

Table 3. Distribution of ODA Commitments to IDA-Eligible Countries by Bilateral Donors and Multilateral Organizations

US\$ millions at 2004 prices, period averages, %, 1990-2004

Sector	1990-1994		1995-1999		2000-2004	
	Amount	%	Amount	%	Amount	%
Education	1,926	7%	2,289	7%	3,771	8%
Other social sectors	4,782	16%	7,120	23%	11,914	25%
Infrastructure	7,084	24%	7,243	23%	7,695	16%
Production	5,220	18%	3,598	11%	3,406	7%
Multi-sector	2,592	9%	2,735	9%	3,110	6%
Total Sector Allocable	21,604	73%	22,986	73%	29,897	62%
General Program Assistance	5,235	18%	3,421	11%	5,886	12%
Actions Relating to Debt	1,769	6%	2,625	8%	8,072	17%
Emergency	838	3%	1,958	6%	3,642	8%
Administrative costs of donors	-	0%	20	0%	76	0%
Support to NGOs	25	0%	12	0%	88	0%
Unallocated	123	0%	351	1%	344	1%
Grand total	29,594	100%	31,374	100%	48,006	100%

Source: CRS online (Table 1)

III. PROLIFERATION OF AID CHANNELS

23. **The global aid architecture has become increasingly complex, with the growing importance of non-DAC and other “emerging” donors²⁸ as well as with a high degree of aid proliferation and ODA fragmentation.** This paper associates “proliferation” with the number of donor *channels* providing ODA to a given recipient country, and “fragmentation” with the number of donor-funded *activities* as well as their average value.²⁹ Data analysis shows that there are a growing number of bilateral donors and international organizations, funds and programs over the last half century. The number of bilateral donors grew from 5-6 in the mid 1940s to at least 56 today (see Annex II for a partial list). There has also been a dramatic increase in the number of international organizations, funds and programs (see Annex III for a preliminary list³⁰ of over 230 of them). Many of these new funds and programs are specialized in a particular sector or theme.

24. **The impact of the proliferation of aid channels can be seen from the perspective of both donors and recipients.** Subsection A deals with the donors’ viewpoint, while subsection B deals with the recipients’ viewpoint. It is useful to first clarify a few conceptual issues. Aid channels can be either bilateral or multilateral, while ODA can be bilateral, multilateral or multi-bilateral. Multi-bilateral ODA refers to voluntary external assistance from donors for a multilateral agency which is supplementary to core membership contributions and which is earmarked for specific purposes.³¹ Given that such multi-

²⁸ See Box 1 for a brief discussion on non-DAC and emerging donors.

²⁹ See Box 2 for alternative measures of proliferation and fragmentation.

³⁰ All organizations included in the DAC *List of Main International Organizations* plus 10 well-known global programs not included in the list.

³¹ As stated in DAC’s *Managing Aid* (2005), “aid contributions qualify for recording as multilateral assistance only if: (a) they are made to an international institution whose members are governments and who conduct all or a significant part of their activities in favour of developing (or transition) countries; (b) those contributions are pooled with other amounts received so that they lose their identity and become an integral part of the institutions financial assets; and (c) the pooled contributions are disbursed at the institution’s discretion. Any ODA or official aid which does not fulfil these criteria is classified as bilateral assistance. This includes multi-bilateral (multi-bi) assistance, i.e.,

bilateral aid is classified as bilateral aid in published DAC statistics, it has been necessary to separately estimate this significant and growing type of ODA.

Box 1. Non-DAC and Emerging Donors

Non-DAC and emerging donors are becoming increasingly important as ODA providers. New donors bring with them more resources to help developing countries reach their MDGs. At the same time, new challenges for harmonization and alignment are created. Non-DAC donors are a fairly heterogeneous set of countries, which can be broadly classified into four groups³²: (i) OECD countries which are not members of DAC, such as Korea, Mexico, Turkey and several European countries; (ii) new European Union countries which are not members of the OECD; (iii) Middle East and OPEC countries, particularly Saudi Arabia; and (iv) non-OECD donors that do not belong to any of the previous groups, including Brazil, China, India and Russia. Two of the most important policy challenges as regards non-DAC and emerging donors are: (i) the limited availability of data regarding their aid volumes and terms; and (ii) their diverse approaches to harmonization and alignment.

Insufficient data on non-DAC ODA makes it difficult to accurately assess aid volumes and prospects from these sources.³³ Non-DAC OECD countries alone are expected in aggregate to double their current ODA levels to over \$2 billion by 2010. See Manning (2006), *op. cit.*, p. 373. Available information suggests that non-DAC donors have been particularly involved in humanitarian aid. In response to the Indian Ocean tsunami in early 2005, for example, 70 non DAC donors responded with pledges of support. A recent ODI study³⁴ found that non-DAC donors accounted for up to 12 percent of official humanitarian financing in the period 1999-2004 (based on data from OCHA's Financial Tracking System), focused their efforts in a few countries (i.e., Afghanistan, Iraq, North Korea and the occupied Palestinian Territories), and preferred bilateral aid over multilateral routes.

Although a number of non-DAC donors signed the Paris Declaration (see subsection IV.C), harmonization challenges remain present. The degree to which DAC approaches and norms as regards the provision aid finance are applied by different non-DAC countries varies across the four country groupings described above. Manning (2006) highlights three main risks for low-income countries (LICs) associated with insufficient harmonization between DAC and non-DAC donors: (i) LICs – particularly those with enhanced “borrowing space” in the wake of MDRI – might find it easier to borrow on inappropriately non-concessional terms; (ii) LICs may also have increased opportunities to access low-conditionality aid that could help postpone much-needed reforms; and (iii) if good practices in project appraisal are not followed, increased aid could translate partly into more unproductive capital projects in LICs. These risks could be mitigated by means of a strong, coordinated effort to implement the principles and targets of the Paris Declaration (see subsection IV.C).

voluntary external assistance from donors for a multilateral agency, supplementary to core membership contributions, which is earmarked for specific purposes.” (p. 102)

³² See Manning, R. (2006). “Will ‘Emerging Donors’ Change the Face of International Co-Operation?”, *Development Policy Review*, 24(4).

³³ See IMF and World Bank (2006). *Global Monitoring Report*, p. 75: “Data on so-called South-South Assistance are incomplete, however, making it difficult to obtain comprehensive information on South-South aid volumes and prospects.”

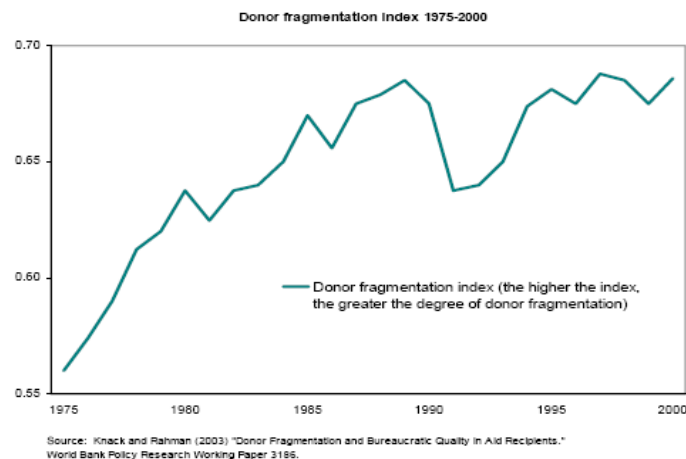
³⁴ Harmer, A. and L. Cotterrell (2005). *Diversity in Donorship: The changing landscape of official humanitarian aid*. The Humanitarian Policy Group at the Overseas Development Institute.

Box 2. Alternative Measures of Proliferation and Fragmentation

The definitions of proliferation and fragmentation adopted in this paper are simple and intuitive, but these terms are used in a somewhat different way in recent empirical studies. For example, Knack and Rahman (2004, p. 12) define “donor fragmentation” as a large number of donors each with a small share of the total aid provided to a given recipient country. Their definition – which is more closely related to the definition of proliferation adopted in this paper – is translated into a measure that equals one minus a Hirschman-Herfindahl donor concentration index³⁵, as follows:

$$1 - \sum s_d^2,$$

where s_d is the share of each donor in total ODA provided to a given recipient. By subtracting the Hirschman-Herfindahl donor concentration index – which varies from 0 to 1 – from one, a measure of donor dispersion or “fragmentation” is obtained. They calculate this measure using two alternative sources of data: DAC and Development Gateway’s AiDA (Accessible Information on Development Activities) database. Based on the DAC data, they conclude (p. 14) that “year-by-year changes in this fragmentation index, average over all countries, show an upward trend from 1975 onward. This increase largely reflects an increase in the number of DAC donors.” This upward trend can be seen in the chart below:



Acharya *et al.* (2006, p. 8) point out that “from the perspective of the aid recipient, donors can be responsible for proliferation of two distinct kinds. The first we label *source proliferation*: the provision of aid to a particular country from a wide variety of donors in relatively small amounts. The second, *use proliferation*, is the division of aid among a wide variety of end-uses in-country. This latter concern is essentially the old question of how far a given volume of aid is divided into small packets (‘projects’) or large packets (‘programmes’).” What they call “source proliferation” is closer to the notion of proliferation adopted in this paper, while their concept of “use proliferation” is closer to “fragmentation” as used here.

Like Knack and Rahman, Acharya *et al.* calculate an Index of Recipient Fragmentation (IRF) – measuring “use proliferation” – based on a Hirschman-Herfindahl index. In addition, they calculate an Index of Donor Proliferation (IDP) which aims to measure “how widely each donor disperses a budget of \$X” (p. 9). The IDP is based on an alternative measure of concentration, the Theil Index³⁶. They show that the IRF and the IDP are positively correlated, suggesting that “the very high degree of *fragmentation* experienced by some aid recipients is directly attributable to the fact that their donors are especially likely to *proliferate* their aid.” (p. 14).

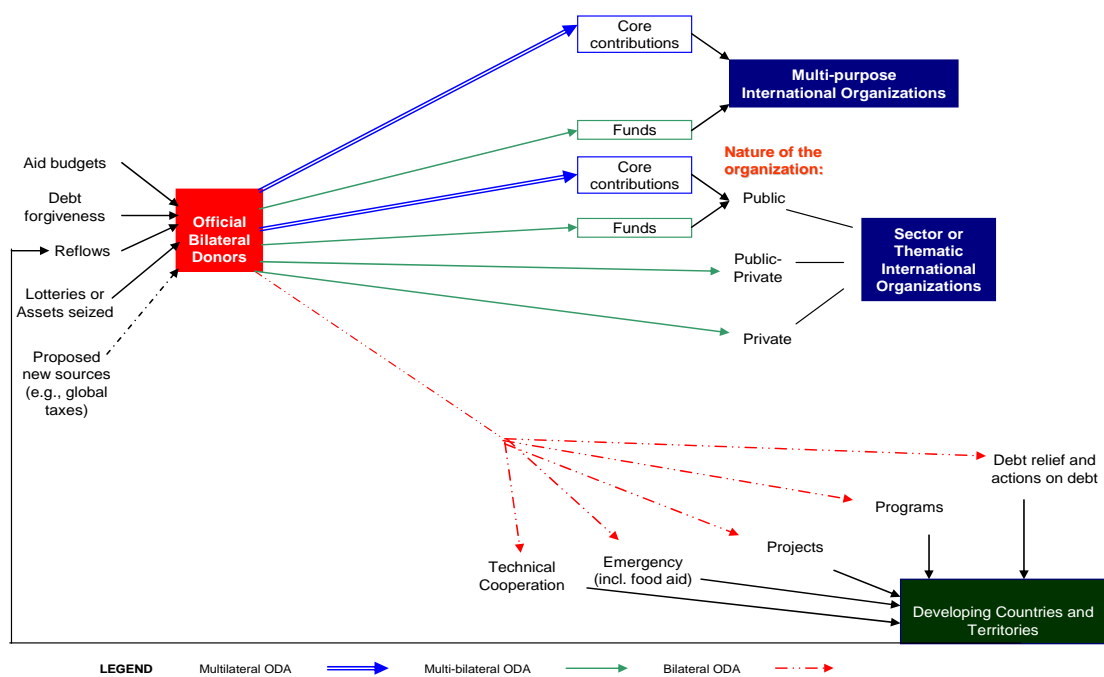
³⁵ The Hirschman-Herfindahl index is more commonly used as a measure of the degree of concentration – in terms of the number and size of firms – in a given industry. In this case, the parameter s would be interpreted as the market share of each individual firm. The lower (higher) is the index, the more (less) competitive is the industry. A value of 1 for the index indicates a single monopolistic firm.

³⁶ See also Kapoor, S. (2006). “Making Aid More Effective: Tackling Aid Proliferation and Aid Fragmentation – A Think Piece”. World Bank, processed, for a review of this literature.

A. The Donors' Viewpoint

25. **Official bilateral donors channel resources through both bilateral and multilateral channels.** This is shown in Chart 8. In 2005, about a third of ODA (32 percent) was channeled through multilateral channels, while the balance went directly to developing countries as described below. Over two thirds (70 percent) of the aid disbursed to multilateral channels was multilateral, while the balance (30 percent) was multi-bilateral, including trust funds. Multilateral channels can be distinguished between multi-purpose international organizations (that operate in several sectors and countries like the European Commission or IDA) and specialized or thematic international organizations (whose activities are focused on a particular theme or sector, like UNICEF or GFATM).³⁷

Chart 8. Donor View of ODA through Bilateral and Multilateral Channels



26. **About half of the bilateral contributions channeled through multilateral channels in 2005 went through some degree of earmarking by sector or theme.** This figure is an approximation based on 2005 annual reports. It includes not only trust funds and other multi-bilateral ODA, but also contributions to sector or thematically targeted multilateral organizations.³⁸ Besides complicating budgetary management,³⁹ earmarking may lead to a misalignment between donors' and recipient countries' priorities. By constraining recipients' flexibility in allocating resources, earmarking may contribute to

³⁷ Within the latter group, it is also possible to differentiate between organizations that are controlled and managed by public entities (i.e., inter-governmental or inter-agency organizations like UNAIDS), public-private partnerships (i.e., funded and operated through a partnership of government and/or intergovernmental organizations and one or more private sector companies or private foundations – as in the case of GAVI), or purely private (i.e., international NGOs like Médecins Sans Frontières).

³⁸ Staff estimates of the distribution among channels are purely indicative, as DAC statistics do not provide this level of detail. Estimates have been derived from the various organizations' Annual Reports (latest available) and then combined with information from DAC online.

³⁹ See e.g. Gottret, P. And G. Schieber (2006). *Health Financing Revisited. A Practitioner's Guide*. Washington, D.C.: The World Bank, 131.

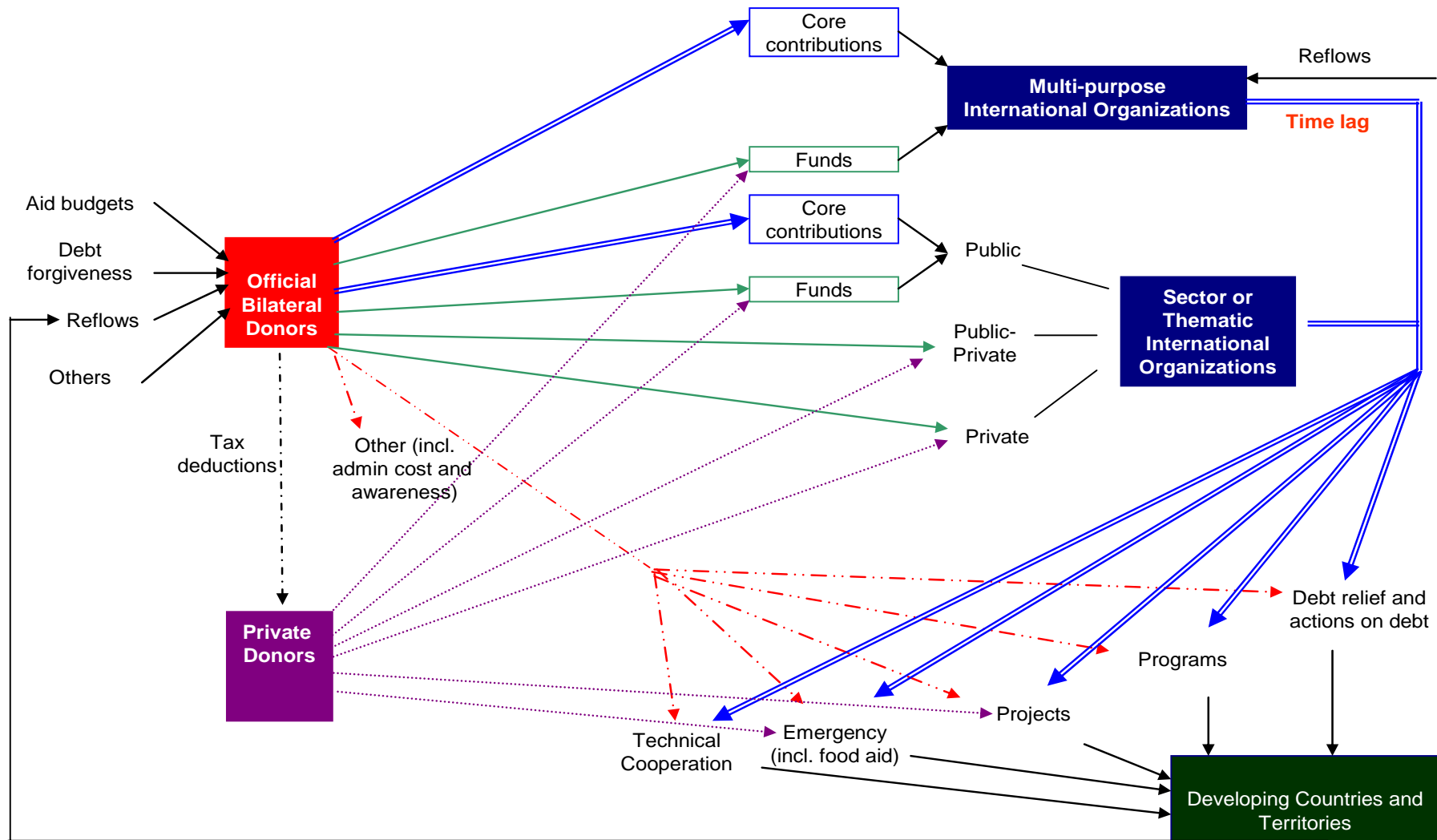
underfunding of other investments which are equally important for economic growth and poverty reduction.

B. The Recipients' Viewpoint

27. **The growing importance of sector/thematic international organizations and private donors further increased the complexity of the aid architecture from the recipients' standpoint.** The complexity of the various inter-linkages can be gauged by inspecting Chart 8 which also shows – besides ODA – a greater role for the private sector in aid funding and implementation. Private philanthropy in aid has grown in importance in recent years.⁴⁰ In addition, competition among multilateral channels for a largely stable pool of resources has been combined with an increase in the role of private providers/managers of aid. About 6 percent of all reported official aid to developing countries has been provided through NGOs and public-private partnerships. The latter are a new phenomenon that emerged in the mid 1990s when global programs started to be deliberately set up outside the UN system. Global programs and “vertical funds” are discussed in more detail in Box 3.

⁴⁰ As noted in a recent study by the World Bank's Global Programs and Partnerships (GPP), “according to the U.S. Foundation Center, US foundations gave a record estimated \$3.8 billion in 2005. The Gates Foundation's international giving is the major component of this, doubling from \$526 million in 2002 to \$1.2 billion in 2004.” See World Bank (2006), “Changes in the International Aid Architecture and ODA Trends”, Global Programs and Partnerships, processed, p. 30. See also US Foundation Center (2006). *International Grantmaking Update*. Private philanthropic aid is also significant in Europe and Japan.

Chart 9. Recipient Countries' View of Aid Channels



LEGEND Multilateral ODA Multi-bilateral ODA Bilateral ODA Private Aid

Box 3. Global Programs and Vertical Funds

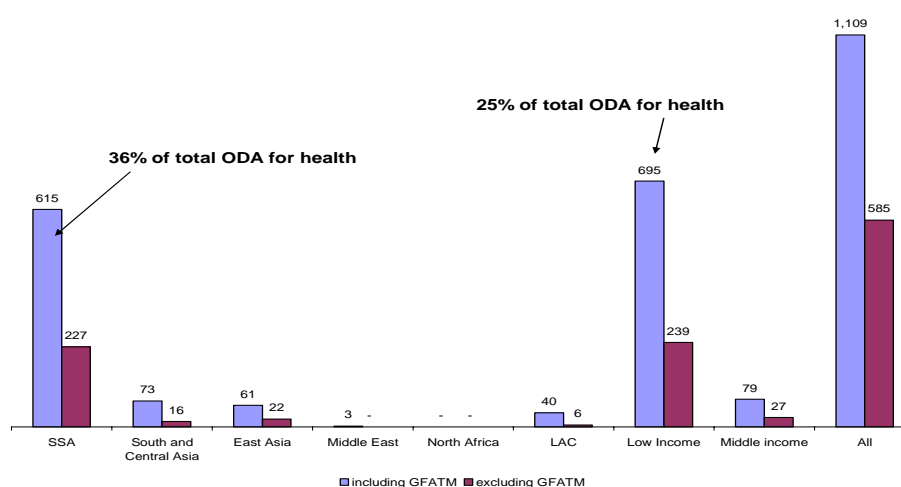
Global programs – often referred to also as “global funds” or “vertical funds” – are defined (see IEG, 2004) as “partnerships and related initiatives whose benefits are intended to cut across more than one region of the world and in which the partners: (a) reach explicit agreement on objectives; (b) agree to establish a new (formal or informal) organization; (c) generate new products or services; and (d) contribute dedicated resources to the program.” In other words, global programs focus “vertically” on specific issues or themes, in contrast with the “horizontal” approach of the country-based model of aid.

While the first major global program, the Consultative Group on International Agricultural Research (CGIAR), was established 35 years ago, the current “boom” in vertical funds started in earnest when several large such funds were created in the late 1990s. Contributions to global programs represented 3 percent of total ODA in 2005. The main sectors covered by global programs are health (e.g., the Global Fund for Aids, Tuberculosis, and Malaria, GFATM) and environment (e.g., the Global Environmental Facility, GEF). The rapid increase – in both size and country eligibility – of the Catalytic Fund (CF) under the Education for All/Fast Track Initiative (EFA/FTI) in recent months will also mean that a rising share of education sector financing will come from a global program.

“Verticalization” or earmarking of ODA can also be seen in bilateral assistance programs, such as the U.S. government’s PEPFAR.⁴¹ The PEPFAR has been driving the rising trend in bilateral assistance for HIV/AIDS among DAC donors.⁴²

Vertical funds may lead to an increase in the importance of the specific interventions they support in the overall financing for a given country. For example, GFATM has increased the weight of infectious disease control in total aid for the health sector, particularly in Sub-Saharan Africa (see chart below).

Aid for Infectious Disease Control (US\$ million at 2004 prices, 2005)



The effectiveness and the sustainability of global programs will ultimately rest on the presence of complementary sector-level and country-level policies. As noted in the 2006 Global Monitoring Report (p. 78), “global funds need to support country-led strategies and priorities (...)”. A recent joint DAC-World Bank workshop (Paris, December 5, 2006) concluded that a “mutually reinforcing approach” between global programs and the country-based aid delivery model should be developed, focusing on complementarities and strengthening the alignment of “vertical” aid with country programs.

⁴¹ President's Emergency Plan for AIDS Relief.

⁴² See Gottret and Schieber (2006), *op. cit.*, p. 135. According to the PEPFAR website (www.pepfar.gov), “the U.S. President's Emergency Plan for AIDS Relief (Emergency Plan/PEPFAR) is the largest commitment ever by any nation for an international health initiative dedicated to a single disease -- a five-year, \$15 billion, multifaceted approach to combating the disease around the world.”

28. **Donor proliferation at the country level has continuously increased over time.** The average number of donors per country nearly tripled over the last half century, rising from about 12 in the 1960s to about 33 in the 2001-2005 period. The combination of more bilateral donors and of an increasing number of multilateral channels has led to an increasingly crowded aid scene.⁴³ Aid channel proliferation at the country level has been substantial, particularly after the end of the Cold War when the number of countries with over 40 active donors and international organizations grew from zero to thirty-one.⁴⁴ The number of international organizations, funds and programs is now higher than the number of developing countries they were created to assist.

29. **Multiple aid channels impose an additional strain on already weak implementation capacities in low-income countries.**⁴⁵ In fact, “managing aid flows from many different donors is a huge challenge for recipient countries, since different donors usually insist on using their own unique processes for initiating, implementing, and monitoring projects. Recipients can be overwhelmed by requirements for multiple project audits, environmental assessments, procurement reports, financial statements, and project updates”.⁴⁶

30. **Proliferation of aid channels is particularly pronounced in the health sector.** In fact, more than 100 major organizations are involved in the health sector, a much higher degree of proliferation than in any other sector.⁴⁷ Insufficient clarity of mandates and roles for the various donor organizations – associated with the earmarking of much such aid – makes it difficult to reconcile with “the development of a holistic approach to health systems and sustainable financing at the country level.”⁴⁸ The effectiveness of increased ODA financing for health will rest on finding an appropriate balance between providing resources for disease- and intervention-specific health programs and strengthening health systems. The Rwanda case (see Box 4) clearly shows that work on health systems and sustainable financing requires a substantial increase in coordination and harmonization in the health sector. This needs to be done in a manner that enhances inter-sectorality and country focus, while strengthening recipient country leadership and ownership of ODA financed efforts in the health sector.

⁴³ Available data do not indicate that donor proliferation has been particularly more severe in IDA-eligible countries.

⁴⁴ The year of the start of donor operations in a particular country has been made equal to the year when each donor reported its first disbursement to DAC. While this is the best available data, donors may have started operations earlier without reporting it to DAC, while some non DAC donors (e.g., China, India) do not report data on their activities to DAC and therefore are not included.

⁴⁵ See Knack, S. and A. Rahman (2004). “Donor Fragmentation and Bureaucratic Quality in Aid Recipients”. World Bank Policy Research Working Paper 3186, January. The authors show that aid fragmentation across donors could be taxing on the bureaucratic quality of recipient countries (with causation running from fragmentation to bureaucratic quality). See also Box 1 in this paper.

⁴⁶ Radelet, S. (2006). “A Primer on Foreign Aid”. Center for Global Development Working Paper, No. 92, July, p. 15.

⁴⁷ This figure includes private donors, but not NGOs. Schieber, G., L. Fleisher, and P. Gottret (2006). “Getting Real on Health Financing”. Finance and Development, Vol. 43, No. 4, December, p. 8.

⁴⁸ Schieber, G., L. Fleisher, and P. Gottret (2006), op. cit., p. 7.

Box 4. Health Sector Financing and Public Spending: The Case of Rwanda

The health sector in Rwanda has received increased funding both from donors and the State budget. As noted in a recent report prepared by the government of Rwanda, the health sector share of public expenditure quadrupled over the last decade: the health sector accounted in 2005 for about 10 percent of government spending – up from 2.5 percent in 1998.^{1/} In addition, health sector interventions (including HIV/AIDS-related interventions, which DAC classifies under "Population Programmes" rather than health) received 14.5 percent of total ODA and 21.5 percent of sector allocable ODA to Rwanda in the period 2001-2005. In 2004, donor grants represented about half of total government spending in Rwanda, but this figure would actually underestimate the importance of foreign aid in Rwanda because of off-budget funding, especially in the health sector.

Rwanda’s experience highlights the fundamental problems with the ways in which aid for health is delivered. A recent review of development assistance for health (DAH) to Rwanda documented three major issues the government faces in making sure resources translate into results.

The first is the challenge of achieving policy coherence – and even basic fiscal monitoring – given the fact that only 14 percent of total donor support for health is channeled through the Rwandan Ministry of Health and another 12 percent by local governments or health districts. The remaining 75 percent of donor aid goes directly to NGOs or is directly managed by the donors through their own projects (see Table below).

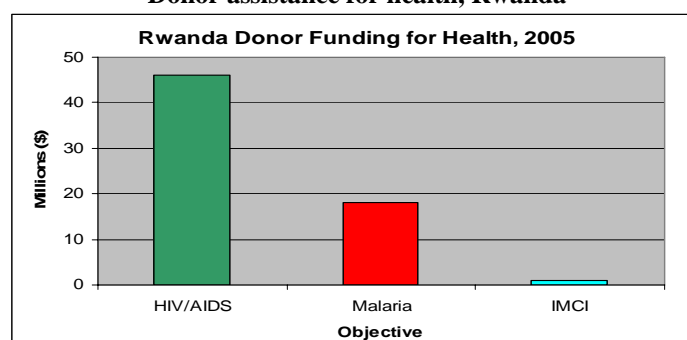
Who Spends Donor Aid for Health in Rwanda?

Financing Agent	Percentage of Donor Aid
Central Government	14.3
NGOs	54.8
Development Partner Direct Management	19.0
Direct to Local Government or Health District	11.9
Total	100.0

Source: MINISANTE, National Health Accounts, April 2006

A second issue is misalignment of funding in relation the country’s burden of disease and with government priorities as established in the country’s own health strategy: \$46 million of its current assistance is earmarked for HIV/AIDS, \$18 million for malaria, and only \$1million for the integrated management of childhood illnesses (IMCI) (see chart below). Rwanda has a 3 percent HIV/AIDS prevalence rate and despite progress, infant mortality rate remains high at 118 per 1000 and maternal mortality at 1,400 per 100,000. The Rwanda health strategy calls for improving the health system and incentives therein in order to improve access to the population to essential health services.

Donor assistance for health, Rwanda



A third issue is volatility and the absence of long term commitments: much of the assistance to Rwanda, like other countries, reflects annual or biannual commitments, with the notable exception of bilateral aid from the UK. This leads to substantial variations in the level of funding from year to year, and inhibits long-term planning. In two areas in particular – national decisions to scale up health service provision by training and hiring more doctors and nurses, and the increase in the number of patients on long-term anti-retroviral (ARV) treatment – Rwanda incurs major risks of sustainability.