

THE SUSTAINABILITY OF DONOR FUNDED PROJECTS IN THE HEALTH SECTOR

T MITCHELL (B.Com Honours)

Student number: 13101021

DISSERTATION

submitted as fulfilment of the
requirements for the degree

MAGISTER COMMERCII

in the
SCHOOL OF ACCOUNTING SCIENCES
at the
VAAL TRIANGLE CAMPUS
of the

NORTH-WEST UNIVERSITY

Supervisor: Prof. Dr. P Lucouw

CO-Supervisor: Prof. Dr. P Buys

May 2013

ABSTRACT

The need for donor funding has increased significantly over the last decade. Without donor funding millions of people wouldn't be alive today. Thanks either to research finding a cure, successful treatment, funds donated for food, aid toward building infrastructure, or giving people the opportunity to further their education. Donor funding thus facilitates a better future.

A literature review was conducted to give background on the health sector and how these funds were distributed, ethical clearance, different types of reporting, the role project managers play in a project and the sustainability of projects. Expenses in different countries were evaluated by gathering data from the internet, while two international funded projects are also used to state how funders divide their line items into different categories. The empirical study used a qualitative research approach by collecting and analysing data obtained from the MDG 2010 report and other freely available data on the web.

The main findings from this thesis are:

- The Millennium Development Goals (MDG's) influence donor funding as it gives donors a guide towards funding needs. Donors are also influenced by their own preferences or what poses a burden to them individually.
- The different types of reporting required for funding received, delay a project and the bureaucratic structures thereof are a hindrance.
- Ethical clearance plays a fundamental role in the outcome of a project, as without ethical clearance a project cannot commence.
- The objectives of a project play a critical role when applying for funding. This can change the focus of a project.
- Expenses differ from country to country and funders need to take this into account when giving funding to recipient countries.
- Project Managers and community involvement play a critical role in ensuring sustainability of projects.

- The MDG's are not on track and aid are focus on singular goals instead of multiple goals, to ensure an overall improved result.

There is a major gap between needed funds and given funds. A single injection of funds will not be the solution to our health problem; different sectors need to collaborate together as we are facing a multi-dimensional problem. Trade and reform must also form part of this aid, ensuring a sustainable progression in the life's of people. Donor funded projects may have a sustainable future, when taking in account the abovementioned findings.

With the world trend in reporting changing rapidly, cost and management accountants as well as financial accountants and project managers have to equip them to adhere to the new way of reporting, namely integrated and sustainability reporting. South Africa is way behind and needs to catch up fast if they want to stay competitive in the "global donor funding market".

The limitations in this study were that not all expenses were evaluated and only 15 countries were looked at. An indebt look was taken into Africa with the empirical review, while Asia is also combating poor health issues. Some African countries like Sierra Leone and Zimbabwe did not have sufficient data to compare with other countries.

From the research conducted, the following topics were identified that require further research:

- Why are most projects in Third World countries not sustainable?
- What plans are put into action to ensure that the MDG goals are reached?
- Investigate what works for First World countries health systems and consider how that can be applied to Third World countries to ensure that they also get the best health care available.
- Do donors take into account the different costs of countries when allocating funding to that specific country?
- Establishing models to evaluate the sustainability of pilot projects and normal projects.
- Establishing a model on how to distribute donor funds across different needs and not only one specific need.

UITTREKSEL

Die vraag na skenkingsfondse het oor die afgelope dekade aansienlik toegeneem. Die fondse wat beskikbaar gestel word vir navorsing, voedsel of die opbou van infrastruktuur kan toegeskryf word aan die oorlewing van sekere mense vandag. Befondsing lei ook daartoe dat mense hul kwalifikasies kan verbeter en soedoende 'n beter lewe kan lei.

'n Literatuurstudie is uitgevoer om 'n agtergrond te gee op die gesondheid sektor en hoe fondse versprei is, etiese keuring, verskillende tipes van verslagdoening, die rol wat projek bestuurders speel in 'n projek en die volhoubaarheid van die projekte. Uitgawes in verskillende lande is geëvalueer deur die insameling van data vanaf die internet, terwyl twee internasionale gefinansierde projekte ook gebruik was om aan te dui dat befonders hul gelde in lyn items binne verskillende kategorieë verdeel. Die empiriese studie is gedoen deur 'n kwalitatiewe navorsings benadering. Data van die MDG 2010 verslag en ander vrylik beskikbare data op die internet is versamel en ontleed.

Die belangrikste bevindings van hierdie tesis is:

- Die Millennium Ontwikkelingsdoelwitte (MDG's) het 'n invloed op hoe skenkers geld gee. Skenkers word ook beïnvloed deur hul eie voorkeure, of iets wat hulle as individu persoonlik raak.
- Die verskillende tipes verslagdoening wat vereis word vir skenkings befondsing ontvang, kan as 'n hindernis gesien word in 'n projek as gevolg van die burokratiese strukture daarvan.
- Etiese keuring speel 'n belangrike rol in die uitslag van 'n projek, want sonder etiese keuring kan 'n projek in die gesondheidsektor nie begin word nie.
- Die doelwitte van 'n projek speel 'n belangrike rol by die aansoek om befondsing. Befondsing wat wel beskikbaar is, kan die fokus van 'n projek verander.
- Uitgawes verskil van land tot land en befonders moet dit in ag neem wanneer hul befondsing gee aan ander lande.
- Projek Bestuurders asook die gemeenskap se betrokkenheid speel 'n kritieke rol in die versekering in volhoubaarheid van projekte.
- Die MDG's se doelwitte is nie naasteby bereik nie en befondsing is gefokus op enkele doelwitte, in plaas daarvan om veelvoudige doelwitte gelyktydig te befonds, wat 'n algehele beter resultaat sal verseker.

Daar is 'n groot gaping tussen die befondsing wat nodig is en die befondsing gegee. Die skenking van geld alleenlik as hulp, sal nie die oplossing vir ons gesondheid probleem bied nie; verskillende sektore moet saamwerk, aangesien daar 'n multidimensionele probleem teenwoordig is.. Handel en hervorming moet ook deel vorm van hierdie hulp, dit sal sorg vir 'n volhoubare verbetering in die lewe van mense. Skenker-gefinansierde projekte kan slegs 'n volhoubare toekoms hê met inagneming van die bogenoemde bevindinge.

Met die wêreld tendens in verslaggewing wat vinnig besig is om te verander, sal koste en bestuurs rekenmeesters, sowel as finansiële rekenmeesters en projek-bestuurders hulle moet toerus om te voldoen aan die nuwe manier van verslagdoening, naamlik geïntegreerde en volhoubare verslagdoening. Suid-Afrika is egter ver agter aan hierdie manier van verslagdoen en sal vinnig moet inhaal, as hulle kompetend wil bly in die "globale skenker geld mark".

Die beperkinge in hierdie studie was dat, nie alle uitgawes geëvalueer was nie en slegs 15 lande gebruik is in die ontleding van uitgawes. Daar is in diepte gekyk na Afrika in die empiriese hoofstuk, terwyl Asië ook geklassifiseer is as een van die kontinente met swak gesondheid kwessies bekampings. Sommige Afrika-lande soos Sierra Leone en Zimbabwe het nie voldoende data om met ander lande te vergelyk nie.

Uit die navorsing wat gedoen is, is die volgende onderwerpe geïdentifiseer wat verdere navorsing ontluik het:

- Hoekom is die meeste projekte in Derde Wêreld-lande nie volhoubaar nie?
- Watter planne in werking gestel om te verseker dat die MDG doelwitte bereik word?
- Ondersoek wat werk vir die Eerste Wêreld-lande se gesondheidstelsels en kyk hoe dit toegepas kan word na die Derde Wêreld-lande, om te verseker dat hulle ook die beste gesondheidsorg beskikbaar is.
- Neem skenkers kennis van die verskillende kostes van die lande by die toekenning van befondsing aan daardie spesifieke land?
- Die vestiging van modelle om die volhoubaarheid van die loods projekte en normale projekte te evalueer.
 - Die vestiging van 'n model vir die verspreiding van skenker geld oor verskillende behoeftes en nie net een spesifieke behoefte nie..

ACKNOWLEDGEMENTS

Do not withhold good from those to whom it is due, when it is in the power of your hands to do so.

Proverbs 3:27

I would like to express my sincere thanks and gratitude to all the people who were involved in making the writing and completion of this thesis possible, particularly the following individuals:

- * My supervisors: Prof Pierre Lucouw and Prof Pieter Buys, for their professional guidance, patience, time and encouragement. Thank you very much.
- * My colleagues at work: Prof Hester Klopper, Dr Siedine Knobloch-Coetzee, Ms Engela van der Walt, Dr Petra Bester and Mr Francois Watson, for all the help, guidance, support and motivation you provided me. Especially for the opportunity that Prof Klopper gave me to further my studies.
- * My family: My mom, sister & husband, and grandparents, for all the support you have given me during this time.
- * All my friends: Ms Daleen Schoombee, Ms Elbie Barends, Ben and Petro Coetzee, Ms Carina Grobelaar and Ms Andrea Burger – for all your support during this time. Ms Rojanette van Tonder – for all your help and guidance, as well as showing me useful shortcuts, it really helped a lot. Dr Charl Schutte: for overseeing the language editing.
- * The staff of the Ferdinand Postma Library; for all their help in searching for relevant information and obtaining research material, thank you very much.
- * Everyone that supported me in any way in finishing my masters on time: thank you for your motivation, guidance, love and patience. Without you I would never have finished it.

TABLE OF CONTENTS:

| | |
|--|-------------|
| LIST OF ABBREVIATIONS: | xi |
| LIST OF FIGURES | xiii |
| LIST OF TABLES | xix |
| LIST OF GRAPHS | xx |
| CHAPTER 1: INTRODUCTION | 1 |
| 1 INTRODUCTION | 1 |
| 1.1 Background on Donor Funding..... | 1 |
| 2 BACKGROUND ON DONOR FUNDING IN THE HEALTH SECTOR | 2 |
| 3 STATEMENT OF THE PROBLEM AND BACKGROUND | 3 |
| 3.1 Background on the Health Sector | 3 |
| 3.2 The Problem Statement | 4 |
| 4 OBJECTIVES | 4 |
| 4.1 Main Objective | 4 |
| 4.2 Secondary Objectives | 4 |
| 5 RESEARCH METHOD | 5 |
| 5.1 Literature Review | 5 |
| 5.2 Empirical Review | 6 |
| 6 OVERVIEW | 6 |
| <input type="checkbox"/> Chapter 1: Introduction..... | 6 |
| <input type="checkbox"/> Chapter 2: Donor Funding in the Health sector | 6 |
| <input type="checkbox"/> Chapter 3: Sustainability Reporting | 7 |
| <input type="checkbox"/> Chapter 4: Ethical Clearance for Research in the Health sector | 7 |
| <input type="checkbox"/> Chapter 5: Goal versus Financing Conditions | 7 |
| <input type="checkbox"/> Chapter 6: The Sustainability of a Project after Donor Funding has ended..... | 7 |
| <input type="checkbox"/> Chapter 7: Empirical Review about Donor Funding in the Health Sector | 8 |
| 7.1–7.4 Research Conducted through Statistical Analysis..... | 8 |
| 7.5 Conclusions made from Empirical Review conducted in 7.1 – 7.4..... | 8 |
| <input type="checkbox"/> Chapter 8: Conclusions and Recommendations | 8 |

| | |
|--|-----------|
| CHAPTER 2: DONOR FUNDING IN THE HEALTH SECTOR | 10 |
| 2.1 Introduction | 10 |
| 2.2 The Value Chain | 10 |
| 2.3 The MDG'S | 13 |
| 2.4 WORLD WIDE VIEW | 17 |
| 2.4.1 Canada | 21 |
| <input type="checkbox"/> Background on Canada | 21 |
| <input type="checkbox"/> Background on the health sector in Canada: | 21 |
| <input type="checkbox"/> Funding towards Canada's health sector: | 22 |
| 2.4.2 Germany | 24 |
| <input type="checkbox"/> Background on Germany | 24 |
| <input type="checkbox"/> Background on Germany's health sector | 25 |
| <input type="checkbox"/> Funding towards Germany's health sector: | 25 |
| 2.4.3 Australia | 27 |
| <input type="checkbox"/> Background on Australia | 27 |
| <input type="checkbox"/> Background to Australia's health sector | 27 |
| <input type="checkbox"/> Funding towards Australia's health sector: | 28 |
| 2.5 AFRICA | 30 |
| 2.5.1 Kenya | 32 |
| <input type="checkbox"/> Background to Kenya | 32 |
| <input type="checkbox"/> Background to Kenya's health sector | 32 |
| <input type="checkbox"/> Funding towards Kenya's health sector | 34 |
| 2.5.2 Zambia | 35 |
| <input type="checkbox"/> Background to Zambia | 35 |
| <input type="checkbox"/> Background to Zambia's health sector | 35 |
| <input type="checkbox"/> Funding towards Zambia's health sector | 36 |
| 2.5.3 Sierra Leone | 38 |
| <input type="checkbox"/> Background on Sierra Leone | 38 |
| <input type="checkbox"/> Background on Sierra Leone's health sector | 39 |
| <input type="checkbox"/> Funding towards Sierra Leone's health sector | 39 |
| 2.6 SOUTH AFRICA | 41 |
| <input type="checkbox"/> Background to South Africa | 41 |
| <input type="checkbox"/> Background to the health sector in South Africa | 42 |

| | | |
|-------------------|---|------------|
| 4.3.1 | Background on RN4CAST Project | 78 |
| 4.3.2 | Ethical Clearance obtained for RN4CAST | 78 |
| 4.4 | Time versus Cost | 82 |
| 4.5 | Effectiveness of Reaching Original Goals | 82 |
| 4.6 | Chapter Summary | 82 |
| CHAPTER 5: | GOAL VERSUS FINANCING CONDITIONS | 84 |
| 5.1 | Introduction | 84 |
| 5.2 | Funding versus Burden | 84 |
| 5.3 | An Investigation of how Applicants Alter their Original Goals to Apply for Funding | 88 |
| 5.3.1 | The MDG's | 88 |
| 5.3.2 | Funding Indicators | 89 |
| 5.4 | Expenses in Different Countries | 90 |
| 5.4.1 | Travel costs (fuel price per litre) | 92 |
| 5.4.2 | Subsistence/refreshments/catering costs (cost of living per month) | 95 |
| 5.4.3 | Training costs | 96 |
| 5.4.4 | Remuneration in different countries (annual) | 97 |
| 5.4.5 | Equipment expenses | 98 |
| 5.4.6 | Transcription costs | 99 |
| 5.4.7 | Accommodation costs | 100 |
| 5.5 | Teasdale Corti Funding Breakdown | 101 |
| 5.5.1 | A brief description of the Teasdale Corti project | 101 |
| 5.5.2 | Funding breakdown of Teasdale Corti | 102 |
| 5.6 | RN4CAST Funding Breakdown | 105 |
| 5.6.1 | A brief description of the RN4CAST project | 105 |
| 5.6.2 | Funding breakdown of RN4CAST project | 105 |
| 5.7 | Chapter Summary | 107 |
| 5.7.1 | Summary of most and least expensive countries for above expenses | 107 |
| CHAPTER 6: | THE SUSTAINABILITY OF DONOR FUNDING AFTER A PROJECT HAS ENDED | 110 |
| 6.1 | Introduction | 110 |
| 6.2 | Sustainability of Projects | 110 |

| | |
|--|------------|
| 6.2.1. Features that must be present for a project to be sustainable (economic concepts in sustainability using the triple bottom line approach) | 110 |
| 6.3. Project Managers | 112 |
| 6.3.1. Investigation of a project manager | 113 |
| 6.4. Chapter Summary | 115 |
| CHAPTER 7: EMPIRICAL REVIEW ON DONOR FUNDING IN THE HEALTH SECTOR..... | 116 |
| 7.1. Introduction | 116 |
| 7.2. Background on Sample Size | 116 |
| 7.3 Research Conducted Using Statistical Analysis..... | 117 |
| 7.3.1 Total donor funding | 117 |
| 7.3.2 Top ten countries that gave funding..... | 120 |
| 7.3.3 Top ten countries that received funding | 121 |
| 7.3.4 Donor funding towards health sector | 122 |
| 7.3.5 Different countries that contributed funds to the health sector | 124 |
| 7.3.6 Different country's receiving donor funding in the health sector | 125 |
| 7.3.7 Proportion of donations allocated towards the seven countries in the chapters on literature..... | 127 |
| 7.4 Millennium Development Goals Analysis | 128 |
| 7.4.1 Funding given specifically towards the MDG's | 128 |
| 7.4.2 In-depth analysis of the eight MDG's | 130 |
| 7.5 Conclusions made from Empirical Review conducted in 7.1 – 7.4:..... | 186 |
| CHAPTER 8: CONCLUSIONS AND RECOMMENDATIONS..... | 187 |
| 8.1. Introduction | 187 |
| 8.2. Summary..... | 187 |
| 8.3. Limitations of this study..... | 193 |
| 8.4. Implications for the Health- and Finance Profession..... | 193 |
| 8.5. Recommendations for Future Research | 193 |
| 8.6. Conclusion | 194 |
| BIBLIOGRAPHY | 197 |

LIST OF ABBREVIATIONS:

| | |
|----------|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ARI | Acute Respiratory Infection |
| ART | Anti-retroviral therapy |
| BERD | Business Enterprise Research and Development |
| CHAK | Christian Health Association of Kenya |
| CVD's | Cardiovascular Diseases |
| DAC | Development Assistance Countries |
| DANIDA | Danish International Development Agency |
| DFID | Department for International Development |
| DHS | Demographic and Health Survey |
| DPHK | Development Partners in Health in Kenya |
| EC | European Commission |
| EU | European Union |
| G8 | Canada, France, Germany, Italy, Japan, Russia, United Kingdom and the United States |
| GAVI | Global Alliance for Vaccines and Immunisations |
| GDP | Gross Domestic Product |
| GOK | Government of Kenya |
| GRZ | Government of the Republic of Zambia |
| HENNET | Health NGOs Network |
| HIPC | Heavily Indebted Poor Countries |
| HIV | Human Immunodeficiency Virus |
| HIV/AIDS | Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome |
| JICA | Japan International Cooperation Agency |
| KDHS | Kenya Demographic Health Survey |
| MDG's | Millennium Development Goals |
| NASCOP | National AIDS and STI Control Programme |
| NGO's | Non-Government Organisations |

| | |
|----------|---|
| ODA | Official Development Assistance |
| OECD | Organization for Economic Co-operation and Development |
| OECD-DAC | Organization for Economic Co-operation and Development-Development Assistance Committee |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| SWAp | Sector-Wide Approaches |
| TB | Tuberculosis |
| UN | United Nations |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |
| IFRS | International Financial Reporting Standards |
| GAAP | General Accepted Accounting Principles |
| EMA | Environmental Management Accounting |
| FCA | Full Cost Accounting |
| NRA | Natural Resource Accounting |
| GRI | Global Reporting Initiative |
| IFAC | International Federation of Accountants |
| A4S | the Accounting for Sustainability Project |
| CFO | Chief Financial Officer |
| CIMA | Chartered Institute of Management Accountants |
| MNC's | Multinational corporations |
| ACCA | Association of Chartered Certified Accountants |

LIST OF FIGURES

| FIGURES: | Page |
|--|-------------|
| Figure 1.1: Secondary Objectives | 5 |
| Figure 2.1: Value Chain Model of Michael Porter | 11 |
| Figure 2.2: Value Chain for the Health Sector | 12 |
| Figure 2.3: The Millennium Development Goals | 13 |
| Figure 2.4: World Map | 17 |
| Figure 2.5: Descriptive Map of the World..... | 20 |
| Figure 2.6: Total expenditures on Health as a Share of Gross Domestic Product (GDP) from 1987 to 2007 for Selected OECD Countries..... | 24 |
| Figure 2.7: Map of Africa..... | 30 |
| Figure 2.8: Percentage Share of Health Resources from 2003/04 to 2007/08..... | 33 |
| Figure 2.9: Map of South Africa | 41 |
| Figure 2.10: Summary of Funding towards Health Sector | 46 |
| Figure 3.1: Country Overview of Sustainability Reporting..... | 52 |
| Figure 3.2: Industry Overview of Sustainability Reporting..... | 52 |
| Figure 3.3: Reporting Progress..... | 54 |
| Figure 3.4: The Integrated Report – SA IRC..... | 55 |
| Figure 3.5: Sustainability Leadership – Capturing Value in Three Key Areas..... | 58 |
| Figure 3.6: Triple Bottom Line..... | 65 |
| Figure 4.1: NHREC Graphic Depiction..... | 77 |
| Figure 4.2: The Path of Ethical Clearance RN4CAST followed | 79 |
| Figure 4.3: Extent of Ethics Clearance and Consent to Conduct Research and Access Patient’s Records | 81 |
| Figure 5.1: Average Annual Donor Funding in Millions of Dollars (1996-2000)..... | 86 |
| Figure 5.2: Funding vs. Burden..... | 86 |
| Figure 5.3: The Millennium Development Goals | 88 |
| Figure 5.4: Fuel costs in different countries | 92 |
| Figure 5.5: Country square kilometres | 93 |
| Figure 5.6: Subsistence/Refreshments/Catering costs per different country (Cost of living per month) | 95 |

| | |
|---|------------|
| Figure 5.7: Training Costs according to Country..... | 96 |
| Figure 5.8: Annual Remuneration Costs of Different Countries | 97 |
| Figure 5.9: Equipment Expenses for Different Countries..... | 98 |
| Figure 5.10: Transcription Rates per Hour, for Different Countries..... | 99 |
| Figure 5.11: Accommodation Costs of Different Countries | 100 |
| Figure 5.12: Summary of Expenses in this Chapter..... | 108 |
| Figure 6.1: Triple bottom line | 111 |
| Figure 6.2: The Iron Triangle | 113 |
| Figure 7.1: Illustration of Bilateral and Multilateral funding from 2000 to 2010..... | 119 |
| Figure 7.2: Summary of the global progress on the MDG goals | 128 |
| Figure 7.3 Regional Groupings | 129 |
| Figure 7.4: The proportion of people living on less than \$1.25 a day, 1990 and 2005 (Percentages) | 130 |
| Figure 7.5: Employment-to-population ratio, 200, 2009 and 2010 preliminary estimates | 131 |
| Figure 7.6: Proportion of own-account and contributing family workers in total employment, 1999, 2008 and 2009 (Percentages) | 132 |
| Figure 7.7: Proportion of employed people living on less than \$1.25 a day (Percentages) and number of working poor (Millions), 1999-2009 | 133 |
| Figure 7.8: Number and proportion of people in the developing regions who are undernourished, 1990-1992, 1995-1997, 2000-2002 and 2005-2007..... | 133 |
| Figure 7.9: Proportion of undernourished population, 2005-2007 (Percentages) | 134 |
| Figure 7.10: Proportion of children under age five who are underweight, 1990 and 2009 (Percentages) | 134 |
| Figure 7.11: Number of refugees and internally displaced persons, 2000-2010 (Millions) | 135 |
| Figure 7.12: Adjustment net enrolment ratio on primary education. *1998/1999 and 2008/2009 (Percentages) | 137 |
| Figure 7.13: Distribution of out-of-school children by region, 1999 and 2009 (Percentages) | 138 |
| Figure 7.14: Youth literacy rate, 1990 and 2009 (Percentages)..... | 139 |
| Figure 7.15: Gender parity index for gross enrolment into primary, secondary and tertiary education (girls' school enrolment ration in relation to boys' enrolment ratio: 1998/9 and 2008/9 – girls per 100 boys)..... | 140 |

| | |
|---|------------|
| Figure 7.16: Proportion of seats held by woman in single or lower houses of national parliaments, 200 and 2011 (Percentages) | 141 |
| Figure 7.17: Employees in non-agriculture employment who are women, 1999, 2009 and projections of 2015 (Percentages) | 142 |
| Figure 7.18: Under-five mortality rate, 1990 and 2009 (deaths per 1 000 live births)..... | 143 |
| Figure 7.19: Ratio of rural to urban under-five mortality rate, 2000/2008..... | 144 |
| Figure 7.20: Ratio of under-five mortality rate for children from the poorest households to that of children from the richest households 2000/2008 | 144 |
| Figure 7.21: Ratio of under-five mortality rate of children of mothers with no education to that of children of mother with secondary or higher education; ratio of under-five mortality rate of children of mothers with no education to that of children of mothers with primary education, 2000/2008..... | 145 |
| Figure 7.22: Proportion of children 12-23 months old who received at least one dose of measles vaccine, 2000 and 2009 (percentages) | 146 |
| Figure 7.23: Estimated child deaths due to measles, 1999-2008 | 147 |
| Figure 7.24: Maternal deaths per 100 000 live births, 1990, 2000 and 2008 | 148 |
| Figure 7.25: Proportion of deliveries attended by skilled health personnel, around 1990 and around 2009 (percentages)..... | 149 |
| Figure 7.26: Proportion of woman (15-49 years old) attended at least once by skilled health personnel during pregnancy, 1990 and 2009 (percentages)..... | 150 |
| Figure 7.27: Proportion of women (15-49 years old) attended four or more time's by any provider during pregnancy, 1990 and 2009 (percentages)..... | 151 |
| Figure 7.28: Number of births per 1 000 women aged 15-19, 1990, 2000 and 2008 | 152 |
| Figure 7.29: Proportion of women who are using some form of contraception among women aged 15-49, being married or in a union, 1990, 2000 and 2008 (percentages)..... | 153 |
| Figure 7.30: Proportion of women who have an unmet need for family planning among woman aged 15-49 who are married or in a union, 1990, 2000 and 2008 (percentages)..... | 154 |
| Figure 7.31: Contraceptive prevalence, unmet need for contraception, and total demand from contraception that is satisfied among women who are married or in union, by age group, selected countries in Sub-Sahara Africa, 1998/2008 (percentages)..... | 155 |

| | |
|--|------------|
| Figure 7.32: Official development assistance to health, total (Constant 2009 US\$ millions) and proportion going to reproductive health care and family planning 2000-2009 (percentages) | 156 |
| Figure 7.33: HIV incidence rates, 2001 and 2009..... | 157 |
| Figure 7.34: Number of people living with HIV, number of people newly infected with HIV and number of AIDS deaths worldwide, 1990-2009 (millions) | 158 |
| Figure 7.35: Proportion of women and men aged 15-24 who know they can reduce their risk of getting HIV by using a condom every time they have sexual intercourse, selected countries, 2005/9 (percentages) | 159 |
| Figure 7.36: Proportion of woman and men aged 15-24 reporting use of a condom during higher-risk sex, selected countries 2005/9 (percentages)..... | 160 |
| Figure 7.37: Ratio of school attendance of children aged 10-14, who have lost both biological parents compared to school attendance of non-orphaned children of the same age. Selected countries in Sub-Saharan Africa, around 2000 and around 2008 where evaluated | 161 |
| Figure 7.38: Proportion of population living with HIV who is receiving anti-retroviral treatment, 2004 and 2009 (percentages)..... | 162 |
| Figure 7.39: Proportion of women receiving anti-retroviral drugs to prevent mother-to-child transmission of HIV, 2004 and 2009 (percentages)..... | 163 |
| Figure 7.40: Proportion of children under age five sleeping under an insecticide-treated mosquito net in sub-Saharan African countries with two or more comparable data points, around 2000 and around 2010 (percentages) | 164 |
| Figure 7.41: Number of tuberculosis deaths per 100 000 populations (excluding people who are HIV-positive), 1990 and 2009..... | 165 |
| Figure 7.42: Net change in forested area between 1990 and 2000 and between 2000 and 2010 (million hectares per year) | 167 |
| Figure 7.43: Emissions of carbon dioxide (CO ₂), 1990 and 2008 (billions of metric tons)..... | 168 |
| Figure 7.44: Consumption of all ozone-depleting substances (ODSs), 1986-2009 (thousands of tonnes of ozone depletion potential) | 169 |
| Figure 7.45: Proportion of terrestrial areas protected and proportion of coastal waters (up to 12 Nautical miles) protected 1990-2010 (percentages) | 169 |
| Figure 7.46: IUCN Red List Index of species survival for mammals (1996-2008), birds (1988-2008) and aggregate index (1986-2008) | 170 |

| | |
|--|------------|
| Figure 7.47: Status of the exploited fish stocks, 1974-2008 (percentages) | 171 |
| Figure 7.48: Surface water and groundwater as a percentage of internal renewable water resources, taking into consideration official treaties between countries, around 2005 | 171 |
| Figure 7.49: Proportion of population using different sources of water, 1990 and 2008 (percentages)..... | 173 |
| Figure 7.50: Proportion of population using different sources of water by wealth quintile, rural and urban areas, sub-Saharan Africa, 2004/9 (percentages).. | 174 |
| Figure 7.51: Proportion of population using an improved sanitation facility, 1990 and 2008 (percentages)..... | 175 |
| Figure 7.52: Urban/rural ratio of the proportion of population using an improved sanitation facility, 1990 and 2008..... | 176 |
| Figure 7.53: Proportion of population by sanitation practices and wealth quintile, Southern Asia, 1995 and 2008 (percentages) | 177 |
| Figure 7.54: Population living in slums and proportion of urban population living in slums, developing regions, 1990-2010 | 178 |
| Figure 7.55: Official development assistance (ODA) from developed countries, 2000-2010 (Billions of constant 2009 US\$ and current US\$)..... | 179 |
| Figure 7.56: Net official development assistance from OECD-DAC countries as a proportion of donors' gross national income to all developing countries and to the least developed countries (LDC's), 1999-2010 (percentages) | 180 |
| Figure 7.57: Proportion of developed country imports from developing countries and from the LDC's admitted free of duty, all duty-free access and preferential duty-free access, 1996-2009 (percentages) | 181 |
| Figure 7.58: Developed countries' average tariffs on imports of key products from developing countries, 1996-2009 (percentages)..... | 181 |
| Figure 7.59: Developed countries' average tariffs on imports of key products from LDC's, 1996-2009 (percentage)..... | 182 |
| Figure 7.60: External debt service payments as a proportion of export revenues, 2000, 2008 and 2009 (percentages)..... | 183 |
| Figure 7.61: Number of fixed telephone lines and mobile cellular subscriptions per 100 inhabitants, 1995-2010 | 184 |
| Figure 7.62: Number of Internet users per 100 inhabitants, 1995-2010 | 184 |

| | |
|--|------------|
| Figure 7.63: Fixed broadband subscriptions and mobile broadband subscriptions per 100 inhabitants, 200-2010 | 185 |
|--|------------|

LIST OF TABLES

| TABLES: | Page |
|--|-------------|
| Table 2.1: Annual Funding Situation for Zambia EPI Programme 2003-2012 | 37 |
| Table 3.1: Reporting Principles | 64 |
| Table 5.1: Diseases ranked from Highest to Lowest per disease | 87 |
| Table 5.2: Conversions to Rand | 91 |
| Table 5.3: Budget Categories and Budget Lines of Teasdale Corti Project | 103 |
| Table 5.4: RN4CAST Budget Categories and Budget Lines | 106 |

LIST OF GRAPHS

| GRAPHS: | Page |
|--|-------------|
| Graph 2.1: Contributions to Donor Funding in Billions of Dollars | 14 |
| Graph 2.2: Contributions in Billions of Dollars to different categories | 15 |
| Graph 2.3: Health Official Development Assistance (ODA) by Region 2001 – 2008 | 19 |
| Graph 2.4: Health Sector Funding | 22 |
| Graph 2.5: Public Sector Healthcare Expenditure 2008..... | 23 |
| Graph 2.6: Health Sector Funding in 2007..... | 25 |
| Graph 2.7: Healthcare Expenditure 2007 | 26 |
| Graph 2.8: Recurrent Expenditure on Health Research, 2003–04..... | 28 |
| Graph 2.9: Estimated Total Health Expenditure 2003-04..... | 29 |
| Graph 2.10: Financing sources for 2005 - 2006..... | 34 |
| Graph 2.11: Funding from Different Donors in 2000 - 2002. | 38 |
| Graph 2.12: Health Care Financing 2006..... | 40 |
| Graph 2.13: Government Expenditure share 2000/01 (functional classification)..... | 43 |
| Graph 2.14: Government Expenditure Share 2007/08 (functional classification) | 43 |
| Graph 2.15: Health Sector Financing South Africa 2007..... | 44 |
| Graph 2.16: Distribution of Total Government Health Care Expenditure | 45 |
| Graph 2.17: Health Requirements and Funding for 2006 - 2010 | 47 |
| Graph 3.1: GRI Reporters 1999 – 2010 | 63 |
| Graph 7.1: Donor Funding in Total for 2009 towards Recipient Sectors | 117 |
| Graph 7.2: Donor Funding in Total for 2009 towards Recipient Countries..... | 118 |
| Graph 7.3: 2001 and 2008 distribution of funding towards recipient countries..... | 118 |
| Graph 7.4: Top ten countries that donated funds in 2009. | 120 |
| Graph 7.5: Top ten countries that received funding analysed for 2009..... | 121 |
| Graph 7.6: Donor Funding towards the Health Sector in 2009..... | 122 |
| Graph 7.7: Further breakdown of Funding towards the Health sector..... | 122 |
| Graph 7.8: Different countries contributing towards the Health Sector | 124 |
| Graph 7.9: Different countries receiving funding in the Health sector, in 2009..... | 125 |
| Graph 7.10: Health requirements and funding for 2006 - 2010..... | 126 |

Graph 7.11: Funding analysed towards the seven countries mentioned in Chapter 2 of the literature study **127**