

# Assessing size and structure of worldwide funds for population and AIDS activities

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## Executive summary

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Are the financial promises made in 1994 during the International Conference on Population and Development (ICPD) being fulfilled? This simple yet difficult question is the focus of the Resource Flows project of UNFPA/UNAIDS/NIDI. Monitoring progress is one of the tools which stakeholders can use to make promises stick. This report gives an insight into the size and structure of the flow of funds generated by donors and by the governments and NGOs in developing countries and countries in transition for the years 2003-2005. In addition to these flows the report also tries to construct an estimate of the funds that consumers might possibly generate. The ICPD clearly recognizes the contribution of the private sector in meeting goals of population and development but so far attempts to measure this contribution were restricted to country case studies.

The overall conclusion of this report is that on a global scale the financial targets of Cairo are not attained: the total amount of resource flows (recalculated in constant 1993 US dollars) will probably be 10 billion US constant dollars in the year 2005, whereas the goal was set at 18.5 billion US dollars. Both donors and domestic governments are still lagging behind their promises. However, there is also some good news as substantial progress can be expected in generating funds based on commitments and expected income developments in the world. The total flow of resources will increase from 14.2 billion current US dollars in 2003 to 18.5 billion current US dollars in 2005. Donors as a whole are living up to their commitment by giving more than the aimed 4 percent of ODA and in nominal terms they provide approximately one third of total generated funds.

What lies behind the development in the size and structure of funds? Four elements can be distinguished: (1) the role of consumer spending; (2) the sharing of the burden between donors and developing countries; (3) the dominance of large players; and (4) the shift towards STD/HIV/AIDS at the expense of other population activities. Each element will be elaborated in brief.

First of all, the role played by consumers is hard to track and in this report a counterfactual has been constructed to gauge the effect of out-of-pocket expenditures of consumers: if spending on population and AIDS activities is

completely in line with spending on health in general then consumers in developing countries pay more than half of the burden of the health package designed in 1994.

Second, donors seem to have lived up to their promises to a larger extent than the stakeholders in the developing countries. In real terms donors will reach a funding level at 70 percent of their attained goal set in 1994. The developing world and countries in transition will reach a funding level at 45 percent of their 1994 goal.

Three, the attainment of goals is driven to a large extent by the funding behavior of 'big players': the US on the donor side and China on the developing side. The US will fund approximately 3.2 billion (in current US dollars) in the year 2005, thereby effectively contributing more than half of the total donor contributions. And to reflect on the developing side: the Chinese government spends 1.7 billion (current US dollars) on family planning in the year 2005, thereby contributing to a third of all domestic government spending.

Four, there has been a substantial shift in spending among the various categories of the so-called 'costed population package'. Especially the US has made some firm commitments to finance HIV/AIDS projects through the PEPFAR initiative. The shift towards STD/HIV/AIDS expenditures will probably be the most dominant trend among the donor countries: in 2005 66 percent of donor funds will be allocated to STD/HIV/AIDS activities. This is in marked contrast to the targeted share for 2005 of 8 percent. The other elements of the ICPD package are therefore crowded out by the drive to fighting AIDS.

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## Acronyms and abbreviations

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BR	Basic Research
CPP	Costed-Population Package of the ICPD
DAC	Development Assistance Committee
DHS	Demographic Health Survey
EU	European Union
FC	Financial Co-operation
FP	Family Planning
FRFPAR	Financial Resource Flows for Population Activities report
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GGHE	General Government Health Expenditures
GPAR	Global Population Assistance Report
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
ICPD	International Conference on Population and Development (1994)
IMF	International Monetary Fund
IPPF	International Planned Parenthood Federation
LDC	Least Developed Countries
NAA	National AIDS Account
NGO	Non Governmental Organization
NHA	National Health Account
NIDI	Netherlands Interdisciplinary Demographic Institute
ODA	Official Development Assistance
OECD	Organization for Economic Co-operation and Development
PAI	Population Action International
PEPFAR	President's Emergency Plan For AIDS Relief
PoA	Programme of Action
PPP	Purchasing Power Parity
RF	Resource Flows
RH	Reproductive Health

RHA	Reproductive Health Account
STD	Sexually Transmitted Disease
SWAp	Sector Wide Approach
UNAIDS	Joint United Nations Program on AIDS
UNFPA	United Nations Population Fund
WB	World Bank
WHO	World Health Organization

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# 1. Introduction

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At the International Conference on Population and Development (ICPD) in Cairo 1994, donor governments, developing countries and countries in transition<sup>1</sup> committed themselves to financing population and AIDS activities. The financial target set at Cairo was to increase funding substantially in order to meet the needs of developing countries. Around the year 2000 the total resource flow needed was projected to be 17 billion US dollars and in the year 2005 this figure would have to be raised to 18.5 billion US dollars.

The Resource Flows (RF) project has collected data on financial flows for population and AIDS activities since financial year 1996. Over the past years donors as well as government departments and NGOs in developing countries have reported their disbursements in order to assess the yearly financial resource flows. Through the means of a detailed survey, information is gathered from different types of donor organizations and all developing countries and countries in transition. Because of the bottom-up approach, the Resource Flows data set gives a wealth of information on projects and programs in the field of population and AIDS. These reports in both the developed and developing world have led to an increase in knowledge of the actual disbursements and commitments.

This report will assess the size and structure of total global funds to population and AIDS activities. This includes the domestic resources in the developing countries (i.e. government funds, national NGO and private spending of all developing countries). In addition to these funds these resources are

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<sup>1</sup> We will use the term 'developing countries' throughout the text to denote not only what is traditionally understood as the developing countries or LDCs but also countries in transition.

complemented by the donor funds from OECD/DAC governments, international NGOs, foundations, UN-organizations<sup>2</sup> and development banks.

The method of using actual reported disbursements has some drawbacks. First, because of non-response and underreporting within organizations or countries, the total of reported funds does not provide us with a complete picture. This applies in particular to developing countries. An incomplete picture may seriously hamper monitoring the progress achieved in attaining the Cairo goals. The ICPD goals are stated in aggregate terms and as long as observations are missing one will never be able to tell whether the world is getting closer to the promises once made. Second, the monitoring is further restricted as the actual disbursements are often reported with a delay of two years. Actual disbursements can only be reported once the books of the financial year are closed. Yet, UNFPA and UNAIDS have indicated their increasing need for up-to-date data for resource mobilization and advocacy purposes. This report will address these two limitations and it will be done in two steps:

1. *Estimation.* In assessing the size and structure of worldwide resource flows on population and AIDS activities, we split up the analysis in estimation, which means determining by means of an econometric model the underlying coefficients of funding for population and AIDS activities in both the developed and developing world.
2. *Projection.* Based on the estimated models and coefficients of funding together with reported figures from 1996 to 2002 (and whenever possible 2003) and other sources of information, projections are presented from 2003 to 2005.

The set-up of the report is quite straightforward. First, the methodology and the results of the estimation and projection exercise for donors are presented in section 2. Section 3 will be more or less similar in nature as section 2: the estimation results and subsequently the projections for the developing countries are presented. However, the ICPD Programme of Action explicitly recognizes the role played by the private sector. Therefore, a separate subsection (3.3) will be added to reconstruct the possible role of consumer expenditures before showing the global estimate of domestic resources. In section 4, the worldwide total of financial resources for population and AIDS activities is presented. The

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<sup>2</sup> The term UN-organizations is used for both organizations and agencies that fall under the auspices of the UN.

conclusion (section 5) sums up the main results and avenues for future research, which might alleviate some of the shortcomings of the data set and the methodology applied.





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## 2. Donors

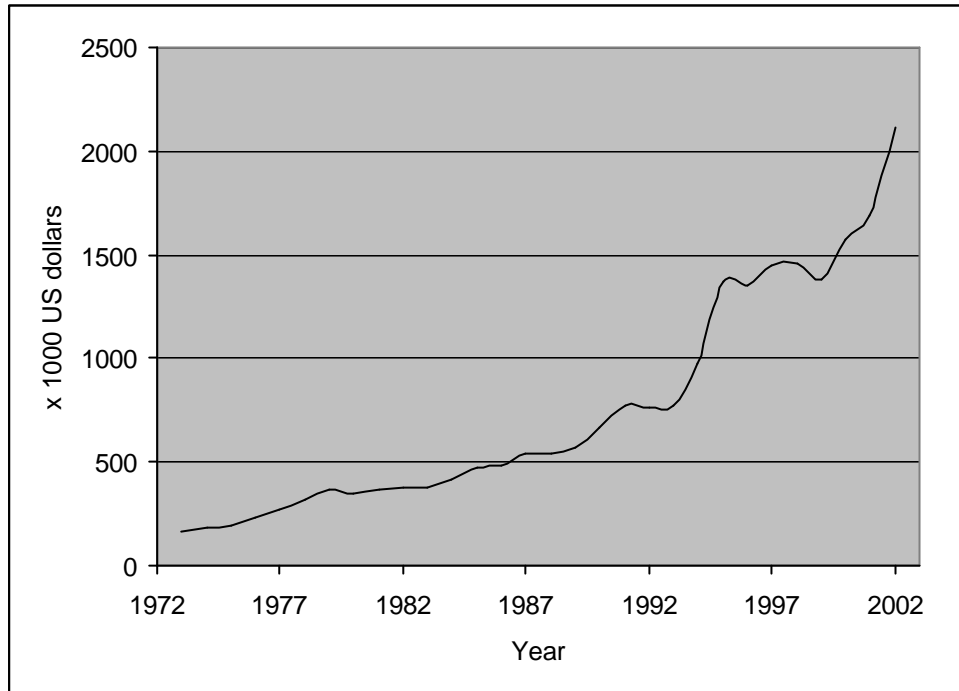
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### 2.1 Estimation of donor funding

Donors play a large role in generating funds for population and AIDS activities. At the time of ICPD the goal for donors was stated in broad terms: “The international community should strive for the fulfilment of the agreed target of 0.7 percent of GNP for overall official development assistance (ODA) and endeavour to increase the share of funding for population and development programmes commensurate with the scope and scale of activities required to achieve the objectives and goals of the Programme of Action.” The level of primary funds generated by donors has increased substantially over the last few years. Primary funds refer to the financial resources contributed by a primary donor via general contributions (for example to UN-organizations) or directly to projects/programs. For intermediate donors, such as multilateral organizations and international NGOs, primary funds only include self-generated income. Donor assistance has always been dominated by the funds provided by OECD/DAC governments. *Figure 2.1* gives an impression of how the level of primary funds (in current US dollars) has increased from 1973 to 2002. Especially since the ICPD in Cairo in 1994 the level of funds has increased substantially. The reasons behind this increase in the total of primary funds can be traced to three main sources:

- *Changing definitions.* Part of the puzzle may be the fact that definitions of funding have changed thereby making the comparison across time of the levels difficult. This applies especially to the case of the breakpoint in 1995, after the ICPD in Cairo, because starting in 1995 funding for reproductive health projects was added to the list of primary funds and the reproductive health funds comprised 23 percent of donor commitments (Bulatao, 1998). However, a breakpoint in 1995 would still not alter the general impression that over time funds are steadily increasing, and understanding the mechanisms behind this increase will help us project future funding levels.

Figure 2.1. Trends in primary funds of donor governments, 1973-2002



Source: UNFPA

- Changing number of donors.* Another explanatory factor for the increase in funds has not so much to do with the underlying mechanisms but with the fact that over time the number of OECD/DAC participants has increased. Table 2.1 gives a fair impression of what the various developed countries contribute to population and AIDS activities on a regular basis. The United States are and always have been the largest donor in absolute terms, but when the primary funds are expressed as a percentage of the GDP countries such as the Netherlands, Luxembourg, and the Scandinavian countries (Denmark, Finland, Sweden and Norway) are even more generous. Among the list of countries a few have joined recently (Greece, Spain, Portugal). Their donor contributions are relatively small compared to average contributions of other countries, hence, their contribution to the strong increase during the nineties does not carry much explanatory weight.

*Table 2.1. Overview of Primary Funds for Population and AIDS Activities  
(in 1000 current US dollars), 1996-2002*

Country	1996	1997	1998	1999	2000	2001	2002
Australia	32558	45235	44562	30530	14673	13088	21257
Austria	861	577	1784	1449	870	979	1520
Belgium	5475	9814	10148	10443	15768	19138	44101
Canada	36497	34520	38568	37212	37441	12689	82845
Denmark	63038	46990	60114	54877	44640	48852	73830
Finland	19828	17335	23114	19957	19766	23730	24353
France	16500	16500	16500	7977	12360	8242	83687
Germany	96033	122462	124806	119764	96398	108660	106763
Greece	-	-	-	-	-	13	58
Ireland	728	-	-	2673	4240	6255	11787
Italy	3607	2203	6385	10042	24921	25038	22641
Japan	93760	93760	88879	111691	130674	115346	180167
Luxembourg	1176	1176	4257	3313	10726	5627	7458
Netherlands	111707	146428	119230	115781	170077	132032	164310
New Zealand	1222	1806	2316	2316	2308	2150	3288
Norway	46125	54296	71394	61671	59957	42960	80793
Portugal	249	414	1244	440	400	689	571
Spain	7438	7438	4320	9466	6208	14380	3291
Sweden	57923	53177	78270	61602	73142	56270	61107
Switzerland	16212	16626	17818	17796	16074	23534	23403
United Kingdom	106422	117431	125934	95703	169602	80971	168803
United States	637696	662360	619729	603003	658614	951012	962969
European Union	14021	79387	79387	33400	28883	28054	184891
<b>Total countries</b>	<b>1369075</b>	<b>1529936</b>	<b>1538760</b>	<b>1411106</b>	<b>1597743</b>	<b>1719708</b>	<b>2313893</b>
Int. Foundations	92412	62784	72498	175545	250652	201620	460110
International NGOs	48111	42923	51107	64104	48053	39089	70314
UN Organizations	18037	49109	34530	31390	77289	96048	31419
<b>Total</b>	<b>1527635</b>	<b>1684751</b>	<b>1696895</b>	<b>1682145</b>	<b>1973737</b>	<b>2056464</b>	<b>2875736</b>

Source: Resource Flows database.

- *Changes in the behavior of donors.* In estimating the most important driving mechanisms behind the transfers of donor governments, one should be aware that such an analysis revolves very much around the inner workings of bureaucracies and democracies in general. The decision making units—governments—are known to be highly unpredictable as their course may change due to a change in government or a change in priorities (cf. the Global Gag Rule instituted by the US government or the increased sense of

urgency with respect to AIDS). This applies equally to developing and developed countries. Resources have to compete with conflicting goals, e.g., giving aid to population and AIDS activities in developing countries may conflict with the economic situation at home. Predicting changes in policy preferences is therefore a difficult exercise and one should be cautious in putting too much weight on the straightforward predictions that flow from such estimates. To complement the unrestricted predictions from econometric models, one should always use extraneous information, if available. Most of the donor governments provide commitments for years to come and these projected funds have therefore been used extensively in the projections exercise (see next section).

Besides donor governments, there are also other collective non-bilateral donor organizations which make contributions, to wit:

- (1) Private foundations channel privately generated funds to developing countries. The most visible foundation is the Bill and Melinda Gates Foundation.
- (2) International NGOs are another major donor category, like Marie Stopes International (MSI) and International Planned Parenthood Federation (IPPF).
- (3) UN-organizations like UNFPA, UNAIDS and UNICEF have been major organizations involved in the allocation of funds. The funds presented in table 2.1 represent only the self-generated funds of international NGOs and UN-organizations as these are intermediate organizations. This is to prevent double counting of primary funds that are channeled through the intermediates.
- (4) The development banks. For development banks only the grants are considered primary funds, as the loans have to be refunded.

To explain what is behind these trends in primary funds one can use dynamic panel estimation, a method which allows one to pool the experiences of 21 OECD/DAC countries.<sup>3</sup> Over the years 1973-2002 information is available only for the total primary funds (although the panel of donor countries was at the start of 1973 far smaller than in 2002).<sup>4</sup> For the period 1996 to 2002, the funds can be

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<sup>3</sup> The experiences of Greece and the European Union have not been included. Greece has joined the club of donors recently and in the case of the European Union it is difficult to treat it as a separate country.

<sup>4</sup> To take account of serial correlation in the time series data, we have used country-specific autoregressive terms. Serial correlation occurs when the disturbances in one

broken down by 5 subcategories: General contributions (i.e. not earmarked funds) and the four ICPD categories that are part of the so-called ICPD ‘Costed Population Package’<sup>5</sup>. To make the results comparable, we have estimated an identical reduced form equation for each of these five funding categories. As potentially explanatory variables we have included the following set of variables:

- National income level (as represented by GDP in US dollars, current prices). The idea behind using this variable to explain donor funding behavior is quite straightforward, as the level of national income might very well approximate the income (tax) base of donor governments. Both – national income and income of the government – are assumed to move in tandem over time.
- ODA as a percentage of GDP. Each and every country seems to differ in the giving of foreign aid. To gauge these differences in generosity across countries, the ODA figures are used to see how this impinges on the giving of population and AIDS assistance.
- The size of government expenditures as percentage of GDP. Another characteristic of donor governments that might affect their generosity is the size of the government sector in the respective countries. Large governments may be a sign that in these countries citizens prefer more interference of governments with economic activities and also prefer more income redistribution than smaller governments.
- The overall unemployment rate as percentage of the labor force. Commitments can be withdrawn or adjusted once a government encounters a setback. A risk which governments generally encounter is the risk of a business cycle downturn. To approximate this possibility, we include the unemployment rate. The implicit assumption is that an increase in funds will follow once the unemployment rate declines and a decrease in funds when the reverse situation applies.
- Income inequality in the respective donor countries as measured by the Gini-index. The preference for redistribution is well approximated by the (ex

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period are correlated with disturbances of one or more of the preceding periods. In the estimation exercise an AR(1) process is invoked, i.e. the current disturbance  $u_t$  depends on the disturbance of the previous period:  $u_t = \phi u_{t-1} + \varepsilon_t$  where  $\varepsilon_t$  is the fundamental random variable driving the process.

<sup>5</sup> The four ICPD ‘costed population package’ categories are: (1) Family planning services; (2) Basic reproductive health services; (3) STDs and HIV/AIDS activities; and (4) Basic research and data and population and development policy analysis.

post) income inequality in a country. The hypothesis is that governments of egalitarian countries are more willing to generate funds for population and AIDS activities as they will probably care more about the world income distribution.

- Being an EU-member (or not). The last variable is a dummy variable included in the analysis to take account of the fact that the European Union (EU) at the federal level is a separate donor. Individual EU members may perhaps decrease their funds when the EU becomes a bigger donor over time. Unfortunately, the expenditure data on the separate categories by the EU are not available over time and hence we have to do with a dummy variable. Another reason for including this dummy may be that being an EU member makes one stand out either positively or negatively from the other donor countries.
- A dummy variable representing the break in primary funds time series as a consequence of changed definitions of population and AIDS activities (to include reproductive health services) after the Cairo conference of 1994. The dummy variable takes on value 1 from 1995 onwards; before that time it has the value zero.

Table 2.2 presents the estimation results for the five separate categories and the overall level of primary funds. For each of the separate donor categories ( $D$ ) a model is estimated of the form  $D_t = \beta_1 x_{1t} + \beta_2 x_{2t} + \dots + \beta_N x_{Nt} + \varepsilon_t$ , where  $\varepsilon_t$  is the error term,  $x_i$  represents the  $N$  number of explanatory variables and  $\beta_i$  represents the set of estimated parameters which describe the extent to which a change in an explanatory variable affects the donor givings. Standard errors to evaluate whether coefficients make a statistical significant contribution are given within brackets below the estimated coefficients in Table 2.2. All variables are measured in logarithmic form, except for the two dummy variables. Three variables (ODA, government size and unemployment) are expressed in percentage form. Therefore care should be taken in interpreting the results from the estimation exercise. The data sources for the series on GDP, government size and unemployment rate are the World Bank Development Indicators (issue 2004), the Gini-index comes from the Luxembourg Income Studies databank and the population aid figures have been based on various annual reports of UNFPA on financial resource flows for population and AIDS activities, FRFPAR.<sup>6</sup>

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<sup>6</sup> Formerly known as Global Population Assistance Report (GPAR).

The general conclusion to be drawn from table 2.2 is that all the variables play some role for one of the categories of population and AIDS activities, although all the variables are not all of the time relevant in explaining funding behavior of donor governments. Naturally the level of income has the strongest impact on donor funding, and the income elasticity with respect to funding is close to 1: a one percent change in GDP is associated with a one percent change in donor funding. The elasticity varies somewhat around the value 1.1 for the various categories. However, the elasticity for the total of primary funds (column 6) is clearly below 1, which seems to contradict the elasticities of the underlying categories.

Table 2.2. Explaining donor funding (various ICPD categories)

Explanatory variables	Dependent variable: funds generated by donor countries allocated to:					
	General contributions (1)	Family planning (2)	Reproductive health (3)	STD/HIV/AIDS (4)	Basic research (5)	Total primary funds <sup>a</sup> (6)
GDP	1.09** (0.09)	1.17** (0.17)	1.15** (0.13)	1.17** (0.13)	1.07** (0.13)	0.90** (0.07)
ODA	1.02** (0.24)	-0.42 (0.46)	1.04** (0.36)	1.26** (0.42)	1.10 (0.60)	0.78** (0.15)
Government size	-0.81 (0.97)	-3.58** (1.36)	-4.12** (1.26)	-2.67 (1.53)	2.61** (1.61)	1.19* (0.59)
Unemployment	-0.52* (0.26)	-0.58 (0.46)	0.26 (0.30)	0.08 (0.38)	0.19 (0.57)	-0.36** (0.12)
Income inequality	-4.44** (1.12)	-8.72** (1.85)	-5.13** (1.56)	-4.41** (1.59)	0.53 (1.71)	-3.64** (0.94)
EU membership	-1.06** (0.14)	-0.68 (0.35)	-0.42 (0.29)	-0.57* (0.29)	-0.21 (0.33)	-1.01** (0.16)
ICPD-1994	-	-	-	-	-	0.91** (0.11)
Constant	-9.27 (5.31)	22.93* (9.40)	16.84 (8.40)	11.08 (8.04)	-21.71** (8.38)	4.34 (4.36)
N=	140	112	137	128	106	395
Log likelihood	-123.8	-164.3**	-195.5	-184.9	-176.2	-301.3

<sup>a</sup> The estimation results for the total primary funds are based on the years 1973-2002, whereas the underlying categories are available only from 1996 onwards. Standard errors are between brackets below the estimated coefficients. \* denotes significance at 5 percent level and \*\* at 1 percent significance level.

These estimates are based on the time period 1996-2002, whereas the total primary funds coefficient is based on the sample period 1973-2002. Given the fact that this last estimate is based on a more varied history one could interpret

the coefficient of 0.9 as a long-run estimate. The fact that the estimates of the underlying categories exceed this long-run estimate is an indication that donor countries may have become more sensitive to the ICPD cause in the years 1996-2002. The estimated coefficient for the foreign aid (ODA) variable is also of some interest as it gives an idea which ICPD category will profit most if governments become more generous towards developing countries. If the percentage of GDP which donor governments spend on foreign aid increases by 1 percent, STD/HIV/AIDS programs, reproductive health programs and the general contributions will benefit most and increase more or less with one percent and in the case of STD/HIV/AIDS even 1.3 percent. It will hardly affect basic research projects and family planning, which may be a reflection of the era in which the attention shifted from family planning to STD/HIV/AIDS and, to a lesser extent, to reproductive health.

The estimated parameters that measure the sensitivity of donors to vary their funding with respect to the size of their own government are puzzling. One would expect countries with a growing government sector to be more generous. The estimate for the total of primary funds (in column 6) suggests that this is true: an increase of the government size (as a percentage of GDP) in a donor country with 1 percent is associated with an increase in primary funds of 1.2 percent. However, this general rule does not apply to two of the underlying categories in the period 1996-2002, where growth of government is associated with a decrease in funding. A plausible explanation for this negative effect may be the retrenchment of the government in this specific era. A decline of the government share in the economy is seen in that light accompanied by an increase in funding on AIDS, reproductive health and general contributions and a significant decrease in funds allocated to basic research. The estimated coefficients of total primary funds in column 6 are based on a longer time series and in our opinion it is bound to be a more accurate description of how this mechanism works compared to the estimated models based on the relatively short period of 1996-2002.

The unemployment rate seems to have a negligible influence on donor funding. For the specific ICPD categories one can only detect some influence of the unemployment rate on the general contributions – a part of the donor budget in which governments have some discretionary power. The commitments to the other categories are apparently more firm and make it more difficult to change plans when the national economy is up or down. For the longer sample period which refers to total primary funds the effect of unemployment is, however,



robust and negative: a ten percent increase in the unemployment rate (e.g. from 5 to 5.5 percent of the labor force) will lead to a drop in funding of 3.6 percent.

A more robust influence in donor behavior is to be detected in the egalitarian preferences of donor countries. The more equal the income distribution (as measured by the Gini-index) in a country is, the higher the level of funds provided by the government of this country. In other words, a concern for an equal national income distribution seems to carry over to a preference for global equality, in particular in the field of the population and AIDS activities.

Finally, the two dummy variables —EU membership and ICPD-break point— offer some insight into intercountry differences and differences across time respectively, and the estimation results are quite plausible. The reason why EU-members might give less on account of their membership is that indirectly they give resources through funds at the ‘federal’ level of Europe, i.e. the European Union. As one can see from table 2.1, the amounts the EU gives to population and AIDS activities have recently become quite large and, hence, a substitution effect would be expected.

The effect of the Cairo conference is also quite plausible as population and AIDS activities have covered the expenditures on reproductive health from 1995 onwards. An upward shift in primary funds is therefore in line with this policy change.

## 2.2 Projections of donor funding

### *Donor governments*

In making projections for the years 2003-2005, we have based our calculations on the estimated coefficients of table 2.2 in conjunction with future commitments which some countries have previously made and reported in the Resource Flows survey. However, not all countries report commitments, and the construction of projections based on these two information bases —estimation driven projections and reported future commitments of governments (either commitments on the total amount and/or commitments on STD/HIV/AIDS activities)— is quite complicated. The following rules have been applied in constructing projections:

1. Whenever donor governments report future commitments we have used these numbers. Commitments are generally given for total primary funds and/or for the sub-component STD/HIV/AIDS activities.
2. In the absence of future commitments, we will use the estimation results of table 2.2 in order to construct projections. In constructing these projections we have kept the explanatory variables constant over the years 2003-2005 with the exception of the level of GDP. The projected level of GDP is based on IMF forecasts as reported in the World Economic Outlook 2004 (<http://www.imf.org/external/pubs/ft/weo/2004/02/data/index.htm>). The (unrestricted) projected growth in funds for population and AIDS activities is therefore completely driven by the growth of national income.
3. The distribution and level of primary funds over the various categories are estimated first by calculating the projected total primary funds. To make the underlying categories of spending consistent with the total we have used unrestricted projections of the separate categories as the basis for establishing a distribution per year.
4. As commitments can be highly volatile and deviate substantially from the unrestricted projections, we have used the rule to make future projections depend on the *last observed* stated funding (whether in terms of future commitments or realized funding) of a donor government. In making projections based on the combination of unrestricted projections together with commitments, we assume that projected funding levels grow smoothly. In order to establish this we have used the residual (i.e. the difference between the realized and predicted value) of the year in which a commitment or realization of funds was reported to correct the future unrestricted projections.
5. In the absence of times series data for Greece and the EU we have used the forecasted income growth together with the primary funds elasticity to project the total primary funds for these members. The distribution over the various categories is assumed to fit the average of the 21 countries in the case of Greece, and the last distribution registered (in 2002) in the case of the EU.

#### *Other donors*

For other types of donors —foundations, international NGOs, UN organizations and development banks— it is more difficult to predict the level of funding. The intentions of these donors to support population and AIDS activities are very different from the political incentives of governments. Besides, as one can see from Table 2.1, the reported figures for these donors fluctuate heavily over the

years. This is especially true for development banks, UN-organizations and international NGOs. The number of organizations reporting is low and hence, the amount of total funds depends highly on the response. The projections for these donor types are based on a rule that each category will grow with 4 percent per year after 2002, which amounts approximately to the nominal output growth forecasts in these years. One exception was made for development banks. The World Bank - being a major provider of bank grants to population and AIDS activities - reported a strong increase in its grants for 2003. As we assume this trend to continue after 2003, the estimated growth of 4 percent is only applied for 2004 and 2005 with reference year 2003, whereas for the other donors the year 2002 is the starting point for the projection.

*Table 2.3. Donor funds. 1996-2005 (in million current US dollars)*

Year	Developed countries	Foundations	Bank Grants development banks	UN system	NGO	Total funds
	(1)	(2)	(3)	(4)	(5)	Sum of (1) to (5)
1996	1369.1	92.4	7.8	18.0	48.1	1535.4
1997	1529.9	62.8	9.1	49.1	42.9	1693.8
1998	1538.8	72.5	10.4	34.5	51.1	1707.3
1999	1411.1	175.6	9.2	31.4	64.1	1691.4
2000	1597.7	250.7	0.8	77.3	48.1	1974.6
2001	1719.7	201.6	3.2	96.1	39.1	2059.7
2002	2313.9	460.1	2.0	31.4	70.3	2877.7
2003*	2644.7	478.5	27.7	32.7	73.1	3256.7
2004*	3382.6	497.7	28.8	34.0	76.1	4019.2
2005*	5221.3	517.6	29.9	35.3	79.1	5883.2

\* Projections. The funds provided by individual OECD/DAC members are presented in detail in Appendix A1.

The aggregate result of the projections is reported in table 2.3. The overall conclusion is that primary funds provided by donor governments will increase rapidly over the years from 2.6 billion US dollars in 2003 to 5.2 billion US dollars in 2005. If we include the funds provided by foundations, NGOs, bank grants, and the UN-system the total funds provided by the developed countries rises from 3.3 billion US dollars in 2003 to 5.9 billion US dollars in 2005. This is a noteworthy observation which merits some further explanation. The projected donor funds include two important sources of additional funding: the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the US President's Emergency Plan for AIDS relief (PEPFAR). Both initiatives are

captured in the developed countries' projected funds. GFATM is considered a non-UN multilateral organization and is therefore an intermediate organization. Intermediate donor channel funds from primary donors to developing countries. The funds of GFATM are included in the unearmarked contributions of developed countries' governments and, to a lesser extent, foundations.

A second important source of additional funding is the President's Emergency Plan for AIDS Relief, PEPFAR. With PEPFAR the United States commit 15 billion US dollars to STD/HIV/AIDS over the 5-year period from 2004 to 2008.<sup>7</sup> These commitments are represented in the projections of United States donor assistance, showing an impressive 3.2 billion US dollars in 2005 of which 2.5 billion US dollars for STD/HIV/AIDS expenditures (see for a breakdown for individual countries Appendix A1).

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<sup>7</sup> See President's Emergency Plan for AIDS Relief (2004).

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## 3. Developing countries

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In deriving projections for the developing countries, a similar approach to the one for the developed countries was used. There are, however, a number of provisos to be made, because the construction of projections in the case of developing countries is a far more difficult and tedious exercise on a number of counts: (1) the number of countries covered is larger than the number of OECD/DAC countries; (2) the number of countries unreported is also larger and (3) the reported time series in domestic expenditures are not continuous and extremely volatile because of different organizations within countries reporting over time. Distinguishing trends over time it is therefore quite difficult, as the number of organizations (within and across countries) reporting differs quite strongly over time. With these ‘caveat emptor’ clauses in mind this report will elaborate and discuss on the estimation and projection of spending in the developing countries.

### 3.1 Estimating expenditures in developing countries

The quality of the RF data set on population and AIDS expenditures in developing countries depends to a large extent on the reports of respondents. Many developing countries do not have an accurate administrative system to easily track health expenditures. Sometimes they also lack the personnel or financial resources to collect and provide the national expenditure information. And even when a dedicated national consultant is identified, he is very much dependent on the commitment and capacity of national health providers, both government departments and NGOs to response adequately to the survey. Because of the above mentioned reasons, the RF database does not include data covering all years for all developing countries.

In order to discover the amount developing countries would have spent and will spend in the near future on population and AIDS activities, one can rely on (1) stated preferences: What country experts and representatives of government

departments and NGOs say in questionnaires; or (2) revealed 'stated' preferences: by discovering a pattern in domestic expenditures as reported over time and across countries, one can impute values in and out of sample. By choosing the second method, one can rely on the existing sample of developing countries and use their experience to impute values for missing countries or missing observations. As long as the sample of countries represents the total sample of developing countries well, full global coverage is not a necessity. The problem with the existing database may not be its representativeness but mainly the quality of the reported data. The reported expenditure figures vary enormously because (1) country experts do not always report in a given year; (2) distinguishing the various categories of population and AIDS activities from the government budget is sometimes a tedious and arbitrary activity; and (3) over time and across countries different consultants and organizations respond to the questionnaire making it difficult to assess the quality of the data. These problems cannot be dealt with immediately. Consistent data collection over time has to show whether or not the current data give an accurate description. Across and within countries reports differ widely, but the registered volatility may perhaps be a true characteristic of government spending in those countries. Still, the ultimate objective of this estimation exercise is to extract robust estimates from the existing sample of countries. In this section we present these parameter estimates on which we base the projections (see section 3.2). In dealing with these shortcomings, two steps have been carried out.

As a first step some sensitivity analyses were performed with different samples to see whether the estimated coefficients are robust across different sub-samples. The sub-samples were defined by (1) the number of organizations reporting (i.e. only the country observations were considered in case more than 5 organizations reported), (2) leaving out extreme values, i.e. a sample in which the outliers have been left out, and (3) the maximum amount observed over the years per country, i.e. a sample in which only the maximum figures per country have been included.

It appears that the raw data (i.e. the full sample), as registered by NIDI, give a fair impression of how sensitive domestic expenditures by governments and NGOs are to some of the driving forces (such as national income). The estimated coefficients based on the sub-samples did not differ very much from the full sample estimates. Therefore, the raw data set is preferred as the basis for estimation and subsequently in offering some guidance in making out-of-sample predictions and assessing the size of expenditures in the developing world as a

whole. Needless to say, the explained variation in specific country estimates will be small as for most countries there are only a few observations, sometimes even one observation, which makes it virtually impossible to make accurate out-of-sample projections.

The second step boils down to the actual estimation of the parameters explaining the growth of spending by governments and NGOs. In estimating the parameters which might explain spending by domestic governments and NGOs, we have used four explanatory variables. The domestic expenditures on population and AIDS activities (i.e. family planning, reproductive health, STD/HIV/AIDS and basic research) depend on:

- National income (measured by GDP in US dollars);
- The foreign funds on population and AIDS activities which governments and NGOs may receive from donors on the specific category concerned. The reason for including this variable is to test the hypothesis that donor funds for specific ICPD categories crowd out domestic spending on family planning, by either governments or NGOs;
- The number of new AIDS cases per country as reported by the UN (in the UN Demographic Yearbook); and
- Regional dummies to correct for possible differences across regions in spending. We will use four region dummies (with the Sub-Saharan African region as the reference category).

Table 3.1a and table 3.1b present the estimation results for domestic governments and NGOs. All variables are measured in logarithmic form, except for the regional dummy variable. Four conclusions can be drawn from these two tables.

First of all, the income elasticity with respect to government spending (table 3.1a) in the four categories differs somewhat but is clearly different from zero, a characteristic which is clearly lacking for the NGOs (table 3.b). To some extent this is understandable as the national income development may be a good approximation of the wealth of a government but it might be a poor approximation of the wealth of domestic NGOs. These NGOs depend on other resources: multilateral and bilateral donor contributions and self-generated income. In that respect, the fact that donor contributions from abroad might have more impact on the expenditures of NGOs than it has on the expenditures of domestic governments is a plausible observation.

A second fact, which may be of interest to development aid policy makers is that donor funds *do not crowd out* national spending by governments on population and AIDS activities. A significant negative coefficient would be a sign of such an effect. The coefficients in Table 3.1a do not differ significantly from zero we cannot see any signs of such effects. In other words, additionality of funding seems to be the rule in case of foreign population aid. The same conclusion cannot yet be made for NGOs as the finance structure of domestic NGOs is more complex than that of domestic governments. External funds of NGOs can come from the national government or from international sources. Such an estimation exercise falls also outside the range of this projection exercise. By lack of a better explanatory variable, the domestic NGO expenditures in this paper will be estimated by GDP.



*Table 3.1a. Domestic government expenditures on various ICPD categories*

Explanatory variables	Dependent variable: domestic expenditures by governments on:			
	Family planning	Reproductive health	STD/HIV/AIDS	Basic research
GDP	0.92** (0.16)	0.77** (0.16)	0.64** (0.16)	0.85** (0.13)
Donor funds on exp. category	0.16 (0.11)	-0.02 (0.12)	0.08 (0.10)	0.04 (0.10)
Number of new AIDS cases	0.00 (0.11)	-0.03 (0.11)	0.16 (0.11)	-0.03 (0.09)
<i>Regions:</i>				
Asia and the Pacific <sup>a</sup>	1.71* (0.79)	1.79* (0.73)	1.14 (0.78)	-0.38 (0.64)
Latin America and the Caribbean <sup>a</sup>	0.27 (0.85)	1.31* (0.67)	0.61 (0.71)	-0.03 (0.60)
Western Asia and North Africa <sup>a</sup>	1.19 (0.85)	1.64* (0.80)	0.37 (0.90)	-0.19 (0.69)
Eastern and Southern Europe <sup>a</sup>	-0.71 (1.03)	0.18 (0.97)	0.82 (0.98)	-1.29 (0.87)
Constant	-10.46** (1.94)	-6.79** (1.85)	-6.20** (2.03)	-6.23* (2.76)
N =	197	190	184	199
R <sup>2</sup>	0.58	0.51	0.39	0.40

a Sub-Saharan Africa is the reference category.

A third noteworthy observation is the fact that the variable ‘AIDS cases’ does not lead to a significant increase in spending across the national governments and results in a weak increase in the case of domestic NGOs. The discussion of this effect warrants some additional comments. The effect could be interpreted to mean that domestic governments and NGOs are to a large extent incapable of generating extra funds in the face of increases in new AIDS cases. However, this simple interpretation would suggest that governments act after the fact: first, AIDS cases have to increase before funding of health care starts. The absence of a strong positive correlation between AIDS cases and AIDS spending could also mean that farsighted and nearsighted governments are lumped together in one sample pool. The farsighted governments who spend substantially on AIDS programs may perhaps be the countries where the AIDS prevalence is low and the shortsighted governments who start spending on AIDS once the epidemic has become real. In other words, one can have countries where the relationship is negative and others where the relationship is positive. Distinguishing both cases is a research project that falls outside the scope of this paper. We merely

note that AIDS prevalence in various countries is a poor predictor of AIDS spending.

*Table 3.1b. Domestic NGO expenditures on various ICPD categories*

Explanatory variables	Dependent variable: expenditures by domestic NGOs on:			
	Family planning	Reproductive health	STD/HIV/AIDS	Basic research
GDP	0.19 (0.10)	0.30** (0.07)	0.20 (0.11)	0.38** (0.11)
Donor funds on exp. category	0.21** (0.07)	0.19** (0.05)	0.16** (0.06)	0.17* (0.08)
Number of new AIDS cases	0.14* (0.07)	0.11* (0.05)	0.17** (0.07)	0.00 (0.08)
<i>Regions:</i>				
Asia and the Pacific <sup>a</sup>	0.37 (0.53)	0.38 (0.36)	0.49 (0.52)	-0.18 (0.54)
Latin America and the Caribbean <sup>a</sup>	0.62 (0.45)	0.58* (0.32)	-0.11 (0.46)	0.86 (0.48)
Western Asia and North Africa <sup>a</sup>	0.72 (0.59)	0.05 (0.41)	-0.03 (0.64)	0.21 (0.63)
Eastern and Southern Europe <sup>a</sup>	-0.60 (0.68)	-0.99** (0.50)	-0.16 (0.67)	-1.48* (0.77)
Constant	-0.15 (1.31)	-1.54 (0.88)	-0.49 (1.36)	-3.26* (1.39)
N =	212	212	201	182
R <sup>2</sup>	0.42	0.50	0.38	0.35

(a) Sub-Saharan Africa is the reference category

Fourth and finally, for some of the categories substantial differences across regions can be detected. E.g., family planning spending is far higher in Asia, which is significantly driven by the fact that the government of the People's Republic of China spends a substantial sum on family planning.

### 3.2 Projections of domestic expenditures, 2003-2005

Projection of the domestic expenditures will be done in a rudimentary fashion as the number of explanatory variables per country is limited and because the most influential variable in this regard is the national income as measured by the level of GDP. GDP-figures are available on a worldwide scale, so we can also use the estimation outcomes as an input for predicting expenditures of countries which

have not reported expenditures or are not included in the questionnaire sample. The predicted GDP figures for the years 2003-2005 are based on the predictions made by the IMF as reported in its latest World Economic Outlook. The other explanatory variables —donor funding on the various categories and new AIDS cases— have been left out the analysis because of their poor or weak predictive power. Based on a rudimentary model with the level of GDP as an explanatory variable, regional dummies and a dummy variable for the family planning government expenditures of China (as this represents one of the biggest outliers in this category) we calculate the expenditures of NGOs and domestic governments.

The estimation results described in section 3.1 give a very rough indication of government and NGO spending for each of the categories per region. However, individual countries may reveal a spending pattern that differs markedly from the reconstructed spending figures based on parameter estimates. Just like in the case of donor countries, priorities may shift over time due to the emergence or the threat of, for example, the AIDS epidemic. To use primary and secondary information as much a possible we will apply the following hierarchical set of rules for making projections for both governments and NGOs.

1. If available, reliable secondary sources on national spending for any of the categories for the years 2003, 2004 or 2005 are used. This information comes directly from country experts or, for example, from the National AIDS Accounts (NAAs). Although we consider the latter information source as more reliable than the reports of national consultants, the coverage of NAAs is still very poor.
2. If no reliable secondary sources are available, the reported figures from the past are used to project future expenditures. The past could mean any year before 2003. In some cases, there are expenditures available for the year 2003 and in that case this figure will, of course, be used. The use of reported expenditures in constructing projections differs per category in the following way:
  - Family Planning (FP). As the trend over time clearly shows a decline in expenditures allocated to family planning, we will take the *most recent* reported FP expenditures figure of a country as its projection for 2003.
  - Reproductive Health (RH): For reproductive health the trend has been fairly stable from 1996 to 2003. Therefore, we will take *the average* of the reported RH expenditures of a country as a projection for 2003.

- STD/HIV/AIDS (AIDS): Since the expenditures on AIDS have shown a steep increase over the past few years, the most recent observation would give the best impression of AIDS spending in 2003. However, if the most recent figure has been underreported (for example if the National AIDS Control Program has not replied), the country's reported figure may be an underestimation of the true capacity to fund AIDS projects. Therefore, the *highest ever reported* funds on AIDS are preferred as the basis for a projection for 2003, assuming that this shows the maximum in-country funding capacity for AIDS activities.
  - Basic Research (BR): The occurrence of population censuses - which constitute one of the most important parts of the basic research category - can boost reported spending figures for basic research quite strongly. Given that population censuses do not occur regularly, this fact makes it difficult to predict per country spending on this category. We therefore take the *average reported* figures per country to smooth the volatile character of this expenditure category. This means that, although global and regional basic research figures are very close to what has been reported in a particular year, the per country estimates might not give a fair picture of national BR spending in that year.
3. The projections for the years 2004 and 2005 are based on the combination of unrestricted projections together with secondary sources (or reported information). We assume that projected funding levels grow smoothly and in order to establish this we will use the residual derived from the difference between the last reported information and the unrestricted projections. This is the same approach as followed in the case of donor governments. In absence of secondary information, the growth in funds in 2004 and 2005 is completely driven by developments in national income growth.

Table 3.2. Estimates of Government and NGO expenditures for population activities, by region and category of activity, 2003-2005 (thousands current US dollars)

2003	Government				NGO				Total
	Family planning services	Basic reproductive health services	STD/HIV/ /AIDS activities	Basic Research	Family planning services	Basic reproductive health services	STD/HIV/ AIDS activities	Basic Research	Total expenditures
Africa (sub-Saharan)	66.947	13.411	127.076	21.977	16.896	10.017	43.868	2.334	302.527
Asia and the Pacific	2.051.383	472.050	294.982	117.242	20.823	14.719	30.554	3.715	3.005.467
Latin America and the Caribbean	33.024	86.126	714.222	45.788	25.722	13.574	56.960	4.659	980.077
Western Asia and North Africa	80.642	80.919	38.635	35.221	10.880	8.650	9.121	2.528	266.595
Eastern and Southern Europe	15.409	54.324	65.791	14.155	2.616	577	4.855	187	157.914
<b>Total</b>	<b>2.247.405</b>	<b>706.829</b>	<b>1.240.706</b>	<b>234.384</b>	<b>76.938</b>	<b>47.537</b>	<b>145.358</b>	<b>13.423</b>	<b>4.712.580</b>
<b>2004</b>									
Africa (sub-Saharan)	72.141	16.396	155.128	33.997	25.146	17.263	87.073	3.994	411.139
Asia and the Pacific	2.183.636	543.473	386.051	154.889	32.196	29.240	63.151	6.675	3.399.310
Latin America and the Caribbean	59.380	107.178	720.891	69.732	35.328	22.759	72.886	6.606	1.094.761
Western Asia and North Africa	110.851	96.633	52.126	46.065	16.341	14.037	15.169	3.666	354.888
Eastern and Southern Europe	35.197	59.312	91.408	19.294	3.408	1.156	9.652	345	219.773
<b>Total</b>	<b>2.461.204</b>	<b>822.993</b>	<b>1.405.605</b>	<b>323.977</b>	<b>112.418</b>	<b>84.454</b>	<b>247.931</b>	<b>21.287</b>	<b>5.479.870</b>
<b>2005</b>									
Africa (sub-Saharan)	72.881	16.621	136.735	34.861	25.479	17.596	88.988	4.065	397.225
Asia and the Pacific	2.208.927	551.073	417.602	158.859	32.779	30.042	64.854	6.821	3.470.957
Latin America and the Caribbean	61.113	108.532	723.090	71.211	35.675	23.135	73.470	6.678	1.102.903
Western Asia and North Africa	114.814	98.310	53.718	47.188	16.621	14.340	15.492	3.724	364.208
Eastern and Southern Europe	38.030	59.950	94.965	19.936	3.464	1.202	10.030	357	227.934
<b>Total</b>	<b>2.495.764</b>	<b>834.486</b>	<b>1.426.110</b>	<b>332.054</b>	<b>114.019</b>	<b>86.315</b>	<b>252.834</b>	<b>21.646</b>	<b>5.563.227</b>

4. In case there are no secondary information sources available and the country has never reported figures to the RF project, the projection will be solely based on the unrestricted projections explained in section 3.1. This is the case for 66 developing countries.

The projections show a steady increase of funds for almost all categories and regions. The increase is however stronger between 2003 and 2004 than between 2004 and 2005. Two remarks should be made concerning these results.

First, as a rule the NAA data for STD/HIV/AIDS are higher than the figures reported by national experts or consultants to the RF project. Since NAA data are available for almost all Latin American countries, the projections in this region are mainly based on NAA data while for other regions the reported figures and unrestricted projections are the only guideline for the future. Hence, the relatively high level of STD/HIV/AIDS spending in Latin America might be the result of using different sources of information.

*Table 3.3. Projected Regional GDP levels 2003-2005*

Region	Year	GDP (in current billion US dollars)
Africa (sub-Saharan)	2003	405
	2004	457
	2005	494
Asia and the Pacific	2003	8737
	2004	9629
	2005	10087
Latin America and the Caribbean	2003	1758
	2004	1948
	2005	2052
Western Asia and North Africa	2003	1114
	2004	1289
	2005	1356
Eastern and Southern Europe	2003	12219
	2004	13915
	2005	14535

Source: IMF World Economic Outlook (2004).

Second, in case no secondary information is available, the projections are solely driven by growth in national income. These growth rates for the years 2003-

2005 are based on IMF forecasts as reported in the World Economic Outlook. As one can deduce from table 3.3, especially the growth for Sub-Saharan Africa is strong between 2003 and 2004 and this explains in part why spending on population and AIDS activities goes up substantially between 2003 tot 2004. The fact that the spending in Sub-Saharan Africa drops between 2004 and 2005 is a result of using NAA-figures as the preferred source of information. The NAA for Kenya projects a decline in STD/HIV/AIDS expenditures of 20 million US dollars between 2004 and 2005 (see also Appendix A2), which clearly influences the regional total.

### 3.3 Accounting for consumer expenditures in developing countries

Private consumer expenditures on health care are known to constitute a substantial part of the total spending on health care (WHO, 2004). Still, not much is known about the worldwide flow of health care spending on population and AIDS activities (cf. McGreevey, 2003, Rosen and Conly, 1999, and Hanson et al., 2001). A preliminary estimate was once given for the case of family planning spending in 1995 by Conly *et al.* (1995) based on a mixture of data sources in 79 developing countries. Of the total of 3.1 billion US dollars spent on family planning in the developing countries, 14 percent was financed by consumers.

Table 3.4. Earlier estimate of family planning expenditures by region and source of financing based on 79 countries

	Government		World Bank		Donors		Consumers		Total
	\$	%	\$	%	\$	%	\$	%	\$
	millions		millions		millions		millions		millions
All developing countries	2035.4	65.4	217.0	7.0	433.6	13.9	426.7	13.7	3112.7
East and Southeast Asia	1469.1	88.1	27.2	1.6	58.1	3.5	114.0	6.8	1668.4
China	1229.7	98.9	0.0	0.0	14.0	1.1	na	na	1243.7
South Asia	334.0	55.2	143.8	23.8	94.1	15.6	32.8	5.4	604.7
India	255.0	70.7	64.9	18.0	35.6	9.9	5.1	1.4	360.6
Latin America	107.0	27.8	7.8	2.0	82.9	21.6	186.6	48.6	384.2
Sub Saharan Africa	63.1	28.4	28.4	10.1	152.4	53.9	38.6	13.7	282.5
North Africa and West Asia	62.2	36.0	9.8	5.7	46.2	26.7	54.7	31.6	172.9

Source: Conly *et al.* (1995: 10-11).

Table 3.4 presents in short the figures on which the often cited 14 percent was based (cf. Potts, et al., 1998). Conly *et al.*, relied for a number of countries on the questionnaire which PAI sent out to country experts who provide data on contraceptive sales through fully commercial or social marketing channels, but they also used in-depth countries analysis on the finance of family planning and UNFPA reports. In most countries information was simply lacking and consumer spending was reconstructed by a combination of DHS and demographic data provided by the UN Population Division. However, even then Conly *et al.*, stated that their estimates would probably underestimate the true private spending figure, as the contraceptive price information used to reconstruct spending represents the low end of the scale. Moreover, in most countries fees charged by private health care providers for contraceptive services could not be easily captured and on that count also present a factor of underestimation.

In light of the ICPD agenda the estimate presented by Conly et al. (1995) does not offer an appropriate benchmark as it mainly concentrates on family planning and not on categories such as reproductive health care and AIDS. Furthermore, it did not obtain any information on private spending in China even though they state that “in China and Vietnam [...] consumer expenditures on family planning are believed to be relatively negligible”. China is, however, the country with the highest aggregate spending on family planning in the world. A similar message was brought across in a report on China by Exterkate (2000): more than 98 percent of contraceptives are provided by the public sector. However, three comments are warranted at this point. First of all, Exterkate (2000) acknowledges that a different picture might emerge if one looks at the local (government) level, where consumer spending plays a larger role than at the central level. Second, the fact that family planning and reproductive health care is publicly provided is certainly not proof of an absence of private spending. Public health care can be designed in such a manner that consumers pay through user fees for health care. Third, it turns out that economic and fiscal reforms move fast in China and that the distribution in public and private responsibilities in health care finance has reversed the situation that existed twenty years ago: in 1980 16 percent of health care spending was covered by households and in 2001 this percentage has become 61 percent (Zhang and Kanbur, 2003).



*Per country private expenditures on STD/HIV/AIDS*

Special attention should be paid to the private expenditures of specific ICPD categories, in particular private spending on STD/HIV/AIDS. National Health Accounts (NHA) estimate the percentage of private expenditures on health in general, but it is highly probable that private expenditures on specific health related activities like STD/HIV/AIDS show a very different pattern or distribution. Probably the best source of information on national private spending on population and AIDS are the NAAs and the NHA sub-analysis for HIV/AIDS or for Reproductive Health. The few sources of information on private spending reveal a great diversity between countries. Besides, the share of private spending can also change drastically over a short period of time, as the case of Rwanda has shown. To get a feeling for how strong the differences can be across countries table 3.5 shows some figures on out-of-pocket expenditures. These figures are based on NAAs and in some cases on a HIV/AIDS sub-analysis of National Health Accounts.

*Table 3.5. Share of out-of-pocket expenditures of total STD/HIV/AIDS spending*

Country	Year	% OOP of total STD/HIV/AIDS expenditures
Argentina	2002	10
Chile	2002	41
Ghana	2003	7
Honduras	2001	62
Kenya	2002	45
Rwanda	1998	93
Rwanda	2002	13
Thailand	2003	2 <sup>a</sup>
Zambia	2002	29

a Preliminary data.

Source: UNAIDS.

Table 3.5 shows that out-of-pocket expenditures for STD/HIV/AIDS can differ tremendously between regions and countries. This makes it extremely difficult to extrapolate these figures to all other countries that do not have NAAs yet. For the other three categories projections of private expenditures are even more complicated as information is simply lacking. In constructing an estimate for the private sector we have taken the national health account figures, as collected by the WHO and presented in its World Health Reports.

Table 3.6 presents in short for our distribution of regions the extent of public and private spending on health care for the years 1997-2001. Although one can detect some trends in the distribution, the movement is too slight to be trusted as a true trend. A robust conclusion one can draw from this table is that private spending plays a large role in Sub-Saharan Africa and Asia, and these are the regions where most of the attention in population and AIDS activities is focused. The private health care spending in more developed regions is less pronounced and more in line with spending levels in OECD/DAC countries where 36 percent of health care spending is covered by the private sector.

*Table 3.6. Public-private distribution in health expenditures in developing countries (percentages), 1997-2001*

Regions	Categories	1997	1998	1999	2000	2001	average 1997-2001
Sub-Saharan Africa	Government	37.6	38.2	37.9	39.3	41.3	38.9
	Private	62.4	61.8	62.1	60.7	58.7	61.1
Asia	Government	31.6	32.6	31.8	31.2	31.5	31.7
	Private	68.4	67.4	68.2	68.8	68.5	68.3
Latin America	Government	47.7	49.6	49.7	49.4	49.3	49.2
	Private	52.3	50.4	50.3	50.6	50.7	50.8
North Africa/Middle East	Government	53.8	53.9	52.8	53.0	54.8	53.7
	Private	46.2	46.1	47.2	47.0	45.2	46.3
Europe (non-OECD)	Government	73.0	70.1	68.4	70.7	70.2	70.5
	Private	27.0	29.9	31.6	29.3	29.8	29.5

Source: WHO (2004, <http://www.who.int/whr/2004/annex/en/>) and own calculations, percentages are weighted for population size of countries.

However, in order to understand what the WHO precisely defines as public and private sector, the WHO-definitions on public and private health care spending are reiterated at this point. For the case of health care spending on population and AIDS activities it would seem that the category that would interest us most are the out-of-pocket expenditures made by consumers, as these resources compete directly with other private spending categories. Out-of-pocket spending is also the category that is at the focus of attention in policy initiatives and debates about reducing poverty and income inequality in the developing world.

According to WHO (2004) general government health expenditures (GGHE) include outlays earmarked for the enhancement of health status of population

segments and/or the distribution of medical care goods and services among population segments by:

- Central/federal, state/provincial/regional, and local/municipal authorities.
- Extra-budgetary agencies, principally social security schemes, which operate in several countries.
- External resources (mainly grants and credits with high grant components to governments).

The private expenditures on health have been defined by the WHO as the sum of expenditures by the following entities:

- Prepaid plans and risk-pooling arrangements: the outlays of private and private social (with no government control over payment rates and participating providers with broad guidelines from government) insurance schemes, commercial and non-profit (mutual) insurance schemes, health maintenance organizations, and other agents managing prepaid medical and paramedical benefits.
- Household out-of-pocket spending: the direct outlays of households, including gratuities and in-kind payments made to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services, whose primary intent is to contribute to the restoration or the enhancement of the health status of individuals or population groups. This includes household payments to public services, non-profit organizations or NGOs and non-reimbursable cost sharing, deductibles, co-payments and fee-for-service. It excludes payments made by enterprises which deliver medical and pharmaceutical benefits, mandated by law or not, to their employees and payments.
- Firms's expenditures on health: outlays by public and private enterprises for medical care and health-enhancing benefits other than payment to social security.
- Non-profit institutions serving mainly households: resources used to purchase health goods and services by entities whose status does not permit them to be source of income, profit or other financial gain for the units that establish, control or finance them. This includes funding from internal and external sources.

The last two categories are not present in full by the WHO and are presented in table 3.7 as 'other private spending'. As mentioned earlier, we are mainly

interested in the out-of-pocket expenditures made and one can deduce from table 3.7 that this type of spending is highest in Latin America.

*Table 3.7. Per capita expenditures on health in developing countries, 1997-2001 (at international dollar exchange rates)<sup>a</sup>*

Regions	categories	1997	1998	1999	2000	2001	average 1997-2001
Sub-Saharan Africa	Government <sup>b</sup>	29.6	27.5	26.9	27.2	28.3	27.9
	External sources	4.0	5.3	5.4	6.5	6.9	5.7
	Out-of-pocket	22.8	25.0	24.0	24.5	25.8	24.4
	Prepaid plans	20.2	20.3	21.3	21.6	21.1	20.9
	Other private spending	3.1	3.0	3.2	3.2	4.4	3.4
Asia	Government <sup>b</sup>	38.1	41.6	44.9	48.6	53.9	45.5
	External sources	1.5	1.6	2.0	2.2	1.6	1.8
	Out-of-pocket	65.9	69.5	78.2	87.7	94.9	79.5
	Prepaid plans	2.1	2.5	3.0	3.5	3.8	3.0
	Other private spending	3.9	4.2	4.6	5.0	5.1	4.6
Latin America	Government <sup>b</sup>	214.1	220.8	232.8	229.6	240.3	227.7
	External sources	2.7	3.6	4.0	3.8	3.6	3.5
	Out-of-pocket	179.4	173.6	181.6	181.2	192.0	181.7
	Prepaid plans	58.9	58.6	62.1	66.4	69.7	63.2
	Other private spending	5.2	5.7	5.8	6.2	5.7	5.7
North Africa/Middle East	Government <sup>b</sup>	160.3	167.6	163.8	168.4	180.2	168.2
	External sources	1.3	1.5	1.2	1.4	1.4	1.3
	Out-of-pocket	91.1	98.2	105.6	109.0	111.0	103.2
	Prepaid plans	7.5	8.1	8.1	8.2	8.2	8.2
	Other private spending	6.7	7.1	7.2	8.2	8.9	7.7
Europe (non-OECD)	Government <sup>b</sup>	258.9	255.5	249.0	274.1	297.9	267.0
	External sources	1.8	3.5	8.2	8.0	8.0	5.9
	Out-of-pocket	80.9	94.5	100.4	99.1	108.8	96.7
	Prepaid plans	6.6	7.2	6.4	6.3	6.6	6.6
	Other private spending	7.5	7.5	6.5	5.9	7.3	6.9

Source: WHO (2004) and own calculations, per capita figures are weighted for the population size of respective countries.

<sup>a</sup> The international dollar values are derived by dividing local currency units by an estimate of their purchasing power parity (PPP) compared to US dollars, i.e. a rate or measure that minimizes the consequences of differences in price levels existing between countries.

<sup>b</sup> Government expenditures as presented in this table exclude the external resources as measured by WHO. External resources are presented here separately.

However, in comparing out-of-pocket spending to the spending level by the government in the various regions it is clear that the out-of-pocket spending is highest in Asia.

### **3.4 A projection of global domestic resource flows**

In this section we sum up all the projections of developing countries by region and by source. The inclusion of projections of consumer spending merits some explanation as precise information on this category is sadly lacking. The consumer expenditures are reconstructed by using the assumption that the out-of-pocket health expenditures of households in developing countries are completely in line with their out-of-pocket expenditures on population and AIDS activities. The consumer expenditures per region are derived from table 3.2 for the total government expenditures. For every region we have used the ratio of private out-of-pocket versus government expenditures of table 3.7 and applied this to the aggregate government figure of table 3.2. The reason for using government expenditures as the benchmark for our calculation is that this category seems to be more accurately registered by WHO than NGO spending.

Table 3.8 presents the final outcomes per region for the years 2003-2005. As one can deduce from the table, consumer spending represents the largest part of resources spent on population and AIDS activities and given the fact that the ratio is fixed, consumer spending developments over time simply follow the government spending projections. The domestic resources spent on STD/HIV/AIDS activities are presented in the last column. In general one can say that 25 percent of the total domestic resources goes to STD/HIV/AIDS activities. However, there are clear exceptions to this rule. Sub Saharan Africa and Latin America are regions in which more than half of the total amount of resources goes to STD/HIV/AIDS. Part of this dominance can be explained for Latin America as being the result of more reliable observations generated from NAAs. For Sub-Saharan Africa the shift towards STD/HIV/AIDS must be to some extent the result of the threat of the AIDS pandemic.

*Table 3.8. Projection of global domestic expenditures on population and AIDS activities, 2003-2005 (in 1000 current US dollars)*

Year	Funds provided for population and AIDS activities by:				
	Government	NGO	Consumers <sup>a</sup>	Total	Of which spent on STD/HIV/AIDS
	(1)	(2)	(3)	(4)	(5)
<b>2003</b>					percentage of total
Africa (sub-Saharan)	229.411	73.116	200.735	503.262	56.1
Asia and the Pacific	2.935.656	69.811	5.128.592	8.134.059	10.3
Latin America and the Caribbean	879.161	100.916	701.570	1.681.647	79.8
Western Asia and North Africa	235.416	31.179	144.546	411.141	17.4
Eastern and Southern Europe	149.679	8.235	54.184	212.098	44.5
<b>Total</b>	<b>4.429.324</b>	<b>283.256</b>	<b>6.229.626</b>	<b>10942206</b>	<b>24.0</b>
<b>2004</b>					
Africa (sub-Saharan)	277.663	133.476	242.955	654.093	57.8
Asia and the Pacific	3.268.048	131.262	5.709.281	9.108.591	12.3
Latin America and the Caribbean	957.181	137.580	763.830	1.858.591	73.7
Western Asia and North Africa	305.676	49.212	187.685	542.573	18.3
Eastern and Southern Europe	205.211	14.562	74.286	294.059	45.6
<b>Total</b>	<b>5.013.779</b>	<b>466.091</b>	<b>6.978.037</b>	<b>12457907</b>	<b>24.9</b>
<b>2005</b>					
Africa (sub-Saharan)	261.097	136.128	228.460	625.685	55.2
Asia and the Pacific	3.336.461	134.496	5.828.797	9.299.753	13.0
Latin America and the Caribbean	963.946	138.957	769.229	1.872.132	73.4
Western Asia and North Africa	314.030	50.178	192.815	557.023	18.3
Eastern and Southern Europe	212.881	15.054	77.063	304.997	45.7
<b>Total</b>	<b>5.088.414</b>	<b>474.813</b>	<b>7.096.363</b>	<b>12659590</b>	<b>25.1</b>

<sup>a</sup> Consumer spending on population and AIDS activities covers only out-of-pocket expenditures and is based on the average amount per region as measured by the WHO (2004) for health care spending in general. For every region we have used the ratio of private out-of-pocket versus government expenditures of Table 3.7 to derive consumer expenditures in the case of population and AIDS activities.

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## 4. Worldwide projection of funds for population and AIDS activities

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The figures presented so far offer an opportunity to gain some insight into the question whether the world as a whole will reach the targets it once set at the ICPD in Cairo in 1994. The financial targets of the Cairo-conference in 1994 are presented in table 4.1. At that moment in time the Programme of Action stated: “It is tentatively estimated that up to two thirds of the costs will continue to be met by the countries themselves and in the order of one third from external sources, with considerable variations between and within regions. In order to meet and reinforce social development goals and satisfy previously undertaken intergovernmental commitments, governments are urged to devote an increased proportion of their public-sector expenditures to the social sectors, stressing in particular poverty eradication in the context of sustainable development.” The developed world and the developing world have a shared responsibility in achieving these goals. In reviewing the financial goals of ICPD the aggregate goal is first reviewed, and subsequently the role of donors and developing countries, and finally the goals set with respect to the distribution across population activities is discussed.

*Table 4.1. Financial resources needed to address demographic challenges  
(in billion US dollars)*

Year	Donor Assistance	Domestic Resources	Total Resources
2000	5.7	11.3	17.0
2005	6.1	12.4	18.5
2010	6.8	13.7	20.5
2015	7.2	14.5	21.7

Source: ICPD Programme of Action.

*Total level of funds*

The ICPD Programme of Action does not explicitly state whether the targets, as mentioned in Table 4.1, are in current or in constant dollars. Only for donors it is stated under paragraph 14.11 that the complementary resource flows should be expressed in 1993 US dollars. It stands to reason that one should express the funds of developing countries in the same 1993 US dollars. With hindsight it makes sense to state goals in the constant dollar terms as one would like to be able to buy the same health package across time, but it remains something of a puzzle why conference participants at that time were not more specific in defining the financial terms like the use of constant dollars and the exchange rate at which local currency units should be transferred into US dollars.

*Table 4.2. Worldwide projection of expenditures on population and AIDS activities (billion US dollars, current and constant), 2003-2005*

Year	Total donor assistance	Domestic resources			Total donors and domestic resources <sup>a</sup>
		Government	NGO	Consumers	
In current US dollars					
2003	3.3	4.4	0.3	6.2	14.2
2004	4.0	5.0	0.5	7.0	16.5
2005	5.9	5.1	0.5	7.1	18.5
In constant US dollars (1993 = 100) <sup>b</sup>					
2003	2.6	2.0	0.1	3.1	7.8
2004	3.1	2.2	0.2	3.3	8.8
2005	4.4	2.1	0.2	3.3	10.0

a Due to rounding errors the total may not always be the sum of the underlying components.

b Projected total donor resources stated in current US dollars are deflated by the US consumer price index and all domestic resources are deflated by national inflation indices. The data source used is the World Economic Outlook..

In evaluating the aggregate result in constant 1993 dollars, it becomes clear that the ICPD goal will not be reached in 2005.<sup>8</sup> In table 4.2 the aggregate results are

<sup>8</sup> In translating the current dollars into constant 1993 dollars one can use a number of assumptions. The present report has used the crude assumption that donor flows are completely mobile and the current dollar exchange rate has covered all existing inflation differences between countries, hence the value of US inflation rate can be used to calculate the sum in constant dollars. For developing countries, the resource flows are assumed to be immobile and local inflation conditions matter and therefore the national



presented both in constant and current US dollar rates. In 2005, donors will probably fund 4.4 billion US dollars (constant 1993 prices) compared to the target of 6.1 billion US dollars. And developing countries reach 5.6 billion US dollars in 2005 instead of the needed 12.4 billion US dollars.

### *The Role of Donors*

In the early 1990s, it was agreed that the international community should not only strive to achieve the agreed target to give 0.7 percent of their gross national product as ODA, but they should also consider meeting the generally accepted target of devoting 4 per cent of their ODA-funds to population and AIDS activities.<sup>9</sup> For 2003 the projected percentage of OECD/DAC funds to population and AIDS as a share of ODA amounts to 3.9 percent.<sup>10</sup> However, considering the expected steep increase in STD/HIV/AIDS funds in the years 2004 and 2005, it is also expected that the share will easily surpass the 4 percent target.

In real and nominal terms substantial progress has been realized over the years. By taking the long view and recalculating the primary funds of donor governments of OECD/DAC members in constant 1993 US dollars, one can see from figure 4.1 that the projected funds for the years 2003-2005 deviate strongly from the past. One can also see the break around 1994 in the time series, which is in part a result of a change of definitions of what constitutes population activities. But overall, the year 2002 marks the beginning of an upward drive towards funding. It is, however, clear from the underlying data and commitments from donors that the AIDS pandemic is a major driving force and the strong increase is on that count accompanied with mixed feelings.

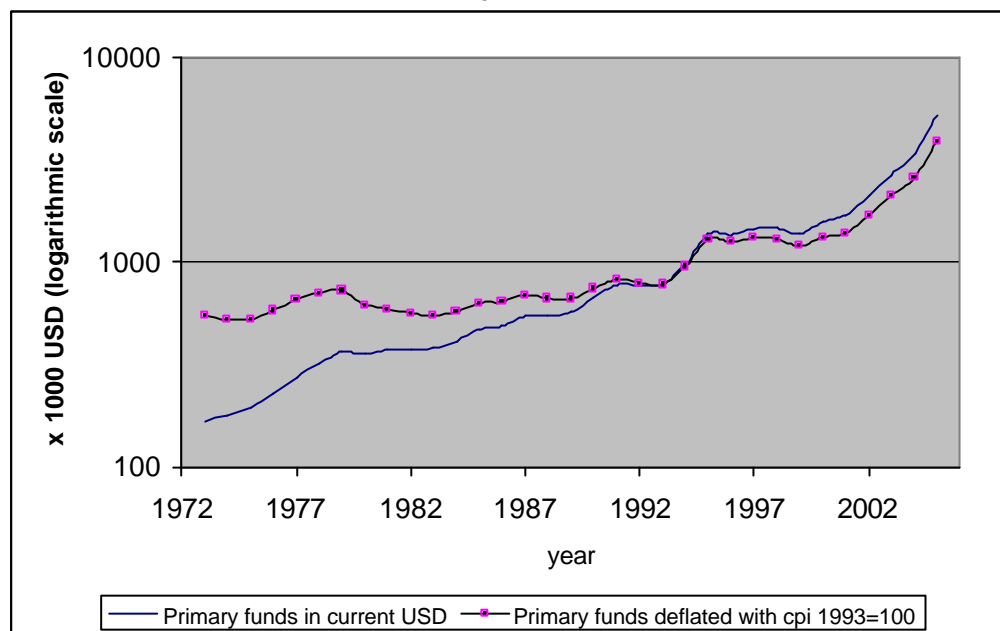
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inflation rates in these countries have been used to make the necessary calculations to arrive at amounts stated in 1993 constant dollars.

<sup>9</sup> United Nations Economic and Social Council, Partnerships and Resources, Resource Mobilization in the ESCAP region, Bangkok 2002.

<sup>10</sup> Donor funds of OECD/DAC countries (2.6 billion US dollars) as a percentage of total ODA of all OECD/DAC countries (68.5 billion US dollars, source: OECD/DAC database).

Figure 4.1. Primary funds of donor governments in constant 1993 and current dollars, 1973-2005 (logarithmic scale)



A more important question is whether donors have carried their weight in supporting the ICPD goals. It was stated that donors should finance one third of the total predicted expenditures. In 2005 this goal would be attained in nominal terms. In real terms, the donor community attains even a higher share, viz. 44 percent of the projected 10 billion dollars are financed by donors.

#### *The Role of Developing Countries*

The ICPD Programme of Action encourages governments, NGOs, private sector and local communities, assisted upon request by the international community to strive to mobilize and effectively utilize resources for population and development programs (paragraph 3.22 of the PoA). Of these resources, two third of the stated targets should be raised by developing countries. The results of this report show that in nominal terms the burden of developing countries decreases between 2003 and 2005 from 77 to 69 percent and in real terms (in 1993 prices) it decreases from 67 to 56 percent. However, table 4.2 shows that more than half of the domestic resources is financed by consumers. The role played by the private sector, and the consumers in particular, has for long been neglected although the private sector was explicitly envisioned to play a role in

the Programme of Action: “Non-governmental organizations and the private sector are acknowledged as partners in national policies and programmes.” However, so far information on consumer spending on family planning, reproductive health and STD/HIV/AIDS remains scattered, sometimes even contradictory, and only with the advent of developing countries setting up detailed national health accounts this state of affairs may perhaps improve. In the mean time, the estimated figures for consumer spending are more speculative in nature than the spending and funding figures presented on NGOs and government.

#### *Distribution of Spending across ICPD Categories*

At the time when the ICPD-targets were set, the current magnitude of the AIDS pandemic was not expected. The ICPD Programme of Action targeted STD/HIV/AIDS-costs for 2005 at only 8 percent of the total budget needed for population assistance. The family planning component for 2005 was estimated to be 62 percent, reproductive health 29 percent and basic research 1 percent (ICPD PoA paragraph 3.15). This scenario has changed drastically over the years because of the outbreak of the AIDS pandemic. The number of people living with HIV/AIDS in 1994 was 14 million. The latest update by UNAIDS for 2004 mentions an estimate of around 40 million people living with HIV/AIDS.<sup>11</sup>

The results of this report show that over time the share of STD/HIV/AIDS has increased significantly at the expense of spending on family planning, reproductive health services, and basic research. For developing countries, the projected share of STD/HIV/AIDS in the ‘costed population package’ for 2005 is 25 percent (see Table 3.8). The shift towards STD/HIV/AIDS becomes even more apparent for donor assistance: for 2005 donors are expected to spend 66 percent of their population assistance on STD/HIV/AIDS activities (see Appendix A1). This is partly due to the financial response by GFATM and PEPFAR initiative of the United States. The increased financial support for STD/HIV/AIDS activities by donors is in line with what one can gather from the policy preferences of governments as registered by UN (2004) in its report on world population policies: STD/HIV/AIDS is at the forefront of attention of governments, as 74 percent of the governments in the developed world is concerned with STD/HIV/AIDS. Only the concern for population aging can count on more attention of OECD/DAC governments: 76 percent.

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<sup>11</sup> UNAIDS, AIDS epidemic update: December 2004.



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## 5. Summary and Conclusions

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Are the financial promises made in 1994 during the International Conference on Population and Development being fulfilled? This simple yet difficult question is the focus of the Resource Flows project of UNFPA/UNAIDS/NIDI. Monitoring progress is one of the tools which stakeholders can use to make promises stick. This report gives an insight into the size and structure of the flow of funds generated by donors and by the governments and NGOs in developing countries for the years 2003-2005. In addition to these flows, the report also tries to construct an estimate of the funds that consumers might possibly generate. The ICPD clearly recognizes the contribution of the private sector in meeting goals of population and development but so far attempts to measure this contribution were restricted to some scattered country case studies.

The overall conclusion of this report is that on a global scale the financial targets of Cairo are not attained: the total amount of resource flows (recalculated to the level of 1993 prices) will probably be 10 billion US constant dollars in the year 2005, whereas the goal was set at 18.5 billion US dollars. Both donors and domestic governments are still lagging behind their promises. However, there is also some good news as substantial progress can be expected in generating funds based on commitments and expected income developments in the world. The total flow of resources will increase from 14.2 billion current US dollars in 2003 to 18.5 billion current US dollars in 2005. Donors as a whole are living up to their commitment by giving more than the aimed 4 percent of ODA and in nominal terms they provide approximately one third of total generated funds. What lies behind the renegeing of promises, lies outside the scope of this report, although the estimation results, especially for OECD/DAC countries, go some way to explaining it. This report mainly offers a statistical overview of the possible sources in the world for the near future.

Four important elements should be distinguished in discussing the development in the size and structure of funds on a worldwide scale: (1) the role of consumer spending; (2) the sharing of the burden between donors and developing

countries; (3) the dominance of large players; and (4) the shift towards STD/HIV/AIDS. Each element will be elaborated in brief.

First of all, the role played by consumers is hard to track and in this report a counterfactual has been constructed to gauge the effect of out-of-pocket expenditures of consumers: if spending on population and AIDS activities is completely in line with spending on health in general, then consumers in developing countries *pay more than half* of the burden of the health package designed in 1994.

Second, donors seem to have lived up to their promises to a larger extent than the stakeholders in the developing countries. In real terms donors will reach a funding level at approximately 70 percent of their attained goal set in 1994. The developing world (i.e. governments, NGOs and consumers) in 2005 will reach a funding level at 45 percent of the 1994 ICPD goal (in constant US dollars).

Three, the attainment of goals is driven to a large extent by the funding behavior of 'big players': the United States on the donor side and China on the developing side. The United States will fund approximately 3.2 billion (in current US dollars) in the year 2005, thereby effectively contributing more than half of the total donor contributions. And to reflect on the developing side: the Chinese government spends 1.7 billion (current US dollars) on family planning in the year 2005, thereby contributing to a third of all domestic government spending in the developing world.

Four, there has been a substantial shift in spending among the various categories of the so-called 'costed population package'. Especially the United States has made some firm commitments to finance HIV/AIDS projects through the PEPFAR initiative. The shift towards STD/HIV/AIDS expenditures will probably be the most dominant trend among the donor countries: donor funds will consist in 2005 for 66 percent out of funds for STD/HIV/AIDS. This is in marked contrast to the targeted ICPD share for 2005 of 8 percent. The other elements of the ICPD package are therefore crowded out by the drive to fighting the AIDS pandemic.

The present projection and estimation exercise has not been without its difficulties and some assumptions used in the construction of worldwide resource flows have to be tested to see whether they ring true. But these

difficulties also point to interesting avenues for future research. Two avenues are suggested.

First of all, in making projections, the commitments made by OECD/DAC countries have been used as extraneous information and were given higher priority in predicting the future than the unrestricted predictions flowing from the econometric model. It would be of some interest to see whether the commitments made by governments are being lived up to. The provision of commitments has been a recent innovation in the UNFPA/UNAIDS/NIDI survey so in the near future the commitments can be evaluated on their accuracy.

Second, the role played by consumers remains somewhat vague and preliminary information from National Health or AIDS Accounts suggest a wide variety in spending pattern across time and place. The present study has used the assumption that private health spending on population and AIDS activities is completely in line with the private health spending in general. Based on this crude assumption it becomes clear that consumer spending plays the largest role in financing health care and given this prominent position and the concern for poverty in the developing world it would seem of utmost importance to gain an insight into the inner workings of the private sector in population and AIDS activities. In this respect, not only consumers should be taken into account, but also the roles played by firms (both profit and non-profit).





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## **Appendix**



Table A1. Primary funds of governments in donor countries, 2003-2005  
(in current US dollars)

Country	Year	General contributions	Family planning	Reproductive health	Basic research	STD/HIV/AIDS	Total primary funds
Australia	2003	1134787	601951	2469297	773003	17431858	22410896
	2004	1027487	553137	2261491	698775	34196006	38736895
	2005	825592	445087	1819140	561380	32023321	35674520
Austria	2003	136533	472610	246198	34499	54160	944000
	2004	154670	540504	280961	39041	61553	1076730
	2005	161224	565191	293584	40681	64231	1124911
Belgium	2003	11062198	1425819	6985869	4865759	19761372	44101018
	2004	12623273	1643297	8033312	5546314	22767009	50613205
	2005	13110339	1711582	8361723	5758510	23710546	52652700
Canada	2003	2472498	748158	1397309	1835149	31552190	38005304
	2004	11285618	3447484	6424957	8367705	99759774	129285537
	2005	12257912	3765384	7008595	9083048	107516436	139631376
Denmark	2003	46612239	217014	4714597	214161	1675945	53433955
	2004	46566965	218869	4744719	213729	1689673	53433955
	2005	48125847	226739	4912653	220826	1750268	55236332
Finland	2003	15127279	148098	2516946	1458366	843971	20094660
	2004	12758946	126064	2138031	1228800	7448760	23700600
	2005	13553023	134237	2275394	1304926	7561620	24829200
France	2003	75377942	586348	1644839	897016	4203162	82709307
	2004	752934	5918	16563	8950	61360000	62144365
	2005	75831221	597795	1671900	901084	169290000	248292000
Germany	2003	10888652	17473050	14348697	135365	12415996	55261760
	2004	11403107	18466225	15133049	141619	79002000	124146000
	2005	11104376	18015555	14757588	137880	82387800	126403200
Greece	2003	39730	30076	19803	4790	188800	283200
	2004	44727	35195	26711	6227	790020	902880
	2005	48738	33070	25200	5853	902880	1015740
Ireland	2003	12235463	229139	1216975	478423	37760000	51920000
	2004	12223120	231838	1227772	477271	37760000	51920000
	2005	13292166	253550	1341033	518689	40759707	56165145
Italy	2003	5891346	1053375	2055524	802524	14067279	23870048
	2004	6715024	1212641	2360997	913724	16188154	27390540
	2005	6996542	1267427	2465924	951703	16917533	28599129
Japan	2003	127657420	3385982	44398410	450124	14058416	189950351
	2004	139112148	3713239	48619943	490172	15413524	207349026
	2005	140625562	3756630	49179172	495461	15593161	209649986
Luxembourg	2003	2193100	322803	292118	23979	4720000	7552000
	2004	2480189	369125	333201	27085	5286400	8496000
	2005	2645178	395461	356609	28872	5617601	9043721

Country	Year	General contributions	Family planning	Reproductive health	Basic research	STD/HIV/AIDS	Total primary funds
Netherlands	2003	108419233	891232	23328444	720028	39873505	173232441
	2004	69641188	577536	15087185	462048	176287320	262055277
	2005	98752543	820541	21425913	655054	195406933	317060984
New Zealand	2003	1952827	33891	193051	1995	560547	2742310
	2004	2217882	39067	221789	2262	672657	3153656
	2005	2267281	40000	227007	2312	687207	3223806
Norway	2003	40587100	2634328	12212938	7320537	22425101	85180003
	2004	51374840	3362075	15557840	9257897	28611317	108163969
	2005	52379284	3432741	15879678	9437406	29211126	110340236
Portugal	2003	192083	59495	95281	50470	202671	600000
	2004	96398	30137	48162	25303	400000	600000
	2005	101297	31778	50746	26578	419146	629545
Spain	2003	3017620	26791	1087628	20445	314352	4466837
	2004	16953025	152296	6166215	114713	314352	23700600
	2005	24276622	219134	8862772	164181	335290	33858000
Sweden	2003	27837166	5291927	7628067	1435698	22285142	64478000
	2004	16321043	3132499	4505591	840867	99200000	124000000
	2005	16308623	3139173	4512243	839961	111600000	136400000
Switzerland	2003	18739647	1364372	2183687	137127	1403167	23828000
	2004	18710790	1373681	2194441	136790	1412299	23828000
	2005	19666130	1449092	2313003	143716	1489627	25061568
UK	2003	36136749	32626912	69613435	2197639	37394597	177969332
	2004	43821043	40149031	85379281	2660656	45990590	218000602
	2005	46163856	42463334	90219869	2801679	48634335	230283073
USA	2003	26708847	365222848	87670368	45397937	800000000	1325000000
	2004	22533922	309895097	74293297	38277684	1200000000	1645000000
	2005 <sup>a</sup>	200000000	355813872	85186128	41244218	2501000000	3183244218
European Union	2003	15870464	40517699	38829462	16882375	84563520	196663520
	2004	16491986	42104462	40350109	17543526	78497779	194864050
	2005	16396927	41861774	40117533	17442406	72797270	192895920
Total	2003	590290922	475363917	325148943	86137408	1167755751	2644696942
	2004	515310525	431379281	335405477	87481228	2013109188	3382561885
	2005	814896645	480436341	363260506	92765769	3465676038	5221315310

Note: Projections for the various categories of population and AIDS activities in Greece are based on the average distribution for 21 countries in the absence of any previous figures for Greece and the total primary fund projection is based on the income elasticity of Table 2.2. For the EU the projections of distributions are based solely on the distribution of 2002.

<sup>a</sup> For the case of the USA in the year 2005 we had to deviate from the projection rules because of the extremely large commitment to fund STD/HIV/AIDS activities and the absence of reported commitment for the total primary funds. The total primary funds in this year are the sum of commitments on STD/HIV/AIDS, general contributions, family planning and reproductive health, and the unrestricted projection for basic research.

Table A2. Projected government expenditures for 61 selected core-countries, 2003-2005  
(in current US dollars)

Country	Year	Family Planning	Reproductive Health	STD/HIV/ AIDS	Basic Research	Total
Angola	2003	336.228	134.490	573.886	535.206	1.579.811
	2004	472.758	178.660	782.843	705.618	2.139.879
	2005	559.588	205.614	912.840	809.034	2.487.077
Bangladesh	2003	100.689.470	75.958.720	19.431.340	24.730.750	220.810.280
	2004	101.195.164	76.123.791	19.553.457	24.820.084	221.692.496
	2005	101.717.440	76.292.234	19.678.771	24.911.097	222.599.542
Bénin	2003	97.203	47.815	185.259	4.198	334.476
	2004	111.438	53.583	209.825	222.729	597.575
	2005	118.516	56.404	221.933	233.921	630.773
Botswana	2003	37.689	77.596	27.996	772.860	916.141
	2004	260.406	173.012	422.313	1.156.063	2.011.795
	2005	267.223	175.440	433.294	1.165.549	2.041.506
Brazil	2003	63.381	56.999	438.404.264	53.867	438.578.511
	2004	9.445.459	7.355.788	439.574.388	8.017.586	464.393.221
	2005	9.888.358	7.641.807	440.085.678	8.321.183	465.937.026
Burkina Faso	2003	6.504.335	1.599.319	2.430.000	1.989.817	12.523.470
	2004	6.639.947	1.662.426	2.461.847	2.246.072	13.010.293
	2005	6.648.729	1.665.814	2.476.611	2.259.452	13.050.606
Burundi	2003	35.231	206.123	232.165	139.010	612.529
	2004	57.227	219.983	280.006	197.613	754.829
	2005	59.056	220.937	283.617	201.536	765.147
Cambodia	2003	538.166	1.248.489	8.390.550	1.253.268	11.430.473
	2004	1.243.752	1.652.264	8.619.462	1.489.410	13.004.887
	2005	1.274.955	1.667.090	8.628.667	1.497.846	13.068.558
Cameroon	2003	21.964	7.321	528.276	44.546	602.108
	2004	371.581	146.260	594.670	596.974	1.709.484
	2005	391.438	152.806	625.368	622.291	1.791.902
Central African Republic	2003	19.845	16.154	1.468.936	98.069	1.603.005
	2004	61.636	39.817	1.554.792	196.701	1.852.946
	2005	64.358	41.095	1.559.873	201.881	1.867.207
China	2003	1.699.469.000	31.022.235	115.070.000	50.403.698	1.895.964.933
	2004	1.720.093.000	64.060.699	182.850.000	67.584.530	2.034.588.229
	2005	1.727.478.000	66.684.107	210.450.000	68.911.020	2.073.523.127
Congo, Democratic Republic	2003	151.014	69.026	276.763	279.618	776.422
	2004	176.364	78.554	318.793	317.123	890.834
	2005	189.899	83.547	341.011	336.725	951.182
Cote d'Ivoire	2003	425.652	80.169	101.803	1.126.574	1.734.198
	2004	800.839	227.526	735.976	1.711.555	3.475.896
	2005	821.492	234.255	767.706	1.737.541	3.560.994

Table A2. (continued)

Country	Year	Family Planning	Reproductive Health	STD/HIV/ AIDS	Basic Research	Total
Dominican Republic	2003	389.408	514.840	656.036	602.901	2.163.184
	2004	387.318	512.537	652.828	600.276	2.152.958
	2005	429.582	558.736	717.429	652.879	2.358.626
Egypt	2003	357.236	17.394.873	3.152.215	3.037.285	23.941.610
	2004	5.426.959	20.045.455	5.430.484	4.863.621	35.766.518
	2005	5.661.192	20.147.122	5.526.195	4.931.770	36.266.279
Eritrea	2003	1.338.500	880.356	1.002.000	392.884	3.613.741
	2004	1.359.128	893.495	1.047.122	448.513	3.748.257
	2005	1.362.295	895.156	1.053.395	455.348	3.766.193
Ethiopia	2003	4.760.744	993.308	4.777.329	957.012	11.488.393
	2004	4.968.233	1.083.256	5.147.006	1.318.823	12.517.318
	2005	4.985.087	1.089.304	5.174.269	1.342.483	12.591.144
Gambia	2003	12.357	8.572	28.291	36.712	85.933
	2004	13.708	9.346	31.095	39.935	94.084
	2005	14.765	9.943	33.273	42.416	100.398
Ghana	2003	250.781	63.859	9.108.000	740.593	10.163.234
	2004	471.137	158.432	9.146.354	1.120.498	10.896.421
	2005	488.679	164.666	9.174.581	1.144.850	10.972.776
Guinea	2003	60.963	34.485	129.282	126.886	351.616
	2004	159.497	82.845	316.850	324.656	883.848
	2005	160.525	83.265	318.632	326.328	888.750
Haiti	2003	896.965	91.217	349.664	278.241	1.616.087
	2004	1.026.193	296.553	589.803	524.666	2.437.215
	2005	1.047.955	324.989	626.388	557.824	2.557.155
Honduras	2003	9.022	1.554.534	7.664.617	89.201	9.317.374
	2004	199.737	1.838.537	7.680.406	427.099	10.145.778
	2005	210.172	1.851.429	7.697.433	442.020	10.201.054
India	2003	68.446.770	33.613.230	6.100.500	94.500	108.255.000
	2004	74.915.545	35.088.241	7.390.565	855.470	118.249.822
	2005	80.455.275	36.331.148	8.485.866	1.495.314	126.767.603
Indonesia	2003	45.654.872	18.921.216	29.192.199	6.531.130	100.299.417
	2004	69.196.731	26.429.630	34.784.049	10.593.054	141.003.464
	2005	71.383.511	27.006.493	35.255.409	10.896.502	144.541.915
Iran, Islamic Republic of	2003	31.127.079	223.520.934	13.344.515	13.760.974	281.753.502
	2004	49.244.008	229.556.964	17.749.161	17.045.426	313.595.560
	2005	50.732.005	229.967.354	18.077.602	17.262.588	316.039.550
Jamaica	2003	1.653.900	905.352	672.694	783.161	4.015.107
	2004	1.860.189	1.208.552	1.040.420	1.143.271	5.252.432
	2005	1.862.983	1.211.971	1.044.955	1.147.222	5.267.131
Kenya	2003	611.000	601.000	23.634.000	1.180.000	26.026.000
	2004	637.231	609.683	39.676.000	1.213.601	42.136.515
	2005	659.203	616.876	20.228.000	1.241.395	22.745.474



Table A2. (continued)

Country	Year	Family Planning	Reproductive Health	STD/HIV/ AIDS	Basic Research	Total
Lesotho	2003	51.183	34.733	339.017	126.501	551.433
	2004	91.564	57.728	422.229	222.425	793.946
	2005	92.946	58.383	424.820	225.080	801.229
Madagascar	2003	33.486	55.625	18.972	59.020	167.104
	2004	148.827	110.767	235.482	283.738	778.813
	2005	161.277	115.684	256.677	303.221	836.859
Malawi	2003	4.500.000	450.660	2.034.343	390.440	7.375.442
	2004	4.554.882	480.355	2.144.395	513.470	7.693.102
	2005	4.558.590	482.018	2.151.149	520.170	7.711.926
Mauritania	2003	30.768	91.875	238.155	713.138	1.073.936
	2004	69.595	114.130	318.443	806.056	1.308.223
	2005	72.090	115.316	323.131	810.871	1.321.407
Mexico	2003	629.327	47.915.801	56.783.760	12.456.422	117.785.310
	2004	11.579.731	56.218.006	57.414.076	21.483.906	146.695.719
	2005	12.023.255	56.497.294	57.919.246	21.779.364	148.219.159
Morocco	2003	4.444.307	14.884.167	5.516.523	11.758.946	36.603.942
	2004	7.949.304	16.832.938	7.144.158	13.112.770	45.039.170
	2005	8.118.574	16.911.056	7.215.625	13.165.564	45.410.820
Mozambique	2003	473.576	745.467	8.212.015	270.549	9.701.607
	2004	614.914	810.787	8.251.438	535.544	10.212.682
	2005	625.691	814.912	8.269.479	551.818	10.261.899
Myanmar	2003	1.235.405	643.955	801.050	371.949	3.052.358
	2004	1.147.002	605.319	1.157.440	350.211	3.259.972
	2005	1.111.029	589.457	1.147.242	341.275	3.189.003
Namibia	2003	29.655.000	54.944	430.981	1.410.234	31.551.159
	2004	29.664.070	114.257	665.458	1.651.481	32.095.266
	2005	29.672.219	117.440	679.249	1.664.073	32.132.982
Nepal	2003	4.860.440	4.764.448	4.431.895	918.476	14.975.259
	2004	4.896.208	4.780.717	4.442.204	927.678	15.046.808
	2005	4.942.947	4.801.823	4.455.624	939.606	15.140.000
Niger	2003	4.736	799.509	3.636.362	53.013	4.493.620
	2004	95.433	844.642	3.810.288	237.924	4.988.287
	2005	100.682	846.808	3.819.437	246.559	5.013.487
Nigeria	2003	98.822	190.003	13.422.070	948.677	14.659.572
	2004	1.559.862	647.493	15.610.538	2.710.786	20.528.679
	2005	1.681.977	679.142	15.776.592	2.829.332	20.967.042
Pakistan	2003	32.624.956	16.835.501	3.075.660	755.736	53.291.853
	2004	42.213.938	20.387.651	5.542.608	2.716.129	70.860.325
	2005	43.022.106	20.635.435	5.731.354	2.849.111	72.238.006
Papua New Guinea	2003	917.724	985.983	116.823	419.578	2.440.108
	2004	1.544.892	1.352.000	322.435	634.199	3.853.526
	2005	1.540.608	1.349.915	321.155	633.009	3.844.687

Table A2. (continued)

Country	Year	Family Planning	Reproductive Health	STD/HIV/AIDS	Basic Research	Total
Peru	2003	6.456.402	1.162.153	19.931.476	5.294.250	32.844.280
	2004	6.560.784	1.255.946	20.075.189	5.398.291	33.290.210
	2005	6.628.914	1.316.522	20.168.464	5.465.390	33.579.291
Philippines	2003	690.145	8.910.318	3.600.284	2.580.744	15.781.490
	2004	10.527.496	12.538.976	6.125.384	4.582.223	33.774.079
	2005	11.275.715	12.767.553	6.299.793	4.704.838	35.047.898
Poland	2003	3.529.026	2.353.030	5.652.772	1.149.516	12.684.344
	2004	7.744.674	3.459.354	11.399.695	2.283.808	24.887.532
	2005	8.018.707	3.518.967	11.739.100	2.343.256	25.620.030
Romania	2003	721.797	14.847.436	34.434.702	3.013.179	53.017.114
	2004	2.113.341	15.286.718	36.528.122	3.474.797	57.402.978
	2005	2.219.413	15.314.449	36.673.031	3.503.138	57.710.031
Russian Federation	2003	700.999	30.738.439	5.108.801	3.478.421	40.026.660
	2004	10.285.066	32.931.852	17.254.305	5.686.611	66.157.835
	2005	11.781.523	33.213.747	18.970.775	5.962.383	69.928.428
Rwanda	2003	38.196	43.774	470.236	251.414	803.619
	2004	89.720	71.947	574.136	368.302	1.104.105
	2005	92.328	73.131	578.916	373.079	1.117.453
Senegal	2003	324.422	310.207	2.093.573	369.436	3.097.639
	2004	516.908	394.702	2.438.814	709.877	4.060.301
	2005	529.277	399.203	2.458.971	727.516	4.114.967
Sierra Leone	2003	31.170	18.533	65.726	9.660	125.089
	2004	32.336	19.109	67.963	89.766	209.174
	2005	35.246	20.532	73.515	95.566	224.859
South Africa	2003	3.044.159	453.890	15.635.970	2.344.559	21.478.578
	2004	3.292.773	1.354.349	20.224.472	5.750.785	30.622.380
	2005	3.510.758	1.403.758	20.500.439	5.932.573	31.347.528
Sudan	2003	1.296	1.283.460	4.198.244	1.313.960	6.796.960
	2004	1.572.448	2.282.009	4.981.786	2.020.138	10.856.381
	2005	1.748.810	2.374.577	5.061.537	2.083.781	11.268.706
Swaziland	2003	53.998	5.431	35.302	923.200	1.017.931
	2004	57.952	36.504	150.947	1.051.783	1.297.186
	2005	62.113	38.353	158.490	1.059.223	1.318.180
Tajikistan	2003	275.628	184.481	97.214	110.168	667.491
	2004	302.390	199.291	105.778	118.768	726.227
	2005	322.289	210.161	112.102	125.069	769.621
Tanzania, United Republic of	2003	4.554.000	126.000	17.484.000	1.335.000	23.499.000
	2004	4.561.675	128.668	17.496.205	1.345.391	23.531.938
	2005	4.594.978	140.099	17.548.812	1.389.844	23.673.733
Thailand	2003	3.487.458	5.925.172	56.700.000	531.619	66.644.250
	2004	21.579.629	11.954.327	57.197.482	3.812.430	94.543.868
	2005	23.353.275	12.443.001	57.588.760	4.070.982	97.456.017

Table A2. (end)

Country	Year	Family Planning	Reproductive Health	STD/HIV/ AIDS	Basic Research	Total
Turkey	2003	16.740.920	16.740.920	35.700	1.248.774	34.766.314
	2004	20.662.261	18.144.745	1.481.565	2.165.934	42.454.505
	2005	21.720.237	18.514.577	1.866.737	2.406.788	44.508.339
Uganda	2003	25.953	73.795	515.347	420.409	1.035.505
	2004	218.183	158.196	860.169	760.482	1.997.030
	2005	229.351	162.263	878.375	776.420	2.046.409
Ukraine	2003	547.151	330.200	2.563.700	52.500	3.493.551
	2004	1.839.937	393.085	2.887.051	117.063	5.237.136
	2005	2.090.042	458.691	3.229.334	184.141	5.962.208
Viet Nam	2003	15.447.402	8.046.248	4.042.037	2.071.647	29.607.334
	2004	15.907.001	8.205.202	4.156.499	2.158.336	30.427.038
	2005	16.282.832	8.333.403	4.249.412	2.228.126	31.093.773
Zambia	2003	1.232	146.324	85.088	1.370.401	1.603.045
	2004	139.143	210.321	339.884	1.630.172	2.319.520
	2005	144.328	212.320	348.598	1.638.067	2.343.312
Zimbabwe	2003	8.100.534	3.827.364	15.326.446	810.930	28.065.274
	2004	8.253.485	3.897.126	15.606.441	1.093.453	28.850.506
	2005	8.190.800	3.872.318	15.499.619	995.129	28.557.867

Table A3. Projected NGO expenditures for 61 selected core-countries, 2003-2005  
(in current US dollars)

Country	Year	Family Planning	Reproductive Health	STD/HIV/ AIDS	Basic Research	Total
Angola	2003	348.792	316.263	1.926.220	75.193	2.666.468
	2004	412.026	380.740	2.292.729	88.489	3.173.984
	2005	447.430	417.348	2.499.087	95.913	3.459.778
Bangladesh	2003	1.531.472	826.592	6.090.292	326.992	8.775.349
	2004	2.190.683	1.469.164	7.583.702	467.064	11.710.613
	2005	2.213.914	1.494.432	7.638.767	471.886	11.819.000
Bénin	2003	366.044	160.923	1.021.507	41.560	1.590.034
	2004	569.325	173.354	1.095.411	44.364	1.882.454
	2005	575.537	179.264	1.130.434	45.689	1.930.924
Botswana	2003	94.919	9.668	46.700	57.529	208.817
	2004	380.095	262.399	1.607.251	61.761	2.311.506
	2005	384.330	266.582	1.631.484	62.657	2.345.052
Brazil	2003	2.190.560	422.817	1.882.211	148.441	4.644.029
	2004	3.966.122	2.359.831	4.877.166	517.319	11.720.438
	2005	4.006.617	2.409.092	4.948.614	525.539	11.889.861
Burkina Faso	2003	221.554	278.882	2.425.961	139.220	3.065.616
	2004	445.313	471.792	3.636.999	187.947	4.742.051
	2005	452.284	478.496	3.676.468	189.430	4.796.678
Burundi	2003	81.596	172.344	1.444.906	18.102	1.716.949
	2004	173.551	244.002	1.922.872	38.536	2.378.961
	2005	177.213	247.187	1.942.790	39.331	2.406.522
Cambodia	2003	36.571	427.569	582.309	265.553	1.312.002
	2004	249.573	610.180	1.040.701	311.990	2.212.444
	2005	254.127	614.534	1.050.953	312.960	2.232.574
Cameroon	2003	85.032	6.902	136.660	859	229.453
	2004	440.546	329.961	2.101.708	77.467	2.949.683
	2005	450.279	339.825	2.157.984	79.516	3.027.604
Central African Republic	2003	17.344	34.111	172.427	24.236	248.117
	2004	143.194	135.742	835.968	52.002	1.166.906
	2005	147.137	139.294	857.719	52.852	1.197.002
China	2003	777.365	614.018	843.217	543.693	2.778.293
	2004	892.409	3.859.479	7.674.008	1.123.896	13.549.792
	2005	897.683	4.025.608	8.001.750	1.149.879	14.074.920
Congo, Democratic Republic	2003	235.842	204.546	1.279.486	51.297	1.771.170
	2004	254.429	222.578	1.385.096	55.245	1.917.347
	2005	263.795	231.721	1.438.445	57.231	1.991.193
Cote d'Ivoire	2003	1.588.773	51.167	344.643	14.442	1.999.024
	2004	1.956.770	386.883	2.381.883	93.678	4.819.213
	2005	1.966.538	396.821	2.438.450	95.733	4.897.541

Table A3. (continued)

Country	Year	Family Planning	Reproductive Health	STD/HIV/ AIDS	Basic Research	Total
Dominican Republic	2003	374.751	342.585	588.964	80.657	1.386.957
	2004	373.767	341.583	587.346	80.450	1.383.146
	2005	393.179	361.397	619.275	84.531	1.458.381
Egypt	2003	1.865.997	802.065	192.351	203.322	3.063.736
	2004	2.596.905	1.522.933	1.002.125	358.265	5.480.227
	2005	2.613.224	1.540.879	1.021.036	361.645	5.536.783
Eritrea	2003	81.417	80.676	496.671	30.445	689.209
	2004	170.530	149.872	959.205	50.261	1.329.868
	2005	176.977	155.469	994.241	51.661	1.378.348
Ethiopia	2003	2.051.907	603.639	919.767	73.250	3.648.563
	2004	2.327.378	846.810	2.424.839	132.956	5.731.984
	2005	2.338.100	857.373	2.486.131	135.225	5.816.829
Gambia	2003	69.367	52.351	355.967	15.513	493.199
	2004	72.975	55.393	375.348	16.301	520.018
	2005	75.675	57.680	389.879	16.891	540.126
Ghana	2003	854.085	389.699	606.807	93.872	1.944.463
	2004	1.137.779	640.967	2.158.879	155.319	4.092.944
	2005	1.148.604	651.667	2.220.849	157.609	4.178.731
Guinea	2003	157.482	20.173	14.898	2.801	195.354
	2004	348.892	182.292	1.043.528	44.632	1.619.344
	2005	349.866	183.210	1.048.999	44.840	1.626.915
Haiti	2003	988.414	1.021.475	3.262.592	183.346	5.455.827
	2004	1.206.960	1.209.387	3.597.744	230.963	6.245.054
	2005	1.224.238	1.226.004	3.625.494	234.639	6.310.374
Honduras	2003	3.275.405	787.709	1.372.466	116.338	5.551.918
	2004	3.539.754	1.019.972	1.781.382	173.687	6.514.795
	2005	3.546.729	1.026.807	1.792.669	175.166	6.541.372
India	2003	4.486.179	2.374.241	838.840	275.471	7.974.731
	2004	6.390.621	4.468.465	5.366.416	670.495	16.895.997
	2005	6.471.596	4.567.865	5.567.867	686.901	17.294.229
Indonesia	2003	170.733	590.394	889.819	296.923	1.947.869
	2004	1.354.059	1.823.144	3.642.832	545.040	7.365.074
	2005	1.406.577	1.884.225	3.770.697	555.796	7.617.296
Iran, Islamic Republic of	2003	2.808	41.243	24.215	123.406	191.672
	2004	1.043.902	1.110.153	2.432.269	342.337	4.928.661
	2005	1.084.863	1.157.091	2.531.406	350.751	5.124.111
Jamaica	2003	272.650	240.399	6.000	59.108	578.157
	2004	274.690	242.404	431.655	59.540	1.008.289
	2005	276.503	244.186	434.592	59.924	1.015.205
Kenya	2003	1.014.614	1.515.115	1.172.257	158.761	3.860.748
	2004	1.377.105	1.845.242	3.177.639	236.839	6.636.824
	2005	1.387.648	1.855.952	3.238.657	239.057	6.721.314

Table A3. (continued)

Country	Year	Family Planning	Reproductive Health	STD/HIV/ AIDS	Basic Research	Total
Lesotho	2003	391.941	41.896	244.989	14.539	693.366
	2004	515.697	141.646	896.992	41.854	1.596.189
	2005	517.750	143.491	908.307	42.297	1.611.845
Madagascar	2003	201.378	128.741	161.213	48.184	539.515
	2004	408.107	305.373	1.276.065	93.284	2.082.829
	2005	418.732	315.511	1.336.032	95.547	2.165.822
Malawi	2003	376.580	818.596	10.232.154	73.908	11.501.238
	2004	520.364	936.482	10.994.862	105.536	12.557.244
	2005	525.034	940.753	11.020.777	106.539	12.593.103
Mauritania	2003	83.410	62.878	104.961	10.801	262.050
	2004	204.813	160.518	744.012	37.608	1.146.951
	2005	208.567	163.886	764.683	38.418	1.175.553
Mexico	2003	4.077.893	3.150.839	38.579.730	766.230	46.574.692
	2004	5.992.834	5.257.924	41.820.900	1.163.382	54.235.039
	2005	6.030.368	5.303.968	41.887.346	1.170.987	54.392.669
Morocco	2003	225.779	168.614	397.120	43.904	835.417
	2004	836.012	758.249	1.067.674	173.797	2.835.732
	2005	850.246	773.586	1.084.035	176.757	2.884.624
Mozambique	2003	451.466	186.353	1.476.621	11.748	2.126.188
	2004	679.795	383.656	2.713.525	61.447	3.838.422
	2005	688.146	391.709	2.760.862	63.223	3.903.940
Myanmar	2003	280.099	247.724	610.337	60.686	1.198.846
	2004	270.114	237.910	587.610	58.571	1.154.205
	2005	265.938	233.818	578.117	57.686	1.135.560
Namibia	2003	122.131	72.969	2.220.000	16.627	2.431.728
	2004	337.897	258.221	2.263.715	63.653	2.923.486
	2005	344.616	264.657	2.301.698	65.084	2.976.055
Nepal	2003	609.754	763.809	6.564.511	147.017	8.085.091
	2004	856.765	979.172	7.099.684	200.687	9.136.308
	2005	862.601	984.846	7.112.911	201.926	9.162.284
Niger	2003	212.243	41.229	39.550	6.941	299.963
	2004	396.052	196.195	1.025.516	47.148	1.664.911
	2005	401.179	201.016	1.054.283	48.243	1.704.721
Nigeria	2003	558.745	784.233	2.158.761	331.579	3.833.318
	2004	1.274.050	1.487.985	6.240.161	483.288	9.485.484
	2005	1.302.679	1.519.423	6.411.093	489.220	9.722.414
Pakistan	2003	3.670.382	1.495.998	774.787	99.294	6.040.461
	2004	4.433.171	2.251.967	2.514.350	260.838	9.460.326
	2005	4.463.951	2.286.016	2.587.803	267.205	9.604.975
Papua New Guinea	2003	10.805	8.104	32.414	2.701	54.023
	2004	211.885	179.369	464.019	46.596	901.869
	2005	211.212	178.731	462.509	46.453	898.906

Table A3. (continued)

Country	Year	Family Planning	Reproductive Health	STD/HIV/ AIDS	Basic Research	Total
Peru	2003	2.328.339	786.747	1.102.432	723.635	4.941.154
	2004	3.022.931	1.467.842	2.225.114	871.050	7.586.938
	2005	3.039.539	1.486.003	2.253.194	874.494	7.653.230
Philippines	2003	2.156.310	850.567	494.741	201.682	3.703.299
	2004	2.928.695	1.617.135	2.257.189	365.211	7.168.230
	2005	2.956.878	1.648.348	2.324.475	371.040	7.300.741
Poland	2003	111.869	46.795	140.576	3.687	302.926
	2004	247.611	150.687	1.025.761	32.139	1.456.198
	2005	251.856	154.311	1.054.718	33.008	1.493.893
Romania	2003	1.350.666	93.760	329.051	1.353	1.774.831
	2004	1.429.621	150.581	831.396	18.108	2.429.706
	2005	1.432.508	152.899	850.616	18.706	2.454.730
Russian Federation	2003	205.654	14.568	238.406	5.491	464.119
	2004	408.467	177.039	1.585.320	47.616	2.218.442
	2005	423.375	190.394	1.688.998	50.639	2.353.407
Rwanda	2003	176.913	50.582	323.442	59.766	610.703
	2004	316.327	164.484	1.061.930	90.454	1.633.194
	2005	319.733	167.588	1.080.804	91.186	1.659.311
Senegal	2003	625.532	267.696	889.768	68.949	1.851.945
	2004	891.078	501.130	2.338.195	126.552	3.856.955
	2005	899.287	509.181	2.385.042	128.291	3.921.803
Sierra Leone	2003	33.219	6.755	14.487	24.137	78.597
	2004	144.236	95.139	596.500	24.564	860.440
	2005	149.014	99.385	622.709	25.597	896.704
South Africa	2003	132.685	858.014	650.313	162.889	1.803.901
	2004	1.196.877	1.953.366	6.833.040	386.565	10.369.848
	2005	1.230.755	1.992.269	7.038.961	393.522	10.655.506
Sudan	2003	136.605	221.986	346.765	110.305	815.660
	2004	548.828	602.929	791.731	198.836	2.142.324
	2005	570.835	625.645	816.596	203.452	2.216.529
Swaziland	2003	139.792	23.674	200.069	1.078	364.613
	2004	287.453	145.105	984.289	33.539	1.450.386
	2005	292.545	149.777	1.012.584	34.633	1.489.540
Tajikistan	2003	134.526	109.464	283.523	29.636	557.149
	2004	140.761	115.128	297.275	30.978	584.141
	2005	145.216	119.193	307.117	31.935	603.461
Tanzania, United Republic of	2003	3.127.613	823.644	2.522.037	177.107	6.650.400
	2004	3.438.331	1.101.707	4.229.000	244.268	9.013.306
	2005	3.456.814	1.120.189	4.335.299	248.170	9.160.473
Thailand	2003	310.133	756.159	812.510	35.133	1.913.934
	2004	1.350.531	1.824.273	3.218.882	253.920	6.647.607
	2005	1.399.204	1.880.067	3.336.700	263.918	6.879.888

Table A3. (end)

Country	Year	Family Planning	Reproductive Health	STD/HIV/ AIDS	Basic Research	Total
Turkey	2003	252.036	220.800	334.901	299.097	1.106.833
	2004	1.627.558	1.678.493	1.903.279	586.528	5.795.857
	2005	1.665.512	1.723.354	1.948.549	594.276	5.931.691
Uganda	2003	677.338	257.288	309.669	51.728	1.296.023
	2004	942.711	490.554	1.757.110	109.294	3.299.669
	2005	950.140	497.837	1.799.496	110.868	3.358.340
Ukraine	2003	5.222	72	268.919	633	274.847
	2004	81.386	54.660	752.714	16.809	905.570
	2005	88.265	60.178	798.484	18.235	965.162
Viet Nam	2003	133.004	440.206	213.033	95.123	881.366
	2004	692.179	975.168	1.470.376	214.384	3.352.107
	2005	712.032	996.363	1.517.084	218.521	3.443.999
Zambia	2003	108.573	99.839	1.408.933	23.913	1.641.258
	2004	334.178	294.523	2.630.416	73.033	3.332.149
	2005	338.286	298.474	2.653.677	73.907	3.364.343
Zimbabwe	2003	190.808	24.861	703.254	14.463	933.386
	2004	428.123	230.831	1.991.100	66.073	2.716.127
	2005	374.190	179.426	1.686.825	54.578	2.295.019