

German Development Cooperation's Contribution to Global Health

Portfolio Analysis

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Acronyms and Abbreviations

AfGH	Action for Global Health
BMZ	Federal Ministry for Economic and Development Cooperation
CRS	Creditor Reporting System
EUR	Euro
GAVI	Global Alliance for Vaccines and Immunisation
GDC	German Development Cooperation
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIZ	<i>Deutsche Gesellschaft für Internationale Zusammenarbeit</i> (German Agency for Technical Cooperation)
GNI	Gross National Income
HIV/AIDS	Human Immuno-deficiency Virus/Acquired Immune Deficiency Syndrome
HSS	Health Systems Strengthening
KfW	<i>Kreditanstalt für Wiederaufbau</i> (German Development Bank)
MNCH	Maternal, Newborn and Child Health
NGO	Non-governmental Organisation
ODA	Official Development Assistance
OECD/DAC	Organisation for Economic Cooperation and Development/ Development Assistance Committee
SRHR	Sexual and Reproductive Health and Rights
STD	Sexually Transmitted Disease
WHO	World Health Organization

Executive Summary

This portfolio analysis aims to give an overview of Germany's financial contribution to global health in the period 2002–13 in order to inform the continued development of health strategies and future allocations of official development assistance (ODA) for health, and to ensure transparency to the general public. The main source of data used in the analysis was the Creditor Reporting System (CRS) Aid Activity Database, which is the most comprehensive dataset available for ODA. However, a number of limitations affect the validity of CRS data analysis, including the fact that each ODA activity in the database can only be assigned one purpose code. In part to address these limitations, other data sets, external reports and German Development Cooperation (GDC) health-related strategies were also incorporated into the analysis.

German health ODA has nearly tripled in absolute value in just over a decade, rising to approximately EUR 786 million in 2013. This is in spite of the fact that total ODA in this period has not even doubled, indicating an impressive rise in health ODA and overall importance of the health sector within the GDC. In the period 2008–13, the period for which BMZ-funded health ODA could be analysed, the BMZ was responsible for the majority of the bilateral ODA awarded to health – contributing on average 84% of the total.

On a strategic level, as reflected in policy documents, health has remained a focal area of the GDC throughout the analysed time. However, the analysis also shows that only 6.5% of total German ODA has been disbursed for health during this time, indicating a relatively low priority given to it in relation to other sectors.

The GDC has, however, committed to the G7/8 health-related goals of the Heiligendamm and Muskoka Summits. Whereas the GDC already achieved the Heiligendamm goal of EUR 4 billion in 2013, fulfilment of the goals from the Muskoka commitment as well as the BMZ Initiative for rights-based family planning and maternal health will require considerably increased disbursements. Furthermore, the international recommendation for donor countries to contribute 0.1% of their gross national income (GNI) to global health has not been met by Germany, which contributed only 0.027% of GNI for global health in 2013.

Analysis of the thematic focus of BMZ-supported health ODA reveals that it falls well in line with the priorities laid out in the BMZ Sector Strategy for German Development Policy in the Health Sector (2009): strengthening of health systems, HIV/AIDS and other infectious diseases, and sexual and reproductive health and rights. In 2008–13, HIV/AIDS and sexual and reproductive health and rights (SRHR) accounted for 24.7% and 16.4% of BMZ-supported bilateral health ODA, respectively. The remaining priority of the strategy – health systems strengthening (HSS) – cannot be adequately analysed with the CRS database due to inability of the coding system to capture the vastness and complexity of HSS. It is recommended that the GDC works towards a monitoring system that would enable a valid analysis of HSS efforts and improve resource allocation.

The vast majority of GDC health ODA is channelled to Asia and Africa, with Africa being the top receiving region since 2010. However, a number of the top recipient countries of BMZ-supported health ODA are within Asia. Several are recipients of non-grant ODA, albeit only lower-middle-

income economies (India, Indonesia and Pakistan). Overall, total health disbursements of the BMZ in the analysed period consisted of approximately 91% grants and 9% loans.

In the period 2002–13, 55.4% of GDC health ODA has been disbursed through multilateral channels. Germany is also among the top donors globally for multilateral health ODA, ranking as the fourth largest in 2013. Notable among the top recipients of German multilateral health ODA is the Global Fund, with which the GDC has a multifaceted relationship. With the GDC taking a more active role in supporting GAVI, the trend of strong multilateral health engagement is expected to continue.

In comparing German health ODA with that of other global health donors, Germany ranks third among European DAC donors for the period 2002–13. In 2013, Germany came in third overall among global health donors, and second among European DAC donors. However, regarding its economic capacity, Germany has a low performance compared with other donors in health ODA.

This portfolio analysis has revealed a number of topics for future research, including the need to better understand the negotiation process between the GDC and partner countries and the conditions qualifying a country to receive non-grant health ODA. Furthermore, it is recommended to standardise and instate a quality assurance process for the assignment of CRS purpose codes to ODA activities in order to improve the validity and accuracy of German ODA recorded in the CRS database.

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Introduction

As the period of the Millennium Development Goals draws to a close, a number of issues have spurred debate within the global health donor community. These issues include, among others, the importance of health within the development agenda, aid effectiveness and efficiency, and the respective advantages and disadvantages of multilateral and bilateral aid. Germany is no exception as a forum for these debates. As one of the largest donors in global health, both in Europe and globally, it is a timely and relevant exercise to reflect on Germany's development aid in the global health sector.

This portfolio analysis aims to give an overview of the German Development Cooperation's (GDC)¹ contribution to global health by providing various perspectives on its official development assistance (ODA) in health from 2002 to 2013, with a particular focus on ODA for health issued by the Federal Ministry for Economics and Development Cooperation (BMZ). This period was selected because the Creditor Reporting System (CRS) of the Organisation for Economic Cooperation and Development/Development Assistance Committee (OECD/DAC), which was the primary source of data used in this analysis, entails comprehensive and reliable data starting from 2002 (DAC, 2014) up to the most recent in 2013. Therefore this 12-year period was chosen to observe the continuing trends and development of Germany's health ODA. Furthermore, this portfolio analysis involves the BMZ contribution from 2008 to 2013. Owing to frequent changes in the CRS database, analysis on BMZ specific contributions was only found to be valid for the time period from 2008 onwards (see Chapter II for more information on the CRS database).

Although portfolio reviews of GDC's contribution to global health have been undertaken, they have either been limited to single implementing agencies or are broadly covered as a part of larger evaluative undertakings. An example of the former is KfW's portfolio analysis of health sector activities in 2013 (Strehl & Hellstern, 2013). In the same year, GIZ also published a review of health programmes, which included 37 selected health projects (GIZ, 2013). Various analyses of Germany's contribution to global health have also been published by a number of NGOs and think tanks (DSW *et al.*, 2012; Seek Development, 2012; AfGH, 2013). Given this context of brief and agency-specific overviews of health sector activities and the lack of a health portfolio issued by a centrally governing body, this portfolio analysis attempts to take the first comprehensive look at the GDC's contribution to global health.

Research questions addressed in this portfolio analysis are as follows:

- How does Germany perform monetarily in terms of international recommendations and commitments in global health?
- What is the thematic focus of Germany's ODA in global health?
- Where is Germany's ODA in global health focused geographically?
- How significant is Germany's multilateral ODA in relation to bilateral ODA?

¹ In this analysis, GDC refers to the community of ODA-issuing bodies within Germany, including the BMZ, BMBF, BMG, AA, etc.

- How does Germany compare with other donors in global health in view of economic capacity?

In providing an overview of the GDC’s contribution to global health, this analysis can be used to inform the continued development of GDC health strategies and to streamline implementing agencies’ health activities. Moreover, the analysis’ findings on the GDC’s alignment with strategic priorities in global health and fulfilment of policy commitments are made transparent to implementing agencies as well as to the general public. A number of questions are also left open throughout the analysis, indicating the potential for further research or evaluation.

The following chapter outlines the data sources and methods used in this portfolio analysis, as well as data considerations and limitations that should inform interpretation of the presented analysis. Following this, the chapter on results addresses the research questions listed above. Each section in the results chapter presents data and corresponding analysis, as well as discussion remarks to contextualise findings. Last, a chapter on conclusions summarises and contextualises the main findings of the portfolio analysis and puts forward recommendations for the GDC health sector.

I. DATA SOURCES, METHODS AND CONSIDERATIONS

Data used for the calculation of each individual element of analysis presented in this report are summarised in the table below.

Table 1. Data sources used for analysis

Element of analysis	DATA SOURCES			
	CRS	OECD/DAC Secretariat multilateral calculations	BMZ strategic documents	Other sources
GNI/ODA	X	X		GNI data from World Bank
G8 commitments	X	X	X	G7/8 accountability reports and research from G8 Research Group
ODA grants vs loans	X			
Thematic areas	X		X	
Geographic areas	X		X	
Multilateral ODA		X		Donor documentation from GFATM and GAVI
Comparison with other donors	X	X		GNI data from World Bank

In addition to the listed sources, a number of other documents supplemented the analysis, including OECD/DAC peer reviews, think tank reports on German contributions to global health, etc. BMZ strategic documents entail various health-related strategies, official communications, as well as unpublished documents.²

The main source of data used in the analysis was from the CRS Aid Activity database, maintained by the OECD/DAC. This database is composed of project and programme data submitted to the OECD/DAC by donor agencies. The purpose of the database is to provide readily available data that

² DEval refers to unpublished documents with the pseudonym “Doc.” plus a consecutive number.

enables analysis on the flow and purpose of aid, on a basis that is comparable for all DAC members. Data on disbursements from 2002 onwards is considered to be the most comprehensive and therefore most valid (DAC, 2014). Within the CRS database, sectors are classified through five-digit purpose codes. The first three digits of the code refer to the corresponding DAC sector or category. Code 120 includes general health (code 121) and basic health (code 122). Code 130 includes population policies and reproductive health (e.g. reproductive health care, family planning, STI control and HIV/AIDS). Hereafter, CRS sector codes 121, 122 and 130 will be used in the analysis when discussing health ODA. A complete list of CRS codes used in the analysis is provided in Annex II.

All CRS data used was downloaded directly from the CRS database in December 2014 (the most recent CRS update at the time of the analysis) and was formatted and processed prior to analysis. Preliminary CRS data for 2014 released in March 2015 has also been considered in the analysis. However, that data is not sector-specific, hence preventing its utilisation within the health sector-specific analysis undertaken in this report. CRS data only reports on bilateral ODA, which is why the majority of analysis has focused on bilateral health ODA. Calculations based on the CRS data were done and double checked through Excel and R. Most analyses were done using constant 2012 US dollars (USD), with the exception of the analysis on the fulfilment of international health goals. In this case, CRS data was downloaded in current USD and deflated according to 2012 rates (the latest rates available at the time of the analysis), and then converted to euro (EUR). This allowed the volume of each respective goal to stay consistent throughout the analysis.³ All analyses incorporating figures based on the region and purpose codes in the CRS database also reflected changes in the CRS coding system over the considered time period.⁴ Furthermore, unless otherwise noted, all ODA values reported in the analyses are gross figures.⁵

CRS data limitations are a common problematic issue within the field of health. In the case of this particular portfolio analysis, several limitations are worthy of discussion:

- First, the OECD/DAC classification of aid activities into sectors is commonly accepted as limited and misleading (AfGH, 2012; MacKellar *et al.*, 2012). Due to the fact that each ODA activity can only fall within one sector and purpose code when categorised, the range of multi-sector projects cannot truly be reflected in the data. In the case of health, which is often connected with water and sanitation, agriculture, education, etc., this is a particularly limiting factor, and is further exacerbated by the description fields for projects within the data often being empty or inadequately describing the project.
- The purpose code classification system in the CRS database provides the sole means to analyse the thematic content of German health ODA. However, a standardised procedure for purpose code classification of health ODA is lacking, both from the OECD/DAC and the GDC, ultimately limiting the possibility to thematically analyse German health ODA. Furthermore, the CRS purpose code classification processes of other ODA financing entities would have to

³ The BMZ methodology for interpreting health ODA varies from that used in this analysis and, consequently, the results of some calculations in this analysis might differ from those of the BMZ.

⁴ Changes in the coding system here refer to changes within the clusters of countries making up regions, and the introduction of new purpose codes over time.

⁵ "Gross ODA is the amount that a donor actually spends in a given year. This figure becomes net once repayments of the principal on loans made in prior years (but not interest) are taken into account, as well as offsetting entries for forgiven debt and any recoveries made on grants" (see <http://www.oecd.org/dac/stats/faq.htm>)

be identified to produce a valid analysis. For these reasons, CRS purpose codes were used in this analysis to identify broad regional trends.

- Tracking of Muskoka-relevant contributions, which is done through CRS purpose codes recommended by the G8 Research Group, is also hindered by the limitations listed above.
- A comprehensive view of all health-related activities by the GDC would require either access to the GDC's own records or categorisation of each aid activity on an individual basis, as was done by the European Commission in its 2012 thematic evaluation of the health sector (MacKellar *et al.*, 2012). Because the analysis lacks a comprehensive view of all BMZ-funded health-related interventions, this has limited the validity of its findings on the thematic focus of said activities. Furthermore, a comprehensive view of all BMZ-funded health-related interventions would have potentially enabled this portfolio analysis to investigate ODA flows for HSS.
- The validity of the data provided by CRS is also influenced by the completeness of data, which has varied over the years, and was not considered sufficiently comprehensive until recently (Grepin *et al.*, 2012). As a result, there is a danger that some ODA activities were not considered at all in this analysis. CRS purpose code classification of individual ODA entries are also updated retrospectively, which means that the results in this analysis may not be consistent with results calculated from CRS data versions prior to/following December 2014.
- CRS data reports on all bilateral ODA that is funded by all official entities. Though the data differentiate between donor agencies, the coding in the case of BMZ is only valid from 2008 onwards. This is because BMZ-financed ODA that was implemented through GIZ was systematically listed in the CRS under the BMZ agency heading from 2008 onwards.
- The availability of exact figures for multilateral health ODA was also limited. Thus for the purposes of multilateral health ODA, the OECD/DAC Secretariat imputed calculations for multilateral health contributions was regarded as the most reliable source of data. These calculations are produced by taking pre-set percentages of total flows to each multilateral organisation (OECD, n.d.). While bilateral ODA is based on actual volumes of individual projects and programmes, data on multilateral ODA does not provide exact figures. However, it is worth noting that the BMZ figures on total health ODA also calculate total health ODA by combining bilateral ODA data from CRS and multilateral ODA data from the imputed calculations (Doc. 4).
- With respect to the tracking of Muskoka commitment contributions, bilateral and multilateral flows were calculated in current EUR and constant USD (2011), respectively. Ideally, data on both flow types would have been available in current values, which would ensure that the baseline amount would not be influenced by variance in the currency over time. While this was the case for bilateral flows, data on core multilateral contributions were only available for 2007–11 in constant 2011 disbursements. The deflator base for 2011 is not made available by the OECD, preventing the analysis of multilateral Muskoka disbursements in current USD, which in turn prevents a valid conversion of the values into EUR. The OECD/DAC does not have any additional information to what is already published online on core multilateral contributions. For these reasons, combining bilateral and multilateral flows in order to track the Muskoka commitment would produce invalid results. As a result, Muskoka-relevant disbursements are disaggregated by bilateral and multilateral flows in the analysis.

Further considerations relate to GNI data and the analysis of G8 commitments:

- In comparing donors' ODA/GNI ratios, GNI data for 2012 was taken from the World Bank as opposed to OECD/DAC. This was because GNI figures are reported to the OECD/DAC from individual countries. In contrast, the World Bank calculates GNI according to the atlas method, ensuring that GNI for all countries is calculated consistently. It should be noted that the differences between World Bank GNI figures and those of OECD/DAC are minimal.
- The strategic priorities and policy commitments of the GDC were analysed primarily on the basis of Germany's G8 commitments. In this regard, the information in this analysis stems primarily from the G8 Research Group reports, which provide assessments of G8 countries' progress in fulfilling G8 commitments, and the official G8 accountability reports. In terms of the analysis provided by the G8 Research Group, it should be noted that not all G8 commitments are assessed. Rather, an extended committee comprising G8 Research Group researchers and sector experts work together to choose the most influential and indicative commitments for assessment.

Of course, when attempting to capture the GDC monetary contribution to health, ODA analysis is not enough. Due to data availability and the mandate to consider BMZ-funded activities, analysis of ODA was deemed sufficient for this analysis. However, future analyses should also consider other official flows and other flows of development assistance as well.

Throughout this analysis every effort was made to use the most valid and reliable data sources. Further development of the GDC's health portfolio analysis would require access to better synchronised data that is consistently collected and recorded, and which also details all ODA flows accurately.

II. RESULTS

1. GERMAN ODA AND HEALTH AS PRIORITY

At a policy level, health has remained a priority sector for the GDC throughout the entire period of 2002–12 (SPD *et al.*, 2002; CDU *et al.*, 2005; CDU *et al.*, 2009) and is one of the current government's six focus areas (CDU *et al.*, 2013). At the time of analysis, it was also a priority area of development within 14 partner countries of the BMZ and one regional programme in the Caribbean.⁶ The most recent health sector strategy released by the BMZ in 2009 categorises involvement in health into three thematic areas: health systems strengthening; HIV/AIDS and other infectious diseases; and sexual and reproductive health and rights (SRHR) (BMZ, 2009b). The German health sector strategy is also rooted in a very strong human rights-based approach, which entails a deep commitment to gender and encourages engagement with civil society (BMZ, 2009a).

A further publication was released in 2013: "Shaping Global Health – Taking Joint Action – Embracing Responsibility" (The Federal Government of the Republic of Germany, 2013). As an inter-ministerial concept on global health, it was a testament to the German government's collective commitment to health – both out of strategic security interest and drive for development assistance. Although the paper has received mixed reactions, it is still recognised as a commendable effort in unifying the

⁶ As seen on the BMZ website, June 2014

stance of the ministries involved in global health, and there is hope that it will improve both GDC policy coherence and support for global health institutions (The Lancet Editorial Board, 2013).

Health is clearly a policy priority within the GDC, in accordance with the international priority given to health within the overall development cooperation agenda. Health is also directly related to three of the Millennium Development Goals, and was named a tracer sector for aid effectiveness and architecture (OECD, 2011). With this background, it is increasingly relevant to consider donor prioritisation of health. The next sections follow this logic and address German ODA⁷ performance and prioritisation of health among other sectors, and in relation to German GNI. Additionally, German performance in health ODA is viewed in comparison with other donors.

1.1 GERMAN ODA AND GNI

Since 2013, Germany's ODA/GNI ratio has stood at 0.38%. Preliminary CRS figures for 2014 show a rise in the ODA/GNI ratio to 0.41% (OECD/DAC, 2015). Overall, German ODA as a percentage of GNI has been on the rise from the early 2000s onwards, the only exceptions being in 2009 due to the decrease of debt relief as part of ODA (OECD/DAC, 2010), and the most recent decrease in 2012, where ODA as a percentage of GNI fell from 0.39% to 0.37% (OECD/DAC, 2013). Despite this general trend of ODA/GNI increase, Germany has not met the international target of 0.7% ODA/GNI. In 2010, Germany's ODA was at 0.39% of GNI, thus not reaching the self-declared interim goal of 0.51% of GNI, as laid out in the European plan to reach the 0.7% target by 2015 (EC, 2010).

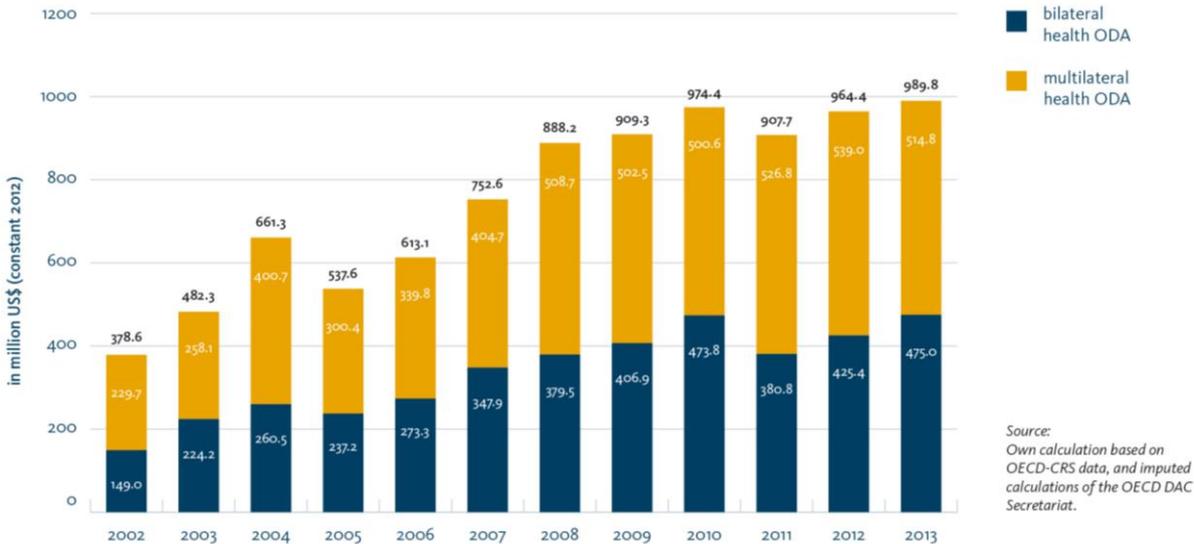
1.2 GLOBAL HEALTH WITHIN THE GDC

German health ODA has nearly tripled in absolute value in just over a decade, rising to approximately EUR 786 million in 2013 (see Fig. 1). Given that total ODA in this time period has not even doubled, the impressive rise in health ODA and overall importance of health within the GDC should not go unnoticed. The trend for German health ODA throughout 2002–13 has steadily risen, with the exception of a drop in 2005 and slight decrease in 2011.⁸ Throughout this period, multilateral ODA has comprised a little over half of German health ODA. In the period 2008–13, the BMZ was responsible for the majority of bilateral German health ODA, contributing to approximately 84% of the total on average.

⁷ Note that German ODA refers to ODA originating from all federal ministries and federal regions.

⁸ BMZ calculations for health ODA reflect a continuous rise from 2004 onwards.

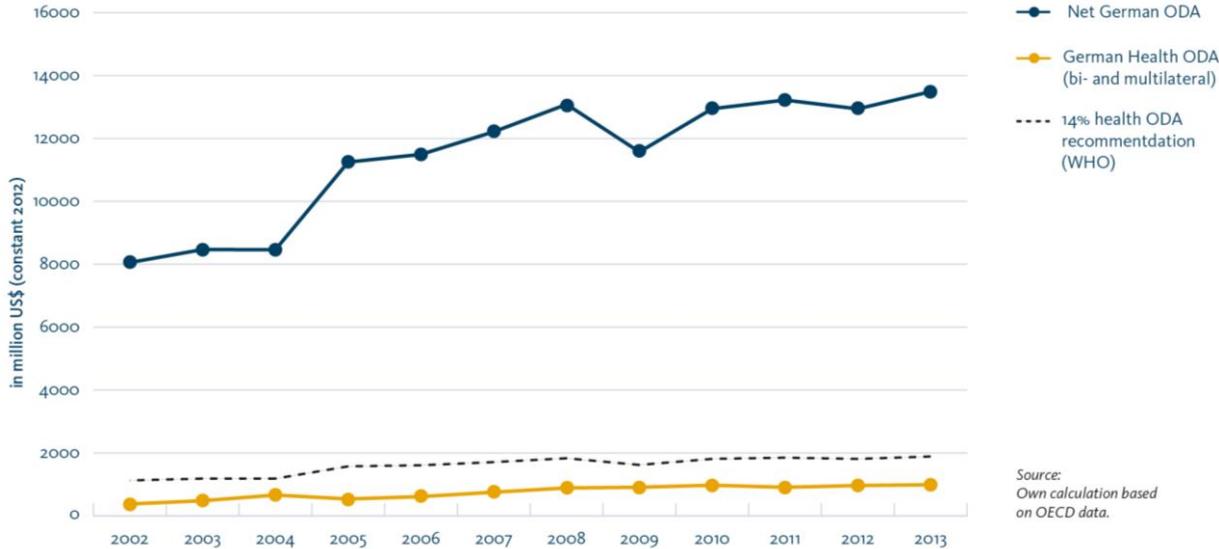
Figure 1. Total German health ODA (disbursements), 2002–13



Health has and continues to be featured prominently within Germany’s development cooperation, both politically and in absolute values of ODA. A different approach to analysing German priority for health in its development cooperation can be seen through the lens of WHO recommendations. In 2001, the World Health Organization (WHO) Commission on Macroeconomics and Health concluded that if DAC donors contributed a minimum of 0.1% of GNI to global health, it would be possible to deliver health for all in almost all low-income countries (Sachs, 2001).

In the latest data from 2013, German health ODA as a percentage of GNI was 0.027%, less than a third of the amount recommended by the WHO. Taking another perspective, a comparison of Germany’s health ODA versus total ODA provides insight on Germany’s practical commitment to and prioritisation of health. According to the WHO recommendation, when a donor has reached the 0.7% ODA/GNI target, the allocation to health should comprise 14% of total ODA ($0.1 / 0.7 = 0.143$). Though Germany has not reached the 0.7% ODA/GNI target it is still useful to see what a 14% of ODA commitment to health would look like. As Figure 2 shows, German health ODA in 2002–13 has not reflected the level of priority recommended by the WHO. Nevertheless, German health ODA in absolute value has shown significant progress over the analysed time period, and as the later sections of the analysis will show, German health ODA is likely to increase even further.

Figure 2. German health ODA vs total German ODA (disbursements), 2002–13



Analysis of German bilateral ODA trends for all CRS sector codes from 2002 onwards shows that included among the sectors receiving the largest ODA commitments are action relating to debt, energy, post-secondary education, and government and civil society.⁹ Throughout the analysed time period, health comprised a total of 6.5% of total German ODA disbursements. Health ODA as a percentage of total German ODA has fluctuated in this time period between 5% and 8%, peaking in 2004 and 2009–10, and being at its lowest in 2002 and 2005–06. In the years 2011–13, the portion of health ODA within German ODA has remained steady at approximately 7%.

1.3 GDC PERFORMANCE IN RELATION TO OTHER DONORS/EUROPEAN DAC MEMBERS

In the period 2002–13, Germany ranked third among European DAC donors for total health ODA, and contributed approximately 5.3% of total health ODA globally. Germany was exceeded by the United Kingdom (18.1% of total health ODA globally) and France (9.5% of total health ODA globally).¹⁰ In the year 2013, Germany ranked third globally and second among European DAC members in health ODA after the US and UK.

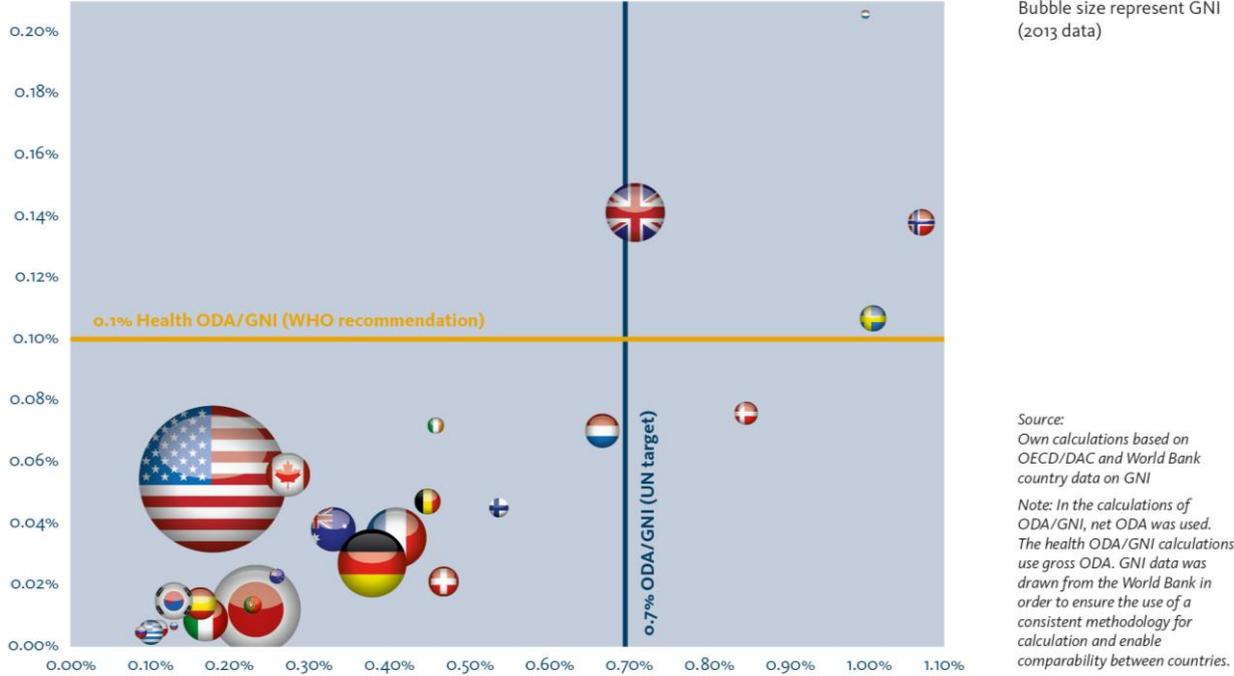
On average, DAC donors contributed USD 754.6 million in ODA for health in 2013. In comparison, Germany’s health ODA was relatively high at USD 1.04 billion (equivalent to EUR 786.4 million), and was superseded by the US (USD 9.2 billion) and the UK (USD 3.8 billion).

A further illuminating measure of donor performance in health ODA is with respect to GNI. In Figure 3, each respective country donor’s total ODA and total health ODA is analysed against its GNI. When considering total ODA, Germany performs better with respect to GNI than the US and Japan, both of which are larger economies. The US, however, outranks Germany in health ODA/GNI. France, with the closest economic capacity to that of Germany, ranks slightly better in both health ODA/GNI and total ODA/GNI. Ranking not far behind Germany in terms of economic capacity, the UK achieved both the 0.7% ODA/GNI goal and 0.1% health ODA/GNI recommendation. In addition, Norway, Sweden

⁹ A look at disbursements reveals similar trends as commitments.
¹⁰ The largest contribution to health ODA made in this time period was from the United States (41.9%).

and Luxemburg also reached and surpassed both thresholds. Based on the information presented in this figure, **Germany ranks relatively low in comparison with its fellow donors in health ODA. Given its economic capacity, and relative performance to other donors, increased prioritisation of health ODA (as well as total ODA in general) is arguably necessary.**

Figure 3. DAC members’ contribution to health relative to economic capacity, 2013¹¹



Main findings on German ODA and health as priority

- German health ODA has risen relatively steadily since 2002, almost tripling by 2013. In recent years, the overall trend for total German health ODA has remained fairly stable. As the comparative analysis of global health donors shows, Germany ranks well when observing absolute values, ranking third globally in 2013. However, the allocative priority given to global health by a donor demonstrates its overall commitment to the sector. The fact that Germany does not meet the health ODA/GNI ratio recommendation, and that only 6.5% of total ODA (2002–13) has been disbursed for health, indicates relatively low priority for global health.
- Though the 0.1% of GNI recommendation for health ODA is not an internationally adhered to commitment, it provides a standard through which it is expected that a significant improvement in global health can be made. Other countries such as the UK, Sweden, Norway and Luxemburg have been able to comply with this recommendation. As one of the economic powerhouses in Europe, Germany has the capacity to increase its ODA, both in terms of total ODA and health ODA.
- The German government has several health-related policies in place to guide its development cooperation, and has also emphasised the importance of health for sustainable development. Given this context, as well as the established relationship between health and other development sectors, Germany has the opportunity to improve its own aid effectiveness by leveraging the focus on health in its development assistance, thereby enabling other related sectors such as water, sanitation, nutrition, agriculture and education to also make gains.

2. G7/8 COMMITMENTS IN HEALTH

In light of increasingly complex aid architecture consisting of donors, global health initiatives and other actors involved in global health development, the need for coordinated and effective efforts for health is all the more necessary. Combining the decision-making power of the largest economies, the G7/8 has unparalleled capacity in the global health arena.¹² In 2009, the G8 Accountability Working Group was established to officially monitor the progress of G7/8 countries' fulfilment of their own development commitments, collectively and individually, and to make results transparent to the wider public.

Among international commitments in global health, the German government gives primary importance to two for which it monitors ODA commitments and disbursements (Doc. 1, 2, 3, 5), both of which are directly related to G8 commitments. The first of these is the set of health commitments of G8–Heiligendamm in 2007 concerning HIV/AIDS, malaria, tuberculosis and health system strengthening. A cumulative commitment of USD 60 billion was pledged by all G8 members, to which Germany would contribute EUR 4 billion over eight years (Erdman *et al.*, 2008, pp. 189–200).

The second major commitment prescribed to by Germany is the 2010 G8–Muskoka commitment, which calls on all G8 members to give an additional USD 5 billion over a five-year period for maternal, newborn and child health (MNCH) through both bilateral and multilateral channels. Germany's committed contribution was announced at EUR 400 million (BMZ, 2011) or USD 500 million (G8 Research Group 2011, pp. 42–7).) Following this, the GDC established the BMZ Initiative on Rights-based Family Planning and Maternal Health in May 2011 as a means of working towards the Muskoka commitment. With this Initiative, Germany pledged to double the amount of bilateral funding provided for reproductive health and family planning during the time 2011–15, using the base year of 2008 as a reference point. Through the BMZ Initiative, it was planned that an *additional* EUR 400 million would be provided in health ODA (BMZ, 2011),¹³ thus enabling Germany to fulfil its commitment to the Muskoka Initiative.

The following sections track Germany's progress of the Heiligendamm and Muskoka Summit commitments, as well as the BMZ Initiative on Rights-based Family Planning and Maternal Health. As the running time of the commitments extends beyond the time period analysed, all results presented and discussed in this analysis are provisional. Overall German compliance to G7/8 health commitments and health-related results of the 2015 Elmau Summit are also addressed at the end of the chapter.

¹² There is no explicit institutional process for global health policy making. In light of this gap, and with the exceedingly high number of initiatives and donors, as well as increasingly complex health aid architecture, the G7/8 has the potential to catalyse efforts in a more coherent direction.

¹³ This additional amount of EUR 400 million is the same as that which was pledged for the Muskoka commitment.

2.1 G8 HEILIGENDAMM

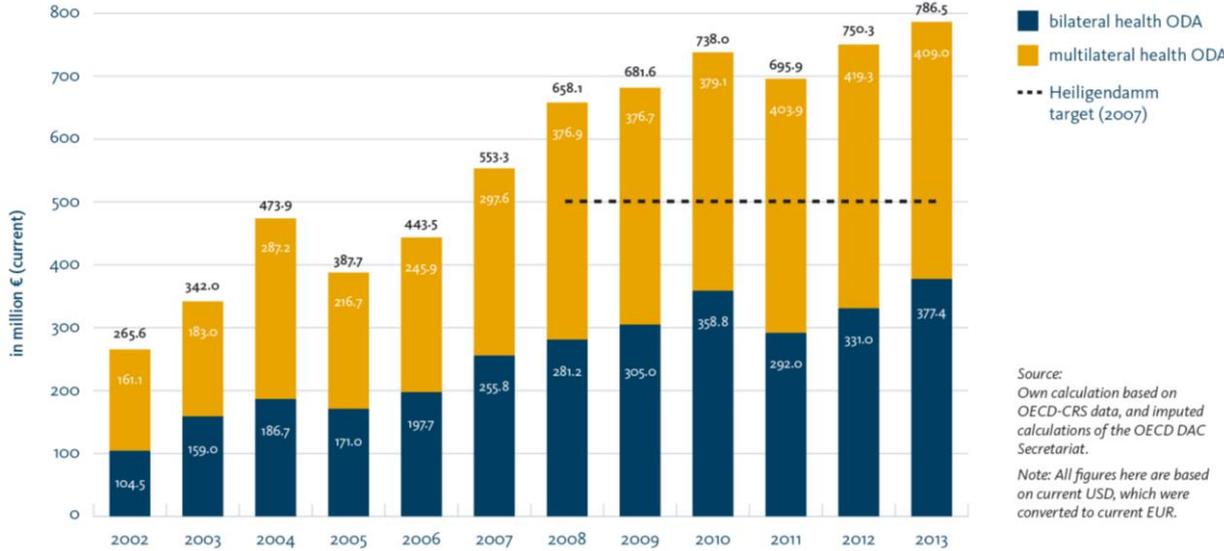
At the German-hosted G8 Summit in 2007, health accounted for 16.4% of all G8 commitments, indicating the importance of global health among G8 countries that year. G8 members agreed to invest USD 60 billion towards health, a historic amount that was focused at the time of commitment on Africa (G8 Summit, 2007), but was practically acted upon with a global focus (G8 Summit, 2008). Chancellor Angela Merkel pledged EUR 4 billion towards the Heiligendamm health commitment over a period of eight years (2008–15), averaging out to EUR 500 million each year. However, in the lead up to the 2008 Hokkaido Summit, the international time frame for the Heiligendamm health commitment was specified to be five years from 2008 to 2012 (G8 Summit, 2008). Due to the differences in the international and German time periods to act on the Heiligendamm commitments, tracking progress on the commitment varies between Germany and other G8 members.

The follow-up of the commitment in the 2013 Lough Erne Accountability Report shows that the G8 members are on track to reach the target, with USD 52.6 billion, or 88% of the overall goal having been provided already between 2008 and 2011 (G8 UK, 2013).¹⁴ As the third largest contributor to the Heiligendamm goal, until 2011 Germany's share of contributions in this pool was 7.3%. **Since 2013, Germany has met its share of the commitment, having contributed approximately EUR 4.3 billion.** Whereas the contributions of the overall G8 membership have grown at an annual average rate of 9%, Germany has shown no significant changes in terms of annual growth over the time period (G8 UK, 2013).

As shown in Figure 4, Germany has met the EUR 500 million per year target for every year of the commitment. Of note is that Germany had already achieved its yearly target in disbursements in 2007, the same year the commitment was made. The relevance of this observation is in connection to the fact that the USD 60 billion Heiligendamm commitment did not call for *additional* money. As such, it built on pre-existing funds from donors and focused on maintaining momentum for health ODA (Cooper & Jackson, 2007). Furthermore, Germany specifically intended for its EUR 4 billion commitment to further strengthen its already prominent contributions to HIV, tuberculosis and malaria, along with the necessary HSS required to achieve these vertical objectives (Kortmann, 2008).

¹⁴ Analysts have not yet assessed whether or not the G8 goal for 2012 has been met.

Figure 4. German health ODA over time in fulfilment of the Heiligendamm commitment



In regards to tracking progress in disbursements for the Heiligendamm commitments, one should note that Germany utilises total health ODA (Doc. 5). All German health ODA is thereby considered to be in fulfilment of the Heiligendamm commitment, which is primarily focused on HIV/AIDS, tuberculosis, malaria and HSS. Many commitments call for action on HIV/AIDS in the context of HSS – which is also reflected by a number of global health donors as well as the BMZ health sector strategy (BMZ, 2009b).

2.2 MUSKOKA INITIATIVE ON MATERNAL, NEWBORN AND CHILD HEALTH

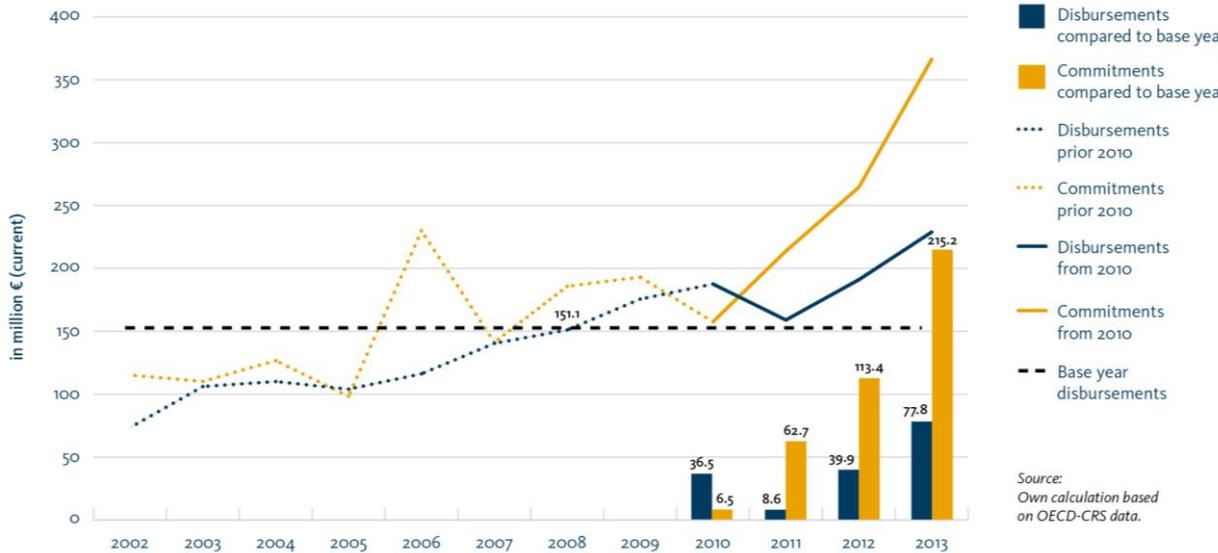
Following the Muskoka Summit in 2010, **Germany committed to providing an additional EUR 400 million for MNCH until 2015**. Germany tracks its Muskoka-relevant commitments and disbursements through the G8 Research Group’s “Methodology for Calculating Baselines and Commitments: G8 Member Spending on Maternal, Newborn and Child Health.”¹⁵ With this methodology, bilateral contributions towards Muskoka are calculated by using imputed percentages applied to pre-selected MNCH-related OECD/DAC CRS purpose codes (G8 Research Group, 2010). For calculating multilateral contributions, the methodology uses an imputed percentage of core contributions to multilateral agencies and initiatives (2010). In following this methodology, the 2008 German disbursement baseline, according to BMZ calculations based on the above-mentioned methodology, is EUR 302 million (BMZ 2011, OECD/DAC 2014). When distributing the additional EUR 400 million across the five-year period of the Muskoka commitment, EUR 80 million must be added to the baseline amount, resulting in approximately EUR 382 million annually in disbursements for Muskoka.

As Figure 5 tracing bilateral Muskoka disbursements and commitments shows, commitments increased sharply from 2010 onwards, while disbursements actually decreased between 2010 and 2011 – right after the Muskoka commitment was pledged – and started rising thereafter, but at a much slower pace than commitments. This is perhaps due to the inevitable time lag in between commitments and disbursements, particularly owing to the fact that Muskoka required the implementation of additional health ODA by the GDC, which led to long project gestation phases.

¹⁵ This methodology was consulted on with the World Bank, OECD/DAC, and Countdown to 2015.

Between 2010 and 2013, approximately EUR 767.2 million in bilateral flows and EUR 444.6 million in multilateral flows were disbursed towards the Muskoka commitment. **Of these amounts, the additional ODA called for in the Muskoka commitment amounted to EUR 184.5 million, or 46% of the total commitment made. If Germany is to fulfil its pledge to Muskoka, a further EUR 215.5 million in additional ODA will be required by 2015.** While it may be too early to predict if Germany will fulfil its Muskoka commitments, the GDC’s focus on MNCH is historically quite strong and is likely to remain so.¹⁶

Figure 5. Bilateral German health ODA over time in fulfilment of the Muskoka commitment



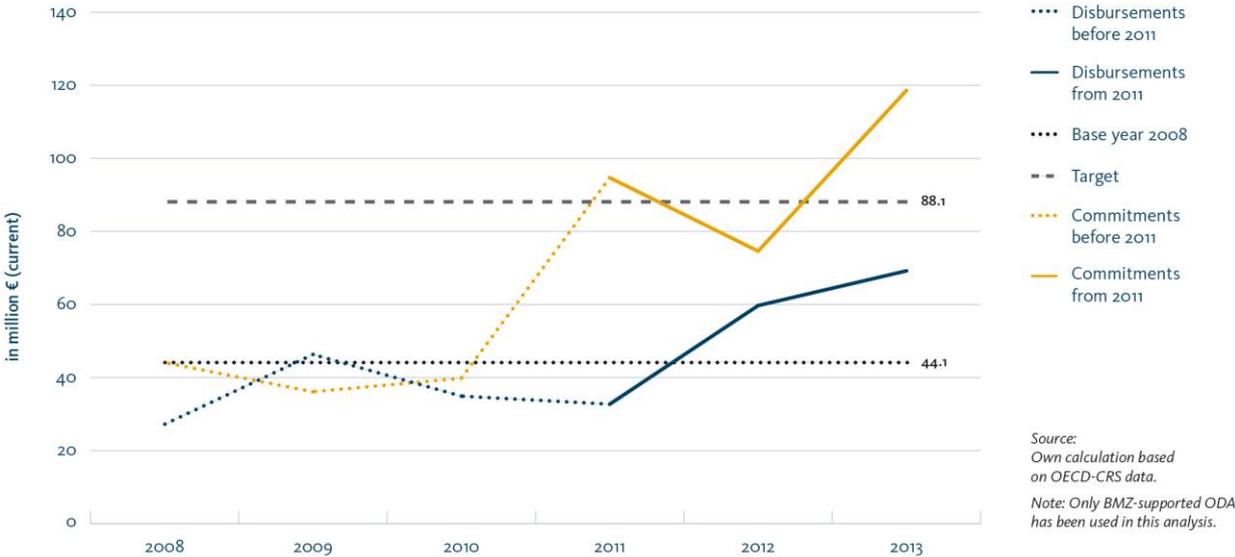
2.3 BMZ INITIATIVE ON RIGHTS-BASED FAMILY PLANNING AND MATERNAL HEALTH

Launched in 2011 as part of Germany’s contribution towards the 2010 Muskoka commitment, the BMZ Initiative was meant to be primarily bilaterally driven (BMZ, 2011, 2012a). All amounts disbursed for the BMZ Initiative are also counted towards fulfilment of the Muskoka commitment. Germany pledged to double the amount of ODA (baseline 2008) for reproductive health care, family planning and personnel development for population and reproductive health¹⁷ to approximately EUR 88.2 million annually and to set family planning and reproductive health prominently on the international development agenda over the next five years (BMZ, 2011). As shown in Figure 6, the BMZ significantly raised its commitments to the projected target level in 2011 but dropped them back to EUR 74.5 million in 2012, approximately EUR 14 million below the projected target line. Even though commitments increased dramatically in 2013, disbursements have lagged behind and have not yet reached the annual target of EUR 88.2 million. **Up until 2013, 36.5% (EUR 160.7 million) of the EUR 400 million target of the BMZ Initiative had been met. In order to meet the Initiative’s target, another approximately EUR 280 million must be disbursed in the period 2014–15.**

¹⁶ Since the time of analysis, the period of Germany’s commitment to Muskoka for maternal and child health has been extended until 2018.

¹⁷ CRS purpose codes 13020, 13030, and 13081 respectively.

Figure 6. BMZ Initiative on rights-based family planning and maternal health, commitments and disbursements



2.4 OVERALL GERMAN COMPLIANCE TO G8 COMMITMENTS

The Canadian-based G8 Research Group, which tracks G8 commitments of all members, has assessed G8 members’ performance on a total of 38 identified priority commitments in health through the period 2002–12.¹⁸ Germany’s track record as a G8 member shows relatively positive compliance in terms of international commitments to global health, with most assessed commitments scoring as “work in progress” (50%) or “fully compliant” (44%). The two commitments for which Germany was non-compliant were in 2006 and 2008 (Kirton & Guebert, 2008, pp. 2–3). Overall, Germany’s compliance score for all assessed health commitments measures at 0.4, which falls below the overall G8 member average of 0.51, according to the G8 Research Group’s methodology.¹⁹

In the first of the commitments rated with a lack of compliance in 2006, G8 members were called on to scale up support to address rising rates of HIV infection among young people, particularly girls and young women. The reasons for Germany’s lack of compliance here were not shared either in the G8 Research Group documentation or in the 2007 G8 Compliance Report. However, Germany would later go on to address this particular concern, among others in the area of women and children’s health, in fulfilment of the Muskoka Summit commitments in 2010. The second commitment found with a lack of compliance was in 2008 and pertained to neglected tropical diseases. According to the 2009 G8 Compliance Report, Germany failed to pursue prevention, treatment or research on neglected tropical diseases. The example cited in the report related to an unanswered request from the African Union to Germany for medications to treat *Schistosoma* and liver fluke (Martell *et al.*, 2009, pp. 158–68). Overall, however, with Germany’s scoring a lack of compliance in only two commitments since 2002, Germany’s track record with G7/8 commitments is relatively positive.

¹⁸ While assessing compliance of G8 countries, the G8 Research Group does not consider whether the G8 member officially reflects the commitment in question in its policy decisions. All G8 members are assessed equally for all commitments selected for compliance assessment. In the calculations of compliance scores for G8 commitments, “Full compliance” corresponds to a score of 1, “work in progress” with a score of 0, and “lack of compliance” with a score of -1.

¹⁹ Note: The G8RG applies a mean to an ordinal scale, thus this score might show a slightly distorted overview.

The recent German-hosted Elmau Summit of 2015 featured health high on the agenda as well, addressing issues related to Ebola and pandemic preparedness, and research oriented towards antimicrobial resistance and neglected tropical diseases (G7, 2015). The declaration of G7 leaders from this summit was particularly tailored to the aftermath of the Ebola epidemic, emphasising health as a human right for all and focusing on the need to strengthen health systems both bilaterally and multilaterally. Resulting from the Elmau Summit was a commitment to assist at least 60 countries in strengthening their health systems over the next five years. Simultaneously, G7 leaders agreed to coordinate their fight against future epidemics and strengthen mechanisms for rapid deployment of expert teams. To this end, Germany launched the White Helmets against Ebola Initiative in early 2015, which encompasses a six-point plan to address international health emergencies in an appropriate and timely fashion (The Federal Government of the Republic of Germany, 2015). This plan was announced at the Global Alliance for Vaccines and Immunisation (GAVI) Replenishment Conference in Berlin, where over USD 7.5 billion was mobilised to vaccinate an additional 300 million children by 2020. Furthermore, Germany joined Ghana, Norway, as well as the UN Secretary-General, in encouraging the formation of a high-level panel to work on effective crisis management in the area of health. A comprehensive proposal is expected to be produced by the end of 2015.

Main findings on G7/8 commitments in health

- *Germany seems to be relatively stable in its disbursements for internationally agreed upon commitments. Though the rest of the G8 countries ended their Heiligendamm health commitments in 2012, Germany committed to invest for another three years, thereby having a longer period in which to deliver the committed amount. The German goal of EUR 4 billion was achieved in 2013, one year after the international deadline. In terms of the Muskoka commitments, German disbursements should have increased significantly in 2014–15 if the goal is to be fulfilled, with only 36% of the goal having been reached by 2013. Support for the fulfilment of the Muskoka commitment is also provided by the BMZ Initiative on Rights-based Family Planning and Maternal Health. Although it is too early to definitively say if the 2015 goal for the BMZ Initiative will be met, tracking disbursements over the first three years of the five-year commitment reveals that a little less than half of the goal has been achieved. Furthermore, it will be important to monitor if the funds allocated towards the Muskoka commitment are in the form of additional ODA, or if previous ODA funds were simply shifted.*
- *As the only international commitments in health that the GDC prescribes to and regularly tracks, the Heiligendamm and Muskoka Summit commitments indicate a great deal about Germany's role in global health aid architecture. Of relevance here is that Germany confirmed that in its pursuit of fulfilling the EUR 4 billion commitment it would support vertical initiatives related to HIV/AIDS, malaria and tuberculosis, and pursue the thereby necessary and accompanying health system strengthening measures. In the 2015 Elmau Summit, Germany once again put health on the agenda and has played an essential role in steering international attention towards the strengthening of health systems. This time, the importance of health systems was stressed in and of itself and not tied as strongly with disease-related goals.*

3. HEALTH ODA GRANTS VS LOANS

ODA is composed of various official financing flows, including grants, loans, debt relief and equity investment. In the context of health and in the attempt to grasp real GDC contribution to health in developing countries, which is strategically oriented towards poverty reduction, it is relevant to analyse health ODA composition with respect to grants and concessional loans.

Up until 2014, all ODA loans had to fulfil the following requirements:

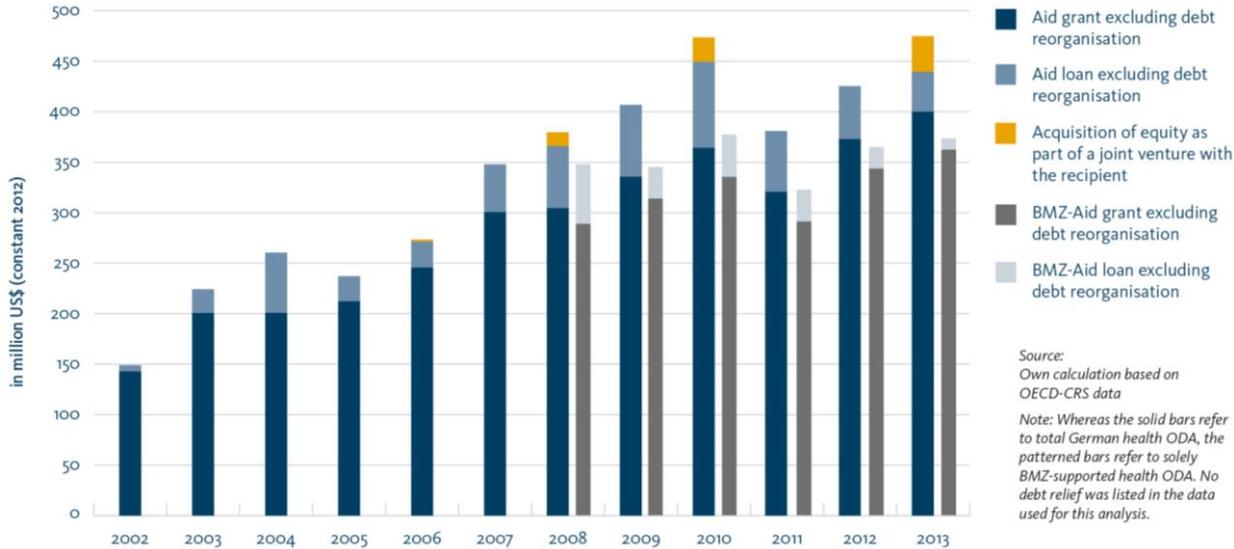
- They should have development as their main purpose, defined by the DAC as “the promotion of the economic development and welfare of developing countries”
- They should be concessional, defined as having an interest rate below the prevailing market
- They must include a grant element of at least 25% calculated on the basis of a 10% discount reference rate.

An International Monetary Fund (IMF) review of its policy on debt limits revealed that debt accumulation in low-income countries is largely driven by an accumulation of concessional debt (IMF, 2013 #967). In turn, loan repayments generate significant reverse flows that can undermine developing countries’ future resources, and in the worst cases, destabilise a country’s economy (Colin, 2014 #966). Furthermore, a high proportion of these repayable funds is raised on the capital market and then mixed with budget resources in order to lower the interest ratio to a level of concessionality that is required by the OECD to qualify as ODA (AfGH, 2013; OECD/DAC, 2013), and thus enable profit without budgetary effort on the part of the donor.²⁰

Between 2008 and 2013, total BMZ disbursements consisted of 90.8% of grants and 9.2% of loans, with no acquisition of equity or debt relief. Indicating the percentage of non-grant health ODA per year, Figure 7 shows that along with the rise of German health ODA, the non-grant portion thereof has also increased. Although non-grant total ODA (for all sectors) decreased significantly in 2009 – due largely to the stock of debt to be forgiven running low (OECD/DAC, 2010), non-grant ODA for health seemed to remain stable.

²⁰ Germany has also been criticised alongside France for taking advantage of the rule that a loan may qualify as ODA if it has an interest ratio of less than 10%. As wealthy governments that are able to borrow at relatively low interest rates and then lend with high interest rates, Germany and France are able to turn over a profit in the guise of ODA (Roodman, 2014).

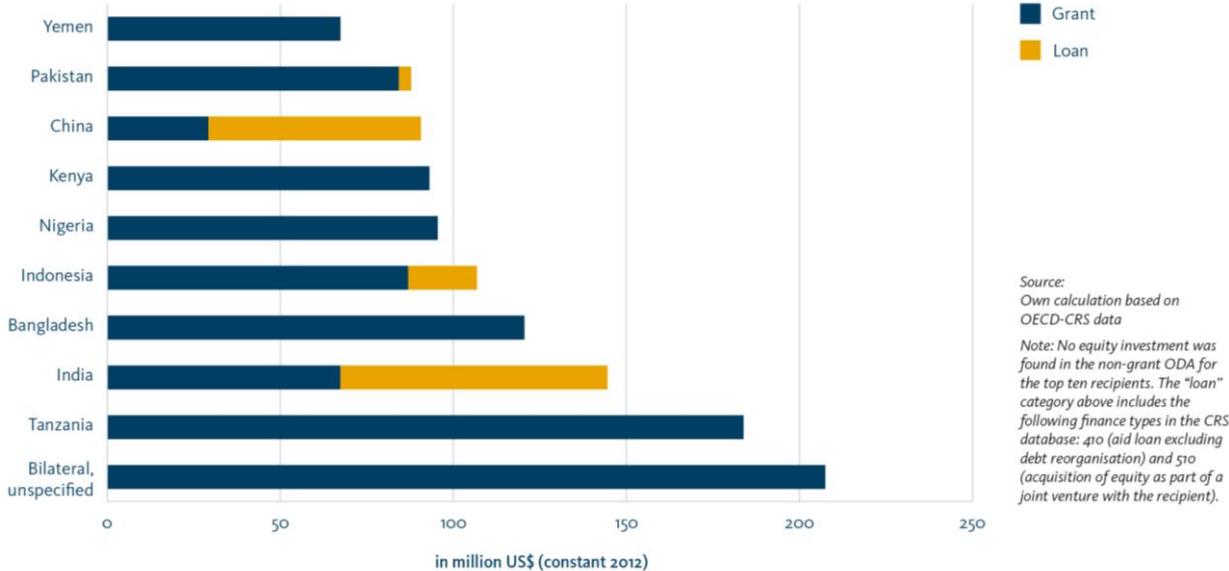
Figure 7. Bilateral German health ODA disbursements by ODA type, 2002–13



A look at the top 10 recipients of BMZ-supported bilateral health ODA (Figure 8) reveals that three countries carry a particularly large portion of non-grant ODA: India, Indonesia and China – and, to a lesser extent, Pakistan. These countries all fall under the OECD/DAC classification of lower-middle-income countries, with the exception of China, which is an upper-middle-income country (since 2011; prior to that it was a lower-middle-income country). The economic status and capacities of some countries, particularly of China and India, also indicates better suitability for loans than other countries, i.e. in Africa (Doc. 3). Indonesia and Pakistan, on the other hand, do not share in this trait and can be observed more closely.

An example of a project supported through loans can be found in China. KfW’s support of hospitals in China through concessionary loans has been deemed largely successful because the hospitals were successfully stocked with necessary materials and equipment with credit that came with better conditions than those offered by domestic banks (KfW, 2013). While such cases suggest a positive development effect of concessionary loans, further evidence is required to assess the effectiveness of non-grant ODA in the health sector.

Figure 8. Top 10 recipients of BMZ-supported bilateral health ODA disbursements over time, 2008–2013



A closer look at the non-grant BMZ-supported ODA in Indonesia for the period 2008–13 reveals that the total volume of ODA loans amounted to USD 20.1 million. These loans were categorised with the CRS purpose codes “medical services” (12191) and “basic health infrastructure” (12230). Approximately half of the ODA activities were for hospital improvements. Indonesia would also later go on to be included among Germany’s partnerships in the Debt2Health Initiative.

Non-grant health ODA in Pakistan supported by the BMZ amounts to USD 3.75 million, all of which has been categorised under the CRS purpose code “basic health care” (12220), and has been for the project “Northern Areas Health Development.” This project has received increasing amounts, starting with USD 416,000 in 2011 and reaching USD 2.74 million in 2013.

The **Debt2Health Initiative**, launched in Germany at a Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) replenishment meeting in 2007, marked a unique turn for non-grant ODA. The Initiative aimed to utilise the established method of debt conversion in combination with proven GFATM finance mechanisms to finance health programming at country level. Through the process of debt conversion, a creditor can cancel a portion of a country’s debt on condition that the beneficiary invests a previously agreed upon counterpart amount towards a GFATM approved programme. Germany was the first creditor to join the Initiative. In the same year it began, former BMZ Minister Wieczorek-Zeul signed a EUR 50 million debt relief agreement with Indonesia, amounting to a 50% reduction of national debt owed to Germany. In return, Indonesia promised to invest half of the amount in domestic GFATM programming, primarily for urgent and lifesaving HIV services and public health interventions (Filipp, 2007). Through this agreement with Indonesia, Germany contributed EUR 25 million to the Initiative. Simultaneously, Germany collaborated with the GFATM in a Framework Agreement to make a total contribution of EUR 200 million to the Debt2Health Initiative until 2010. Correspondingly, further debt relief agreements in the context of the Debt2Health Initiative have also been signed with Pakistan in 2008 (EUR 40 million) and Côte d’Ivoire in 2010 (EUR 19 million). A further innovative mechanism was supported by Germany through an agreement worth EUR 6.6 million with Egypt, under which counterpart payments benefited malaria programmes

in Ethiopia. Further agreements were expected with Kenya and Peru (GFATM, 2010) but have not yet come to fruition. As listed in The GFATM's 2010 Annual Report, Germany had pledged a total of EUR 54 million to the Debt2Health Initiative in the period 2007–10²¹ (Bernescut *et al.*, 2011).

While the Debt2Health Initiative represents an innovative means of debt relief in health ODA, the measures undertaken in this Initiative have not been listed under German health ODA in the CRS database. It is likely that these measures are listed under the sector “action related to debt”, however, which entails the CRS purpose codes “debt forgiveness” (60020) and “debt for development swap” (60061).²²

It is known that the BMZ individually collaborates with partner countries to form strategic agreements and decide which programmes and projects are to be supported and through which means (grants vs concessionary loans). However, in order to understand which partner countries are deemed by the GDC to be well suited for non-grant health ODA, it would be an interesting point of further research to explore the process of negotiation between the GDC and its partner countries. Furthermore, following the long-term financial and development outcomes of partner countries with non-grant health ODA would reveal interesting insight into debt sustainability. Assessing whether or not a partner country is able to punctually pay back debt in relation to the achievement of its development outcomes would provide useful data for the guidance of partner country negotiations.

Main findings on health ODA grants vs loans

- *While the majority of BMZ-supported bilateral health ODA remains in the form of grants, non-grant health ODA has been and continues to play an important role that warrants future monitoring. Non-grant health ODA can be counter-productive to global health development potential, and can cripple nations without stable health financing. To this end, the cases of non-grant ODA to Indonesia and Pakistan would prove to be interesting points of further research. While the importance of country-specific context and status has an established importance in ODA allocative decisions, the financial and development outcomes of these decisions should be further researched. Insight on the trajectory of partner countries in their ability to repay debts and achieve their development goals would provide guidance for country negotiations.*
- *The Debt2Health Initiative, in which Germany took a leading role, seems to respond to the concerns over debt-inducing cooperation. Although debt relief does not play a seemingly large role in German health ODA, it does provide positive publicity and enables Germany to take a leading role in innovative global health financing.*

²¹ This calculation takes into account agreements with Indonesia, Pakistan and Côte d'Ivoire, and corresponds to the amount of forgiven debt that was invested by partner countries into Global Fund programming.

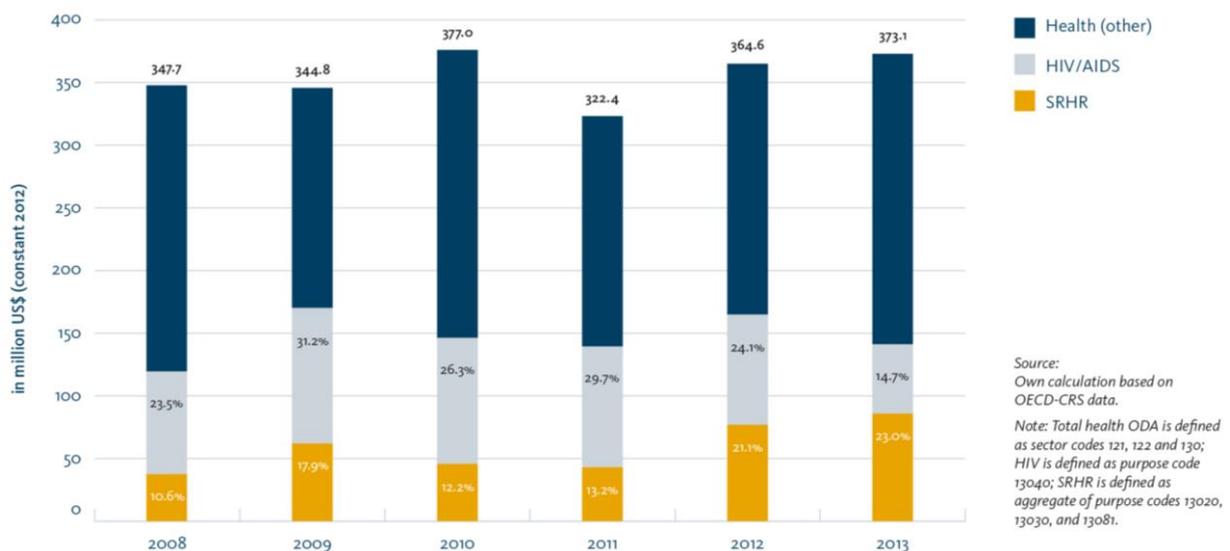
²² This could not be confirmed through the data provided in the CRS database due to the fact that ODA activities are only qualified through titles and inconsistently with project descriptions. However, it is most likely the case that debt forgiveness under the Debt2Health Initiative has been categorised under “action related to debt”.

4. GDC HEALTH ODA BY THEMATIC AREA

Within the health sector strategy of the BMZ, health systems strengthening, HIV/AIDS and other infectious diseases, and SRHR are defined as the main areas of activity (BMZ, 2009b). While the CRS data purpose codes do not provide a clear means of analysing HSS, which can entail a complex set of measures and interventions, engagement with HIV/AIDS and SRHR is relatively easier to grasp through CRS data. Thus, this chapter uses these thematic categories to analyse German bilateral health ODA.

HIV/AIDS, categorised under the CRS purpose code “STD control including HIV/AIDS”, comprises a large part of German bilateral health ODA, as seen in the percentages shown in Figure 9.²³ Assuming that this purpose code primarily addresses HIV/AIDS, the data indicates that **between 2008 and 2013, on average, HIV/AIDS accounted for approximately 25% of German bilateral health ODA.**²⁴ Bearing in mind that the ODA for HIV/AIDS given through GFATM and other multilaterals is in addition to the amounts represented in Figure 9, and that this figure does not consider bilateral measures against HIV/AIDS that are encompassed within CRS purpose codes other than “STD control including HIV/AIDS”, it is clear that HIV/AIDS comprises a very large part of German health ODA.

Figure 9. Bilateral BMZ-supported health ODA disbursements over time by thematic area, 2008–13



The recent increase since 2012 of SRHR in bilateral health ODA can arguably be attributed to the Muskoka Initiative on Maternal, Newborn and Child Health, to which Germany committed in 2010, as well as the BMZ Initiative on Rights-based Family Planning and Maternal Health. A slight increase will be seen in the coming years with the recently established regional programme in eastern and southern Africa focused on comprehensive sexuality education and sexual and reproductive health

²³ It is acknowledged that HIV activities within the GDC are not limited to control of the disease and include prevention. Furthermore, activities under other CRS purpose codes, such as health personnel development (12281), basic health infrastructure (12230), etc. also contribute to Germany’s fight against HIV/AIDS but are not included in this analysis due to unclear division between CRS purpose code assignment.

²⁴ CRS purpose code 16064 (social mitigation of HIV and AIDS) was not included in this analysis as it did not belong to either CRS sector 120 (health) or 130 (population policies/programmes and reproductive health), which were the sectors considered in this analysis.

services for adolescents and young people. The regional programme, which commits EUR 3 million over 2015–17, falls within the context of the Eastern and Southern Africa Initiative, which was conceived in 2011 with the BMZ as one of the first donor supporters (BMZ, 2015). Multilateral involvement in SRHR is further evinced through German support for the London Family Planning Summit, its active role in the International Conference on Population and Development beyond 2014 and the post-MDG processes.

The last remaining focal point in the BMZ health sector strategy – health systems strengthening – could not be adequately analysed for with CRS data. The WHO defines a health system as “the sum total of all the organisations, institutions and resources whose primary purpose is to improve health” (WHO, 2007). The numerous factors necessary to strengthen a health system cannot therefore be estimated through the CRS purpose codes for health, which tend to be either very broad or intervention-specific. Furthermore, HSS components may be present in any given project/programme, ultimately resulting in the analysis of HSS funding to become increasingly complex.²⁵

Main findings on GDC health ODA by thematic area

- *German bilateral health ODA has reflected the SRHR and HIV/AIDS focal areas of the BMZ health sector strategy (2009). Health systems strengthening (HSS), which is too complex to be accounted for in the CRS coding system, could not be adequately analysed for. However, the importance given to HSS in existing German health-related strategies and the recent commitment of an additional EUR 200 million to be devoted to HSS indicate the need to effectively measure German health ODA that enables the strengthening of health systems. Though this analysis may not reflect true ODA allocations across the thematic areas, it does provide a general picture of the GDC health priorities, and highlights the problematic aspects of analysing HSS within CRS data.*
- *In line with European trends, bilateral German ODA for sexually transmitted diseases (STDs) and HIV/AIDS took a leading role around 2006, and has continued to comprise a significant portion of bilateral German health ODA since then. The importance of this analysis, however, is not to assess how much bilateral German ODA goes to which category, but how Germany wishes to define its global health priorities through the allocation and categorisation of its health ODA. The past decade’s predominant focus on the MDGs, which entail a clear focus on maternal and child health as well as HIV/AIDS, malaria and tuberculosis, has greatly influenced the development of German priorities in global health. As the recent focus on universal health coverage has redirected from HIV/AIDS to health systems-related topics such as SRHR, it will be interesting to observe whether or not the increase for SRHR seen in 2012 in German health ODA will continue.*

This quandary is particularly problematic in light of the recent announcement made by Chancellor Merkel at the World Health Assembly in May 2015 for a commitment of an additional EUR 200 million devoted to the development of health systems in 2015–16 (Merkel, 2015). Of this amount, EUR 70 million is to be devoted specifically to West Africa. While the commitment is arguably relevant, especially in the aftermath of the Ebola epidemic, it remains to be seen how fulfilment of the commitment will be effectively measured.

²⁵ Health system strengthening in the GDC is the topic of another DEval publication. See Munir (2015) for further analysis on the GDC approach.

5. GEOGRAPHIC PERSPECTIVE OF BILATERAL GERMAN HEALTH ODA

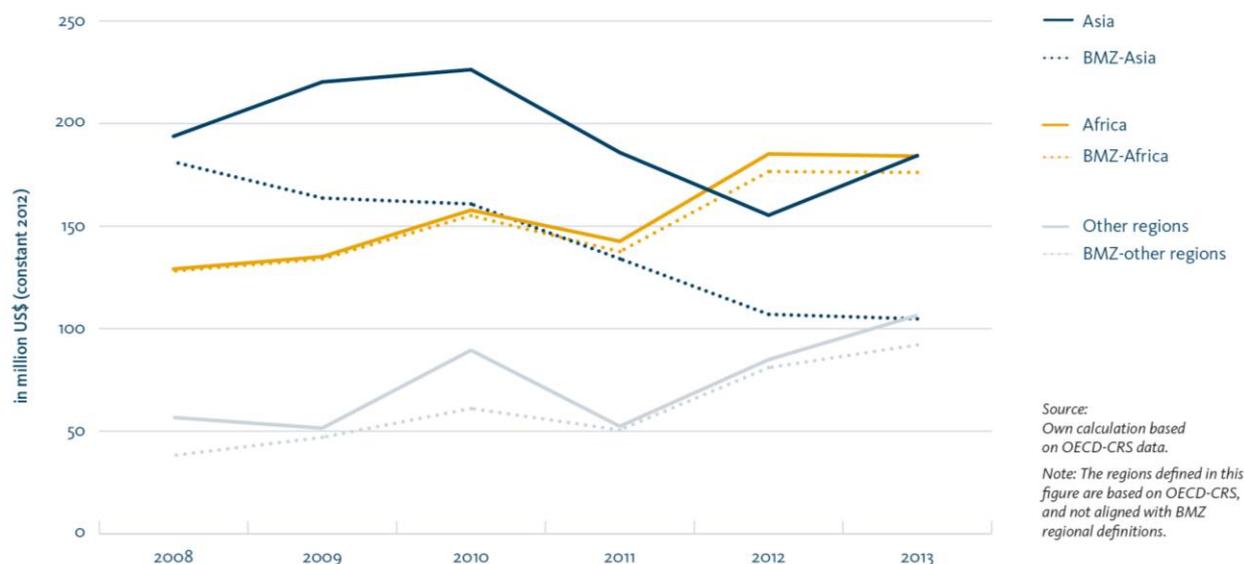
The majority of bilateral German health ODA flows are received by Asia and Africa. The following section provides an analysis of the change in these flows across time and the predominant uses for these flows according to CRS purpose code. The top ten recipients of bilateral health ODA are also explored as well as GDC partner countries with a specific health focus in their strategic agreements.

5.1 REGIONAL DISTRIBUTION OF GERMAN BILATERAL HEALTH ODA

From 2008 to 2013, Africa has received a greater amount of BMZ-supported bilateral health ODA than Asia (EUR 907.7 million and 851.7 million respectively), and six of the ten largest bilateral recipients of BMZ-supported health ODA have also been in Asia (see Figure 8). When considering total German health ODA during the same time period, however, Asia has received a greater amount than Africa.

When viewed across the time period, German bilateral health ODA distributed across regions tells a more nuanced story (see Figure 10). The increasing amount of German bilateral health ODA in Asia leading up to 2010 might be explained by the numerous ODA loans given to India and China. The drop in bilateral health ODA in Asia after 2010 is mainly owing to the end of health ODA in China in 2010. Following this, a regional shift in bilateral health ODA took place after 2011, with Africa receiving more health ODA than Asia. More recently in 2013, both regions received similar amounts of German health ODA. Also evident in Figure 10 is that the BMZ has been primarily responsible for health ODA in Africa. Whereas the BMZ has also been responsible for the majority of health ODA in Asia, other ministries including the Federal Foreign Office (*Auswärtiges Amt*) and KfW funds (not originating from the BMZ) have also contributed 15 and 8%, respectively.

Figure 10. BMZ Bilateral German health ODA disbursements by region, 2008–13



In taking a deeper look at the allocation of CRS purpose codes within German bilateral health ODA in Africa, the most prominent include “STD control including HIV/AIDS”, “Health policy and

administrative management” and more recently, “Infectious disease control”. Polio programmes in Nigeria and immunisation programmes in Tanzania account for approximately 60% of ODA classified under infectious disease control in Africa.

A similar look into German bilateral health ODA in Asia reveals that the CRS purpose codes having received the most bilateral health ODA are “Medical services”, “Basic health infrastructure”, “Health policy and administrative management”, and “Infectious disease control”. In the cases of Asia and Africa, analysis suggests interaction between region and thematic area (as defined by CRS purpose codes), which might be reflected by factors such as the relatively high HIV/AIDS burden in Africa.

Historically, Germany has placed a strong focus on middle-income countries, which received more than 50% of bilateral funds until the early 2000s. Least developed and other low-income countries now account for more than 50% of bilateral ODA, partly due to the increasing importance of debt relief (OECD/DAC, 2010). By and large, this shift to low-income countries also holds true for bilateral German health ODA when observing the nine largest recipient countries as described above. As seen in Figure 8, the largest recipients of BMZ-supported bilateral health ODA between 2008 and 2013 include three least developed countries (Bangladesh, Tanzania, Yemen), one low-income country (Kenya), four lower-middle-income countries (Pakistan, Indonesia, India, Nigeria) and one upper-middle-income country (China).²⁶

Notably, the largest recipient of bilateral German health ODA is classified as “bilateral, unspecified”. This recipient category includes bilateral ODA that is excluded from country-programmable aid, such as administrative costs, refugees in donor countries, and research costs (OECD/DAC). In the health sector, this recipient category includes funds allocated to global programmes that are not country-specific, such as GIZ’s Programme to Foster Innovation, Learning and Evidence in HIV and Health Programmes (PROFILE) on behalf of the BMZ. Also included in this recipient category in the health sector are “ear-marked funds”, which are ODA to bilateral entities, distributed through multilateral channels. Included in these multilateral agencies are international organisations (e.g. the WHO and European Commission) and international partnerships, such as the Global Health Investment Fund.

5.2 BMZ PARTNER COUNTRIES WITH A HEALTH FOCUS

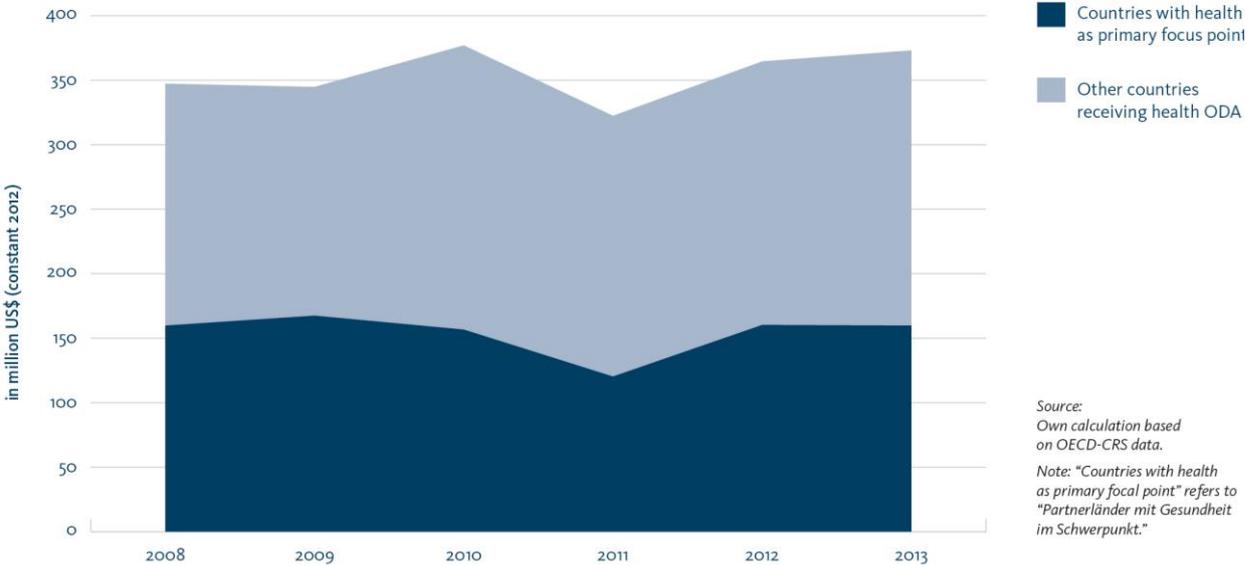
Since 2009, there have been a total of 17 BMZ partner countries and one region having a focal area in health (*Partnerländer mit Gesundheit im Schwerpunkt*). These include: Bangladesh, Cambodia, Cameroon, Guinea, Indonesia, Kenya, Kyrgyzstan, Malawi, Nepal, Pakistan, Rwanda, South Africa, Tajikistan, Tanzania, Ukraine, Uzbekistan, Vietnam and the Caribbean Region.²⁷ **Of these partner countries with a focal area in health, six countries fall within the top ten recipient countries list as well.** That China and India are among the largest recipients of German health ODA and do not have a specific focus within their development partnerships on health is due to their large population sizes (Doc. 5).

²⁶ All country classifications according to the 2011 DAC country recipient list retrieved from <http://www.oecd.org/dac/stats/DAC%20List%20used%20for%202011%20flows.pdf>

²⁷ This is a cumulative list of all partner countries with a health focus since 2009. Currently, Bangladesh, Guinea, Indonesia, Rwanda and the Central American Region do not have health focus in their partnership agreements, and Pakistan will no longer have specific focus on health in 2016.

Furthermore, as Figure 11 indicates, of the BMZ-supported bilateral health ODA to countries, the amount disbursed to BMZ partner countries with a primary health focus has remained relatively steady throughout 2008–13, averaging in this period to approximately 48% of total BMZ-supported bilateral health ODA. The remaining portion of the bilateral health ODA is divided between GDC partner countries with a non-primary focus on health (*Gestaltungsspielraum*)²⁸ and no health focus at all. **Analysis of BMZ-pledged commitments in health in 2013 reveals that 66% of the budget was allocated to partner countries with a focal area in health. However, disbursements for these countries in 2013 only amounted to 44% of total BMZ-supported health ODA.** The dispersed focus of BMZ-supported health ODA among partner countries shows divergence with the recommendations from previous DAC peer reviews to narrow down the number of partner countries and remain focused on priorities (OECD, 2006; OECD/DAC, 2010).

Figure 11. Bilateral German health ODA disbursements by partner country classification, 2008–13



²⁸ For each partner country there is an ODA fund for non-focal areas, which lie outside the two to three focal areas defined in country partnerships. This allows flexibility in assistance for the country and funding for projects or programmes in other, non-focal areas.

Main findings on geographic perspective of bilateral German health ODA

- *Africa has received a greater amount of BMZ-supported health ODA than Asia in the period 2008–13, despite six of the largest bilateral recipients of BMZ-supported health ODA being in Asia. Whereas the most common CRS sector for health ODA in Asia is basic health, the CRS sector population policies/programmes and reproductive health is most frequently seen in Africa. Of great influence here are China and India, two of the largest bilateral German health ODA recipients. Neither of these countries are currently BMZ partner countries with a focal area in health, and both have received a substantial portion of health ODA in non-grant form.*
- *Further investigation could also be made of the “bilateral, unspecified” recipient of bilateral German health ODA, which ranked first in terms of total volume over the period 2008–12. The high volume in this category signifies the importance of global programmes and international partnerships in the GDC’s contribution to global health. In particular, an analysis of international partnerships would also be relevant in light of the emphasis of the GDC on private sector engagement for health.*
- *Of interest is the flow of health ODA to BMZ partner countries with a focal area in health. On average, these countries have received less than half of BMZ-supported health ODA to countries, which brings into question the effectiveness of widely disbursed aid versus more concentrated aid. The previous OECD/DAC Peer Reviews (2005 and 2010) recommended that the GDC become more focused in its aid and narrow down the number of partner countries. Although this analysis does not show BMZ compliance with this recommendation, it is expected that following the BMZ new Africa policy in 2014, health ODA will begin to be considerably more concentrated within Africa.*

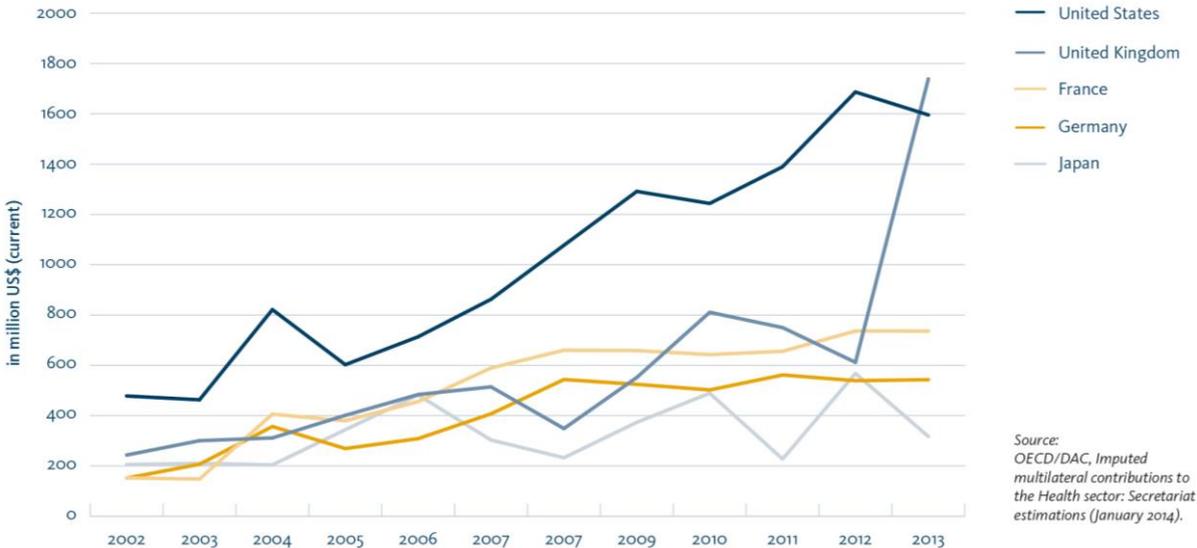
6. MULTILATERAL VS BILATERAL HEALTH ODA

While this analysis primarily incorporates bilateral ODA, it would be incomplete without addressing multilateral ODA as well. The following section encompasses an analysis of multilateral health ODA trends over time and the leading donors in multilateral health ODA. Perspectives are also provided on the division between bilateral and multilateral German health ODA.

The Coalition Agreement of 2009 encouraged the increase of bilateral ODA across all sectors, with the target of two-thirds of total ODA (CDU, CSU & FDP, 2009) – which has been a cause of concern for many global health advocates who fear that this would result in a decrease of major multilateral health commitments (Countdown 2015 Europe, 2012b). This has, however, not reflected the development of German health ODA. Although German bilateral ODA flows for health have been increasing since 2011, the **majority of German health ODA has consisted of multilateral aid in the period 2002–13, approximating to 55% of total German health ODA.** A trend for the overall increase of total German health ODA began in 2007, influenced by the fact that GFATM began to receive relatively large contributions by the GDC that year. However, the relative portion of multilateral aid in total health ODA remained relatively the same as before (57.2% in 2002–06, and 54.7% in 2007–12).

Overall, **Germany ranks among the top donors for multilateral health ODA in the time period 2002–13, ranking most recently as the fourth largest in 2013** (see Figure 12). Furthermore, **Germany’s contribution to multilateral health ODA given by all DAC donors over this period has been approximately 8.7%.**

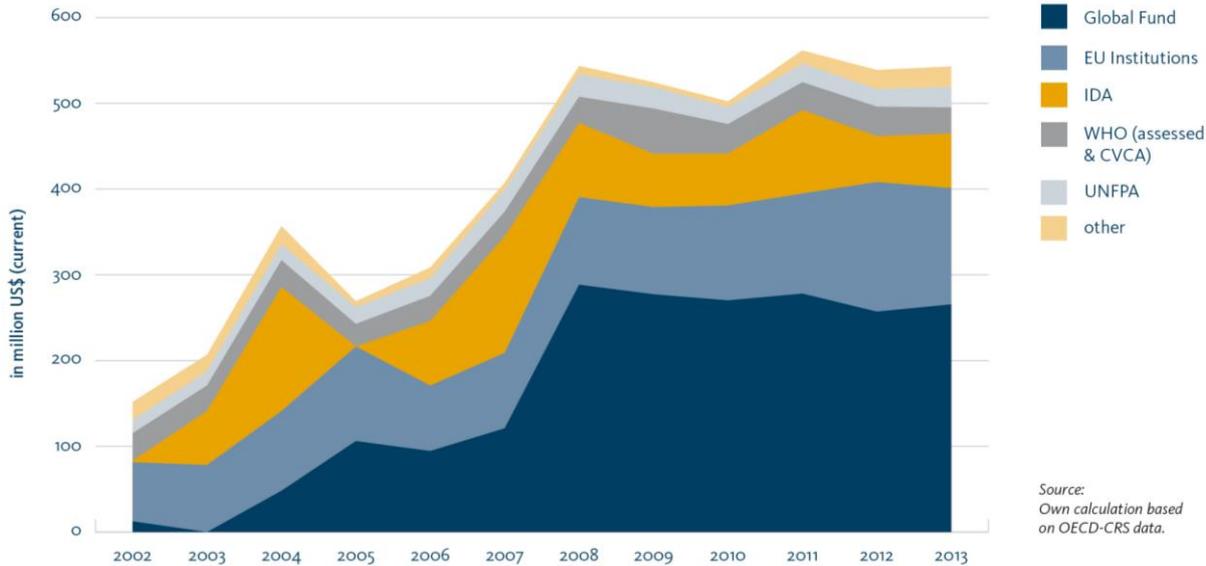
Figure 12. Top country donors for multilateral health ODA, 2002–13



The top recipients of Germany’s multilateral health ODA are seen in Figure 13, with GFATM, EU institutions, International Development Association (World Bank), WHO and United Nations Population Fund in the lead. Furthermore, GAVI has recently gained significance as a multilateral health ODA recipient with disbursements of USD 221.9 million (EUR 172 million) from 2006–14 (GAVI Alliance, 2014) and a further USD 720 million (EUR 600 million) for 2016–20 pledged at the GAVI replenishment conference of January 2015 in Berlin (GAVI Alliance, 2015).

Figure 13 also shows a declining role of the regional development banks, International Development Association and EU institutions, and an increasing role of the GFATM. From 2008 onwards, GFATM far outranks other recipients, substantiating the strong emphasis on HIV and infectious diseases within the health engagement of the GDC. **The importance of the relationship between GFATM and the GDC is manifested in several ways:** on top of being the largest recipient of multilateral health ODA, Germany has also held a position on the GFATM board since 2012. Germany’s presence at the GFATM was promoted with the recent selection of Norbert Hauser as chair for a two-year term (2015–17) (GFATM, 2015). On an operational level, the German BACKUP Initiative, a GIZ programme on behalf of the BMZ, also provides technical assistance for GFATM proposals and project implementation in recipient countries across the world. Following a freeze in funding to the GFATM over criticism of its management and administration (in 2011), Germany has been disbursing steadily increasing amounts to the organisation over the analysed time period. Disbursements to the Global Fund were resumed after the Global Fund introduced a fundamental reform. From the period 2001–10, Germany was the fourth largest country donor to the GFATM, and from 2011–13, it was the third largest (GFATM, 2014).

Figure 13. Composition of multilateral German health ODA by recipient, 2002–13



Main findings on multilateral vs. bilateral health ODA

- Multilateral health ODA comprises the majority of German health ODA and is an essential element of the GDC’s contributions to global health. Likewise, Germany is a major country donor in the multilateral health ODA field, ranking fourth globally in 2013, and having contributed 8.7% of all multilateral health ODA between 2002 and 2013.
- The division between multilateral and bilateral ODA has remained relatively stable, even as total German health ODA has increased, indicating that the preference for multilateral and international institutions as recipients of health ODA has been consistent across the time period of analysis. This has been despite the encouragement of the German government to increase bilateral spending in 2009. Simultaneously, however, it was acknowledged that an increase in multilateral ODA is necessary to reach the 0.7% ODA/GNI target. The simultaneous growth in total German health ODA in 2007 and the greater involvement of the GDC in GFATM also proves to have a meaningful connection. The importance of multilateral health ODA was made clearer after the G8 Summit of Heiligendamm, where commitments were made to fight HIV/AIDS, tuberculosis and malaria. Since then Germany has played a major role in the development and growth of GFATM, which has allowed the GDC to fulfil its commitment to the Heiligendamm Summit, as well as take a leading role as an innovative financier of global health. Germany’s recent hosting of the GAVI replenishment conference and increased contributions have further raised the GDC’s position in the field of multilateral health ODA and global health development overall.

III. CONCLUSIONS

This analysis has sought to understand and contextualise the trends of German health ODA over time on the basis of: international commitments; comparison with other donors in health; the division between grant and non-grant health ODA; thematic and geographic perspectives; and the division between bilateral and multilateral health ODA. Available data has allowed a view into all of these perspectives, though they could be investigated further with additional data, particularly when it comes to the subject of thematic focus within German health ODA.

The research leading up to this portfolio analysis confirmed that the assignment of CRS purpose codes to individual ODA activities is not consistently applied. This, in addition to many projects/programmes not being exclusively related to either HIV/AIDS or maternal and child health, creates the possibility of CRS purpose code adjustment for future calculations of the fulfilment of the Muskoka commitments. HIV/AIDS programming also frequently addresses maternal and/or child health, and it would be relatively easy to mark projects with a primary focus on HIV to count towards the fulfilment of the Muskoka commitments, thus allowing the derailment of the pursuit of Muskoka objectives. To prevent this from happening, measures that could be pursued include, among others, the standardisation within the GDC of the process for CRS purpose code assignment, or instating a quality assurance procedure to assess how well CRS purpose codes fit with the activities they are assigned to.

Also stemming from the problematic aspects of CRS purpose codes is the lack of ability to track health systems strengthening. In light of the importance attributed to HSS within the GDC's engagement in health, a means of tracking its HSS contributions is essential. By enabling improved monitoring and analysis of HSS activities, Germany would take a step towards elucidating its multifaceted approach to HSS. In the long term, this would result in improved allocative decisions.

Another caveat evinced by this analysis pertains to Germany's place among other donors in global health. Although Germany ranks high within Europe and globally for health ODA, economic capacity must also be taken into account to adequately address the responsibility of the global donor community towards development objectives. With respect to the economic capacity as indicated by GNI, Germany is outranked by a number of other countries. Health is an important sector within the GDC, and in order to raise the significance of its contributions and match ODA with its strategic priorities, Germany will have to rise among donors by increasing ODA for health.

Germany has also been criticised over its high rate of ODA loans (AfGH, 2012; Roodman, 2014), but as this analysis shows, lending in the health sector does not seem to play an overtly influential role, with the exception of a few countries. Although a number of top recipients of bilateral German health ODA have received a great deal of non-grant health ODA, the majority of bilateral German health ODA overall has consisted of grants. Further investigation is warranted to better understand what qualifies a partner country to receive non-grant health ODA, and how non-grant health ODA is reported to the OECD/DAC, particularly with reference to debt relief. To understand the effectiveness of ODA loans as a channel of development (for health as well as other sectors), it will also be necessary to assess the long-term financial and development outcomes of concessionary loans.

As a leader at the forefront of the global health forum, Germany has a unique opportunity to fulfil key commitments that would move the global health agenda forward. It is hoped that this analysis will inspire further exploration in the GDC's involvement in global health, and help to steer its future development in this regard.

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I. DATA TABLES

GERMAN HEALTH ODA, 2002–13

	Net German ODA	Total German health ODA	German bilateral health ODA	German multilateral health ODA
2002	8054.41	378.64	148.99	229.65
2003	8467.91	482.29	224.19	258.10
2004	8461.16	661.20	260.46	400.73
2005	11247.67	537.56	237.15	300.41
2006	11491.45	613.11	273.27	339.83
2007	12212.04	752.67	347.94	404.73
2008	13082.47	888.26	379.56	508.70
2009	11571.46	909.39	406.91	502.48
2010	12944.11	974.24	473.66	500.58
2011	13219.25	907.70	380.86	526.84
2012	12939.49	964.40	425.41	538.99
2013	13487.95	989.86	475.05	514.80

In constant USD millions (2012)

TOP 10 BILATERAL RECIPIENTS OF GERMAN HEALTH ODA, 2002–13

	German bilateral ODA in grants (110)	German bilateral ODA in loans (410)	Total German bilateral health ODA
Bilateral, unspecified	207.26	0.00	207.26
Tanzania	183.68	0.00	183.68
India	67.16	77.23	144.40
Bangladesh	120.39	0.00	120.39
Indonesia	86.69	20.08	106.77
Nigeria	95.27	0.00	95.27
Kenya	92.87	0.00	92.87
China	28.98	61.61	90.59
Pakistan	84.01	3.75	87.76
Yemen	67.16	0.00	67.16

In constant USD millions (2012)

BILATERAL GERMAN HEALTH ODA TO REGIONS, 2008–13

	German health ODA			BMZ only		
	Asia	Africa	Other	Asia	Africa	Other
2008	193.77	129.11	56.68	181.31	128.13	38.23
2009	220.32	135.10	51.49	163.70	134.03	47.05
2010	226.34	157.83	89.48	160.82	155.08	61.10
2011	185.87	142.61	52.38	134.13	137.65	50.65
2012	155.31	185.16	84.94	106.98	176.59	80.99
2013	184.36	184.15	106.55	104.80	176.17	92.11

In constant USD millions (2012)

COMPARISON OF ODA TO GNI RATIOS OF DAC DONORS IN 2013

DAC member	ODA/GNI 2013 %	Health ODA/GNI %	GNI
Australia	0.33	0.04	1512605
Austria	0.27	0.01	427321.1
Belgium	0.45	0.05	518241.4
Canada	0.27	0.06	1835383
Czech Republic	0.11	0.01	199407.5
Denmark	0.85	0.08	346278
Finland	0.54	0.05	265538.8
France	0.41	0.04	2869763
Germany	0.38	0.03	3810597
Greece	0.10	0.01	250269
Iceland	0.25	0.02	14987.5
Ireland	0.46	0.07	198114.5
Italy	0.17	0.01	2145347
Japan	0.23	0.01	5899905
Korea	0.13	0.01	1301575
Luxembourg	1.00	0.21	37972.49
Netherlands	0.67	0.07	858027.8
New Zealand	0.26	0.02	157614.2
Norway	1.07	0.14	521712.9
Poland	0.10	0.00	510004.9
Portugal	0.23	0.01	222403
Slovak Republic	0.09	0.01	96417.73
Slovenia	0.13	0.01	47825.16
Spain	0.17	0.01	1395916
Sweden	1.01	0.11	592410.9
Switzerland	0.47	0.02	733437
United Kingdom	0.71	0.14	2671728
United States	0.18	0.05	16903045

**In constant USD millions (2012), as reported by The World Bank (2014).*

II. LIST OF RELEVANT CRS SECTOR AND PURPOSE CODES

Sector code	Purpose code	DESCRIPTION	Definitions				
			Health	Heiligendamm	Muskoka	BMZ Initiative	Education
120		HEALTH	X	X	X		
121		Health, general	X	X	X		
	12110	Health policy and administrative management	X	X	X		
	12181	Medical education/training	X	X	X		
	12182	Medical research	X	X	X		
	12191	Medical services	X	X	X		
122		Basic health	X	X	X		
	12220	Basic health care	X	X	X		
	12230	Basic health infrastructure	X	X	X		
	12240	Basic nutrition	X	X	X		
	12250	Infectious disease control	X	X	X		
	12261	Health education	X	X	X		
	12262	Malaria control	X	X	X		
	12263	Tuberculosis control	X	X	X		
	12281	Health personnel development	X	X	X		
130		POPULATION POLICIES/PROGRAMMES AND REPRODUCTIVE HEALTH	X	X	X		
	13010	Population policy and administrative management	X	X	X		
	13020	Reproductive health care	X	X	X	X	
	13030	Family planning	X	X	X	X	
	13040	STD control including HIV/AIDS	X	X	X		
	13081	Personnel development for population and reproductive health	X	X	X	X	
140		WATER AND SANITATION					
	14030	Basic drinking water supply and basic sanitation			X		
	14031	Basic drinking water supply			X		
	14032	Basic sanitation			X		
510		General budget support					
	51010	General budget support			X		

III. MAP OF PARTNER COUNTRIES WITH PRIMARY AND SECONDARY HEALTH FOCUS (2013)

