

What do we learn from studies on aid allocation to the health sector?

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Development Initiatives was commissioned by the Bill and Melinda Gates Foundation to conduct a scoping study on initiatives tracking aid to the health sector. This aimed to highlight areas for future research and key areas where evidence was missing.

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The analysis presented and views expressed in the report are the responsibility of Development Initiatives.

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List of acronyms

BRICS	Brazil, Russia, India, China, South Africa
CRS	Creditor Reporting System
DAC	Development Assistance Committee
DAH	Development Assistance to Health
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
IHME	Institute for Health Metrics and Evaluation
MDG	Millennium Development Goal
NTD	neglected tropical disease
ODA	official development assistance
OECD	Organisation for Economic Co-operation and Development
R&D	research and development
SDG	Sustainable Development Goal
SSA	sub-Saharan Africa
SUN	Scaling Up Nutrition
WHO	World Health Organization

Executive summary

This scoping study aims to review initiatives and studies on aid to the health sector in order to understand the key research priorities and as a result give insights on research opportunities for aid analysis for the health sector. We use three main approaches. First, we analyse aid funding to health as reported on the OECD Creditor Reporting System (CRS) database. Second, we draw on our literature review of existing studies on aid analysis classified in various ways to include subsector, disease type, sources of data and the producers of these studies. Through the literature we also identify initiatives that track health ODA on a regular basis such as annual reports. Third, we carry out a light-touch mapping of data platforms on health indicators and health financing as key evidence products.

Our findings suggest that many studies on aid to health seem to be driven more by the need to inform global processes and forums such as the Global Partnership for Effective Development Cooperation (GPEDC), and so do not target specific health needs or donors. This could be a strategy of influence rather than a limitation in itself. The challenge however is measuring the extent to which these studies influence donor decisions considering that the burden of disease remains high and that Millennium Development Goals (MDGs) in this area were not achieved. There is a considerable number of studies on aid effectiveness – a focus on the qualitative side of aid that is quite advanced and even includes a quality index to measure aid effectiveness.

Where analysis has been carried out on specific areas or diseases it has tended to focus on HIV/AIDS, tuberculosis, malaria and nutrition. Again, this is possibly due to global commitments. This has posed a threat to other illnesses which are equally important such as the neglected tropical diseases (NTDs) and to other subsectors such as human resources for health. Studies highlighting these overlooked areas would be useful to create interest and pressure to allocate more funding. A related finding from the studies reveals that aid is not targeted to country priorities or disease burdens.

China (a non-DAC donor) is among the top 10 donors to health in Africa. China's funding seems to be closing the gap left by DAC donors (especially allocations to health infrastructure and systems). Non-DAC donors therefore could help to meet the health needs of developing countries, and a better understanding of this potential is required.

Most studies on aid to health are carried out by academic and international organisations. Some of these studies are available on open access but the peer-reviewed (which we would regard as high-quality) publications are in journals not fully accessible to the public. It is therefore not clear to what extent these studies are able to influence change in the modality of delivery of aid to the health sector.

The regularity of studies on aid analysis could be strengthened. We find only four institutions producing publications on aid to health on an annual basis (focusing on donor funding to nutrition, EU donor countries, global health aid, and aid to health research and development). Most studies rely on OECD data due to its completeness. We encourage the use of other data sources such as the International Aid Transparency Initiative (IATI) and in-country online aid portals hosted by recipient countries, such as e-ProMIS in Kenya.

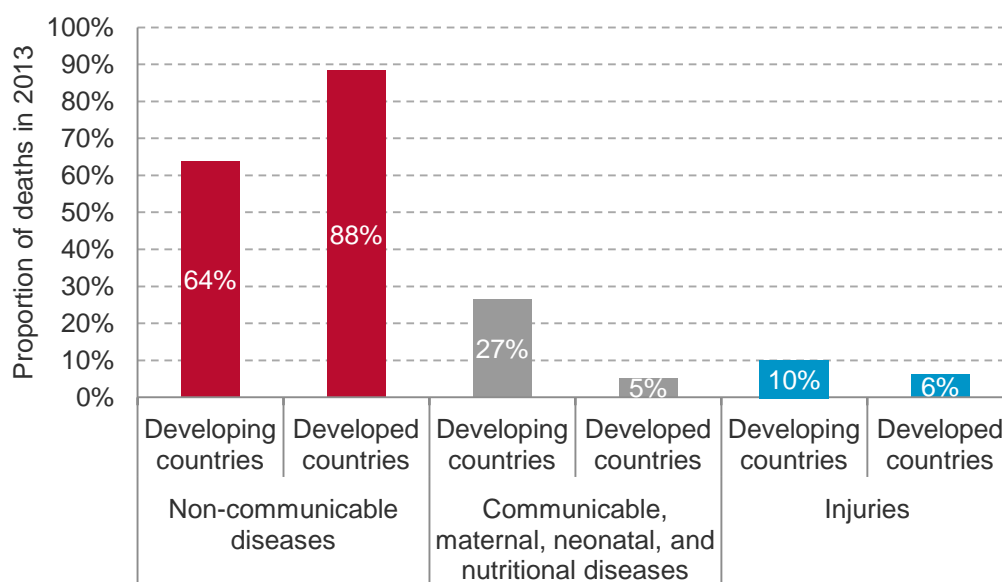
Introduction

Health as a global agenda

The Sustainable Development Goals (SDGs)¹ have set a road map and pace for the need, drive and provision to improve health services globally. Goal 3 of the SDGs sets out to ensure healthy lives and promote wellbeing for all. This is a continuation of the Millennium Development Goals (MDGs). While some progress was made, as highlighted by the [Global Monitoring 2015 Report](#), most targets were missed, particularly on health (maternal and infant mortality), nutrition (undernourishment and hunger) and sanitation.

According to the [Global Burden of Disease](#) data for 2013, non-communicable diseases² accounted for the highest burden of disease in developing countries (Figure 1), with mortality rates standing at 456 deaths per 100,000 population (which is 64% of total mortality). This is followed by communicable, maternal, neonatal and nutrition illness which, combined, are the second-highest burden of disease at 190 deaths per 100,000 population (27%).

Figure 1: Mortality causes in developed and developing countries in 2013

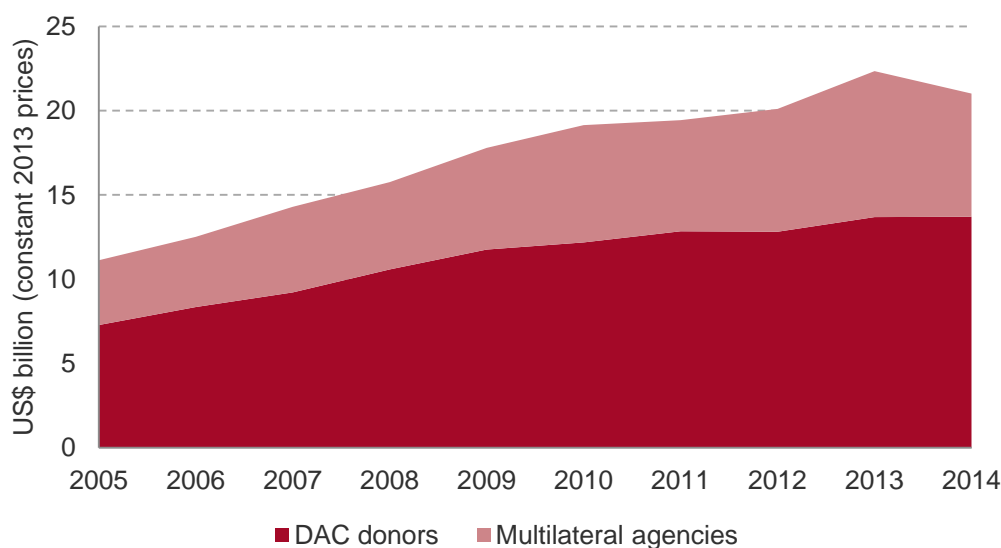


Source: [Global Burden of Disease online portal](#)

Health as a donor priority: analysis of aid to health

Official Development Assistance (ODA) to health (including both general health, population policies/programmes and reproductive health) more than doubled in real terms between 2005 and 2013, but then fell by US\$1.3 billion in 2014 (Figure 2). This fall was entirely due to a drop in disbursements from multilateral bodies. The largest reduction was in disbursements from the Global Fund which were US\$1.1 billion lower in 2014 than in 2013. Although ODA disbursements to health have risen in real terms in most years of the last decade, the proportion of ODA going to the health sector has remained fairly constant at between 12% and 14% in each year since 2007.³

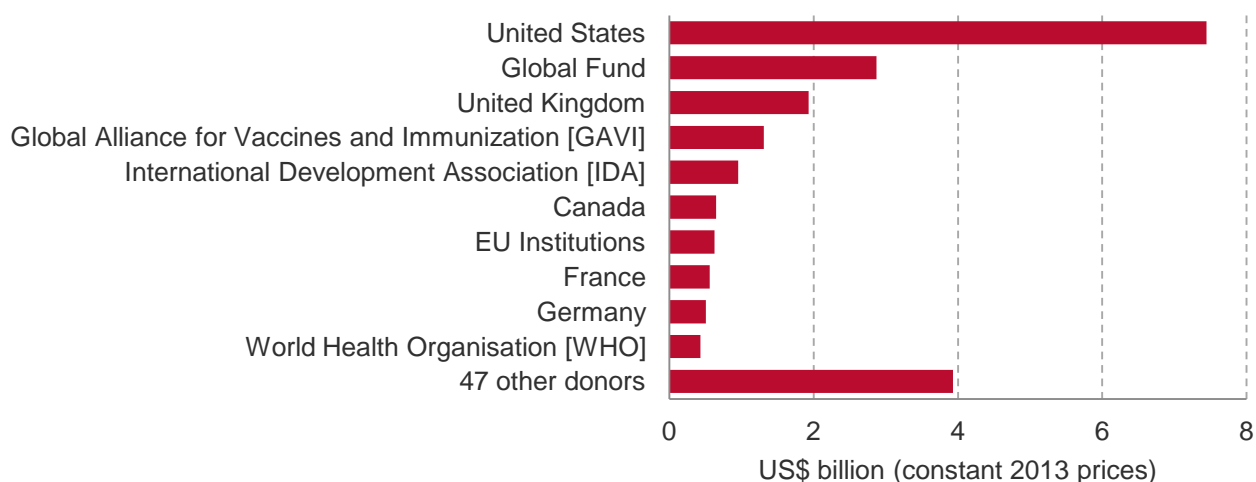
Figure 2: Trends in gross ODA to health, 2005–2014



Source: Development Initiatives based on OECD CRS database

The United States was by far the largest donor of ODA to health in 2014, providing more than one-third of gross disbursements (Figure 3). The Global Fund was next, despite its disbursements to health falling by almost 30% between 2013 and 2014. In aggregate, the top 10 donors of ODA to health gave more than 80% of total gross disbursements to this sector.

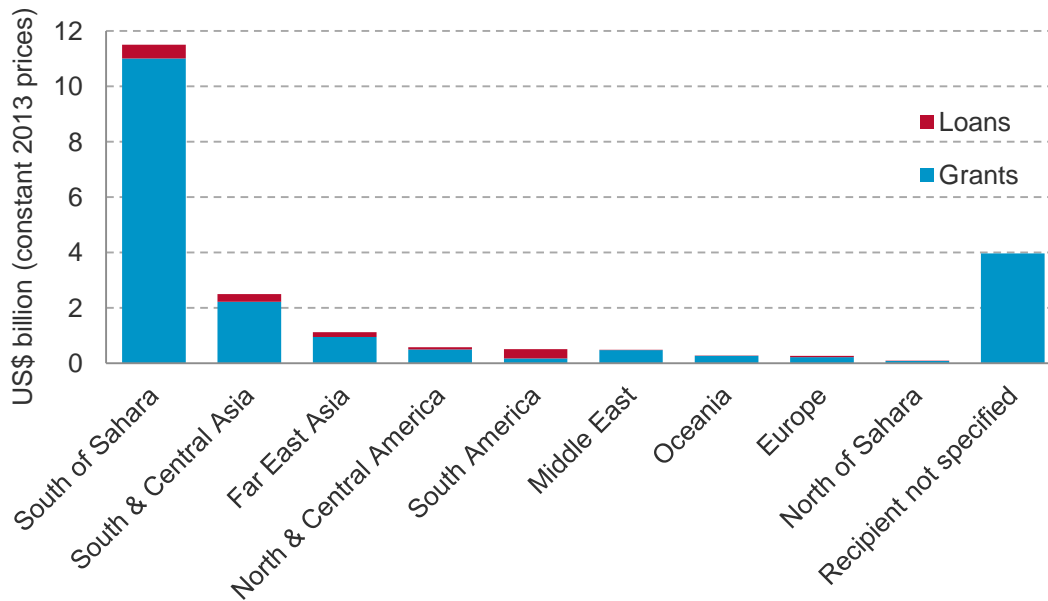
Figure 3: Gross ODA to health from top 10 donors in 2014



Source: Development Initiatives based on OECD CRS database

In 2014, US\$11.5 billion of ODA to health was directed to sub-Saharan Africa – over half of total disbursements and more than four times the amount disbursed to South and Central Asia, the second-largest recipient region (Figure 4). US\$4 billion of ODA to health – almost one-fifth of the total – went to activities with no specific recipient, including contributions to health research and other international partnerships and initiatives. The great majority of ODA to health comes in grant form – 93% of total disbursements in 2014. However, one region, South America, received two-thirds of ODA to health in the form of loans.

Figure 4: The majority of ODA to health in 2014 went to sub-Saharan Africa



Source: Development Initiatives based on OECD CRS database

More details on aid allocations are included in Annex 1. We find that top aid recipients in 2014 were Nigeria, Tanzania, Ethiopia and Kenya; 22% of aid is channelled through recipient governments. In the following sections, we explore studies that analyse aid to health. We try to understand which areas of aid to health are researched, why, and who produces these studies. We look at the sources of aid data beyond the OECD CRS and the potential of these data sources. In addition we carry out a light-touch scoping of online platforms on aid to health and make inferences. More details of the portals are highlighted in Annex 2. Annex 3 provides more information on the methodology used in this study.

Findings: extent, nature and range of research on aid to the health sector

Who are the main producers of research on aid to health?

These are mainly organisations seen as leaders through the World Health Organization (WHO), World Bank or international academic institutions – commissioned by donors. A number of key studies are published in journals such as the *Lancet* and *PubMed*, which are not accessible on open source.

Besides publications, there exist online portals that map aid to health. From our light-touch scoping of these portals, we find that most are developed by academic and research organisations. Donors – bilateral, multilateral and private – have also developed online data portals on aid to health.

We see these publications and online portals as key tools that would inform donor priorities on aid allocation, given that donors would be the main consumers of such studies. However, we are not able to confirm the extent to which these studies are used by donors, as we have not made detailed follow-up of the uptake of the findings presented in the research we reviewed.

Donors are also producers or commissioners of information, with multilateral donors such as the WHO and World Bank carrying out research on aid to health and publishing these on their websites. The Organisation for Economic Co-operation and Development (OECD) – given its role in producing data on aid – has also been positioned as a leading expert in generation of

evidence on aid to health. The OECD produces research on aid to health but not all of this is available to the public on open source.

Non-state actors form the other main group producing research on aid to the health sector. These include both international non-governmental organisations (NGOs), who tend to look at both international and country/regional scales of aid allocation, and national organisations which focus on specific countries. The reasons for carrying out these analyses vary from their use as advocacy tools (see [Action for Global Health](#)) to informing ongoing processes and commitments such as the Financing for Development Conference 2015 (see [Results-UK](#)).

Besides Development Initiatives' annual analysis of aid to nutrition, three other organisations produce annual analysis on aid to the health sector. Action for Global Health analyses European Union country funding to health to determine the extent to which countries are meeting their commitments. This cross-country analysis relies on aid data from the OECD. The Institute for Health Metrics and Evaluation (IHME) uses data from Development Assistance for Health (DAH) to generate an annual [Financing Global Health](#) report. Lastly, [Policy Cures](#), through the [G-Finder](#), produces much more specific annual reports focusing on aid to research and development for neglected diseases and reproductive health.

[Studies are more qualitative than quantitative: aid effectiveness](#)

Studies on aid to health have both qualitative and quantitative elements. Quantitative studies, on which we focus more in this paper, analyse aid to health to understand trends and patterns across geographical locations or in specific countries. On the qualitative side, aid studies tend also to interrogate underlying issues beyond aid figures – to highlight governance and systemic issues such as aid effectiveness, accountability and health financing systems.

There are a good number of aid effectiveness studies in the health sector. A word search on 'aid effectiveness' in the *Lancet* journal returned 22,896 publications.⁴ These studies are largely intended to inform global processes and to develop country case studies which in turn inform global processes. Aid effectiveness studies are linked to the former Working Party on Aid Effectiveness⁵ which has now given way to the Global Partnership for Effective Development Co-operation (GPEDC). They monitor implementation of global processes such as the [Accra Agenda for Action](#), and the [Busan Partnership for Effective Development Cooperation](#) on what needs to be in place for aid to be effective while evaluating these frameworks.

The health sector has been used as a tracer sector to inform these global processes and the formation of global initiatives to finance health. In fact, there are over 100 programmes financing global health initiatives as seen through the [Global Health Community](#). Studies on health aid effectiveness have been commissioned to such an extent that more focus has been put on demonstrating aid effectiveness than on the impact of aid efforts.⁶ The extent to which these aid effectiveness studies influence the GPEDC agenda has not been explored in this study but definitely ought to be investigated.

Aid effectiveness studies on health have extended to the development of an index of 'quality of ODA'. The [QuODA](#) index measures aid on four dimensions: its ability to reduce burden, maximising efficiency, fostering institutions, and transparency and learning. [Duran](#),⁷ applying this index on aid to health, reveals that while aid to health has a more significant relation to reducing the funding burden, it does not target disease burdens and that there is fragmentation across donor agencies; health aid is also less transparent than aid overall.

[Looking beyond aid funding: other sources of health financing](#)

There are studies that analyse funding to health beyond aid. These look at the mix of financial sources to include domestic resources and private funding. David Mc Coy and colleagues,⁸ indicate that private financing to global health, while large, is often not captured. The same study also calls for examination of the key beneficiaries of global health financing. On comparison with domestic expenditures, Ooms⁹ finds that aid crowds out domestic funding and governments re-allocate funds initially set for health on receiving aid. This study calls for increased aid transparency and suggests pooling of international aid to health using the example of the Global Fund. A report from the OECD and Kenyan Ministry of Health¹⁰ reveals

some of the challenges in comparing the two sources of health financing. Mostly, these are due to the differences in the quantities and hence incomparability of commitments, disbursements, planned government spending and actual spending. In addition, reporting is done using different reference periods (financial versus calendar years), making comparison studies a challenge.

Health subsector analysis

Using the OECD CRS health subsectors, we explore the existence of research on aid to: i) general health, including health management and training; ii) basic health, including disease control, nutrition, malaria, tuberculosis, health personnel; and iii) population policy, including HIV/AIDS, reproductive health and family planning.

Data on aid funding in 2014 (Annex 1) shows that HIV/AIDS received the largest proportion of funding (US\$6.9 billion) followed by Malaria (US\$1.9 billion). Matching the existence of research on these two subsectors, we find a good amount of research focusing on these two diseases separately or in comparison. Research exploring whether funding to HIV/AIDS has displaced funding to malaria and tuberculosis highlights that this is so at country level but not globally. Funding to malaria is more displaced, especially in countries with at least 1% prevalence of the illness.¹¹

The existence of analysis on funding to nutrition is possibly due to the global movement, **Scaling Up Nutrition**. These studies highlight allocation to nutrition and the extent to which countries are meeting their commitments to fund nutrition. Again, there are more studies on aid modalities and how aid to nutrition can be tracked than there are on actual aid analysis. Development Initiatives is the only organisation we found carrying out **annual aid analysis** on donor funding to nutrition.

Studies on aid to reproductive health have focused on funding to specific countries, or from top donors. When analysed across countries, this has tended to focus on fragile states or countries in conflict, reflecting the view that reproductive health needs are higher in conflict-affected countries.¹²

Non-communicable diseases (NCDs) account for the greatest burden of disease to both developing and developed countries. Aid to NCDs has however remained low,¹³ with studies attributing this to the lack of measurable targets and agreement on interventions required. The benefits of preventive care and investing in health personnel, including health management and training, cannot be underestimated. Yet these areas – like NCDs – still do not receive sufficient aid allocation nor are there studies that have highlighted this as an urgent priority.

Beyond DAC donors: studies on non-DAC donors' funding

Understanding aid from the non-DAC donors, such as Brazil, Russia, India, China and South Africa (BRICS), helps to understand the bigger resource picture on who else funds the health sector. There seems to be a limited number of studies on these donors, which **WHO** recognises as a limitation of access to the data as the BRICS, for example, do not report to the OECD. That said, attempts have been made to analyse China's funding to health in Africa.

Findings indicate increased support to health, population policies/programmes, water and sanitation – making China among the top 10 bilateral global health donors to Africa.¹⁴ China's funding focuses on health infrastructure and human resources; malaria is a priority area but HIV/AIDS is not. China's approach to South–South cooperation represents an important and distinct source of financial assistance for health in Africa. However, this assistance is not easily tracked and documented.

The role played by BRICS and other non-DAC donor countries needs to be captured for better analysis and assessment of aid to the health sector. From the example of China, patterns of funding to the health sector seem to reveal that the BRICS (or other non-DAC) donors are filling the funding gaps of the DAC donors. This presents an entry point for them to support developing countries and strengthen their partnerships. Beyond the BRICS, other non-DAC donors (Kuwait and the United Arab Emirates) have allocated aid to the health sector from

2009. Lithuania, Estonia, Hungary, Kazakhstan and Romania also allocated some funding to health in 2014 – each less than US\$2 billion.¹⁵

Linking aid to country health priorities and the disease burden

As highlighted above, studies reveal that aid to health could be better aligned to health priorities at country level for it to be more effective. In Uganda, for example, there is increased donor funding to HIV/AIDS yet funding to primary health care, and other priorities in the **Health Sector Strategic Plan** remain underfunded.¹⁶ The country's most recent strategic plan highlights limited funding to curative and preventive care, health-related human resources and infrastructure but more funding targeting HIV/AIDS, malaria and tuberculosis.

Similar findings are shared by WHO research,¹⁷ indicating that countries with similar health needs and poverty indicators received different levels of aid. There is a pattern of donor funding targeting global goals (such as the MDG 6 indicators) and therefore excluding funding to health systems, management and workforce development – which are country priorities. Shiffman,¹⁸ also finds that donor funding does not match with disease burden.

Comparative studies highlighting ability or inability of health allocations to meet country priorities or disease burdens should be encouraged. This would include analysis of donor funding to the countries' priorities such as preventive and curative care, human resources for health and health system financing, and to specific diseases such as non-communicable diseases which are the largest causes of mortality according to the **Global Burden of Disease Mapping**.

Comparing donor funding to recipient countries' allocations would be useful to highlight better ways for aid to health to align and for the mix of the various health financing mechanisms to contribute to better health outcomes. The research mentioned above by WHO and Shiffman area was published in 2009 and 2003, respectively. The quality of the OECD-CRS data has improved since then, and there is an opportunity to perform analysis with more recent data to investigate the extent to which aid to health is aligned to country priorities, matching with poverty indicators or aligned to the disease burden.

Beyond OECD-DAC data: what other data sources are used for health aid analysis?

Most studies have relied on the OECD Creditor Reporting Systems (CRS). Other sources include the IHME DAH data which is based on the OECD data and includes data from multilateral donors and foundations. **AidData** has been relied upon to report funding from emerging donors and multilaterals.¹⁹

There seems to be limited research linking aid reported to the Creditor Reporting System (CRS) and recipient government databases that track ODA resources.²⁰ Kenya for example has an online portal, **ePROMIS**, to report on aid spending in-country, which could be compared to the aid reported by the OECD. We feel more of these comparisons are important in order to be able to see the value of the different sources of data and create opportunities to harness various funding streams to the health sector. This would also help to understand the amount of aid that is actually received as reported by recipient countries, which might differ from what is reported by donors to the OECD.

That said, we note the challenge of joining up the data, particularly due to differences in the structure of the data for international and national health data systems. The International Aid Transparency Initiative (**IATI**) reports funding from donors and recipients and includes civil society and NGOs to report their funding in a standard that allows comparisons to be made; this would be a welcomed solution to this limitation. This makes comparing data across governments and organisations possible. The data on IATI is also more recent as it is updated monthly or quarterly, so there is no time lag as is the case with the OECD CRS. One study carried out by Development Initiatives comparing IATI data with the CRS reveals that investments reported on CRS are significantly lower than what is reported on IATI. This study looked at other sectors beyond health, but revealed health and education as two sectors with higher allocations than reported on the CRS.²¹

We carried out a light-touch mapping of other platforms or data sources of aid (and other financial resources) to the health sector. We found close to 15 such online platforms which rely largely on data from the OECD, in-country data and other donor reporting mechanisms. While this seems like an innovative way of presenting aid to the health sector in a more consumable way, we note that there are growing criticisms of the multiplicity of data portals.²² In order for this innovation to have impact and be scaled up, there is need to encourage the use of the data on these portals more proactively. We did not assess the extent of use of these portals or the quality of their data – which would be a natural next step before promoting their use.

Key research gaps and priorities

This scoping paper aimed to understand the key research areas on aid allocation to the health sector and make recommendations on areas for future research identified as gaps in the existing literature. We summarise this in Table 1.

Table 1: Tabulation of research strengths and gaps/opportunities

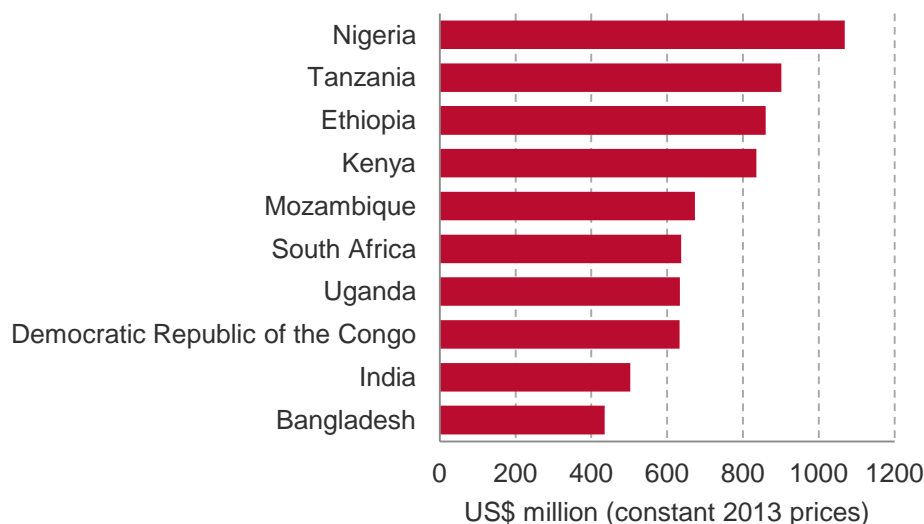
	Strengths of existing literature	Opportunities for further research/strengthening
Producers of research on aid to health	Most research is carried out by academia and international organisations to inform global processes.	Encourage other organisations to carry out these analyses, particularly those involved in advocacy or health service delivery, in order to better inform donors' allocations (while noting the limited capacity they may have to carry out such studies might require promoting linkages between international and advocacy organisations).
	Some of these studies are available on open access, but the high-quality publications are in journals not fully accessible to the public. It is therefore not clear to what extent these studies are able to influence change in the modality of delivery of aid to the health sector.	Promote the open publishing of these analyses for them to reach more audiences and influence change.
	Only four studies on aid to health are carried out annually: European Union donor focus, Global level, nutrition focus, and research & development (R&D) to neglected diseases and reproductive health.	Commission more regular aid-to-health analysis, particularly to developing countries as recipient countries or to specific health subsectors.
Health subsectors	Analysis exists of aid to specific diseases: HIV/AIDS, tuberculosis and malaria.	Analysis of aid to other diseases such as NCDs and respiratory diseases (to match with the global disease burden); G-finder does this but focuses on aid to R&D.
	Studies on nutrition exist – partly due to the SUN movement.	Studies on other subsectors such as aid allocation to health systems financing, basic health, human resources for health.
Range of studies	There are studies on aid effectiveness focusing more on the qualitative side of aid – this is quite advanced and includes a quality index to measure aid effectiveness.	More studies on the impact of aid are required – to analyse aid over time and compare this to levels of poverty in a country.

	<p>Studies reveal that aid is not targeted to country priorities or disease burdens – but these studies are done at country level.</p>	<p>Studies that compare aid to disease burdens (updating the work of Shiffman published in 2003). Studies that compare aid funding to a country's health priorities. Looking across countries to see if there are donors who meet country health needs (updating the work of Paolo published in 2009).</p>
	<p>There is some analysis on China's funding to health; similar studies seem to be limited by access to data.</p>	<p>Encourage aid analysis of other non-DAC donors such as Kuwait, United Arab Emirates and BRICS.</p>
<p>Data sources</p>	<p>Most studies rely on OECD data due to its completeness.</p>	<p>Commission studies using other existing and reliable data sources such as IATI.</p> <p>Studies that compare aid data from the OECD and in-country databases with that of recipient governments, such as e-ProMIS, to find out more about how aid is reported and see ways of improving the systems.</p> <p>Quality assessments of the various existing online portals of health aid in order to improve understanding of their value, promote their use and ascertain their target audience.</p>

Annex 1: Further analysis of ODA to the health sector

In 2014, ODA was disbursed to the health sector in 145 named countries with over one-third of gross disbursements going to the top 10 recipients. The top eight recipients were all sub-Saharan African nations (Figure 5).

Figure 5: Gross ODA to health – top 10 recipients in 2014

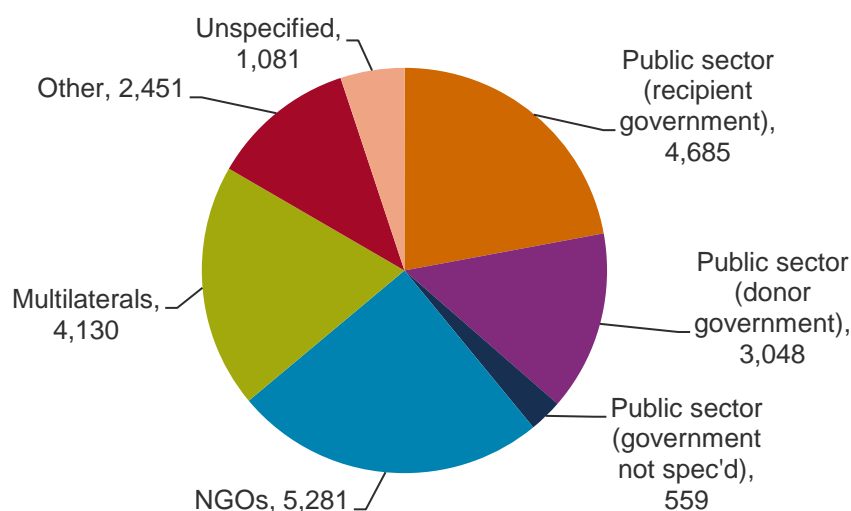


Source: Development Initiatives based on OECD CRS database

Almost two-fifths of ODA to health in 2014 was channelled via the public sector, with 22% delivered via recipient-country governments and 14% via donor-country governments. (Another 3% of disbursements went via the public sector, but it was not specified whether activities were implemented by the donor or the recipient government.) A further quarter of all disbursements went via NGOs and just under one-fifth was bilateral aid delivered via multilateral bodies (Figure 6).

Figure 6: Gross ODA to health in 2014 by channel of delivery

US\$ billion, constant 2014 prices

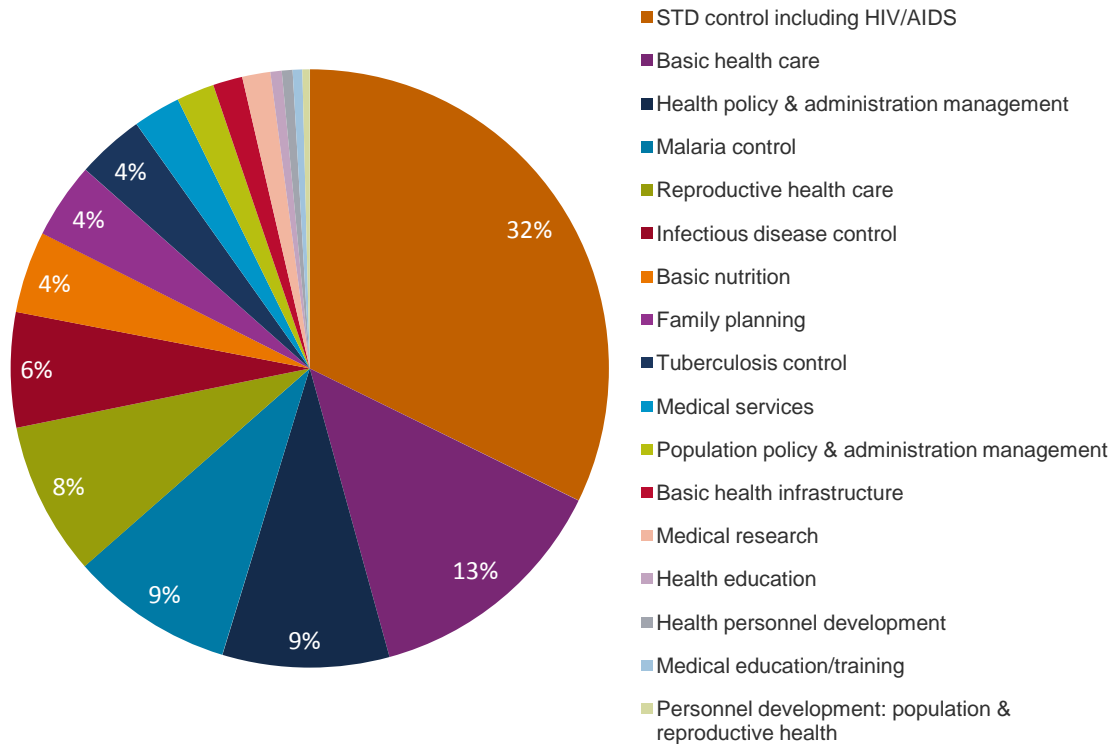


Source: Development Initiatives based on OECD CRS database

Examining the sub-categories within the health sector it is apparent that HIV/AIDS projects receive far more ODA than any other single category (Figure 7). In 2014 almost one-third of gross ODA to health was disbursed to activities relating to HIV/AIDS. The amount of ODA to HIV/AIDS is mainly due to the fact that the United States – the largest donor of ODA to health – concentrates its health funding in this area. In 2014 the United States disbursed over 63% of its health-sector ODA to HIV/AIDS-related projects.

Figure 7: Gross ODA to health in 2014 by subsector

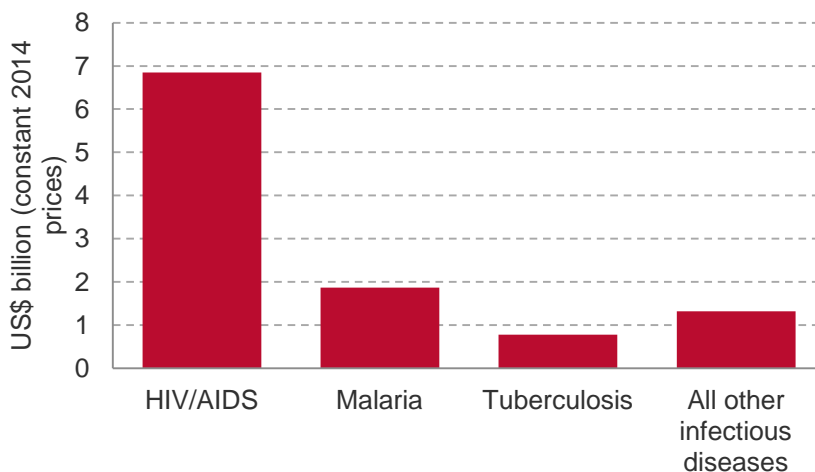
Total gross disbursements to health (%)



Source: Development Initiatives based on OECD CRS database

Focusing on ODA directed at specific categories of disease it can be seen that, in 2014, ODA disbursed to HIV/AIDS was over 3.5 times the amount directed to malaria and nearly 9 times the amount spent on tuberculosis (Figure 8).

Figure 8: Gross ODA to health in 2014 directed to specific diseases



Source: Development Initiatives based on OECD CRS database

Annex 2: Mapping of data portals on aid to health

	Organisation name	Content held	Organisation type	Presentation of data	Geographical data	Link
1	Development Initiatives	Aid and domestic budget data to health health indicators	International NGO	Raw datasets and visualisations	Global	http://devinit.org/#!/post/unbundling-aid
2	G-Finder	Aid data to neglected disease and reproductive health R&D	Donor	Raw datasets and visualisations	Global	https://gfinder.policycures.org/PublicSearchTool/search
3	World Bank	Aid data to various sectors obtained from OECD, World Bank and regional development banks	Donor	Raw datasets and visualisations	Global	http://www.aidflows.org/
4	Global Vaccine Alliance	Donor profiles providing funding to GAVI	Donor	Visualisations	Global – donors	http://www.gavi.org/funding/donor-profiles/
5	Kenya Open Data Initiative	Health indicators and domestic finance data	Government	Raw datasets and visualisations	Kenya	https://opendata.go.ke/
6	AidSpan	Health aid data particularly allocations to the Global Fund	International NGO	Visualisations	Global	http://www.aidspan.org/page/global-fund-pledges-and-contributions
7	Trust for America's Health	Domestic health spending and health Indicators	Donor-trust	Visualisations	USA	http://healthyamericans.org/states/?stateid=SC
8	IATI	Health aid data	International NGO	Raw datasets and visualisations	Global	http://www.iatiregistry.org/
9	Kaiser Family Foundation	US domestic health spending	Donor	Visualisations	USA	http://www.healthsystemtracker.org/interactive/health-spending-explorer/?display=U.S.%2520%2524%2520Billions&service=All%2520Types%2520of%2520Services&source=Health%2520Insurance%2520Out%2520of%2520Pocket&tab=1

10	World Health Organization	Health financing to include out-of-pocket, domestic, health insurance and external financing	Donor	Raw datasets and visualisations	Global	http://apps.who.int/gho/data/node.main.75?lang=en
11	Africa Development Bank	Health expenditure data as proportion of total country expenditures	Donor	Raw datasets and visualisations	Africa	http://www.africanhealthstats.org/
12	Open Aid Sweden	Aid data from Sweden to various sectors including health	Donor	Visualisations	Sweden's aid to various countries	http://openaid.se/aid/sweden/kenya/2015/#orgs
13	Action for Global Health	Aid-to-health data from EU donors	International NGO	Visualisations	EU donors	http://odaforhealth.medmissio.de/
14	AidData	Aid data to various sectors including health	International NGO	Raw datasets and visualisations	Global	http://aiddata.org/
15	e-ProMIS	Aid and domestic finance data to include health	Government	Raw datasets and visualisations	Kenya	http://e-promis.treasury.go.ke/e-promis/
16	Institute for Health Metrics and Evaluation	Finance and Indicators	Academia	Raw datasets and visualisations	Global	http://www.healthdata.org/results/data-visualizations and http://ghdx.healthdata.org/

Notes: Donors include DAC donors, private donors and foundations. 'Raw datasets' means downloadable. 'Visualisations' include graphs, maps and tables.

Annex 3: Methodology

This paper applies three methodologies.

Aid analysis

We obtained data from the Organisation for Economic Co-operation and Development Creditor Reporting System (OECD CRS) database to compare aid across donors, recipients, channels of delivery, subsectors and disease types.

Literature review

Using a desk search, we obtained and reviewed grey literature, peer-reviewed publications, reports and briefs. The grey literature was obtained by word searches: 'aid for health' 'ODA for health' and 'aid patterns for health'. For the peer-reviewed articles, we visited two main journals – *Lancet* and *PubMed* – and carried out word searches. All these sources then went through an assessment template that included: search criteria/words used, search engine used, type of publication (article/journal/report), publication title, publication date, author, research funder/publisher, geographical scope/area/topic of focus. We then summarised the findings and highlighted the study limitations and recommendations.

Data portal mapping

We did this through a random Google search. This was intended to be a light-touch mapping to identify the existence of data portals on aid to health. We acknowledge that this approach may not be exhaustive or systematic.

Notes

- 1 A set of goals developed to end poverty and ensure prosperity for all over the next 15 years. See <http://www.undp.org/content/undp/en/home/sdgoverview/post-2015-development-agenda.html>.
- 2 Non-communicable diseases include: cardiovascular diseases (like heart attacks and stroke), cancers, chronic respiratory diseases and diabetes.
- 3 Health spending comprised a lower percentage of overall ODA in 2005 and 2006, but data for these years is distorted due to high levels of exceptional debt relief.
- 4 Leni, W. & Domingo, P. (2010) *Accountability and Aid in the Health Sector*. ODI & World (<http://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/6188.pdf>); <https://www.wider.unu.edu/sites/default/files/wp2012-069.pdf>.
- 5 The working party was a multi-stakeholder group consisting of developing and developed countries, South–South cooperation providers and civil society organisations. It was formed in 2008 and led at the OECD, aiming to build stronger ties between partners to work together to improve the impact of efforts on development.
- 6 OECD (2012) *Aid Effectiveness in the Health Sector*. OECD.
- 7 Duran, D. (2012, February) *An Index of the Quality of Official Development Assistance in Health*. Center for Global Development Working Paper 287.
- 8 McCoy, D, Chand, S. and Sridhar, C. (2009) 'Global health funding: how much, where it comes from and where it goes', *Health Policy and Planning* 10.
- 9 Ooms, G.D.K. (2010) 'Crowding out: are relations between international health aid and government health funding too complex to be captured in averages only?', *The Lancet*.
- 10 OECD, Republic of Kenya Ministry of Health (2014) *Strengthening Resource Tracking and Monitoring Health Expenditure*. OECD.
- 11 Lordan, G.T. (2013). 'Has HIV/AIDS displaced other health funding priorities? Evidence from a new dataset of development aid for health', *Social Science and Medicine*. Elsevier.
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- 13 <http://www.who.int/bulletin/volumes/90/7/12-108795/en/>.
- 14 Grepin, K.A. (2014). 'China's role as a global health donor in Africa: what can we learn from studying under reported resource flows?', *Globalisation and Health*; and see <http://www.globalizationandhealth.com/content/pdf/s12992-014-0084-6.pdf>.
- 15 Data from OECD-CRS accessed 21 April 2016.
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- 19 <http://www.who.int/bulletin/volumes/91/7/12-115410/en/>.
- 20 OECD, Republic of Kenya Ministry of Health (2014) *Strengthening Resource Tracking and Monitoring Health Expenditure*. OECD.
- 21 <http://devinit.org/offices/nairobi/#!/post/iati-data-tell-us-dfid-aid-bangladesh>.
- 22 http://www.paris21.org/sites/default/files/Paper_on_Data_Portals%20wcover_WEB.pdf.