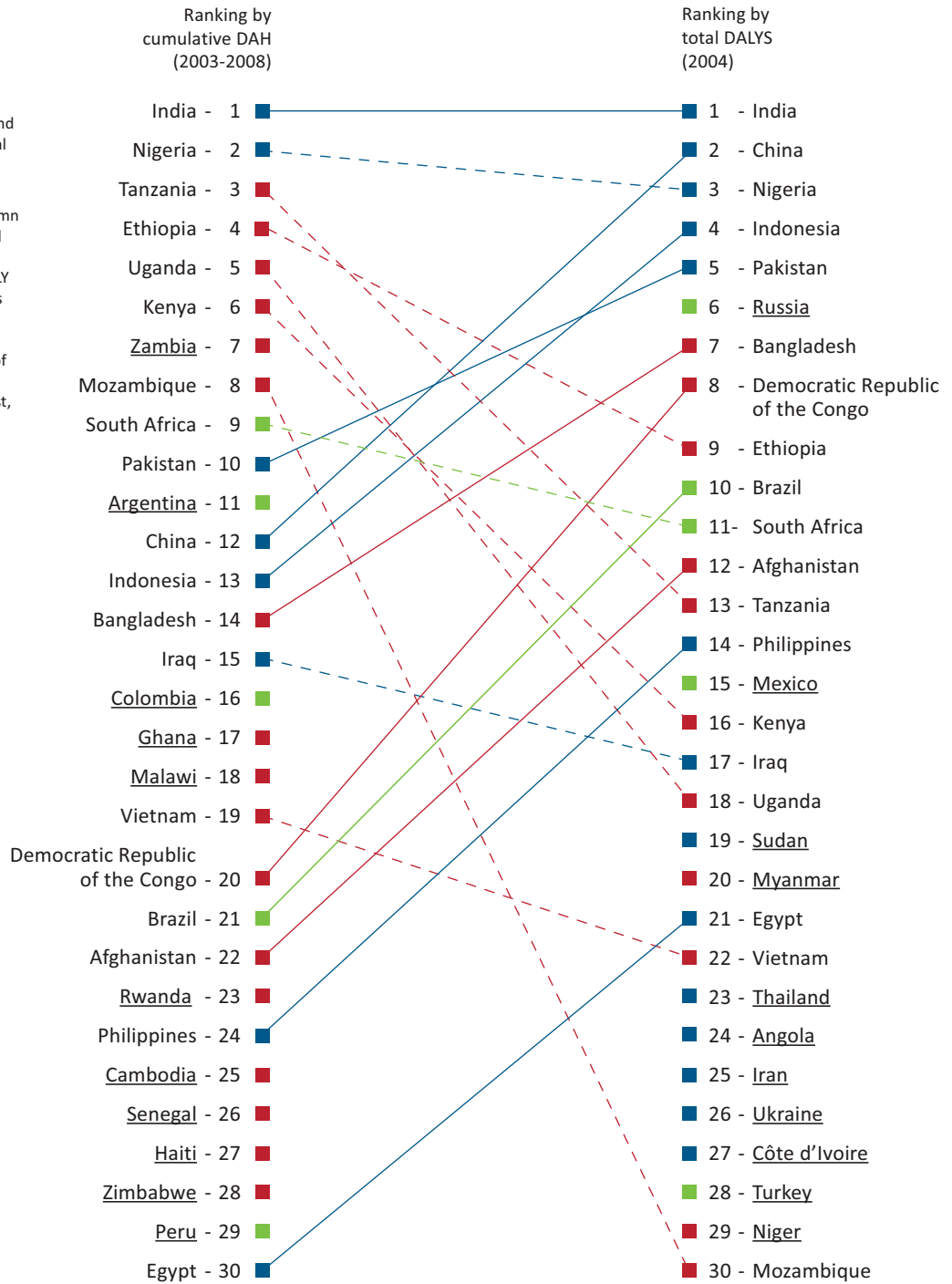
We made a few assumptions: that all spending by the Joint United Nations Programme on HIV/AIDS (UNAIDS) was for HIV/AIDS; that all spending by the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) was for MNCH; and that all spending by the GAVI Alliance (GAVI) was for MNCH. In this section, we compare the funding of these health focus areas and then expand on each focus area in subsequent sections, in order by their share of DAH funding.

FIGURE 15:
Top 30 country recipients of DAH, 2003-2008, compared with top 30 countries by all-cause burden of disease, 2004

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

Sources: IHME DAH Database (Country and Regional Recipient Level) 2010 and Global Burden of Disease 2004 Summary Tables 2009

Notes: Countries that appear in one column but not the other are underlined. Dashed line indicates country ranks higher in cumulative DAH column than in total DALY column. Solid line indicates country ranks the same or higher in total DALY column than in cumulative DAH column. In this year's report, we used the 2004 update of DALYs from WHO. This contributed to the change in composition from last year's list, which relied on 2002 DALYs. Only DAH allocable by country is reflected.



It is difficult to draw conclusions regarding health-focus-specific funding from 2002 to 2004 because of inconsistency in US reporting. Another limitation of this analysis is missing data on health focus areas indicated by the portion marked “unallocable” in the figures.

Figure 16 shows that spending on programs targeting HIV/AIDS has continued to rise. HIV/AIDS programs received nearly as much funding as all other health focus areas combined: \$6.16 billion for HIV/AIDS compared to \$6.31 billion for MNCH, malaria, health sector support, tuberculosis, and NCDs in 2008. Funding for HIV/AIDS rose from \$0.20 billion in 1990 to \$0.96 billion in 2001, an average rate of growth of 15%. Between 2001 and 2002, though, funding for HIV/AIDS programs increased 53%, and since then, funding increased every year by more than 25% until 2007. Between 2007 and 2008, funding increased by 20%.

MNCH programs received the second largest share of funding, totaling \$3.17 billion in 2008. MNCH once received much more funding than all other categories.

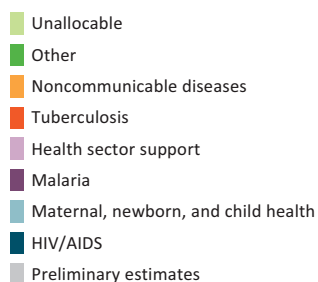
In 1990, MNCH received \$0.95 billion, or about 17% of all DAH. By 2008, that share had declined to 13%, while funding for HIV/AIDS had grown from 3% to 26% in that same period.

DAH for malaria and tuberculosis remained modest: \$1.19 billion and \$0.83 billion, respectively, in 2008. Between 2007 and 2008, though, malaria funding increased by 57%, faster than HIV/AIDS funding and much faster than tuberculosis funding, which increased 27%. Health sector support more than doubled since 2005 to \$1.00 billion in 2008, but it remains low compared to other health focus areas.

The NCD focus area, including cancer, diabetes, heart disease, and other significant contributors to disease burden, continues to receive the least amount of funding compared with other health focus areas, although there has been steady growth in recent years. NCDs received \$30.14 million in 1990. By 2008, that number had grown to \$121.25 million, just a sliver of all DAH funding at 0.5%.

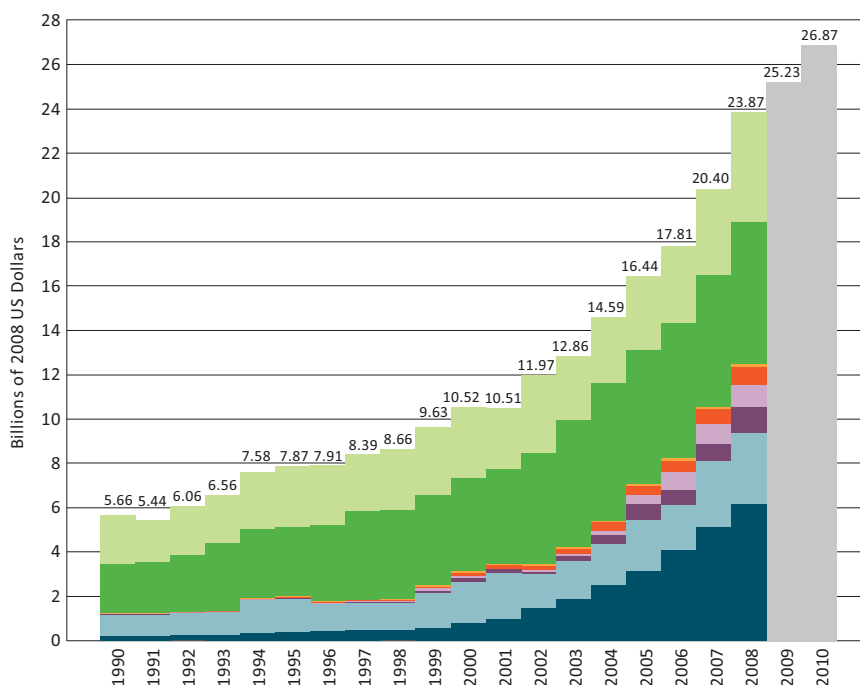
FIGURE 16:
DAH for HIV/AIDS; maternal, newborn, and child health; malaria; health sector support; tuberculosis; and noncommunicable diseases, 1990-2010

“Unallocable” corresponds to DAH for which we did not have information on disease focus.



Sources: IHME DAH Database 2010 and IHME DAH Database (Country and Regional Recipient Level) 2010

Notes: 2009 and 2010 data are preliminary estimates based on information from channels of assistance, including budgets, appropriations, and correspondence. Data were unavailable to show total DAH by health focus area for 2009 and 2010.



Funding for HIV/AIDS by channel of assistance

The increase in DAH for HIV/AIDS programs has been driven largely by two channels – the US government and GFATM. Figure 17 shows the US spent \$958.29 million on HIV/AIDS-related DAH in 2003 and increased spending to \$3.29 billion in 2008, a 243% increase in funding. That reflects the strong focus on HIV/AIDS established in 2004 when PEPFAR began disbursing funds. GFATM disbursements for HIV/AIDS programs, which started in 2002 at \$0.50 million, reached \$150.78 million in 2003, then increased 802% to reach a total of \$1.36 billion in 2008. UNAIDS and the Bill & Melinda Gates Foundation (BMGF) also have continued to increase funding for HIV/AIDS programs, although BMGF's total contribution is much larger than what is shown in this figure because it also contributes money through other channels, including GFATM.

Viewed on the map in Figure 18, the countries that receive the most HIV/AIDS funding per HIV/AIDS-related DALY are not always the countries with the highest disease burdens. Russia, China, and much of Central Asia receive more funding per HIV/AIDS-related DALY than countries in sub-Saharan Africa, which have much higher HIV/AIDS burdens. Bhutan, Albania, Mongolia, Bulgaria, and Georgia all receive more than \$4,000 for every HIV/AIDS-related DALY. Zimbabwe, the Democratic Republic of the Congo, Cameroon, and Gabon, by contrast, receive less than \$19 per DALY.

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

In September 2010, world leaders attending the Millennium Development Goals (MDG) Summit hosted by the UN in New York City pledged to spend \$40 billion in new funding over the next five years to improve the health of mothers and children worldwide.³⁶ The announcement followed new findings by the Institute for Health Metrics and Evaluation (IHME)^{37, 38} and UN agencies³⁹ that showed both the maternal mortality ratio and the child mortality rate declining worldwide but not at a fast enough pace to achieve the MDG targets of a 75% reduction in the maternal mortality ratio between 1990 and 2015 and a 66% reduction in the child mortality rate during the same period. If this pledge is fully funded, the amount would be more than MNCH efforts have received over the past two decades combined.

As seen in Figure 19, MNCH efforts have fluctuated greatly in year-to-year funding levels, unlike the other focus areas in this study. Some of this fluctuation is related to problems with the data. For example, in the data that the US government reported to the Organisation for Economic Co-operation and Development's Creditor Reporting System (CRS) from 2002 to 2004, it did not provide enough information in its project descriptions to determine the health focus areas of its DAH. Because the data have been more specific in recent years, we are more confident in the MNCH funding numbers from 2005 onward.

Figure 19 shows that funding for MNCH efforts has been sustained by consistent spending from the European Commission (EC) and the UN agencies dating back to 1990. The EC has increased its funding for MNCH more than any other health focus area it funds. But the UN agencies have not increased spending on MNCH at the same rate as they have in other areas. For example, WHO increased spending on MNCH from \$84.50 million in 1990 to \$95.56 million in 2008, an annual growth rate of less than 1%. During the same period, WHO increased spending on malaria from \$16.60 million to \$101.96 million, an average growth rate of 11%.

The significant growth since 2006 has been largely driven by one channel: GAVI. Without GAVI's contributions of \$1.00 billion in 2007 and \$812.38 million in 2008, spending on MNCH would have been relatively flat since 2001 when compared with the other health focus areas.

The range in spending per MNCH-related DALY is narrower than for most other health focus areas, as seen in Figure 20. For example, excluding extreme outliers, the range for spending on HIV/AIDS for most countries is \$9 to \$15,000 per DALY. MNCH spending in most countries ranges from less than 5 cents per DALY for countries such as Belarus, Thailand, Venezuela, and Algeria to more than \$100 per DALY for Belize, Colombia, and Uruguay. In Figure 20, we can also see the contrast between need and DAH funding level. Afghanistan ranks eighth²⁹ in the world for DALYs attributable to diseases that impact maternal, newborn, and child health. Yet it received \$1.27 per DALY, well below the amount received by countries with much lower MNCH-related DALYs and stronger economies, such as Turkey, Vietnam, and Costa Rica.

FIGURE 17:
DAH for HIV/AIDS by channel of assistance, 1990-2008

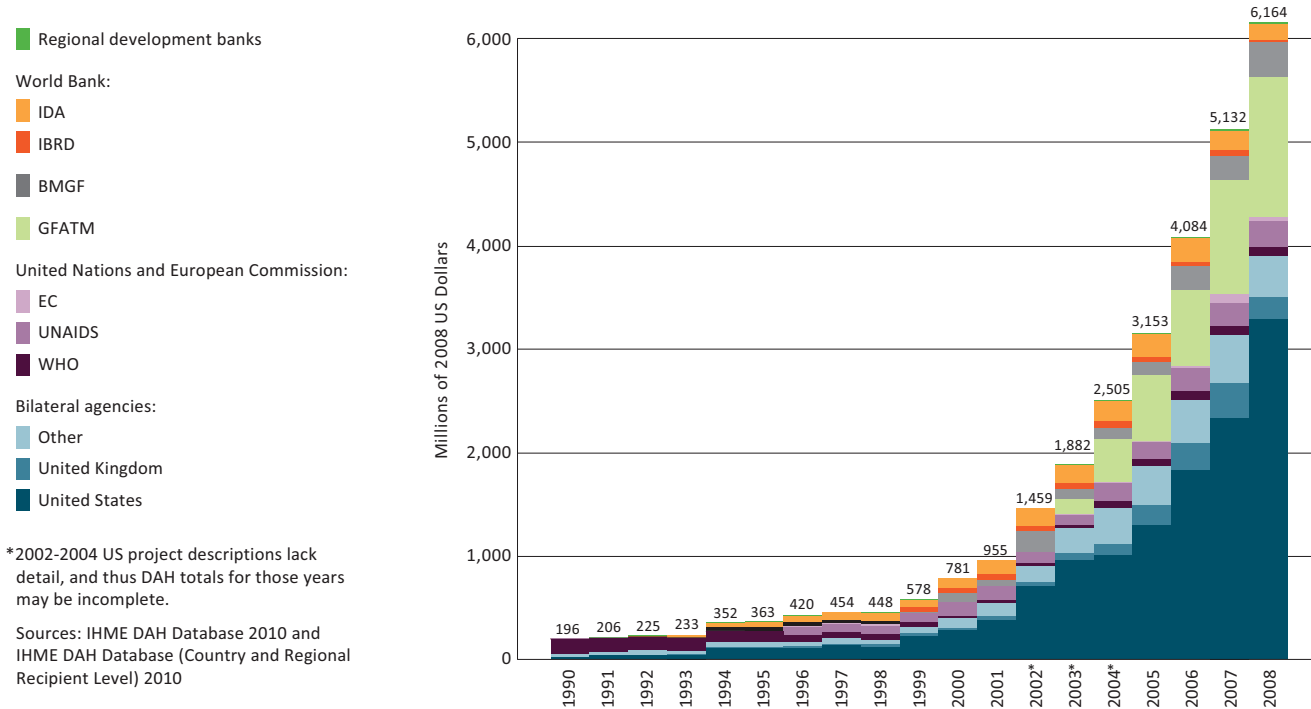


FIGURE 18:
HIV/AIDS: DAH per related DALY, 2003-2008

We used DALY data for 2004 as a proxy for burden in all subsequent years. Countries that received no DAH over the study period and countries with zero or missing burden data are not shown. DAH received is shown in real 2008 US\$.

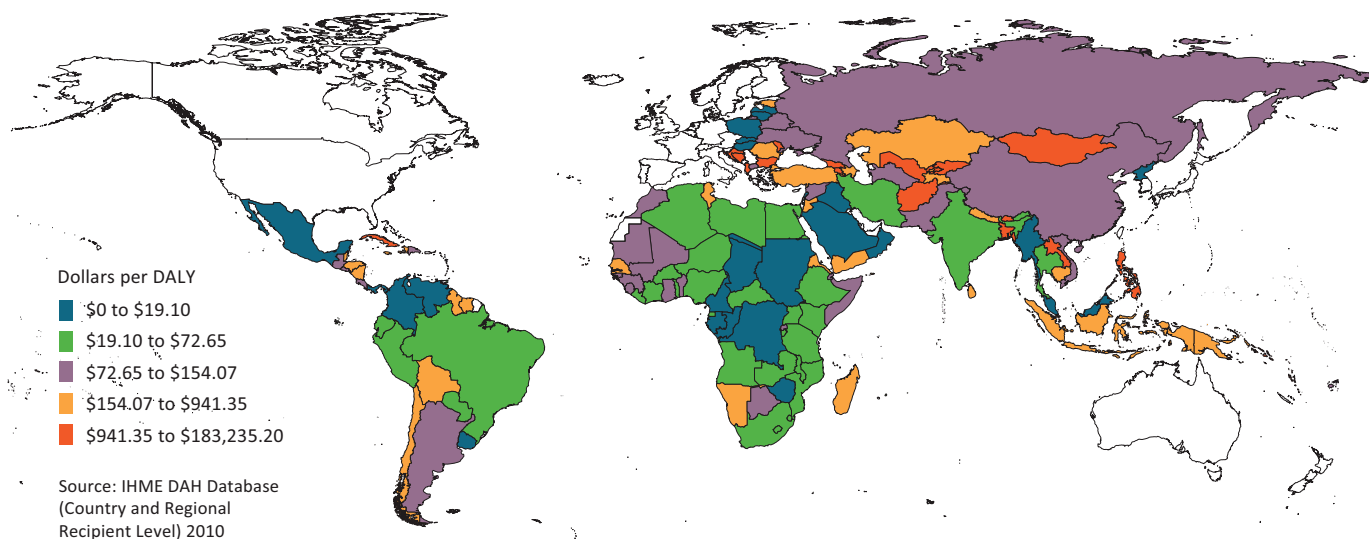


FIGURE 19:
DAH for maternal, newborn, and child health by channel of assistance, 1990-2008

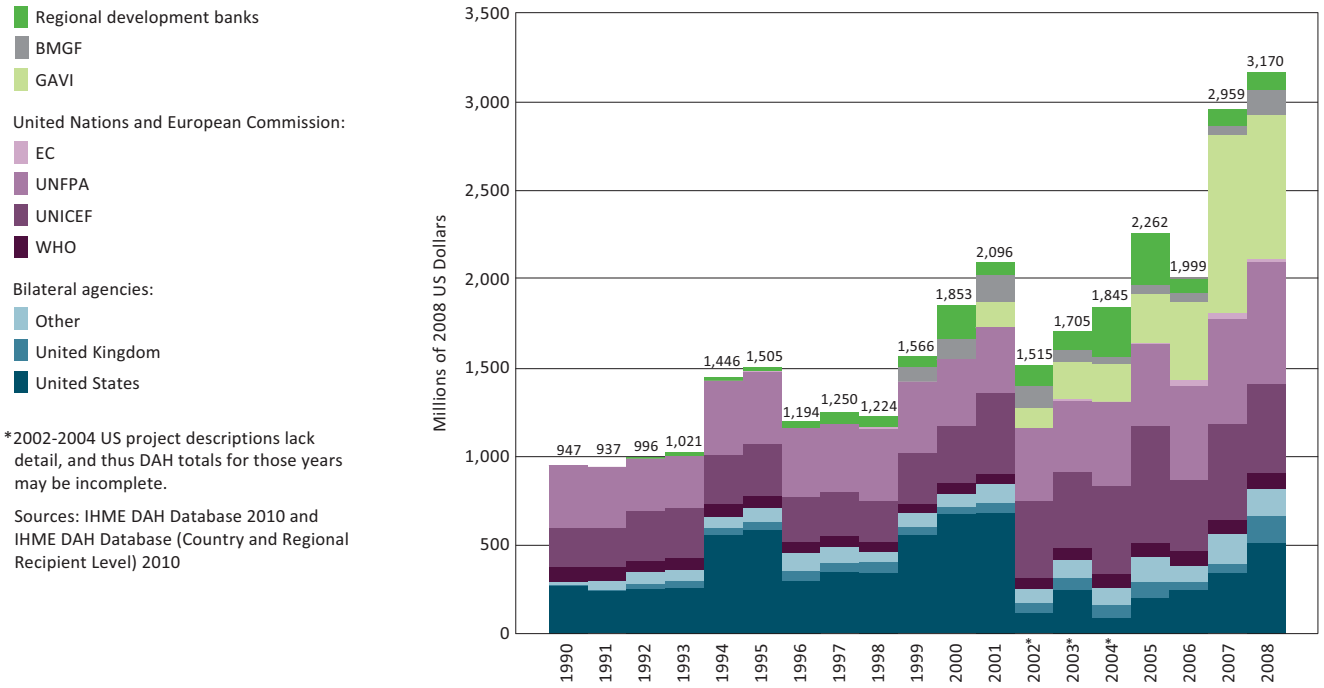
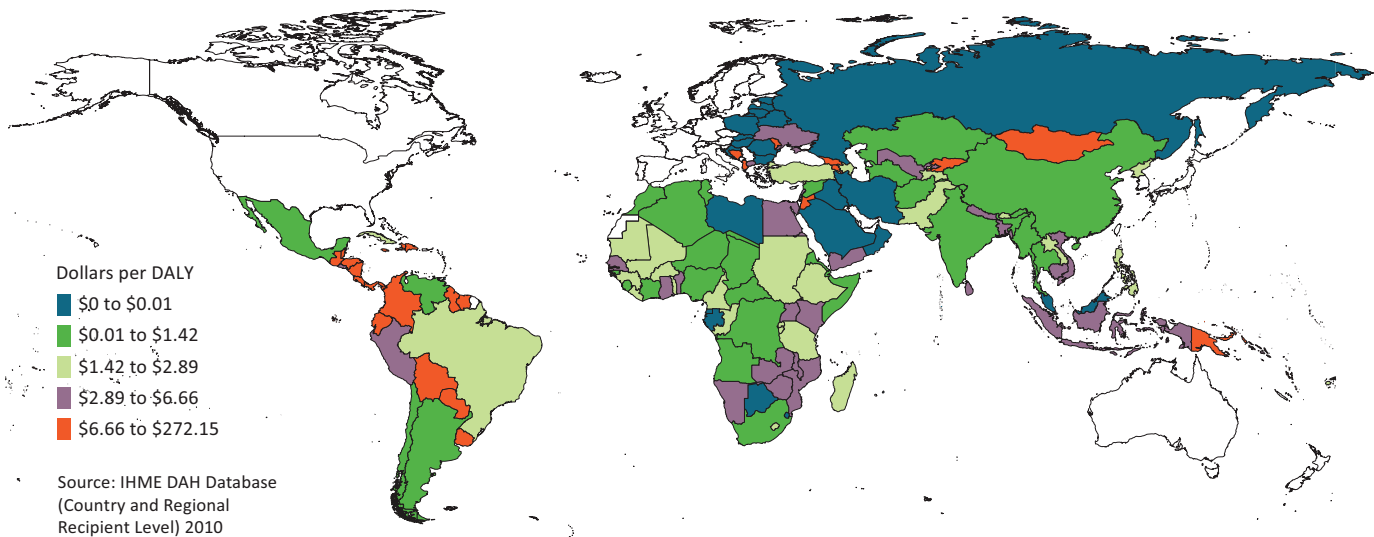


FIGURE 20:
Maternal, newborn, and child health: DAH per related DALY, 2003-2008

We used DALY data for 2004 as a proxy for burden in all subsequent years. Countries that received no DAH over the study period and countries with zero or missing burden data are not shown. DAH received is shown in real 2008 US\$.



Funding for malaria by channel of assistance

The African Summit on Roll Back Malaria held in Abuja, Nigeria, on April 25, 2000, set a target of reducing mortality from malaria in African countries by 50% between 2000 and 2010. Representatives from 44 African countries affected by malaria signed what became known as the Abuja Declaration.⁴⁰

IHME is researching the change in malaria-related mortality as part of its ongoing investigation of causes of death worldwide. In Figure 21, it appears that funding for malaria did not increase immediately following the Abuja Declaration. Instead, it dropped between 2000 and 2002. In more recent years, there has been a year-after-year increase in funding for antimalaria programs, particularly as the US government has taken on a larger role in funding antimalaria campaigns.

DAH from GFATM for antimalaria efforts increased from \$56.95 million in 2003 to \$514.93 million in 2008. BMGF funding grew from \$23.01 million to \$223.48 million in the same period.

Since it began in 2005, the US President's Malaria Initiative showed little effect on malaria funding patterns through 2006, when funding stood at \$14.14 million.⁴¹ By 2007, though, US funding had doubled and then shot up to \$198.08 million in 2008. The Group of Eight's commitments in 2005 to contribute an additional \$1.5 billion per year to malaria have yet to materialize.

Figure 22 shows dramatic differences in the distribution of malaria funding across countries when compared with the other health focus areas. This is largely because of the low incidence of malaria in most countries. There are only 81 countries that we identified as receiving any DAH for malaria out of 155 countries receiving DAH. Interestingly, of the 30 countries that receive the most DAH per malaria-related DALY, only three – Eritrea, Sao Tome and Principe, and Swaziland – are located in sub-Saharan Africa, the region with the highest malaria burden.

Instead, the countries that receive the most DAH per malaria-related DALY include Georgia, Sri Lanka, Azerbaijan, Uzbekistan, Nicaragua, Kyrgyzstan, Tajikistan, Honduras, and Guatemala, all of which received more than \$2,000 per DALY between 2003 and 2008.

Funding for health sector support by channel of assistance

Policymakers and researchers have recognized since at least the 1980s that some developing countries would benefit from aid for the general health sector and not only through disease-specific programs and interventions. At a 1997 meeting in Copenhagen hosted by the Danish Ministry of Foreign Affairs and the World Bank, the term "sectorwide approach" was coined.⁴² Since that time, various modes of health sector support have been tried through the channels covered in this report, but research continues to show that DAH for health sector support is weak in comparison with other health focus areas. One of the biggest funders of health sector support has been the EC. In 2008, a Court of Audit assessment of DAH from the EC found that "EC funding to the health sector has not increased since 2000 as a proportion of its total development assistance despite the Commission's MDG commitments and the health crisis in sub-Saharan Africa."⁴³

Data on DAH for health sector support are difficult to collect because of a lack of uniformity in how sectorwide approaches are defined. There are fewer data available on health sector support in part because the consensus around a need for general support for the health sector is more recent than the increased awareness around other health focus areas. For the EC, for example, we were only able to identify DAH for health sector support in six of the past 19 years. As seen in Figure 23, though, the data are strong enough to identify a trend beginning in 2006. From 2006 to 2008, funding grew by 22% to \$999.58 million, or 4% of all DAH. The growth rate was 2 percentage points faster than the overall growth rate for DAH, but it was still slower than disease-specific health focus areas. During the same period, DAH for malaria, tuberculosis, and HIV grew by 73%, 60%, and 51%, respectively.

Funding for tuberculosis by channel of assistance

In 1998, WHO led the creation of the Stop TB Initiative, which has expanded into the Stop TB Partnership, a global effort to marshal resources against one of the leading causes of death in the developing world.⁴⁴ The urgency behind this work has increased as more research shows how tuberculosis can compound health

FIGURE 21:
DAH for malaria by channel of assistance, 1990-2008

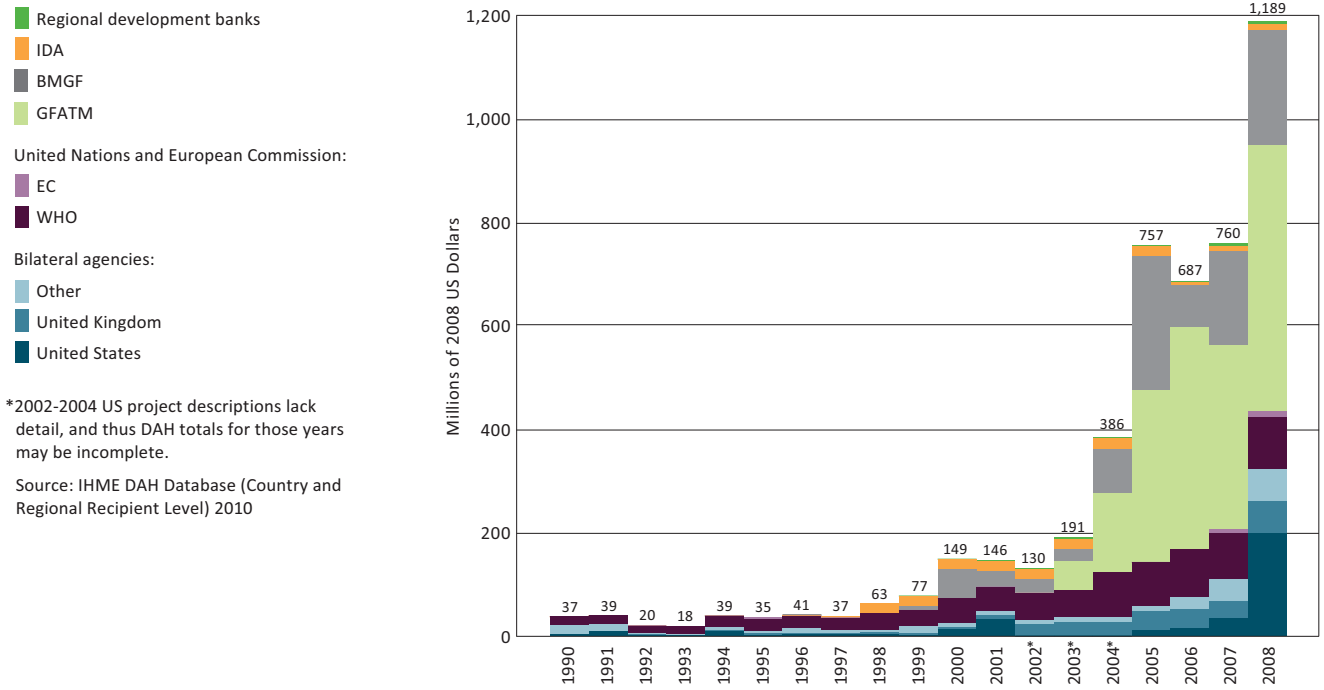
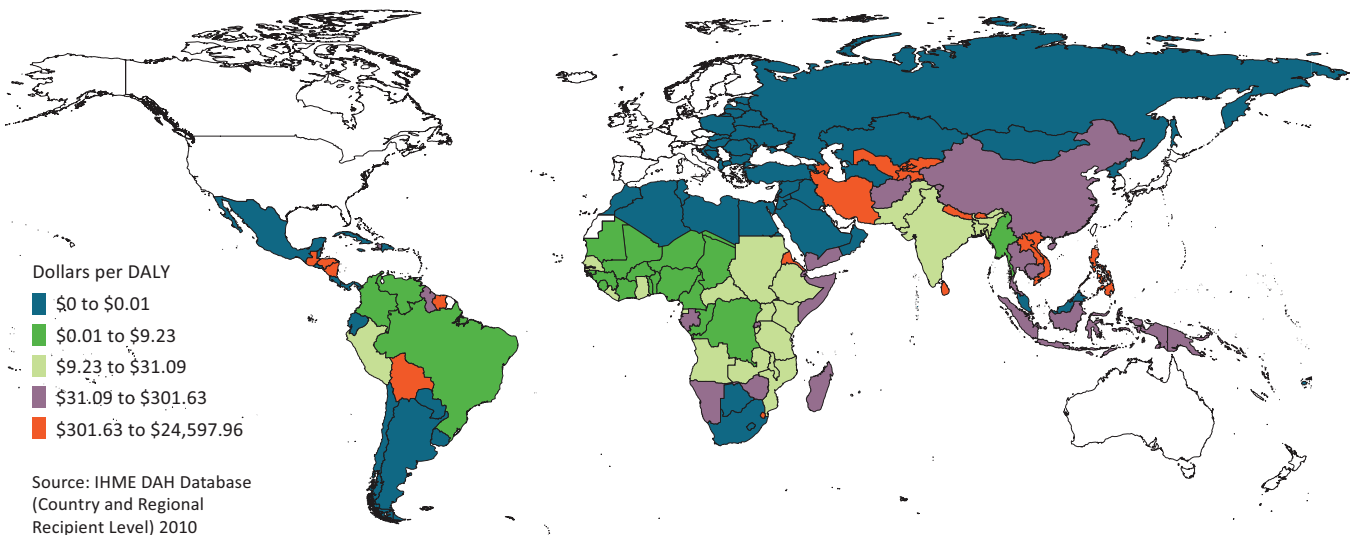


FIGURE 22:
Malaria: DAH per related DALY, 2003-2008

We used DALY data for 2004 as a proxy for burden in all subsequent years. Countries that received no DAH over the study period and countries with zero or missing burden data are not shown. DAH received is shown in real 2008 US\$.



complications related to HIV/AIDS. By WHO estimates, tuberculosis is the leading cause of death among people with HIV/AIDS in sub-Saharan Africa.⁴⁵

The Second Stop TB Partners Forum in New Delhi in 2004 pledged to cut mortality from tuberculosis in accordance with the MDG target of reducing it by half between 1990 and 2015.⁴⁶ The assembled partnership members, who included representatives from 29 countries, the UN, the World Bank, the World Economic Forum, and dozens of pharmaceutical companies and research organizations, also reaffirmed previous commitments to support GFATM.

As shown in Figure 24, funding flowing through GFATM did increase beginning in 2004, from \$58.28 million in 2003 to \$132.95 million in 2004. It grew to \$342.78 million in 2008.

Funding for tuberculosis control is dominated by GFATM and BMGF. Between them, they accounted for 69% of all funding for tuberculosis programs in 2008. They also have increased funding for tuberculosis more

than other channels of assistance. Funding channeled through BMGF grew from \$7.32 million in 1999 to \$232.65 million in 2008.

We expect that shifts in this funding pattern will be revealed as data for 2009 and 2010 are made available. In March 2010, the United States Agency for International Development (USAID) announced the Lantos-Hyde United States Government Tuberculosis Strategy, which promised “a substantial increase in US Government funding for TB treatment and control over a five-year period.”⁴⁷

Interesting patterns emerge when looking at funding in the context of disease burden. The countries that receive the most funding per tuberculosis-related DALY are mostly in Eastern Europe. Serbia and Montenegro, Georgia, Bulgaria, Moldova, and Armenia all receive more than \$100 per tuberculosis-related DALY. At the other end of the spectrum, countries with higher tuberculosis burdens receive less than \$5 per tuberculosis-related DALY. These include Uganda, Zimbabwe, Côte d’Ivoire, Nigeria, and Chad.

FIGURE 23:
DAH for health sector support by channel of assistance, 1990-2008

- Regional development banks
- IDA
- EC
- Bilateral agencies:
 - Other
 - United Kingdom
 - United States

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

Source: IHME DAH Database (Country and Regional Recipient Level) 2010

Note: For search terms used to define health sector support, please visit our online Methods Annex at: http://www.healthmetricsandevaluation.org/publications/financing_global_health_2010_methods_IHME.pdf

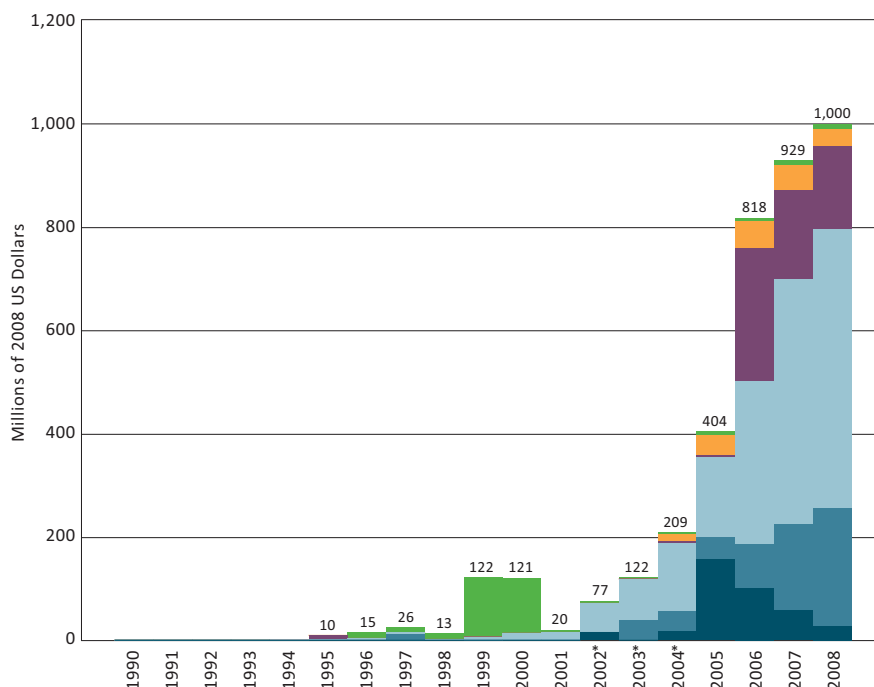


FIGURE 24:
DAH for tuberculosis by channel of assistance, 1990-2008

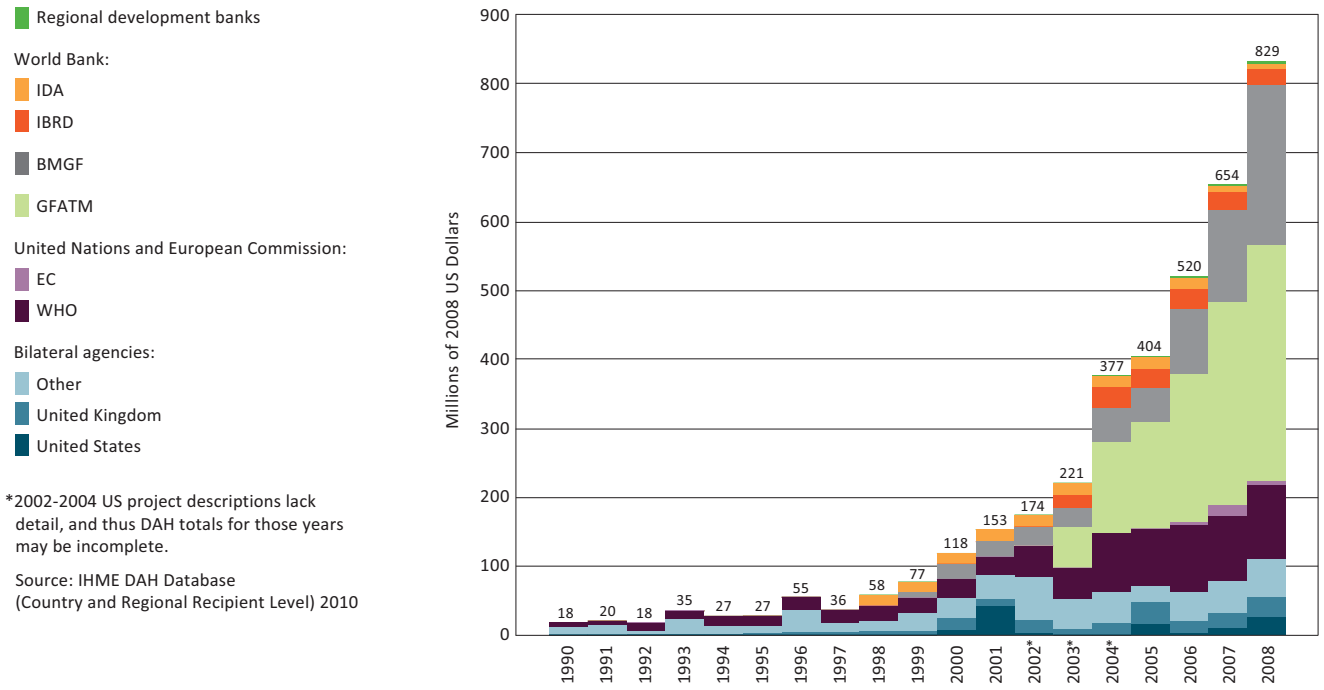
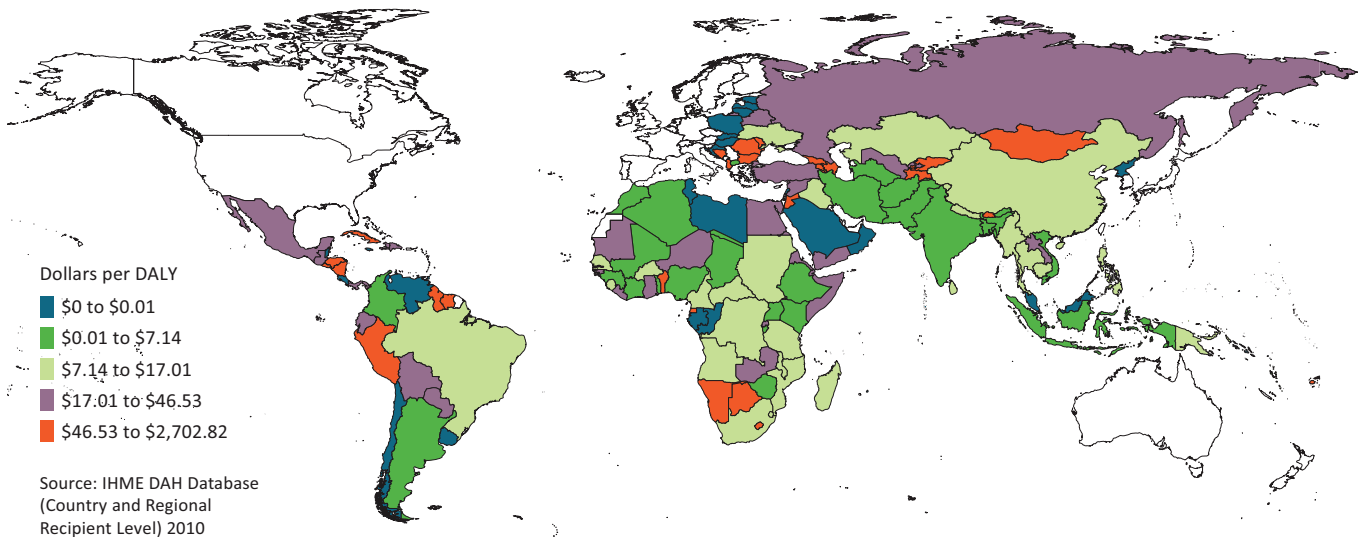


FIGURE 25:
Tuberculosis: DAH per related DALY, 2003-2008

We used DALY data for 2004 as a proxy for burden in all subsequent years. Countries that received no DAH over the study period and countries with zero or missing burden data are not shown. DAH received is shown in real 2008 US\$.



Funding for noncommunicable diseases by channel of assistance

For decades, donor countries have focused on infectious diseases that spread rapidly, including the diseases discussed in the previous sections: HIV/AIDS, malaria, and tuberculosis. As efforts to address those diseases have made headway, child and adult mortality have declined.^{38,48} In 1990, 12 countries had an under-5 mortality rate (defined as the probability of death between birth and age 5) of more than 200 deaths per 1,000 live births.³⁸ In 2010, no country had an under-5 mortality rate that high.³⁸ Adult mortality has fallen globally, too.⁴⁸ These trends, coupled with rising income levels in many developing countries, have given rise to the well-documented increase in the incidence of chronic diseases such as cancer, heart disease, and diabetes.³⁵

In May 2008, the World Health Assembly endorsed an action plan for preventing NCDs. In May 2009, the Doha Declaration on Noncommunicable Diseases and Injuries was made at a meeting convened by UN agencies.⁴⁹ The

declaration stated: “The socioeconomic cost of NCDs and injuries is enormous and is rising rapidly. These conditions cause considerable disability and premature death, leading to lost productivity. The rapidly increasing health costs are impoverishing, and inaction is a tremendous burden to sustainable development.”

These statements came during a period of shrinking financial commitments to NCDs by UN agencies and donor governments. Figure 26 shows that WHO spending on NCDs peaked in 2002 at \$64.47 million before dropping to \$43.74 million in 2008. Donor governments channeling funds through bilateral agencies spent less in 2008 on NCDs than they did in 1995.

Overall spending on NCDs increased because of funding channeled through BMGF, which spent a total of \$207.16 million on NCDs between 1999 and 2008. Much of this funding was targeted at efforts to reduce the use of tobacco.

The range of DAH per DALY for NCDs is narrower than for any other health focus area in the study, from

FIGURE 26:
DAH for noncommunicable diseases by channel of assistance, 1990-2008

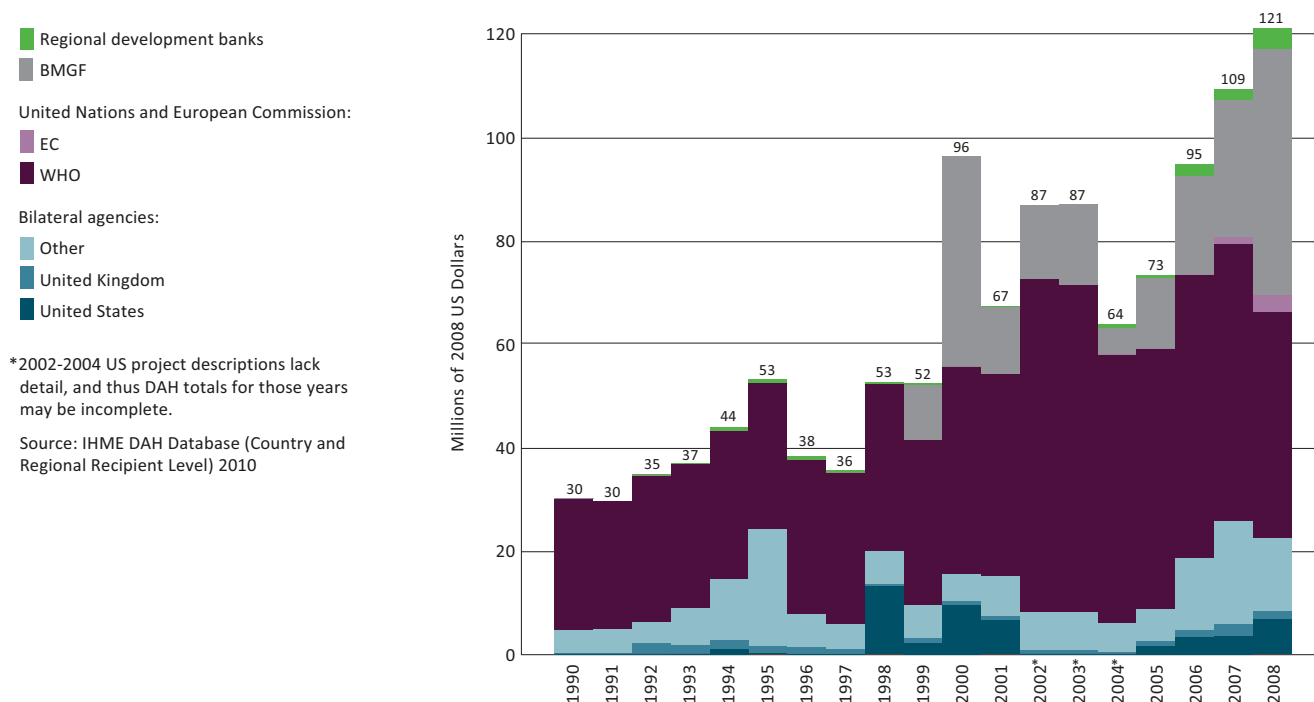
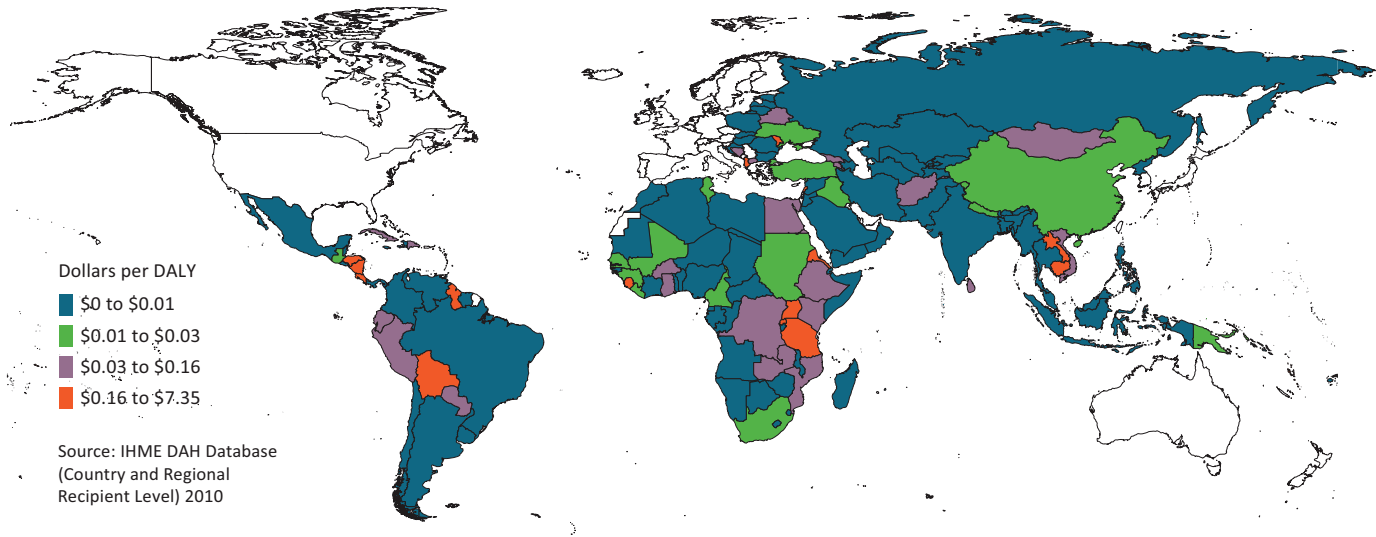


FIGURE 27:
Noncommunicable diseases: DAH per related DALY, 2003-2008

We used DALY data for 2004 as a proxy for burden in all subsequent years. Countries that received no DAH over the study period and countries with zero or missing burden data are not shown. DAH received is shown in real 2008 US\$.



less than 1 cent per DALY to \$7.35. This is partially a result of missing and sparse project descriptions in the data reported by channels. We were only able to find funding targeted specifically for NCDs in 85 out of 155 countries, even though NCDs affect every country.

Figure 27 shows that countries receiving the most DAH per DALY for NCDs are primarily in Africa and Latin America. We found 56 countries that received between 1 cent and \$1 per NCD-related DALY between 2003 and 2008. At the low end were Benin, Liberia, Mali, Ukraine, Turkey, and China. At the high end, this included Samoa, Vanuatu, Albania, Nicaragua, Honduras, and Rwanda.

Through 2008, at least, the discussion around increasing funding for MNCH and NCDs had yet to translate into the kind of increases in spending seen following similar global pledges to focus on HIV/AIDS, tuberculosis, and malaria. It remains to be seen how the push to increase funding for MNCH and NCDs will shift priorities for the US government, the largest funder of global health projects. The US Global Health Initiative promises to put \$63 billion in new funding toward global health, and MNCH is listed among the initiative’s priorities, though NCDs are not.⁵⁰