How to do (or not to do) . . . Tracking data on development assistance for health

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Development assistance for health (DAH) has increased substantially in recent years and is seen as important to the improvement of health and health systems in developing countries. As a result, there has been increasing interest in tracking and understanding these resource flows from the global health community. A number of datasets, each with its own strengths and weaknesses, are available to track DAH. In this article we review the available datasets on DAH and summarize the strengths and weaknesses of each of these datasets to help researchers make the best choice of which to use to inform their analysis. Finally, we also provide recommendations about how each of these datasets could be improved.

Keywords Development assistance for health, global health data, foreign aid, bilateral donors, multilateral donors, Global Fund, GAVI

KEY MESSAGES

• The provision of development assistance for health (DAH) is important to the improvement of health and health systems in developing countries, and has increased substantially. Interest in tracking and understanding these resource flows from the global health community has likewise increased.

• This review provides an overview of the strengths and weaknesses of the datasets available to track DAH, in order to help users decide which dataset is best suited for their analysis.

Introduction

Development assistance for health (DAH) has increased substantially in recent years.1 According to the Organisation for Economic Co-operation and Development’s (OECD) Creditor Reporting System (CRS), total DAH commitments have increased from $6.6 billion in 2000 to $19.9 billion in 2009.2 These resources have not only increased in absolute amount but have also increased relative to the gross domestic product of recipient countries (Lu et al. 2010). These increases have been driven by larger commitments from both traditional donors and from new donors, such as the Bill & Melinda Gates Foundation (BMGF) (McCoy et al. 2009).

Over the past decade, the global health community has shown greater interest in understanding general trends in DAH (Ravishankar et al. 2009; Murray et al. 2011; Stuckler et al. 2011), how DAH has been allocated among different health priorities (Greco et al. 2008; Shiffman 2008; Sridhar and Batniji 2008; Liese and Schubert 2009; Patel et al. 2009; Piva and Dodd 2009; Ravishankar et al. 2009; Schaferhoff et al. 2010), the allocations of DAH made by particular donors (McCoy et al. 2009), and the impact of these resources on health outcomes (Mishra and Newhouse 2009). There has also been an increase in the availability of DAH statistics; in the past few years alone two major new datasets have been developed to provide data on DAH. Those interested in conducting research on DAH now
have a choice between datasets on DAH. Since each of these datasets has been developed for a different purpose, for a different audience and using a different approach, one dataset might be better suited than another for a particular type of analysis.

The purpose of the following article is to provide an overview of the data sources currently available to track DAH. We summarize the features of the main datasets, including the kind of DAH tracked, the donors and recipients included, the years for which the data were available and types of outlays included. We discuss the strengths and limitations of each dataset and describe how to access the data. Table 1 provides a summary of the main features and information of each dataset included in this review. In addition, we provide recommendations about how data collection efforts could be improved.

## DAH datasets

### OECD-DAC

The most commonly used source of information on DAH comes from the OECD Development Assistance Committee (DAC), which collects on an ongoing basis data on aid and other resource flows to developing countries from member institutions, some multilateral organizations, and other donors. These data feed into two databases: the DAC annual aggregate statistics, which provide data on aid flows broken down by either donor, geographic region, type of aid, or sector; and the DAC aid activity database, which provides project-level data, including descriptive data of the projects when provided by donors, which can be more flexibly manipulated by users. DAC members report annually to the DAC secretariat official development assistance (ODA), other official flows (OOF) and private funding (foreign direct investment, bank and non-bank flows) to developing countries. The DAC secretariat is responsible for processing and disseminating the data.

The aid component of these flows is known as ODA, which is defined as grants, technical assistance or concessional loans given by official donors to developing countries for the purpose of improving welfare or promoting economic development (OECD-DAC, no date, a). The CRS reports ODA and OOF, while the aggregate data also contain additional aid flows (OECD-DAC, no date, b). To avoid double counting, the CRS only reports the bilateral contributions of donors and not their contributions to the regular budgets of multilateral institutions; however, data on these contributions can be obtained in the aggregate DAC statistics. For example, Canada may provide bilateral funding directly to the government of Mali and some of the funds it contributes to the World Bank’s regular budget may also be used to finance health projects in Mali. The CRS would only attribute the former and not the latter as aid flowing from Canada to Mali. Expenditures from the regular budgets of multilateral institutions are counted as multilateral aid in the CRS database.

There are many advantages to using the OECD-DAC databases. First, they are the most comprehensive source of data on development assistance in general and therefore can be used to make comparisons across sectors. The DAC has been collecting data since 1967 and therefore provides the longest times series of any dataset. In addition, the DAC uses standard reporting procedures across a range of donors, thereby collecting comparable data from a diverse set of donors. Finally, the OECD provides the data freely on its website which can be easily downloaded in a number of formats (http://www.oecd.org/dac/stats/idsonline).

There are also a number of limitations to using the DAC datasets. While the completeness of data reporting to the DAC has improved over the years, the comprehensiveness of the CRS data varies overtime and was not considered sufficiently comprehensive until recently. Furthermore, since only bilateral contributions of donor countries are reported in the CRS, it is not possible to account for all resource contributions from an individual donor country using the CRS alone. Plus, the CRS mainly only collects data from DAC members, so it only captures limited data from select global health initiatives and non-DAC bilateral donors and does not capture data from non-governmental organizations (NGOs) or foundations, with the exception of data from BMGF which began reporting data to the DAC in 2009, and can be downloaded from the CRS online in the file containing data on Other Official Flows and Private Grants.

### AidData/PLAID dataset

Designed to address some of the limitations of the CRS dataset, the Project-Level Aid (PLAID) dataset was developed by researchers at the College of William and Mary and Brigham Young University in the United States (US). It has built on the CRS dataset by including data from more non-DAC bilateral and other donors, collecting data directly from multilateral donors, standardizing some problematic variables, improving project-level data descriptions and increasing the accessibility of the data via a more user-friendly interface. In 2010, PLAID partnered with Development Gateway to become known as AidData. AidData tracks ODA plus additional aid flows, such as market-rate loans, but like CRS it currently only tracks aid flows from official aid agencies.

A major advantage of AidData over CRS is that it includes more data from non-DAC bilateral donors, as well as additional multilateral and inter-governmental organizations. Data from these agencies were collected from a number of sources, such as annual reports, public websites or the statistical agencies of the donors. While expanding the availability of data, this approach has led to a less standardized data collection process across donors than is used by the CRS, which uses the same data collection procedure across all reporting agencies. In addition, the approach of collecting data from multilateral donors directly may have lead to some double counting of aid flows. Moreover, the availability of historical data by donor varies greatly and therefore aggregate estimates of aid flows will also be influenced by the entry of new agencies into the dataset and not just a change in funding commitments of previously reporting agencies.

AidData has made efforts to recode traditionally problematic CRS variables, such as country names and dollar amounts. The development team has also developed a new coding scheme to allocate aid flows to multiple sectors and purposes, if appropriate, thus enabling users to gain more insight into the use of the aid flows. To construct such variables, however, the developers had to manually inspect project descriptions and
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Notes:

1. While data on commitments and disbursements are available from 1971 onwards, although data on a few select donors are available prior to 1973, the DAC only recommends using commitment data after 1996, and disbursement data after 2002.
2. The vast majority of projects in the AidData database are from 1973 onwards, although data on a few select donors are available prior to 1973.
3. WHO is the World Health Organization; GAVI is the Global Alliance for Vaccines and Immunization; BMGF is the Bill & Melinda Gates Foundation; EC is the European Commission; USAID is the United States Agency for International Development; UNAIDS is the Joint United Nations Programme on HIV/AIDS; UNICEF is the United Nations Children's Fund; US is the United States; WHO is the World Health Organization; WHOSIS is the WHO Health Organization Statistical Information System.
subjectively code the new variables, which might introduce some errors. At the time of writing, these new codes had only been introduced for a subset of the dataset. Finally, AidData has had to make some assumptions about categorizing the CRS data as a commitment or a disbursement, which may have led to under-reporting of disbursements. AidData aims to provide ongoing updates to their databases, however, it is not known when additional releases will be made.

**IHME DAH databases**

The Institute for Health Metrics and Evaluation (IHME) has developed its own DAH databases, which unlike the previous databases discussed, were developed specifically to track health projects (Institute for Health Metrics and Evaluation 2010). To compile their datasets, IHME begins with the data available in the OECD databases and then complements with additional data collected from reports, financial statements, online databases, tax filings and other sources of information (Institute for Health Metrics and Evaluation 2010). IHME uses a broader definition of aid that includes both ODA and non-ODA flows, including aid provided through private donors such as select NGOs and foundations as well as loans from IBRD. The IHME databases, updated annually, primarily include flows channelled through institutions whose main objective is the provision of development assistance. There are two main databases:

1. **The IHME DAH Database** (http://www.healthmetricsandevaluation.org/record/development-assistance-health-database-1990-2008), which allows users to examine the volume and sources of DAH received by different global health actors, referred to as ‘channels of assistance’, and to analyse trends in the volume of DAH disbursed by each channel over time; and

2. **The IHME DAH Database (Country and Regional Recipient Level)** (http://www.healthmetricsandevaluation.org/record/development-assistance-health-country-and-regional-recipient-level-database-1990-2008), which can be used to analyse DAH flowing from channels to countries and regions over time and to assess trends in aid earmarked for six health focus areas, HIV/AIDS; malaria; tuberculosis; health sector support; non-communicable diseases; and maternal, child and newborn health (Institute for Health Metrics and Evaluation 2010).

The IHME databases provide a number of advantages over the other datasets. First, the databases contain estimated disbursements from both public and private sources, including foundations such as BMGF. Second, as with AidData, multilateral donors are tracked using information obtained directly from the donors instead of using the data from CRS, which is incomplete for some multilateral donors (Ravishankar et al. 2009). Disbursement data not included in the CRS, such as data from GAVI prior to 2007, and the World Health Organization (WHO) and Pan-American Health Organization (PAHO), are also included. Third, IHME has carefully eliminated double-counting among those channels that provided sufficient data about sources of income and aid recipients. Finally, since there is usually a delay of a year or two on development assistance reporting, in addition to reporting actual disbursement data, IHME also generates preliminary estimates (i.e. projections) of DAH to provide more current estimates. The preliminary estimates are based on data from bilateral, multilateral and private channels including data from budgets, appropriations and correspondence. These data should be interpreted more cautiously than estimates based on actual disbursements.

Users should also keep in mind some of the limitations of the IHME datasets. IHME used statistical models to impute certain quantities in the dataset when faced with missing data, such as DAH flowing through NGOs (Institute for Health Metrics and Evaluation 2010). Also, while the IHME DAH Database includes DAH from many non-DAC bilateral donors, it only includes their contributions to the European Commission, the World Bank, UN Agencies and public–private partnerships that are tracked through these institutions’ income statements, but does not include direct transfers to developing countries. Furthermore, in tracking private flows, IHME’s databases only include DAH channelled through a subset of US-based NGOs and foundations, as non-US NGOs and foundations are more difficult to track. Finally, while the IHME DAH Database (Country and Regional Recipient Level) includes DAH estimates for six health focus areas, the raw project descriptions are not included in the databases, therefore it cannot be used to track DAH to health focus areas beyond those reported on by IHME.

In future updates of its DAH research, IHME is working on strategies to expand the scope of its databases and address these limitations.

**Donor-specific tracking mechanisms**

**Global Fund to Fight AIDS, Tuberculosis and Malaria**

The Global Fund provides detailed information on approved grants and disbursements against these grants on its website (http://portfolio.theglobalfund.org/). For each approved grant agreement, the Global Fund provides information on the principal recipient, the target disease area, the amounts disbursed and the date of disbursement. This information is reported in Excel format, summaries of which can also be obtained through the website. The data are updated as new grant agreements are signed and as disbursements against existing projects are made. However, the Global Fund does not provide any information on how the resources are used by the principal recipient, thereby limiting the usefulness of this data for analysis.

**GAVI Alliance**

GAVI Alliance data are available in the OECD-DAC databases. They provide detailed information on annual grant commitments and disbursements, project descriptions, country focus and primary recipient from 2007 onwards. GAVI’s financial statements include annual expenditure data on an accruals basis, which reflects expenditure when incurred instead of actual disbursements, from 2005 onwards (GAVI Alliance, no date; OECD-DAC, no date, c). For years prior to 2007, researchers can obtain country-level disbursement data from GAVI’s website (http://www.gavi alliance.org/performance/disbursements/index.php), but disbursement data comparable to the GAVI disbursement data reported to the OECD-DAC are not available on the GAVI website for these years. Users can obtain GAVI’s disbursement data for missing years from IHME’s DAH databases (Institute for Health Metrics and Evaluation 2010).
The OECD-DAC data allows users to analyse commitments and disbursements by recipient country, primary recipient and health focus area. Expenditure totals from GAVI’s financial statements are useful for observing time trends and comparing administrative vs programme expenses, but are not as detailed as the OECD-DAC data.14

GAVI updates its data annually. While it has made significant progress in transparency by reporting to the OECD-DAC, it could further improve its aid reporting by providing commitment and disbursement data for all years and all grants on its website, as GFATM does.

**Bill & Melinda Gates Foundation**

BMGF is the first foundation to report to the OECD-DAC, reporting 2009 data that have been included into the CRS including information such as sector and purpose codes, project descriptions, identification of primary recipient, and commitments and disbursements. Also, BMGF’s online grant database includes data on annual commitments for global health and other sectors from 1995 onwards (http://www.gatesfoundation.org/grants/Pages/search.aspx). Additional data include: name, location and website of the primary aid recipient; project description; terms of commitment; health focus area; and region.

While BMGF provides more detailed grant disbursement information than many other US foundations, users should be aware of the online grant database’s limitations. Disbursement data are missing, and details about recipient country or countries are sometimes available in the project description, but this level of detail is not systematically reported. Project-level disbursement data are available in BMGF’s tax forms, but these lack information on sector, region and health focus area that is available in the online grants database (Bill & Melinda Gates Foundation, no date; Guidestar, no date, a; Guidestar, no date, b). Researchers can merge data from these two sources, as IHME has done, but this process is arduous.15

BMGF’s online grant database is updated frequently, but it does not publish notifications about updates to the database. To analyse the data, users must copy and paste data into Excel, which makes using the data time-consuming.

While BMGF provides useful DAH data, several improvements could be made. It would be helpful if more years of data could be included in the CRS. In its online database, the inclusion of a variable denoting grant recipient country (when applicable) in addition to reporting the region(s) to which grants are allocated would be helpful. In addition, BMGF could set up a subscription service to alert users to updates, include disbursement information in the online grant database and allow users to export data. Since the CRS data has a one year lag, the availability of detailed disbursement data in BMGF’s online grants database could give users more timely access to data.

**World Bank**

The World Bank provides on its website a Projects Portfolio Search which allows users to search projects by recipient country, sector, theme and goal as well as year of project approval.16 The database is available from 1947 onwards and allows users to specify a particular theme, such as human development, as well as sub-themes (e.g. tuberculosis, malaria and injuries). Users can also search by goal, which includes health, communicable disease and health-related Millennium Development Goals. This basic information, as well as amount of commitment and year of approval, is provided in multiple formats making it easy for users to manipulate the data. Cumulative disbursement data are available upon exporting to Excel. Upon clicking on individual projects, further information is available such as the breakdown of the loan as well as the name of the recipient in-country.

Given these features, the World Bank database has many advantages for users looking for information on closed and on-going projects. However, it has two major limitations. First, data are provided cumulatively, not annually. The commitment amount is provided only for the year of approval with details on project duration, making it difficult to estimate yearly disbursements. Second, the database does not provide any information on World Bank Trust Funds, which have grown from $95 million in 2003–04 to $2.4 billion in 2006–07, which is almost equal to the core funding, provided by the International Bank for Reconstruction & Development (IBRD) and International Development Association (IDA) ($2.8 billion). In 2009, health and social services received 42% of all Trust Fund disbursements meaning that a large amount of finance is not recorded in the project portfolio search (World Bank Group et al. 2009).

The World Bank database could be improved by providing yearly disbursements and by establishing a Trust Fund database, similar to the Projects Portfolio database, to provide information on the significant resources flowing through this mechanism.

**The Regional Development Banks**

The Asian Development Bank (AsDB), the African Development Bank (AFDB) and the Inter-American Development Bank (IDB) have searchable project databases starting in the years 1968, 1991 and 1963, respectively, and up to the present.17 While all three banks generate lists similar to the World Bank project portfolio, this information is not exportable. In addition, limited information on the amount of the project is only available when clicking on each individual project. For the AsDB, for further details on the project, such as project length and cumulative disbursement information, users must go to a different part of the website which has a detailed description of the project in question. Complete information is only available on the commitment amount, not on annual disbursements. In contrast, the IDB provides detailed information on the description of the project, the objectives, the rationale and benefits, and finally the estimated cost (i.e. commitment). It also provides the name of the key contact for the project. Disbursement data are available for closed projects only. The IDB provides minimal project descriptions with cumulative commitments and disbursements, not annual disbursements, through the ‘Advanced Search’ on its website.

While the data provided by the Regional Development Banks are perhaps useful for those looking for individual project details, to move towards better accessibility and transparency, these banks should consider developing a similar online database to the World Bank that gives more detailed information in an exportable format. All of these banks also report their
data to the CRS and users may find that interface more useful for extracting aggregate data from these donors.

**USAID**
The US produces an annual publication known as the Greenbook, which provides data on the foreign aid loans and grants authorized\(^\text{18}\) by the US Government every fiscal year (http://www.usaid.gov/policy/greenbook.html). The data are available from 1946 onwards and are organized by recipient country and by programme area. Relevant to global health, the data can be categorized by a number of programme areas (e.g. the Global HIV/AIDS Initiative). However, if health projects are covered by other programme areas, these funds cannot be tracked using the Greenbook. The data reported in the Greenbook differ in a number of ways from the ODA flows reported to the OECD-DAC. Greenbook data are reported using a different calendar year, they include military assistance and contain reports on all countries that receive foreign aid from the US. The Greenbook does not provide any information about the primary recipient of each loan or grant in a given recipient country.

**Other relevant datasets**
WHOSIS, housed in WHO’s Global Health Observatory (http://www.who.int/gho/en/), provides data on external resources for health as a percentage of total expenditure on health from 1995 onwards, while the WHO’s National Health Accounts (NHA) include estimates of external resources for health from 1995 onwards (http://www.who.int/nha/en/). For some country years, these datasets contain estimates from in-country reports or NHAs. For other years, WHO relies on data sources such as the OECD-DAC and data from other international funders such as the Global Fund.\(^\text{19}\)

These data have important limitations. First, these databases neither disaggregate external resource data by donor, nor do they provide descriptions about the primary recipient and health focus areas of flows. Second, when WHO relies solely upon OECD-DAC to estimate external resources, private flows to countries are not captured, and flows from some global health actors like GAVI are likely underestimated (Institute for Health Metrics and Evaluation 2010).

For additional information on US foundations providing DAH, the Foundation Center provides tabular data on the foundations giving the most international health grants from 2004 onwards, and the total value of grants for international health since 2005 (http://foundationcenter.org/findfunders/statistics/listing02.html). Total grants for international health are grouped into six categories, including reproductive health care and mental health. While helpful for understanding the overall amount of DAH given by US foundations and information about total contributions from a select number of foundations, these data are highly aggregated. A publicly available database at the individual grant level that contained variables such as foundation name, grant amount, project descriptions, recipient name and recipient country would allow users to better track the geographical focus and purpose of DAH from US foundations.

Users in search of detailed information on DAH from foundations can also go straight to the source of these funds. In addition to BMGF, many foundations that provide large amounts of DAH have online grant databases, such as the Doris Duke Charitable Foundation, the Ford Foundation, the David & Lucile Packard Foundation and the William and Flora Hewlett Foundation.\(^\text{20}\) For more finely detailed information on foundations’ international health grants, users can collect data directly from these online resources if time permits.

Users seeking to find in-depth data on DAH from bilateral donors can review detailed project data on the following agencies’ websites: the UK’s Department for International Development (DFID), the Canadian International Development Agency (CIDA), the Swedish International Development Cooperation Agency (SIDA) and the Agence Française de Développement (AFD).\(^\text{21}\) These project databases provide information such as project descriptions, details about primary recipients and financial data. If using these databases, researchers should be aware that they may not capture all of the DAH provided by a bilateral donor during a given period of interest. If comparing the data from these agencies’ databases to OECD-DAC data, users need to consider that the data may not match due to differences in reporting standards.

**Discussion and conclusion**
The choices made in the design and construction of the various datasets that are available to track DAH may make one dataset more suitable to answer a particular question than another. Our goal is to provide an overview of these datasets to allow users to better understand the advantages and limitations of the datasets and to help them determine which dataset is best suited for their particular research question.

The CRS, AidData and IHME databases are all suitable for estimating trends in DAH. However, if users are interested in trends in ODA from the same set of donors over time, then the CRS might be the best option. If users wish to also include estimates of flows from non-DAC members, then AidData might be the most useful. If users are also interested in trends including select NGOs and foundations, when these data are available, then the IHME datasets might be the most appropriate.

The CRS and the AidData datasets also contain information on development assistance flows to the non-health sectors, and can provide estimates of total aid flows from particular donors or to particular recipients. Therefore, these datasets are the most appropriate to use when comparing DAH with other forms of international financial flows.

If users are more interested in overall allocations to particular disease areas, including funding that is channelled into countries and regions, then the IHME databases might be helpful. For other health areas, some disaggregation is also available using the purpose codes contained in the CRS and the AidData databases. If users are interested in aid flows from a particular donor, then users might be advised to use data directly from the donor.

No dataset is perfect. Users just need to understand the strengths and weaknesses of each dataset before using them. Furthermore, the authors encourage users to read the user guides or manuals that accompany these datasets for more details before using the data.
We welcome the efforts of donors and other agencies to increase the accessibility and transparency of DAH data. However, more improvements can still be made. First, the movement towards making data on DAH resource flows available on the web should be encouraged. While availability is the first step, accessibility, i.e., user friendliness, is equally important; for example, by making data downloadable in multiple formats. Second, donors should highlight when they release new versions of data and make efforts to ensure that users can easily incorporate newer updates into their analysis. Third, for most donors there are significant differences between the amounts they commit to a project in a given year and how much they actually disburse, and therefore all donors should report both commitments and disbursements. Finally, donors should provide timely information, as the Global Fund does, to enable researchers and decision-makers to understand what is happening to health aid flows with little delay.

A key step in improving the effectiveness of DAH is understanding where money comes from and where it goes. We hope this paper will be useful to a range of researchers, policy makers, donors and aid recipients so that they can choose the best data on which to base their DAH research.

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**Conflict of interest**

KAG: none. KLK and MS participated in the development of the IHME development assistance for health data datasets discussed in this manuscript. DS is a member of the IHME's Financial Flows Advisory Panel which advised the development of the IHME DAH datasets.

**Endnotes**

1. DAH is generally defined as external resources, financial or in-kind, that are channelled into a country from external sources to support health-related activities. It generally includes funding for health sector activities, as well as population programmes, but generally does not include activities outside the health sector that may impact health (e.g., water and sanitation programmes).

2. Calculated as the sum of commitments to purpose codes 120 (health), 130 (population) and 160.64 (social mitigation of HIV/AIDS) by both bilateral and multilateral donors in the CRS database in 2009 constant US dollars.

3. As of 1 January 2010, OECD-DAC members included: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Japan, Korea, Luxemburg, Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, United Kingdom, United States, and the Commission of the European Communities. Korea only became a member of the OECD-DAC in 2010. The multilateral organizations that report to the DAC are the World Bank, the African Development Bank, the Asian Development Bank, the Inter-American Development Bank, the International Fund for Agricultural Development, the United Nations Children’s Fund, the Joint United Nations Programme on HIV/AIDS, the United Nations Development Programme, the United Nations Population Fund, the United Nations Economic Commission for Europe, and the World Food Programme.

4. However, contributions from bilateral donors for projects executed by multilateral institutions but that are not financed through regular budgets (for example, Canada provides funding for a health system project in Mali but executed by the World Bank) would be included in the CRS under bilateral aid.

5. The DAC publishes coverage ratios for reported commitments and disbursement data in the CRS database. In general, commitments have higher coverage than disbursements. Users are encouraged to analyse the coverage ratios for the data before undertaking any analyses using the CRS data. As such, the DAC recommends not using the CRS commitment data prior to 1995 or disbursement data prior to 2002.

6. A number of non-DAC countries have begun to report their ODA contributions to the DAC secretariat on a voluntary basis in aggregate form; however, such data are not reported in the regular DAC databases. A list of these non-DAC countries, as well as aggregate aid data, can be obtained from the following website: http://www.oecd.org/document/0,3343_en_2649_34447_41513218_1,1_1_1_100.html.

7. In the future, it hopes to cover other forms of aid, such as those originating from NGOs and foundations, but this information is not yet available.

8. The additional donors include the Economic and Social Commission for Asia and the Pacific, the Economic and Social Commission for Western Asia, the Food and Agriculture Organization, the Fast Track Initiative, the World Trade Organization (WTO), the WTO - International Trade Centre, the World Bank, the European Investment Bank, the World Food Programme, the United Nations Children’s Fund, the Joint United Nations Programme on HIV/AIDS, the United Nations Development Programme, the United Nations Economic Commission for Europe, the World Food Programme.


11. IHME provides STATA code that allows users to eliminate double-counting in the data provided in the IHME DAH Database.


13. IHME has not directly tracked NGOs and foundations based outside the US due to data limitations.

14. Users should keep in mind that the GAVI data in the OECD-CRS and financial statements are produced using different accounting methods.

15. Alternatively, users can obtain BMGF disbursement data from IHME’s databases.


18. Actual disbursements, or outlays, are not recorded in the Greenbook.

19. The ‘Sources and Methods’ tab in NHA country pages contains information on data sources that WHO has used to estimate external resources for health.

References


