OECD DEVELOPMENT CENTRE

Working Paper No. 244

PRIORITIES IN GLOBAL ASSISTANCE FOR HEALTH, AIDS AND POPULATION (HAP)

by

Landis MacKellar

Research programme on:
Development Finance and Public Support

June 2005
DEV/DOC(2005)04

DEVELOPMENT CENTRE WORKING PAPERS

This series of working papers is intended to disseminate the Development Centre's research findings rapidly among specialists in the field concerned. These papers are generally available in the original English or French, with a summary in the other language.

Comments on this paper would be welcome and should be sent to the OECD Development Centre, 2, rue André Pascal, 75775 PARIS CEDEX 16, France; or to dev.contact@oecd.org. Documents may be downloaded from: http://www.oecd.org/dev/wp or obtained via e-mail (dev.contact@oecd.org).

THE OPINIONS EXPRESSED AND ARGUMENTS EMPLOYED IN THIS DOCUMENT ARE THE SOLE RESPONSIBILITY OF THE AUTHOR AND DO NOT NECESSARILY REFLECT THOSE OF THE OECD OR OF THE GOVERNMENTS OF ITS MEMBER COUNTRIES

CENTRE DE DÉVELOPPEMENT DOCUMENTS DE TRAVAIL

Cette série de documents de travail a pour but de diffuser rapidement auprès des spécialistes dans les domaines concernés les résultats des travaux de recherche du Centre de Développement. Ces documents ne sont disponibles que dans leur langue originale, anglais ou français ; un résumé du document est rédigé dans l'autre langue.

Tout commentaire relatif à ce document peut être adressé au Centre de Développement de l'OCDE, 2, rue André Pascal, 75775 PARIS CEDEX 16, France; ou à dev.contact@oecd.org. Les documents peuvent être téléchargés à partir de: http://www.oecd.org/dev/wp ou obtenus via le mél (dev.contact@oecd.org).

LES IDÉES EXPRIMÉES ET LES ARGUMENTS AVANCÉS DANS CE DOCUMENT SONT CEUX DE L'AUTEUR ET NE REFLÈTENT PAS NÉCESSAIREMENT CEUX DE L'OCDE OU DES GOUVERNEMENTS DE SES PAYS MEMBRES

TABLE OF CONTENTS

PREFACE

The Development Centre has for some years been at the forefront of the debates on aid effectiveness in poverty reduction, on the appropriate governance of development finance and on the importance of financial-resource alignment to recipient countries' priorities. This working paper addresses these issues as they relate to health sector financing. It is particularly timely in light of the continued spread of HIV/AIDS, the acuteness of health risks from infectious diseases and the increased focus policy makers have placed, in the context of the Millennium Development Goals, on improving health conditions for the poor.

International development assistance directed towards health falls far short of needs. Priority setting is therefore all-important. This study takes a close look at aid allocations for health and reaches three major conclusions:

The increased share of ODA from OECD donors devoted to health in recent years has essentially been a response to the HIV/AIDS crisis. With the exception of infectious disease control, other health assistance has lost weight in total ODA, as have the major pro-poor areas of health intervention. Second, resource allocations towards combating HIV/AIDS and to a lesser degree improving reproductive health are much higher than those that would have been expected had the " burden of disease criterion" been used to set priorities, as measured by disability-adjusted life years lost due to any given disease. The implication of this finding is that nutritional deficiencies or injuries are not given the priority they deserve. Finally, there seems to be no clear relationship between the health-care priorities of poor-countries, as expressed in Poverty Reduction Strategy Papers, and health-related ODA. This last finding demonstrates that improving the alignment between health assistance and recipient-country priorities remains an important challenge for donor countries.

Prof. Louka T. Katseli
Director
OECD Development Centre
9 June 2005

RÉSUMÉ

Ce document se propose d'analyser l'évolution de l'aide publique au développement (APD) consacrée à la santé, au sida et à la population (HAP) afin de collecter des informations sur les priorités identifiées. Plusieurs conclusions s'imposent.

Le VIH/sida apparaît clairement comme la première priorité de l'aide internationale en matière de santé. Si la part globale de l'aide HAP dans le total de l'APD a sensiblement augmenté au cours des dix dernières années, l'assistance à la santé perd en fait du terrain dès lors que l'on exclut les données relatives au VIH/sida. Mais il y a plus : les sous-secteurs de la santé (hors VIH/sida), qui sont en général considérés comme « favorables aux pauvres », perdent en importance dans l'APD en matière de santé. Ces évolutions — qui contredisent la place officielle accordée à la santé en tant que secteur primordial du développement et la reconnaissance croissante des liens entre santé et pauvreté – se retrouvent autant chez les pays bénéficiaires de l'aide pris dans leur ensemble que chez les pays moins avancés. Elles permettent d'expliquer et de souligner l'importance des mises en garde de la communauté internationale chargée de la santé publique, qui estime que l'aide internationale en matière de santé reste insuffisante. Elles soulèvent également une interrogation quant à l'efficacité de l'allocation de l'aide HAP par rapport aux besoins des pauvres.

Seule exception à ce déclin, le contrôle des maladies infectieuses qui a vu sa part augmenter. Étant donné les fortes externalités transfrontalières associées aux maladies infectieuses, cette augmentation pourrait être liée au regain d'intérêt pour les biens publics mondiaux, notamment dans le domaine de la santé dans les pays pauvres. D'autres explications peuvent cependant être avancées.

Des recherches précédentes avaient montré que, dans le domaine des maladies infectieuses, les priorités de l'APD reflètent des facteurs autres que la charge de morbidité telle que mesurée par l'indicateur des années de vie corrigées de l'incapacité (AVCI), qui reste l'outil de hiérarchisation le plus cité. Ce document confirme cette conclusion et l'élargit à toutes les grandes catégories de maladies. Le VIH/sida et, dans une moindre mesure, la santé maternelle et génésique reçoivent davantage de ressources que leur contribution à la charge de morbidité ne le justifie. Plusieurs explications sont discutées. Les catégories de maladie qui attirent bien moins d'APD que prévu, étant donné leur contribution à la charge globale de morbidité, sont la nutrition et les lésions. De nouvelles recherches s'imposent donc, pour définir de manière explicite des stratégies de hiérarchisation dans lesquelles la charge de morbidité ne sera que l'un des nombreux facteurs pris en compte.

La question des biens publics mondiaux étant de plus en plus évoquée pour justifier l'aide internationale, certains craignent que les bailleurs n'intègrent plus les priorités des pays bénéficiaires au moment de décider des orientations de l'APD. Ce document compare la composition de l'APD au niveau d'un pays avec les priorités sanitaires exprimées dans les documents de stratégie pour la réduction de la pauvreté (DSRP). Aucune corrélation claire n'est identifiée. Si l'on peut invoquer des problèmes de méthodologie, il n'en reste pas moins que cette incapacité à trouver une corrélation tangible entre la place de la santé dans les DSRP et la composition de l'APD est préoccupante. D'où la nécessité d'apporter des améliorations au processus DSRP et aux décisions d'allocation de l'APD, voire dans ces deux domaines.

SUMMARY

In this paper, trends in official development assistance (ODA) for Health AIDS and Population (HAP) are analysed to gain information about revealed priorities. The major findings are as follows:

HIV/AIDS is clearly the top priority in international health assistance. While the share of HAP in total ODA has increased significantly over the last decade, however, if HIV/AIDS is excluded, health assistance is actually losing, not gaining share in total ODA. Even more striking, apart from HIV/AIDS, the health sub-sectors generally considered pro-poor are losing share in health ODA. These trends, inconsistent with the emphasis placed on health as a key sector in development and with growing recognition of the links between health and poverty, are true both for aid-recipient countries as a whole and for least-developed countries. They help to explain and underscore the urgency of warnings emanating from the international public health community that international support for health development is insufficient. They also raise the issue of whether HAP assistance is being effectively allocated to address the needs of the poor.

An exception to the rule of declining shares is infectious disease control, which has experienced an increase in share. Given the strong cross-border externalities associated with infectious disease, this increase would be consistent with growing interest in global public good (GPG) aspects of health in poor countries. However, other explanations are possible, as well.

Previous research has shown that in the area of infectious diseases, ODA priorities reflect factors other than the most commonly cited prioritization tool, the burden of disease as measured by Disability Adjusted Life Years (DALYs). This paper extends and confirms this finding for all major disease categories. HIV/AIDS and, to lesser degree, maternal and reproductive health receive resource allocations larger than their contribution to the burden of disease. Possible reasons are discussed. Disease categories attracting much less ODA than would be expected based on their contribution to the total burden of disease are nutrition and injuries. There is clearly need for further work to explicitly define priority-setting approaches in which the burden of disease is only one of many factors taken into account.

As the GPG perspective has increasingly been cited as a rationale for international support, concern has been expressed that donors may not take account of recipient-country priorities when they determine ODA priorities. In this paper, the composition of ODA at the country level is compared to health priorities as expressed in country Poverty Reduction Strategy Papers (PRSPs). No clear relationship is found. Methodological problems may be to blame; however, our failure to find a discernable relationship between the treatment of health in the PRSP and the composition of ODA is a source for concern. It suggests room for improvement in the PRSP process, in the allocation of ODA, or both.

I. INTRODUCTION[1]

The level of international assistance required to finance adequate levels of health in poor countries was estimated by the World Health Organisation (WHO) Commission on Macroeconomics and Health (2001) to be $27 billion per year by 2007: $22 billion for in-country programmes, $3 billion for research and development targeted at diseases of the poor, and $2 billion in classic global public goods (GPGs) such as collection and analysis of epidemiological data and surveillance of infectious disease. This is to be compared to an actual level of approximately $6 billion per year in 2001.

When needs vastly outstrip resources, priority setting is crucial. Aggregate trends in ODA for Health, AIDS and Population (HAP) have been documented (OECD, 2001, pp. 139-150; OECD Development Assistance Committee-UNAIDS, 2004, for HIV/AIDS) and the question of how disease priorities *ought* to be set has received a great deal of attention. However, apart from work by Shiffman (2004) on infectious disease, there has been little work on how they actually *are* set.

This paper consists of three parts. In the first, international assistance in HAP is examined for two years, 1993 and 2003. This period is roughly framed by two landmark events in international health policy: publication in 1993 of the World Bank World Development Report *Investing in Health*, and publication at the end of 2001 of the Report of the WHO Commission on Macroeconomics and Health. It corresponds to a period over which health emerged as a key strategic sector in development and links between health and poverty were increasingly recognised (OECD Development Centre, 2003).

In the second part, building on the approach that Shiffman (*op. cit.*) has applied to infectious diseases, HAP ODA in various intervention categories is compared to the burden of disease in the corresponding disease categories. It is asked how closely ODA allocations match the burden of disease and, where they do not, what the explanation might be.

In the third part, an ad hoc but innovative attempt is made to systematically assess revealed health priorities in poor countries and the extent to which ODA patterns conform to them. While concerns have long been expressed that international assistance may not reflect priorities in recipient countries (Maizels and Nissanke, 1984), this concern has been heightened as the GPG perspective has increasingly been used to justify support for HAP (Sagasti and Bezanson, 2001).

1. Landis MacKellar, Vienna Institute of Demography; International Institute for Applied Systems Analysis (Vienna); City Health Economics Centre, City University, London.

II. TRENDS IN AGGREGATE ODA AND HEALTH AND POPULATION ODA BY INTERVENTION SECTOR

In view of the gap between resources and needs, a range of innovative approaches to financing development assistance has been proposed (Atkinson, 2003; Reisen, 2004). In health, innovative public-private partnership initiatives are underway in the form of the Global Fund for AIDS, Tuberculosis and Malaria (GFATM), the International AIDS Vaccine Initiative (IAVI), the President's Emergency Program for AIDS Relief (PEPFAR), the Global Alliance for Vaccines and Immunization (GAVI), Stop TB, and Roll Back Malaria. However, the bulk of resources for these initiatives still come from the traditional sources: donor country governments as represented in the Development Assistance Committee (DAC) and multilateral institutions such as the World Bank. The primary vehicle for in-country projects remains official development assistance (ODA). For these reasons, trends in ODA should be a reasonable measure of global priorities.

The standard source for data on ODA is the Creditor Reporter System (CRS) database maintained by the DAC. In Annex A, Tables A.1-A.4, data from the CRS on commitments of ODA by sector and recipient-country income level are given for 1993 and the most recent year available, 2003. The totals presented in Table A.1 were compiled by aggregating the most fine-grained data available, the country and project-level data in the "All details" database available online at http://www1.oecd.org/scripts/cde/members/CRSAuthenticate.asp.

The limitations of the CRS database are well known. The OECD has estimated that the CRS database is only about 75-80 per cent complete for the 1990s (OECD, 2001, p. 140). Data are for commitments, not actual disbursements, which may be significantly lower. Other problems include the fact that classification in the CRS is all-or-nothing, e.g. a reproductive health and family planning project that includes a substantial HIV/AIDS component will not appear in the HIV/AIDS category. The CRS database does not cover private foundations and NGOs and is incomplete for UN agencies and the European Commission. All in all, though, the data are sufficient to identify major trends and characteristics of HAP assistance and its relation to total ODA. In an effort to be comprehensive, all donors, all recipients, and all types of assistance, including loans, are included.

In the DAC classification system, health activities fall under the "Social infrastructure and services" category of activities. They are further sub-divided into "General Health" (health policy and administrative management, medical education / training, medical research, and medical services) and "Basic Health" (basic health care, basic health infrastructure, basic nutrition, infectious disease control, health education, and health personnel development). Population activities encompass population policy and administrative management, reproductive health care, family planning, sexually transmitted disease (STD) control including HIV/AIDS, and

personnel development for population and reproductive health. In fact, almost all assistance for STD control including HIV/AIDS is devoted to HIV/AIDS.

In an effort to put HAP in the broadest context, estimates for all categories of ODA are given in Annex A. The "Other social infrastructure and services" category consists of aid to the education sector, water and sanitation projects, and projects aimed to encourage good governance and the development of civil society. Other major categories include economic infrastructure (banking, transport, etc.), production sector aid (agriculture, industry, etc.), and commodity and general programmatic assistance (chiefly non-emergency food aid, structural adjustment funds, and general budget / balance of payments support). "Multi-sector" assistance covers women in development, environment, and rural development while "Actions related to debt" covers debt forgiveness, rescheduling, etc.

HAP ODA Trends, 1993-2003

As shown in Table 1, ODA for HAP is estimated to have more than doubled, from $3 107 million in 1993 to $6 719 million in 2003 (these and all other figures given here are in 2002 prices). The implied growth rate of 8 per cent per annum confirms that there has been rapid expansion in the HAP sector. Total ODA grew more slowly, by 5.9 per cent per annum over the period, so the share of HAP increased from 5.5 per cent to 6.7 per cent of total ODA. This is evidence that increasing attention to the health sector in development is being backed up with ODA resources.

Table 1. **Official Development Assistance for Health, AIDS and Population (HAP)**
$ million (2002 prices)

	1993	2003	Growth rate (% per annum)
Health, AIDS and population (HAP)	3 107	6 719	8.0
- AIDS	77	1 754	36.7
- Health and population	3 030	4 965	5.1
Total ODA	56 451	99 892	5.9
HAP share in total ODA	5.5%	6.7%	
- AIDS share in total ODA	0.1%	1.8%	
Health and population share in total ODA	5.4%	5.0%	

However, many of these resources were devoted to the unforeseen HIV/AIDS crisis. In 1993, HIV/AIDS represented only an insignificant 0.1 per cent of total ODA; in 2003, it represented 1.8 per cent. This represents increase at a staggering rate of 36.7 per cent per annum. HAP minus HIV/AIDS actually lost share in total ODA over the decade, from 5.4 per cent in 1993 to 5 per cent in 2003.

Table 2 focuses on the HAP intervention sub-sectors most broadly identified as "pro-poor." These are:

— basic health infrastructure and care,

— health education and personnel development,

— basic nutrition,

— infectious disease control excluding HIV/AIDS,

— reproductive health and family planning, and

— STDs including HIV/AIDS.

Table 2. **HAP Intervention Sub-sector Shares in ODA, 1993 and 2003 (%)**

HAP intervention sub-sector	Share of intervention sub-sector in all ODA		Share of intervention sub-sector in HAP ODA	
	1993	2003	1993	2003
Basic health care and infrastructure	0.8	0.8	14.1	12.2
Health education and personnel development	0.3	0.1	6.2	0.8
Basic nutrition	0.6	0.2	10.9	2.8
Infectious disease control (excl. HIV/AIDS)	0.2	0.7	3.5	10.2
Reproductive health and family planning	1.2	1.1	22.5	16
Total, pro-poor sub-sectors excl. STDS and HIV/AIDS	3.1	2.8	57.2	42
STDs incl. HIV/AIDS	0.1	1.8	2.5	26.1
Grand total, pro-poor HAP sub-sectors	3.3	4.6	59.7	68.1

Note that this list consists of "Basic Health" as defined by the DAC, plus reproductive health and family planning and STDs including HIV/AIDS.

Taken together, the pro-poor sub-sectors experienced an increase in share between 1993 and 2003, from 3.3 per cent to 4.6 per cent of total ODA and from 59.7 per cent to 69.1 per cent of HAP ODA. Once HIV/AIDS is removed, however, the share of the remaining pro-poor intervention sub-sectors declined from 3.1 per cent to 2.8 per cent of total ODA and from 57.2 per cent to 42 per cent of HAP ODA.[2] Removing HIV/AIDS from the calculations reveals that, not only did health lose share of total ODA, HAP aid became less pro-poor over the decade. This raises issues regarding the effectiveness of HAP assistance in addressing the needs of the poor.

The only one of the non-HIV/AIDS sub-sectors in Table 2 that experienced an increase in share was infectious disease control, from 0.2 per cent to 0.7 per cent of total ODA and from 3.5 per cent to 10.2 per cent of HAP ODA. Since infectious disease control is a classic public good, this increase in share is some evidence of the growing importance of the GPG perspective on health. However, to anticipate the discussion in the next section, the existence of cost-effective solutions, recognition of the impact of malaria and tuberculosis on economic growth, and other factors may also be important.

While not shown in Tables 1 and 2, the same trends may be confirmed for least-income countries. Data in Annex A Table A.1 show that HAP ODA increased from 5.9 per cent to 7.2 per cent of total ODA, but once HIV/AIDS is removed, health and population experienced a decline

2. If account were taken of the fact that many reproductive health and family planning projects contain HIV/AIDS components, the decline in share for that sub-sector would be more pronounced.

in share, from 5.6 per cent to 4.6 per cent. ODA in the pro-poor, non-HIV/AIDS sub-sectors declined from 3.2 per cent to 2.4 per cent of total ODA and from 54.8 per cent to 36.3 per cent of HAP ODA. HIV/AIDS increased from 0.2 per cent to 2.6 per cent of total ODA and from 4.3 per cent to 36.3 per cent of HAP ODA. Thus, while the pro-poor sub-sectors taken as a whole experienced an increase from 3.2 per cent to 5 per cent of total ODA and from 54.8 per cent to 70 per cent of HAP ODA, it was HIV/AIDS that accounted for this increase. Infectious disease control again stands out, however, as a sub-sector that gained share, from 0.2 per cent to 0.4 per cent of total ODA and from 2.7 per cent to 5 per cent of HAP ODA.

To summarise the trends presented in this section, over a decade during which health became a major component of development strategy and links between health and poverty were increasingly recognised, health and population apart from HIV/AIDS actually lost share in total ODA. Even more striking, with the exception of HIV/AIDS, HAP sub-sectors generally considered pro-poor also lost weight, both in total ODA and in HAP ODA. An exception is infectious disease control, perhaps in part because of its well-established status as a GPG, although there are other plausible reasons, as well. These trends are observed not only for low- and middle-income countries as a whole, but also for the subset of least-income countries. They underscore the urgent concern, expressed by groups such as the WHO Commission on Macroeconomics and Health, that global support for health needs to be strengthened.

III. HEALTH AND POPULATION ODA AND THE BURDEN OF DISEASE

Priority setting, always important, is even more so when available resources fall far short of needs. There has been a great deal of normative work on how international disease control priorities should be set. The flagship project in this area, the WHO - World Bank - US National Institutes of Health Disease Control Priorities Project (DCPP), places emphasis on the burden of disease as measured in Disability Adjusted Life Years (described below). The Global Forum for Health Research (2004) has proposed a framework in which health research and development priorities should be set according to reduction in the burden of disease per dollar spent, the determinants of the burden of disease, impact on equity, the scientific probability of success, feasibility, and contribution to capacity building.

Much less attention has been given to the equally important question of how global disease priorities actually are set. An exception to this is ongoing work by Shiffman (2004), who examines donor priorities in the area of infectious diseases and concludes that considerations include not only the burden of disease, but also:

— the speed of spread,

— the ability of poor countries to cope on their own,

— the existence of cost-effective interventions,

— the characteristics of the victims,

— the prevalence and risk of infection in donor countries, and

— other political and economic factors.

In this section, we extend the work of Shiffman to cover all forms of disease, not just infectious disease. Like him, we compare CRS data on health interventions with WHO data on the burden of disease, concluding that the burden of disease as conventionally measured can explain only part of revealed priorities.

The burden of disease has many dimensions – years of life foregone due to premature death, physical suffering due to pain and disability, economic opportunity costs, social stigma, and so on. No single measure can capture all these aspects; however, health policy makers have by and large accepted Disability Adjusted Life Years (DALYs) lost to given disease categories as the best comprehensive measure of the burden of disease. One DALY represents a single lost year of healthy life, and the sum of DALYs lost to all causes can be interpreted as the gap between the actual health situation and an ideal world in which everyone lives disease- and disability-free to an advanced age (80 for men and 82.5 for women, according to the convention

used by WHO). DALYs lost to a given disease category divided by total DALYs lost is a measure of the importance of that disease category relative to all diseases combined.

Comprehensive global estimates of DALYs by disease category were first prepared by the WHO Global Burden of Disease Project in the context of background research for the 1993 *Investing in Health* World Bank World Development Report (Murray and Lopez, 1996). DALYs were proposed, and have been broadly accepted, as one of the most important tools for health policy priority setting (Jamison *et al.*, 1993; World Bank, forthcoming 2006). In recent years, WHO produced updated burden of disease estimates for 2000, 2001, and 2002 (Mathers *et al.*, 2002). A minor inconvenience is that the regions used by WHO for aggregating country-level DALY estimates across countries are not comparable to the regions used by the DAC. However, the WHO estimates for 2001 have been re-aggregated according to World Bank income regions (which are comparable to DAC regions) by the DCPP alluded to above. These estimates, to be published next year in the second edition of *Disease Control Priorities in Developing Countries* (World Bank, forthcoming 2006), have been posted online (with accompanying methodological information) at http://www.fic.nih.gov/dcpp/gbd.html and provide the basis for the discussion in this section.

Table 3. **Burden of Disease in Low-and Middle-income Countries and ODA Shares, compared**

Disease category	DALYs lost, 2001 (thousands)	Share of total burden of disease (%)	Share of HAP ODA, 2003 (%)	
			Directly assignable interventions	Directly assignable interventions plus imputed general HAP sector assistance
Communicable diseases, maternal health, perinatal conditions, and nutritional deficiencies	552 639	39.8	54.9	72.9
Infectious diseases (excluding STDs and HIV/AIDS)	327 407	23.6	10.2	20.8
STDS and HIV/AIDS	80 173	5.8	25.9	28.5
Maternal health and perinatal conditions	115 494	8.3	16.0	19.8
Nutritional deficiencies	29 564	2.8	2.8	3.8
Non-communicable diseases	678 842	48.9	0.0	22.1
Injuries	155 945	11.2	0.0	5.1
Total burden of disease	1 387 426	100.0	54.9	100.0

In Table 3, column 1 contains the estimated burden of disease (in DALYs) by major disease category for the year 2001. Four of these disease categories are directly comparable to ODA intervention sub-sectors in the CRS database. These disease categories are:

— Infectious, parasitic and respiratory disease including malaria and tuberculosis but excluding HIV/AIDS and other STDs. This category, accounting for 23.6 per cent of the total burden of disease in 2001, corresponds to "infectious disease control" in the CRS database.

— STDs including HIV/AIDS, accounting for 5.8 per cent of the total burden of disease, is directly comparable to the same category in the CRS database. Readers are sometimes

surprised by the modest share of DALYs accounted for by HIV/AIDS, but this is simply the result of the very large number of DALYs lost to other conditions such as malaria and respiratory infections.

— Maternal health and perinatal conditions; this category corresponds to "reproductive health care" and, because of the important role of child spacing, "family planning" in the CRS. It is estimated to account for 8.3 per cent of the total burden of disease.

— Nutritional deficiencies, which correspond to "basic nutrition" in the CRS. These were estimated to account for 2.8 per cent of the total burden of disease.

Non-communicable diseases — largely cardiovascular conditions, cancers, and mental illness — are completely unrepresented in the attributable ODA basket, as are injuries, because interventions to address these disease categories are not perceived to be pro-poor. A detailed search of project titles, as opposed to 5-digit CRS codes, would turn up a handful of projects in these areas, however, for practical purposes we may assume that ODA directly targeted at non-communicable disease and injuries is zero or very close to it.

Looking only at directly attributable interventions is misleading because general interventions ("policy administration and management", "basic health care", "basic health infrastructure", "medical education", etc.), amounting to 45.1 per cent of all HAP sector ODA, also contribute to reducing the burden of disease. How to distribute general health expenditure across disease categories is a contentious issue, but in Table 3 we follow one rule appealing in its simplicity, namely imputing general HAP sector ODA across burden of disease categories using the burden of disease shares. For example, of the 45.1 per cent of HAP sector ODA that cannot be directly identified by intervention sub-sector, we impute 5.8 per cent to STDs including HIV/AIDS, 8.3 per cent to maternal and reproductive health, etc. The issue of how to deal with complementary categories of ODA, such as education and sanitation, or even infrastructure improvement in the case of injuries, is even more difficult, and we do not attempt to address it.

Particularly noteworthy is that HIV/AIDS is being allocated a much higher share of ODA than can be explained by its share in the total burden of disease. STDs including HIV/AIDS accounted for 5.8 per cent of the total burden of disease in 2001, but for 25.9 per cent of HAP sector ODA in 2003, 28.5 per cent if our approach to imputation of non-specific health assistance is accepted. Maternal health and perinatal conditions, accounting for 8.4 per cent of the total burden of disease but 16 per cent of directly attributable HAP sector ODA and 19.8 per cent if general assistance is imputed, also received a share of resources higher than its share in the total burden of disease. This is despite the significant reduction in share during the 1990s that was alluded to in the previous section. If direct interventions only are counted, infectious diseases apart from HIV/AIDS received far less attention than would be warranted on the basis of their share in the burden of disease: 10.2 per cent of ODA as opposed to 23.6 per cent of the burden of disease. However, if general assistance is imputed, this anomaly is resolved, as infectious diseases excluding HIV/AIDS are estimated to account for 20.8 per cent of HAP ODA, not far out of line with their 23.6 per cent share in the burden of disease. Non-communicable diseases and injuries, by construction, are estimated to receive far less ODA than would be justified by their contribution to the total burden of disease.

Figure 1. Share of HAP ODA (including imputed general HAP assistance) plotted against share of DALYs

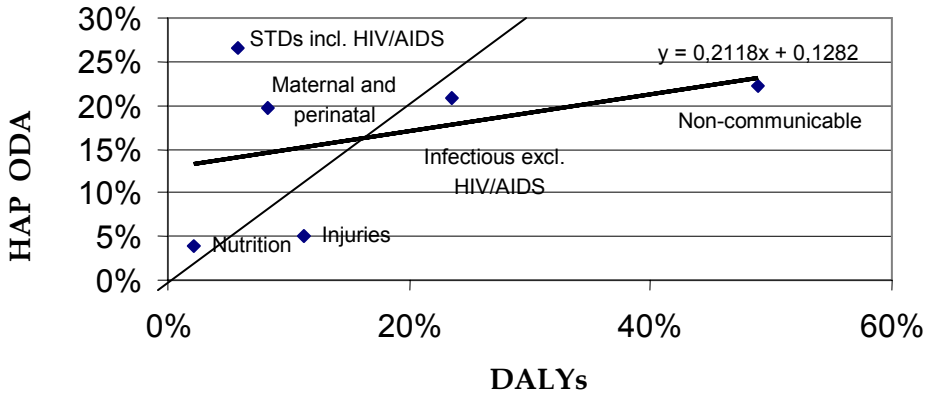
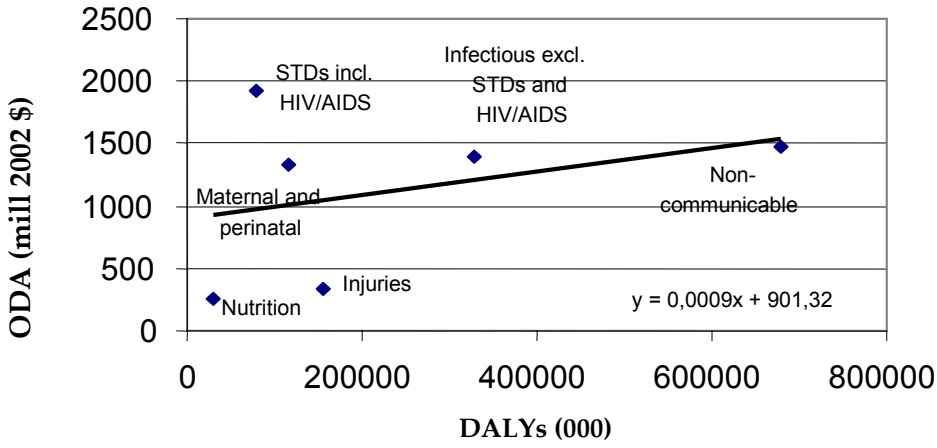


Figure 2. HAP ODA (including imputed general HAP assistance) plotted against DALYs



The data in Table 3 are plotted in Figure 1. A 45-degree line, representing the locus along which each disease category receives the same share of ODA as its share in the total burden of disease, is drawn. The discussion above has implicitly compared the data points in Figure 1 with the 45-degree line. But we know, from Shiffman's work on infectious diseases, that ODA shares are decided based on factors in addition to the burden of disease. Therefore, it is unreasonable to expect the data points in Figure 1 to rest on the 45-degree line. For this reason, we also draw a least-squares trend line through the data points. Statistical inference is not possible with so few data points, but the trend line is still useful to give an idea of the "average" relationship between

the burden of disease and ODA. HIV/AIDS, in particular, and to lesser extent maternal and reproductive health, still stand out as disease categories that receive relatively generous allocations of ODA; nutrition and injuries appear as sectors that receive far less support than might be expected[3].

Looking at levels, as opposed to shares, does nothing to alter the impressions described above. In Figure 2, ODA is plotted against DALYs. Again, HIV/AIDS lies significantly above the trend line and so, less markedly, does maternal health and perinatal conditions. Nutrition and injuries lie far below the line.

Finally, we might look simply at ODA per DALY, i.e. the slope of a line from the origin to the corresponding data point in Figure 2 (divided by 1 000 to make units consistent). The results of this calculation are shown in Table 4 and reveal that regardless of whether general assistance is imputed or not, HIV/AIDS is receiving far more ODA dollars per DALY than any other disease category. Other infectious diseases, even when assigned a share of general assistance commensurate with their large share of the total burden of disease, receive a relatively low amount of ODA per DALY. By this criterion, the rising share of infectious disease in ODA discussed in the previous section appears to be well founded.

Table 4. **ODA per DALY (2002 $)**

Disease category	Directly attributable interventions only ($)	Including imputed general HAP assistance ($)
Infectious diseases (excl. STDs and HIV/AIDS)	2.09	4.27
STDs and HIV/AIDS	21.88	24.06
Maternal health and perinatal conditions	9.29	11.46
Nutritional deficiencies	6.30	8.45
Non-communicable diseases	0.0	2.18
Injuries	0.0	2.17

The main conclusion of this section is that health priorities as revealed by patterns of ODA differ markedly from the ones that might be predicted based only on the most widely-used indicator of what those priorities ought to be, namely the burden of disease as measured in DALYs. This broadens, to all disease categories, Shiffman's conclusion that infectious disease control priorities in ODA reflect many factors, not just the burden of disease.

3. The slope of the trend line in Figure 1 is admittedly sensitive to whether our imputation assumption is accurate, especially as it applies to non-communicable diseases. If general health sector ODA is disproportionately benefiting the well to do through public health systems that do not meet the needs of the poor (an argument that has been made by many) the trend line might be steeper. This is because the rich live longer and are more likely to suffer from chronic and degenerative conditions; hence, the data point corresponding to non-communicable diseases would shift vertically upwards. However, reallocating general HAP sector assistance to non-communicable diseases would mean reallocating it away from other disease categories. It is likely that HIV/AIDS, which places heavy demands on hospital systems, would still be an outlier on the high side of the new trend line. It is difficult to make similar speculations about other disease categories.

The most striking example that emerges from the data presented here is HIV/AIDS, which receives an allocation of resources that is proportionally far greater than its contribution to the total burden of disease. Yet this should not come as a surprise:

- The virus is spreading rapidly in many parts of the world, and current aid allocations may reflect the conviction that, if not addressed now, the epidemic will be much worse in the future. For example, based largely on the availability of cost-effective interventions for HIV/AIDS prevention, the Copenhagen Consensus of economists recently rated slowing the spread of HIV/AIDS as the top-priority intervention for sustainable development (Lomborg, 2004).
- In those countries that are most heavily affected, governments are entirely unable to cope with the consequences of the epidemic. The gap between an adequate response and available resources is enormous and has been effectively documented by UNAIDS.
- If uncontrolled, the epidemic has the potential to undermine all health activities in some countries; indeed, all development (Roberts, 2003, pp. 80-81). Studies illustrating the grave impact of the epidemic on economic growth and public health budgets in the worst-affected countries are too numerous to cite. For this reason, the disease has become a favoured subject for those who work in the grey area between development, geopolitics, and security (for example, Eberstadt, 2002).
- AIDS is a disease well known in donor countries, and there is an effective global advocacy community.
- AIDS victims must cope with social stigma, a component of the burden of disease entirely missing from DALYs as conventionally estimated.

The special status given to HIV/AIDS has been made explicit by the WHO Commission on Macroeconomics and Health, which in its Key Findings termed the epidemic a "distinct and unparalleled catastrophe" requiring "special consideration". This view has been bolstered by the joint World Bank — International Monetary Fund Development Committee (World Bank, 2003, pp. 9-10), which in a survey of GPGs identified HIV/AIDS control as an area as "especially" in need of attention and action.

A word is also in order on disease categories apart from HIV/AIDS. Maternal and reproductive health interventions are also attractive for a number of reasons:

- They are typically highly cost-effective.
- Maternal and reproductive health is of concern to a group widely perceived as vulnerable (women, children, and adolescents).
- There is an effective global advocacy community.

However, poor nutrition also disproportionately affects children (and women), there are cost-effective interventions, and recent work suggests that poor nutrition is enormously important if attention is given to its role as a co-factor in infectious disease (Mason *et al*., 2003). Yet the disease category receives little support. Nor do injuries, perhaps because the best way to reduce injuries is to improve transport infrastructure and workplace safety, both areas well outside the HAP umbrella.

IV. DOES HEALTH AND POPULATION ODA REFLECT POOR COUNTRY PRIORITIES?

There is no clear-cut way to quantitatively measure government health priorities in poor countries, let alone the priorities of poor households themselves. Despite the growing number of countries with National Health Accounts (NHA), it is still not possible to assemble consistent data on how health resources are spent in a broad range of countries. However, it is usually assumed that areas such as infectious disease have priority for the poor because of the heavy toll they exact. Evidence of substantial out-of-pocket expenditure on health by low-income households, as well as evidence of the catastrophic impact of adverse health events on the poor, is abundant.

The same lack of information is no longer a constraint when it comes to *qualitative* indicators of government health priorities. Systematic evidence on the role of the health in country Poverty Reduction Strategy Papers (PRSPs) is now available in the form of the WHO PRSP Database available online, together with background documentation, at http://www.who.int/hdp/database/. This database contains analytical findings on how health and poverty issues were dealt with in 36 PRSPs drafted ca. 2000-03.

The PRSP process (World Bank, nd, pp. 7-8; World Bank, 2002, p. 5) is meant to encourage countries to adopt a long-term strategic view of development. PRSPs are meant to be country-driven ("country ownership"), results-oriented, and participatory, i.e. reflect input of civil society and the private sector (Christiansen and Hovland, 2003, p. 3). In the course of producing the PRSP, countries are called upon prioritize Millennium Development Goals (MDGs) in accordance with their long-term vision of development needs. By linking poverty reduction goals to Medium Term Expenditure Frameworks, the PRSP process is meant to encourage realistic comparison of goals with resources, resulting in more effective priority-setting (Roberts, 2003).

In Annex B, we summarise information available in the WHO PRSP Database for three disease categories: infectious disease excluding HIV/AIDS, HIV/AIDS, and maternal and reproductive health. In order to roughly quantify the degree of government priority attached to each area, we selected three criteria:

— Is the disease category explicitly identified in the PRSP?

— Are proposed interventions targeted at the poor (or, in the case of HIV/AIDS, at vulnerable populations)?

— Is strategy in the area explicitly linked to the relevant MDG?

If the answer to the question is "Yes", we assign a score of 1, if "No", a score of 0; summing across the three criteria, we arrive at an index of disease-category prioritization that runs from 0 to 3[4].

The logic behind the index is simple. Take a given disease category, such as infectious disease. Most countries identified infectious disease as an area of concern, i.e. most scored "1" on the first criterion. However, it stands to reason that, if a country truly ascribed a high priority to infectious disease control, it would take the subsequent steps of targeting proposed interventions towards the poor and linking their intervention strategy to the relevant MDG. When these additional requirements for effectively prioritizing the disease category are added, what results is an index with a mean of 1.81 and a standard deviation 0.54. The comparable parameters for HIV/AIDS are a mean of 1.99 and a standard deviation of 0.98; for maternal and reproductive health, a mean of 2.24 and a standard deviation of 0.64. As evidenced by the coefficients of variation (0.30 for infectious disease, 0.49 for HIV/AIDS, and 0.29 for maternal and reproductive health), there is a reasonable "spread" of scores in each category over the 36 countries.

Figure 3. Infectious disease control as share of total ODA

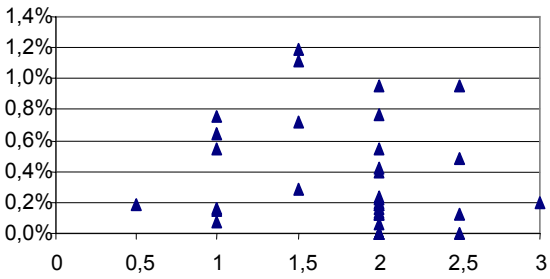
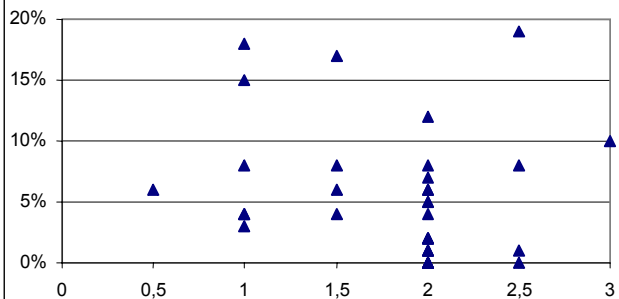


Figure 4. Infectious disease control as share of HAP ODA



4. Some improvisation was required when the entry given in the WHO database was "implicitly", "not explicitly" and so on. Rules followed in these special cases were as follows:
"N/A": 0
"No entry " (Honduras maternal and reproductive health MDG linkage): 0
"Implicitly": 0.5
"Very limited" (Mali maternal and reproductive health PRSP inclusion): 0.5
"Indirect" (Georgia infectious disease PRSP inclusion): 0.5
"Not explicitly" (Pakistan infectious disease targeting): 0.5
"Some targeting" (Mozambique infectious disease and HIV/AIDS targeting): 0.5
"Similar" (Cambodia infectious disease MDG linkage): 0.5
"Vulnerable groups": 1
"High risk areas / groups": 1
"Woman and children" (Madagascar infectious disease): 1
"Rural targeting": (Mongolia and Nepal maternal and reproductive health): 1

Figure 5. HIV/AIDS as share of total ODA

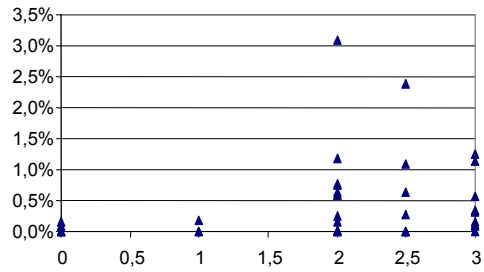


Figure 6. HIV/AIDS as share of HAP ODA

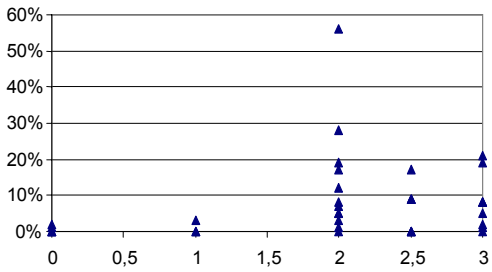


Figure 7. Reproductive health and family planning as share of total ODA

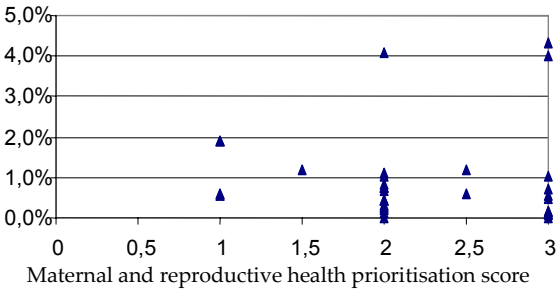
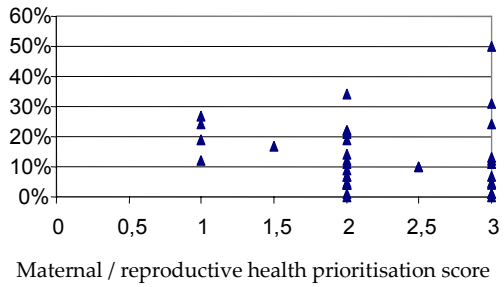


Figure 8. Reproductive health / family planning as share of HAP ODA



Figures 3-8 are scatter plots of the share of the corresponding intervention sub-sector in total ODA and in HAP sector ODA against the disease-category prioritization score[5]. Nothing in these charts, unfortunately, shows evidence that recipient-country disease priorities as expressed in the PRSP strongly affect either how much of total ODA is devoted to the corresponding intervention sub-sector category or how much of HAP assistance is devoted to it. Countries not prioritizing infectious disease are just as likely to have received a high share of total and HAP ODA dedicated to infectious disease control as countries prioritizing the disease category. A number of countries that assigned no priority to HIV/AIDS did, as is sensible, receive little assistance in that area. However, some countries that satisfied all three criteria above in the area of HIV/AIDS

5. The HAP intervention sub-sector shares plotted were taken from DAC Aid at a Glance Health Focus Charts posted online at www.oecd.org/dac/htm/aid_health.htm and represent 1998-2000 averages. There were two reasons for using these secondary data rather than calculating shares from scratch using the country — and project-level CRS data assembled for 2003 in order to calculate the regional totals presented in Annex A. The first reason was convenience — since the Health Focus Charts were based on CRS data, the work had already been done by the DAC Secretariat. The second was that, at the country level, intervention sub-sector shares can be volatile from year to year; this is much less of a problem when countries are aggregated into regions as in Annex A. A country average for 1998-2000 is likely to be more comparable to a PRSP written in 2000-03 than a single-year observation for 2003.

received no more assistance in this area, proportionally speaking, than countries assigning less priority to the disease. The same observation holds for maternal and reproductive health.

These negative results admit three interpretations:

— One, predicated on the assumption that our disease-category prioritization scores accurately measure country priorities, is that donors do not take these priorities into account when allocating ODA. Alternatively, perhaps the sub-set of developing countries in the WHO database is not representative.

— A second interpretation is that the ad hoc index we have calculated is unsatisfactory, i.e. our disease-category prioritization scores are meaningless and Figures 3-8 are best ignored.

— A third interpretation is that the scores are simply measuring how well countries followed the guidelines of the PRSP process. In other words, the degree to which a country explicitly targeted strategies towards the poor and linked proposed interventions to the relevant MDG may reflect not priorities per se, but whether the country was able to produce a PRSP which conformed to international standards. In this case, the index scores in Annex B are measuring country capacity, not priorities.

In the latter case, it would seem likely that donor countries would be more willing to allocate resources to general health policy, administration and management, leaving it to recipient-country governments to make allocation decisions across disease categories. After all, the move from project-based approaches to sector-wide support is a vital aspect of country ownership, and the main constraint to country ownership is generally held to be country capacity. In Figures 9 and 10, we plot general health policy, administration, and management support against the average of the infectious disease, HIV/AIDS, and maternal and reproductive health prioritization scores described above. Our hypothesis is that the average prioritization score is serving as a proxy for country capacity. There is some evidence in favour of this third interpretation — most countries receiving a high share of ODA in the form of general support scored at least 2 on the average index. The evidence is hardly compelling however; some countries that scored high received relatively small amounts of general health sector assistance; some that scored low received relatively large amounts.

Figure 9. Health policy and administration as share of total ODA

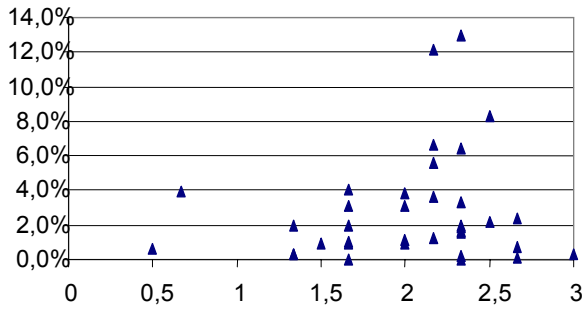
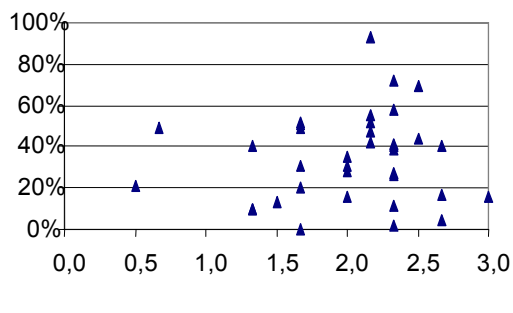


Figure 10. Health policy and administration as share of HAP ODA



The evidence presented in this section is ambiguous. This in itself, however, is cause for some concern: however imperfect our index, we would expect to see at least some evidence of a relationship between the way a disease category is treated in the PRSP and the allocation of ODA. It appears that a hypothetical advisor preparing for a country mission or a new programme officer in an international development organisation, if he or she read the health section of the PRSP, would not be able to infer with any degree of confidence how health ODA was being allocated. This suggests room for improvement in the PRSP process, the allocation of ODA, or both.

V. CONCLUSIONS

The gap between needs and resources in global health development is enormous, and, as a result, so is the importance of priority. Three questions of importance to policy makers as they address this challenge are:

— What are the recent trends in health ODA and what do they tell us about overall priorities in health as well as aid effectiveness in addressing the needs of the poor?

— What factors explain priorities within the health sector?

— How well do observed ODA priorities line up with the health priorities expressed by policy makers in poor countries?

In this paper, findings related to these questions have been presented.

The answer to the first question, in a nutshell, is that HIV/AIDS is the priority. While the share of health in total ODA has increased over the last decade, it is HIV/AIDS that accounts for this increase in share. If HIV/AIDS is excluded from the calculation, health has actually declined as a share of ODA, from 5.4 per cent in 1993 to 5 per cent in 2003. Within the Health, AIDS and Population (HAP) sector, only infectious disease control has increased its share of ODA resources. It is possible that the rising share of infectious disease control, a classic public good, reflects growing reliance on the global public good rationale for international assistance, but other explanations cannot be excluded. Basic health care and infrastructure, health education and personnel development, reproductive health and family planning, and basic nutrition, all pro-poor interventions, have experienced declining shares in ODA. Perhaps most striking, pro-poor health intervention sub-sectors apart from HIV/AIDS have actually seen their share of health assistance drop from 57.2 per cent to 42 per cent. These trends apply not only to aid-recipient countries as a whole, but to the subset of least-income countries.

The observed declines in share are not consistent with the current emphasis on health as a priority sector in development and with growing awareness of links between health and poverty. They lend strength to concerns that have been voiced by groups such as the WHO Commission on Macroeconomics and Health regarding the insufficiency of international support for health. They also raise the issue of whether HAP assistance is being effectively allocated to address the needs of the poor.

The answer to the second question is that is that the most commonly-cited prioritization tool, the burden of disease as measured in Disability Adjusted Life Years, is insufficient to explain observed priorities. Previous research in the area of infectious diseases has already concluded that factors apart from the burden of disease play a role in determining how ODA is

allocated. Such factors, it has been argued, include the existence of cost-effective interventions, the characteristics of the victims, the presence of a global advocacy community, the inability of countries to cope on their own, and the possibility of catastrophic country- and worldwide impacts if steps are not taken. This paper has extended and strengthened these results by concluding that they apply to all disease categories, not just infectious diseases. HIV/AIDS stands out for the large allocation of resources it receives relative to its contribution to the total burden of disease; so, less dramatically, does reproductive and maternal health. Reasons for these priorities have been discussed. Disease categories receiving less support than might be expected based on their contribution to the burden of disease are injuries and nutritional disorders.

These results suggest a handsome payoff to efforts to devise explicit priority-setting frameworks in which the burden of disease is only one factor among many. Ongoing work by the Global Forum for Health Research (2004) provides a model for such approaches, albeit this work is limited to priority setting in health research and development.

In making the first systematic attempt to compare aid allocations to low-income country health priorities as expressed in their Poverty Reduction Strategy Papers, this paper has arrived only at an ambiguous answer to the third question, namely: "If ODA allocations and country priorities do line up, we cannot see it". No clear relationship has been detected between priorities expressed in PRSPs and the composition of ODA. Methodological problems may be to blame, for example, the index we have devised may not measure priorities per se but rather how well these priorities have been translated into the PRSP framework. In this case, however, we would expect our index to be related to the share of ODA allocated to general health policy, administration, and management. We found only slim evidence of this. Whatever the explanation, we have concluded, the absence of a clear relationship between how health is treated in the PRSP and the composition of ODA signals policy makers that there is room for improvement in the PRSP process, in the allocation of ODA, or both.

ANNEX A. ODA BY RECIPIENT-COUNTRY INCOME GROUP AND SECTOR, 1993 AND 2003

Table A.1. **ODA by Sector and Recipient-country Income Level, 1993 and 2003 (million 2002 $)**

	1993						2003					
	Least	OLIC	LMIC	UMIC	Unspec.	Total	Least	OLIC	LMIC	UMIC	Unspec.	Total
Social infrastructure & services	2 208.8	4 590.4	2 867.0	1 358.5	1 260.4	12 285.1	7 126.9	6 933.6	10 855.2	4 564.2	5 151.9	34 631.8
Health & population	582.4	1 151.2	646.7	389.0	338.2	3 107.4	1 694.0	1 360.3	1 188.9	886.1	1 589.5	6 718.8
Health	410.6	858.1	508.5	384.9	127.6	2 289.7	888.4	997.8	904.9	79.5	679.2	3 549.9
Policy / admin. / management	216.0	273.1	265.2	252.3	55.0	1 061.7	338.7	345.0	598.2	56.6	110.7	1 449.2
Medical education / training	0.6	14.2	0.0	0.0	0.0	14.9	11.3	14.1	4.0	1.5	15.1	46.0
Medical research	0.8	5.5	6.5	0.5	7.7	21.0	5.8	1.6	0.8	0.1	7.7	15.9
Medical services	21.3	16.1	33.3	39.4	4.0	114.1	68.0	160.4	55.1	3.0	4.1	290.7
Basic health care	15.9	26.1	0.0	0.0	0.4	42.3	309.4	181.9	166.1	10.2	55.5	723.1
Basic health infrastructure	96.0	88.8	121.5	90.6	0.2	397.1	24.5	23.6	42.9	1.5	6.0	98.4
Basic nutrition	33.9	207.9	72.4	1.2	22.4	337.8	27.6	4.0	3.5	1.3	149.8	186.2
Infectious disease control	15.8	68.6	6.0	0.3	18.5	109.3	85.4	263.5	16.3	3.1	314.8	683.1
Health education	0.3	157.9	3.4	0.0	0.0	161.6	8.6	1.9	6.1	0.6	12.4	29.7
Personnel development	10.0	0.0	0.1	0.5	19.3	29.9	9.2	1.7	11.9	1.6	3.1	27.6
Population	171.8	293.1	138.2	4.1	210.6	817.7	805.6	362.5	284.0	806.6	910.2	3 168.9
Policy/ admin. / management	24.5	3.1	7.8	1.0	5.0	41.4	83.7	53.5	47.1	1.3	155.8	341.4
Reproductive health	31.3	217.0	63.3	3.0	28.9	343.5	68.7	32.0	40.8	663.3	106.5	911.3
Family planning	90.7	51.6	59.1	0.0	154.4	355.9	38.6	5.2	50.7	0.0	67.3	161.9
HIV/AIDS	25.3	21.4	7.9	0.0	22.4	77.0	614.5	271.7	145.1	142.0	580.6	1 753.8
Personnel development	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.4	0.0	0.0	0.5
Other social infra. & services	1 626.5	3 439.2	2 220.3	969.6	922.2	9 177.7	5 432.8	5 573.3	9 666.3	3 678.2	3 562.4	27 913.0
Economic infrastructure	2 323.6	9 847.9	5 360.1	2 189.2	843.1	20 563.9	3 101.4	6 850.6	2 929.0	1 317.0	1 536.4	15 734.4
Production sectors	1 303.9	2 730.7	1 559.7	208.8	756.5	6 559.6	1 362.9	1 997.4	1 896.0	647.9	1 307.7	7 211.9
Multisector	862.9	1 577.5	1 423.9	602.7	1 630.8	6 097.8	1 415.0	1 422.3	2 864.7	463.8	1 255.9	7 421.6
Commodity & general	1 508.5	1 459.5	1 285.5	69.2	1 519.4	5 842.2	2 666.1	1 072.1	3 584.0	2 530.7	1 043.4	10 896.4
Action related to debt	1 025.9	86.3	2 301.6	181.4	80.4	3 675.5	5 509.2	8 363.0	674.0	76.2	201.3	14 823.8
Emergency assistance	602.8	81.2	211.3	32.6	172.5	1 100.4	2 245.0	387.1	1 485.0	39.2	1 988.8	6 145.1
Unallocated	93.2	16.4	56.6	20.8	139.1	326.0	142.0	92.4	161.8	34.1	2 596.8	3 027.2
Total	9 929.6	20 389.9	15 065.8	4 663.2	6 402.1	56 450.6	23 568.5	27 118.6	24 449.8	9 673.1	15 082.2	99 892.2

Source: OECD Development Assistance Committee Creditor Reporting System. Data cover all donors / recipients.

Notes: Least: least developed countries; OLIC: other low-income countries; LMIC: lower middle income countries; UMIC: upper middle income countries; Unspec: unspecified recipient.

Table A2. **Sector Distribution of ODA by Recipient-country Income Level, 1993 and 2003 (%)**

	1993						2003					
	Least	OLIC	LMIC	UMIC	Unspec.	Total	Least	OLIC	LMIC	UMIC	Unspec.	Total
Social infrastructure & services	22.2	22.5	19.0	29.1	19.7	21.8	30.2	25.6	44.4	47.2	34.2	34.7
Health & population	5.9	5.6	4.3	8.3	5.3	5.5	7.2	5.0	4.9	9.2	10.5	6.7
Health	4.1	4.2	3.4	8.3	2.0	4.1	3.8	3.7	3.7	0.8	4.5	3.6
Policy / admin. / management	2.2	1.3	1.8	5.4	0.9	1.9	1.4	1.3	2.4	0.6	0.7	1.5
Medical education / training	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.1	0.0
Medical research	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.1	0.0
Medical services	0.2	0.1	0.2	0.8	0.1	0.2	0.3	0.6	0.2	0.0	0.0	0.3
Basic health care	0.2	0.1	0.0	0.0	0.0	0.1	1.3	0.7	0.7	0.1	0.4	0.7
Basic health infrastructure.	1.0	0.4	0.8	1.9	0.0	0.7	0.1	0.1	0.2	0.0	0.0	0.1
Basic nutrition	0.3	1.0	0.5	0.0	0.3	0.6	0.1	0.0	0.0	0.0	1.0	0.2
Infectious disease control	0.2	0.3	0.0	0.0	0.3	0.2	0.4	1.0	0.1	0.0	2.1	0.7
Health education	0.0	0.8	0.0	0.0	0.0	0.3	0.0	0.0	0.0	0.0	0.1	0.0
Personnel development	0.1	0.0	0.0	0.0	0.3	0.1	0.0	0.0	0.0	0.0	0.0	0.0
Population	1.7	1.4	0.9	0.1	3.3	1.4	3.4	1.3	1.2	8.3	6.0	3.2
Policy / admin. / management	0.2	0.0	0.1	0.0	0.1	0.1	0.4	0.2	0.2	0.0	1.0	0.3
Reproductive health	0.3	1.1	0.4	0.1	0.5	0.6	0.3	0.1	0.2	6.9	0.7	0.9
Family planning	0.9	0.3	0.4	0.0	2.4	0.6	0.2	0.0	0.2	0.0	0.4	0.2
HIV/AIDS	0.3	0.1	0.1	0.0	0.3	0.1	2.6	1.0	0.6	1.5	3.8	1.8
Personnel development	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other social infrastructure & services	16.4	16.9	14.7	20.8	14.4	16.3	23.1	20.6	39.5	38.0	23.6	27.9
Economic infrastructure	23.4	48.3	35.6	46.9	13.2	36.4	13.2	25.3	12.0	13.6	10.2	15.8
Production sectors	13.1	13.4	10.4	4.5	11.8	11.6	5.8	7.4	7.8	6.7	8.7	7.2
Multisector	8.7	7.7	9.5	12.9	25.5	10.8	6.0	5.2	11.7	4.8	8.3	7.4
Commodity & general	15.2	7.2	8.5	1.5	23.7	10.3	11.3	4.0	14.7	26.2	6.9	10.9
Action related to debt	10.3	0.4	15.3	3.9	1.3	6.5	23.4	30.8	2.8	0.8	1.3	14.8
Emergency assistance	6.1	0.4	1.4	0.7	2.7	1.9	9.5	1.4	6.1	0.4	13.2	6.2
Unallocated	0.9	0.1	0.4	0.4	2.2	0.6	0.6	0.3	0.7	0.4	17.2	3.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Calculations based on Table A1.
Notes: See Table A1 for abbreviations.

Table A.3. **Recipient-country Income-level Distribution of ODA by Sector, 1993 and 2003 (%)**

	1993						2003					
	Least	OLIC	LMIC	UMIC	Unspec.	Total	Least	OLIC	LMIC	UMIC	Unspec.	Total
Social infrastructure & services	18.0	37.4	23.3	11.1	10.3	100.0	20.6	20.0	31.3	13.2	14.9	100.0
Health & population	18.7	37.0	20.8	12.5	10.9	100.0	25.2	20.2	17.7	13.2	23.7	100.0
Health	17.9	37.5	22.2	16.8	5.6	100.0	25.0	28.1	25.5	2.2	19.1	100.0
Policy / management	20.3	25.7	25.0	23.8	5.2	100.0	23.4	23.8	41.3	3.9	7.6	100.0
Medical education / training	4.0	95.7	0.3	0.0	0.0	100.0	24.5	30.7	8.6	3.4	32.8	100.0
Medical research	3.6	26.2	31.1	2.2	36.9	100.0	36.4	10.0	4.8	0.6	48.2	100.0
Medical services	18.7	14.1	29.1	34.6	3.5	100.0	23.4	55.2	18.9	1.0	1.4	100.0
Basic health care	37.5	61.6	0.0	0.0	0.9	100.0	42.8	25.2	23.0	1.4	7.7	100.0
Basic health infrastructure	24.2	22.4	30.6	22.8	0.0	100.0	24.9	24.0	43.6	1.5	6.1	100.0
Basic nutrition	10.0	61.5	21.4	0.4	6.6	100.0	14.8	2.2	1.9	0.7	80.4	100.0
Infectious disease control	14.5	62.7	5.5	0.3	17.0	100.0	12.5	38.6	2.4	0.5	46.1	100.0
Health education	0.2	97.7	2.1	0.0	0.0	100.0	28.8	6.6	20.6	2.1	41.9	100.0
Personnel development	33.5	0.0	0.2	1.7	64.6	100.0	33.4	6.2	43.3	5.7	11.3	100.0
Population	21.0	35.8	16.9	0.5	25.8	100.0	25.4	11.4	9.0	25.5	28.7	100.0
Policy / admin. / management	59.2	7.4	18.9	2.5	12.0	100.0	24.5	15.7	13.8	0.4	45.7	100.0
Reproductive health	9.1	63.2	18.4	0.9	8.4	100.0	7.5	3.5	4.5	72.8	11.7	100.0
Family planning	25.5	14.5	16.6	0.0	43.4	100.0	23.9	3.2	31.3	0.0	41.6	100.0
HIV/AIDS	32.8	27.8	10.3	0.0	29.1	100.0	35.0	15.5	8.3	8.1	33.1	100.0
Personnel development	--	--	--	--	--	--	17.6	2.3	74.1	0.0	6.1	100.0
Other social infrastructure & services	17.7	37.5	24.2	10.6	10.0	100.0	19.5	20.0	34.6	13.2	12.8	100.0
Economic infrastructure	11.3	47.9	26.1	10.6	4.1	100.0	19.7	43.5	18.6	8.4	9.8	100.0
Production sectors	19.9	41.6	23.8	3.2	11.5	100.0	18.9	27.7	26.3	9.0	18.1	100.0
Multisector	14.2	25.9	23.4	9.9	26.7	100.0	19.1	19.2	38.6	6.2	16.9	100.0
Commodity & general	25.8	25.0	22.0	1.2	26.0	100.0	24.5	9.8	32.9	23.2	9.6	100.0
Action related to debt	27.9	2.3	62.6	4.9	2.2	100.0	37.2	56.4	4.5	0.5	1.4	100.0
Emergency assistance	54.8	7.4	19.2	3.0	15.7	100.0	36.5	6.3	24.2	0.6	32.4	100.0
Unallocated	28.6	5.0	17.3	6.4	42.7	100.0	4.7	3.1	5.3	1.1	85.8	100.0
Total	17.6	36.1	26.7	8.3	11.3	100.0	23.6	27.1	24.5	9.7	15.1	100.0

Source: Calculations based on Table A1.
Notes: See Table A1 for abbreviations.

Table A.4. **Growth in ODA by Sector and Recipient-country Income Level, 1993-2003**
(% per annum)

	Least	OLIC	LMIC	UMIC	Unspec.	Total
Social infrastructure & services	12.4	4.2	14.2	12.9	15.1	10.9
Health & population	11.3	1.7	6.3	8.6	16.7	8.0
Health	8.0	1.5	5.9	-14.6	18.2	4.5
Policy / management	4.6	2.4	8.5	-13.9	7.2	3.2
Medical education / training	34.4	-0.1	56.8	--	--	12.0
Medical research	22.6	-11.7	-19.4	-14.0	-0.1	-2.7
Medical services	12.3	25.9	5.2	-22.7	0.2	9.8
Basic health care	34.6	21.4	--	--	65.1	32.8
Basic health infrastructure	-12.8	-12.4	-9.9	-33.9	40.7	-13.0
Basic nutrition	-2.0	-32.6	-26.1	0.4	21.0	-5.8
Infectious disease control	18.4	14.4	10.5	25.7	32.7	20.1
Health education	40.1	-35.6	5.9	--	--	-15.6
Personnel development	-0.8	73.4	67.4	12.1	-16.7	-0.8
Population	16.7	2.1	7.5	69.8	15.8	14.5
Policy / administration / management	13.1	33.1	19.6	2.2	41.1	23.5
Reproductive health	8.2	-17.4	-4.3	71.5	13.9	10.2
Family planning	-8.2	-20.5	-1.5	--	-8.0	-7.6
HIV/AIDS	37.6	28.9	33.8	--	38.5	36.7
Personnel development	--	--	--	--	--	--
Other social infrastructure & services	12.8	4.9	15.8	14.3	14.5	11.8
Economic infrastructure	2.9	-3.6	-5.9	-5.0	6.2	-2.6
Production sectors	0.4	-3.1	2.0	12.0	5.6	1.0
Multisector	5.1	-1.0	7.2	-2.6	-2.6	2.0
Commodity & general	5.9	-3.0	10.8	43.3	-3.7	6.4
Action related to debt	18.3	58.0	-11.6	-8.3	9.6	15.0
Emergency assistance	14.1	16.9	21.5	1.8	27.7	18.8
Unallocated	4.3	18.8	11.1	5.1	34.0	25.0
Total	9.0	2.9	5.0	7.6	8.9	5.9

Source: Calculations based on Table A1.
Notes: See Table A1 for abbreviations.

ANNEX B. HEALTH AND POVERTY REDUCTION STRATEGY PAPERS (PRSPs)

Table B.1. **Health in Poverty Reduction Strategy Papers (PRSPs)**

	Infectious diseases				HIV/AIDS				Maternal and reproductive health				
	In PRSP?	Targeted at poor?	Linked to MDGs?	Score	In PRSP?	Targeted at poor?	Linked to MDG?	Score	In PRSP?	Targeted at poor?	Linked to MDG?	Score	Average score
Albania	Yes	Yes	No	2	Yes	No	N/A	1	Yes	Not explicitly	Yes	2	1.7
Armenia	Yes	Yes	N/A	2	Yes	No	N/A	1	Yes	Not explicitly	Yes	2	1.7
Azerbaijan	Yes	Implicitly	Yes	2.5	Yes	Not explicitly	Yes	2.5	Yes	Yes	Yes	3	2.7
Benin	Yes	No	Yes	2	Yes	Vulnerable groups	Yes	3	Yes	No	Yes	2	2.3
Bolivia	Yes	No	No	1	No	N/A	N/A	0	Yes	No	No	1	0.7
Burkina Faso	Yes	No	No	1	Yes	Vulnerable groups	No	2	Yes	No	No	2	1.7
Cambodia	Yes	Yes	Similar	2.5	Yes	Yes	Similar	2	Implicitly	N/A	Yes	1	1.5
Cameroon	Yes	No	Yes	2	Yes	No	Yes	2.5	Yes	No	Yes	2	2.2
Chad	Yes	No	Yes	2	Yes	Vulnerable groups	Yes	3	Yes	No	Yes	2	2.3
Ethiopia	Yes	No	Yes	2	Yes	No	Yes	2	Yes	No	Yes	2	2.0
Gambia	Yes	No	Yes	2	Yes	Implicitly	Yes	2.5	Yes	Not explicitly	Yes	2	2.2
Georgia	Indirect	No	N/A	0.5	No	N/A	N/A	0	No	N/A	Yes	1	0.5
Ghana	Yes	No	Yes	2	Yes	Vulnerable groups	Yes	3	Yes	Yes	Yes	3	2.7
Guinea	Yes	Implicitly	Yes	2.5	Yes	No	Yes	2	Yes	No	Yes	2	2.2
Guyana	Yes	No	Yes	2	Yes	No	Yes	2	Yes	Yes	Yes	3	2.3
Honduras	Yes	No	No	1	Yes	No	Yes	2	Yes	No	No entry	1	1.3

Table B.1. **Heath in Poverty Reduction Strategy Papers (PRSPs)** (continued)

	Infectious diseases				HIV/AIDS				Maternal and reproductive health				
	In PRSP?	Targeted at poor?	Linked to MDG?	Score	In PRSP?	Targeted at poor?	Linked to MDG?	Score	In PRSP?	Targeted at poor?	Linked to MDG?	Score	Average socore
Kyrgyzstan	Yes	No	No	1	Yes	No	Yes	2	Yes	No	Yes	2	1.7
Madagascar	Yes	Women / children	N/A	2	Yes	High risk areas / groups	Yes	3	Yes	No	Yes	2	2.3
Malawi	Yes	Implicitly	N/A	1.5	Yes	Not explicitly	Yes	2.5	Yes	Yes	Yes	3	2.3
Mali	Yes	No	Yes	2	Yes	Vulnerable groups	Yes	3	Very limited	No	Yes	1.5	2.2
Mauritania	Yes	Yes	N/A	2	Yes	Implicitly	Yes	2.5	Yes	Yes	Yes	3	2.5
Mongolia	Yes	No	Yes	2	Yes	No	Yes	2	Yes	Rural targeting	Yes	3	2.3
Mozambique	Yes	Some targeting	No	1.5	Yes	Some targeting	Yes	2.5	Yes	No	Yes	2	2.0
Nepal	Yes	No	Yes	2	Yes	No	Yes	2	Yes	Rural targeting	Yes	3	2.3
Nicaragua	Yes	Yes	No	2	No	N/A	N/A	0	Yes	Yes	Yes	3	1.7
Niger	Yes	No	Yes	2	Yes	No	Yes	2	Yes	No	Yes	2	2.0
Pakistan	Yes	Not explicitly	Yes	2.5	Yes	Vulnerable groups	Yes	3	Yes	No	Yes	2	2.5
Rwanda	Yes	Yes	No	2	Yes	Yes	Yes	3	Yes	No	Yes	2	2.3
Senegal	Yes	No	Yes	2	Yes	No	Yes	2	Yes	Yes	Yes	3	2.3
Sri Lanka	Yes	No	N/A	1	Yes	No	N/A	1	Yes	Vulnerable groups	Yes	3	1.7
Tajikistan	Yes	No	Yes	2	No	N/A	N/A	0	Yes	No	Yes	2	1.3
Tanzania	No	Implicitly	Yes	1.5	Yes	Implicitly	Yes	2.5	Yes	Implicitly	Yes	2.5	2.2
Uganda	Yes	No	Yes	2	Yes	No	Yes	2	Yes	No	Yes	2	2.0
Vietnam	Yes	Yes	Yes	3	Yes	Yes	Yes	3	Yes	Yes	Yes	3	3.0
Yemen	Yes	No	N/A	1	No	N/A	N/A	0	Yes	Yes	Yes	3	1.3
Zambia	Yes	Implicitly	Yes	2.5	Yes	Yes	Yes	3	Yes	Implicitly	Yes	2.5	2.7

BIBLIOGRAPHY

ATKINSON, T. (2003), "Innovative Sources for Development Finance: Global Public Economics", paper prepared for ABCDE-Europe 2003.

CHRISTIANSEN, K. and I. HOVLAND (2003), "The PRSP Initiative: Multilateral Policy Change and the Role of Research", *Overseas Development Institute Working Paper* No. 216, ODI, London.

EBERSTADT, N. (2002), "The Future of AIDS", *Foreign Affairs* 81(6), pp. 22-45.

GLOBAL FORUM FOR HEALTH RESEARCH (2004), *The 10/90 Report on Health Research 2003-2004*, Global Forum for Health Research, Geneva, available online at www.globalforumhealth.org.

JAMISON, D.T, W.H. MOSLEY, A.R. MEASHAM and J.L. BOBADILLA (1993), *Disease Control Priorities in Developing Countries*, Oxford University Press.

LOMBORG, B. (ed.) (2004), *Global Crises, Global Solutions*, Cambridge University Press.

MAIZELS, A. and M.K. NISSANKE (1984), "Motivations for Aid in Developing Countries", *World Development* 12(9), pp. 879-900.

MASON, J.B., P. MUSGROVE and J.-P. HABICHT (2003), "At Least One-third of Poor Countries' Disease Burden is Due to Malnutrition", *Disease Control Priorities Project Working Paper* No. 1, Fogarty International Center, National Institutes of Health, Bethesda, Maryland.

MATHERS, C.D., C. STEIN, D. MA FAT, C. RAO, M. INOUE, N. TOMIJIMA, C. BERNARD, A.D. LOPEZ and C.J.L MURRAY (2002), "Globel Burden of Disease 2000: Version 2 Methods and Results", *Global Programme on Evidence for Health Policy Discussion Paper* No. 50, World Health Organization, Geneva.

MURRAY, C.J.L. and A.D. LOPEZ (eds.) (1996), *The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries, and Risk Factors in 1990 and Projected to 2020*, Harvard University Press, Cambridge.

OECD (2003*), Poverty and Health in Developing Countries: Key Actions*, OECD Policy Brief, November, Paris.

OECD (2001), *Development Co-operation Report: 2000*, OECD, Paris.

OECD DEVELOPMENT ASSISTANCE COMMITTEE-UNAIDS (2004), *Analysis of Aid in Support of HIV/AIDS Control:* 2000-2002, OECD, Paris.

REISEN, H. (2004), *Innovative Approaches to Funding the Millennium Development Goals*, Policy Brief No. 24, OECD Development Centre, Paris.

ROBERTS, J. (2003), "Poverty Reduction Outcomes in Education and Health Public Expenditure and Aid", *Overseas Development Institute Working Paper* No. 210, ODI, London.

SAGASTI, F. and K. BEZANSON (2001), "Financing and Providing Global Public Goods", *Development Financing 2000*, Study 2001(2), Swedish Ministry for Foreign Affairs, Stockholm, Sweden.

SHIFFMAN, J. (2004), "Donor Funding Priorities for Communicable Disease Control in Developing Countries", unpublished Working Paper, Department of Public Administration, Maxwell School of Public Administration, Syracuse University, Syracuse, New York.

WHO COMMISSION ON MACROECONOMICS AND HEALTH (2001), "Macroeconomics and Health: Investing in Health for Economic Development", World Health Organization, Geneva.

WORLD BANK (forthcoming 2006), *Disease Control Priorities in Developing Countries*, second edition, World Bank, Washington D.C.

WORLD BANK (2003), "Supporting Sound Policies with Adequate and Appropriate Financing", report prepared for the 22 September 2003 meeting of the Development Committee, Document No. DC2003-0016, World Bank, Washington, D.C.

WORLD BANK (2002), "Better Measuring, Monitoring, and Managing for Development Results", September, World Bank, Washington, D.C.

WORLD BANK (nd), "Getting Serious about Meeting the Millennium Development Goals", World Bank, Washington, D.C.

WORLD BANK (1993), *World Development Report 1993: Investing in Health*, World Bank, Washington D.C.

OTHER TITLES IN THE SERIES/ AUTRES TITRES DANS LA SÉRIE

The former series known as "Technical Papers" and "Webdocs" merged in November 2003 into "Development Centre Working Papers". In the new series, former Webdocs 1-17 follow former Technical Papers 1-212 as Working Papers 213-229.

All these documents may be downloaded from:
http://www.oecd.org/dev/wp *or obtained via e-mail* (dev.contact@oecd.org).

Working Paper No.1, *Macroeconomic Adjustment and Income Distribution: A Macro-Micro Simulation Model*, by François Bourguignon, William H. Branson and Jaime de Melo, March 1989.
Working Paper No. 2, *International Interactions in Food and Agricultural Policies: The Effect of Alternative Policies,* by Joachim Zietz and Alberto Valdés, April, 1989.
Working Paper No. 3, *The Impact of Budget Retrenchment on Income Distribution in Indonesia: A Social Accounting Matrix Application*, by Steven Keuning and Erik Thorbecke, June 1989.
Working Paper No. 3a, *Statistical Annex: The Impact of Budget Retrenchment*, June 1989.
Document de travail No. 4, *Le Rééquilibrage entre le secteur public et le secteur privé : le cas du Mexique*, par C.-A. Michalet, juin 1989.
Working Paper No. 5, *Rebalancing the Public and Private Sectors: The Case of Malaysia,* by R. Leeds, July 1989.
Working Paper No. 6, *Efficiency, Welfare Effects, and Political Feasibility of Alternative Antipoverty and Adjustment Programs,* by Alain de Janvry and Elisabeth Sadoulet, December 1989.
Document de travail No. 7, *Ajustement et distribution des revenus : application d'un modèle macro-micro au Maroc*, par Christian Morrisson, avec la collaboration de Sylvie Lambert et Akiko Suwa, décembre 1989.
Working Paper No. 8, *Emerging Maize Biotechnologies and their Potential Impact*, by W. Burt Sundquist, December 1989.
Document de travail No. 9, *Analyse des variables socio-culturelles et de l'ajustement en Côte d'Ivoire*, par W. Weekes-Vagliani, janvier 1990.
Working Paper No. 10, *A Financial Computable General Equilibrium Model for the Analysis of Ecuador's Stabilization Programs,* by André Fargeix and Elisabeth Sadoulet, February 1990.
Working Paper No. 11, *Macroeconomic Aspects, Foreign Flows and Domestic Savings Performance in Developing Countries: A "State of The Art" Report*, by Anand Chandavarkar, February 1990.
Working Paper No. 12, *Tax Revenue Implications of the Real Exchange Rate: Econometric Evidence from Korea and Mexico,* by Viriginia Fierro and Helmut Reisen, February 1990.
Working Paper No. 13, *Agricultural Growth and Economic Development: The Case of Pakistan*, by Naved Hamid and Wouter Tims, April 1990.
Working Paper No. 14, *Rebalancing the Public and Private Sectors in Developing Countries: The Case of Ghana,* by H. Akuoko-Frimpong, June 1990.
Working Paper No. 15, *Agriculture and the Economic Cycle: An Economic and Econometric Analysis with Special Reference to Brazil,* by Florence Contré and Ian Goldin, June 1990.
Working Paper No. 16, *Comparative Advantage: Theory and Application to Developing Country Agriculture,* by Ian Goldin, June 1990.
Working Paper No. 17, *Biotechnology and Developing Country Agriculture: Maize in Brazil,* by Bernardo Sorj and John Wilkinson, June 1990.
Working Paper No. 18, *Economic Policies and Sectoral Growth: Argentina 1913-1984,* by Yair Mundlak, Domingo Cavallo, Roberto Domenech, June 1990.
Working Paper No. 19, *Biotechnology and Developing Country Agriculture: Maize In Mexico,* by Jaime A. Matus Gardea, Arturo Puente Gonzalez and Cristina Lopez Peralta, June 1990.
Working Paper No. 20, *Biotechnology and Developing Country Agriculture: Maize in Thailand,* by Suthad Setboonsarng, July 1990.

Working Paper No. 21, *International Comparisons of Efficiency in Agricultural Production*, by Guillermo Flichmann, July 1990.
Working Paper No. 22, *Unemployment in Developing Countries: New Light on an Old Problem*, by David Turnham and Denizhan Eröcal, July 1990.
Working Paper No. 23, *Optimal Currency Composition of Foreign Debt: the Case of Five Developing Countries*, by Pier Giorgio Gawronski, August 1990.
Working Paper No. 24, *From Globalization to Regionalization: the Mexican Case*, by Wilson Peres Núñez, August 1990.
Working Paper No. 25, *Electronics and Development in Venezuela: A User-Oriented Strategy and its Policy Implications*, by Carlota Perez, October 1990.
Working Paper No. 26, *The Legal Protection of Software: Implications for Latecomer Strategies in Newly Industrialising Economies (NIEs) and Middle-Income Economies (MIEs)*, by Carlos Maria Correa, October 1990.
Working Paper No. 27, *Specialization, Technical Change and Competitiveness in the Brazilian Electronics Industry*, by Claudio R. Frischtak, October 1990.
Working Paper No. 28, *Internationalization Strategies of Japanese Electronics Companies: Implications for Asian Newly Industrializing Economies (NIEs)*, by Bundo Yamada, October 1990.
Working Paper No. 29, *The Status and an Evaluation of the Electronics Industry in Taiwan*, by Gee San, October 1990.
Working Paper No. 30, *The Indian Electronics Industry: Current Status, Perspectives and Policy Options*, by Ghayur Alam, October 1990.
Working Paper No. 31, *Comparative Advantage in Agriculture in Ghana*, by James Pickett and E. Shaeeldin, October 1990.
Working Paper No. 32, *Debt Overhang, Liquidity Constraints and Adjustment Incentives*, by Bert Hofman and Helmut Reisen, October 1990.
Working Paper No. 34, *Biotechnology and Developing Country Agriculture: Maize in Indonesia*, by Hidjat Nataatmadja *et al.*, January 1991.
Working Paper No. 35, *Changing Comparative Advantage in Thai Agriculture*, by Ammar Siamwalla, Suthad Setboonsarng and Prasong Werakarnjanapongs, March 1991.
Working Paper No. 36, *Capital Flows and the External Financing of Turkey's Imports*, by Ziya Önis and Süleyman Özmucur, July 1991.
Working Paper No. 37, *The External Financing of Indonesia's Imports*, by Glenn P. Jenkins and Henry B.F. Lim, July 1991.
Working Paper No. 38, *Long-term Capital Reflow under Macroeconomic Stabilization in Latin America*, by Beatriz Armendariz de Aghion, July 1991.
Working Paper No. 39, *Buybacks of LDC Debt and the Scope for Forgiveness*, by Beatriz Armendariz de Aghion, July 1991.
Working Paper No. 40, *Measuring and Modelling Non-Tariff Distortions with Special Reference to Trade in Agricultural Commodities*, by Peter J. Lloyd, July 1991.
Working Paper No. 41, *The Changing Nature of IMF Conditionality*, by Jacques J. Polak, August 1991.
Working Paper No. 42, *Time-Varying Estimates on the Openness of the Capital Account in Korea and Taiwan*, by Helmut Reisen and Hélène Yèches, August 1991.
Working Paper No. 43, *Toward a Concept of Development Agreements*, by F. Gerard Adams, August 1991.
Document de travail No. 44, *Le Partage du fardeau entre les créanciers de pays débiteurs défaillants*, par Jean-Claude Berthélemy et Ann Vourc'h, septembre 1991.
Working Paper No. 45, *The External Financing of Thailand's Imports*, by Supote Chunanunthathum, October 1991.
Working Paper No. 46, *The External Financing of Brazilian Imports*, by Enrico Colombatto, with Elisa Luciano, Luca Gargiulo, Pietro Garibaldi and Giuseppe Russo, October 1991.
Working Paper No. 47, *Scenarios for the World Trading System and their Implications for Developing Countries*, by Robert Z. Lawrence, November 1991.
Working Paper No. 48, *Trade Policies in a Global Context: Technical Specifications of the Rural/Urban-North/South (RUNS) Applied General Equilibrium Model*, by Jean-Marc Burniaux and Dominique van der Mensbrugghe, November 1991.
Working Paper No. 49, *Macro-Micro Linkages: Structural Adjustment and Fertilizer Policy in Sub-Saharan Africa*, by Jean-Marc Fontaine with the collaboration of Alice Sindzingre, December 1991.
Working Paper No. 50, *Aggregation by Industry in General Equilibrium Models with International Trade*, by Peter J. Lloyd, December 1991.
Working Paper No. 51, *Policy and Entrepreneurial Responses to the Montreal Protocol: Some Evidence from the Dynamic Asian Economies*, by David C. O'Connor, December 1991.
Working Paper No. 52, *On the Pricing of LDC Debt: an Analysis Based on Historical Evidence from Latin America*, by Beatriz Armendariz de Aghion, February 1992.
Working Paper No. 53, *Economic Regionalisation and Intra-Industry Trade: Pacific-Asian Perspectives*, by Kiichiro Fukasaku, February 1992.
Working Paper No. 54, *Debt Conversions in Yugoslavia*, by Mojmir Mrak, February 1992.
Working Paper No. 55, *Evaluation of Nigeria's Debt-Relief Experience (1985-1990)*, by N.E. Ogbe, March 1992.
Document de travail No. 56, *L'Expérience de l'allégement de la dette du Mali*, par Jean-Claude Berthélemy, février 1992.
Working Paper No. 57, *Conflict or Indifference: US Multinationals in a World of Regional Trading Blocs*, by Louis T. Wells, Jr., March 1992.
Working Paper No. 58, *Japan's Rapidly Emerging Strategy Toward Asia*, by Edward J. Lincoln, April 1992.

Working Paper No. 59, The Political Economy of Stabilization Programmes in Developing Countries, by Bruno S. Frey and Reiner Eichenberger, April 1992.
Working Paper No. 60, *Some Implications of Europe 1992 for Developing Countries*, by Sheila Page, April 1992.
Working Paper No. 61, *Taiwanese Corporations in Globalisation and Regionalisation*, by Gee San, April 1992.
Working Paper No. 62, *Lessons from the Family Planning Experience for Community-Based Environmental Education*, by Winifred Weekes-Vagliani, April 1992.
Working Paper No. 63, *Mexican Agriculture in the Free Trade Agreement: Transition Problems in Economic Reform*, by Santiago Levy and Sweder van Wijnbergen, May 1992.
Working Paper No. 64, *Offensive and Defensive Responses by European Multinationals to a World of Trade Blocs*, by John M. Stopford, May 1992.
Working Paper No. 65, *Economic Integration in the Pacific Region*, by Richard Drobnick, May 1992.
Working Paper No. 66, *Latin America in a Changing Global Environment*, by Winston Fritsch, May 1992.
Working Paper No. 67, *An Assessment of the Brady Plan Agreements*, by Jean-Claude Berthélemy and Robert Lensink, May 1992.
Working Paper No. 68, *The Impact of Economic Reform on the Performance of the Seed Sector in Eastern and Southern Africa*, by Elizabeth Cromwell, June 1992.
Working Paper No. 69, *Impact of Structural Adjustment and Adoption of Technology on Competitiveness of Major Cocoa Producing Countries*, by Emily M. Bloomfield and R. Antony Lass, June 1992.
Working Paper No. 70, *Structural Adjustment and Moroccan Agriculture: an Assessment of the Reforms in the Sugar and Cereal Sectors*, by Jonathan Kydd and Sophie Thoyer, June 1992.
Document de travail No. 71, *L'Allégement de la dette au Club de Paris : les évolutions récentes en perspective*, par Ann Vourc'h, juin 1992.
Working Paper No. 72, *Biotechnology and the Changing Public/Private Sector Balance: Developments in Rice and Cocoa*, by Carliene Brenner, July 1992.
Working Paper No. 73, *Namibian Agriculture: Policies and Prospects*, by Walter Elkan, Peter Amutenya, Jochbeth Andima, Robin Sherbourne and Eline van der Linden, July 1992.
Working Paper No. 74, *Agriculture and the Policy Environment: Zambia and Zimbabwe*, by Doris J. Jansen and Andrew Rukovo, July 1992.
Working Paper No. 75, *Agricultural Productivity and Economic Policies: Concepts and Measurements*, by Yair Mundlak, August 1992.
Working Paper No. 76, *Structural Adjustment and the Institutional Dimensions of Agricultural Research and Development in Brazil: Soybeans, Wheat and Sugar Cane*, by John Wilkinson and Bernardo Sorj, August 1992.
Working Paper No. 77, *The Impact of Laws and Regulations on Micro and Small Enterprises in Niger and Swaziland*, by Isabelle Joumard, Carl Liedholm and Donald Mead, September 1992.
Working Paper No. 78, *Co-Financing Transactions between Multilateral Institutions and International Banks*, by Michel Bouchet and Amit Ghose, October 1992.
Document de travail No. 79, *Allégement de la dette et croissance : le cas mexicain*, par Jean-Claude Berthélemy et Ann Vourc'h, octobre 1992.
Document de travail No. 80, *Le Secteur informel en Tunisie : cadre réglementaire et pratique courante*, par Abderrahman Ben Zakour et Farouk Kria, novembre 1992.
Working Paper No. 81, *Small-Scale Industries and Institutional Framework in Thailand*, by Naruemol Bunjongjit and Xavier Oudin, November 1992.
Working Paper No. 81a, *Statistical Annex: Small-Scale Industries and Institutional Framework in Thailand*, by Naruemol Bunjongjit and Xavier Oudin, November 1992.
Document de travail No. 82, *L'Expérience de l'allégement de la dette du Niger*, par Ann Vourc'h et Maina Boukar Moussa, novembre 1992.
Working Paper No. 83, *Stabilization and Structural Adjustment in Indonesia: an Intertemporal General Equilibrium Analysis*, by David Roland-Holst, November 1992.
Working Paper No. 84, *Striving for International Competitiveness: Lessons from Electronics for Developing Countries*, by Jan Maarten de Vet, March 1993.
Document de travail No. 85, *Micro-entreprises et cadre institutionnel en Algérie*, par Hocine Benissad, mars 1993.
Working Paper No. 86, *Informal Sector and Regulations in Ecuador and Jamaica*, by Emilio Klein and Victor E. Tokman, August 1993.
Working Paper No. 87, *Alternative Explanations of the Trade-Output Correlation in the East Asian Economies*, by Colin I. Bradford Jr. and Naomi Chakwin, August 1993.
Document de travail No. 88, *La Faisabilité politique de l'ajustement dans les pays africains*, par Christian Morrisson, Jean-Dominique Lafay et Sébastien Dessus, novembre 1993.
Working Paper No. 89, *China as a Leading Pacific Economy*, by Kiichiro Fukasaku and Mingyuan Wu, November 1993.
Working Paper No. 90, *A Detailed Input-Output Table for Morocco*, 1990, by Maurizio Bussolo and David Roland-Holst November 1993.
Working Paper No. 91, *International Trade and the Transfer of Environmental Costs and Benefits*, by Hiro Lee and David Roland-Holst, December 1993.
Working Paper No. 92, *Economic Instruments in Environmental Policy: Lessons from the OECD Experience and their Relevance to Developing Economies*, by Jean-Philippe Barde, January 1994.

Working Paper No. 93, *What Can Developing Countries Learn from OECD Labour Market Programmes and Policies*?, by Åsa Sohlman with David Turnham, January 1994.
Working Paper No. 94, *Trade Liberalization and Employment Linkages in the Pacific Basin*, by Hiro Lee and David Roland-Holst, February 1994.
Working Paper No. 95, *Participatory Development and Gender: Articulating Concepts and Cases*, by Winifred Weekes-Vagliani, February 1994.
Document de travail No. 96, *Promouvoir la maîtrise locale et régionale du développement : une démarche participative à Madagascar*, par Philippe de Rham et Bernard Lecomte, juin 1994.
Working Paper No. 97, *The OECD Green Model: an Updated Overview*, by Hiro Lee, Joaquim Oliveira-Martins and Dominique van der Mensbrugghe, August 1994.
Working Paper No. 98, *Pension Funds, Capital Controls and Macroeconomic Stability*, by Helmut Reisen and John Williamson, August 1994.
Working Paper No. 99, *Trade and Pollution Linkages: Piecemeal Reform and Optimal Intervention*, by John Beghin, David Roland-Holst and Dominique van der Mensbrugghe, October 1994.
Working Paper No. 100, *International Initiatives in Biotechnology for Developing Country Agriculture: Promises and Problems*, by Carliene Brenner and John Komen, October 1994.
Working Paper No. 101, *Input-based Pollution Estimates for Environmental Assessment in Developing Countries*, by Sébastien Dessus, David Roland-Holst and Dominique van der Mensbrugghe, October 1994.
Working Paper No. 102, *Transitional Problems from Reform to Growth: Safety Nets and Financial Efficiency in the Adjusting Egyptian Economy*, by Mahmoud Abdel-Fadil, December 1994.
Working Paper No. 103, *Biotechnology and Sustainable Agriculture: Lessons from India*, by Ghayur Alam, December 1994.
Working Paper No. 104, *Crop Biotechnology and Sustainability: a Case Study of Colombia*, by Luis R. Sanint, January 1995.
Working Paper No. 105, *Biotechnology and Sustainable Agriculture: the Case of Mexico*, by José Luis Solleiro Rebolledo, January 1995.
Working Paper No. 106, *Empirical Specifications for a General Equilibrium Analysis of Labor Market Policies and Adjustments*, by Andréa Maechler and David Roland-Holst, May 1995.
Document de travail No. 107, *Les Migrants, partenaires de la coopération internationale : le cas des Maliens de France*, par Christophe Daum, juillet 1995.
Document de travail No. 108, *Ouverture et croissance industrielle en Chine : étude empirique sur un échantillon de villes*, par Sylvie Démurger, septembre 1995.
Working Paper No. 109, *Biotechnology and Sustainable Crop Production in Zimbabwe*, by John J. Woodend, December 1995.
Document de travail No. 110, *Politiques de l'environnement et libéralisation des échanges au Costa Rica : une vue d'ensemble*, par Sébastien Dessus et Maurizio Bussolo, février 1996.
Working Paper No. 111, *Grow Now/Clean Later, or the Pursuit of Sustainable Development?*, by David O'Connor, March 1996.
Working Paper No. 112, *Economic Transition and Trade-Policy Reform: Lessons from China*, by Kiichiro Fukasaku and Henri-Bernard Solignac Lecomte, July 1996.
Working Paper No. 113, *Chinese Outward Investment in Hong Kong: Trends, Prospects and Policy Implications*, by Yun-Wing Sung, July 1996.
Working Paper No. 114, *Vertical Intra-industry Trade between China and OECD Countries*, by Lisbeth Hellvin, July 1996.
Document de travail No. 115, *Le Rôle du capital public dans la croissance des pays en développement au cours des années 80*, par Sébastien Dessus et Rémy Herrera, juillet 1996.
Working Paper No. 116, *General Equilibrium Modelling of Trade and the Environment*, by John Beghin, Sébastien Dessus, David Roland-Holst and Dominique van der Mensbrugghe, September 1996.
Working Paper No. 117, *Labour Market Aspects of State Enterprise Reform in Viet Nam*, by David O'Connor, September 1996.
Document de travail No. 118, *Croissance et compétitivité de l'industrie manufacturière au Sénégal*, par Thierry Latreille et Aristomène Varoudakis, octobre 1996.
Working Paper No. 119, *Evidence on Trade and Wages in the Developing World*, by Donald J. Robbins, December 1996.
Working Paper No. 120, *Liberalising Foreign Investments by Pension Funds: Positive and Normative Aspects*, by Helmut Reisen, January 1997.
Document de travail No. 121, *Capital Humain, ouverture extérieure et croissance : estimation sur données de panel d'un modèle à coefficients variables*, par Jean-Claude Berthélemy, Sébastien Dessus et Aristomène Varoudakis, janvier 1997.
Working Paper No. 122, *Corruption: The Issues*, by Andrew W. Goudie and David Stasavage, January 1997.
Working Paper No. 123, *Outflows of Capital from China,* by David Wall, March 1997.
Working Paper No. 124, *Emerging Market Risk and Sovereign Credit Ratings,* by Guillermo Larraín, Helmut Reisen and Julia von Maltzan, April 1997.
Working Paper No. 125, *Urban Credit Co-operatives in China,* by Eric Girardin and Xie Ping, August 1997.
Working Paper No. 126, *Fiscal Alternatives of Moving from Unfunded to Funded Pensions,* by Robert Holzmann, August 1997.
Working Paper No. 127, *Trade Strategies for the Southern Mediterranean*, by Peter A. Petri, December 1997.
Working Paper No. 128, *The Case of Missing Foreign Investment in the Southern Mediterranean*, by Peter A. Petri, December 1997.

Working Paper No. 129, *Economic Reform in Egypt in a Changing Global Economy*, by Joseph Licari, December 1997.
Working Paper No. 130, *Do Funded Pensions Contribute to Higher Aggregate Savings? A Cross-Country Analysis*, by Jeanine Bailliu and Helmut Reisen, December 1997.
Working Paper No. 131, *Long-run Growth Trends and Convergence Across Indian States,* by Rayaprolu Nagaraj, Aristomène Varoudakis and Marie-Ange Véganzonès, January 1998.
Working Paper No. 132, *Sustainable and Excessive Current Account Deficits,* by Helmut Reisen, February 1998.
Working Paper No. 133, *Intellectual Property Rights and Technology Transfer in Developing Country Agriculture: Rhetoric and Reality,* by Carliene Brenner, March 1998.
Working Paper No. 134, *Exchange-rate Management and Manufactured Exports in Sub-Saharan Africa,* by Khalid Sekkat and Aristomène Varoudakis, March 1998.
Working Paper No. 135, *Trade Integration with Europe, Export Diversification and Economic Growth in Egypt,* by Sébastien Dessus and Akiko Suwa-Eisenmann, June 1998.
Working Paper No. 136, *Domestic Causes of Currency Crises: Policy Lessons for Crisis Avoidance,* by Helmut Reisen, June 1998.
Working Paper No. 137, *A Simulation Model of Global Pension Investment,* by Landis MacKellar and Helmut Reisen, August 1998.
Working Paper No. 138, *Determinants of Customs Fraud and Corruption: Evidence from Two African Countries,* by David Stasavage and Cécile Daubrée, August 1998.
Working Paper No. 139, *State Infrastructure and Productive Performance in Indian Manufacturing,* by Arup Mitra, Aristomène Varoudakis and Marie-Ange Véganzonès, August 1998.
Working Paper No. 140, *Rural Industrial Development in Viet Nam and China: A Study in Contrasts,* by David O'Connor, September 1998.
Working Paper No. 141,*Labour Market Aspects of State Enterprise Reform in China,* by Fan Gang,Maria Rosa Lunati and David O'Connor, October 1998.
Working Paper No. 142, *Fighting Extreme Poverty in Brazil: The Influence of Citizens' Action on Government Policies,* by Fernanda Lopes de Carvalho, November 1998.
Working Paper No. 143, *How Bad Governance Impedes Poverty Alleviation in Bangladesh,* by Rehman Sobhan, November 1998.
Document de travail No. 144, *La libéralisation de l'agriculture tunisienne et l'Union européenne: une vue prospective*, par Mohamed Abdelbasset Chemingui et Sébastien Dessus, février 1999.
Working Paper No. 145, *Economic Policy Reform and Growth Prospects in Emerging African Economies,* by Patrick Guillaumont, Sylviane Guillaumont Jeanneney and Aristomène Varoudakis, March 1999.
Working Paper No. 146, *Structural Policies for International Competitiveness in Manufacturing: The Case of Cameroon*, by Ludvig Söderling, March 1999.
Working Paper No. 147, *China's Unfinished Open-Economy Reforms: Liberalisation of Services*, by Kiichiro Fukasaku, Yu Ma and Qiumei Yang, April 1999.
Working Paper No. 148**,** *Boom and Bust and Sovereign Ratings*, by Helmut Reisen and Julia von Maltzan, June 1999.
Working Paper No. 149, *Economic Opening and the Demand for Skills in Developing Countries: A Review of Theory and Evidence*, by David O'Connor and Maria Rosa Lunati, June 1999.
Working Paper No. 150, *The Role of Capital Accumulation, Adjustment and Structural Change for Economic Take-off: Empirical Evidence from African Growth Episodes,* by Jean-Claude Berthélemy and Ludvig Söderling, July 1999.
Working Paper No. 151, *Gender, Human Capital and Growth: Evidence from Six Latin American Countries,* by Donald J. Robbins, September 1999.
Working Paper No. 152, *The Politics and Economics of Transition to an Open Market Economy in Viet Nam,* by James Riedel and William S. Turley, September 1999.
Working Paper No. 153, *The Economics and Politics of Transition to an Open Market Economy: China,* by Wing Thye Woo, October 1999.
Working Paper No. 154, *Infrastructure Development and Regulatory Reform in Sub-Saharan Africa: The Case of Air Transport,* by Andrea E. Goldstein, October 1999.
Working Paper No. 155, *The Economics and Politics of Transition to an Open Market Economy: India,* by Ashok V. Desai, October 1999.
Working Paper No. 156, *Climate Policy Without Tears: CGE-Based Ancillary Benefits Estimates for Chile,* by Sébastien Dessus and David O'Connor, November 1999.
Document de travail No. 157, *Dépenses d'éducation, qualité de l'éducation et pauvreté : l'exemple de cinq pays d'Afrique francophone*, par Katharina Michaelowa, avril 2000.
Document de travail No. 158, *Une estimation de la pauvreté en Afrique subsaharienne d'après les données anthropométriques*, par Christian Morrisson, Hélène Guilmeau et Charles Linskens, mai 2000.
Working Paper No. 159, *Converging European Transitions,* by Jorge Braga de Macedo, July 2000.
Working Paper No. 160, *Capital Flows and Growth in Developing Countries: Recent Empirical Evidence,* by Marcelo Soto, July 2000.
Working Paper No. 161, *Global Capital Flows and the Environment in the 21st Century,* by David O'Connor, July 2000.
Working Paper No. 162, *Financial Crises and International Architecture: A "Eurocentric" Perspective,* by Jorge Braga de Macedo, August 2000.
Document de travail No. 163, *Résoudre le problème de la dette : de l'initiative PPTE à Cologne*, par Anne Joseph, août 2000.

Working Paper No. 164, *E-Commerce for Development: Prospects and Policy Issues,* by Andrea Goldstein and David O'Connor, September 2000.
Working Paper No. 165, *Negative Alchemy? Corruption and Composition of Capital Flows*, by Shang-Jin Wei, October 2000.
Working Paper No. 166, *The HIPC Initiative: True and False Promises*, by Daniel Cohen, October 2000.
Document de travail No. 167, *Les facteurs explicatifs de la malnutrition en Afrique subsaharienne*, par Christian Morrisson et Charles Linskens, octobre 2000.
Working Paper No. 168, *Human Capital and Growth: A Synthesis Report*, by Christopher A. Pissarides, November 2000.
Working Paper No. 169, *Obstacles to Expanding Intra-African Trade*, by Roberto Longo and Khalid Sekkat, March 2001.
Working Paper No. 170, *Regional Integration In West Africa*, by Ernest Aryeetey, March 2001.
Working Paper No. 171, *Regional Integration Experience in the Eastern African Region*, by Andrea Goldstein and Njuguna S. Ndung'u, March 2001.
Working Paper No. 172, *Integration and Co-operation in Southern Africa*, by Carolyn Jenkins, March 2001.
Working Paper No. 173, *FDI in Sub-Saharan Africa*, by Ludger Odenthal, March 2001
Document de travail No. 174, *La réforme des télécommunications en Afrique subsaharienne*, par Patrick Plane, mars 2001.
Working Paper No. 175, *Fighting Corruption in Customs Administration: What Can We Learn from Recent Experiences?*, by Irène Hors; April 2001.
Working Paper No. 176, *Globalisation and Transformation: Illusions and Reality*, by Grzegorz W. Kolodko, May 2001.
Working Paper No. 177, *External Solvency, Dollarisation and Investment Grade: Towards a Virtuous Circle?,* by Martin Grandes, June 2001.
Document de travail No. 178, *Congo 1965-1999: Les espoirs déçus du « Brésil africain »*, par Joseph Maton avec Henri-Bernard Solignac Lecomte, septembre 2001.
Working Paper No. 179, *Growth and Human Capital: Good Data, Good Results*, by Daniel Cohen and Marcelo Soto, September 2001.
Working Paper No. 180, *Corporate Governance and National Development,* by Charles P. Oman, October 2001.
Working Paper No. 181, *How Globalisation Improves Governance*, by Federico Bonaglia, Jorge Braga de Macedo and Maurizio Bussolo, November 2001.
Working Paper No. 182, *Clearing the Air in India: The Economics of Climate Policy with Ancillary Benefits,* by Maurizio Bussolo and David O'Connor, November 2001.
Working Paper No. 183, *Globalisation, Poverty and Inequality in sub-Saharan Africa: A Political Economy Appraisal*, by Yvonne M. Tsikata, December 2001.
Working Paper No. 184, *Distribution and Growth in Latin America in an Era of Structural Reform: The Impact of Globalisation*, by Samuel A. Morley, December 2001.
Working Paper No. 185, *Globalisation, Liberalisation, Poverty and Income Inequality in Southeast Asia,* by K.S. Jomo, December 2001.
Working Paper No. 186, *Globalisation, Growth and Income Inequality: The African Experience,* by Steve Kayizzi-Mugerwa, December 2001.
Working Paper No. 187, *The Social Impact of Globalisation in Southeast Asia*, by Mari Pangestu, December 2001.
Working Paper No. 188, *Where Does Inequality Come From? Ideas and Implications for Latin America*, by James A. Robinson, December 2001.
Working Paper No. 189, *Policies and Institutions for E-Commerce Readiness: What Can Developing Countries Learn from OECD Experience?*, by Paulo Bastos Tigre and David O'Connor, April 2002.
Document de travail No. 190, *La réforme du secteur financier en Afrique,* par Anne Joseph, juillet 2002.
Working Paper No. 191, *Virtuous Circles? Human Capital Formation, Economic Development and the Multinational Enterprise*, by Ethan B. Kapstein, August 2002.
Working Paper No. 192, *Skill Upgrading in Developing Countries: Has Inward Foreign Direct Investment Played a Role?*, by Matthew J. Slaughter, August 2002.
Working Paper No. 193, *Government Policies for Inward Foreign Direct Investment in Developing Countries: Implications for Human Capital Formation and Income Inequality*, by Dirk Willem te Velde, August 2002.
Working Paper No. 194, *Foreign Direct Investment and Intellectual Capital Formation in Southeast Asia*, by Bryan K. Ritchie, August 2002.
Working Paper No. 195, *FDI and Human Capital: A Research Agenda,* by Magnus Blomström and Ari Kokko, August 2002.
Working Paper No. 196, *Knowledge Diffusion from Multinational Enterprises: The Role of Domestic and Foreign Knowledge-Enhancing Activities*, by Yasuyuki Todo and Koji Miyamoto, August 2002.
Working Paper No. 197, *Why Are Some Countries So Poor? Another Look at the Evidence and a Message of Hope*, by Daniel Cohen and Marcelo Soto, October 2002.
Working Paper No. 198, *Choice of an Exchange-Rate Arrangement, Institutional Setting and Inflation: Empirical Evidence from Latin America,* by Andreas Freytag, October 2002.
Working Paper No. 199, *Will Basel II Affect International Capital Flows to Emerging Markets?*, by Beatrice Weder and Michael Wedow, October 2002.
Working Paper No. 200, *Convergence and Divergence of Sovereign Bond Spreads: Lessons from Latin America,* by Martin Grandes, October 2002.

Working Paper No. 201, *Prospects for Emerging-Market Flows amid Investor Concerns about Corporate Governance,* by Helmut Reisen, November 2002.
Working Paper No. 202, *Rediscovering Education in Growth Regressions,* by Marcelo Soto, November 2002.
Working Paper No. 203, *Incentive Bidding for Mobile Investment: Economic Consequences and Potential Responses,* by Andrew Charlton, January 2003.
Working Paper No. 204, *Health Insurance for the Poor? Determinants of participation Community-Based Health Insurance Schemes in Rural Senegal,* by Johannes Jütting, January 2003.
Working Paper No. 205, *China's Software Industry and its Implications for India,* by Ted Tschang, February 2003.
Working Paper No. 206, *Agricultural and Human Health Impacts of Climate Policy in China: A General Equilibrium Analysis with Special Reference to Guangdong,* by David O'Connor, Fan Zhai, Kristin Aunan, Terje Berntsen and Haakon Vennemo, March 2003.
Working Paper No. 207, *India's Information Technology Sector: What Contribution to Broader Economic Development?,* by Nirvikar Singh, March 2003.
Working Paper No. 208, *Public Procurement: Lessons from Kenya, Tanzania and Uganda,* by Walter Odhiambo and Paul Kamau, March 2003.
Working Paper No. 209, *Export Diversification in Low-Income Countries: An International Challenge after Doha,* by Federico Bonaglia and Kiichiro Fukasaku, June 2003.
Working Paper No. 210, *Institutions and Development: A Critical Review,* by Johannes Jütting, July 2003.
Working Paper No. 211, *Human Capital Formation and Foreign Direct Investment in Developing Countries,* by Koji Miyamoto, July 2003.
Working Paper No. 212, *Central Asia since 1991: The Experience of the New Independent States,* by Richard Pomfret, July 2003.
Working Paper No. 213, *A Multi-Region Social Accounting Matrix (1995) and Regional Environmental General Equilibrium Model for India (REGEMI),* by Maurizio Bussolo, Mohamed Chemingui and David O'Connor, November 2003.
Working Paper No. 214, *Ratings Since the Asian Crisis,* by Helmut Reisen, November 2003.
Working Paper No. 215, *Development Redux: Reflactions for a New Paradigm,* by Jorge Braga de Macedo, November 2003.
Working Paper No. 216, *The Political Economy of Regulatory Reform: Telecoms in the Southern Mediterranean,* by Andrea Goldstein, November 2003.
Working Paper No. 217, *The Impact of Education on Fertility and Child Mortality: Do Fathers Really Matter Less than Mothers?,* by Lucia Breierova and Esther Duflo, November 2003.
Working Paper No. 218, *Float in Order to Fix? Lessons from Emerging Markets for EU Accession Countries,* by Jorge Braga de Macedo and Helmut Reisen, November 2003.
Working Paper No. 219, *Globalisation in Developing Countries: The Role of Transaction Costs in Explaining Economic Performance in India,* by Maurizio Bussolo and John Whalley, November 2003.
Working Paper No. 220, *Poverty Reduction Strategies in a Budget-Constrained Economy: The Case of Ghana,* by Maurizio Bussolo and Jeffery I. Round, November 2003.
Working Paper No. 221, *Public-Private Partnerships in Development: Three Applications in Timor Leste,* by José Braz, November 2003.
Working Paper No. 222, *Public Opinion Research, Global Education and Development Co-operation Reform: In Search of a Virtuous Circle,* by Ida Mc Donnell, Henri-Bernard Solignac Lecomte and Liam Wegimont, November 2003.
Working Paper No. 223, *Building Capacity to Trade: What Are the Priorities?,* by Henry-Bernard Solignac Lecomte, November 2003.
Working Paper No. 224, *Of Flying Geeks and O-Rings: Locating Software and IT Services in India's Economic Development,* by David O'Connor, November 2003.
Document de travail No. 225, *Cap Vert: Gouvernance et Développement,* par Jaime Lourenço and Colm Foy, novembre 2003.
Working Paper No. 226, *Globalisation and Poverty Changes in Colombia,* by Maurizio Bussolo and Jann Lay, November 2003.
Working Paper No. 227, *The Composite Indicator of Economic Activity in Mozambique (ICAE): Filling in the Knowledge Gaps to Enhance Public-Private Partnership (PPP),* by Roberto J. Tibana, November 2003.
Working Paper No. 228, *Economic-Reconstruction in Post-Conflict Transitions: Lessons for the Democratic Republic of Congo (DRC),* by Graciana del Castillo, November 2003.
Working Paper No. 229, *Providing Low-Cost Information Technology Access to Rural Communities In Developing Countries: What Works? What Pays?* by Georg Caspary and David O'Connor, November 2003.
Working Paper No. 230, *The Currency Premium and Local-Currency Denominated Debt Costs in South Africa*, by Martin Grandes, Marcel Peter and Nicolas Pinaud, December 2003.
Working Paper No. 231, *Macroeconomic Convergence in Southern Africa: The Rand Zone Experience*, by Martin Grandes, December 2003.
Working Paper No. 232, *Financing Global and Regional Public Goods through ODA: Analysis and Evidence from the OECD Creditor Reporting System*, by Helmut Reisen, Marcelo Soto and Thomas Weithöner, January 2004.
Working Paper No. 233, *Land, Violent Conflict and Development*, by Nicolas Pons-Vignon and Henri-Bernard Solignac Lecomte, February 2004.
Working Paper No. 234, *The Impact of Social Institutions on the Economic Role of Women in Developing Countries*, by Christian Morrisson and Johannes Jütting, May 2004.
Document de travail No. 235, *La condition desfemmes en Inde, Kenya, Soudan et Tunisie*, par Christian Morrisson, août 2004.

Working Paper No. 236, *Decentralisation and Poverty in Developing Countries: Exploring the Impact*, by Johannes Jütting, Céline Kauffmann, Ida Mc Donnell, Holger Osterrieder, Nicolas Pinaud and Lucia Wegner, August 2004.
Working Paper No. 237, *Natural Disasters and Adaptive Capacity*, by Jeff Dayton-Johnson, August 2004.
Working Paper No. 238, *Public Opinion Polling and the Millennium Development Goals*, by Jude Fransman, Alphonse L. MacDonnald, Ida Mc Donnell and Nicolas Pons-Vignon, October 2004.
Working Paper No. 239, *Overcoming Barriers to Competitiveness*, by Orsetta Causa and Daniel Cohen, December 2004.
Working Paper No. 240, *Extending Insurance? Funeral Associations in Ethiopia and Tanzania*, by Stefan Dercon, Tessa Bold, Joachim De Weerdt and Alula Pankhurst, December 2004.
Working Paper No. 241, *Macroeconomic Policies: New Issues of Interdependence*, by Helmut Reisen, Martin Grandes and Nicolas Pinaud, January 2005.
Working Paper No. 242, *Institutional Change and its Impact on the Poor and Excluded: The Indian Decentralisation Experience*, by D. Narayana, January 2005.
Working Paper No. 243, *Impact of Changes in Social Institutions on Income Inequality in China*, by Hiroko Uchimura, May 2005.