Beyond Promises!

Civil Society Appraisal on Germany's Financial Contributions for the Implementation of the International HIV/AIDS Commitments during the Period 2005- 2009

edited by:
Action against AIDS Germany

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Required dimensions of the analysis

The worldwide HIV epidemic has special features leading to complex interactions with social, economic, political as well as cultural factors. On the one hand, the social disadvantage and the deprivation of fundamental human rights enhance the vulnerability to get infected with the HI-Virus. On the other hand, even more than any other health problem, the HIV pandemic aggravates poverty and social inequality. Due to prejudices prevailing in most societies regarding the special ways of transmission the situation of affected and vulnerable people is worsened even more by fatal tendencies of stigmatisation and discrimination.

Thus a comprehensive and objective assessment of donor contributions for the response to the threat by the HIV-epidemic cannot focus solely on the aid for specific programmes to prevent new infections as well as to treat and support affected persons. Beyond that, we have to look on the total contribution for development cooperation and the support of health care as a whole. Investments in other areas of development such as nutrition, education or drinking water and sanitation are not only indispensable to satisfy basic needs and to further human development, but they should also be designed to foster the fight against HIV. This is mainly the case when these efforts address structural risk situations such as work migration under precarious conditions or the disadvantage of women or also when the capabilities of families and communities are strengthened in order to cope with the devastating impact of the epidemic. Health systems play a decisive role in the response to the HIV crisis, not only because they have to ensure therapy and care, but also because they have to render support to a vast number of essential prevention services.

Therefore, this study attempts to analyse the volume of the Official Development Assistance (ODA) on the part of the respective donor country (Germany) on the following levels:

- Total volume of resources differentiating between official figures and real resource transfers
- ODA contributions for health promotion, and finally
- ODA contributions for specific interventions to fight HIV

Obviously, the mobilisation of resources to finance development and health projects represents only one of the necessary preconditions to reduce the burden of poverty and disease. Simultaneously, it is imperative to address the unfair structures of the present economic and power system on global, regional, and local level. Only then will it be possible to allocate the resources according to the needs of the underprivileged population groups instead of serving the interests of already privileged sectors in the end. This also means to ensure through an adequate policy of access to essential medicines[1] that the available funds will not further increase the already above average profit margins of pharmaceutical companies.

[1] A model list of essential drugs is published by the World Health Organisation (WHO) on a regular basis.

Methodology

The following analysis intends to calculate as accurately as possible the real contributions and to assess the donor performance in relation to an adequate level of cooperation. In order to do so the most comprehensive and suitable estimates of the respective financial requirements presently available serve as the basis of this assessment. These estimates are adjusted and updated if required and possible. In addition, the economic capacity of countries measured by their GNI is utilized as a basic criterion. Finally, we need to consider the current realities regarding the politics of development, mainly with respect to the immediate perspectives of individual donor countries and their international associations to increase the mobilisation of ODA resources.

The calculation of available resources is based on the most comprehensive and the most reliable sources of information. The most important ones are the databases and the statistical systems of the DAC. The aggregated DAC statistic records the distribution of financial flows according to different types and sectors of the development aid as well as the contributions for multilateral organizations. There is also a project-related database that aims to inform on central aspects such as where the ODA goes, which purposes it serves, and what central political goals it pursues. This “Creditor Reporting System” (CRS) receives information from the DAC donor countries, the European Union, and most multilateral organizations on all aid activities they are supporting financially, documenting the respective key data.

However, this reporting system has two limitations, which require to critically review the given project specifications and to look for additional information through internet research and direct inquiry with implementing agencies. On the one hand, the sectoral division of the funding areas does not coincide with the definitions of development sectors that are used in the relevant resource needs assessments. Thus an analysis relying on the reported sectoral classification would include activities and the corresponding resources that are not part of the range of interventions serving as the basis of the respective needs estimates. These aid activities that are aiming to serve other purposes than those defined as essential interventions of health promotion and the fight of HIV have to be filtered out through a review process. This includes the support to carry out a population census or to implement projects related to migration movements, which, according to the DAC and CRS classification, are part of the population sector together with the sub-sectors of reproductive health, family planning, and HIV/STI control. Furthermore, the reporting system allows the indication of only one purpose code instead of permitting a differentiated registration of sub-sectors together with the specification of the respective percentage shares in relation to budget and expenditure. This has the effect that diverse projects aiming at health promotion have been reported in other sectors. For instance, several activities for HIV prevention taking place in schools or universities have been registered under the education sector. Thus, a text research is required in numerous other sectors in order to identify the health and HIV-related projects that have been reported there.

In addition to system-related problems, we observe reporting errors by the donor institutions, which, if not corrected, will distort the picture of the allocation of resources. For this reason, the existing data was checked regarding consistency and in those frequent cases of contradictory or missing information we attempted to obtain the required data through internet-based research and, if required, direct requests for information. As an additional element of this verification process the often varying data given over the reporting years

(2000-2008) were compared in order to use the totality of information registered over the implementation period for the description and categorisation of the projects. This allowed to complete insufficient specifications of one year with more detailed information from another year and to determine the purpose of the respective activity. Through this research effort we were able to clarify with ample certainty the objectives of most aid activities related to health promotion and HIV control.

This review and information search does not only serve as a prerequisite to obtain a more accurate result but does first and foremost allow a comprehensive estimate of resources that have been made available to fight HIV. In the course of the review process, in addition to the specific HIV interventions, the projects serving reproductive health and sector-wide programmes are identified. Then we determine the financial volume of the HIV components, which are contained herein using statistical averages. These percentage shares amounting to 10% and 25% respectively can be calculated from special databases provided by OECD and World Bank, which separately specify the respective financing proportion of the HIV components. The results deriving from the OECD surveys for the years 2000 to 2002 have already been described in the alternative report of 2008.[2] They are confirmed by more recent information by the World Bank, as the 19 worldwide approved programmes in support of the health sector between 2000 and 2008 amount to an aggregated financial volume of 1.3 billion US$ and the HIV components that are comprised in them sum up to 127 billion US$, corresponding to barely 10%. This calculation procedure does only constitute an approximation to reality but it provides a more accurate picture rather than completely omitting the HIV components within projects oriented towards broader goals. As long as donor institutions do not provide more precise details on the distribution of funds for specific purposes, it definitely represents a plausible alternative.

Evidently, the analysis takes into account all relevant multilateral organisations. The same procedure for thorough screening as is described above for the bilateral aid activities was used for the cooperation administered by the EU. The World Bank has established its own internet-based project database accounting for the percentage shares corresponding to up to five areas of support in relation to the respective total commitment. Therefore, this more differentiated information system was used to determine the percentage share of health promotion in relation to total contributions. However, it does not provide any information on the disbursements, which have to be determined on the basis of the annual commitments and the calculated average project duration assuming a constant flow of funds for each implementation year. The same applies for the HIV programmes for which, as mentioned before, the amount of commitment is listed separately.[3] The country contributions to the WHO and the allocation of funds by this organisation are unfortunately not included in the statistical systems of the OECD. In this case various documents for the World Health Assembly have to be consulted to obtain the required information. The remaining UN-

[2] Cf. Rüppel: Germany's Contribution to Mobilization of Financial Resources required for a Comprehensive Response to the HIV-Crisis in Developing Countries (2008); in Action Against AIDS Germany (Editor): Global Crisis and Germany's Contribution to the Global Response – Second Civil Society Appraisal on Germany's Contribution to the implementation of international HIV/Aids Commitments 2006/2007

[3] Of course the calculations with regard to the funding via the World Bank consider exclusively IDA funded programmes as only this financing window relies – predominantly – on the replenishment through contributions of donor countries.

Organisations provide direct information on the contributions they receive in their annual reports, which serve as reference for this analysis. They report their interventions also to the CRS but the individual check of this multitude of small scale projects - the average amount is below 100,000 US$ - is certainly an inefficient endeavour. The calculation of the health and HIV shares of the total volume of resources is, therefore, based on a cursory review of the projects reported under the critical sub-sectors in order to identify the approximate proportions of the funds made available for those purposes that are of interest to us. Given the relatively small contributions for these organisations the possible, yet limited, fluctuation ranges hardly influence the total outcome. The Global Fund shows the highest level of transparency regarding the financial structure and reports the supported programmes to the CRS making it easier to obtain the respective information compared to all other institutions. The data on regional development funds were collected analogously as was the case for the EU, while the number and volume of the relevant projects are much lower.

Some contributions to multilateral organisations are registered under the bilateral aid activities in the CRS. However, these are presented as multilateral flows if they are going to the regular budget without earmarking for distinct purposes or if this presentation adds to the preciseness of the estimate. It is especially important to avoid double counting of these flows.

Resource Needs Assessments and Financing Promises

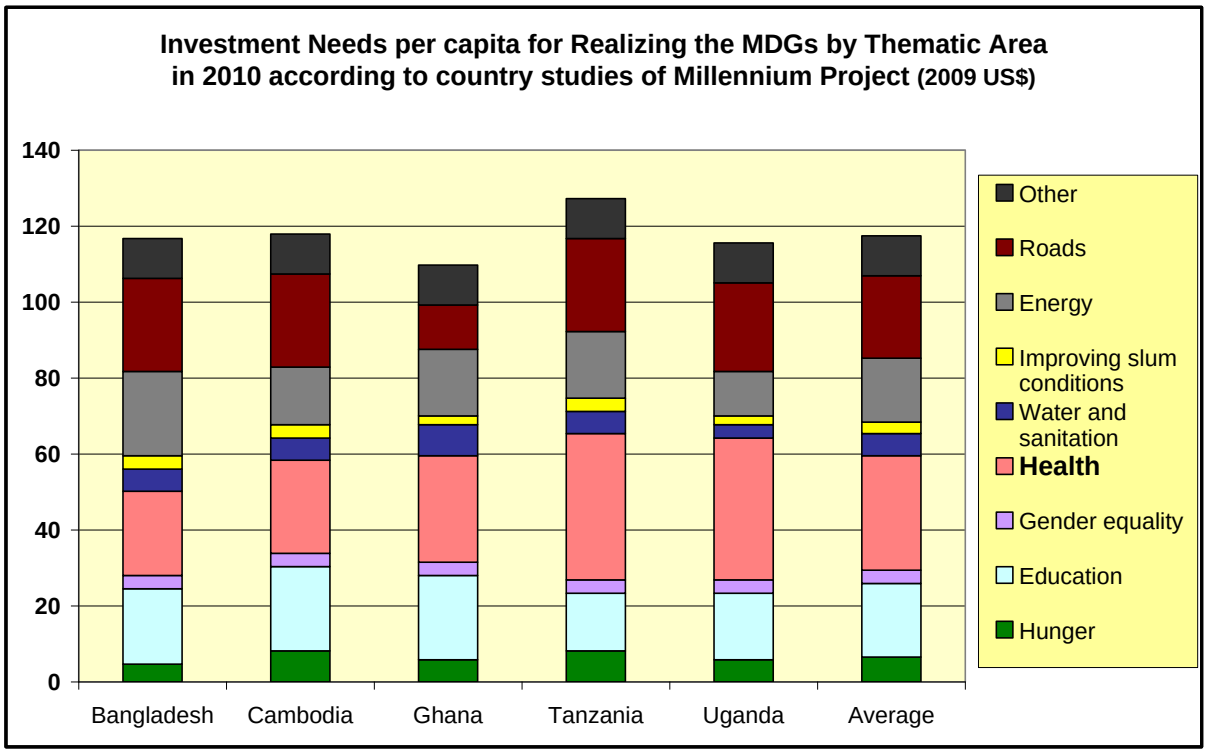
Based on extensive country studies the Millennium Project has computed the types and volumes of investments required to reach the MDGs. The calculation took into account all important development sectors and assumed important efforts by the developing countries themselves. It was estimated that the resources mobilized domestically for the MDGs will rise by 2015 from about 5% to 9% of the GDP, which would correspond to a duplication of the national efforts in absolute values. Furthermore, in areas such as drinking water, sanitation, and energy supply a financial contribution of the served households respectively users is expected. The authors, however, rightly reject fees for primary health care and basic education and advocate the abolition of such access barriers in places where they presently exist. The resulting financial needs have to be covered by budgetary resources of the affected countries and the international cooperation. The envisaged ODA contributions should predominantly benefit low income countries, which would receive roughly 90% of the calculated cooperation needs. In contrast, it is assumed that middle income countries will be able to largely cover their investment needs for the MDGs with their own resources, except for some special poverty areas. Funding restrictions for countries with bad governance and the possibilities to reallocate existing ODA contributions were also considered in the calculation, which was adjusted downward accordingly. Moreover, the cost calculation does not include coping with global problems such as climate change and loss of biodiversity. As a consequence this is a conservative estimate in every respect.

Evidently, health is a central issue with regard to humanitarian as well as development aspects. This area does not only comprise the health sector in the narrow sense but also interventions to prevent the most important epidemics as well as activities to mitigate the socio-economic consequences of diseases taking place in other sectors. On the other hand, those savings that result from the preventive and synergetic activities in the remaining sectors are also taken into account. In detail, the resource needs estimate includes the following elements:

- Health systems

- Child health
- Reproductive and maternal health
- HIV/AIDS
- Malaria
- Tuberculosis
- Access to essential medicines

Thus the estimate of required health funding took into consideration the most important problems in quantitative terms that are covered by the MDGs. Yet, health promotion represents the sector with the highest investment needs as shown in the following graph. With due regard to the exchange rates and prices in 2009, the per capita financing need is calculated to range from 22 to 37 US$ in the surveyed countries. On average 30 US$ would have to be spent per capita. In African countries the necessary investment considerably exceeds the resources assigned for the cost-intensive sectors that are related to the development of infrastructures. It is quite remarkable that the analysis did not include any country of southern Africa, which suffers from the highest HIV infection rates.



Financing Needs to Achieve Country-defined Targets for HIV Services in 2010

(132 Low and Middle Income Countries)

Area	2009	2010
Prevention	9.0	11.6
Treatment and Care	5.5	7.0
Orphans and vulnerable Children	1.7	2.5
Programme Support Costs	3.4	3.7
Prevention of violence against women	0.2	0.3
Total in 2007 US$ billions	**19.8**	**25.1**
Total in 2009 US$ billions	**20.5**	**26.0**
Share of development assistance (2/3) in 2009 US$ bn.	**13.7**	**17.3**

Sources: UNAIDS 2009, OECD deflators

More than one fourth of total funding that needs to be invested directly to achieve the MDGs should be allocated to health promotion. In numbers the currently required resources to improve the health situation would amount to 33.5 billion US$. However, this study was already published in 2005, i.e. before the UN Political Declaration on HIV/AIDS was adopted in June 2006. Therefore, the commitment to strive to meet "the goal of universal access to comprehensive prevention programmes, treatment, care, and support by 2010" (paragraph 20) could not be taken into account. Just to realize the access targets defined up to now by developing countries would require a total investment of 26 billion US$ (as of today) during the current year, according to UNAIDS estimates. The affluent donor countries need to raise two-thirds of this amount, consequently about 17 billion US$. However, the country targets established to date fall short of the universal access and the estimate does not take into account any additional financial requirements resulting from the implementation of the current WHO Treatment Guidelines.[4]

It can be derived from the detailed calculations of the country studies that on average about 21% of the resources destined for the health sector had been intended for HIV interventions. Thus the respective total amount for external HIV funding contained in the demand calculations of the Millennium Project can be estimated at approximately 7 billion US$. In the most recent UNAIDS estimates the financing need for this set of interventions, i.e. excluding the strengthening of health systems amounts to a total of 16.5 billion US$, of which the donor community would have to contribute 11 billion US$. As a consequence, we can estimate that the additional needs for international support in order to achieve the targets defined in the context of implementing the Political Declaration are in the range of 4 billion US$.

[4] To avoid unnecessary casualties they urgently advise to start earlier with therapy, resulting in a considerable increase of the number of people in the need of treatment.

Contribution Scenario to Raise the Required ODA to achieve the MDGs considering specific Financing Needs for Health and HIV, in the year 2010 (in 2009 US$ and Euros)

Development Area	All DAC Countries		Europe (EU+CH+N:50%)		Germany (10,6% of DAC)		Other DAC Countries	
	US$ billions	% of GNI	US$ billions	% of GNI	US$ billions	Euro billions	US$ billions	% of GNI
Original Calculations by Millennium Project in 2009 US$								
Total ODA Needs	177.5	0.43%	88.7	0.54%	18.81	14.90	88.7	0.35%
Direct ODA needs for MDGs (country/reg. level)	131.9	0.32%	66.0	0.40%	13.98	11.08	66.0	0.26%
Direct ODA needs for Health	33.5	0.08%	16.8	0.10%	3.55	2.81	16.8	0.07%
Estimated needs for specific HIV Interventions	*7.0*	*0.02%*	3.5	0.02%	0.75	0.59	3.5	0.01%
Taking into account country-defined targets for Universal Access								
Total ODA needs for HIV Interventions	17.3	0.04%	8.7	0.05%	1.83	1.45	8.7	0.03%
ODA needs for specific HIV Interventions	11.0	0.03%	5.5	0.03%	1.16	0.92	5.5	0.02%
Direct ODA needs for Health	37.4	0.09%	18.7	0.11%	3.97	3.14	18.7	0.07%
Direct ODA needs for MDGs (country/reg. level)	135.9	0.33%	67.9	0.42%	14.40	11.41	67.9	0.27%
Total ODA Needs	181.4	0.44%	90.7	0.56%	19.23	15.23	90.7	0.36%

Sources: Millennium-Projekt (2005); UNAIDS (2009); OECD deflators, OECD Rates of Exchange (Average June-Aug. 2010)

The chart above summarizes the original calculations developed by the Millennium Project as well as the necessary modifications mentioned above. Interestingly the required financial effort is somewhat lower as estimated in the report. According to the data and projections available when it was published the industrialized countries would have had to raise in 2010 a grand total of ODA that is equivalent to 0.46% of their GNI, in order to close the remaining financing gap. A recalculation, taking into account the development of exchange rates and prices, results in a current share of global ODA needs of 0.43% in relation to the aggregated GNI of donor countries, which is expected for 2010.[5] Taking into account the estimated difference regarding ODA needs for specific HIV interventions this figure amounts to 0.44% of GNI.

By absolute numbers in US$ of 2009, the ODA mobilized to meet the MDGs would have to be increased to 177.5 US$ billion according to the former estimate and 181.4 US$ billion with the revision. In contrast, the OECD indicates that the total volume of real ODA transfers made by DAC countries reached 107.7 billion US$ in the past year, so that a difference of roughly 70 billion US$ has to be compensated.[6] Of course, this is only valid under the – highly improbable – assumption that the totality of these resources supports the achievement of the MDGs.[7] The resulting shortfall is equivalent to 0.17% of the GNI that is expected for

[5] Conversion based on the OECD published deflators and projected growth rates of the GDP for 2010.

[6] Excluding debt forgiveness, imputed student costs, support for refugees in donor countries and administrative costs. The total ODA volume in official terms amounted to 119.6 billion US$ in 2009.

[7] As we will see in the analysis of the evolution of total development assistance, a considerable part of ODA as presented in official terms does not constitute a real transfer of financial resources from developed to developing countries.

2010 year according to OECD projections.

The model of contribution shown in the chart presented on the previous page assumes that the European DAC Member Countries will come up with half of the ODA requirements oriented towards the MDGs. This disproportional contribution is based on the consideration that this group of countries has already provided 54% of the ODA contributions in 2009 and countries, which at present exhibit ODA ratios significantly below average will require a few years to offset this backlog. In this scenario, the European donor countries would mobilize an amount of resources that is by one fourth higher than the level corresponding to their GNI share of 40%. The additional effort, i.e. the necessary rise of ODA contributions from 0.46% (achieved in 2009 according to official figures) to 0.56%, would be far less than the increase demanded by extra-European countries of recently 0.20% to 0.36% of the GNI.[8] The difference between the geographical groups of donor countries regarding the ODA efforts would thus be reduced significantly.

Thus there are tangible needs assessments oriented towards the implementation of effective measures to realize internationally agreed targets in the fight against poverty and disease. At the same time, the economically more privileged countries have made respective financial promises within the framework of the United Nations. The most comprehensive commitment was already established in a UN General Assembly Resolution in 1970 and states that at least an amount of 0.7% of the Gross National Income (GNI) has to be raised for the Official Development Assistance (ODA). This pledge was affirmed in all important UN Documents including the Declaration of Commitment on HIV/AIDS of June 2001. Three-and-a-half decades later the EU has determined a plan to reach this target not later than 2015. For the current year the 15 countries, which were already members of the EU in 2002, set a collective intermediate target of 0.56%. In order to achieve this ODA level together, the “old” member states would need to reach a minimum ratio of 0.51%, while more ambitious governments would realize respectively maintain considerably higher ODA contributions.

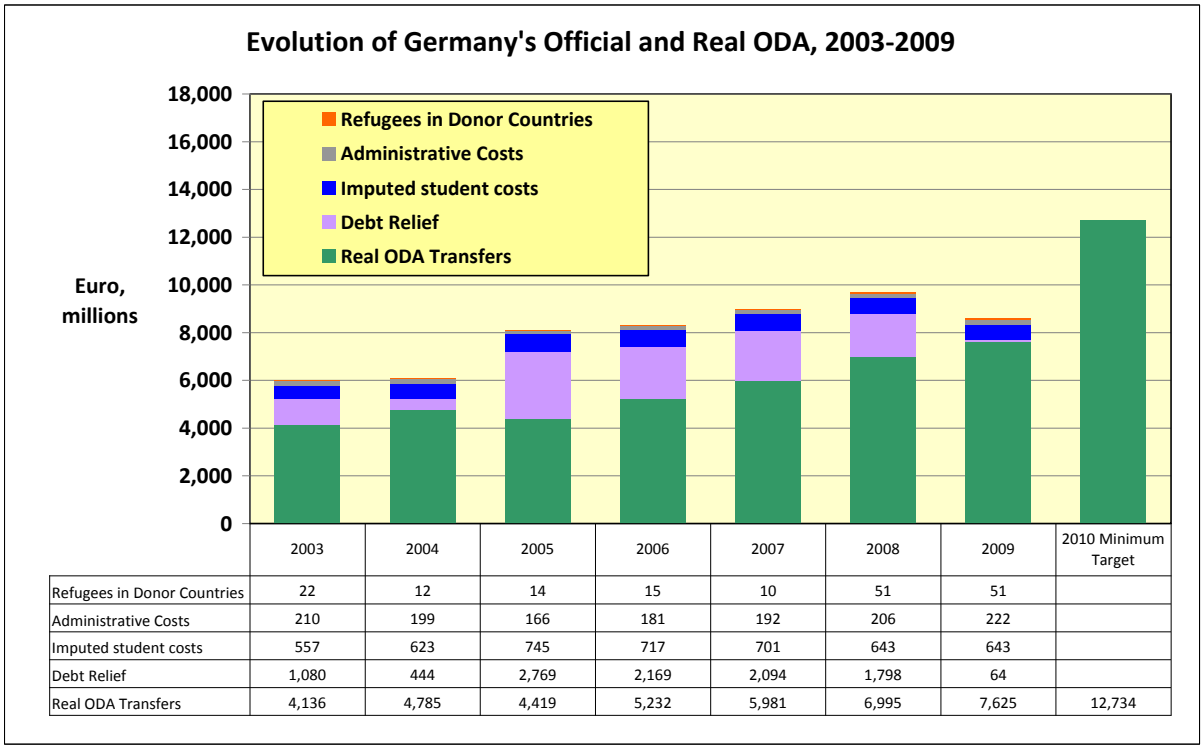
As we can see, the resources then made available would be sufficient to raise the share of 50% of the global financing needs that is required in our contribution scenario. All European countries would have to undertake financial efforts that exceed the minimum ratio set by the EU if we start from the premise of equal burden sharing. In any case, they should at least reach the minimum target in order to live up to the joint promise. This is vital in order to fulfil the historical responsibility and to pass this performance test for the credibility of Europe as a partner for development.

The following chapters will analyse to what extent Germany has made an adequate contribution during the past years supporting the disadvantaged majority of the world population to take important steps to liberate itself from rampant poverty and life-threatening diseases.

[8] For the calculation of the expected GNI of the donor countries, we used the data for the GDP growth according to the latest OECD forecast of May 2010.

Germany's financial contribution towards development, health promotion, and the response to the HIV epidemic

Total ODA contributions



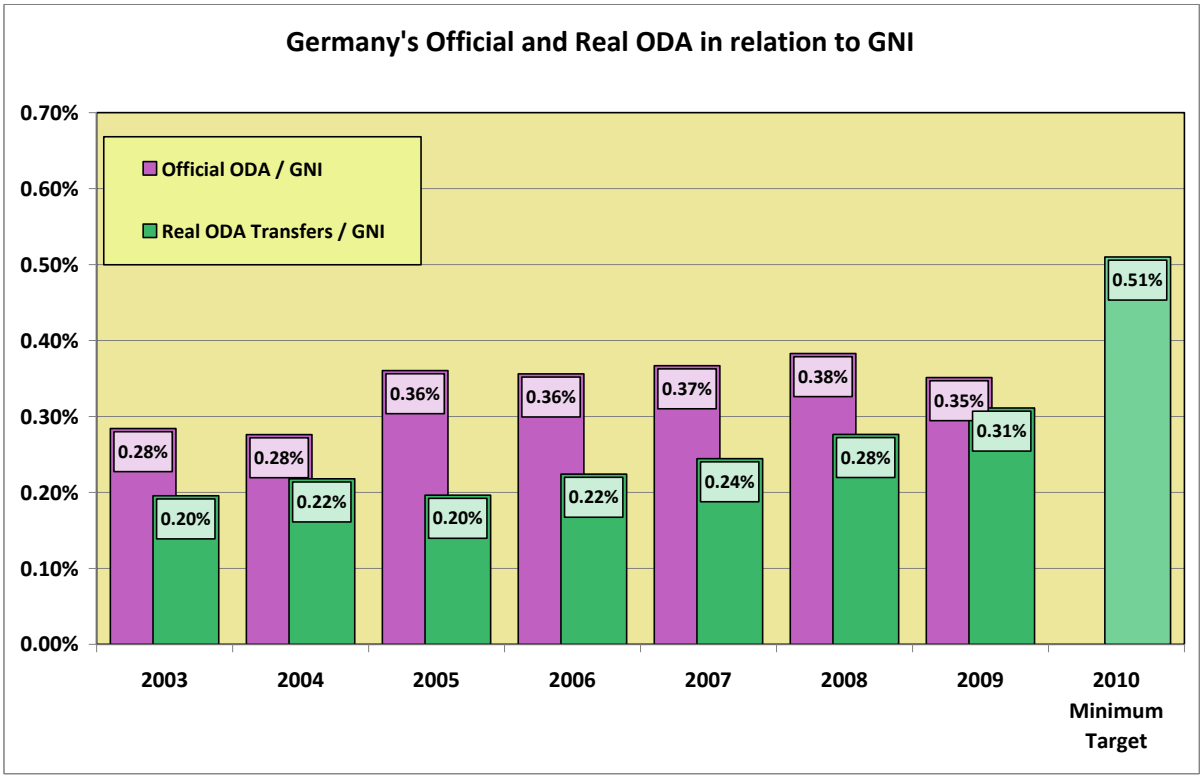
	2003	2004	2005	2006	2007	2008	2009	2010 Minimum Target
Refugees in Donor Countries	22	12	14	15	10	51	51	
Administrative Costs	210	199	166	181	192	206	222	
Imputed student costs	557	623	745	717	701	643	643	
Debt Relief	1,080	444	2,769	2,169	2,094	1,798	64	
Real ODA Transfers	4,136	4,785	4,419	5,232	5,981	6,995	7,625	12,734

The above graph displays the evolution of total official development assistance. It also shows the shares of those items that are included in official figures according to DAC/OEDC reporting guidelines, but do not represent real transfers of financial resources to recipient countries, neither do they contribute to meet the ODA needs for realizing the MDGs.[9] It is evident that the debt relief grants reported in the period from 2005 to 2008 have lead to an artificial inflation of the ODA in official terms. In contrast, only a negligible amount was recorded for the past year. The imputed student costs, however, bring about a significant increase of the officially published aid volumes, as was already the case in preceding years. As the data for this item of expenditure for 2009 - just as for disbursements for the support of refugees – are not yet available, the calculation was done on basis of the amount registered for the previous year.

[9] A detailed discussion on these items can be found at: Rüppel, Weinreich: Global Crisis – Global Action: Germany's Contribution on Trial; A civil society report on Germany's contribution to the international HIV/AIDS commitments; p. 39. Published by Action Against AIDS Germany, 2006

Hence the decline of the ODA according to the official version does not reflect things as they are. In fact, the real resource transfers have steadily risen since 2005. The rate of increase, however, was insufficient to reach the target figure, which should at least correspond to the minimum ratio established by the EU. The calculation of the target figure uses the GNI of 2009 and then applies the latest OECD projection of the expected economic growth of 1.9% for 2010.

As a result, the gap between the real resource transfers and the target figure amounts to 5.1 billion Euro or 6.4 billion US$ using the present exchange rate. In contrast, the moderate increase of the budget for development aid amounted to only 256 million Euros for the present year.



In relation to the GNI the net transfers, which really constitute financial and technical resources for the support of developing countries, increased from 0.20% to 0.31% in the period between 2005 and 2009. Starting from an extremely low base level significant improvements were achieved. On the other side, within four fifths of the period specified only one third of the distance to reach the minimum threshold was covered. In the light of this enormous backlog the increases of real ODA resources can be classified as a moderate partial success, when regarding it with favour.

Officially the ODA ratio for the previous year is indicated with 0.35%. The increase of the budget assigned to the Ministry for Economic Cooperation and Development in the current year represents only 0.01% of the German GNI. The fact that the OECD has predicted an ODA ratio of 0.40% for 2010 indicates that, once again, Germany intends to make use of an expanded volume of debt cancellations in order to sugar-coat the statistics.

ODA contributions towards health promotion

Germany: Estimate of ODA Contributions for Health Promotion, 2005-2008 (in Euro millions)

Financing-Mechanism	Commitments				Disbursements			
	2005	2006	2007	2008	2005	2006	2007	2008
Bilateral Cooperation	167.4	377.2	273.8	345.9	176.3	203.9	251.6	289.1
Programmes Managed by European Commission	123.9	125.2	113.1	131.1	112.8	148.6	143.1	137.3
Programmes by IDA/World Bank	33.1	69.7	37.0	61.8	0.0	43.4	68.1	66.5
Contributions to World Health Organization	22.1	21.6	19.8	19.7	22.1	21.6	19.8	19.7
Contributions to UNAIDS	1.1	1.1	1.1	1.9	1.1	1.1	1.1	1.9
Regular Budgets of other UN-Organizations	14.4	14.2	16.5	16.2	14.4	14.2	16.5	16.2
Global Fund to Fight AIDS, Tuberculosis and Malaria	82.8	79.2	91.7	222.4	86.2	70.2	94.8	219.9
Regional Development Funds	45.5	6.1	3.7	10.7	1.9	4.3	10.0	13.0
Other (World Food Programme, GAVI Alliance)	5.2	8.7	5.3	1.6	5.2	8.7	5.3	1.6
Total (Euro)	495.6	703.1	562.1	811.4	420.0	516.1	610.5	765.3
Health share in bilateral Cooperation (%)	4.0%	8.9%	6.9%	6.2%	7.7%	8.1%	9.0%	8.1%
Share in total Development Cooperation (%)	7.3%	9.7%	7.7%	8.7%	9.5%	9.9%	10.2%	10.9%
ODA-Contributions as % of GNI	0.022%	0.030%	0.023%	0.032%	0.019%	0.022%	0.025%	0.030%

Sources: CRS/DAC, Annual Reports, Financial Reports, Project databases, own Analysis and Calculations

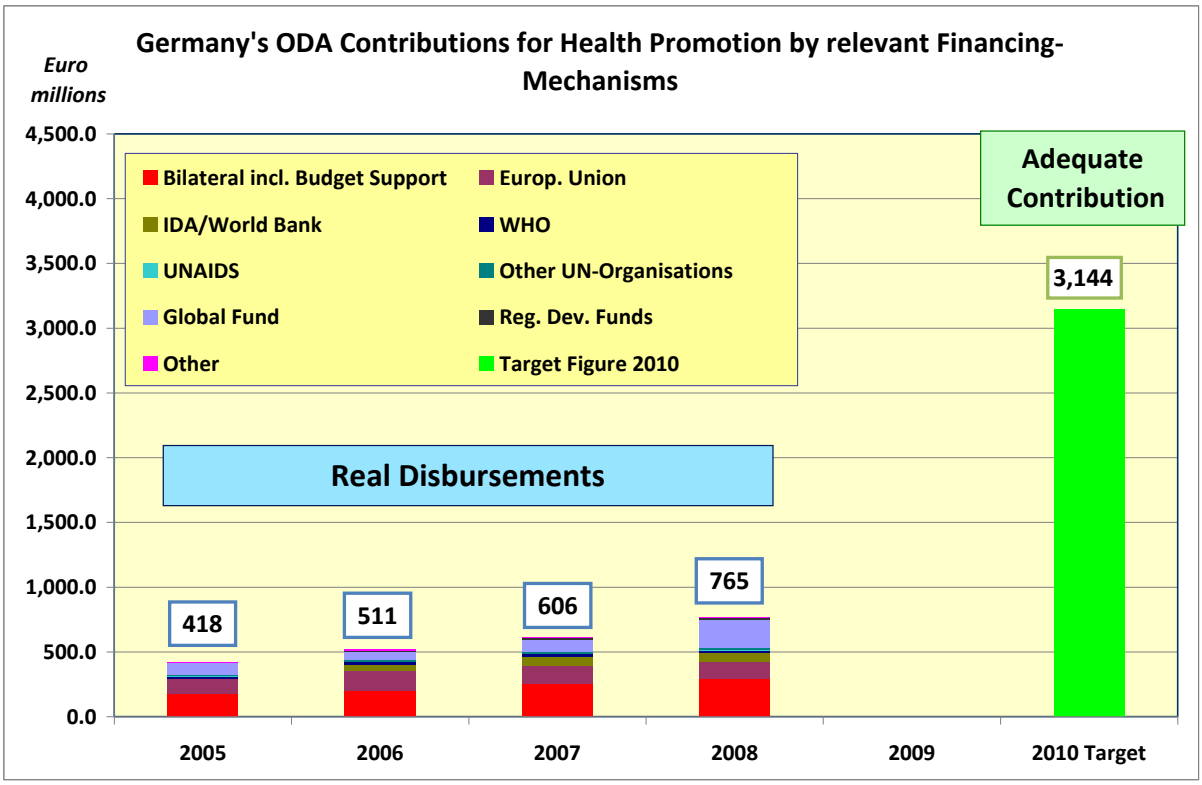
In the period under review a considerable increment of the ODA for health-related programmes and projects can be observed. The financing commitments for this area of funding have increased from just 500 to over 800 billion Euros in the course of these four years. An increase from 420 to 765 billion Euros can be noted for disbursements. While appreciating this positive tendency, we need to take into consideration that the level of contributions was completely insufficient in the base year.

It also has to be said that the relative importance of health promotion within Germany's development cooperation remains still far too low. Proportionally, the financing of prevention and control of the major diseases only increased slightly reaching little more than one tenth of the overall contributions, when looking at the disbursements. Regarding bilateral cooperation the share of merely 8% is notably lower, allowing us to draw the conclusion that multilateral flows compensate to a certain degree the bilateral shortfall.

In conjunction with the insufficient overall ODA this leads to a clearly inadequate level of support for the health sector. The financial efforts have indeed increased from less than 0.02% to 0.03% of the GNI, but this represents merely one fourth of the required target figure according to the revised estimate in our contribution scenario.

The following graph illustrates the dimensions of the financial gap regarding the German ODA contributions. In order to reach the adequate level that considers the funding requirements to achieve universal access to HIV services (shown as revised target figure)[10], Germany would have to raise additional ODA resources for health promotion in the range of 2.5 billion Euros in relation to the level of contribution reached in 2008.

[10] Cf. overview on the contribution scenario and the respective comments.

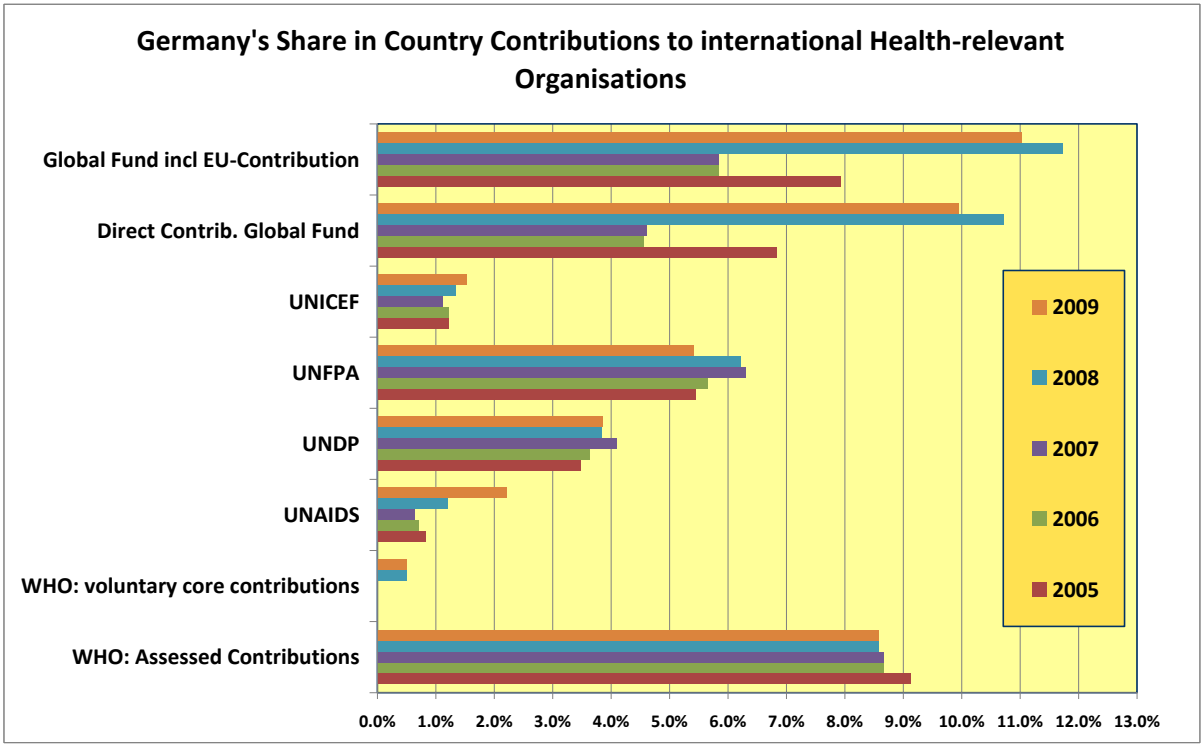


Since Germany's direct contribution to the Global Fund increased to 200 million Euros during the ongoing replenishment period from 2008 to 2010, this financing mechanism ranks second regarding the composition of health-relevant ODA. A further increase of this support that would be commensurate with the calculated financing needs for the coming replenishment period from 2011 to 2013 amounting to at least 20 billion US$ and in line with the proposed contribution share represents an effective way to compensate at least partially the backlog of health financing described above.

In contrast, the mobilization of resources via the European Union has declined after 2006 and only occupies the third place in importance. The main reason for this tendency is the relatively low significance attributed to health promotion within the development cooperation managed by the European Commission. With less than 6% of commitments and 7% of disbursements during 2008 the health share is even lower as in Germany's bilateral ODA. It is high time to overcome this deficit and member countries should advocate for the necessary change in priority setting.

Regarding the financial support for health-relevant international organisations, the German share in relation to the total country contributions has reached an acceptable level in the case of the Global Fund during the current replenishment period (2008 to 2010) – albeit the overall volume of funding was insufficient to meet the needs. Yet, the participation in funding the regular budget of the UN Organisations, which are engaged in health promotion remain clearly inadequate. Only the assessed contributions to WHO that are based on the United Nations' scale of assessments are commensurate with the relative payment capacity. The funds for the voluntary and flexible core contributions that have been introduced recently and that are increasingly important for the realization of the WHO mandate, amounted to 0.5% of the respective overall resources in the biennium 2008-9, which is completely insufficient. The contribution ratios of the other health-relevant UN organisations are also far too low without any tangible perspective of improvement. This does not only impair the financial capacity of

these organisations regarding the fulfilment of their indispensable functions of coordination and technical support. The extremely substandard contribution levels also reduce the possibilities to put forward the positive experiences and conceptual approaches that were elaborated within the German Development Cooperation – e.g. with respect to the orientation towards fundamental human rights or the participation of target groups – in the context of planning processes.



ODA Contributions for the response to the HIV epidemic

The following overview represents a condensed version of Germany's HIV-relevant contributions during the monitoring period, while detailed data can be taken from the annex.

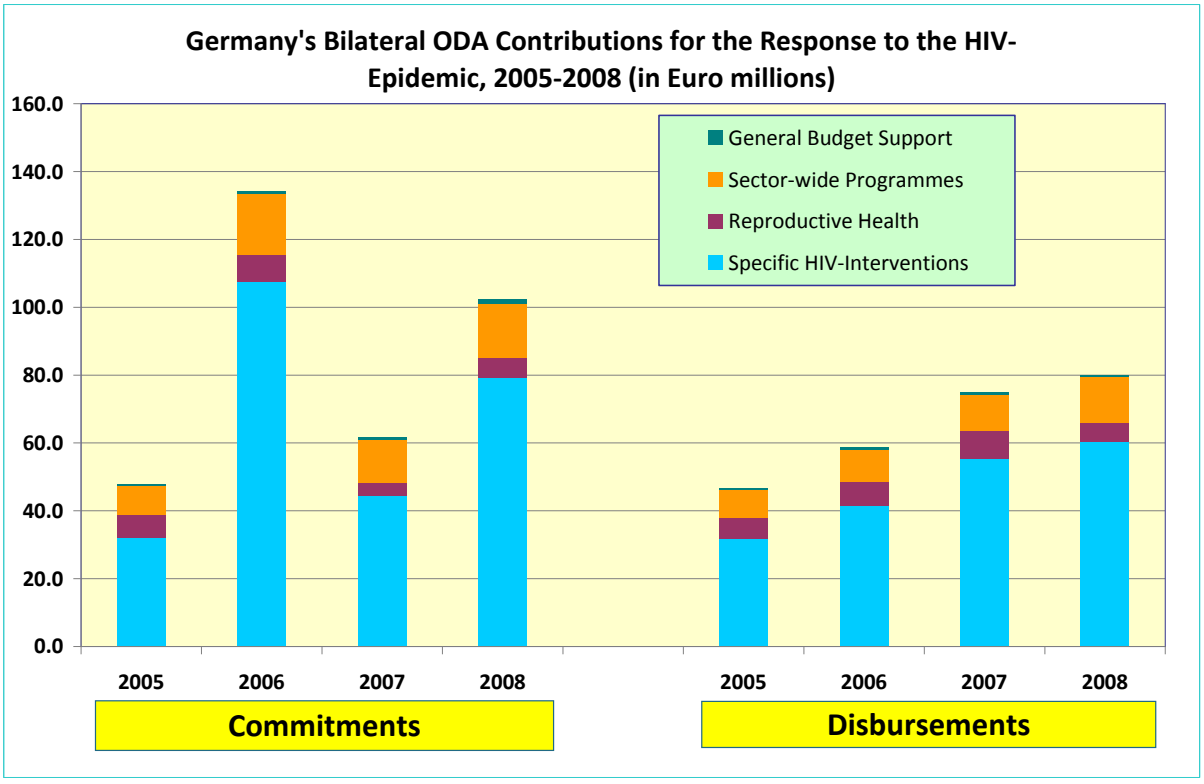
Germany: Estimate of ODA Contributions for the Response to the HIV Epidemic, 2005-2008 (in Euro millions)

Financing-Mechanism	Commitments				Disbursements			
	2005	2006	2007	2008	2005	2006	2007	2008
Bilateral Cooperation	47.8	134.2	61.6	102.3	46.7	58.6	75.0	80.0
Programmes Managed by European Commission	21.0	31.7	26.4	23.5	32.6	37.9	42.6	33.4
Programmes by IDA/World Bank	11.4	11.4	30.3	9.3	0.0	19.9	31.0	26.1
Contributions to World Health Organization	2.1	2.0	1.8	1.9	2.1	2.0	1.8	1.9
Contributions to UNAIDS	1.1	1.1	1.1	1.9	1.1	1.1	1.1	1.9
Regular Budgets of other UN-Organizations	5.8	6.1	7.0	6.9	5.8	6.1	7.0	6.9
Global Fund to Fight AIDS, Tuberculosis and Malaria	42.9	47.6	60.7	138.3	49.0	37.0	60.2	134.4
Regional Development Funds	8.2	1.6	0.4	0.9	0.3	0.7	1.5	2.4
Other (World Food Programme, GAVI Alliance)	5.2	4.6	1.1	1.6	5.2	4.6	1.1	1.6
Total (Euro)	145.6	240.3	190.4	286.6	142.8	167.9	221.4	288.6
Health share in bilateral Cooperation (%)	1.2%	3.2%	1.6%	1.8%	2.0%	2.3%	2.7%	2.2%
Share in total Development Cooperation (%)	2.1%	3.3%	2.6%	3.1%	3.2%	3.2%	3.7%	4.1%
ODA-Contributions as % of GNI	0.006%	0.010%	0.008%	0.011%	0.006%	0.007%	0.009%	0.011%

Sources: CRS/DAC, Annual Reports, Financial Reports, Project databases, own Analysis and Calculations

Regarding the evolution of disbursements we observe a duplication of the total contribution in Euros. The share of HIV projects and components in relation to the total volume of ODA resources shows an increase of almost one percentage point. The a.m. increase of the contribution to the Global Fund has mainly produced this positive trend. In 2008 this financing mechanism ranked first among all funding channels and accounted for roughly 47% of all resources made available by Germany for the fight against AIDS. The co-financing of the development cooperation administered by the EU only represents a minor part of this funding due to the fact that the share of the HIV interventions within overall ODA channelled through the EU oscillates only around 2%. The same is true for funding via IDA/World Bank. In this case the total volume of the German contribution rose significantly, but at the same time the HIV share in relation to total disbursements estimated for this funding institution declined continuously from 4.7% to 3.3%.

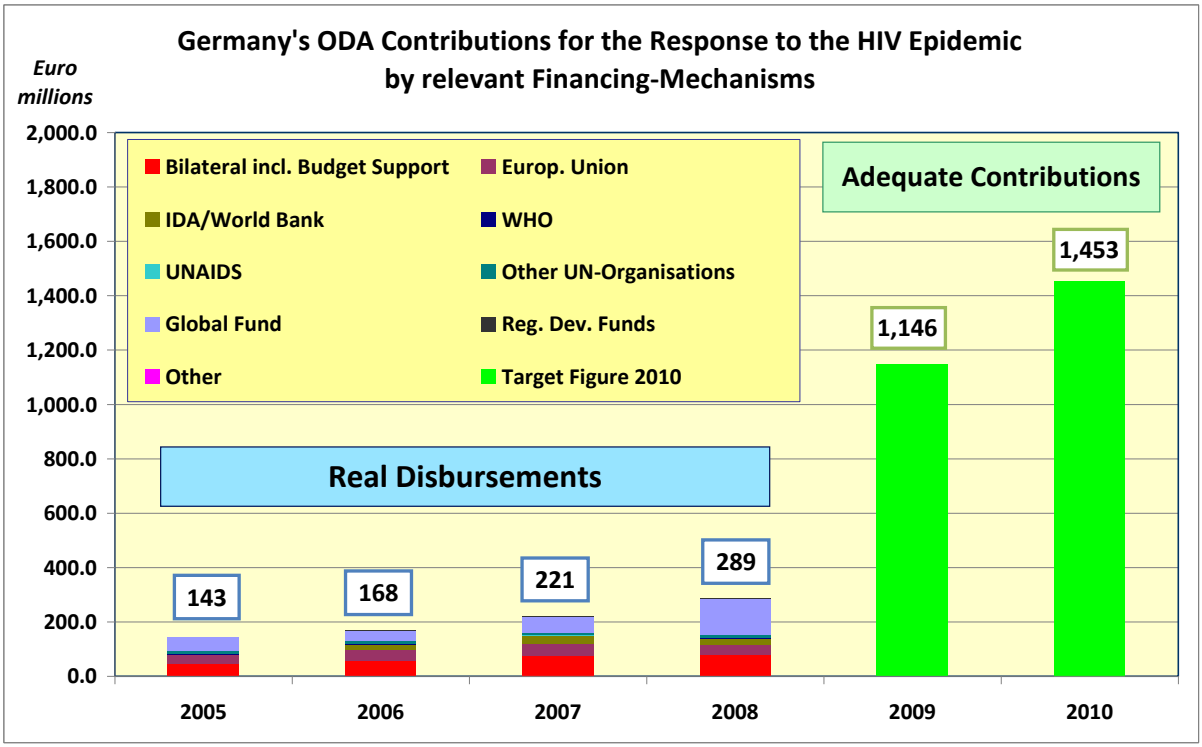
Between 2005 and 2006 bilateral resources also show a significant increase, which is levelling off, however, in the last year of the reporting period. This positive tendency mainly originates from the high level of commitments, which had been achieved during the exceptional year 2006. Thus there is a risk that the annual volumes of disbursements will drop again when the respective programmes will come to an end in a few years time and new commitments will not reach a similar level as recorded in 2006.



It becomes also apparent that the estimated shares of the HIV components within projects serving reproductive health and in sector-wide programmes represented a rather considerable proportion in relation to the overall financial support for the international HIV response. Due to the trend of stagnation regarding the total volume of resources for reproductive health the share of these two project categories with broader goals toward HIV financing is decreasing from 31% to 24% during the monitoring period.

When comparing the ODA disbursements made available through the relevant financing

mechanisms to date with the adequate level of participation in financing the realization of the country-defined targets in the field of HIV, there is still a lot of room for improvement in Germany's case. In order to meet this international responsibility, the promises regarding the increase of the total ODA have to be fulfilled on the one hand. On the other side, it is of utmost importance to attribute a much higher priority in the allocation of funds for the fight against the devastating HIV epidemic.

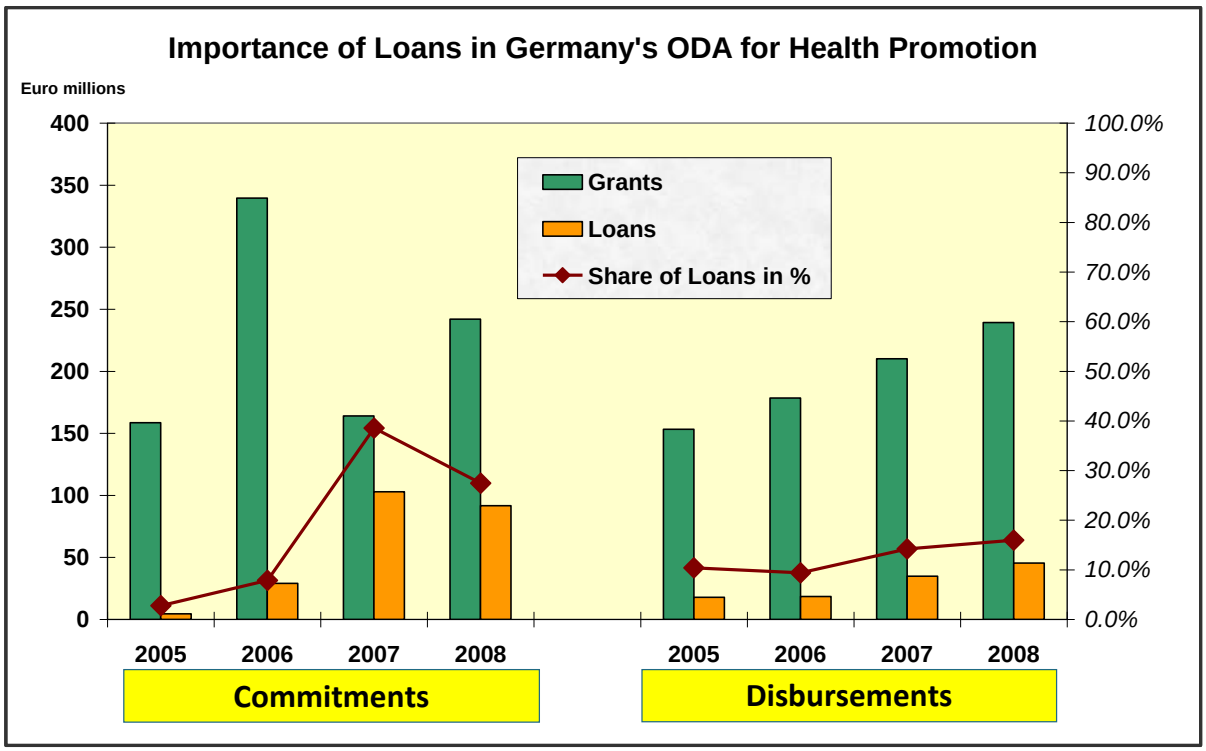


Qualitative Aspects of Bilateral ODA Contributions for Health Promotion

Financial Conditions

As described already in our first alternative report the share of loans within overall ODA made available by Germany to support health promotion was significant and exhibited an upward trend during the initial years of the decade. Unfortunately, this problematic tendency continued in the present reporting period. In fact, the year 2007 saw the highest proportion of loans in relation to total commitments since 2000 amounting to nearly two-fifths. This extremely high ratio declined somewhat in the following year to more than a quarter of overall ODA resources committed to finance activities in the health field, which still represented one of the highest levels recorded since the beginning of the decade. As a consequence, the percentage of disbursements that correspond to ODA loans increased almost continuously from roughly 10% in 2005 and 2006 to 16% in 2008.

This modality of health-related ODA contributions clearly limits the possibilities to allocate the resources according to needs regarding central aspects such as disease burden and poverty level. It is predetermined that this part of cooperation will go to those countries which show the necessary capacity to repay the respective loans. This will necessarily influence the regional distribution of the German funding of health promotion. Furthermore, this type of financing may further increase the debt burden of the recipient countries.

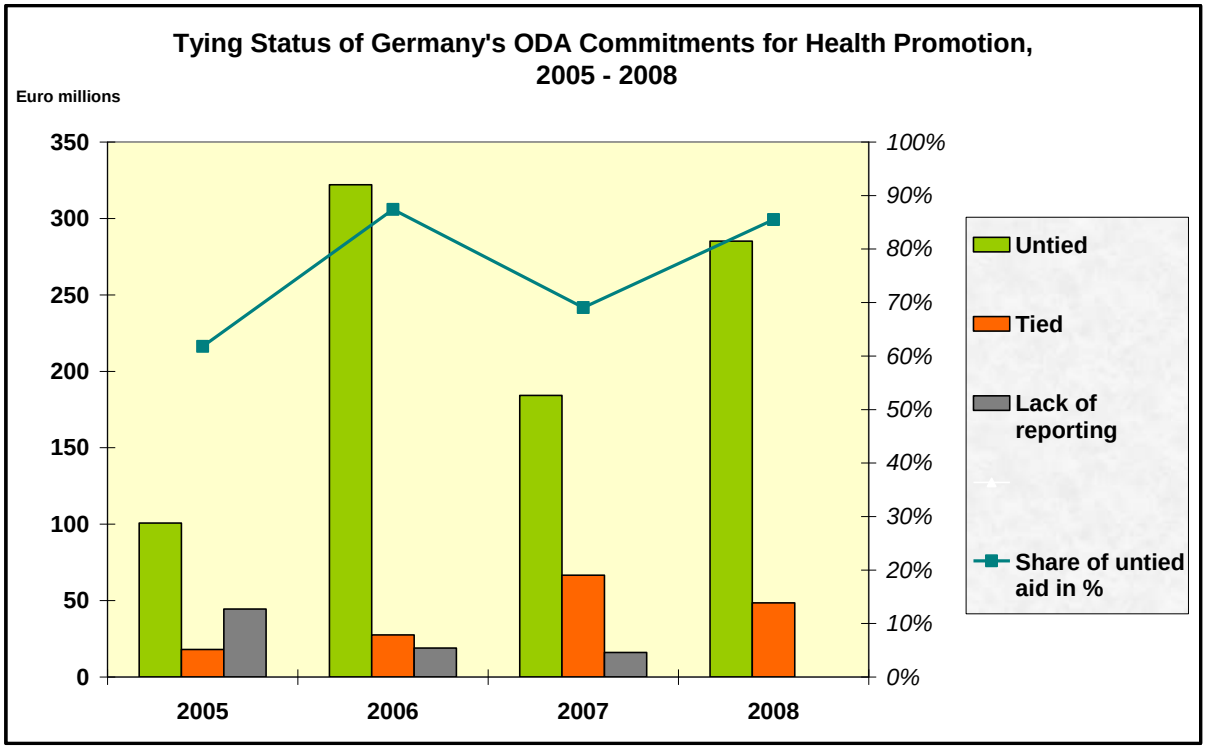


It is remarkable that a considerable part of the volume of ODA loans for health interventions does not come from public funds, i.e. the budget of the central government, but is raised on the capital market by the respective implementing agency (KfW). A change in reporting practices introduced in 2008 allowed for the first time to determine the origin of financial means for individual aid activities. In this year, the commitments relying on resources from the capital market amounted to 91 million US$ and represented nearly 19% of the total funding committed for health interventions. The combination of these so-called own funds of KfW with budget funds in the form of mixed and composite finance permits to extend these loans with concessional terms that satisfy the requirements to qualify as ODA (grant element of at least 25%) This type of funding casts additional doubt on the degree of generosity as well as flexibility of the German support for health promotion in developing countries.

Tying status

According to different studies and conservative estimates, tied aid increases the cost of goods and services by 15 to 30%. In general, untying aid improves aid effectiveness and country ownership. Thus it is part of the Paris Declaration on Aid Effectiveness which establishes to monitor progress in this field by measuring the percentage of bilateral aid that is untied. Moreover, the “proportion of bilateral official development assistance of OECD/DAC donors that is untied" was incorporated in the list of MDG indicators under the new number 8.3 (formerly number 35).

The analysis of the tying status of financial commitments for health related projects shows no clear tendency over the period under review. Interestingly, the year 2006 saw not only the highest volume of newly committed ODA resources, but also the highest proportion of untied aid during these four years. The declining amount of commitments with missing data on the tying status represents a positive trend regarding the completeness of reporting on this indicator of aid quality.

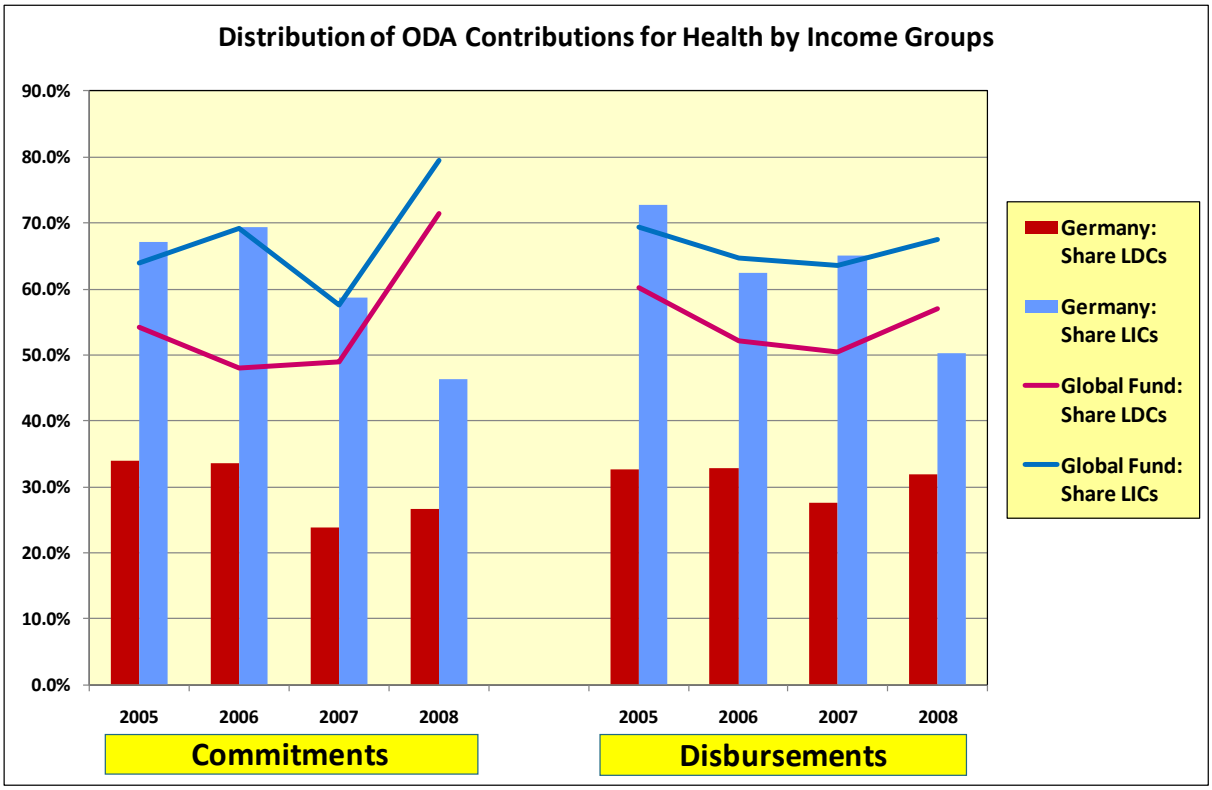


Geographical Distribution

Regarding the allocation of Germany's bilateral development assistance for health by income group, the first aspect that strikes the eye is the low proportion of Least Developed Countries (LDCs), especially when we take the Global Fund to Fight AIDS, Tuberculosis and Malaria as a reference. Whereas the share of LDCs within overall health-relevant ODA disbursements by Germany oscillates around a third, the respective percentage in the distribution of resources administered by Global Fund ranges between 50% and 60% during the period under review. As the programmes with LDCs represented only a fourth of newly committed funding for health promotion in the last two years, the relative importance of the support for the most vulnerable regions in this field may even decline in the immediate future.

During the first years of the reporting period, however, the cooperation with other Low Income Countries (LICs) accounted for a relatively high proportion of overall ODA aiming to improve the health status in the developing world. Thus during that time the share of total resources mobilized for health projects in LICs was rather similar to the corresponding proportion found in the allocation structure of Global Fund resources. Unfortunately, the proportion of German health ODA going to LICs fell considerably in the last years constituting in 2008 only half of the overall volume of bilateral disbursements in this area. Considering the fact that this percentage was even lower in relation to total commitments made in 2008 amounting to 46%, the ODA disbursements benefiting LICs within the overall bilateral cooperation for health promotion may drop below 50% in the coming years. This negative tendency with regard to the poverty orientation of Germany's development assistance is likely related to the growing importance of loans as described in the chapter above, which by

definition are not suitable for the economically weakest countries.[11] In contrast, the share of LICs in relation to the total amount of financing through the Global Fund has significantly increased in the most recent year with available data.

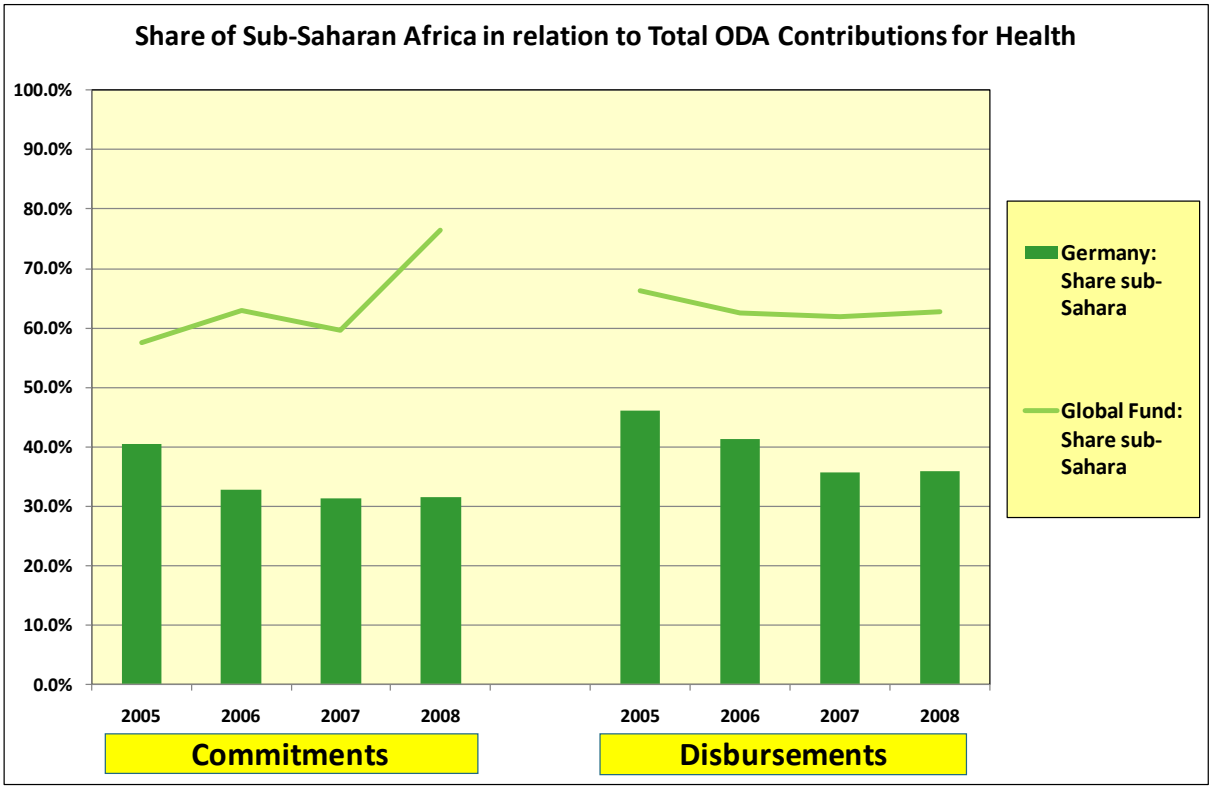


As we can observe in the graph on the following page, the proportion of Sub-Saharan Africa within Germany's ODA contributions for health showed also a downward tendency during the reporting period. Considering that this trend was even more pronounced regarding the commitments, the corresponding proportion within the disbursements is likely to decline further in the next years.

Compared to the geographic distribution of Global Fund resources the respective level of German health ODA that is benefiting the area of the world with the highest disease burden and the lowest availability of resources appears to be clearly unsatisfactory. When we look at the commitments made in the most recent year it was less than half the percentage of that reference institution. Whereas the proportion going to countries located south of Sahara within newly committed funds for health promotion went up from a level of around 60% to over three-fourths in the latter case, this share came down to roughly 31% in German development cooperation. With regard to disbursements the corresponding percentage of the Global Fund oscillates around 65%, while the part of German health ODA destined to Sub-Saharan Africa declined by 10 percentage points from 46% to 36% in the period of four years. Again, this trend seems to reflect a decreasing importance of poverty levels and resource constraints as decision criteria for the allocation of ODA contributions, at least in this critical sector for human development. Obviously it is not congruent with the expectation "of more than doubling aid to Africa compared to 2004" that was formulated at the

[11] The LDCs receive financial cooperation by Germany in the form of non-repayable grants. Developing countries with a per-capita income of less than 1,165 US$ in 2009 (IDA lending category) are eligible for loans at special conditions (In general at 0.75 % p. a. interest, 10 grace years, term of 40 years).

Gleneagles G8 summit in 2005 echoing projections which were developed by OECD on the basis of existing donor commitments at that time.

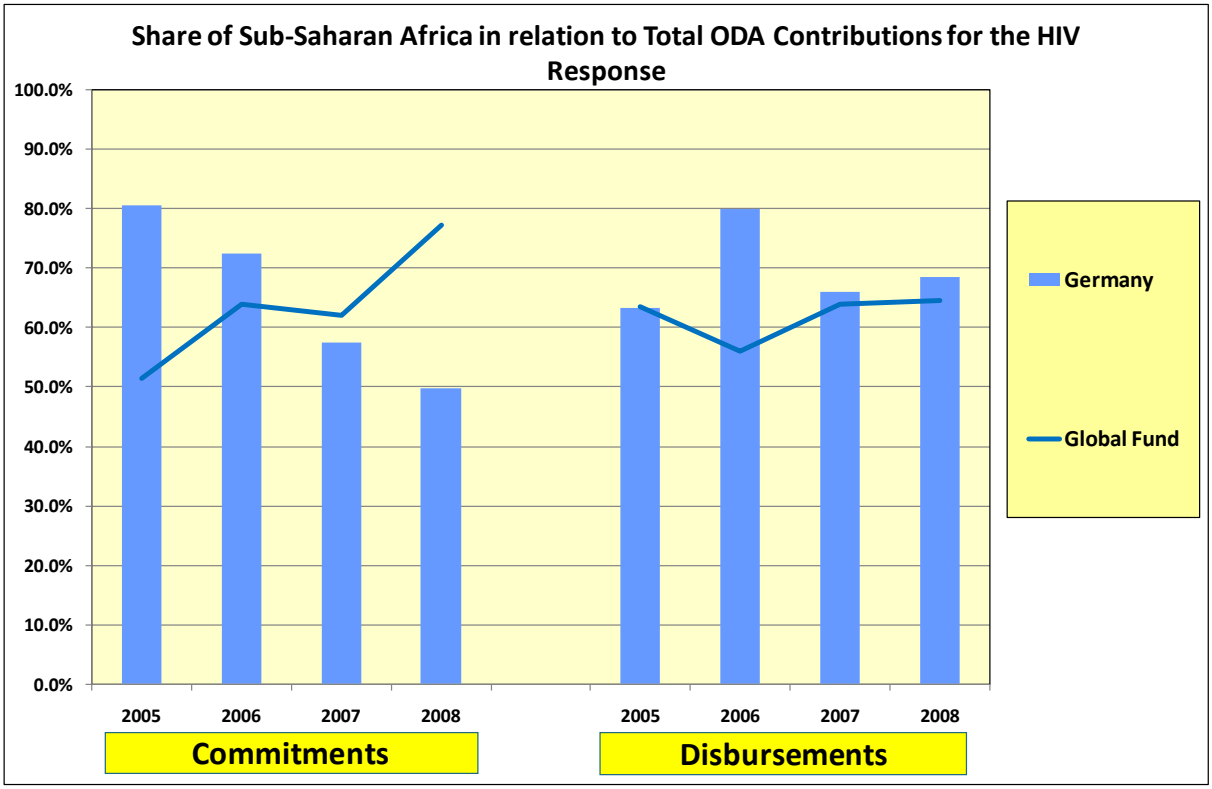


Of special importance is the allocation of ODA contributions for the HIV response considering the situation that Sub-Saharan Africa remains the region most heavily affected by HIV, accounting for two-thirds of people living with HIV worldwide and for 72% of the total number of AIDS-related deaths in 2008. Analysing the distribution of disbursements, the participation of this geographic area in relative terms appears to be in accordance with the disproportionate impact of the pandemic it is suffering. During the period under review between 63% and 80% of the ODA resources provided by Germany directly for the response to HIV went to the countries, which are situated south of Sahara.[12] Thus the regional share of ODA contributions placed at disposal of developing countries maintained a level that exceeded significantly the corresponding percentage of development assistance for the health sector in general. The evolution of commitments, however, shows quite a different picture. On this side of the statistics the share allocated to Sub-Saharan Africa fell sharply from more than 80% in 2005 to barely 50% in 2008. As a consequence, a downward trend of the corresponding proportion within disbursements is foreseeable for the next years.

Interestingly, the share of the most affected region in relation to Germany's bilateral ODA disbursements resembles that observed for the Global Fund and even surpasses considerably this reference level in one year (2006). In this comparative view, it becomes even more evident that the problematic aspect lies in recent trends of commitments, and hence the future perspectives for the regional orientation of the funding of HIV services, which are completely contrasting. Whereas the proportion destined to Sub-Saharan Africa is

[12] This analysis on the regional allocation of ODA in support of the HIV response refers to specific HIV interventions exclusively, and therefore it is not taking into account HIV components in projects and programmes with broader goals.

growing steadily over the reporting years in the case of the international financing mechanism, as mentioned above, just the opposite is true for the bilateral aid mobilized by Germany. Summing up the analysis of the regional distribution of health relevant ODA contributions, it must be stated that in recent years the orientation towards the areas and countries with the most pressing needs appears to decline, even with respect to those aspects for which adequate levels could be observed in previous years.



Statistical Annex

Estimate of ODA Commitments for Health Promotion and the HIV Response, 2005-2008 (in Euro Mio.)

Financing Mechanism		Total Contributions				Contributions for Health Promotion				Contributions for HIV Response			
		2005	2006	2007	2008	2005	2006	2007	2008	2005	2006	2007	2008
Bilateral Cooperation		**4,137.8**	**4,234.9**	**3,958.4**	**5,558.2**	**167.4**	**377.2**	**273.8**	**345.9**	**47.8**	**134.2**	**61.6**	**102.3**
of that:	Specific HIV-Interventions	32.0	107.6	44.2	79.1	32.0	107.6	44.2	79.1	32.0	107.6	44.2	79.1
	Reproductive Health	27.1	31.4	16.1	24.1	27.1	31.4	16.1	24.1	6.8	7.8	4.0	6.0
	Sector-wide Programmes	86.5	178.7	126.0	159.3	86.5	178.7	126.0	159.3	8.6	17.9	12.6	15.9
	Other Health Problems	17.5	50.8	80.5	71.1	17.5	50.8	80.5	71.1	0.0	0.0	0.0	0.0
	General Budget Support	45.0	81.6	54.5	103.0	4.5	8.7	7.0	12.4	0.5	0.9	0.7	1.2
Programmes Managed by European Commission		**1,569.4**	**2,003.6**	**2,063.0**	**2,317.3**	**123.9**	**125.2**	**113.1**	**131.1**	**21.0**	**31.7**	**26.4**	**23.5**
Programmes by IDA/World Bank		**387.7**	**471.2**	**777.4**	**741.6**	**33.1**	**69.7**	**37.0**	**61.8**	**11.4**	**11.4**	**30.3**	**9.3**
World Health Organization		**31.6**	**30.8**	**28.3**	**27.6**	**22.1**	**21.6**	**19.8**	**19.7**	**2.1**	**2.0**	**1.8**	**1.9**
of that:	Assessed Contributions to Regular Budget	31.6	30.8	28.3	27.6	22.1	21.6	19.8	19.3	2.1	2.0	1.8	1.8
	Voluntary Flexible and Core Contributions	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.4	0.0	0.0	0.0	0.0
UNAIDS (Unified Budget and Workplan)		**1.1**	**1.1**	**1.1**	**1.9**	**1.1**	**1.1**	**1.1**	**1.9**	**1.1**	**1.1**	**1.1**	**1.9**
Regular Budgets of other UN-Organizations		**45.8**	**46.9**	**56.4**	**53.5**	**14.4**	**14.2**	**16.5**	**16.2**	**5.8**	**6.1**	**7.0**	**6.9**
	UNDP (United Nations Development Programme)	25.8	26.8	33.5	29.3	1.1	1.3	1.2	1.0	1.1	1.3	1.1	0.9
	UNFPA (United Nations Population Fund)	15.4	15.6	18.5	18.5	12.3	12.3	14.6	14.4	4.5	4.6	5.6	5.8
	UNICEF (United Nations Children's Fund)	4.6	4.5	4.4	5.7	0.9	0.6	0.7	0.8	0.2	0.2	0.2	0.2
Global Fund to Fight AIDS, Tuberculosis and Malaria		**82.8**	**79.2**	**91.7**	**222.4**	**82.8**	**79.2**	**91.7**	**222.4**	**42.9**	**47.6**	**60.7**	**138.3**
of that:	Direct Contribution	82.8	70.2	85.2	216.4	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
	Other: BACKUP Initiative	0.0	9.0	6.5	6.0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
African Development Fund		**286.6**	**94.8**	**150.4**	**151.1**	**43.3**	**6.1**	**3.7**	**9.0**	**7.9**	**1.6**	**0.4**	**0.7**
Asian Development Fund		**46.4**	**40.2**	**36.5**	**37.7**	**2.2**	**0.0**	**0.0**	**1.7**	**0.4**	**0.0**	**0.0**	**0.2**
WFP (World Food Programme)		**55.7**	**47.5**	**48.0**	**69.7**	**5.2**	**4.5**	**1.0**	**1.6**	**5.2**	**4.5**	**1.0**	**1.6**
GAVI Alliance		**0.0**	**4.2**	**4.3**	**0.0**	**0.0**	**4.2**	**4.3**	**0.0**	**0.0**	**0.1**	**0.1**	**0.0**
Total Contribution (Euro)		**6,780.8**	**7,224.8**	**7,339.4**	**9,334.2**	**495.6**	**703.1**	**562.1**	**811.4**	**145.6**	**240.3**	**190.4**	**286.6**
Share of bilateral Cooperation (%)		XXX	XXX	XXX	XXX	**7.7%**	**8.1%**	**9.0%**	**8.1%**	**2.0%**	**2.3%**	**2.7%**	**2.2%**
Share of total Cooperation (%)		XXX	XXX	XXX	XXX	**9.5%**	**9.9%**	**10.2%**	**10.9%**	**3.2%**	**3.2%**	**3.7%**	**4.1%**
ODA Contributions as % of GNI		**0.196%**	**0.224%**	**0.244%**	**0.277%**	**0.019%**	**0.022%**	**0.025%**	**0.030%**	**0.006%**	**0.007%**	**0.009%**	**0.011%**

Estimate of ODA Disbursements for Health Promotion and the HIV Response, 2005-2008 (in Euro Mio.)

Financing Mechanism		Total Contributions				Contributions for Health Promotion				Contributions for HIV Response			
		2005	2006	2007	2008	2005	2006	2007	2008	2005	2006	2007	2008
Bilateral Cooperation		**2,298.5**	**2,522.2**	**2,810.1**	**3,585.5**	**176.3**	**203.9**	**251.6**	**289.1**	**46.7**	**58.6**	**75.0**	**80.0**
of that:	Specific HIV-Interventions	31.7	41.6	55.3	60.2	31.7	41.6	55.3	60.2	31.7	41.6	55.3	60.2
	Reproductive Health	25.4	28.0	33.3	22.6	25.4	28.0	33.3	22.6	6.3	7.0	8.3	5.7
	Sector-wide Programmes	81.8	93.2	107.1	136.2	81.8	93.2	107.1	136.2	8.2	9.3	10.7	13.6
	Other Health Problems	32.1	34.0	49.1	65.6	32.1	34.0	49.1	65.6	0.0	0.0	0.0	0.0
	General Budget Support	45.2	69.8	53.2	40.2	5.4	7.0	6.8	4.5	0.5	0.7	0.7	0.5
Programmes Managed by European Commission		**1,774.0**	**1,711.5**	**1,791.4**	**1,950.0**	**112.8**	**148.6**	**143.1**	**137.3**	**32.6**	**37.9**	**42.6**	**33.4**
Programmes by IDA/World Bank		**0.0**	**471.2**	**801.4**	**787.5**	**0.0**	**43.4**	**68.1**	**66.5**	**0.0**	**19.9**	**31.0**	**26.1**
World Health Organization		**31.6**	**30.8**	**28.3**	**27.6**	**22.1**	**21.6**	**19.8**	**19.7**	**2.1**	**2.0**	**1.8**	**1.9**
of that:	Assessed Contributions to Regular Budget	31.6	30.8	28.3	27.6	22.1	21.6	19.8	19.3	2.1	2.0	1.8	1.8
	Voluntary Flexible and Core Contributions	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.4	0.0	0.0	0.0	0.0
UNAIDS (Unified Budget and Workplan)		**1.1**	**1.1**	**1.1**	**1.9**	**1.1**	**1.1**	**1.1**	**1.9**	**1.1**	**1.1**	**1.1**	**1.9**
Regular Budgets of other UN-Organizations		**45.8**	**46.9**	**56.4**	**53.5**	**14.4**	**14.2**	**16.5**	**16.2**	**5.8**	**6.1**	**7.0**	**6.9**
	UNDP (United Nations Development Programme)	25.8	26.8	33.5	29.3	1.2	1.3	1.2	1.0	1.1	1.3	1.2	0.9
	UNFPA (United Nations Population Fund)	15.4	15.6	18.5	18.5	12.4	12.3	14.6	14.4	4.5	4.6	5.6	5.8
	UNICEF (United Nations Children's Fund)	4.6	4.5	4.4	5.7	0.9	0.6	0.7	0.8	0.2	0.2	0.2	0.2
Global Fund to Fight AIDS, Tuberculosis and Malaria		**86.2**	**70.2**	**94.8**	**219.9**	**86.2**	**70.2**	**94.8**	**219.9**	**49.0**	**37.0**	**60.2**	**134.4**
of that:	Direct Contribution	82.8	70.2	85.2	216.4	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
	Other: BACKUP Initiative	3.4	0.0	9.6	3.4	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
African Development Fund		**0.0**	**186.2**	**91.8**	**147.9**	**0.0**	**2.9**	**9.5**	**12.4**	**0.0**	**0.5**	**1.4**	**2.3**
Asian Development Fund		**39.9**	**38.8**	**37.0**	**37.0**	**1.9**	**1.4**	**0.6**	**0.6**	**0.3**	**0.1**	**0.1**	**0.1**
WFP (World Food Programme)		**55.7**	**47.5**	**48.0**	**69.7**	**5.2**	**4.5**	**1.0**	**1.6**	**5.2**	**4.5**	**1.0**	**1.6**
GAVI Alliance		**0.0**	**4.2**	**4.3**	**0.0**	**0.0**	**4.2**	**4.3**	**0.0**	**0.0**	**0.1**	**0.1**	**0.0**
Total Contribution (Euro)		**4,418.9**	**5,231.5**	**5,981.2**	**6,995.2**	**420.0**	**516.1**	**610.5**	**765.3**	**142.8**	**167.9**	**221.4**	**288.6**
Share of bilateral Cooperation (%)		XXX	XXX	XXX	XXX	**7.7%**	**8.1%**	**9.0%**	**8.1%**	**2.0%**	**2.3%**	**2.7%**	**2.2%**
Share of total Cooperation (%)		XXX	XXX	XXX	XXX	**9.5%**	**9.9%**	**10.2%**	**10.9%**	**3.2%**	**3.2%**	**3.7%**	**4.1%**
ODA Contributions as % of GNI		**0.196%**	**0.224%**	**0.244%**	**0.277%**	**0.019%**	**0.022%**	**0.025%**	**0.030%**	**0.006%**	**0.007%**	**0.009%**	**0.011%**

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September, 2010