The Global Crisis and Germany's Contribution to the Global Response

Fifth Edition of the Civil Society Appraisal of the Political and Financial Contributions provided by the German Government in support of the UN Targets on Global Health and HIV Control

Action against AIDS Germany

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Introduction and summary

Germany's contribution to global health and HIV response

It is one of the most brutal forms of injustice when people are dying at an early age because social deprivation leads to extreme risks of disease and hampers the access to effective treatment. Since the United Nations have adopted the Millennium Declaration as well as the first Declaration of Commitment on HIV and AIDS, the international community has made remarkable progress in curbing the most devastating epidemics along with improving health care. A child that was born in a developing country at the turn of the millennium was faced with a 15 percent risk of dying before the age of 40. This risk of early death could be lowered to an average of 11 percent. But it still has to be expected that in some countries especially affected by HIV or other severe crises, an average of one third of new-borns will not reach the age of 40. In contrast, the risk in most economically privileged countries amounts to less than 2 percent.

Action against AIDS Germany advocates for lifting everyone's life chances to the highest possible level. Especially the economically most disadvantaged countries are dependent on international cooperation in order to take effective and comprehensive measures for prevention and treatment of HIV as well as other serious diseases. Human solidarity, historical responsibility, but also the anticipatory averting of health threats and distributional conflicts, which ultimately will not stop at any frontiers, should motivate privileged countries such as Germany to undertake the required political and financial efforts. This report attempts to objectively evaluate the German Government's contribution in the light of global challenges and agreements and, on this basis, present recommendations for appropriate approaches of political action. We see ourselves as supporters of those who are still suffering from discrimination and marginalization.

Structure of the report and the individual contributions

This report is the fifth publication of this kind and it is divided into two main sections similar to previously published reports. **Part A** covers political government action of previous years in decisive areas for health promotion and HIV response. **Part B** presents essential results and conclusions of a study, which, for the first time, attempted to determine the financial contributions provided by the economically privileged countries for the realization of the health-related Millennium Development Goals covering the complete period from 2000 to 2015.

The report starts with an analysis of the recent agreements of the United Nations, which are of special significance for the global efforts in overcoming poverty and illness. Furthermore, current trends of the HIV epidemic are also described in order to be able to better assess the impact of previous efforts of prevention and treatment as well as the remaining challenges. The different articles were written by members involved in Action against AIDS Germany.

International Agreements in the fight against poverty and HIV: an ambivalent résumé

The New Development Agenda entitled "Transforming our World", which was adopted by the UN General Assembly in September 2015, sets out the global reference framework until 2030 for all world regions and areas of action. Through the implementation of the 17 goals of the Agenda the international community aims to achieve the eradication of poverty and the conservation of natural resources. The UN Declaration on HIV and AIDS adopted in June 2016, entitled "On the Fast Track to accelerate the fight against HIV and to end the AIDS Epidemic by 2030" complements the 2030 Agenda and it is to provide clear guidelines in overcoming one of the most severe threats to human development. It has to be stated, however, that the agreements reached only partially meet the respective requirements. Their structural fault lies in the inherent contradiction to formulate appropriate specific targets and correct insights, yet to avoid concrete obligations for the needed financial efforts and socio-political changes. The irresponsible obstructive position of many governments frustrated the agreement on appropriate time-bound financial commitments and systematic measures to overcome social disadvantage and discrimination. It is getting to the point that important commitments made in previous UN Resolutions and Declarations were diluted or delayed in current documents. These fundamental deficits endanger the realization of the other targets including universal health coverage and ending the AIDS epidemic. This leads to a

dual task for the international civil society: it has to urge government representatives to implement appropriate targets and, simultaneously, to motivate them to take corrective measures regarding political and financial commitments.

A look at the current epidemiological situation shows that HIV as well as the closely related Tuberculosis each has caused more than one million deaths worldwide per year. Regardless of the partial success achieved thus far, these are the most fatal infectious diseases. The number of new HIV infections in adolescents and adults remained at 1.9 million in recent years. Programs for the prevention of vertical HIV transmission have led to quite positive results and the number of annual infections among infants has been lowered by two thirds from 450,000 to 150,000 since 2005. Thus, the global community has to significantly increase its efforts in order to overcome HIV and other devastating diseases. With the condition that the targets agreed upon in the new UN Declaration will be put into effect, new infections as well as HIV-related deaths could be reduced to less than 500,000 by 2020 and this would lay the foundation to end the AIDS epidemic by 2030.

Official statements on global health: Growing problem awareness but hesitant willingness to take action

Part B of the report begins with the careful examination of the political action by Germany's Federal Government in recent years. Although the coalition agreement between the two political parties involved in the present German Government assigns a certain amount of significance to global health, the implemented and planned increases in financial contributions for the internationally agreed development and health targets have remained significantly below the required level so far. Even the previously announced but by far inadequate steps to come closer to reaching the UN target for official development cooperation of 0.7 percent of the Gross National Income (GNI), was only partially fulfilled in the budget decisions.

A critical assessment of specific strategy papers of the German Government to control the global HIV crisis as well as to tackle the problem on the national level concludes that the latest document has a tendency to treat the HIV interventions as part of the efforts to strengthen the health systems. To a certain extent, the integration is necessary under the aspects of effectiveness and universality. However, there is a risk of losing sight of the special challenges such as the by no means overcome discrimination of people with HIV and particularly vulnerable population groups. The mention of the emphasis on human rights for an ethical and effective response to HIV is quite positive. Yet, the insufficient increases of the contributions to the Global Fund and for especially relevant UN organizations as well

as the reduction of partner countries for the bilateral cooperation in the field of health and HIV are in clear contrast to the quite intensified involvement in important multilateral decision bodies. The implementation of strategies can also merely be described as partially fulfilled. Finally, the participation of civil society in the preparation of the 2016 document lagged behind the good practice achieved in the elaboration of the 2012 policy paper. This is evidenced by the fact that important substantive input has not been taken into consideration.

The appropriate aspiration to regard the control of the HIV epidemic as a primary task for the global community can, unfortunately, hardly be found in government declarations. As the respective article in this report shows, the Declaration dealing with the EU-Africa Summit in 2014 did not devote a single word to the threat by HIV in the by far most affected continent. The few statements on global health are also limited to specific individual aspects without sufficient attention to the basic significance for human development. Official statements by Chancellor Angela Merkel at least contain some crucial insights, when she emphasizes the necessity of addressing global challenges such as food safety, health, education and human rights or when she describes the Global Fund to Fight AIDS, Tuberculosis and Malaria as a proven and effective multi-lateral instrument. Her full support of Free Trade Agreements – even with the present predominance of commercial interests – is definitely contrary to the protection of health and human rights.

The global initiative to strengthen health systems entitled "Healthy Systems – Healthy Lives" which has been launched with the direct support of the German Government was initially regarded as an imperative reaction to the Ebola crisis and other health risks. The respective article on this subject shows that the conceptual considerations and financial efforts are not congruent, unfortunately. The so-called "Roadmap" has to be complemented by a global plan for the financing of universal health coverage. This needs to include the pledge to increase Germany's own contributions for health care in the disadvantaged regions to at least the recommended level of 0.1 percent of the economic capacity. Efforts to improve the coordination and the effectiveness of health services are necessary, but they should not detract from the social causes of the HIV epidemic and other health crises or from the own responsibility as Government of an economically privileged country. Furthermore, the path-breaking experiences and positive impacts of the efforts for HIV prevention and treatment should be much more appreciated and should be taken into account for the development of appropriate initiatives.

Due to the leading position of their national economies, the governments of the G7 states have a special joint responsibility for global development. The article on Summit Declarations particularly covers the health-relevant statements. Espe-

cially the 2007 and 2008 commitments to raise 60 million US$ within the period of five years to reach "the Millennium Development Goals for fighting HIV/AIDS, Malaria and Tuberculosis... and strengthening of health systems" as well as the initiative for child and maternal health launched in 2010 were of special significance. The following simple calculation demonstrates that the pledges of health financing were quite moderate despite the seemingly large number when compared with the urgent need and the economic opportunities: if the G7 states had fulfilled the recommendation in the period in question (2008 to 2012) to contribute a total of 0.1 percent of the GNI for global health, an amount of 164 billion US$ would have been provided. Nevertheless, it has to be stated that the G7 Government Representatives have affirmed the 2016 target of the 2030 Agenda to end the major epidemics. The call on other donors to support the required replenishment of the Global Fund, would have been much more convincing and effective, however, if this would have been combined with a pledge of suitable own contributions. The recently announced "Ise-Shima Vision for Global Health" mentions important challenges and targets, but the statements regarding the required financial commitments for the expansion of health services and the intensification of medical research that are required to implement it remain extremely vague.

Insufficient perception of the risks of increasing monopoly rights for scientific and technical progress

The global implementation of patents and other monopoly rights also for procedures and products, which are of vital importance for services of public interest has reached a new level with the foundation of the World Trade Organization (WTO) in January 1995 and the realization of the TRIPS Agreement (Agreement on Trade-Related Aspects of Intellectual Property Rights), which is an obligatory requirement of a membership. Although the agreement comprises possible safeguard measures such as compulsory licenses and the decision-making competence of the states regarding their application has been confirmed by the Doha Declaration in 2001, the use of these so-called flexibilities, however, is obstructed by external pressure and also by internal conflicts of interest and has only taken place in exceptional cases thus far. Only the group of the least developed countries is allowed to benefit from the transition periods, which have been extended for pharmaceutical products until January 2033. The first article on this topic uses the treatment of Hepatitis C as an example to show that the sale revenues resulting from monopoly prices substantially exceed the investments in research and development. The prospect of monopoly profits also intensifies the orientation of research investments towards lucrative

demand rather than essential health necessities. The policy makers finally have to implement the required coordination and support measures in order to give priority to the human right to life and health instead of private profit-oriented interests.

The second article regarding the issue of monopoly rights describes the necessity to interpret and implement the TRIPS Agreement in national law in favour of those people affected by severe diseases. It is vital to limit patentability for minimal innovation and to uphold the full scope of action for the use of compulsory licenses. The attempts of economically privileged countries to enforce even more monopoly rights through bilateral or regional trade agreements and to hamper the use of the TRIPS flexibilities involves a considerable risk for the affordability of essential drugs and other medical products. The highly problematic provisions include the extension of patent terms beyond the minimum period of 20 years, the exclusive use of results of clinical studies for marketing approval and the extraordinary right for companies to sue states in extrajudicial settlement procedures for decisions and measures that might decrease their profits. Should these additional agreements become the rule, the production and marketing of generic drugs will be more and more under pressure with fatal consequences for diagnosis, prevention and treatment of life-threatening diseases.

Yet another article covers the discrepancy between research priorities of commercially oriented pharmaceutical companies on the one hand, and the need of focused research activities to tackle the serious health problems of the disadvantaged majority of the world population on the other hand. The lack of interest of pharmaceutical companies in products for which large sales can only be expected in an insecure future, e.g. when increasing resistances arise, presently hampers the translation of important results of basic research into implementation oriented clinical research. Therefore, scientific and technical progress was limited even for wide-spread and severe illnesses such as Tuberculosis as well as for neglected tropical diseases or the blatant health risks such as Ebola. Hence, there is an urgent need to enhance the support measures and incentives for research efforts in the service of public health instead of leaving this field to market mechanisms. Fatal research gaps need to be closed and new life-saving vaccines, diagnostic devices and drugs need to be made available and be affordable.

Further articles explicitly describe the current situation and the action required regarding the two major epidemics of Tuberculosis and Malaria. The double infection with HIV and Tuberculosis is an exceptionally life-threatening combination. And again, it comes down to sufficient political will and financial resources in order to implement the available effective instruments and strategies of prevention, diagnosis and treatment and to overcome these epidemics as a threat to pub-

lic health. Just as for HIV control, the Global Fund is also of decisive importance in the support of the respective programs.

The joint public tasks on national and global level require the allocation of the required resources. In addition to the urgently needed equitable structuring of the tax system and the fight against tax evasion, innovative financing sources can play an important role. Thus, one article covers the instrument of the financial transaction tax. If the presently interested ten European countries including Germany would agree on an appropriate model for the taxation of financial products and implement it, a substantial amount of financial resources could be raised, which are urgently needed for securing national services of general interest and the global fight against poverty, hunger and disease. For Germany alone an amount in the magnitude of tens of billions euros could be expected. Furthermore, this would also guarantee that those who directly caused the financial crisis will finally be involved in bearing the costs.

The Global Fund, as a partnership for all parties involved, has set new standards regarding the participation of self-help initiatives of affected persons and civil-society organizations. This is absolutely essential in the process of reaching out to vulnerable population groups, the protection of their human rights and thus the effectiveness of interventions. Despite the frequently adverse general context, the programs supported by the Fund have achieved impressive results. The envisaged prevention and treatment interventions including the access to antiretroviral therapy of more than 9 million persons with HIV have saved the lives of 20 million people. The Global Fund is an indispensable instrument in the implementation of the 2030 Agenda. Without sufficient funding, the international community will fail to achieve the Sustainable Development Goal 3 to "ensure healthy lives ...for all at all ages" as well as to realize the resulting positive effects to overcome other dimensions of poverty. Since Germany's annual contribution stagnated at an insufficient level of 200 to 210 million euros for nearly a decade, the increase to a fair level of 400 million euros on average per annum in the coming three years can no longer be postponed.

From 8 to 10 June 2016, the representatives of the member countries met at the United Nations Headquarters in New York for a High Level Meeting to discuss the end of AIDS. The most important outcome was the adoption of a new Declaration on HIV and AIDS, which is discussed in the above-mentioned article. Action against AIDS Germany thankfully accepted an invitation to join the German Government Delegation. The delegation meeting provided the chance to have open and constructive discussions with Federal Minister Hermann Gröhe, the accompanying Members of the German Parliament, the staff of the Permanent Representation, the line ministries, the civil society as well as all other parties involved. Controversial issues

were also addressed such as the necessity to increase Germany's contribution for development cooperation in the health sector and the funds for the research of poverty-related diseases. This opportunity for participation and the debates should be the democratic rule. But this cannot be said about all governments, unfortunately. More than 20 self-help initiatives and civil-society organizations had been excluded from the participation in the UN Meeting by veto of the respective governments. This is a clear indication that the commitment to fundamental rights and the democratic participation of all people has to continue if we want to overcome the HIV epidemic and also develop a more just and human world society.

Germany's insufficient contributions to the Millennium Development Goals need to be compensated by increased aid levels for the implementation of the 2030 Agenda

Since the period for the implementation of the Millennium Development Goals (MDGs) ended in 2015, the question has to be asked which contributions have been made by the better-off countries for the achieved partial success. A study prepared by the Medical Mission Institute in cooperation with Action against AIDS Germany has tried to find an answer to this question. The study focuses on the grants for Official Development Assistance (ODA) which, in contrast to loans, can be used for those countries and population groups most in need of assistance. Part B of the report presents the main results and conclusions. The study covers the contributions for the official development cooperation as a whole as well as financing in support of health care, HIV-control and the Global Fund.

Two results are of particular importance for the political debate in Germany. Firstly, the contributions of all 23 donor countries that have joined the Development Assistance Committee (DAC) of the OECD before 2013 remained far below the required level. Secondly, Germany's contribution, which was far below average, has caused a substantial part of this deficit.

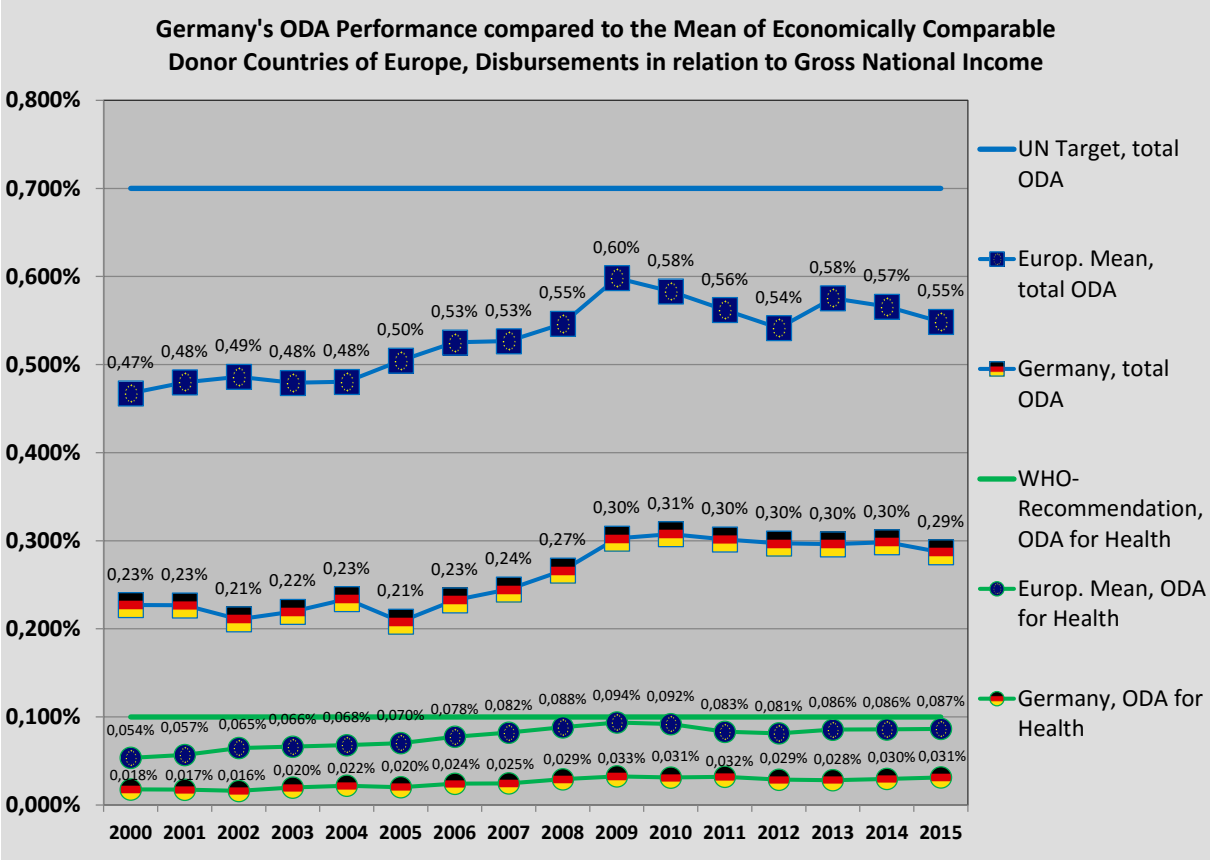
Throughout the MDG period from 2000 to 2015, the contributions of DAC countries for total development cooperation amounted to less than 0.24 percent of the combined economic capacity. This corresponds to just one third of the UN target agreed in 1970 of 0.7 percent of the Gross National Income (GNI). In order to improve the health situation, the DAC countries raised 0.038 percent of their collective GNI, i.e. less than two fifth of the aid level of 0.1 percent recommended by the WHO Commission of Macroeconomics and Health. This gives an indication of the opportunities to fight against poverty, hunger and diseases that were lost because many governments of rich countries did only insufficiently fulfil their obligations.

The overall result of donor contributions is considerably influenced by the particularly low performance shown by the USA and Japan, the two countries with the largest economic capacities. However, Germany has to be measured against the contribution level of comparable European countries. In this case, the reference value is the simple average of the ODA ratios of the 12 European DAC countries, which were less affected by the economic crisis.[1]

This group of countries recorded an average contribution level of around 0.53 percent for total ODA disbursements. In contrast, Germany's ODA grants merely amounted to 0.26 percent of the GNI and represented hardly half of the European average as a consequence. And of all things, Germany performed even worse when looking at the vital health contributions. Whereas the comparison group contributed an average of 0.079 percent, Germany's GNI ratio amounted to only 0.026 percent. Consequently, Germany raised less than one third of the average aid ratio of comparable countries and only reached hardly more than one fourth of the target level.

1 These are in alphabetical order: Austria, Belgium, Denmark, Finland, Ireland, Luxembourg, the Netherlands, Norway, Sweden, Switzerland and the United Kingdom.

As the graph below shows, Germany's backlog has hardly diminished over the years. However, European average contributions have decreased due to the economic crisis, whereas Germany's financial efforts have stagnated since then.



Germany's unsatisfactory performance resulted in substantial consequences for development and health financing. If Germany's total ODA grants during the MDG period had reached the European average level, this would have resulted in an overall amount of 209 billion euros. In reality, Germany contributed less than 104 million euros. And if Germany had raised its ODA grants for health to the average European level between 2000 and 2015, almost 31 billion euros would have been available. In contrast, the actual contributions added up to merely around 10 billion euros. The shortfall of almost 21 billion euros would be sufficient to provide for an entire period of two years the total international resources that according to latest estimates of UNAIDS are required to end the AIDS epidemic.

With 0.009 percent of the GNI between 2007 and 2015 for the response to the HIV epidemic, Germany's ODA contributions also only reached one third of the average value of the mentioned European donor countries. And up to 2016, Germany's contribution to the Global Fund of 0.0066 percent since its foundation, was also far below the European comparative figure of 0.0087 percent.

Demands by the civil society

Based on the available facts and analyses, Action against AIDS Germany sees the urgent need to further develop and correct central points of Germany's political and financial contribution in the vital areas of global health and the HIV response.

The realization of Sustainable Development Goals should not stay a mere lip service. Within the coming one and a half decades this endeavour has to be perceived as a core element of government action in all relevant policy areas. In order to achieve the envisaged targets of universal health coverage and the end of AIDS as well as of other devastating diseases, scientific and technical progress has to be oriented towards the basic needs of the world's population and all people should have full benefit from the respective results. Therefore, there should not be any further trade agreements allowing additional monopoly and extraordinary rights for private companies. Instead, based on the original UN Declaration of Commitment on HIV and AIDS, Germany should advocate for the critical review of the agreements carried out since the foundation of the WTO. Those provisions that have proven to be damaging to public health and other areas of services of public interest should be revised accordingly. The protection of human life should have definite priority over commercial and particular interests.

One of the most essential rectifications of the 2030 Agenda is the agreement on concrete and appropriate financing targets for Official Development Assistance

(ODA) overall as well as for essential funding areas such as health. Instead of postponing the fulfilment of the UN target of 0.7 percent of the GNI for the overall ODA contributions, a firm commitment is required to reach this target level by 2020. The same applies to the WHO recommendation to raise at least 0.1 percent of the GNI for improving the health situation in developing countries. Only then it will be possible to plan and initiate in a timely manner the measures that are required for the realization of the 2030 Agenda. Germany should commit to reach these financing targets without resorting to money from the capital market. Only grants from public budgets can be regarded as genuine contributions to development cooperation that are benefiting the particularly disadvantaged countries and population groups.

Since Germany has largely dodged behind other European donors regarding the financial efforts for the realization of the MDGs, policy makers are called to finally live up to the international responsibility and to make an appropriate contribution towards the implementation of the newly agreed Development Goals. In light of the historical involvement in colonial exploitation and due to the current realities of development financing, Europe should raise half of the required overall funding. This results in a European target level for the health ODA which exceeds by about one third the generally required contribution level of industrialized countries. On average, in recent years the five best-performing donor countries already reached this level of about 0.135 percent. Thus, Germany would have to raise its ODA grants for health by 2020 to 4.8 to 4.9 billion euros per year. An amount of about 1.3 billion euros would be assigned as a suitable share towards the costs for ending the AIDS epidemic. It is also necessary and fair to top up the contribution to the Global Fund to at least 400 million euros on average in the years to come.

Thus, Germany would be able to turn from a laggard to a forerunner for global health and would be regarded as a trustworthy partner in international negotiations in the search for solutions for the most urgent crises. The international community would come closer to the goal to also provide health services in those places with the heaviest burden of health risks and economic hardships.

Furthermore, Germany should use the newly won credibility to advocate for a global plan of action with the goal to provide access to vital health services for all people without running the risk of impoverishing the affected individuals and families. This necessarily includes the development of a qualitatively new funding model, which will overcome the insecurity of voluntary contributions and introduce a fair system of obligatory donations instead. The Global Fund could act as a role model and a breeding ground in this respect. This would facilitate the antici-

patory planning and consistent implementation of necessary interventions for the extension of comprehensive health systems and needs-oriented research. The international community cannot accept that people are dying because insufficient public revenues, lack of understanding of government representatives or the low purchasing power of the vulnerable population groups impede the access to effective prevention and treatment interventions.

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The international reference frame: Agreements of the United Nations and current status of the HIV epidemic

The new Agenda for Sustainable Development: Ambitious goals, modest commitments

In September 2016, the United Nations adopted the new Development Agenda entitled "Transforming Our World". After the period of the Millennium Development Goals has come to an end in 2015, the Agenda will serve as a framework of guidance for worldwide politics until 2030. It has a global aspiration in a double sense as it is supposed to comprise all countries as well as all areas of action. And it is considered to represent an action plan to eradicate extreme poverty in all its forms and dimensions as well as to preserve natural resources.

Action against AIDS Germany has constructively participated in the more than two-year long debates, which preceded the adoption of the Agenda. We attempted to keep track of all important aspects regarding the HIV response. We especially advocated that the Agenda includes the end of the AIDS epidemic as well as universal coverage with essential health services as critical targets. Equally, we urged the economically privileged countries such as Germany to establish a binding commitment regarding their financial contribution for human development and health promotion of the disadvantaged countries and population groups as a much needed demonstration of global solidarity.

Contradiction between human development and maintaining the status quo

When taking stock of the results, unfortunately, these can only be regarded as ambivalent at best. It is true that the Agenda includes essential insights, appropriate principles and ambitious individual targets. However, their realization is put in jeopardy by the fact that the majority of government representatives has blocked any type of specific obligations in order to raise the required financial resources and to overcome unjust social structures. Without the drastic redistribution of resources, incomes and power it will neither be possible to control the HIV epidemic nor to effectively confront other threats for the future of mankind.

The positive results include the maxim established in the preamble to ensure that all human beings can fulfil their potential for development in dignity, equality and in a healthy environment. This is in line with the fundamental policy orientation we are calling for to secure that all people – including future generations – will be able to lead a long, healthy and self-determined life. Goal 3 of the 17 Development Goals is directly devoted to the topic of health and is to ensure healthy lives for all people at all ages. The respective targets also comprise the end of the AIDS epidemic and refer to the issues that are relevant for confronting HIV such as universal access to services of sexual and reproductive health, universal health coverage, the possibility to use to the full the safeguard provisions of the TRIPS Agreement as well as the required increase of financial and personnel resources.

Required policy changes are not addressed

One of the most serious deficits is the fact that Germany and other wealthy countries have overturned the commitment to raise at least 0.7 percent of the GNI for Official Development Assistance by 2020. What fits in with this scandal is the refusal to agree on a concrete target for health financing. The commitments for the reduction of social injustice, which is a major cause for the exposure to HIV and other health risks, fall far short of what is required. Finally, the action approaches aiming at social participation, fail to explicitly mention the discrimination based on sexual orientation.

Sustainable development goals

Goal 1. End poverty in all its forms everywhere

Goal 2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture

Goal 3. Ensure healthy lives and promote well-being of all at all ages

Goal 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

Goal 5. Achieve gender equality and empower all women and girls

Goal 6. Ensure availability and sustainable management of water and sanitation for all

Goal 7. Ensure access to affordable, reliable, sustainable and modern energy for all

Goal 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all

Goal 9. Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation

Goal 10. Reduce inequality within and among countries

Goal 11. Make cities and human settlements inclusive, safe, resilient and sustainable

Goal 12. Ensure sustainable consumption and production patterns

Goal 13. Take urgent action to combat climate change and its impacts

Goal 14. Conserve and sustainably use the oceans, seas and marine resources for sustainable development

Goal 15. Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss

Goal 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels

Goal 17. Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development

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The new UN Declaration on HIV and AIDS: Will the endeavour to end to the most evastating epidemic fail because of the ediocrity of policy makers?

In June of 2016 almost exactly 15 years after the first UN Declaration on HIV and AIDS and five years after the last Political Declaration on this issue, the United Nations adopted a new Declaration with the immodest title "On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030". This Agreement was reached at a High-level Meeting following months of negotiations of the member countries. The Agenda serves to define appropriate strategies that allow the international community to control AIDS as a threat to public health. In his opening speech, the President of the UN General Assembly, Mr. Mogens Lykketoft (Denmark), rightly called this endeavour one of the greatest achievements we will be able to realize in our lifetime. The new Agenda represents an important complement to the 2030 Agenda for Sustainable Development that had been adopted the year before. Unfortunately, both have the immanent contradiction in common that they contain, on the one hand, appropriate individual goals and correct insights, whereas, on the other hand, the commitments for the necessary financial efforts and socio-political changes have remained far too vague. As a consequence, the international civil society is confronted with a dual task now: it has to urge government representatives to achieve the former and, simultaneously, to amend the latter.

Correct insights and blind spots

The Declaration recognizes that the HIV epidemic still has to be perceived as a global emergency situation constituting one of the most formidable challenges for human development and causing immense human suffering. The Declaration also states that the spread of HIV is closely linked to poverty and inequality. It also em-

phasizes fundamental principles such as the respect for human dignity and the participation of people living with HIV, affected by the epidemic or exposed to an increased infection risk. Finally, the Agenda underlines that the fight against HIV should be an integral part of the efforts for sustainable development and the realization of the fundamental right for everyone to the enjoyment of the highest attainable standard of physical and mental health. However, this description of reality also remains contradictory in itself. On the one hand, the Declaration addresses central social causes of the spread of HIV such as the disadvantage faced by girls and women or the discrimination against drug users. On the other hand, the Declaration avoids mentioning equally important social determinants such as the marginalization of sexual minorities or the often precarious living conditions of people forced to migrate in search of work or having to flee.

The Declaration confirms the end of the AIDS epidemic by 2030 as the overall goal, which is also described as a legacy to present and future generations. It also emphasizes the significance of international cooperation in order to achieve this goal as well as all other health-related development goals. In this context, the Declaration also mentions the principles of global solidarity, joint responsibility and political leadership. Regarding the decisive principle to protect the human rights and the fundamental freedoms of the individuals affected or threatened by HIV, the now agreed formulation falls behind the original 2001 Declaration in terms of clarity. This document states that the full enjoyment of these rights must be ensured; the present document, however, is much less conclusive affirming that people living with HIV or threatened by the virus should enjoy all these rights.

Decisive steps until the end of the decade

The concrete and verifiable targets are referring to the time period up to 2020 when the decisive breakthroughs to overcome the epidemic should be achieved. The Declaration states as the overarching targets, in accordance with the Fast Track Initiative of UNAIDS, that the worldwide new HIV infections and AIDS-related deaths should be reduced to 500,000 each per year. This would mean that less than 1,400 people would get infected with HIV per day and just as many would die from an HIV infection instead of the close to 5,800 new infections respectively 3,000 deaths recorded in 2015. The Declaration also requests to eliminate stigma and discrimination related to HIV.

Moreover, the Declaration mentions five strategic areas of action where progress has to be made in order to achieve the set targets. These are in the originally selected sequence: the mobilization of additional financial resources, the access

to testing and treatment programs, gender equality, the access to measures and instruments of prevention as well as overcoming stigma and discrimination in connection with HIV. Notably, the sections in the document demanding concrete pledges from government representatives contain the most substantial deficits.

Insufficient obligations for financial contributions

The strategic section on financing first of all includes a commitment that the investments for HIV control in developing countries have to be increased and that an overall volume of at least 26 billion US$ per year should be provided by 2020, which is in line with the current UNAIDS resource needs calculations. However, there is no mention of the proposed target level suggested by the United Nations regarding official development cooperation to support the HIV programs in the amount of 11.6 billion US$ in 2020 – i.e. merely 45 percent of the overall requirement. Thus, the economically privileged countries are abdicating their global responsibility and they are missing the great opportunity to take, for the first time, the necessary steps towards a financing model of global health based on mutual rights and obligations. And yet, the overall needs estimate as well as the share of international cooperation has been calculated rather conservatively and is only suitable if the favourable forecasts such as further declining prices for drugs and substantially increased domestic financing efforts by developing countries will become a reality.

The fatal attitude of denial adopted by some governments of rich countries is also reflected in the fact that the Declaration incorporates the dilution of the overarching financing goal for Official Development Assistance (ODA) as it has been imposed since the Conference on Financing for Development in July 2015. While the respective October 1970 UN Resolution clearly states that each economically advanced country must increase its ODA contributions to at least 0.7 percent of the Gross National Income, this formulation was watered down by stating that "many" industrialized countries had made this commitment. The weakening of the statement can also be found in a similar form in the target 17.1 of the 2030 Agenda. Finally, the Declaration pledges to mobilize 13 billion US$ for the Global Fund, which corresponds to the Fund's own estimate of the resources needed for the upcoming replenishment period, but fails to give any indications of the fair level of contributions that the economically better-off countries should reach.

No specific statement on public funding of medical research

The agreements regarding the access to therapy initially confirm the planned UNAIDS targets that by 2020 at least 90 percent of people living with HIV should know their infection status, 90 percent of the persons knowing their infection status should be receiving antiretroviral treatment and 90 percent of the individuals on therapy should achieve a reduction of the viral load below the limit of detection. By the end of the decade, 30 million adults worldwide over 15 years of age are to receive a therapy and already by 2018 a total of 1.6 million children should be involved in effective treatment programs. These numerical targets correspond with the scheduled percentage values provided that the envisaged decline in new infections will be achieved and thus the number of people living with HIV will increase at a slower rate than in recent years. The access to treatment for pregnant and nursing women as well as for their partners aims to eliminate HIV transmission to new-borns and children.

The Declaration also confirms the full use of the safeguard provisions, which are included in the TRIPS Agreement and which are further defined in the Doha Declaration, allowing the WTO Members to restrict patent rights on drugs and other products required for public health. Other than the original Declaration, the new Declaration fails to acknowledge the necessity to thoroughly evaluate the impact of the WTO rules and of other trade agreements on access to drugs. A concrete commitment is also missing regarding the increase of funding for public research required in order to orient the development of innovative active substances and dosage forms to the needs of the disadvantaged majority of the world's population.

Social marginalization of key groups is being hushed up

In the section on gender equality, the Declaration requests that the respect for, the protection and the promotion of human rights for women should be regarded as a central task of all policies and programs. Consequently, the Declaration also demands to eliminate all forms of inequality as well as gender-based abuse and violence. Additionally, the universal access to comprehensive services of sexual and reproductive health as well as HIV prevention and treatment are part of the agreed obligations. In this context, it is also demanded to address the problematic norms that induce risk-taking behaviour among men. Finally, by 2020, the global number of annual new infections of girls and young women between the ages 15 and 24 is to be reduced to below 100,000, which coincides with the general prevention target as this population group currently accounts for 20 percent of all infec-

tions. Although the explanations regarding this field of action recognize that the socio-economic discrimination of women limits their possibilities to protect themselves from HIV, the document does not mention any concrete strategies to purposefully improve their social situation. Furthermore, the Declaration ignores the connection between problematic gender norms and social marginalization of people based on their sexual orientation, even though this relation is essential with regard to the challenge posed by HIV.

Neglecting particularly affected people undermines HIV prevention

The following section on prevention efforts demands to take all measures in order to implement evidence-based, comprehensive and non-discriminatory initiatives. The UN member countries also committed themselves to provide adolescents and young adults with scientifically accurate and complete information on sexual and reproductive health as well as protective measures against HIV. Special attention should be paid to the regions with increased infection rates and the key populations with the highest risk of infection, that are to be supplied with especially tailored interventions. All appropriate steps should be taken in order to ensure that 90 percent of the people threatened by HIV will be reached through prevention programs.

The prerequisite for the implementation of these commitments is obviously to mention those population groups with the highest infection risk due to their social situation characterized by discrimination and criminalization, including men who have sex with men, transgender people, injecting drug users and sex workers. The denial of reality and the inhumane attitude by some governments still go as far as attempting to block the reference to key populations in the Declaration and being successful in doing so. These blinders make it difficult to implement targeted and effective prevention work.

Inadequate political will to overcome discrimination

This blockade carries on in the next section dealing with the issue of eliminating the discrimination related to HIV. Although the document states that addressing stigma and discrimination is a critical element in the effort to control HIV and that violence against people affected or vulnerable to HIV infection has to be prevented. Even in this passage, however, the declaration avoids mentioning those key populations that are most affected by and at risk of HIV. Consequently, there is no commitment to support these people, to overcome social marginalization and

to finally reduce the risk of infection in an effective way. This deficit does not only endanger the effectiveness of HIV prevention and treatment, but it also hampers human development as a whole.

Continued demand for comprehensive participation is obligatory

Yet another section of the Declaration covers the central aspect of the participation of people affected and threatened by HIV as well as other persons involved. This passage points out that at least 6 percent of the total funds need to be provided for interventions that impact the social environment and thus enhance the capacity to act of the people. This includes political advocacy, public communication as well as efforts for the promotion of human rights and law reforms. However, such a specification of a percentage rate only makes sense if the mobilized resources for the control of HIV will achieve the overall required volume. Furthermore, regarding the development and implementation of action strategies, the document does not include the commitment to the full and active participation by people with HIV, the members of vulnerable groups and the people most at risk in the design, planning and implementation of the strategies for action.

The Declaration again repeats the necessity of strengthened research in order to provide appropriate diagnostics, more effective prevention commodities as well as more efficacious and more tolerable medical products. In this context, ways are also to be explored to delink development costs from product prices. Again the government representatives avoided accepting the obvious necessity to increase public funding for research and to include a respective commitment. The agreements on the issue of technology transfer and regarding the building of local capacities for the production of pharmaceutical products, the development of an infrastructure for health research as well as the collection of relevant data remain rather vague and merely refer to voluntary activities.

Targets for different world regions

For the first time, the current Declaration contains individual targets for prevention and treatment for the world regions as defined by UNAIDS. These targets are listed in the tables below in order to enable an easier overview and a comparison with the current baseline figures. However, the sum of regional targets remains below the commitments for global efforts, so that adjustments in this regard are required as well.

Current Estimates and Regional Targets: Number of New HIV Infections (in Thousands)

UNAIDS Regions	Adults (15 years and older)		Children (0 to 14 years)		All Age Groups	
	2015	2020	2015	2020	2015	2020
Asia and the Pacific	276,0	88,0	19,0	1,9	295,0	89,9
Eastern Europe and Central Asia	185,0	44,0	0,8	0,1	185,8	44,1
Eastern and Southern Africa	906,0	210,0	56,0	9,4	962,0	219,4
Western and Central Africa	346,0	67,0	66,0	6,0	412,0	73,0
Middle East and North Africa	19,0	6,2	2,1	0,2	21,0	6,4
Latin America and the Caribbean	100,0	40,0	2,1	0,5	102,0	40,5
Western and Central Europe and North America	91,0	53,0	0,6	0,2	91,6	53,2
Worldwide	**1.923,00 €**	**508,20 €**	**145,0**	**18,3**	**2.069,4**	**526,5**

Baseline figures for 2015 are based on data provided through UNAIDS Databases (AIDS Info)

Current Estimates and Regional Targets: People on Antiretroviral Treatment (in Thousands)

UNAIDS Regions	Adults (15 years and older)		Children (0 to 14 years)		All Age Groups	
	2015	2020	2015	2020	2015	2020
Asia and the Pacific	1.991,0	4.100,0	79,0	95,0	2.070,0	4.195,0
Eastern Europe and Central Asia	313,0	1.400,0	–	7,6	313,0	1.407,6
Eastern and Southern Africa	9.594,0	14.100,0	658,0	690,0	10.252,0	14.790,0
Western and Central Africa	1.731,0	4.500,0	99,0	340,0	1.830,0	4.840,0
Middle East and North Africa	36,0	210,0	2,0	8,0	38,0	218,0
Latin America and the Caribbean	1.072,0	1.600,0	20,0	17,0	1.092,0	1.617,0
Western and Central Europe and North America	1.414,0	2.000,0	–	1,3	1.414,0	2.001,3
Worldwide	**16.151,0**	**27.910,0**	**858,0**	**1.158,9**	**17.009,0**	**29.068,9**

Baseline figures for 2015 are based on data provided through UNAIDS Databases (AIDS Info)

Accountability of the UN Member Countries

Finally, the Declaration calls for the creation of transparent and participatory mechanisms in order to be held accountable to each other and to monitor the implementation of the agreement. For this purpose, up-to-date and differentiated data needs to be compiled informing about new infections, people living with HIV, the size of particular population groups as well as the allocation of resources. UNAIDS is expected to continue rendering support to countries in the implementation of comprehensive multi-sectoral approaches, however, omitting any reference

to the required financial assistance. The organization is also to support the UN Secretary General in the compilation of an annual report on the implementation of the commitments. Moreover, the UN System shall ensure that the realization of the commitments on the HIV response laid down in the Declaration will feed into the review processes of the 2030 Agenda. Finally, it was decided to convene a UN High-Level Meeting on the efforts to end the AIDS epidemic. At the latest, an agreement on the date should be reached during the 75th session of the General Assembly, i.e. in 2020/2021.

Joachim Rüppel, Spokesperson of the Catholic Section of Action against AIDS Germany and Consultant with the Medical Mission Institute in Würzburg, Germany.

Global Challenges and Strategies to end the AIDS epidemic by 2030

Latest estimates by UNAIDS on past trends and the current status of the HIV epidemic show that the prevention and treatment efforts have achieved significant progress. Yet, these estimates also demonstrate that the global community must not stop halfway but needs to enhance its efforts in order to end AIDS as a threat to public health and human development by 2030.

Extending the access to antiretroviral therapy represents one of the most important achievements. Worldwide, 17 million people received this life-preserving treatment in December 2015. With a total of 36.7 million people, who were living with HIV at the end of 2015, this corresponds to a coverage rate of 46 percent. In comparison, only 7.5 million people globally were accessing therapy in the year 2010. With the expansion of treatment programs, it has been possible to decrease HIV-related deaths by 45 percent. Whereas in 2005, when mortality had reached its deplorable peak, about 2 million people died of AIDS-related causes, in 2015 there were still 1.1 million deaths from HIV. Thus, HIV together with Tuberculosis is still the deadliest infectious disease.

Quite remarkable results have also been achieved in the prevention of vertical transmission from pregnant women or lactating mothers living with HIV to their new-born children. Between 2010 and 2015 alone, the number of new infections among children has dropped by almost half from 290,000 to 150,000. Recently, 77 percent of pregnant women living with HIV received antiretroviral medicines in order to prevent transmission to their babies. Regarding the prevention of new infections among adolescents and adults, however, the decline has slowed down again. Every year 1.9 million people older than 14 years become infected with HIV. New infections have risen considerably in Eastern Europe, Central Asia, in the Middle East and in Northern Africa. Due to the – even still growing – difference be-

tween new infections and the number of deaths, the total of people living with the virus has increased by 3.4 million since 2010.

With a total of 19.1 million, more than half of the people with HIV live in South and East African countries. Due to its structural conditions rooted in colonialism such as massive migration in search of work and extreme social injustice, this region has been hit exceptionally hard. While the global infection rate in the age groups between 15 and 49 years is at 0.8 percent, the prevalence in this region amounts to an average of 7 percent, and even exceeds 20 percent in three countries.

The share of women among adolescents and adults living with HIV is estimated at 51 percent. However, regarding the new infections currently occurring among people older than 14 years, with a proportion of only 47 percent, women account for less than half of the total, which is most likely due to the higher access rate to HIV services. This difference is demonstrated, e.g. by the higher treatment coverage among women of 52 percent compared to 41 percent among men.

Since the beginning of the epidemic, more than 78 million persons have become infected with HIV and 35 million individuals have already died from AIDS-related illnesses. Presently, there are 5,700 new infections per day, two thirds of them occur in African countries south of the Sahara.

According to UNAIDS estimates, about 19 million US$ have been raised in 2015 to confront the HIV epidemic in developing countries. With a total of 57 percent, low and middle-income countries have contributed the largest part from domestic sources. The group of upper middle-income countries accounted for close to half of the total funding.

The Fast Track Strategy for an end to AIDS by 2030

Within the framework of the Agenda for Sustainable Development adopted in September 2015, the United Nations have pledged to end the AIDS epidemic by 2030. Simultaneously, UNAIDS has developed the Fast Track Strategy pointing out concrete action approaches in order to achieve this major goal.

The coming years will be decisive, as substantial progress has to be made by 2020:

- 90 percent of people living with HIV are to know their HIV status,
- 90 percent of people with a positive test result are to receive access to an antiretroviral combination therapy and
- In 90 percent of the cases treatment is to permanently reduce the viral load below the detection limit.

By 2030 the respective proportions shall increase to 95 percent.

Thereby, in combination with the targeted preventive measures, the annual number of new infections is to decline to less than 500,000 by 2020 and then to further decrease to less than 200,000 by 2030. These interventions are to also ensure that AIDS-related deaths will be reduced to a similar level. Compared to a scenario in which the programs remain at the coverage rates seen in 2014, UNAIDS calculates that the intended interventions will hold the potential to prevent 17.6 million new HIV infections and 10.8 million AIDS-related deaths in the coming one and a half decades. An obligatory prerequisite to do so is the elimination of discrimination against people living with HIV or those, who are especially vulnerable due to their social situation.

Building on previous progress and facing challenges!

The continuous treatment with antiretroviral medicines allows people with HIV to have a similar life-expectancy as HIV-negative people. This can be achieved through good health care with regular medical check-ups and suitable therapy support. Nowadays, nobody has to die of AIDS any more. The effective therapy also makes sexual transmission of HIV unlikely and thus it constitutes an effective means of prevention. This requires reducing the viral load, i.e. the number of copies of HIV in blood and other body fluids, so that it is no longer detectable.

The current guidelines of the World Health Organisation advise that people living with HIV should immediately start therapy. Yet, current surveys show that more than half of them are not even aware of their status.

Apart from the preventive effect of the therapy, other scientifically proven strategies also contribute in the prevention of new infections. In order to stop the epidemic, better tailored programs are needed for those people who are most vulnerable due to their social living conditions. And the preventive efforts need to be increased considerably. Even in countries seriously affected by HIV, hardly 40 percent of young men and 30 percent of young women have sufficient knowledge to correctly identify HIV transmission routes and preventive interventions.

Men having sex with men, transgender, sex workers and drug users are marginalized and criminalized in many societies. Also people living with HIV and AIDS are frequently stigmatized and discriminated. This makes it difficult to openly address the infection risk or the diagnosed infection. The often justified fear to be discriminated prevents people to visit counselling and testing facilities or treatment centres. All of this fuels the spread of the virus, raises the risk of resistances to antiretroviral medicines and excludes people from participation in society. But,

in many instances, self-help and solidarity succeeded in eliminating negative reactions and discriminative laws.

In order to achieve the envisaged goals, which have meanwhile also been adopted by the United Nations, the total expenditures for HIV prevention and treatment in developing countries have to be increased to 26.2 billion US$ by 2020. The countries themselves are expected to make additional efforts in order to increase domestic resources. Yet at the same time, the volume of official development cooperation has to be considerably raised to 11.6 billion US$ to close the financing gaps. However, if the efforts to reduce new infections and to also achieve further decreases of treatment costs will not achieve the expected results, the need for financial resources would be rising significantly.

The international community is able to end the AIDS epidemic until 2030 by implementing the presently available strategies and approaches of action. **Global efforts have now to be increased considerably in order to achieve this goal.**

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Peter Wiessner, Advocacy and Public Relations Officer, Action against AIDS Germany

Viktoria Rappold, Committee Work and Public Relations Officer, Action against AIDS Germany

Sources: Current UNAIDS Publications

Part A: Germanys political engagement for global Health and HIV response

The Coalition Agreement of the German Government: from words to deeds!?

When the two German parties with the highest number of votes – the Social Democratic Party (SPD) and the Christian Democratic Union (CDU) commenced their coalition negotiations for the 18th Bundestag in autumn 2013, the position of the social democrats was actually crystal clear: Their election programm stated that in case of a SPD-participation in any government the financial resources towards development cooperation would be increased every year by one billion Euro until the so-called 0.7 percent target[2] had been reached. The proposed 4 billion Euro increase at the final year of the legislation period[3] would have been a significant step towards the ODA target, though it would not have not been enough to actually fulfil the target. All in all, the additional funds from 2014 to 2017 would have added up to 10 billion Euro according to the election program of the Social Democratic Party. During the negotiations, Action against AIDS Germany mobilised its members and proposed arguments to both negotiating parties regarding the prominent placement of the issues of health and especially the fight against HIV & AIDS as fought by the Global Fund in the Coalition Agreement.

2 Reference value of the 1970 UN Resolution by which the economically privileged countries should at least provide 0.7 percent of their Gross National Income (GNI) for Official Development Assistance – ODA).

3 Page 10 of the SPD Government Program: **https://www3.spd.de/linkableblob/96686/data/20130415_regierungspro-gramm_2013_2017.pdf**

Promising Statement on the Global Fund included in the Coalition Agreement

And successfully so! The Coalition Agreement reads: "Health constitutes the basis for sustainable development. The Global Fund plays an important role, which is to be reflected in Federal Government policy."[4] For

4 On page 182 of the Coalition Agreement: **https://www.bundesregierung.de/Content/DE/_Anlagen/2013/2013-12-17-koalitionsvertrag.pdf?__blob=publicationFile**

the first time in recent German history, a Coalition Agreement of the Federal Republic of Germany recognized the enormous significance of health in developing countries and also acknowledged the related fundamental importance of the Global Fund. It has to be emphasized that not only the responsible Ministry for Economic Cooperation and Development but also the German Government itself were to be held accountable. Thus, comprehensive interventions of far-reaching significance were to be expected. In addition, in those years the international community was negotiating a new global action framework, the now called Sustainable Development Goals (SDGs) or 2030 Agenda, that were building on and exceeding the Millennium Development Goals, which expired in 2015.

And what were the results? This question can unfortunately be answered quite clearly. A substantial increase of the contribution by the Government coalition failed to materialize. Germany's contributions for the promotion of international health, just as the contribution to the Global Fund, have only risen slightly. The only ray of light was the increase of Germany's contribution to the global alliance for vaccines and immunisation (GAVI). Otherwise, Germany's actual contributions towards global health and especially HIV and AIDS, as already extensively analysed in the financial part of this report, remained far below the average of other donors. But why?

Initial foresight is followed by political short-sightedness

Of course this question can only be answered partially. Part of the answer certainly lies in the coalition partners' self-inflicted cut of financial resources. The SPD quickly sacrificed its campaign promise of a significant step towards realising the 0.7 percent financing target to peace within the coalition. Instead of deciding on an increase of development funds by 10 billion euros throughout the legislative period, merely one fifth of this amount was agreed and this apparently only happened due to a direct intervention by Chancellor Merkel, who seemed to fear a decline of the ratio. "I am grateful to the CDU Leader, although in my eyes for that she has not become a heroine in regards to the ODA ratio," wrote the SPD Development Policy Spokesperson, Dr Sascha Raabe disappointment and resigned his post.[5]

In a time of rising tax revenues the world's fourth-largest national economy has effectively deprived itself of possible actions for the implementa-

5 **http://www.sascha-raabe.de/meldungen/29823/152503/Erklaerung-zum-Abschied-als-entwicklungspolitischer-Sprecher.html** Note: the actual extent of additional funds for development cooperation as a result of the replenishments of the he Budget of the Ministry for Development Cooperation in 2014, 2016 and – acc. to the draft agreement – 2017 will be significantly higher. Thus a partial correction has taken place. One fifth, i.e. 2 billion euros had already been achieved in 2014 and 2016.

tion of the developmental part of the Coalition Agreement. Consequently, the fine words about the significance of health as a basis for human development and the role of the Global Fund fell victim to this self-restriction. It should be noted that German civil society has always advocated for an increase of Germany's contribution in the fight against AIDS within the framework of a significant ODA increase in order to avoid cutbacks in other sectors of development cooperation in favour of strengthening global health.

The transition from MDGs to SDGs falls into the present legislative period of the 18th Bundestag. While still three of the eight Millennium Goals targeted at improving concrete but also isolated health chapters – maternal and child mortality as well as AIDS, Tuberculosis and Malaria – the new global framework of health is interconnected with all 17 goals. The 2013 Coalition Agreement already included an anticipatory comment on global health. But this originally foresight was followed by political short-sightedness.

The fight for political will to provide affordable access to health for all continues!

During the upcoming election campaign, it will fall to the German civil society – together with Action against AIDS Germany – to insist that neglected electoral promises will be made up for, that Germany's future development policy will be put within the framework of the 2030 Agenda and the existing deficits regarding the financing of the Global Fund and health financing in general will be remedied. It has to be a central goal to provide appropriate and fair contributions in order for everyone to get affordable access to the health care they need. The financial resources are available, yet political willpower is still lacking to use these funds. The mobilisation of this political willpower will be the primary task of all development actors.

Marwin Meier, Manager Health & Advocacy, World Vision Germany

HIV-Strategies of the German Federal Government from 2012 to 2016

In 2012, the Federal Ministry for Economic Cooperation and Development (BMZ) published its strategy paper on HIV: 'Germany's Contribution to a Sustainable HIV Response – a BMZ Position Paper'. In this paper, Germany commits itself to working towards universal access to HIV prevention and treatment in order to achieve Millennium Development Goal 6. It also mentions the commitment made in 2007 to provide 8 billion euros from 2008 to 2015 for the fight against HIV, Malaria and Tuberculosis as well as for the required strengthening of health systems. As this policy paper was written by the BMZ, its focus is on the international HIV-response; Germany's national situation is hardly mentioned in this paper.

In April 2016, the German Cabinet adopted the 'Strategy for Combating HIV, Hepatitis B and C and other Sexual Transmitted Infections'. As this paper was written under the leadership of the Federal Ministry of Health, the focus lies on the situation in Germany. Only 5 of the 28 pages deal with the international situation of HIV.

Waning importance of HIV in policy papers

While the 2012 document still assigns an exceptional position to HIV in the area of development cooperation, the 2016 paper does not do this any longer. The efforts made in the 2016 paper to increasingly integrate HIV into the strengthening of health systems carries the risk that HIV will become invisible. This counteracts the necessity that Germany intensifies and widens its efforts to contribute to the internationally agreed sustainable development goal for an end to AIDS by 2030. This goal is also mentioned as a reference point in the policy paper published in 2016.

The statements on multilateral and bilateral development cooperation for an adequate HIV response point towards certain tendencies. At a multilateral level, the 2012 strategy underlines the importance of supporting the Global Fund and the World Health Organisation (WHO). These important multilateral organisations are also mentioned in the 2016 strategy so that a continued relevance can be perceived. However, this is hardly reflected in Germany's multilateral financial contributions. Apart from the GAVI Replenishment Conference in early 2015, when the German Government considerably increased its contribution (to 600 million euros by the year 2020 or up to 120 million euros p.a.), no further sustainable increases of the contributions for multilateral financing tools could be detected. Since 2008, when Germany increased its contribution to the Global Fund to 200 million euros per year, Germany's financial support to the Global Fund has not been raised significantly. A one-time increase for 2014 to 245 million euros was unfortunately not continued in subsequent years and also did not result in a Declaration of Commitment for a higher German contribution. In 2016, the direct contribution merely amounted to 210 million euros.[6] The increase announced in September 2016 unfortunately is more of a one-off contribution than a long-term increase, as 100 dollars of the 200 dollar increase over the 3 year period are due to debt-to-health swaps and a further 25 million dollars refer to technical assistance which Germany so far has not calculated into its contribution to the Global Fund. The net increase for the years 2017-2019 therefore boils down to 25 million dollars p.a. Less economically strong European countries such as France and the United Kingdom have meanwhile surpassed Germany, so that Germany only comes fourth in terms of the Global Funds' most significant donor countries; the German contribution lags far behind Germany's economic power. At the same time, Germany has accepted more responsibility and has become more involved in the supervisory boards of these multilateral instruments (Global Fund, GAVI and UNAIDS). It has furthermore included a civil-society representative in the Government Delegation for the Global Fund. Whilst we welcome the additional responsibility that Germany has taken on in the supervisory boards of these important institutions, this should go hand in hand with an increased financial contribution. Since the financial resources of UNAIDS have meanwhile also tumbled, an adequate financial provision for WHO and UNAIDS as important coordination bodies for health and HIV should have high priority for Germany.

6 See also the comparative study on the contributions to the Global Fund in the respective chapter of Part B of the report.

Within the bilateral development cooperation, HIV seems to be losing ground. While the 2012 strategy mentioned 12 partner countries and 2 regions with regard to health, HIV and family planning and additionally the support of health-related

activities in another 23 countries, the 2016 publication only listed 11 partner countries and 2 regions as well as 14 countries where further health activities will be promoted. It is especially difficult to comprehend that the key focus of HIV in the bilateral cooperation with the Ukraine has been dropped. The Ukraine not only had to struggle with the Russian Annexation of its Crimea Peninsula, which resulted in the shutdown of the methadone programmes there, it also had to cope with the occupation of the eastern parts of the country, which led to difficult circumstances there, especially in the health sector. The Ukraine already had a generalized HIV epidemic that grew even worse through the internal displacement of many people. One does not get the impression that the urgency to end AIDS, which is even mentioned in Germany's 2016 strategy, is followed up by adequate action.

Meaningful involvement of civil society in the 2012 strategy – however the invitation to participate left a lot to be desired in 2016

As far as other contents go, there is not much divergence between the 2012 and 2016 papers. The realization of human rights plays a central role in both documents. The 2012 policy paper has been commented on by civil society and especially by Action against AIDs Germany during various stages of the paper's development so that the involvement of civil society can be regarded as quite successful. By contrast, there was only one short meeting with civil society during the development phase of the 2016 strategy. We are particularly dismayed that passages, which dealt with patents, research and development of affordable medication as well as the harmful impact of free trade agreements, had been completely deleted from the text.

The focus of Germany's HIV strategy and commitment remains in the area of prevention – an important topic in the field of HIV, even if prevention and treatment should be seen as belonging together. Global new infections have hardly decreased in recent years – in 2015 2.1 million people got infected with HIV –200 000 more than in 2012! Only with regard to the lower number of new infections among children did we see progress in 2015.

The systematic combination of preventive measures, as promoted by the German Government and programs for key populations still play an important role in HIV prevention. It might have to be examined whether social marketing of condoms achieves better results than free distribution. The focus on private sector investment might not be conducive to reaching the goal of increasing condom usage.

Gender equality is also an important factor in the prevention of infections. It is extensively described in the 2012 as well as in the 2016 documents. However, the

older strategy recommends explicitly the increased participation of men and boys, which cannot be said for the recently published strategy.

The 2012 Strategy mentions the following key issues regarding Germany's HIV commitment:

- Promoter of the global political framework: HIV should be regarded as the priority task of the international community.
- Supporter of sustainable HIV-strategies.
- Initiator for a supportive political and social environment.

As described in our article "Significance of Health and HIV in Government Statements by Angela Merkel ", hardly any of the Government statements addressed the issue of HIV, so that the first key issue does not seem to have been taken very seriously. In the field of bilateral development cooperation, HIV was also no longer a priority in many countries. Furthermore, Germany slipped from third to fourth place in the ranking of absolute contributions to the Global Fund. Unfortunately, there is still a big gap between policy papers and their respective implementation.

Astrid Berner-Rodoreda, Spokesperson for the Protestant Organizations of Action against AIDS Germany and HIV Policy Advisor, Bread for the World

Frank Mischo, Advocacy and Public Awareness Officer, Kindernothilfe, Germany

Significance of Health and HIV in Government Statements by Angela Merkel

The significance of an issue for German politics can also be seen by whether or not it is mentioned in Government statements on a regular basis. Between May 2011 and April 2016, Chancellor Merkel delivered 19 statements. German Government Statements, which contain developmental and health-related aspects, are listed below:

HIV has not been mentioned once in 5 years!

In her speech at the MDG Summit in September 2015, Chancellor Merkel had made the following promising comments on the Global Fund: "One successful example is the Global Fund to Fight AIDS, Tuberculosis and Malaria, a multilateral instrument which has proven itself. The help provided by the Fund reaches people directly. Germany is the third-largest donor and I will work to ensure that Germany continues to support the Fund and the efforts to improve global health at a high level." It is alarming that that not a single Government Statement by the Chancellor throughout the entire 5-year period even mentioned HIV and Germany's financial contribution in that regard.. Global health also does not play a part in the German Government Statements of 2011 and 2012. In her statement during the EU-Africa Summit in 2014, the issues of HIV, infectious diseases and health find no mention. This is shocking, as Africa is still the continent most affected by HIV: In 2015, 70 percent of all people living with HIV lived in Africa and almost 70 percent of all AIDS-related deaths worldwide occurred in Africa.

Only four Government Statements (June 2014, May and September 2015 and March 2016) address the health issue. The 2016 statement mentions the issue of health in relation to refugees. The statement's main thrust, however, is the visible

and long-term reduction of the number of refugees coming to Europe and Germany[7]; this position led to the questionable compromise with Turkey.

7 16 Mar 2016

In June 2014, the German Government Statement covered issues of trade, mother and child health and the GAVI Replenishment Conference. The German pledge for GAVI in January 2015 exceeded expectations. It had taken some time for the German Government to realize that the contributions up to then had been too low and needed to be increased. One can only hope that the same will be applied to Germany's Global Fund contributions, which have not changed much since 2008 despite the fact that global needs have increased dramatically and other donor countries have raised their contributions.

Government Statements by Chancellor Merkel

- 26 May 2011 on G8-Summit taking place on 26/27 May 2011 in Deauville
- 10 May 2012 on G8-Summit taking place on 18/19 May 2012 in Camp David and NATO-Summit taking place on 20/21 May 2012 in Chicago
- 14 Jun 2012 on G20-Summit taking place on 18/19 Jun 2012 in Los Cabos (Mexico)
- 18 Dec 2013 on the European Council taking place on 19/20 Dec 2013
- 29 Jan 2014
- 20 Mar 2014 on a. o. EU-Africa Summit taking place on 2/3 Apr 2014
- 4 Jun 2014 on G7 Summit in Brussels
- 26 Nov 2014 on G20-Summit
- 21 May 2015 on the Eastern Partnership Summit in Riga and the G7 Summit in Elmau
- 24 Sept 2015 on Refugees and Development Policy
- 16 Mar 2016 on Refugees and the EU

Positive assessment of Free Trade Agreements

Chancellor Merkel's statements on trade issues show that she sees free trade only in a positive light and is keen to enter into further Free Trade Agreements. The risks of these agreements regarding the erosion of social standards and also the impeded access to generic drugs are not mentioned at all. Her Government Statement in November 2014 in Brisbane shows an even stronger tendency in this regard. The main concern is that Europe does not lose touch.[8] She calls for swift negotiations and sees the role of Europe as setting social standards. The fact that Free Trade Agreements contain provisions, which undermine these social standards, is not problematized at all.

8 If we do not succeed to swiftly negotiate the Transatlantic Free Trade Agreement, we will have big disadvantages compared to other regions not only in terms of international trade – a heavy burden for an exporting country like Germany – but we will also miss the chance to still participate in the decision on setting international standards in global trade in terms of ecology, consumer protection and legal means and after all that is what we want.

In addition, Chancellor Merkel mentions in her speech in 2012 that the target agreed in the year 2000 of spending 3 percent of Gross National Income on research has almost been realized. In her statement of 29 January 2014, she declares herself in favour of a financial transaction tax (FTT), which is highly appreciated.

Yet, this tax is only mentioned in a half-sentence[9]. The financial transaction tax would bring additional revenues to the German Government for development assistance from which HIV and health could also benefit. A 2016 representative survey by the opinion research institute TNS Emnid on behalf of Oxfam Germany showed that 57 percent of the respondents in Germany would be in favour of the implementation of the financial transaction tax in the year 2016. It still has to be decided what share of the additional financial resources gained through the FTT would be used for overall development assistance and which portion would be earmarked for HIV and health.

9 Financial actors, financial products and financial centers, they all require appropriate control mechanisms; financial actors have to be held accountable through the financial transaction tax (29 Jan 2014)

Astrid Berner-Rodoreda, Spokesperson for the Protestant Organizations of Action against AIDS Germany and HIV Policy Advisor, Bread for the World

Frank Mischo, Advocacy and Public Awareness Officer, Kindernothilfe, Germany

Quo vadis? – The Roadmap of the German Government

At a side event of the UN Summit on the adoption of the 2030 Agenda for Sustainable Development in September 2015, Chancellor Merkel as the highest representative of the German Government, announced her plans of a new health initiative entitled "Healthy Systems – Healthy Lives"[10], oftentimes called "Roadmap" for short. This initiative to strengthen health systems was initiated together with the Norwegian Prime Minister, Ms. Erna Solberg and the Ghanaian President John Dramani Mahama and was accompanied by powerful speeches held by Ban Ki-moon, Margaret Chan und Bill Gates. The initiation of this initiative was certainly assisted by quite a number of high-ranking persons.

10 „Securing a Healthy Future: Resilient Health Systems to Fight Epidemics and Ensure Healthy Lives", **https://www.bundesregierung.de/Content/DE/Pressemitteilungen/BPA/2015/09/2015-09-25-merkel-solberg-mahama.html**

Ebola Epidemic as a starting point

Embedded in Germany's activities as host of the G7 process in 2015 and departing from the dissatisfaction with the slow and insufficient reaction of the global community to the Ebola epidemic in West Africa, the so-called 'Roadmap' serves as Germany's flagship initiative for the implementation of the health targets of the 2030 Agenda. The declared objective of the initiative is the fusion and coordination of the numerous different initiatives in the field of global health with the goal of an effective& verifiable impact on health systems strengthening.[11]

11 **http://health.bmz.de/what_we_do/hss/**

The new initiative is faced with structural challenges regarding the fight of the global AIDS-epidemic. At the turn of the century, the control of the major infectious diseases had been one of the eight MDGs that

the global community had agreed in 2015. This focus was extremely important for the efforts regarding HIV: one of the outcomes was the foundation of the Global Fund.

Today the fight against HIV has become one of many sub-targets

Times are changing and it looks as if HIV does not receive as much attention by the international community (also called 'Aids-fatigue'). Nowadays, global HIV control as part of the SDGs is merely mentioned as one of many sub-targets, subsumed under Goal 3 of the Global Goals.

Although the challenges have not changed by any means and HIV will not be vanquished for a long time, the control of HIV & AIDS, as mentioned before, has to compete with other challenges in the field of health financing.

The declining focus on HIV can certainly be regarded as a step backwards, although the 2030 Agenda takes account of the special status of infectious diseases: *"We will equally accelerate the pace of progress made in fighting Malaria, HIV/AIDS, Tuberculosis, Hepatitis, Ebola and other communicable diseases and other epidemics"*[12]. We sincerely hope that this is more than a lip service.

12 Vereinte Nationen, Transformation unserer Welt: die Agenda 2030 für nachhaltige Entwicklung, Paragraph 26, **http://www.un.org/depts/german/gv-70/a70-l1.pdf**

Civil Society fears, and probably rightly so, that already made gains in the fight against AIDS, could be lost

The focus on health systems strengthening could be regarded as an attempt to refuse taking a closer look at the hard implementation work of fighting HIV. A possibly uncomfortable look at emergency situations and financial bottlenecks of HIV affected groups may be prevented if there are only discussions about health systems strengthening. The members of these highly vulnerable groups are often sex workers & their clients, drug users, migrants and Men Having Sex with Men.

This is certainly not what the German Government has intended. However, it is still surprising that the Roadmap does not deal with the issue of HIV/AIDS at all and that it is only indirectly addressed in the present edition of the working papers by way of mentioning the Global Fund.[13]

This is unfortunate, as there is ample evidence of how the efforts of the fight against HIV positively impacted health systems of Southern and Eastern Africa. Conversely, West Africa is a negative example – that

13 The *political paper* of the Roadmap "Healthy Systems – Healthy Lives" does not mention HIV. The *technical paper* only names the Global Fund (as of 30 Mar 2016), unpublished documents.

part of the continent that was not able to face the Ebola challenge due to its insufficiently robust health structures; it also profited least from most of the health system strengthening side-effects of massive investments in the fight against HIV.[14]

The potentials in reaching the universal health coverage could be realised through the smart use and promotion of enabler interventions of health systems such as, e.g. the explicit efforts by the Global Fund and other global instruments.[15] These synergies are currently not part of the *Roadmap* and it has to be expected that there will be internal competition during the budget proposals of the Federal Ministry for Economic Cooperation and Development (BMZ).

14 For example: **https://www.theguardian.com/global-development/2014/oct/29/hiv-aids-west-africa-health-investment-ebola**

15 The International Vaccination Alliance Gavi devotes itself to the strengthening of health systems

Germany is still lacking a concrete plan on how to implement the WHO recommendation that that the better-off part of the world ought to allocate at least 0.1 percent of its gross income for the development of health services in poor countries. This would help to prevent competition regarding the distribution of scarce financial resource s are urgently required if Germany really wishes to live up to its own desire to have a leading role in s. Financial re-adjustment global health.

Financial rectifications urgently required!

With regards to its economic situation, Germany does not have an excuse for being a laggard regarding the adequate co-financing of global HIV-control and the strengthening of health systems. A concrete commitment for a consistent increase of Germany's contribution for global health is not only a necessary element for the health systems strengthening as it could be easily financed. Thus far, however, the rhetoric and the financial efforts do not match. This is all the more unfortunate as it is obvious that the sustainable and sufficient financing for HIV control and the achievement of SDG 3 – Health for All – are mutually dependent.

Without the end to AIDS, we will miss the central goal of the new Development Agenda, "Ensure healthy lives and promote well-being of all at all ages".[16]

A *Roadmap* should serve as a reference tool. This has not really changed even in times of GPS systems. However, the Roadmap of the German Government lacks ground-breaking pledges, which are indispensable for the way to lead in the right direction.

16 Wortlaut des SDG 3

Marwin Meier, Manager Health & Advocacy, World Vision Germany

Peter Wiessner, Advocacy and Public Relations Officer, Action against AIDS Germany

The mention of HIV and AIDS in the G7/G8 Declarations between 2007 and 2016

The road from Heiligendamm to Ise-Shima

What are the „G7“?

The “Group of Seven” consists of seven leading industrialized countries. Apart from Germany, France, Great Britain, Italy, Japan, Canada and the USA are members of the group. Furthermore, the European Union is also represented at all meetings. These meetings serve as the floor for Heads of State or Government to exchange their points of view in personal discussions. Since 1975 the Summits take place on an annual basis. Up to 2012, Russia has also been invited to the so-called G8 Summit.

A Communiqué is prepared for every Summit Meeting containing the most important outcomes, partially also additional reports and work schedules. The participants consult each other on issues of international significance such as the global economy, foreign affairs, security and development policy. The participants also address issues currently requiring political action and those topics with a broad public interest. Issues and decisions are always determined on the basis of the consensus of all government representative involved.

In 1999, Germany was the host of its first G-7 Summit. The meeting mainly covered issues such as global financing and debt. The Summits mostly deal with one or two main topics. Beginning in 2000 health issues at times played a key role within the framework of the realization of the Millennium Development Goals.

This article examines the statements on HIV and AIDS since the G7 Summit in Heiligendamm, where the issue was of crucial significance. This clearly demonstrates that HIV continues to be on the agenda, but with less emphasis as in previous years.

2007, Heiligendamm (Germany)

Especially during the G8 Summit in Heiligendamm in 2007, based on the Summit results of 60 billion US$, Germany was able to contribute to the efforts regarding the realization of the target of universal access, the Millennium Development Goals to fight HIV/AIDS, Malaria and Tuberculosis as well as the strengthening of health systems. This was an important impetus in the global fight against HIV and AIDS[17].

2008, Toyako (Japan)

In 2008 in Toyako, Japan, the Heiligendamm resolutions were confirmed with 60 billion US$. A time schedule was also appended for the use of these funds within the period of five years. However, new relevant obligations regarding HIV and AIDS were not added[18].

2009, L'Aquila (Italy)

In 2009, in L'Aquila, Italy the Global Fund was highlighted in regard to its extensive options of health for people affected by HIV and other diseases. Despite the prevailing global financial crisis, the necessity of an increase of investments was emphasized for the fulfilment of the Millennium Goals on health[19].

2010, Muskoka (Canada)

In 2010 in Muskoka, Canada, great emphasis was put on the issue of health – especially on child and maternal health and the lacking implementation of the Millennium Goals four and five. In addition, to the 4.1 billion US$ that the G8 invested so far, a further amount of 5 billion US$[20] was to follow in the period from 2010 to 2015. Through the reduction of the HIV parent-to-child transmission and the improvement of the health infrastructure and treatment possibilities, the initiative clearly shifted its focus to the issue of HIV and AIDS and this led to a tangible improvement in this sector[21].

On page 6 of the Muskoka Declaration, the G8 commitment on HIV and AIDS is directly confirmed to strive to provide universal access to prevention,

17 Summit Declaration Heiligendamm 2007: **https://www.g7germany.de/Content/DE/_Anlagen/G8_G20/2007-G8-abschluss-deu.pdf?__blob=publicationFile&v=2**

18 Summit Declaration Toyako 2008: **https://www.g7germany.de/Content/DE/StatischeSeiten/Breg/G7G20/Anlagen/G8-erklaerung-japan-2008-de.pdf?__blob=publicationFile&v=5**

19 Summit Declaration L'Aquila 2009: p. 51 pp, **https://www.g7germany.de/Content/DE/StatischeSeiten/Breg/G7G20/Anlagen/G8-erklaerung-aquila-2009-de.pdf?__blob=publicationFile&v=5**

20 Citation from Muskoka Declaration, para 10: „To this end, the G8 undertake to mobilize as of today $5.0 billion of additional funding for disbursement over the next five years", **http://www.g8.utoronto.ca/summit/2010muskoka/communique.html**; see also Shadow Report of 2001, p. 21 bottom

21 Summit Declaration, Canada 25 to 26 Jun 2010: p.3 pp, **https://www.g7germany.de/Content/DE/StatischeSeiten/Breg/G7G20/Anlagen/G8-Erklaerung-Muskoka-de.pdf?__blob=publicationFile&v=6**

treatment and support in relation to HIV and AIDS. For this purpose, the 3rd Replenishment Conference of the Global Fund to Fight AIDS, Tuberculosis and Malaria in October 2010 was to be a success. Other national and commercial donors were also incorporated and they were called to render financial support to the Global Fund. Simultaneously, HIV as well as the rights and services of sexual and reproductive health were to be included in a wider context of strengthening the health systems[22].

22 Summit Declaration Muskoka: Ibid. p.6

2011, Deauville (France)

The Summit Declaration of Deauville on 27 May 2011 introduced an Accountability Report, which states that the G8, as in previous years, contribute about 78 percent of total funds of the Global Fund to Fight AIDS, Tuberculosis and Malaria.[23] On page 23 of the Summit Declaration the G8 agree that they will continue to support the Global Fund to Fight AIDS, Tuberculosis and Malaria at that level. They also stated that the Global Fund, which is in the process of being reformed and which is operating efficiently, will be supported by the G8 and other donors.

23 Summit Declaration of Deauville, France 26 to 27 May 2011, p.6 **https://www.g7germany.de/Content/DE/StatischeSeiten/Breg/G7G20/Anlagen/G8_Gipfelerklaerung.pdf?__blob=publicationFile&v=6**

The contribution for the improvement of maternal health and the reduction of child mortality through the Muskoka Initiative for the improvement of the health of mothers, new-borns and children under five, will be continued and monitoring of the implementation will be improved. A passage on page 24 appreciates the patent pool initiative by UNITAID for affordable generic drugs for poor countries, which are also very helpful in HIV treatment.[24]

24 Summit Declaration of Deauville: Ibid. p. 23 pp

2012, Camp David (USA)

For the first time, in Camp David, the Summit Declaration of a G8 Meeting on 19 Mal 2012 does neither mention the issue of HIV and AIDS nor the Global Fund. Within the framework of the mother-child-health initiative, GAVI or the health-related consequences of climate change are only briefly addressed.[25] In her Government Statement on Camp David on 10 May 2012, Chancellor Merkel also only talks about security issues of the Summit.

25 Summit Declaration of Camp David, USA 18 to 19 May 2012, **https://www.g7germany.de/Content/DE/_Anlagen/G8_G20/G8-camp-david-gipfelerklaerung-deutsch.pdf?__blob=publicationFile&v=4**

HIV and AIDS as well as other health issues are at least extensively covered on pages 45 to 65 of the Summit's Accountability Report. The 10th Anniversary and the positive impact of the Global Fund are also mentioned. It is also stat-

ed that the G8 will continue to provide 78 percent of financial funds of the Global Fund, thus allowing 3.3 million people affected by HIV and AIDS to get access to treatment. The contribution by the each individual donor to the Global Fund is also mentioned and it is appreciated just like the successful structural reform of the Global Fund.[26]

26 Camp David Accountability Report: pages 45 to 65, **https://www.g7germany.de/Content/DE/_Anlagen/G8_G20/2012-G8-camp-david-accountability-report-eng.pdf?__blob=publicationFile&v=4**

2013, Lough Erne (Great Britain)

Similar to the Camp David Declaration, the Summit Declaration of 18 June 2013 of Lough Erne in Great Britain is missing the issue of HIV and AIDS and the Global Fund.[27] The Declaration also deals with the Accountability Report. In the report, the G8 present their share of more than 3/4 in the financing of the Global Fund with a contribution of 13.5 billion US$.

27 Summit Declaration of Lough Erne on 18 June 2013, **https://www.g7germany.de/Content/DE/_Anlagen/G8_G20/g8-lough-erne-erklaerung-de.pdf?__blob=publicationFile&v=6**

Furthermore, the report's health focus lies on the promised 60 billion US$ from the G8 Heiligendamm and the G8-Muskoka Initiative on mother, new-born and child health and for the new UN Initiative for Maternal and Child Health.[28]

28 Accountability Report of Lough Erne 2013: p. 7 pp, **https://www.g7germany.de/Content/DE/_Anlagen/G8_G20/2013-G8-erne-accountability-report-eng.html?nn=1281552**

2014, Brussels (Belgium)

Due to the political situation around the Ukraine crisis, Russia will be temporarily excluded from the G8; an EU G7 Summit took place in Brussels from 4 to 5 June 2014. The EU G7 Summit mainly focused on the change from G8 to G7 through the exclusion of Russia and the joint Declaration on the situation in the Ukraine. Health is only covered in a short chapter, which is dominated by the Ebola epidemic and a global action plan against antimicrobial resistances. HIV and AIDS as well as the Global Fund are now mentioned again on page 11 of the Summit Declaration. The G7 advocate for an AIDS-free generation and are striving to support the Global Fund to Fight AIDS, Tuberculosis and Malaria, which, through grants paid by the Global Fund, will reduce the burden by these three devastating infectious diseases in the recipient countries and regions.[29]

29 EU G7 Summit on 4 and 5 June 2014 in Brussels, **https://www.g7germany.de/Content/DE/_Anlagen/G8_G20/G7-2014-06-05-abschluss-de.pdf?__blob=publicationFile&v=6**

2015, Elmau (Germany)

Following the far-reaching promises of Heiligendamm, the importance of HIV and AIDS declined and was only dealt with selectively on the agenda. However, health issues were repeatedly covered as main topics. This was also the case during the

last German G7 Summit in Elmau in 2015. The Summit was dedicated to overcoming acute global health crises, the strengthening of health systems and the implementation of the WHO action plan on antimicrobial resistances. HIV and AIDS as well as the Global Fund were less specifically mentioned in a sentence at the end of the health part of the Declaration: "We fully support the ongoing work of the Global Fund to Fight AIDS, Tuberculosis and Malaria and look forward to its successful replenishment in 2016 with the support of an enlarged group of donors"[30]. This is already the announcement of the important perspective on the Replenishment Conference of the Global Fund in Canada on 16 September 2016. Thus, the G7 continue with the G7/G8 tradition of supporting the successful fight against AIDS through the Global Fund.

30 Declaration of the G7 Summit in Elmau on 7 and 8 June 2015, **https://www.g7germany.de/Content/DE/_Anlagen/G8_G20/2015-06-08-g7-abschluss-deu.pdf?__blob=publicationFile&v=5**

2016, Ise-Shima (Japan)

With the adoption of the new Development Agenda by the United Nation in September 2015, Germany commits itself to accept the agreed targets to end AIDs by 2030. The Summit Declaration of the G7 Summit in Ise-Shima, Japan on 26 and 27 May in 2016 confirms this commitment to end AIDS, Tuberculosis and Malaria in partnership with the Global Fund and other institutions.

This comprehensive obligation and the important upcoming Replenishment Conference of the Global Fund for the realization of this target is mentioned, apart from the Summit's key issues of health, universal access to health services in more efficient health systems, antimicrobial resistances and the setup of a crisis reaction structure for global health disasters, is mentioned in one sentence on page 12 of the Ise-Shima Summit Declaration: "We are committed to ending AIDS, tuberculosis and malaria, working in partnership with the Global Fund (GF) and others. To this end, we fully support a successful 5th replenishment of the GF, taking the opportunity of the GF replenishment conference in Montreal in September, and call on traditional and new donors to support the replenishment"[31]. This is again affirmed on page 4 of The Ise-Shima-G7 Summit entitled "Vision for Global Health".[32]

31 Declaration of the G7 Summit in Ise-Shima on 26 and 27 May 2016 in Japan, **http://www.mofa.go.jp/files/000160266.pdf**

32 G7 Summit in Ise-Shima – Vision for Global Health: p. 4 pp, **http://www.mofa.go.jp/files/000160273.pdf**

Outlook: the agreements of the G7 Summits, especially from 2007 to 2012, have been able to generate great stimulus for the fight against HIV and AIDs on a global level.

There have been shifts of various topics from the G7 to the G20 Agenda. These include development issues such as global health. This would indicate to at least attempt to place the issue of HIV and IDS onto the Agenda of the G20 Summit in Germany next year – also because the

biggest donors and countries with the largest number of affected people, such as in South Africa and India, will be represented. Due to the consensus principle of the G20, and also the G7, it is, however, much more difficult to get an issue on the agenda, that not all representatives are willing to discuss. The biggest donors for the G7 are the Global Fund and those countries interested in finding solutions to questions on global health. Thus, the G7 remains a bearer of hope for future agreements on HIV and AIDS. It remains to be seen whether this will already be the case during the next Summit. The 2017 G7 Summit will take place on the island of Sicily. Italy has practically already decided on the issue of refugees as the prevailing topic.

Frank Mischo, Advocacy and Public Awareness Officer, Kindernothilfe, Germany

Patents or Medication?

In the past, it was mainly experts on intellectual property rights who dealt with the issue of patents. Many people and organisations thought that the topic was much too complex to delve into. This attitude changed with the HIV epidemic. In 2000, the World AIDS Conference took place in Africa for the first time. Everyone will still remember the appearance of the 11-year-old boy Nkosi Johnson who had already developed AIDS symptoms and was in dire need of treatment. And the statement by Dr Peter Mugyenyi from Uganda still rings in our ears: „The medicines are where the disease is not. The disease is where the medicines are not". The statement was over-exaggerated; of course, HIV-positive people also lived in the global North and needed treatment; but for the global South, prices between US $10,000 and US $15,000 per person were unaffordable and antiretroviral therapy only took off in Africa when an Indian generic firm produced fixed dose-combination tablets at US $350 per person and year.

TRIPS flexibilities and the right to health

In 1995, the World Trade Organisation was founded and the so-called TRIPS Agreement (the Agreement on Trade-Related Aspects of Intellectual Property Rights) was adopted. From then on, member states had to acknowledge patents on medicines. Middle income countries had to adjust their patent laws by 2005; Least Developed Countries (LDCs) had a longer deadline, which was extended to 2033 in 2015. Due to the great disease burden of AIDS, TB and malaria that Africa was facing, African countries insisted on having the TRIPS exemptions spelt out clearly. This initiative led to the so-called DOHA Declaration which placed the right to health over and above patent considerations. The DOHA Declaration confirmed the TRIPS ex-

emptions and underlined the importance of promoting access to medicines for all; it also clarified that the TRIPS Agreement would not prevent member states from taking measures towards the protection of public health.[33]

However, member states also have to utilize these flexibilities. One important action is to clearly define the term 'innovative step' and to limit patentability accordingly. India and some other countries have done this, for example, by not granting patents for substances which are only slightly modified chemically when the new product does not *result in added therapeutic value compared to the already patented medicine*. Also, a new usage of an already known medication will not be rewarded with a further patent. This is quite different in South Africa where every patent application seems to get approved. South Africa grants more patents on medicines than the USA and the EU. For years, civil society in South Africa has made constructive inputs to 'fixing its patents laws'. Other important TRIPS flexibilities are: parallel imports (imports from another country where the original manufacturer has sold its products more cheaply.); compulsory licences which allow a Government to authorize a pharmaceutical company to manufacture a particular medicine without the consent of the patent holder against a payment of 'adequate remuneration', e.g. when the price of the original manufacturer cannot be afforded by the country. Another important flexibility is the right to make use of pre- or post-grant patent opposition. Yet, it appears that many countries are hesitant to utilize flexibilities such as compulsory licencing, as the USA will usually put them under massive economic pressure when they do so. During the Doha+10 Conference, organised by Action against AIDS, Thai and Brazilian representatives stated that their Governments would not threaten or issue a compulsory licences nowadays.

33 We agree that the TRIPS Agreement does not and should not prevent Members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, to promote access to medicines for all. In this connection, we reaffirm the right of WTO Members to use, to the full, the provisions in the TRIPS Agreement, which provide flexibility for this purpose. (DOHA Declaration, Article 4)

TRIPS-Plus Measures in Free Trade Agreements limit flexibilities even further

Bilateral and regional trade agreements also limit the use of TRIPS flexibilities. Due to the negotiation of Free Trade Agreements, many countries had to change their patent laws earlier than they would have had to according to WTO stipulations. Patent terms are often extended by these agreements; patentability is expanded

by having to grant patents on secondary use (new use of the same substance). Data exclusivity forms part of many free trade agreements thereby delaying the registration of generic drugs and granting a longer monopoly for the original manufacturer. The German Government should take decisive action at EU level against these so-called TRIPS Plus Measures – Chancellor Merkel's completely uncritical support of these trade agreements shows, however, that she has been briefed unilaterally by the industry and that civil society still has to widen and intensify its awareness raising activities on the dangers of free trade agreements.

Monopoly rights lead to higher prices

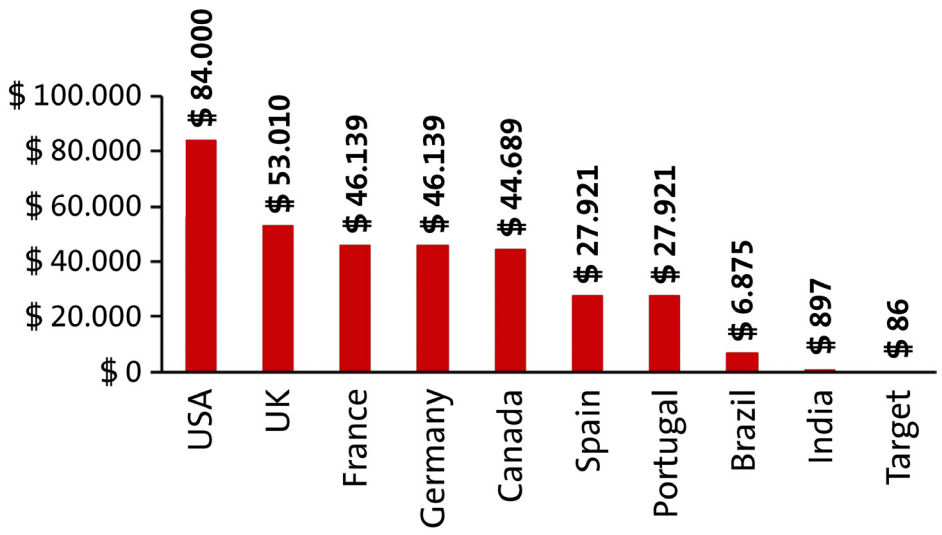
As far as affordability of medication goes, it is not the first line HIV medication that countries are having problems with, it is the second and third line medicines. Annual treatment costs especially for third line therapy amount to thousands of dollars per patient per year. What we have learned from the beginnings of global HIV treatment is that prices fall when a number of generic drugs manufacturers produce the same medicine. By contrast, there will be access problems due to high prices in places where a medicine is protected by a patent and the original manufacturer consequently has monopoly rights to manufacture and sell the medicine at a price the company regards as appropriate or feasible for a particular market.

We are experiencing this phenomenon in the global North at present with regard to new Hepatitis C medication. The example of 'Sofosbuvir' speaks for itself. Sofosbuvir is a Hepatitis C medicine which, in combination with other drugs, can heal chronic Hepatitis C in 12 weeks: an important breakthrough in treatment. But costs for this 12-week Sofosbuvir treatment amount to US $84,000 in the USA and approx. 43,000€ in Germany. The production costs for the 12-week treatment add up to about US $68 to US $163 based on calculations of a pharmacologist of the University of Liverpool.

The fairy tale about high production costs

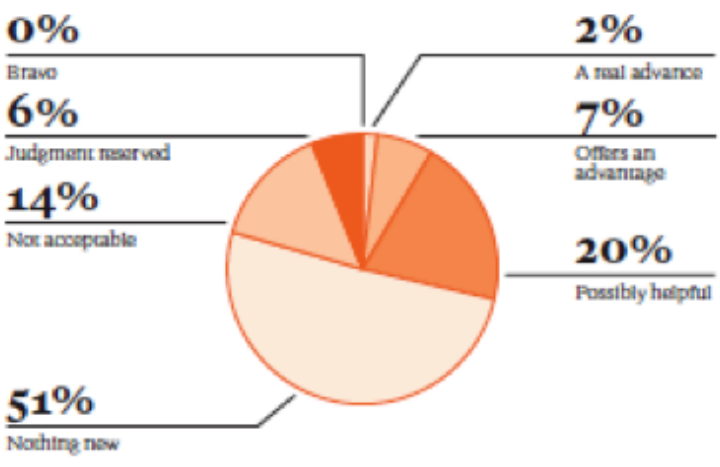
This immense divergence between actual production costs and the astronomical prices that can be charged for medicines has also turned physicians and scientists into activists in recent years. The pharmaceutical company Gilead did not develop Sofosbuvir itself, but bought up Pharmasset which had developed the Hepatitis C medicine. The 'purchase price' of Pharmasset of US $11 billion and the costs to put Sofosbuvir onto the market were redeemed after 15 months. The extremely high profits made by Gilead show that the development costs cannot be all too high.

Price for a 12-week treatment course (in US-Dollar)



Source: Presentation: Andrew Hill, Chelsea and Westminster Hospital, London, July 2016

France has already limited access to Hepatitis C medication for patients. Should this be the answer? At the International AIDS Conference in Durban in July 2016, doctors repeatedly emphasized that they would not take a decision on whether one person deserves a medicine over another person. Prices have to drop so that everyone can get treated. Overall, patents have not enabled access to needed medicines at affordable prices. Patents are an incentive for pharmaceutical companies to produce medicines at high cost and not necessarily the medicines that are needed – Hepatitis C and HIV medication is rather an exception in this regard. The results are sobering when one looks at the number of new medicines developed between 2000 and 2014 and their therapeutic value, see graph.



Prescrire's ratings 2000 to 2014 (Percentages per category, N = 1432)
Source: "L'Année du médicament" Rev Prescrire 2015; 35 (376): 132-136.

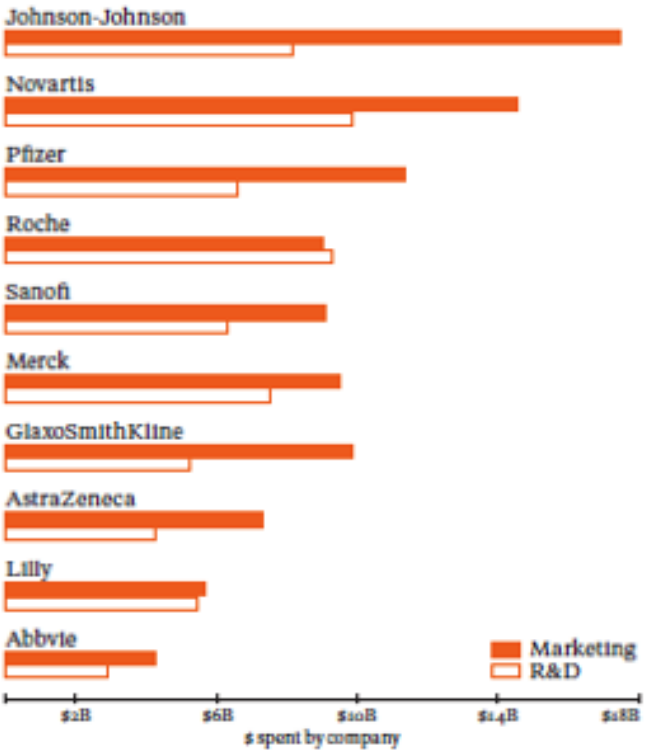
Patents have not been effective in providing appropriate research incentives and in improving access to essential and affordable medicines. Companies are spending considerably more money on marketing their products than on research and development. Therefore, other incentives are needed in terms of large-scale patent pools for all essential

medicines or prize funds which reward the additional therapeutic benefit of new medicines. Product development partnerships are another way forward. Also, more public funds have to be invested in research and development of new medicines that will not be patented. Germany also needs to increase its efforts in this regard.

The call that was made several times during the 2016 International AIDS Conference needs to be responded to at a global level:

- US $90 annually for HIV-treatment
- US $90 annually for a Hepatitis B treatment and
- US $90 for a 12-week Hepatitis C treatment.

Is Germany prepared to confront the mighty lobby of the pharmaceutical industry and to work towards realistic and affordable medicine prices?



Big Pharma Spending: Marketing vs. R&D
Source: Randal S. Olson (2015): Design critique: Putting Big Pharma spending in perspective.

For more information see:
http://www.brot-fuer-die-welt.de/fileadmin/mediapool/2_Downloads/Fachinformationen/Analyse/Analyse_58_Medicine_Patents.pdf

Astrid Berner-Rodoreda, Spokesperson for the Protestant Member Organizations of Action against AIDS Germany and HIV Policy Advisor, Bread for the World

About Risks and Side Effects: Free Trade Agreements and the Access to Medication

In order to ensure health care on a global level, cost-effective vaccines, diagnostics and drugs are imperative – especially for poorer countries but equally for humanitarian organisations and financing instruments such as the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Many vaccines, diagnostics and drugs are too expensive

The problem: A large number of vaccines, diagnostics, and drugs are expensive. Manufacturers are practically able to freely decide on prices due to the intellectual property protection in form of patents, which they are able to obtain for their products. However, for millions of people worldwide these prices are unaffordable, preventing them from getting access to treatment or vaccines that could improve their health or even save their lives. Generic products are much less expensive than the original product. The competition among different manufacturers has been the reason for the decline of prices over time. The best-known example is medication against HIV. Thanks to generic drugs, the prices have decreased from about 10,000 US$ per patient and year to less than 100 US$ within the timeframe of ten years.

Agreement on Trade-Related Aspects of Intellectual Property Rights

The first link between patent right and global trade was established in 1995 along with the legal formation of the World Trade Organisation (WTO). Within the framework of the foundation of the WTO, the Trade-Related Aspects of Intellectual Property Rights Agreement (TRIPS) was adopted, which specifies minimum standards to be implemented in the national law of all WTO members. The **TRIPS Agreement**

contains the patentability of pharmaceutical products for at least 20 years. During this timeframe, the manufacturing company receives the exclusive right to manufacture the patented product and to put it on the market as sole supplier. High prices are the result of this procedure.

In order to align the health needs of people in poorer countries with western commercial interest, the TRIPS Agreement also contains certain **safeguard provisions, the so-called TRIPS flexibilities.** These include, e.g. the possibility to limit product patentability. TRIPS requires that patents are awarded for 'innovative steps'. However, the term 'innovative step' is not clearly defined. In line with this specification, India then created a patient-friendly patent law: Products, which, e.g. are solely brought onto the market in a new dosage form – thus without any therapeutic added value – do not fulfil the criteria for awarding a patent. This allows Indian companies to manufacture affordable generic products. The patient-friendly Indian legislation has mainly contributed for the country to be called the "pharmacy of the developing world".

The TRIPS flexibilities e.g. provide the possibility of issuing compulsory licences for a patented product. This enables the respective government to allow the production of a patented drug by generic manufactures in case of a national health crisis and for public health reasons.

Free Trade Agreements jeopardize access to generic products

Big industrialized nations are trying to defend the economic interests of pharmaceutical companies – mainly located in western countries, i.a. during negotiations on Free Trade Agreements. Clauses signifying a risk for the global availability of affordable drugs are repeatedly suggested. They go beyond the provisions of the TRIPS Agreement and are, therefore, known as **TRIPS Plus Measures**. Some clauses, which can repeatedly be found in drafts of Free Trade Agreements, are described below:

- **Extensions of patent terms** are included in the drafts of several Free Trade Agreements. But a longer patent term will inhibit the price-reducing competition by generic products. The monopoly position of the original manufacturer remains protected. Consequently, patients' will be waiting much longer for affordable products.
- Clauses regarding **data exclusivity** refer to the availability of clinical study data. They determine that manufactures of generic products are not allowed access to clinical studies of the original manufacturer for the purpose of approval. Thus they would have to repeat clinical trials with patients. However,

this leads to an increase in costs and is also quite inefficient and certainly unethical. In addition, data exclusivity can also be harmful when a patent has not even been awarded for a certain drug or when the patent has already expired.

- Provisions regarding **investment protection** enable companies to sue governments before a private arbitration court in case of a government action endangering their investments. Intellectual property could also be perceived as investments in this context. This may jeopardize the TRIPS flexibilities for the protection of public health, e.g. the important option of granting compulsory licences.
- **Customs measures for export products** are to allow companies to prohibit the legitimate export of generic products to developing countries. Legal steps should also be possible against third parties buying or selling these products. This could substantially discredit, if not considerably hamper the affordable access to legal generic products.

Examples for detrimental Free Trade Agreements

Considering the background of these clauses, Médecins Sans Frontières / Doctors Without Borders has been observing with deep concern the developments around diverse Free Trade Agreements. Thus far, the **Trans-Pacific Partnership (TPP)**, which includes 12 countries in the pacific region, if ratified in its present form, would be the most harmful trade agreement regarding the worldwide access to medical products. It contains clauses allowing the extension and strengthening of intellectual property and of patent monopolies, yet delaying or even preventing the access to affordable life-saving generic products for many years. The **Regional Comprehensive Economic Partnership (RCEP)**, a Free Trade Agreement between 16 Asian countries – following pressure from Japan and South Korea – also contains TPP-related clauses for the protection of intellectual property. India and China act as direct contract partners in this case: India is, as described above, the main manufacturer of generic products. China is the world's largest producer of pharmaceutical substances required for the production of medical products, including generic products. In case of an implementation, this would have serious consequences on the global affordable access to generic products. It is to be expected that the negotiations on the **EU-India-Free Trade Agreement** which had been discontinued temporarily, will be reassumed. Already during previous negotiation rounds, the EU had demanded the inclusion of the above-mentioned customs measures or investment protection clauses.

Health care for poorer people has to be a priority

It is the responsibility of all stakeholders that Trade Agreements do in no way endanger the access to affordable vaccines, diagnostics and medication for people in poorer countries. The TRIPS Plus clauses, as described above, should thus not be included in the contract texts. We appeal to all contract partners of Trade Agreements – especially to the EU and its member countries – to respect the interests of those people, who are often not in a position to speak up for their interests like the industry is able to do. The profits of big pharmaceutical companies must not take precedence over the health of people.

Birthe Redepenning, Advocacy Researcher, Médecins Sans Frontières

People Before Profits – Medical Research shall serve the well-being of people and not company profits

Day by day, the staff of Médecins Sans Frontières / Doctors Without Borders is confronted with patients in local projects whom they can only help insufficiently or not at all, because appropriate vaccines, diagnostics or drugs are not available to treat the illnesses these patients are suffering from. This situation is caused by the lack of research and development activities. Commercial pharmaceutical research is oriented towards medical products that promise substantial profit and not towards the medical needs of people worldwide. Diseases that either affect poor people, or that are not very common or don't have to be treated permanently are irrelevant to commercial research. From the economic point of view, this constitutes a market failure within the innovation structure. This has severe consequences for millions of people worldwide:

Antimicrobial resistances (AMR)

The threat by antimicrobial resistances – or antibiotic resistances – is presently very much part of the public debate. It shows that the lack of adequate medical products has a global dimension affecting rich industrialized and poorer countries alike. The World Health Organisation (WHO) has been warning about an era in which we will no longer have effective remedies against diseases that could be treated so far. This is caused by the development of resistances and the unavailability of new and effective antibiotics. However, from the perspective of commercial pharmaceutical research, investments in the development of a product are quite unattractive if it is to be used only very restrictively and for a brief treatment period. Thus, novel antibiotic classes have not been developed since 1987. A glance at the research pipeline shows that especially publicly funded basic research in the

field of antimicrobial resistances actually exists – and is mainly put in practise at universities and research institutes receiving public funding. However, the translation of results from basic research into the field of applied research in clinical studies, which are traditionally carried out by the pharmaceutical industry, does not take place.

Tuberculosis (TB) – a disease with prevalence mainly in poorer countries is quite a typical example for the prevailing dilemma. Although about 1.5 million people die from TB every year (including 400.000 people with HIV co-infection), thus being the deadliest infectious disease, the diagnostics and antibiotics available for treatment are insufficient, especially for resistant forms of TB. Therefore, the treatment of multi-resistant tuberculosis is lengthy and has extreme side-effects. A treatment of severe drug-resistant TB with currently available remedies has asuccess-rate of about 50 percent in global avarage. After more than 50 years without any progress, two new drugs are now available for the treatment of resistant tuberculosis – an important first step. However, so far only a fraction of patients have access to these medications, which they would need so urgently. At the same time, research has to move on regarding new and more effective antibiotics, especially with regard to new complete treatment regimens combining multiple drugs.

Neglected and poverty-related diseases

Diseases such as kala azar, African Trypanosomiasis and Tuberculosis, which are mostly prevalent in poorer countries, and for which adequate medical products for treatment are not available, are referred to as neglected and poverty-related diseases. Although these diseases are widely spread and are oftentimes life-threatening, they do not constitute a lucrative sales market for the pharmaceutical industry as affected people normally cannot afford expensive drugs. This is reflected by the fact that from 2000 to 2011, only 4 of the 336 worldwide newly approved substances – i.e. 1.2 percent – were developed for neglected diseases, although these are responsible for a global disease burden of 11 percent. This is an imbalance by a factor of 10.

Furthermore, available medical products in the field of neglected diseases are frequently not tailored to the circumstances of poorer countries such as high temperatures. The teams of Médecins Sans Frontières / Doctors Without Borders are not able to reach all patients, e.g. in the Democratic Republic of Congo (DRC) in order to conduct examinations for sleeping sickness. The reagents for the diagnostic procedure would require a cold chain, which in many places in DRC cannot be maintained.

New and emerging infectious diseases

The Ebola epidemic, as an example for new and emerging infectious diseases, shows how fatal the orientation of the innovative systems towards the commercial interest can be. Publicly funded pre-clinical trials were conducted for a promising vaccine candidate. However, advanced clinical trials at the applied research stage were not conducted for more than ten years, because the pharmaceutical industry had no commercial interest in an Ebola vaccine at that point in time.

Alternative research incentives

In order to meet the urgent medical needs worldwide, concerted efforts must be made to close existing research gaps. This will require the definition of concrete research priorities as well as increased promotion of alternative incentive models for innovations. It is an important aspect that the costs for research and development are delinked from the price (the so-called **de-linkage concept**) that the developed product will ultimately be available for. This is the only way to ensure that the urgently required research and development activities take place even though high profits are not to be expected and to further ensure that developed vaccines, diagnostics, and drugs are actually affordable.

Alternative measures include the so-called **push, pull and pool mechanisms**.

Push mechanisms are defined as research funding provided independently from the specific success of the project. Publicly funded basic research projects at research institutions or universities are one example for a push-mechanism. They should receive increased public funding – just as clinical trials at the applied research stage. The so-called Product Development Partnerships (PDPs) are non-profit networks active in basic and applied research activities mainly promoting the development of medical products against neglected and poverty-related diseases. Some PDPs are presently supported by the German Ministry of Education and Research with an amount of 50 million euros over a period of five years. However, a variety of non-governmental organisations in Germany, including Médecins Sans Frontières / Doctors Without Borders would welcome a doubling of the funding for PDPs.

Pull mechanisms provide financial benefits, particularly incentive bonuses, when a specific goal or milestone is reached. Examples are the inducement prizes that the British Government and the European Commission recently announced for the development of a diagnostic device to quickly and easily determine whether patients will require antibiotic therapy or not.

Pooling mechanisms are approaches pooling together research results, data and information as well as intellectual property rights, e.g. in the Medicines Patent Pool (MPP). Through pooling mechanisms – also in the spirit of "Open Innovation" – the exchange of data, knowledge and intellectual property is promoted and can simplify and speed up research and development. Another example of pooling is the proposed **Global Research Fund**. It is to be based under the umbrella of the World Health Organization (WHO) and would pool donor funding to foster coordinated international research activities.

The **Global Antibiotic Research and Development Partnership (GARD)** is a newly founded platform, which is expected to put different instruments into practice in order to promote R&D in the context of AMR. The German Government has financially supported the initiation of GARD. It would be desirable if the Partnership would also receive further substantial political and financial support by the German Government.

Germany's G20 Presidency in 2017

During its Presidency of the G7 Summit in 2015, the German Government has already recognized the urgency of required political action regarding the market failure of the medical innovation system. The German Government now has to use its upcoming G20 Presidency in 2017 to promote substantial agreements of the G20 on specific and effective measures contributing to the closure of the globally existing research gaps and to also ensure that vaccines, diagnostics and medicines are available and affordable. Therefore, the G20 should render increased support to push, pull and pool mechanisms based on the de-linkage concept. Profit motives of the pharmaceutical industry may no longer decide about the health of millions of people worldwide.

Marco Alves, Coordinator Access Campaign Germany, Médecins Sans Frontières

Birthe Redepenning, Advocacy Researcher, Médecins Sans Frontières

A deadly combination – The double infection with tuberculosis and HIV/AIDS

On a global level, tuberculosis is the most common cause of death of HIV-positive people. They do not only have a higher risk of dying from the disease, an infection is also much more likely: while on average usually every tenth person who gets infected with tuberculosis will also fall ill, it applies to half of the people who are HIV-positive. Therefore, this double infection is a malicious combination.

Every day, more than 1,000 HIV patients die from tuberculosis; especially those who are not receiving antiretroviral therapy against HIV/AIDS or who got infected with the multi-resistant forms of tuberculosis are at risk. As the medical journal The Lancet reads: "They do not die because we cannot treat HIV or cure tuberculosis. They die because of substantial gaps in the delivery of care and innovation."[34]

Foto: CC AusAID

HIV-AIDS education in China

34 Furin J et al. (2015) No one with HIV should die from tuberculosis. The Lancet; 386, p e48-e50

Poor countries are mostly affected

In 2014, about 12 percent of people suffering from tuberculosis were infected with HIV at the same time, i.e. far more than one million people. Most patients with a double infection of HIV and tuberculosis live in sub-Saharan Africa (74 %), in particular in the southernmost countries of the region. Thus, in 2014, 73% of HIV patients in Swaziland were also tested positive for tuberculosis.

"Tuberculosis is one of the main causes of death among AIDS patients. Inversely, one fourth of the number of people dying from tuberculosis are infected with HIV at the same time. The double infection is a deadly combination, says Ms Sandra Parisi, a medical professional working for the DAHW *Deutsche Lepra- und Tuberkulosehilfe*.

Weakened immune system

And Ms. Parisi also explains the reasons: "An infection with HIV has a weakening effect on the immune system allowing tubercle bacteria to multiply." A healthy immune system would encapsulate these bacteria in the lung and prevent them from multiplying. "People suffering from HIV and AIDS do not have this immune barrier. The bacteria are able to spread through the body and will lead to the classical pulmonary tuberculosis as well as to untypical forms of the disease in other organs, e.g. fluid accumulation in the pleura, meningitis or military tuberculosis." Furthermore, persons affected by both infections may also be weakened by weight loss. Ms. Parisi adds: "The tuberculosis infection takes an atypical course in HIV/AIDS patients and fewer bacteria are coughed up. Therefore, the detection of these bacteria happens less frequently. Some tuberculosis tests are also based on evidence of stimulated immune cells. These types of diagnostic procedures are also not reliable for AIDS patients."

The Three I's Strategy

Still, since the World Health Organisation has adopted the Three I's Strategy (intensified case-finding (ICF), isoniazid preventive therapy (IPT) and infection control (IC)) in 2008, a lot has happened: Estimates by the WHO state that almost 6 million people worldwide have been saved by combined HIV/TB interventions between 2005 and 2014. The interlinkage of treatment and prevention measures has been improved and the therapeutic success has increased considerably. In 2014 after all, about half of the registered tuberculosis patients had been tested for HIV.[35]

35 WHO (2015) Global tuberculosis report: **www.who.int/tb/publications/global_report/en**

Administering a preventive dose of the antibiotic Isoniazid, as recommended by the WHO, within the framework of HIV-treatment will considerably lower the likeliness of falling ill with tuberculosis.[36] However, this preventive measure is only used in about a quarter of affected countries and especially in countries with highly developed structures such as South Africa.

Early treatment of HIV-positive people immediately after diagnosis – as the WHO meanwhile recommends – would significantly reduce the risk of tuberculosis for people infected with HIV. In the opinion of many medical professionals, this early start of therapy is a decisive factor for the reduction of the tuberculosis death rate.[37] However, the early beginning of therapy for people infected with HIV, who are not yet showing symptoms of the disease, can currently not be afforded in poor countries.[38] Presently, only half of HIV-positive people are being treated worldwide.[39] The same unfavourable situation is visible regarding the access to new diagnostics, capable of quickly verifying multi-resistant forms of tuberculosis, making immediate treatment with an effective therapy possible. These innovations would be extremely vital for people with a double infection; people suffering from HIV can die from tuberculosis within a few weeks. Often patients pass away before the diagnosis result for a testing culture is available. Thus, the double infection with tuberculosis and HIV will remain a huge challenge in the years to come.

36 Fischer, C. (2007) Tuberkulose. Da kriegste die Motten. Pharma-Brief Spezial Nr. 2, S. 12 ff.

37 Furin J et al. (2015) No one with HIV should die from tuberculosis. The Lancet; 386, p e48-e50

38 Jenkes C. (2015) Hoffnung bei Aids. Sind die HIV-Leitlinien der WHO umsetzbar? Pharma-Brief Nr. 10, S. 1 ff.

39 Aktionsbündnis gegen Aids (2014) HIV und Aids. Daten & Fakten. **www.aids-kampagne.de/themen/hiv-und-aids-daten-fakten**

Claudia Jenkes, BUKO Pharma-Kampagne

Annotation

The article by the BUKO Pharma-Kampagne emphasizes the fundamental need for a sustainable connection of advocacy on the issues of HIV/AIDS and TB. Therefore, just like the DAHW *Deutsche Lepra- und Tuberkulosehilfe*, BUKO Pharma-Kampagne is a member of Action against AIDS Germany and also the STOP-TB Forum, Germany's largest network of non-governmental organisations in the fight against tuberculosis.

Action against AIDS Germany and the Stop-TB Forum are cooperating closely in order to highlight the significance of HIV-TB-double infections and to put pressure on political decision makers. Thus, a joint press release by both networks on the occasion of the World TB Day 2016, demanded an increased contribution by the German Government for the strengthening of research and stronger engagement for access to medical products against neglected diseases and antimicrobial resistances.

The Opportunity for a Malaria-free world

Despite recent progress against the disease, malaria remains one of the most severe public health problems worldwide. The disease has been a plague to humanity for over 4,000 years.[40] Despite some success in the fight against the disease, Malaria is still one of the biggest problems of public health worldwide. About 3.2 billion people – nearly half of the world's population – are at risk of malaria.[41] It is a leading cause of death and ill health in many affected countries, with children and pregnant women particularly vulnerable. The cost of malaria – 40% of public health spending in most affected countries – goes far beyond public health impact.[42] Malaria costs Africa, where more than 90% of cases occur, more than €9 billion and as much as 1.3% of GDP every year in the worst affected countries. The disease takes a high toll on households and health care systems, and impedes economic development.

40 **https://www.humboldt-foundation.de/web/kosmos-humboldtianer-im-fokus-104-3.html**

41 WHO, World Malaria Report 2015 p. v

42 Attaran A, Narasimhan V. Roll back malaria? The scarcity of international aid for malaria control. Malar J. 2003;2:8

Global malaria progress and the contribution of the Global Fund

Since its creation in 2002, the Global Fund to Fight AIDS, TB and Malaria is an example of where Germany's investment in the malaria fight is making a tangible impact, saving lives on a global scale. New malaria cases fell by 37% globally between 2000 and 2015 and malaria deaths have been cut by 65% over the same period, translating into 6.2 million lives saved, the vast majority of them children.[43] Global Fund-support-

43 WHO, World Malaria Report 2015 p. 8, p.13

ed programmes have played a key role in helping to drive the remarkable progress in reversing malaria mortality and incidence.[44]

Today, the Global Fund is the largest single source of international financing to tackle malaria: currently representing more than half of the global malaria budget.[45] Investments in adequate counter-measures are proven to be among the most cost effective in global health – along with vaccinations.[46] And the return on investment is high; malaria prevention returns €36 into society for every €1 invested.[47]

Beyond the financial return, investing in malaria control and elimination also generates unprecedented socioeconomic, development, humanitarian and equity benefits.[48] Regions that have managed to decrease malaria have seen substantial economic gains, with economic growth more than five times higher than in affected regions.[49] Reducing the malaria burden also increases the likelihood that women and school-age girls can complete school and enter and remain in the workforce. In South West Uganda, malaria interventions contributed to increased primary school completion among girls by 34% and resulted in 5-20% gains in household income annually.[50]

44 Global Fund Results Report 2015, S. 22

45 **http://www.publications.parliament.uk/pa/cm201213/cmselect/cmintdev/126/126we03.htm**

46 Roll Back Malaria Partnership, World Malaria Day 2016 Factsheet

47 Ibid.

48 Purdy, M., Robinson, M., Wei, K. & Rublin, D. The economic case for combating malaria. Am. J. Trop. Med. Hyg. 89, 819-823 (2013).

49 McCarthy, F.D., Wolf, H. & Wu. Y. Malaria and Growth. World Bank Policy Research Working Paper 2303 (2000); Gallup, J.L. & Sachs, J.D. The economic burden of malaria. Am. J. Trop. Med. Hyg. 64, 85-96 (2001).

50 Malaria eradication and economic outcomes in sub-Saharan Africa: Evidence from Uganda; Barofsky, J et al.; Journal of Health Economics, vol. 44, pp 118-136. December 2015.

The partnership between Germany and the Global Fund is achieving is yielding remarkable results

- Distribution and use of long-lasting insecticidal nets (LLINs) has greatly expanded protection for children and families. By successfully using efficiencies of scale to drive down prices for key commodities like LLINs, more than 659 million mosquito nets have been distributed through programmes funded by the Global Fund. People at risk for malaria who gained access to mosquito nets grew in less than ten years from 7% in 2005 to 56% in 2014 in countries where the Global Fund invests.[51]
- The Global Fund is a key source of funding for various malaria commodities and Mosquito nets are just one tool used in the fight against Malaria. Other preventive measures include indoor residual spraying.

51 Global Fund Results Report 2015, page 17.

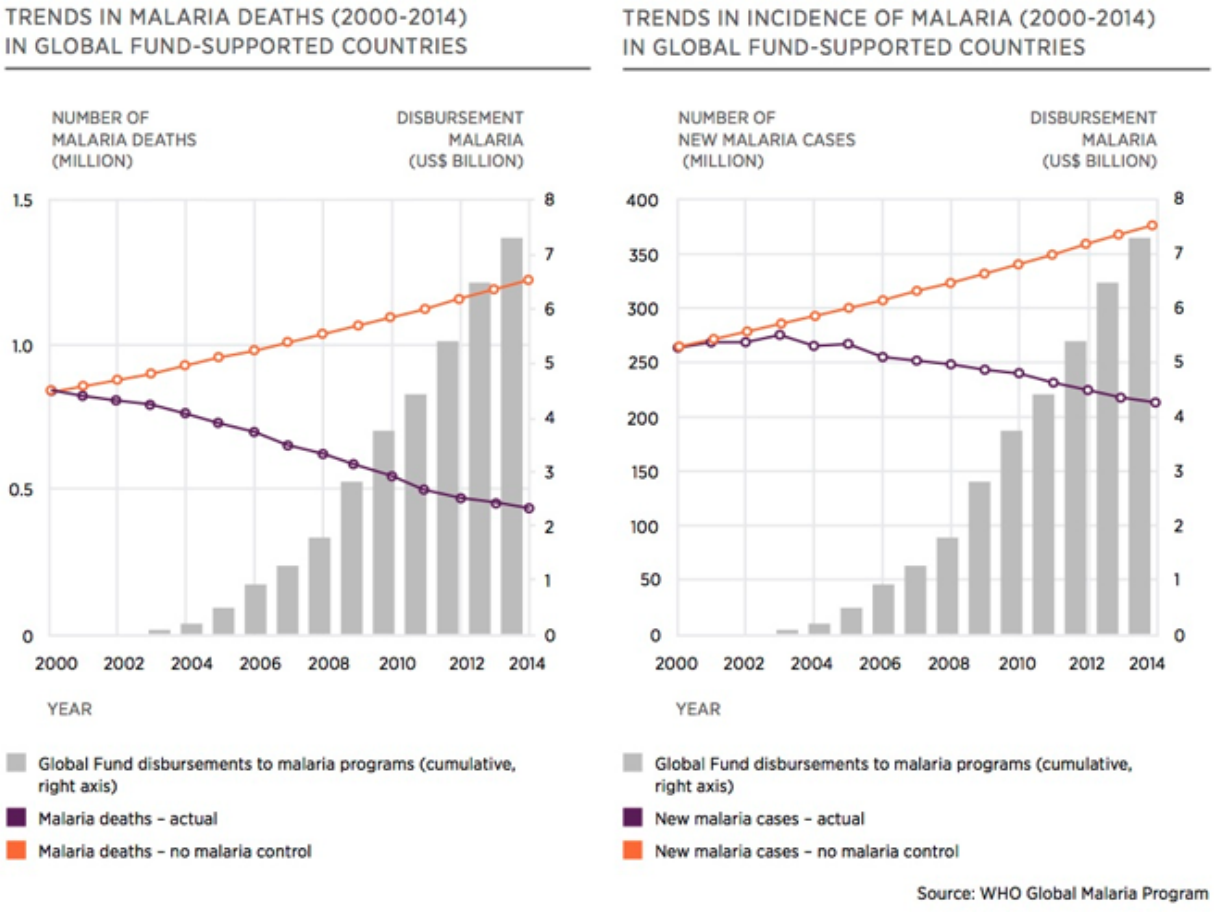
By the end of 2015 indoor spraying was carried out 58 million times by programmes supported by the Global Fund.[52]

- Through Global Fund-supported programmes, access to artemisinin-based combination therapies (ACTs) and to rapid diagnostic tests has improved dramatically. In countries where the Global Fund invests, cases of malaria treated rose 19% to hit a cumulative total of 515 million by the end of 2014.[53]

52 **https://www.eda.admin.ch/dam/deza/en/documents/partnerschaften-auftraege/216416-factsheet-gfatm_EN.pdf**

53 Global Fund Results Report 2015, S.17

Figure 1: Trends in malaria mortality and incidence in Global Fund supported countries, 2000 – 2014



Source: WHO Global Malaria Program

The cost of inaction: drug resistance and weakened health systems

Despite recent progress, over 430,000 people will still lose their lives this year to a disease that costs less than €1 to treat. This means it is critical that malaria interventions supported by the Global Fund are sustained and adequately resourced. Many of the long-lasting insecticidal nets that have proved phenomenally effective in preventing malaria will need to be replaced during the next Global Fund replenishment cycle. If the identified funding gaps are not filled, there is likely to be a significant resurgence in malaria, including outbreaks and epidemics such as was seen in Rwanda in 2010.[54]

In the past, waning political commitment and decreasing budgets has led to massive malaria resurgences, and with resurgence comes increased risk of drug and insecticide resistance.[55] Artemisinin has revolutionised the treatment of malaria but the emergence of artemisinin resistance in the Greater Mekong Sub-region threatens to roll back gains. Insufficient and reduced financing also threatens the success in the fields of surveillance and regional cooperation. Financing has been supporting today's health systems in those countries where the Global Fund is actively involved. Nowadays one third of investments by the Global Fund go to health systems. The 2014 Ebola epidemic in West Africa was a potent reminder of the critical role of effective health systems in disease surveillance, treatment and prevention and why these investments are so important.

54 UK Parliament. International Development Committee. Written evidence submitted by Roll Back Malaria Partnership. May 2012. **http://www.publications.parliament.uk/pa/cm201213/cmselect/cmintdev/126/126we03.htm**

55 Gretchen Newby, Adam Bennett, Erika Larson et al. The path to eradication: a progress report on the malaria-eliminating countries. The Lancet, Vol. 387, No. 10029, pp. 1775–1784, 23 April 2016.

Germany's contribution

Germany's engagement against Malaria in the area of development cooperation is mainly summarized by its contribution to the Global Fund. *In addition, the activities of the Federal Ministry for Economic Development and Cooperation within the framework of Healthy Systems – Healthy Lives-Initiative need to be highlighted in this respect.* The roadmap, initiated through the G7 Process – seeks to strengthen health systems globally, and thus indirectly enhances and the capacities for the fight against Malaria. As one of the outcomes of the G7 Research Minister Meeting in October 2015 in Berlin, the German Ministry of Education and Research (BMBF) revised its 2011 strategic funding framework on neglected and poverty-related diseases and assigned new key priorities to: "Global Health in the Focus of Research" .

These priorities include the promotion of the research landscape with €38 million for the German Centre for Infection Research, established in 2011, and up to €50 million for a second funding round for Product Development Partnerships (PDPs). Germany also supports joint research projects of developing countries and European countries within the framework of the European and Developing Countries Clinical Trials Partnership (EDCTP). The BMBF is planning to substantially increase its financial contribution (€30 million) in order to create further opportunities for German researchers in the field of poverty-related diseases.

The opportunity

Investments to defeat malaria could unlock an estimated USD$4 trillion in economic output by 2030, relieve a huge burden on health systems, and ultimately save 4.5 million lives.

The Global Fund has a central role in unlocking more resources for health and sustainable development. Through its counterpart financing requirements, the Global Fund has encouraged low income countries to commit an additional US$4.3 billion to their health programs for 2015 – 2017. Compared with spending in 2012 – 2014, this represents a 52% increase in domestic financing for health. The Global Fund is also considerably accelerating the impact of private investments. Most affected countries are now able to distribute mosquito nets that cost US$3 per net, a 30% reduction from the price of 2013, allowing distribution of more than 100 million additional nets for the same overall cost

Through collective global commitment and unwavering support from countries including Germany, we have an opportunity to eliminate malaria within our lifetime. A US$13 billion investment in the Global Fund for the 2017-2019 replenishment cycle would lay the groundwork for a malaria-free world.

Bernard Aryeetey, Malaria No More UK

A “Tax against Poverty“ – how Germany can fulfil its international obligation of development financing with the financial transaction tax

The end to Aids, tuberculosis and malaria, basic education for all children worldwide, an annual 110 billion US$ to support poor countries to tackle the climate change- these are only a few of the UN Sustainable Development Goals (SDGs) to be achieved by 2030. The implementation of these goals will be possible, but in order for the poorest of countries to be able to finance them, the OECD states will quickly have to fulfil their 45-year old promise to provide 0.7 per cent of their Gross National Income (GN) for official development cooperation. Germany, one of the economically most powerful countries worldwide, also lagged far behind the international target in recent years. In 2015, the German ODA ratio increased to 0.52 percent for the first time – an increase mainly owed to the imputation of granted loans as well as the incurred refugee costs in Germany itself. In order to finally reach the 0.7 percent target and to fulfil international promises for development financing, alternative financial sources have to be found. The financial transaction tax represents such an innovative financing tool. France has introduced a small national financial transaction tax and its revenues are already being used for health programmes and climate financing.

The financial transaction tax as an innovative financing tool

The financial transaction tax is a tax on the trade of financial products. The model that is currently being discussed is based on a 2013 concept by the EU Commission. This concept foresees a tax rate of 0.1 percent on the trade with stocks and 0.01 percent on the trade with derivatives. The tax is levied when a transaction is carried out, i.e. when financial products are either bought or sold. Thus, the tax targets at the speculative high frequency trading where financial products are being traded

on a large scale in milliseconds and enormous profits are generated through computer-controlled speculations. The tax will hardly affect conventional small investors due to its very low tax rate.

Billions of revenues

Currently, ten European countries – including Germany, France and Italy – are negotiating the implementation of a joint financial transaction tax within the framework of the so-called enhanced cooperation. It is planned to reach a final consensus in the months to come. Some important issues still require clarification, e.g. the tax rate levels and whether certain derivates or bonds will be exempt from taxation. If the financial transaction tax will be implemented with a broad tax base and depending on its structure, Germany alone would have possible annual tax revenues of between 11 and 36 billion euros – funds which are urgently required!

Regarding development cooperating in the health sector, the financial transaction tax could be regarded as an additional means to increase Germany's contributions for health financing to the WHO-recommended level of 0.1 percent of the GNI. Furthermore, it would also be possible to raise Germany's contribution to the Global Fund to Fight AIDS, tuberculosis and malaria of currently 210 million to the adequate annual amount of 400 million euros.[56]

56 See also: Rüppel, Joachim: Germany's Contribution for Global Health and HIV Response in the Context of the Realisation of the Millennium Development Goals produced by Action against AIDS Germany and the Medical Mission Institute Würzburg, Germany

Using financial transaction tax revenues for health – France sets an example

It is a logical step to use a substantial part of tax revenues for development financing. It cannot be denied that international financial stakeholders are responsible for the world-wide economic crisis. However, so far they have not contributed to the costs incurred – tax payers of rich countries and the population of poor countries are carrying most of the burden. By using some of the tax revenues for health, education and climate protection, the financial transaction tax will help to more fairly distribute the burden of the crisis.

This request is also supported by countries wanting to introduce the financial transaction tax within the framework of *enhanced cooperation*. France, in particular, is already using the revenues from a national financial transaction tax for the financing of the Global Fund to Fight AIDS, tuberculosis and malaria. The country

advocates for a joint European solution and demands the implementation of tax revenues for the fight against epidemics and climate change.

Revenues from the financial transaction tax which may run into the billions, would give Germany the historic chance to fulfil international obligations and to finally pay a fair amount in the fight against international poverty. A chance that should not go to waste! Civil society insisted that the financial transaction tax will be established at last and part of the revenues should be used in the struggle against poverty as well as for climate protection. This is the only perspective for the financial transaction tax to become a real ”tax against poverty“!

Pia Schwertner, Oxfam Germany

Full funding of the Global Fund – and ending the epidemics for good!

The Global Fund – a unique public private partnership

The Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) is a unique public-private partnership founded in 2002 and it is an international financing mechanism dedicated to attracting and disbursing additional resources to prevent and treat AIDS, Tuberculosis (TB) and Malaria, working closely with national Governments, civil society and communities affected by the three diseases including strengthening health systems. It also enhances the ownership of the implementing countries, the inclusion of civil society and the private sector as well as gender orientated measures against AIDS, Tuberculosis and Malaria – a genuine partnership in the 21st century. The Board of Global Fund has three seats assigned to civil society. The delegations to the Board include: Communities Delegation, the Developed Country NGO delegation and the Developing Country NGO delegation.

As a financing instrument, the Global Fund does not implement own programmes and does not have any country offices. Each year, the Global Fund mobilises and invests almost 4 billion US$ in order to support programmes, which are being implemented by national organisations and local regional initiatives in more than 100 countries. 95 percent of these funds are provided by donor governments and 5 percent are covered by the private sector as well as by foundations. In true ownership, a Country Coordinating Mechanism – so-called CCM, made up of medical professionals, the Government, Communities affected by the diseases and civil society develops a national strategic plan with essential interventions for the control of the three diseases in their respective countries. An independent team of experts monitors the concept note and is able to request for alterations. The final funding recommendation will then be approved by the Board of the Global Fund.

The Office of the Inspector General of the Global Fund controls the orderly use of funds.

Main achievements by the Global Fund

The Global Fund is the main financier of international efforts against all three diseases and has developed a strategy building on scientific insights allowing us to see for the first time how we can fundamentally change the course of the epidemics. Here are the cumulative highlights, since 2002[57]:

57 www.theglobalfund.org

- 20 million lives have been saved.
- 9.2 million people living with HIV had access to life-saving antiretroviral therapy.
- 15.1 million Tuberculosis patients were diagnosed and treated.
- 659 million insecticide-impregnated mosquito nets were distributed for prevention of Malaria.

The Global Fund considerably contributes in striving to meet Goal 3.3 of the Sustainable Development Goals (SDGs) to end to AIDS, Tuberculosis and Malaria by 2030. Simultaneously, the health systems in partner countries are sustainably strengthened. Through its unique partnership structure, the Global Fund has set standards regarding the involvement of self-help initiatives of affected people and civil society organisations. These standards are indispensable with regards to key affected populations, the protection of human rights and thus the impact of interventions.

Germany's contribution to the Global Fund

Since 2012, Germany holds its own seat on the Board of the Global Fund and since June 2016 it is also represented in the Strategy Committee. Furthermore, Norbert Hauser, a German citizen, has been the Chair of the Board of the Global Fund since April 2015. Therefore, Germany is required to demonstrate more commitment.

Also, two German Civil Society representatives are working on Global Fund issues: one is represented in the German Delegation; the other one is working for the developed Country NGO Delegation, which enables German Civil Society to work very closely on Global Fund issues.

Presently, Germany ranks in fourth place of donors[58] to the Global Fund. However, Germany's contribution has been stagnating, with the exception of a one-time in-

58 ehemaliges Mitglied des Deutschen Bundestags (CDU) und ehemaliger Vizepräsident des Bundesrechnungshofes

crease to 245 million euros in 2014, at about 200 million euros per year. Based on its economic power and compared to other donors, and the commitments made in the health sector, Germany's contribution lies far below the amount it should be contributing. A fair share would amount to at least 400 million euros annually. Since the German Government, other than most donors during the past two Replenishment Conferences of the Global Fund, had not raised its contributions, an increase of presently 210 million euros[59] to at least 300 million euros for 2017 with a significant increase in the subsequent years would be a correct step in the right direction.

59 Behind the US, France and the UK

The Replenishment of the Global Fund and why increasing investments are so important now

Fully replenishing the Global Fund to fight AIDS, Tuberculosis and Malaria is essential for delivering on the promises made in the Sustainable Development Goals and the UN Declaration on ending AIDS to end the three epidemics by 2030. With full replenishment, the Fund would save millions of lives, failure to do so would unravel years of progress and jeopardize effective programs for reaching vulnerable populations at greatest risk.

The Global Fund is preparing for its 2017 to 2019 Replenishment Conference in September 2016, which will be hosted by Prime Minister Justin Trudeau and the Government of Canada. At the Replenishment Conference, the Global Fund will seek to mobilize at least 13 billion US$[60] to meet the following targets by 2020:

60 since 2015

- To save 8 million lives.
- To prevent 300 million new infections regarding the three epidemics.
- To support the set-up of sustainable, durable health systems.
- To increase the general economic capacity by up to 290 billion US$.
- To mobilize 41 billion US$ of partner countries 'own funds.[61]

61 The Global Fund (12/2015): Global Fund Investment Case – Fifth Replenishment 2017-2019

The significant progress of recent years in the control of AIDS, Tuberculosis and Malaria show that we are at a turning point. However, more investments are still required in order to secure the success achieved so far and to prevent the diseases from flaring up again. The status quo will not allow achieving the internationally agreed target of the Development Agenda to end the three epidemics by 2030. Still every year, about 1.1 million people die from AIDS, 1,5 million From TB and 438.000 from

Malaria – urgent action is thus still needed.[62, 63] The envisaged 13 billion US$ can only be the beginning.

Therefore, on the occasion of the 2016 International AIDS Conference in Durban, the international Global Fund Advocates Network (GFAN) published a report[64] with clear calculations of the consequences of insufficient funding of the global response to AIDS, Tuberculosis and Malaria. We are missing the chance:

- To save 10.8 million lives of people affected by HIV and to prevent 17.6 million new HIV-infections by 2030.[65]
- To prevent 45 million new Tuberculosis infections and to allow 29 million people to get Tuberculosis treatment by 2020.
- To prevent 3 billion cases of Malaria and to save the lives of 10 million people affected by Malaria by 2030.

62 UNAIDs 2015, WHO 2015 and World Malaria Report 2015.

63 Annotation from the editors: The number of TB related deaths mentioned here includes the nearly 0.4 million deaths among people with HIV/TB coinfection which are ultimately caused by HIV

64 GFAN (Juli 2016): Global Fund Replenishment 2016: The Cost of Inaction.

65 UNAIDS (4/2016): Fast-track update on investments needed in the AIDS response; GFAN hatte noch mit den Zahlen des UNAIDS Berichts 2015 gearbeitet: bis 2030 21 Millionen Menschenleben von HIV-Betroffenen zu retten und 28 Millionen neue HIV-Infektionen zu vermeiden. Die Differenz kommt daher zustande, weil in den beiden Jahren zwischen den Schätzungen erhebliche Fortschritte bei der Ausweitung von Prävention und Behandlung erreicht wurden und auch weil angepasste Parameter z. B. für die Überlebensraten verwendet wurden.

As the Global Fund is the biggest financial instrument by far regarding the control of the three diseases, it will be decided whether the Global Fund will achieve or miss its funding target of 13 billion US$ in September 2016, whether the payment of these millions will be prevented by additional infections and avoidable deaths. Furthermore, the report impressively shows that investments made today will pay off. These investments avoid high treatment costs in the future and they also allow improved health, thus resulting in a more productive society and increased economic capacity by countries.

The Global Fund – more than a vertical financing instrument

Until a few years ago, the Global Fund had often only been perceived as the health-specific financing instrument for the control of the three epidemics. Despite the success, this criticism was somewhat justified. However, the Global Fund continued to develop, which is reflected in the recently published new Global Fund strategy from 2017 to 2022, entitled *"Investing to End Epidemics"*:

- **Maximise impact against HIV, Tuberculosis and Malaria,**
- **Build resilient and sustainable systems for health,**
- **Promote and protect human rights and gender equality,**
- **Mobilize increased resources.**

The end to AIDS, Tuberculosis and Malaria can only be achieved with the use of effective health systems and by strengthening community systems. Simultaneously, investments and the prevention of HIV, Tuberculosis and Malaria will improve the health systems of countries. This intensifying relationship between funding and disease control and the improvement of general systems is a characteristic feature of the Global Fund today, and it is to be extended in the years to come.

Halting the spread of HIV, Tuberculosis and Malaria will only work if health care will be accessible, affordable and effective. This especially applies for people, who are not granted access due to stigma and discrimination, the inability to pay or who do not have a health centre nearby. In these instances, the Global Fund comes in by supporting programmes targeting at overcoming health-related human rights obstacles as well as to protect and promote human rights. Yet another focus of the Global Fund lies in the fight against gender inequalities as well as the fight against the discrimination of women and girls. In many parts of Africa, this is a decisive factor regarding HIV transmissions.

The Global Fund – a joint responsibility

The efforts of the partners in the global health care, makes a crucial difference in the lives of millions of people who are affected by HIV, Tuberculosis and Malaria. The development of these countries leads to an increase of contributions in the fight against the three diseases and the improvement of health systems. However, this can only be achieved if investments carry on and no one is left behind. Marginalized people, who are often already criminalized and discriminated, may not be left behind just because the average income of their countries has exceeded a certain threshold. The Global Fund should stay involved, until the countries have independently managed the three diseases – both on medium and long term basis – including reasonable transition plans between the Global Fund and these countries. Global health is a shared responsibility. The epidemics can only be jointly terminated. But only if ALL invest, namely NOW.

Beate Fülle, Communication Focal Point
for the developed Country NGO delegation, Action against AIDS Germany

Katja Tielemann-Ruderer, Advocacy Officer
at the Deutsche Stiftung Weltbevölkerung (DSW)

Report on the High Level Meeting in New York: Inclusion of Civil society is not self-evident everywhere

The UN High Level Meeting on HIV and AIDS took place in New York from 8 to 10 June 2016. The three-day gathering opened with the unanimous adoption of a new Political Declaration on HIV to end AIDS by 2030.

Inclusion of Germany's Civil Society

Headed by Federal Health Minister Hermann Gröhe, the German Government Delegation made up of Government representatives, parliamentarians, members of civil society and people living with HIV participated in the meeting. As in previous High Level Meetings, a representative of Action against AIDS Germany was invited to join the Government Delegation. A second member of Action against AIDS Germany was represented by the Civil Society Delegation. In contrast to the marginalization that many representatives of civil society experience in many countries, the German Government needs to be applauded for taking the inclusion of the critical voices of civil society seriously. These critical voices are obviously regarded as an asset rather than a threat in the German Delegation.

In order to prepare for the Conference, civil society representatives were invited to a meeting to exchange ideas about the reception at the Permanent Mission of Germany to the United Nations. We suggested a discussion on the issue of legal discrimination and stigma of people with HIV. We are delighted that our suggestion was taken up by Federal Minister Gröhe. The reception at the Permanent Mission included interesting speeches and discussions. The report by an HIV-positive member of the Government Delegation will be especially remembered. During the reception, we also had the chance to directly talk with Federal Minister Gröhe and the staff of his Delegation.

The adoption of the Declaration during the opening of the High Level Meeting was followed by two-days of discussions by the UN Member States. These primarily involved comments that individual governments wanted to put on record in connection with the Declaration. The Political Declaration serves as a global framework for the implementation of prevention and treatment programmes in coming years.

Different facets of marginalization

It had already been announced in the preparatory stage of this High Level Meeting that more than 20 non-governmental organisations were not permitted to participate in the UN Meeting These were mainly organisations working with men who have sex with men (MSM), transgender people and people using drugs. Some UN Member States including Russia had put in a veto to bar civil society groups working in these fields from attending the meeting. In addition, the final text version of the Declaration submitted for voting hardly mentioned these particular groups. Although the term 'key population' was used in connection with a higher risk of infection, it was not specifically mentioned again when appropriate HIV interventions were named. States criminalizing homosexuality, drug use or sex work, managed to successfully prevent these groups from being mentioned in the Declaration.

Country groups acknowledging the importance as well as the needs of key populations in HIV work regretted that the text remained vague and emphasized that the omission of these groups in relevant text passages was tantamount to further marginalization. They would have wished for a Declaration which named the elimination of all forms of stigma and discrimination. If that had been the case, all signing countries would have committed themselves to changing their legislation so that vulnerable groups would not be stigmatized or criminalized.

On the other hand, some countries commented that the text was going much too far. They indicated their sensitivities regarding sexuality, comprehensive sex education, sex work, MSM, drug use and sexual and reproductive rights. In their speeches they stated that other groups were affected by HIV to a much larger degree in their respective countries. Some countries including Russia and Indonesia, but also some African countries stressed that they did not want to be told who they should regard as vulnerable groups.

An end to AIDS by 2030 will certainly not be achieved by trying to define risk groups based on prevailing ideologies.

The Declaration is a Compromise

The new Declaration provides a new action framework till 2030, even though a number of passages have not been formulated the way we would have preferred. Yet, the UN Member States showed by signing the Declaration that they are aware of the historical time frame: with 37 million people living with HIV on a global level and 2 million new infections every year, tremendous efforts have to be made by all countries in order to end AIDS by 2030.

We also welcome the measures for women, adolescents and children enshrined in the Declaration – the elimination of violence against women and children, access to sexual and reproductive health, gender and age-related prevention measures which also include comprehensive sexual education as well as expanded services for testing and treatment. Greater involvement of men is also an important issue, as gender equality can only be achieved when men are directly addressed. This is also important to improve the health behaviour of men themselves as, due to gender norms, they often do not take their own health seriously. It is a positive step that these issues are included in the Declaration.

The flexibilities enshrined in the agreement on Trade Related Aspects of Intellectual Property Rights by the World Trade Organisation were also confirmed in the Declaration. The patent pool was mentioned as an important instrument for providing access to affordable newer medicines. However, the use of public funds for research and development of essential drugs should also have been mentioned in the Declaration. When referring to the financial resources needed to end AIDS, it would have been an advantage to specify the amount that international donor countries need to provide and to include a commitment by these countries to do so. We welcome the fact that the Declaration mentions the universal financial needs as well as the financial resources required for the Global Fund for the replenishment.

With regard to national legislation, the Declaration unfortunately contains the same vague statements as the 2011 Declaration. In an introductory section, it is left to the individual countries to implement subsequent measures in accordance with their respective domestic laws and the national development priorities. This means that national considerations will have priority over the international obligations in the Political Declaration.

Specific commitments would have been helpful, e.g. regarding the decriminalisation of groups particularly affected by HIV. As we know from other countries, decriminalisation of sex workers and intravenous drug users is one of the most effective measures to improve their access to HIV prevention and treatment and this has led to a drastic decline in new infections in these groups.

Protests outside the UN Building

Representatives of the excluded non-governmental organisations protested in front of the UN Headquarters by clearly articulating their dissatisfaction with the text of the Declaration. They also stated that they are simply fed up with the strategic marginalization of civil society groups. Photos went around the world of placards reading "Our Blood Is On Your Hands"and "Your hypocritical attitude towards gay men is killing us".

Protests like these are commonplace for democracies, whereas in other places they are not. This was also apparent in New York City. The fear by some may be regarded as paranoid by others when for example members of the Russian Delegation took photographs of the participants on the spectator's stage. For civil society members of authoritarian states the articulation of their demands can certainly quickly turn into an actual personal threat.

Now we will have to see how the Declaration will be implemented and translated into action plans. The commitments may need to be filled with life and financed. It is up to the Member States to show that they will take needed and important measures beyond the Declaration. This can be done by prohibiting discrimination and creating a safe legal environment for protecting the most vulnerable

Protest of civil society groups in front of the UN Headquarters "Our Blood is on Your Hands" High Level Meeting New York

Our blood is on your hands! Act now to end AIDS, protest by civil society groups in front of the UN Headquarters in New York

groups and giving them a voice in line with the spirit of the UN where everyone should have a say. The Declaration will enable civil society to hold governments accountable, as all UN Member States have committed themselves to taking these measures. The Replenishment Conference of the Global Fund on 16 September 2016 is of special significance. The German Government will be able to show what relevance the Declaration has for Germany and if the German Government is willing to provide the required financial resources for its implementation!

Astrid Berner-Rodoreda, HIV Policy Advisor, Bread for the World

Peter Wiessner, Advocacy and Public Relations Officer,
Action against AIDS Germany

Part B: Germanys financial contribution for global health and HIV Response in the Context of the Realisation of the Millennium Development Goals

Germany's Health and HIV Response in the Context of the Realisation of the Millennium Development Goals

Joachim Rüppel

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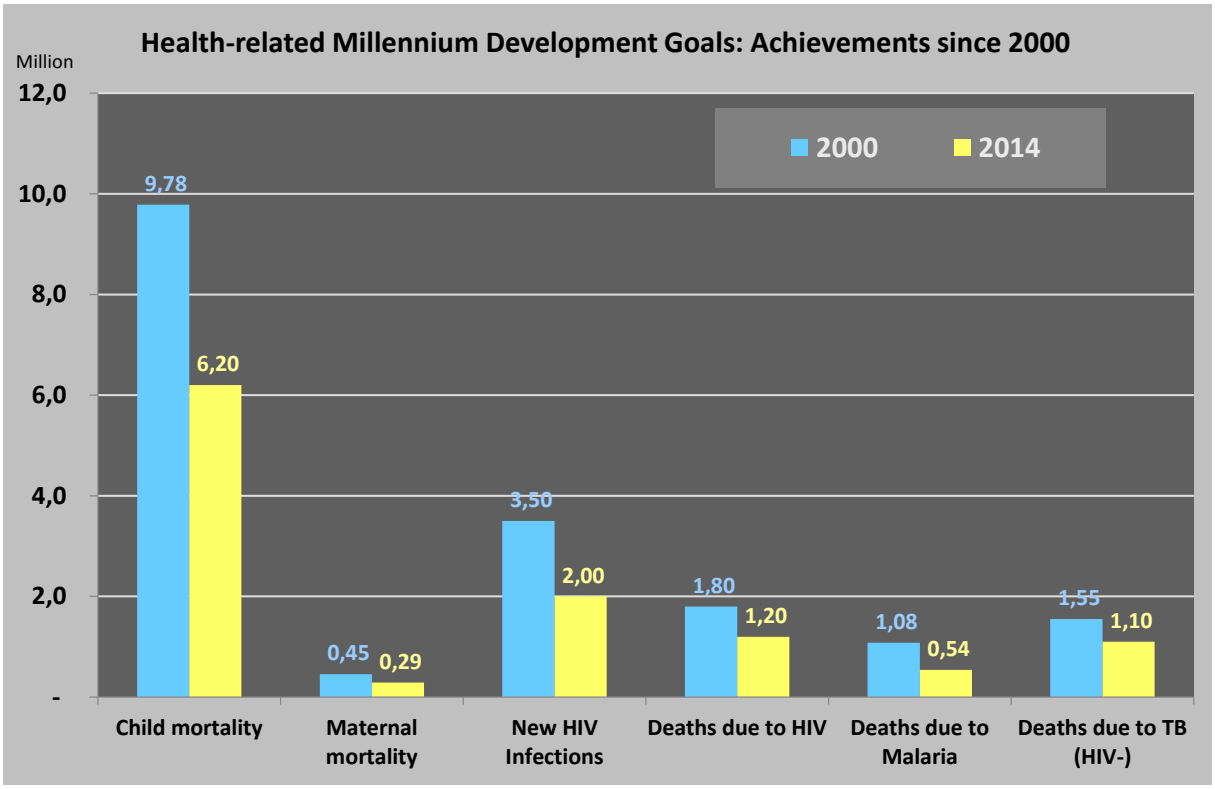
Introduction

Since the adoption of the Millennium Declaration by the United Nations and the Millennium Development Goals derived from it, the International Community was able to make remarkable progress in the control of major epidemics and the improvement of health care. On a global level, this especially applies to all urgent health issues resulting in a large number of deaths at an early age. By 2014, almost eight million deaths could be prevented by extending the access to antiretroviral combination therapy. In most regions of the world, life expectancy has increased considerably, while the massive decline in survival chances that occurred in countries severely affected by the HIV epidemic was at least reversed.

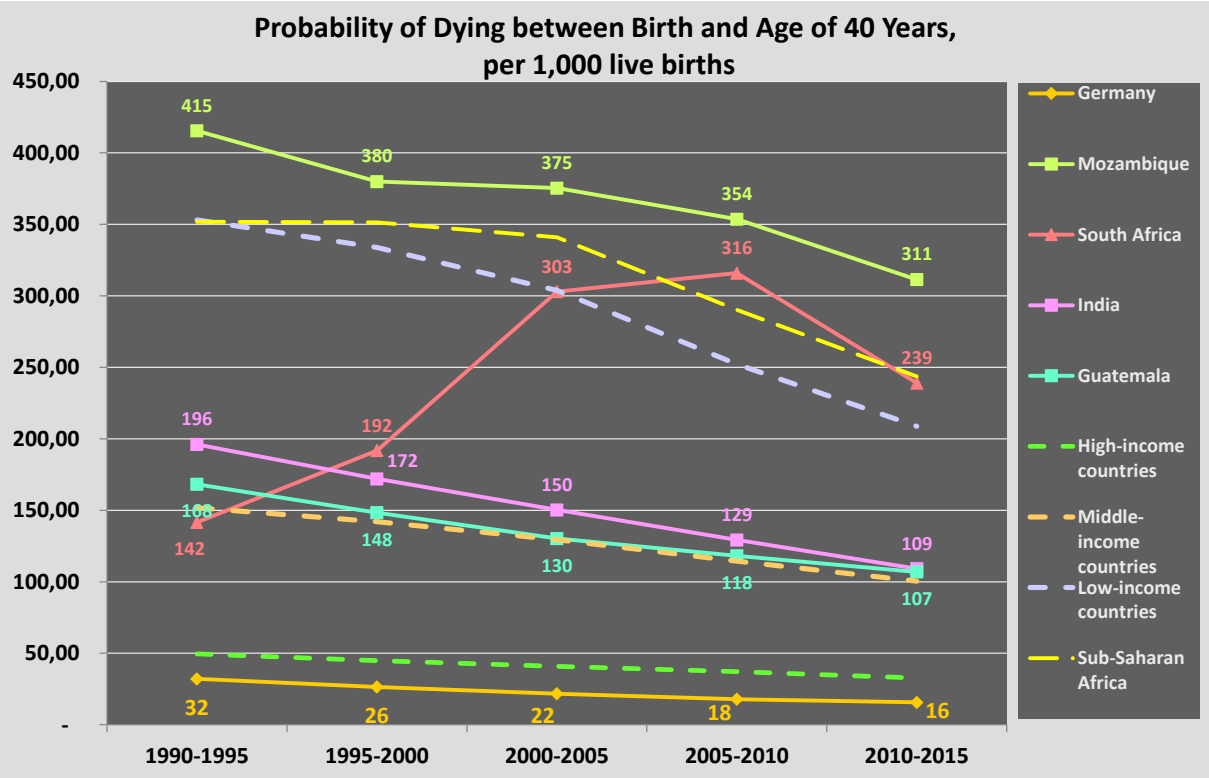


On the other hand, this can only be regarded as partial success, which is incidentally also very unevenly distributed. Many deprived people and population groups are still living under conditions, which are inhumane and hazardous to their health. At the same time, they are particularly excluded from vital health services due to lack of financial resources and political will. Two decades ago, the probability of dying before the age of 40 in low-income countries was seven times higher than in wealthy countries, whereas nowadays the population living in the first income group still faces a risk of premature death that is six times above the level calcu-

lated for the latter group. But the margin for the uneven distribution of survival chances is even higher in individual cases. A child that was born in Mozambique in recent years has a 20 times higher risk of dying at a much too early age under the present circumstances than a baby that was born in Germany.[66]

66 United Nations Population Division (2015): World Population Prospects: The 2015 Revision

This is one of the most dreadful forms of injustice when people lose their lives because they are exposed to serious health risks as a result of their social situation and they are denied access to effective treatment options. The large-scale spread of HIV and the resulting dramatic mortality rate in the regions of sub-Saharan Africa, where a large part of the population has been forced to migrant labour for decades in order to survive, is one tragic example. In these regions the system of exploitation, which was established by colonial domination and was even exacerbated by Apartheid, was the reason for the separation of many families. Furthermore, gender relations were distorted to the extent that the economization and commercialization of sexuality was almost an inevitable consequence. During the era of the HIV epidemic the resulting behaviour led to a high risk of infection, while the political interest in awareness campaigns and health care for the migrant workers toiling in mines and plantations as well as their communities of origin tended to zero. The current patterns of HIV transmission still show that risk is closely related to social disadvantage and marginalization. Of the 2 million new HIV infections that are estimated to have oc-



curred worldwide in 2014, roughly two thirds were recorded in sub-Saharan Africa and almost one out of six affected men who have sex with men.[67]

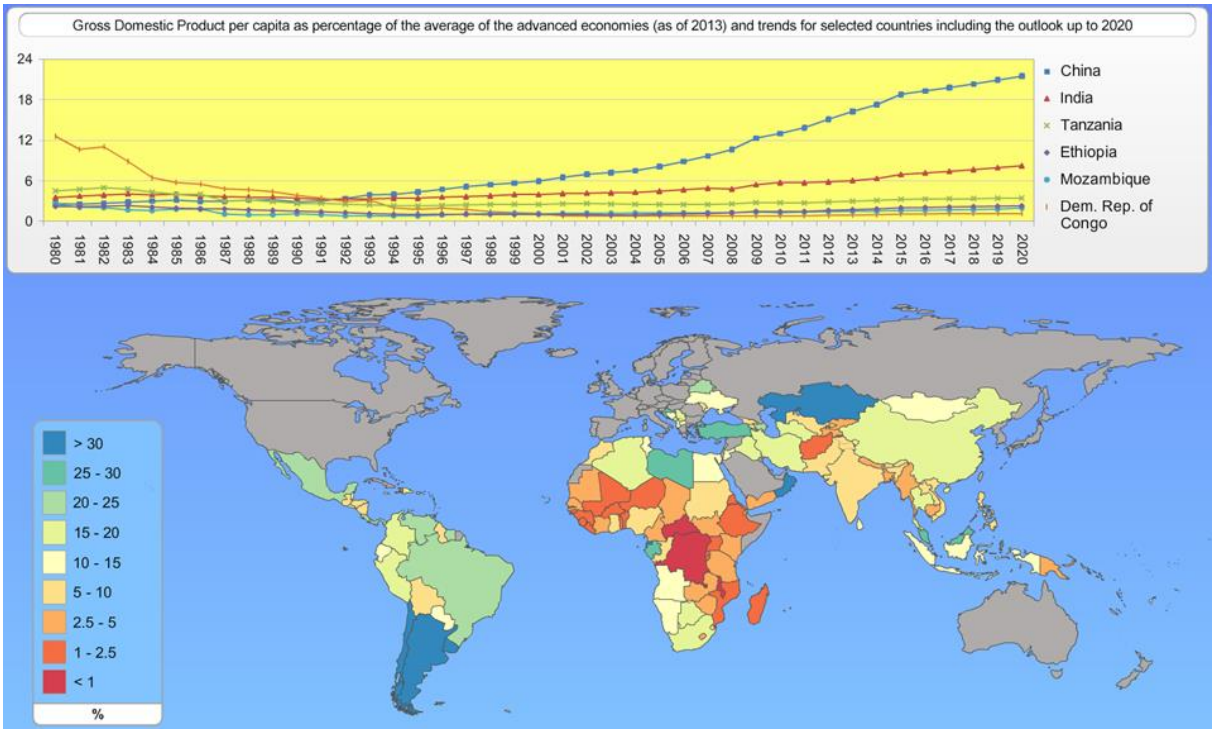
67 UNAIDS (2015): How AIDS changed everything, p. 101

Socio-economic Inequality and the Need for Redistribution of Resources

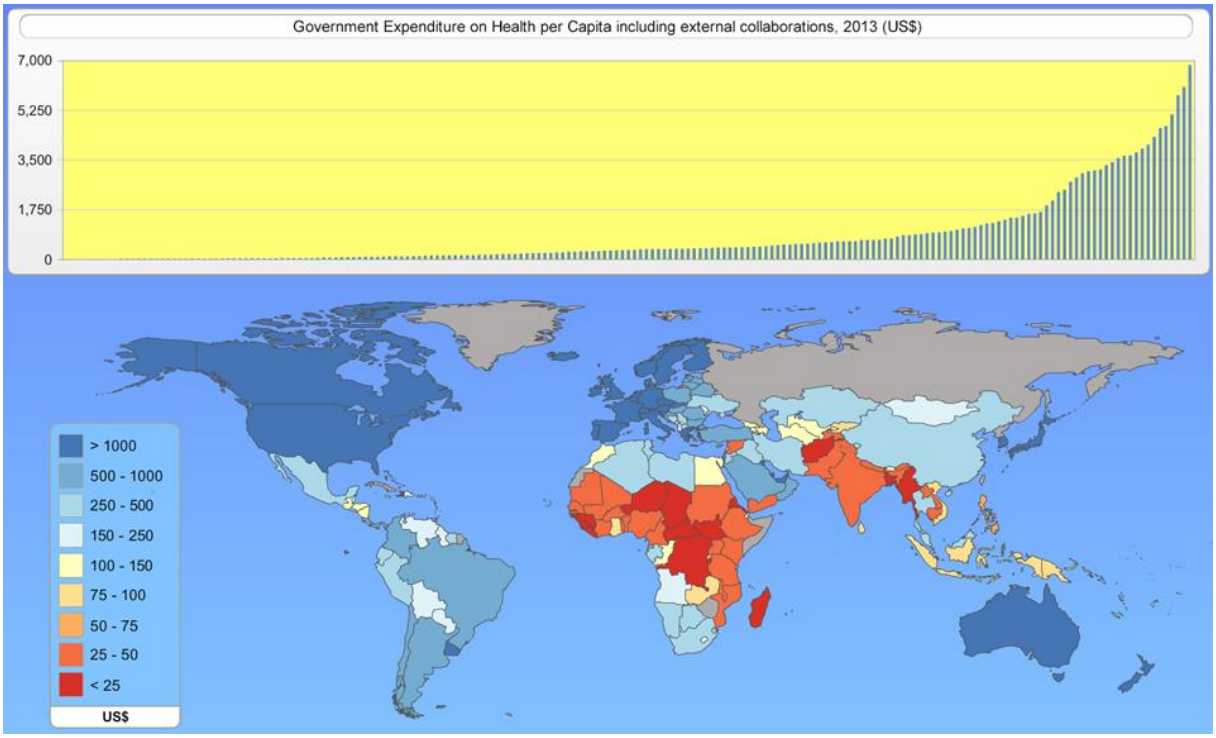
Apart from overcoming structural health risks as well as the investigation of the most serious health problems of mankind, the improvement of survival chances largely depends on raising the required financial and personnel resources. Under the present economic circumstances, many countries are unable to mobilize the financial resources required for the provision of essential health care services from tax revenue and other domestic sources. An analysis of relevant parameters and projections indicates that about 40 countries, even when significantly increasing their individual efforts, will not be in a position to at least cover the minimum financing needs for health by the end of the decade without external support. If the global community intends to take the health-related targets of the 2030 Agenda for Sustainable Development seriously, international cooperation in this area has to be significantly increased and it also has to be put on a more reliable basis. Otherwise, the implementation will fail particularly in those locations and populations that are affected by the most severe deficits in human development. And the noble principle of leaving no one behind could be a hollow phrase right from the beginning.

Regarding health care and other critical areas for people's life chances, the international cooperation should not only strive to ensure the absolute minimum, but also to reduce the huge gaps between and within countries. The overarching goal should be to orient scientific and technical progress towards the basic needs of the underprivileged majority of the world's population, and, at the same time, enabling them to fully participate in the results of this progress.

Contrary to some statements, which only refer to most recent trends, the international income disparities and thus the necessity of resource transfers within the latest generation has not declined. The per capita income of 63 developing countries out of a total of 95 countries with available data, i.e. about two thirds, has decreased between 1980 and 2014 in relation to the average income level of the economically better-off countries. The fact that China and India, the most populous countries, achieved a higher economic growth in this period than the average of advanced economies makes the picture more complicated with regard to global inequality on the population level. At the same time, both countries underwent a pronounced concentration of income in favour of the richest ten percent of their population, whereas the majority of people hardly benefited from the eco-



Source: IMF World Economic Outlook, April 2015, Mixed Calculation of international Dollars (purchasing power parities) and US$ based on exchange rates



Source: Global Health Expenditure Database, combining amounts based on power purchase parities and exchange rates

nomic development. Instead, they endure the destructive consequences linked to the ruthless model of industrialisation and enrichment. Of the remaining development regions, 1.9 billion people are living in countries that have economically fallen even further behind in recent decades compared to the industrialized countries. Presently 55 percent of all developing countries have per capita income levels that do not even reach one tenth of the average seen in economically privileged nations.[68]

Due to the generally lower revenues in relation to the Gross Domestic Product and smaller health shares of public expenditure, the backlog of public spending for health care is often even more pronounced for the majority of developing countries than with regard to the national incomes. When taking into account the overall resources including the contributions through development cooperation, government spending for health per capita in 69 percent of the disadvantaged countries was lower than one tenth of the average level of the rich nations. This percentage rises to 82 percent, when calculating solely the amount of resources that was raised from national financing sources. In 47 countries, domestic funds allocated by governments to provide health services amounted to less than 2 percent of the average spending level in industrialised countries. Apart from the particular importance of health for wellbeing and development opportunities, often even the survival of people, the economic reality also points to the central role of health promotion for international cooperation.

68 See also Rüppel, Joachim (2015): Mobilizing the Resources Required for Universal Health Coverage: Outline of a Global Compact towards Closing the Financing Gap by 2020. Würzburg, p. 16; ed.: Action against AIDS and Medical Mission Institute

International Obligations on Development and Health Financing

Unfortunately, the new development period already begins with severe political restrictions. The reason is that the new development agenda avoids a concrete and timely obligation with respect to the mobilisation of urgently needed financial resources. This applies to the promotion of official development cooperation by the economically privileged nations as well as to the respective efforts by the disadvantaged countries themselves. Government representatives took over this deficit from the outcome document adopted some months before at the Third International Conference on Financing for Development. Sad to say that the target for health financing does not go beyond non-binding statements, even though this sector is especially decisive for the realisation of the overall objective to ensure that all human beings can fulfil their potential in dignity and equality and in a healthy environment (Preamble).

It is imperative to overcome this attitude of many governments, which obviously refuse any firm commitments in order to favour the short-sighted interests of their own well-off clientele at the expense of the well-being of the vast majority of the world population. The definition of binding and appropriate financing targets for developmental efforts in general and health promotion in particular, is an indispensable prerequisite for the consistent implementation of the agenda. It also lays the basis for planning and implementation of the long-term support measures required for the strengthening of health systems, the training of professionals and the expansion of infrastructure.

Already back in 1970, the economically more advanced countries have pledged in a Resolution adopted by the United Nations to increase their Official Development Assistance (ODA) to at least 0.7 percent of their Gross National Income. Since this target was only reached by a few industrialised countries, the European Union decided on a step-by-step plan in May 2005 in order to implement the UN Resolution not later than 2015. Instead of consistently implementing this pledge, the majority of member countries had agreed upon yet another postponement prior to the Financing for Development Conference. Specifically, the European Union is planning to fulfil the UN target within the respective implementation period of the new development agenda, i.e. by 2030. During the crucial meeting of the EU Council for Foreign Affairs, Germany and France, in particular, are said to have prevented a renewed commitment to at least meet the financing target by 2020. This type of delaying tactic endangers the realisation of the sustainable development goals and undermines Europe's credibility as a key player of global cooperation regarding development and humanitarian issues. It is necessary and urgent to revise this position and to replace it with a binding time-plan in order to fulfil the commitment not later than 2020, i.e. half a century after the pledge had been made.

The Commission for Macroeconomics and Health, which had been appointed by the World Health Organization, as a result of detailed research in 2001 came to the conclusion that the better-off part of the world ought to allocate at least 0.1 percent of its gross income for the development of health services in poor countries. Some years later, this recommendation was confirmed by further studies of the United Nations Millennium Project. The project investigated and described the investments required in the different development sectors in order to reach the Millennium Development Goals.

Methodology

There are indeed many reasons to take a closer look at the issue of financing as a key factor of political economy of health. For this reason, for several years now, a close partnership has been established been Action against AIDS Germany and the Medical Mission Institute Würzburg. The objective of this collaboration is the comprehensive and realistic assessment as well as the quantification of Europe's contribution to Official Development Assistance overall and to the areas of health and HIV response, in particular.

For this purpose, the Medical Mission Institute has developed a methodology allowing a more precise estimate of the financial efforts for overall health promotion as well as for health-related Millennium Development Goals, such as HIV response and child health. The main focus lies on the review and the classification of all health-related aid activities according to analytical categories. This procedure comprises not only the projects and components, which have been reported as support to health, but also the activities identified because the respective description contains a health-related term. This applies to direct or bilateral cooperation between donor and developing countries as well as for the activities of health-relevant international organisations. The categorization uses a comprehensive definition of health that includes the basic elements of a health system as well as measures of prevention and the mitigation of social consequences of disease undertaken by other stakeholders outside the health system.

The database that documents the key data and descriptive information for all aid activities funded by official agencies of the member countries of DAC/OECD (Development Assistance Committee) constitutes the primary source of information. Furthermore, additional information is used, such as the reports to the Aid Transparency Initiative, project documents or other descriptions provided by the respective donor countries. This process is applied to correct those distortions that have occurred due to simple reporting errors and varying classification criteria. The primary goal is to provide a more accurate estimate that allows to compare the resource flows of different donor countries over the years as well as to relate them with the relevant needs analyses.

So far, the assessment covers the 17 European countries that had joined DAC/OECD before 2013. The study period begins in 2007, as complete data and meaningful project records were not made available for prior years. Last year, the study closed with the assessment of all aid activities implemented till 2013. This year, projects that have been implemented in 2014 are the main focus of the analysis. We are presently disposing of the assessment results of all health-related projects

that took place in the course of Germany's bilateral cooperation or those that have been funded by the most significant multilateral organisations such as EU institutions, the World Bank, the Global Fund and various UN Organisations. Overall, the research completed to date reviewed almost 105,000 project records containing individual project descriptions. In addition, the classification process included about 95,000 project components funded by the International Development Association (IDA) of the World Bank as well as over 127.000 activities reported by UN Organisations with typological descriptions.

While the study is the core piece, the scope of analysis was extended both geographically and regarding its temporal perspective for this report in order to produce a reliable estimate of the overall ODA disbursements for health in the form of grants during the entire MDG implementation period. For the years 2000 to 2006, the assessment had to resort to the data provided by donors on new commitments specified by sectors, as the data for disbursements are incomplete. The analysis of bilateral cooperation on the part of the six non-European DAC countries from 2007 to 2013 is based on the officially reported aggregate data regarding the volumes and sectoral distribution of the ODA disbursements. In both instances, an adjustment was made using the empirical figures drawn from the study that indicate the respective percentages of resource flows reported in various sectors, which on average are supporting health promotion. On the one hand, this procedure results in lowering the amounts of ODA disbursements that were officially recorded as health activities. On the other hand it takes into account the respective proportions of ODA flows that were reported under other relevant sectors, such as education, governance and civil society, social infrastructure, humanitarian assistance or multi-sectoral approaches. For almost half of the donor countries including Germany, this tends to result in a higher estimate, whereas the adjustment has a reducing effect for all other DAC countries. This is an approximation to reality based on the evidence of the project-based assessment. It has been proven that a substantial amount of projects, which had been reported as directly supporting health promotion and certain sub-sectors, in fact do not coincide with the range of interventions as defined in relevant needs assessments. On the other hand, there is also a range of activities recorded in other sectors, which, at least partially, are to be classified as health measures.

In the case of Germany, the estimate of bilateral ODA disbursements for health in 2014 is already based on the review of the individual projects. For all other DAC countries, a preliminary calculation was prepared on the basis of official figures on the sectoral distribution of ODA disbursements applying the adjustment process described above. The calculation of health disbursements in the framework of

bilateral cooperation of all donors as well as the multilateral organisations in 2015 is based on the determination of the health share in the overall financial commitments over the past three years (2012 to 2014). For this purpose, it was possible to use the consolidated results of the project review in the case of Germany. As far as the disbursements for the fight against the Ebola epidemic are supposed to represent additional funding in support of health, they have been taken into account for these two years. For this purpose, the information provided by "ONE" and the data for humanitarian aid in favour of the three most affected countries have been combined.

The report reflects the current state of the assessment using the best data available at the moment. The future assessment of ODA expenditures for health, the HIV response and other priority health problems will increase the precision of these estimates. Based on previous experience, the project-based review will result in figures, which tend to be higher than official numbers.

This analysis focuses on ODA contributions, which have been actually transferred in the form of grants to developing countries or to relevant international organisations active in development cooperation. Only these resource transfers can, in principle, be used in order to meet the vast financing needs of the particularly disadvantaged countries and population groups supporting the priority sectors, which are imperative for human development such as the health sector. They also represent a real financial effort, whereas loans and equity investments are repaid to the donor countries, frequently with considerable interest rates and profits and in many instances monies from the capital market are used for such investments, as in the case of Germany. Furthermore, the real transfers of ODA grants between donor countries are comparable, whereas the actual financial consequences of the loans, which are imputed as ODA, both on the part of the providing countries as well as on the part of the receiving countries, are hardly calculable.

Overview of the Financial Efforts for the Realisation of the MDGs

Before taking a closer look at the ODA contributions for the different dimensions of the analysis, the below graphs will display the overall constellation of the most important performance benchmarks.

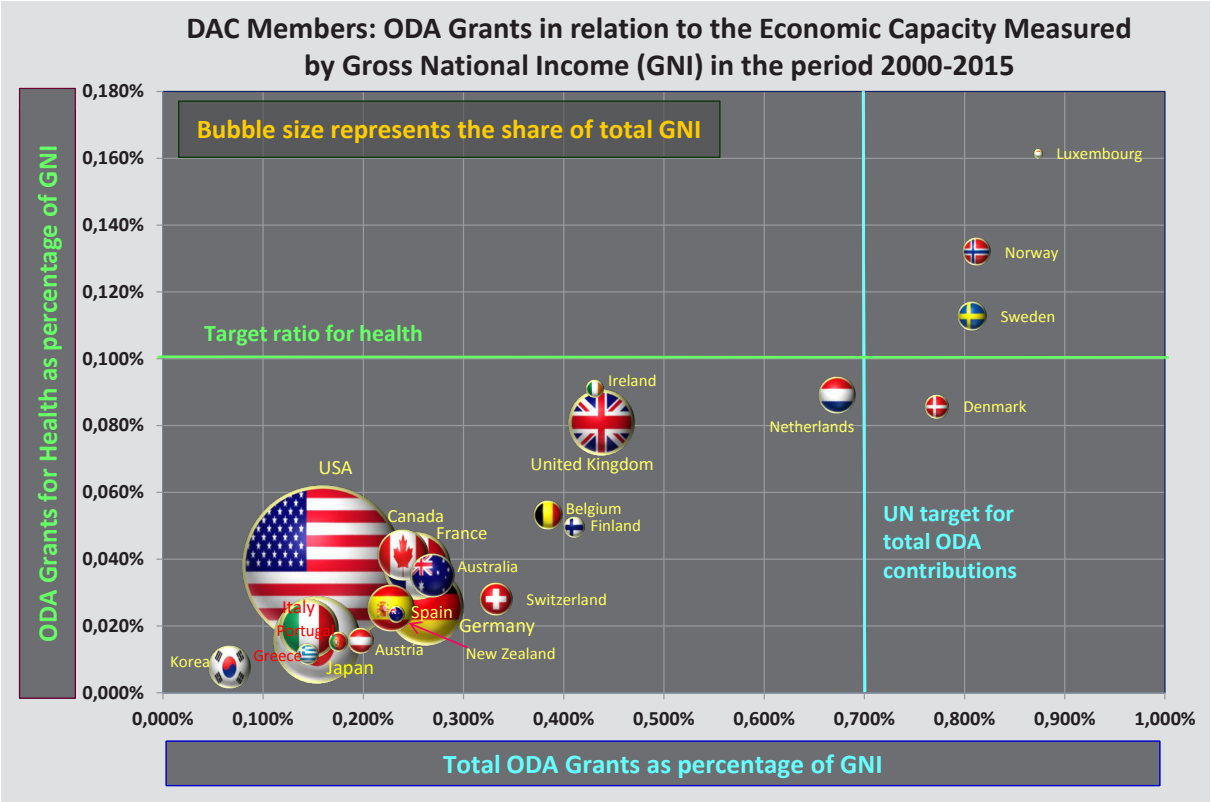
The first overview shows the financial efforts throughout the entire implementation period of the MDGs. This indicates that Norway and Sweden are the only two countries that have consequently fulfilled and exceeded the UN target for the overall ODA contributions as well as the recommendation by the WHO Commission for the cooperation in the health sector. When looking at the entire MDG period, Denmark has also achieved the target for the overall ODA and, with a ratio

of 0.086 percent in relation to GNI, the ODA grants for health remained just below the recommended level. The Netherlands also came close to reaching both target figures. The contributions for the improvement of the health situation in developing countries provided by Ireland and the United Kingdom are also quite remarkable. The United Kingdom is also the only G7-member state, which has at least demonstrated above-average efforts. Belgium and Finland reached almost 50 percent of the envisaged contribution level for both dimensions.

Regardless of the quite significant differences, all other 14 DAC member countries are far from fulfilling their respective obligation. With a ratio of 0.262 percent of GNI for total contributions, i.e. less than 40 per cent of the target level, Germany remained far below its economic potential. The financial effort in supporting health care with a GNI share of 0.026 percent, i.e. only one fourth of the recommended percentage, is even more inadequate. The reverse situation was seen in the case of the United States of America that have the largest economy by far. Regarding the overall contributions, the USA only achieved a ratio of hardly 0.16 percent representing less than one fourth of the UN benchmark, but ODA grants in support of health promotion amounted to 0.038 percent of the GNI. Japan, the donor country having the second-largest economic capacity, even lags far behind these truly unsatisfactory contribution levels only reaching GNI ratios of 0.154 and 0.017 percent, respectively. Since these three countries account for 58 percent of the overall economic capacity for this entire period, the inadequate fulfilment of the internationally agreed or recommended financing targets by the respective governments had a serious impact on the total volume of resources mobilized in order to achieve the MDGs in particularly deprived countries.

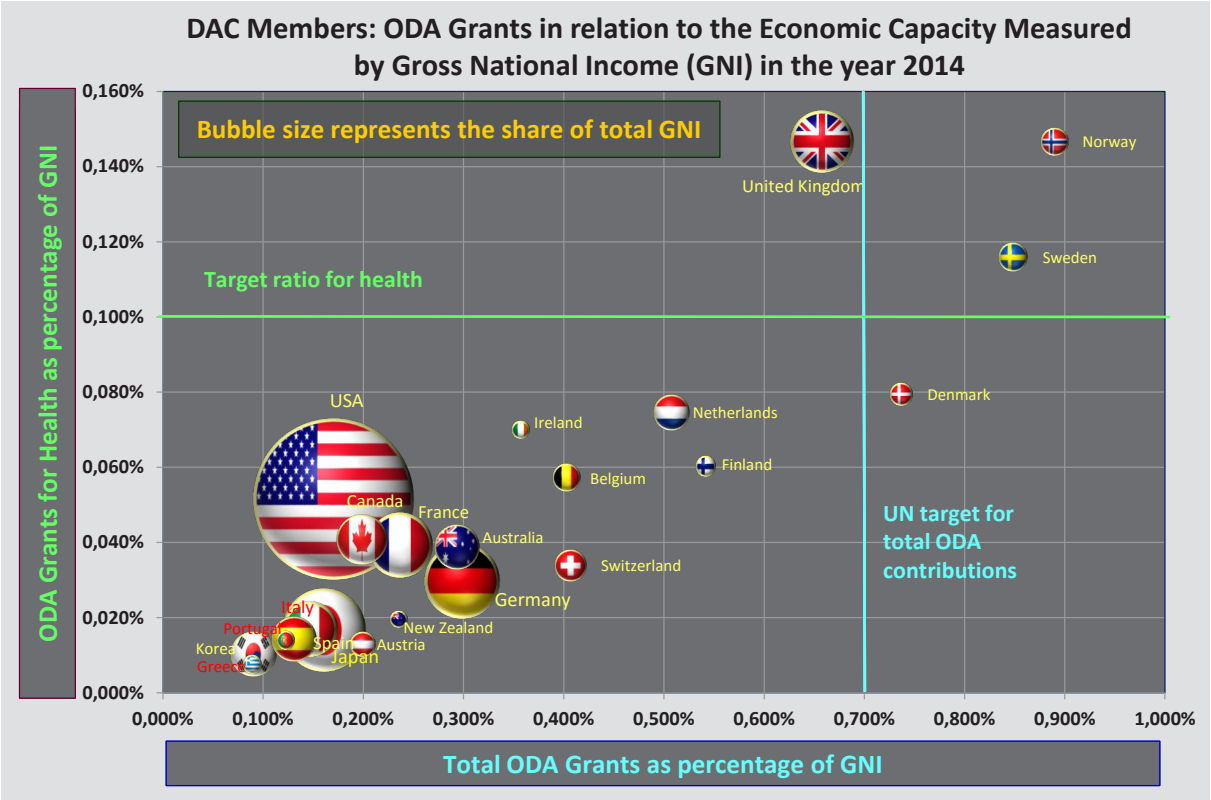
While the debt crisis in some of the remaining countries may be a partial explanation for the insufficient level of contribution, this cannot be accepted as an excuse for the majority of the other countries. Austria's performance has been especially poor in this respect with a total ratio of barely 0.2 percent and contributions for health of merely 0.015 percent of the GNI.

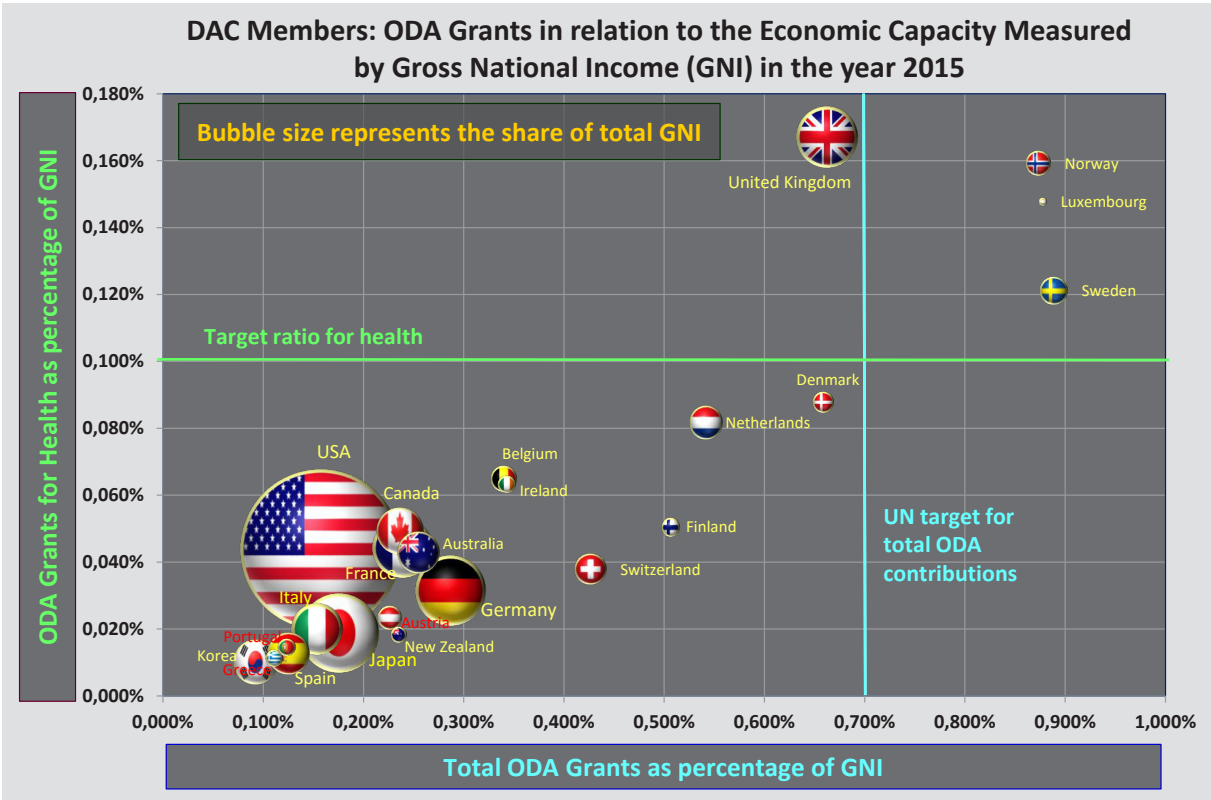
The following graph shows the contributions provided in the year 2014. The calculations are based on final data on the overall ODA grants, whereas the estimates of the contributions for health, with the exception of Germany, were produced by combining the officially reported data with the empirical values resulting from previous research. Thus, the graph allows a comparison of verified and largely secured estimates in the case of Germany with calculated results for all other DAC countries, which, in the course of the project-based analysis, will have to expect minor (in case of 16 European donor countries) or more significant (in case of the non-European countries) adjustments.



The graph for the year 2015 reflects the calculation of the overall grants on the basis of preliminary OECD data and estimates of the ODA for health based on precisely these figures as well as the sectoral distribution of recent commitments. Regardless of the remaining margins of uncertainty, it allows to get a clear picture of the current situation.

First it should be noted that the two best performing donors have held this position also in the recent past. All other countries should take them as an example. On the positive side, it can be said that the United Kingdom has also reached this high contribution level in the health area in recent years. The UK comes close to fulfilling the UN target for overall contributions, even without counting questionable expenditure items and accounting entries. Thus, the first G7 member country has met the targets and, in doing so, has mobilized a considerable amount of additional funds for development cooperation.





In contrast, Germany's financial efforts continue to be quite insufficient, even if the respective ratios were somewhat higher in recent years compared to the period as a whole. With 0.28 percent of GNI recorded for the overall ODA grants (in both

years) that were really transferred to developing countries as well as 0.030 percent (2014) and 0.031 percent (2015) of GNI concerning the grants in support of health, the contributions lag far behind the required level, which would be appropriate for a responsible player in global development. Presently, Germany ranks 11th for overall ODA grants and only 15th regarding the level of support for health promotion. This is indeed a disturbing result, when taking into account that at least 4 of the 22 long-standing DAC member countries are struggling with the massive consequences of the debt crisis, whereas Germany's national economy has recovered outstandingly fast.

Meanwhile, the USA has reached 50 percent of the health-related target ratio, but the country has lately fallen back due to the delayed payment of the contribution to the Global Fund. Regarding the overall contributions, the USA belongs to the worst performing donor countries reaching 18th place in 2015. Similarly, Japan demonstrates a very weak performance, allocating only a small proportion of its limited ODA grants for health promotion and ranking 18th in this respect, with a ratio that increased slightly to 0.019 percent of GNI.

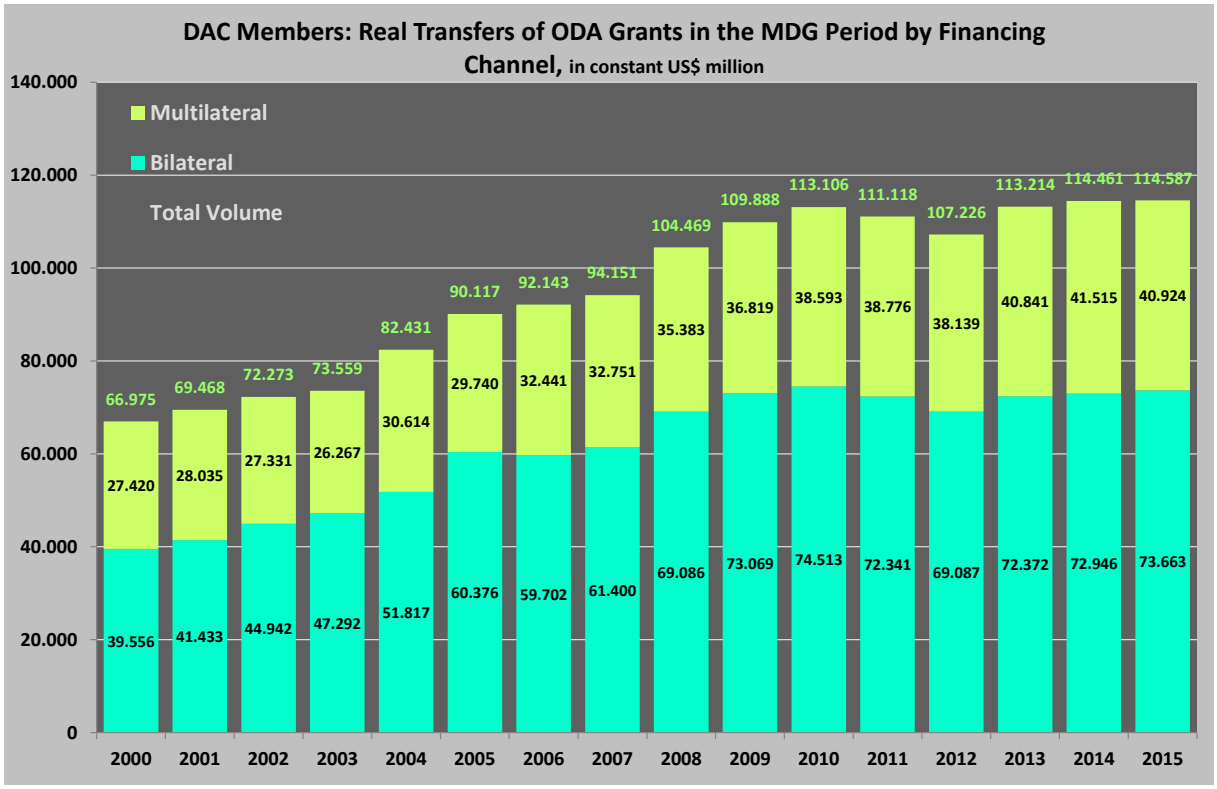
Development cooperation is still suffering from the fact that precisely those countries, which have the highest economic potential and, hence, importance for development cooperation, are showing completely unsatisfactory levels of financial effort. There is also a considerable risk that the majority of the economically advanced countries, which fall well short regarding their real ODA contributions in relation to economic capacity, will virtually turn the non-fulfilment of the international agreements and recommendations pertaining to development and health financing into a factual norm. This would be a fatal convergence not only for the realization of the new development agenda, but also for the urgently required international cooperation in regard to all global challenges and crises posing a threat for the future of the human family.

Overall Performance for Development Cooperation during the MDG Era

Overall ODA grants, after adjusting for inflation and exchange rates, provided by all DAC member countries combined have considerably increased during the first decade and in 2010 they were almost 70 percent higher than at the turn of the millennium. The adoption of the Millennium Declaration and the proclamation of the envisaged Millennium Development Goals have certainly had a positive impact. The pressure that was exerted by the organised civil society as well as the public opinion in general has motivated governments in many countries to increase their financial contributions. However, it has to be taken into account during the as-

sessment, that the initial level was extremely low compared to the huge demand for development financing since many developing countries have fallen back economically even further in the previous decades and the capabilities of their services of general interest suffered from the devastating consequences of so-called structural adjustment programmes. If all DAC countries had just met the UN target in 2015, the total volume of ODA grants would have reached more than 321 billion US$ at constant price and exchange levels of 2014. Instead, the amount of ODA grants that was actually raised merely represents 36 percent of this hypothetical figure.

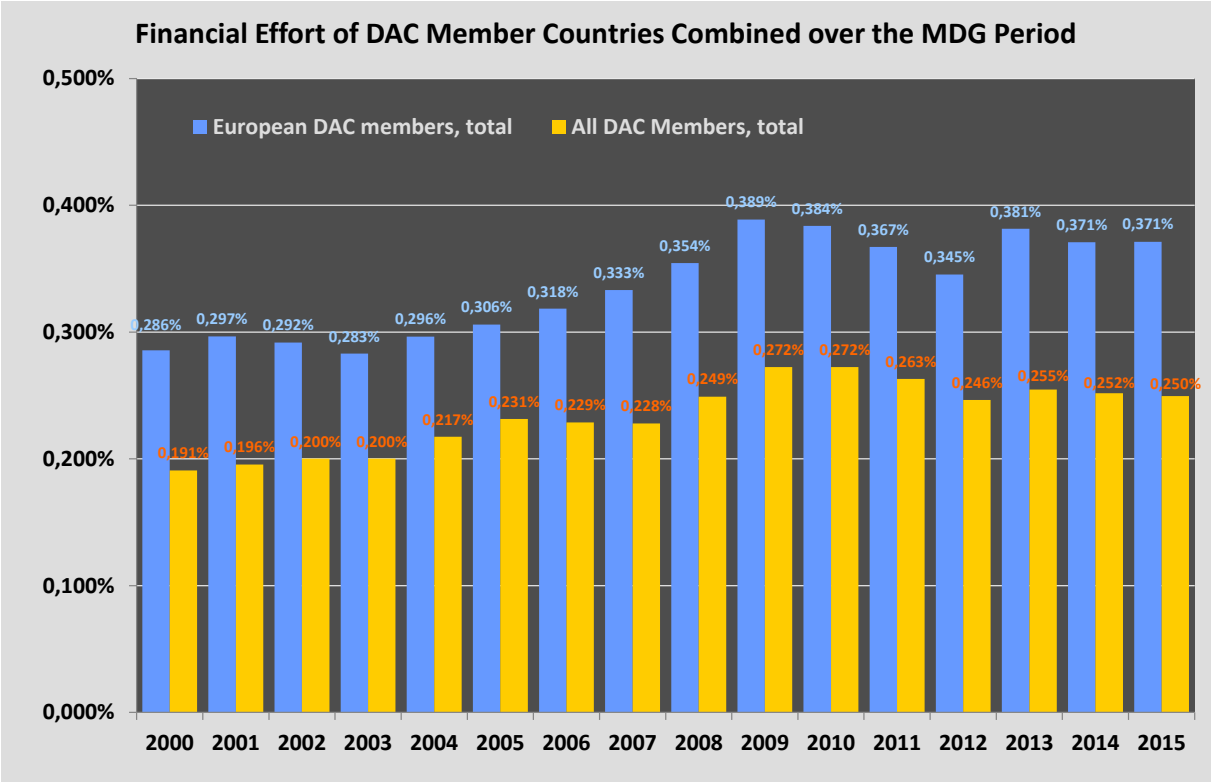
Meanwhile, the setback that occurred in the wake of the debt crisis has been reversed. The absolute level of the total contributions in recent years was only slightly higher than in 2010 and it stagnated during the final year of the MDG period.



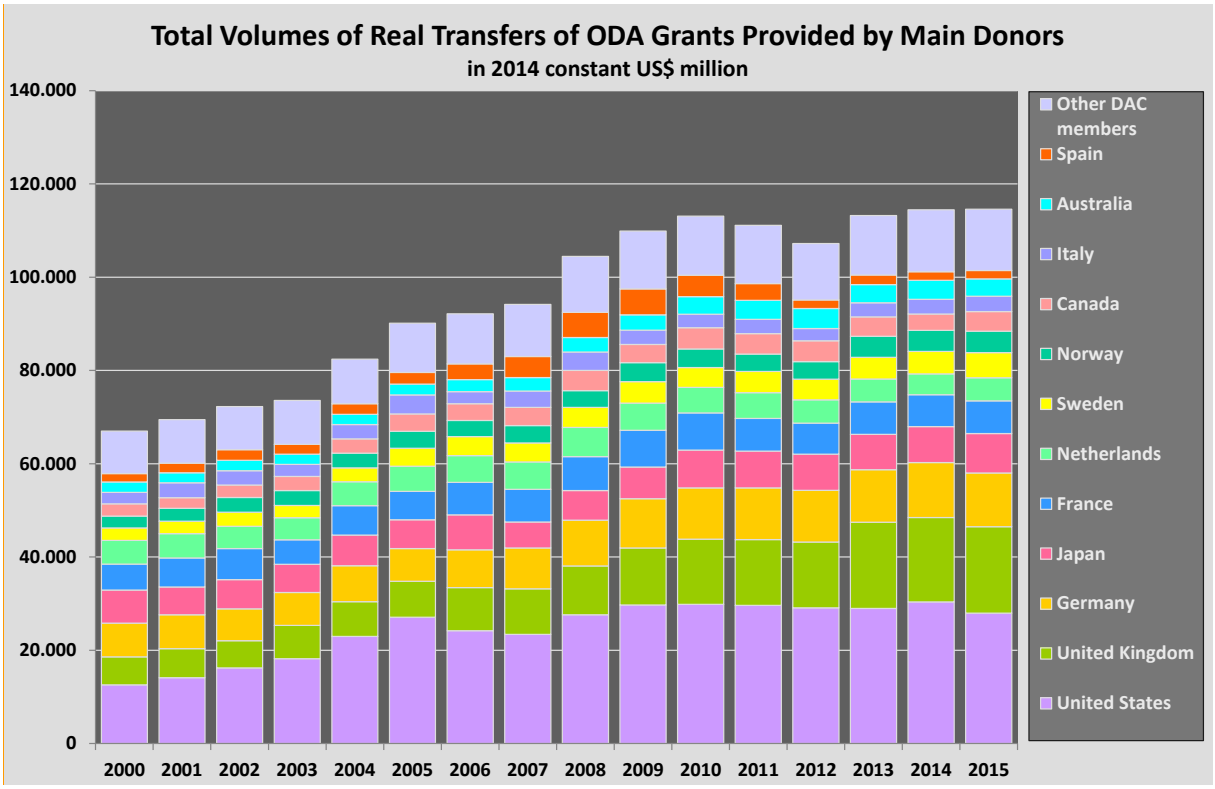
As the following graph shows, the financial efforts during the first decade have increased as well. The ODA grants that have been raised by all DAC countries taken together as well as the contributions made available by all European DAC members combined, reached its highest level relative to the respective GNI in the year 2009 so far. Following the beginning of the debt crisis, both ratios have diminished and they have only slightly recovered up to now. This is the result of the above-men-

tioned tendency of stagnation of the amounts in absolute terms, whereas the GNI values of most countries, except for Greece, Spain and Italy, meanwhile exceed pre-crisis levels by a considerable margin. In 2015, the GNI of the European DAC members was 10 percent higher than in 2009, an increase of close to 14 percent can be recorded for all DAC countries, and Germany even reached a real growth of more than 15 percent.

The contribution level of the European donor countries combined, amounting to 0.338 percent of the GNI, was significantly higher than the average recorded for all DAC countries taken together of 0.236 percent, when looking at the overall MDG period. This difference of about 0.1 percent applies to the entire period and can mainly be ascribed to the extremely below-average efforts by the two countries with the largest economies, namely USA and Japan.



The overview of the real grant transfers provided by the most important donors illustrates that the real renewed growth of the total volumes of ODA grants after 2010 was mainly due to the additional efforts made by the United Kingdom, with an increase of almost 4.6 billion US$. Sweden – also having benefited from an above-average economic growth – and Switzerland increased the amount of ODA grants by more than a billion US$ each.

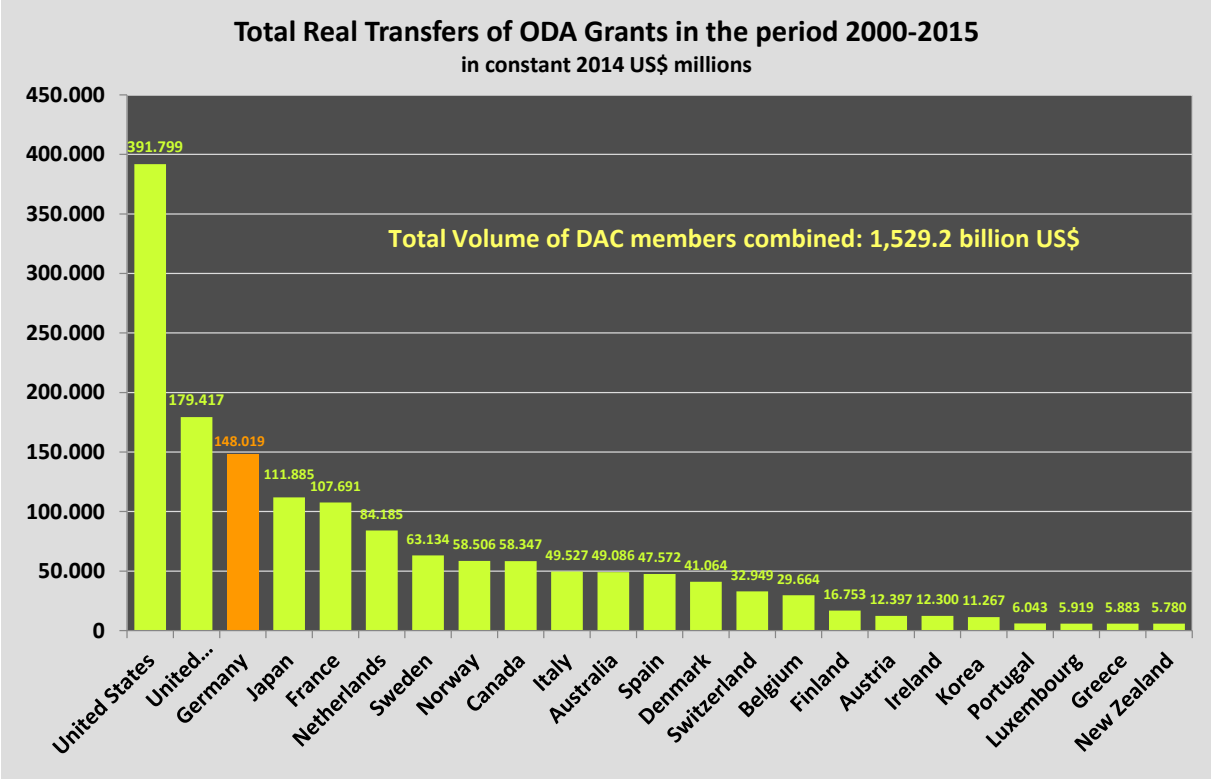


In contrast, the growth of the German contribution by 518 million appears to be quite modest, especially when taking into account the significantly higher economic potential. Since the beginning of the debt crisis, 11 DAC countries have increased their genuine ODA contributions, while the remaining 12 DAC countries reduced their funding. The biggest cuts in absolute numbers over the last five-year period were recorded for Spain (2.8 billion US$), the USA (1.9 billion US$) and France (about 1 billion US$).

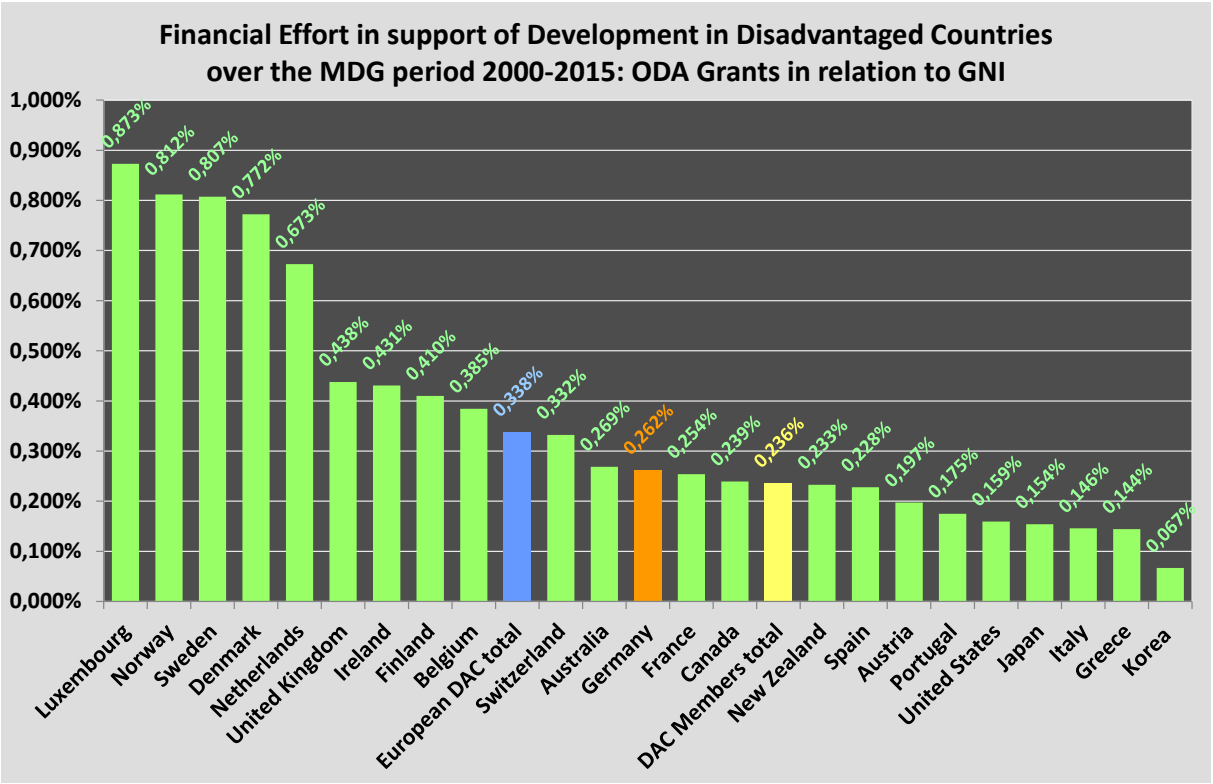
Apart from the special case of Korea that joined DAC more recently in 2010, the United Kingdom achieved the highest growth rates throughout the MDG period by tripling the total amount of grants. After all, Sweden and Ireland doubled their contributions for development cooperation. The same applies for the USA, however starting from an extremely low level. Germany's ODA contributions rose by 60 percent, which is still below the average increase of the DAC countries overall (71 percent) and the European members (63 percent). Out of the 23 DAC member countries, Denmark, Greece, Portugal, the Netherlands and Spain have lowered their contributions since the adoption of the Millennium Declaration.

In the 16 years since the turn of the millennium, the cumulated volume of ODA grants totalled slightly over 1.5 trillion US$ expressed in constant prices and exchange rates of 2014. If all DAC countries had consistently realized the UN target, the total volume would be three times higher and would have added up to over 4.5

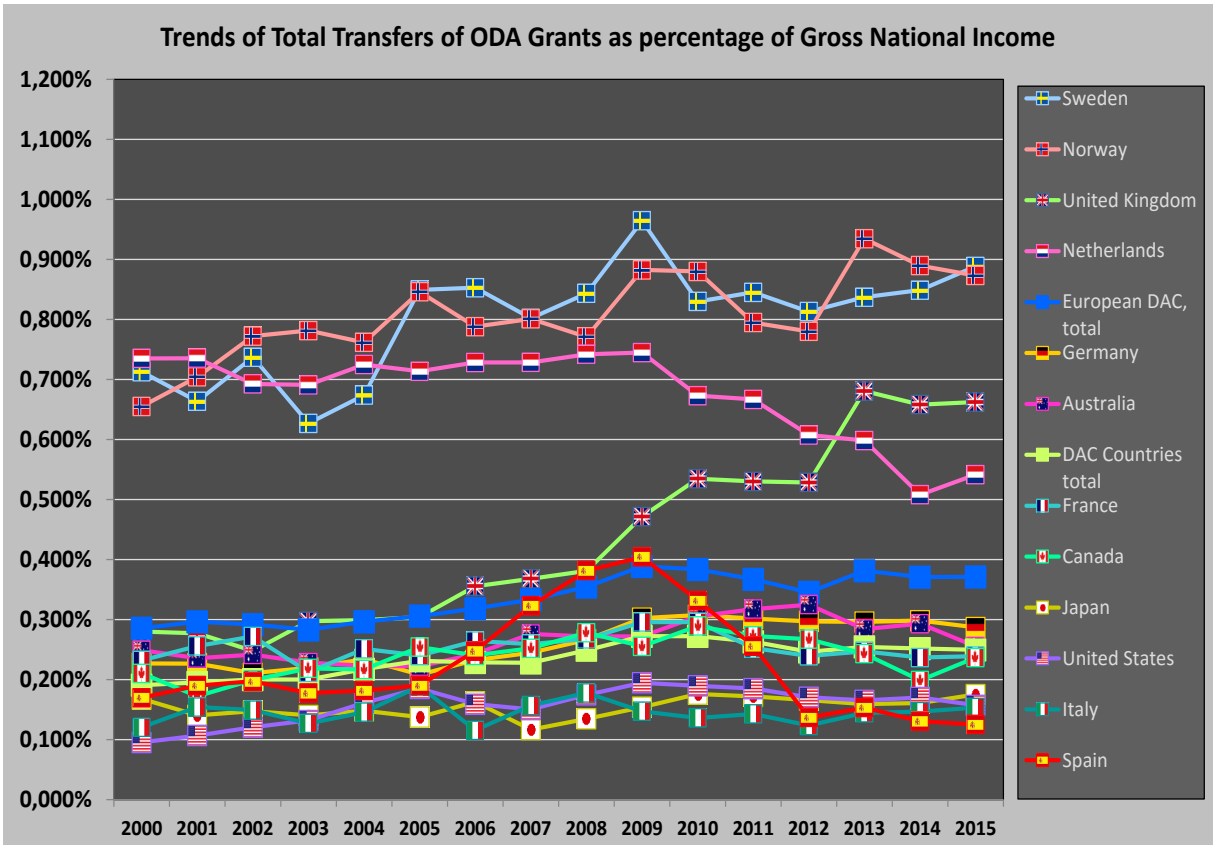
trillion US$. Due to the well below-average performance of Japan and the relatively high efforts by the United Kingdom, Germany ranks third regarding the absolute amounts of ODA grants. The volume of about 148 billion US$ raised in the MDG period represented 9.7 percent of the total financial resources.



The picture is quite different when the ODA contributions of the various countries are put in relation to the economic capacities and thus looking at the actual financial efforts during the MDG era. Only 4 out of the 23 DAC countries reached the UN-agreed ratio and one other country almost met this target. Due to the very low contribution levels of the countries particularly affected by the crisis and the two largest national economies, Germany can be found in midfield. Germany's efforts are far below European average and little above the simple average value of all DAC countries.

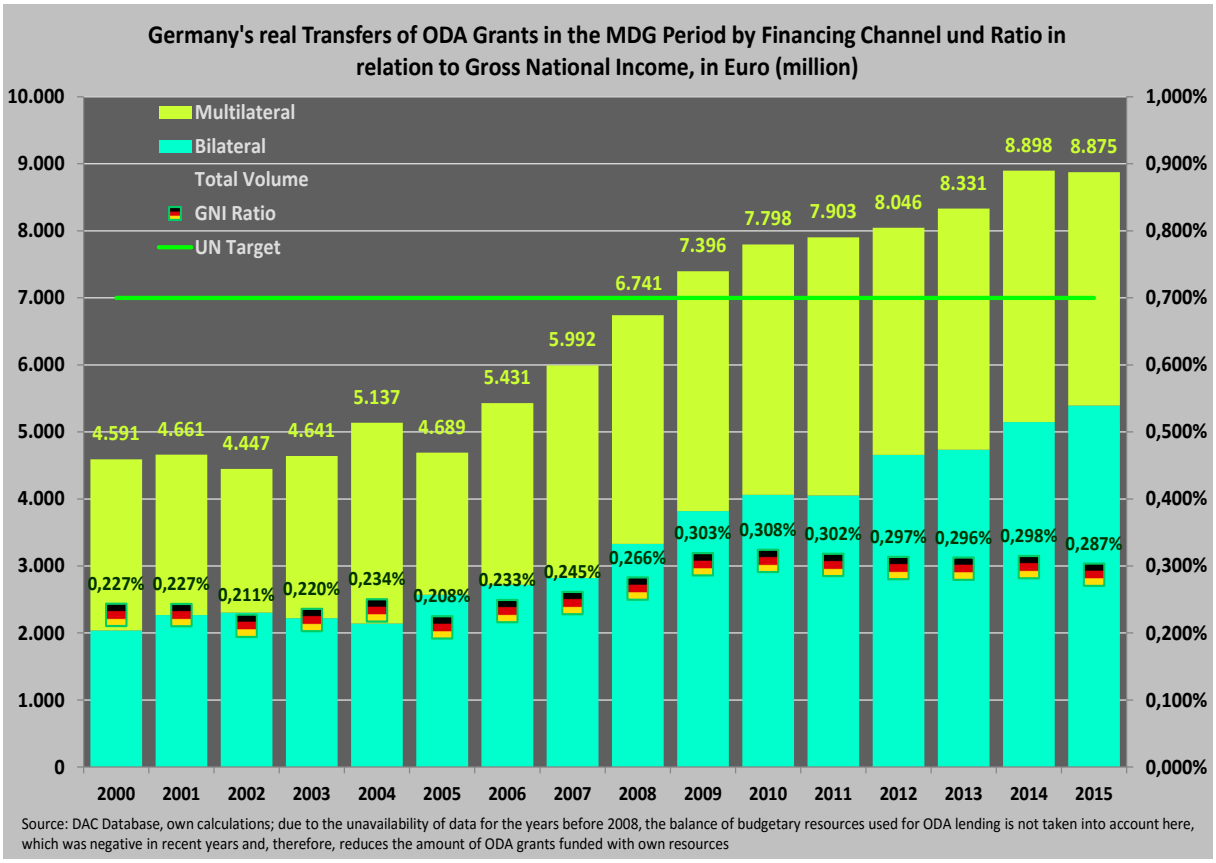


The development of financial efforts since the year 2000 shows that most DAC countries did not undergo noticeable changes of their positions within the donor structure. However, there are some exceptions with positive and also negative tendencies. The United Kingdom has by far made the biggest progress by raising its grant ratio between 2005 and 2013 alone, from 0.304 to 0.681 percent of the GNI and has almost held this level ever since. Special emphasis should also be placed on Norway and Sweden that have continuously fulfilled the UN target since 2001 and 2005, respectively, and even exceeded the benchmark by far in most years.



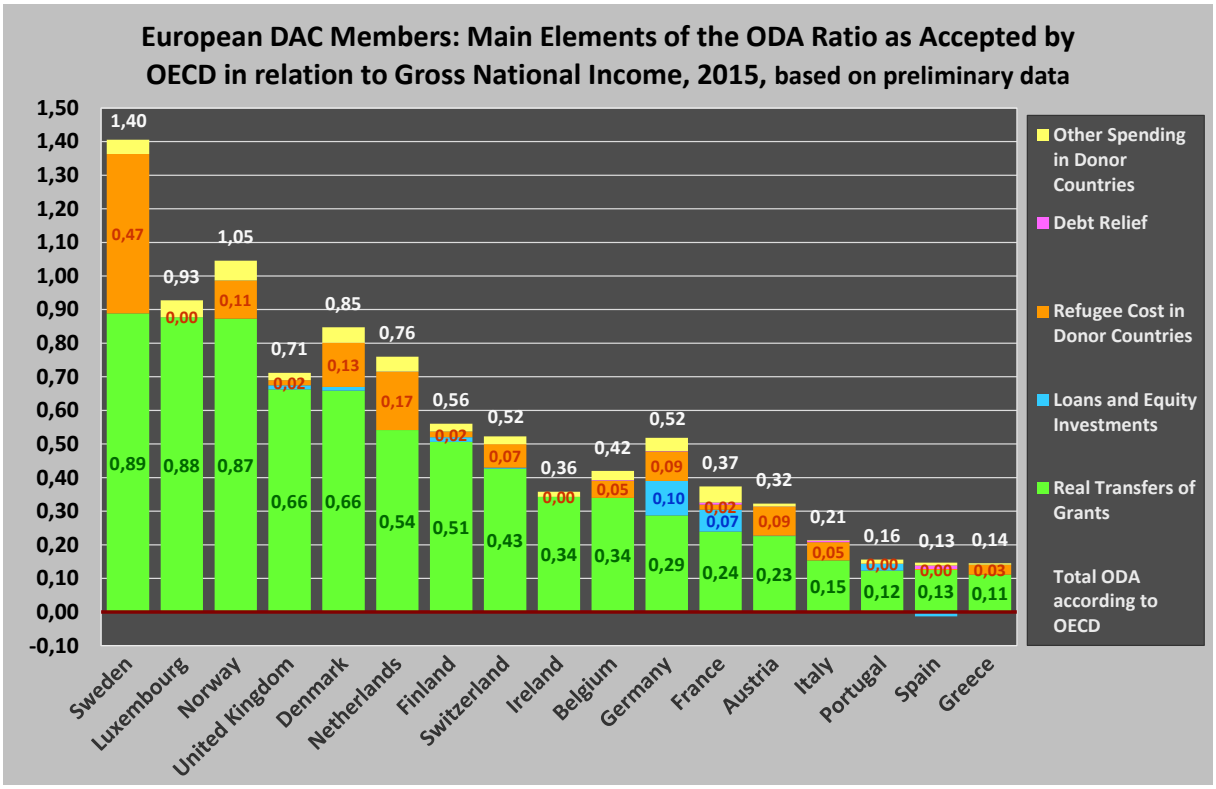
The Netherlands exhibit a trend in the opposite direction to the extent that the GNI ratio fell well below the target level in recent years. Spain represents the most dramatic example here. This country had achieved the highest growth rates between 2005 and 2009. But then within a few years, the country dropped from a good midfield position to last place among the more important donor countries.

When looking specifically at Germany's ODA contributions, we observe that only during the short period from 2006 to 2009 the annual increase of ODA grants was sufficiently high in order to significantly raise the GNI ratio, whereas in most years the trend at best kept up with the economic growth. It must be noted that the financial effort for development cooperation as a whole has been stagnating on a completely insufficient level for a considerable time period since then.

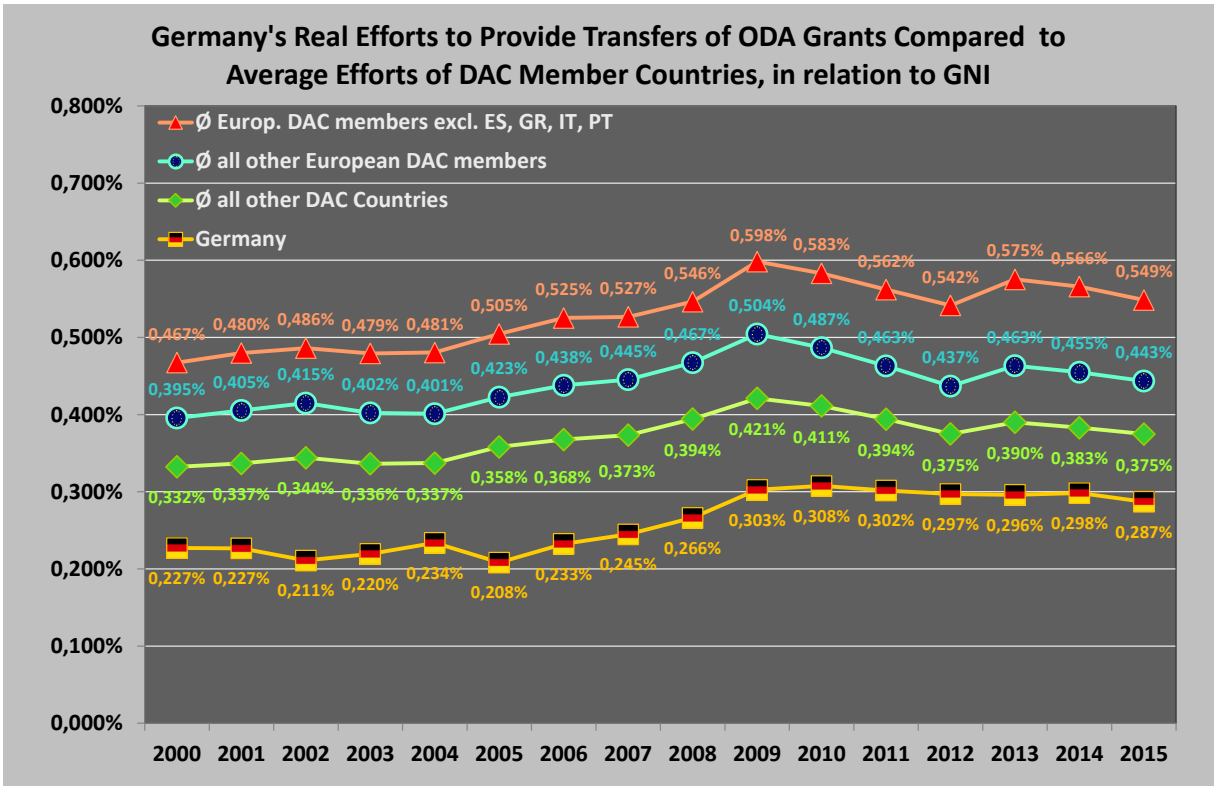


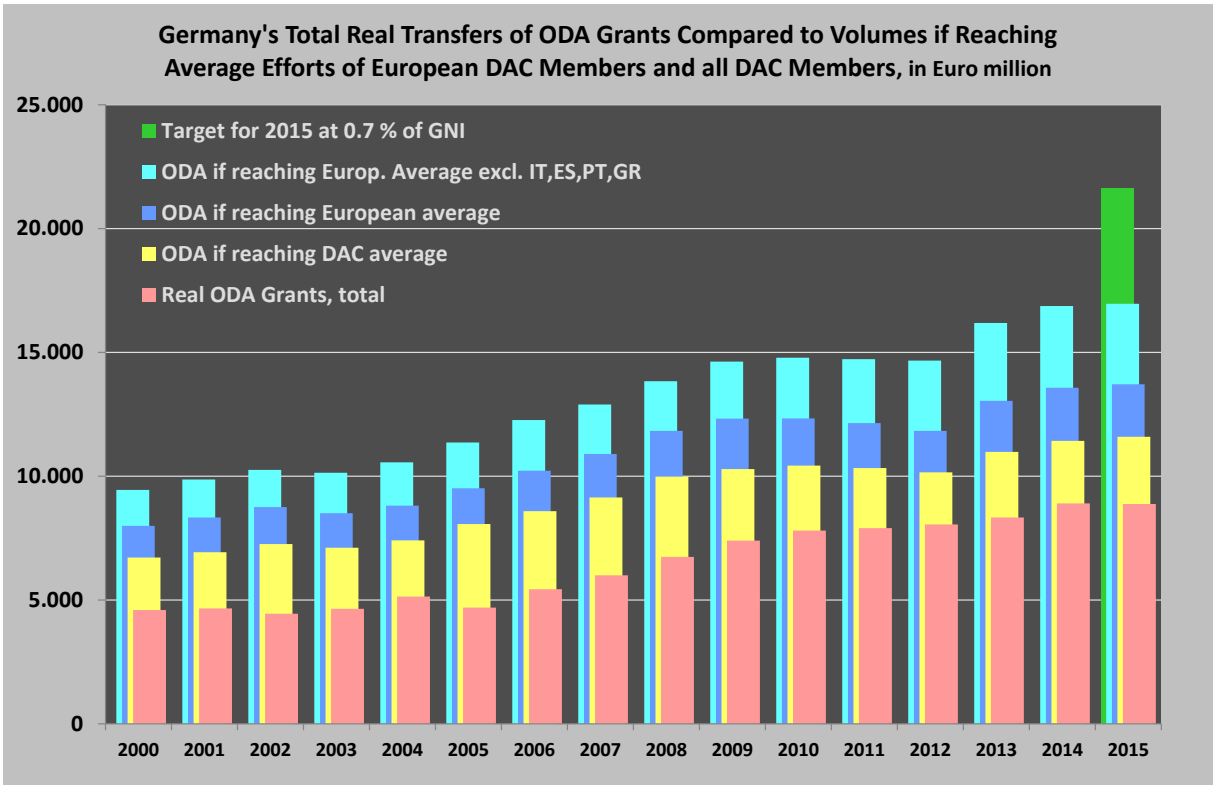
Source: DAC Database, own calculations; due to the unavailability of data for the years before 2008, the balance of budgetary resources used for ODA lending is not taken into account here, which was negative in recent years and, therefore, reduces the amount of ODA grants funded with own resources

Instead of a genuine increase of financial efforts, the focus has obviously shifted to an artificial inflation of the official ODA ratio through an extraordinary expansion of loans and equity investments. Since the reimbursements spread over a number of years, the balance that is counted as ODA applying current OECD criteria can thus be increased, at least on the short term. This type of manoeuvre also benefits from the fact that the official calculation procedure is not taking into account the interest repayments received by donors. The additional funds are not paid out of the government budget but are raised on the capital market, thus making a mockery of the concept of "official" or public development assistance. Except for a small surplus in 2011, the balance of the budgetary resources used for loans was clearly negative, i.e. the recipient countries concerned are practically counter-financing a corresponding portion of the extended grants. Moreover, Germany, with a weighted average of 2.34 percent, charges the highest interest rates of all relevant bilateral and multilateral providers of ODA loans. Meanwhile, there is no other donor country that profits more from this practice of counting questionable items as ODA, which are neither to the benefit of the neediest countries, nor do they represent an actual effort. In 2015 this cosmetic improvement of the ODA statistic increased to 0.1 percent of the GNI.



When looking at the genuine efforts for development financing, it is quite apparent that Germany lagged far behind the average performance of the other DAC countries and especially the European donor countries, and the gap has not become smaller over the years.





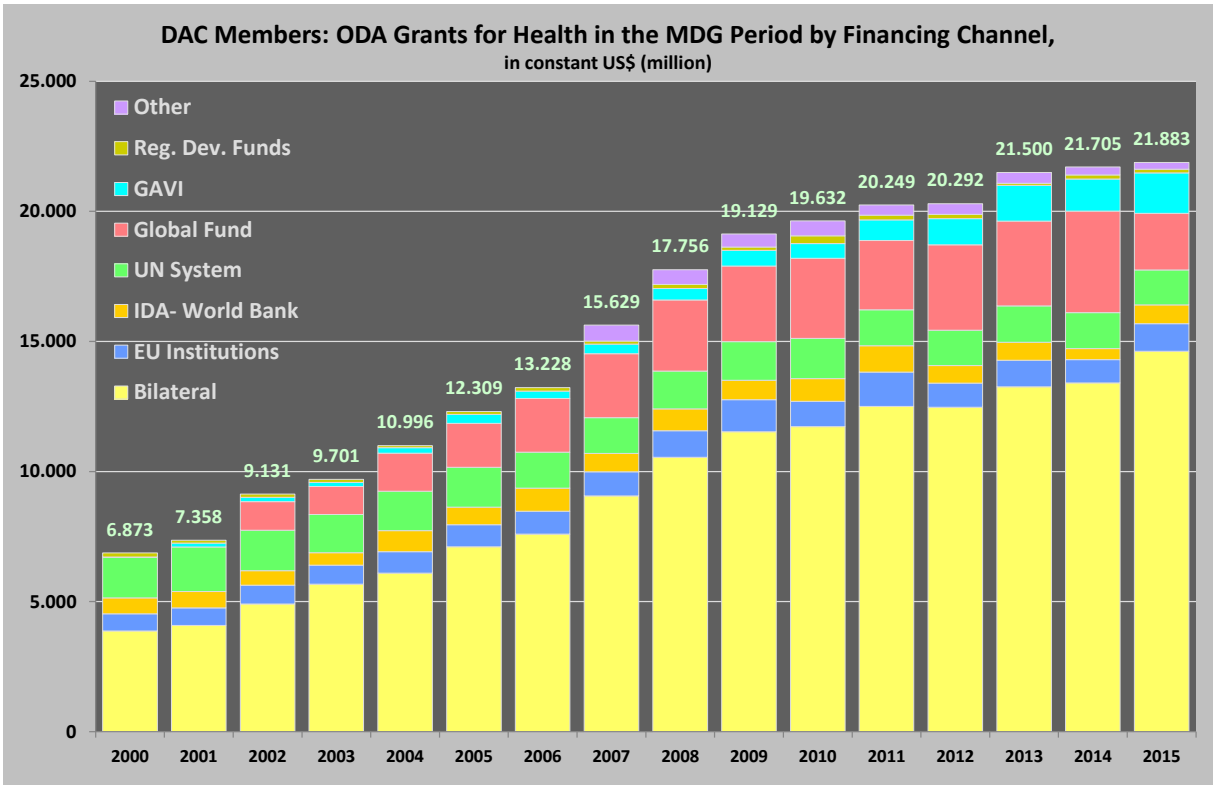
Virtually throughout the entire timeframe of the realisation of the MDGs, Germany's ODA contributions amounted to about half of the average contribution level of the other European DAC members, especially when excluding those countries most severely affected by the debt crisis. If Germany would have reached this level, it would have added up to an overall contribution of more than 209 billion euros, whereas the actual contributions made throughout the MDG period amounted to less than 104 billion euros.

Genuine ODA contributions for Global Health

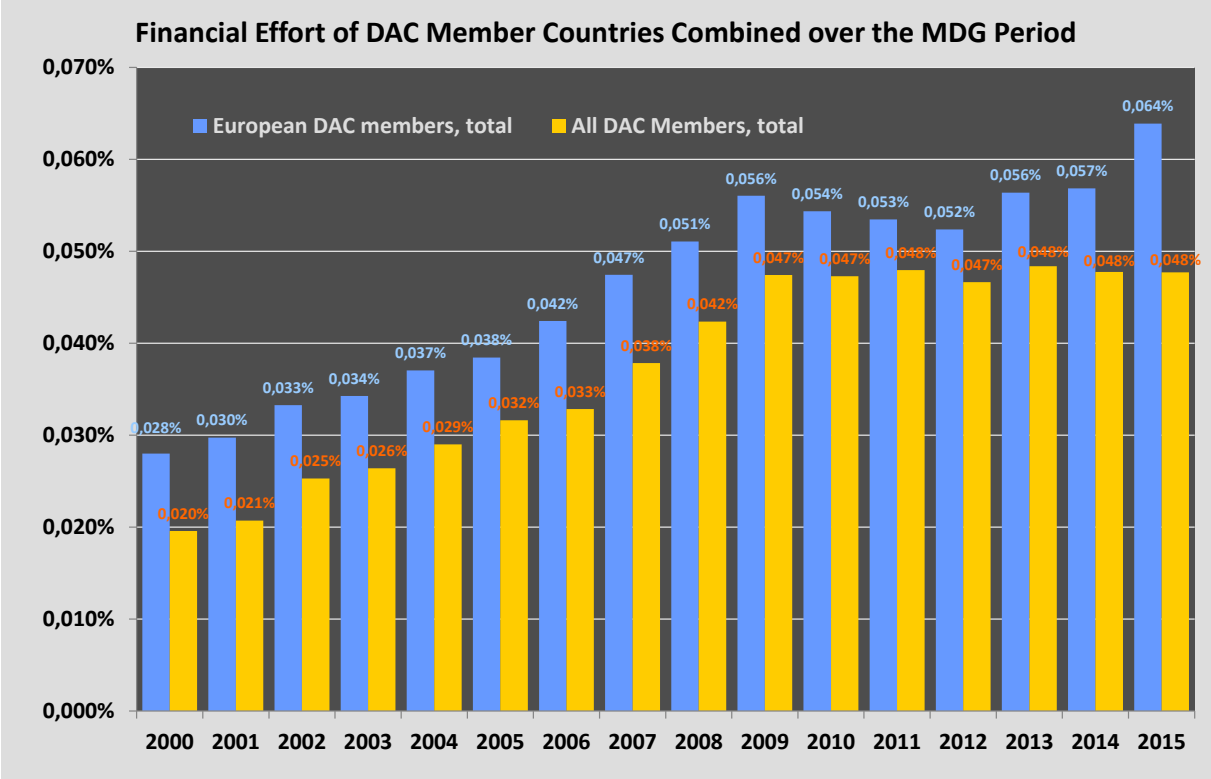
The real ODA grants for the health sector expressed in constant US$ have tripled in the course of the MDG period. This can certainly be regarded as a notable success for the international community and civil society played an essential role in this positive change. Therefore, it was possible to save the lives of millions of people, which is the primary objective of cooperation in support of health care. It also becomes apparent that the Global Fund has quickly turned into the most important multilateral financing instrument, whereby the decline of payments seen in 2015 can mainly be ascribed to the delayed disbursement of the US contribution. The stagnation of the contributions for health through core contributions to the relevant UN organisations did not only have a negative effect on the mobilisation

of the required resources, but also on the conceptual formulation and global coordination of development cooperation in the health sector.

Furthermore, the increase of ODA grants has to be seen in the context of the decade-long underfinancing of health services in most developing countries and the dramatic spread of the HIV epidemic in many resource-poor regions of the world. At the turn of the millennium, the ODA grants of all DAC countries taken together corresponded merely to one-fifth of the magnitude that the Commission for Macroeconomics and Health has considered necessary to establish basic health services also in deprived countries and to confront the most devastating threats for global health. Regardless of the increase during the first decade of the MDG period, the overall financial efforts did not even reach half of the contribution ratio suggested by the Commission and it has stagnated at this insufficient level in recent years. We are still far from closing the huge financing gap that exists regarding international cooperation for health promotion.

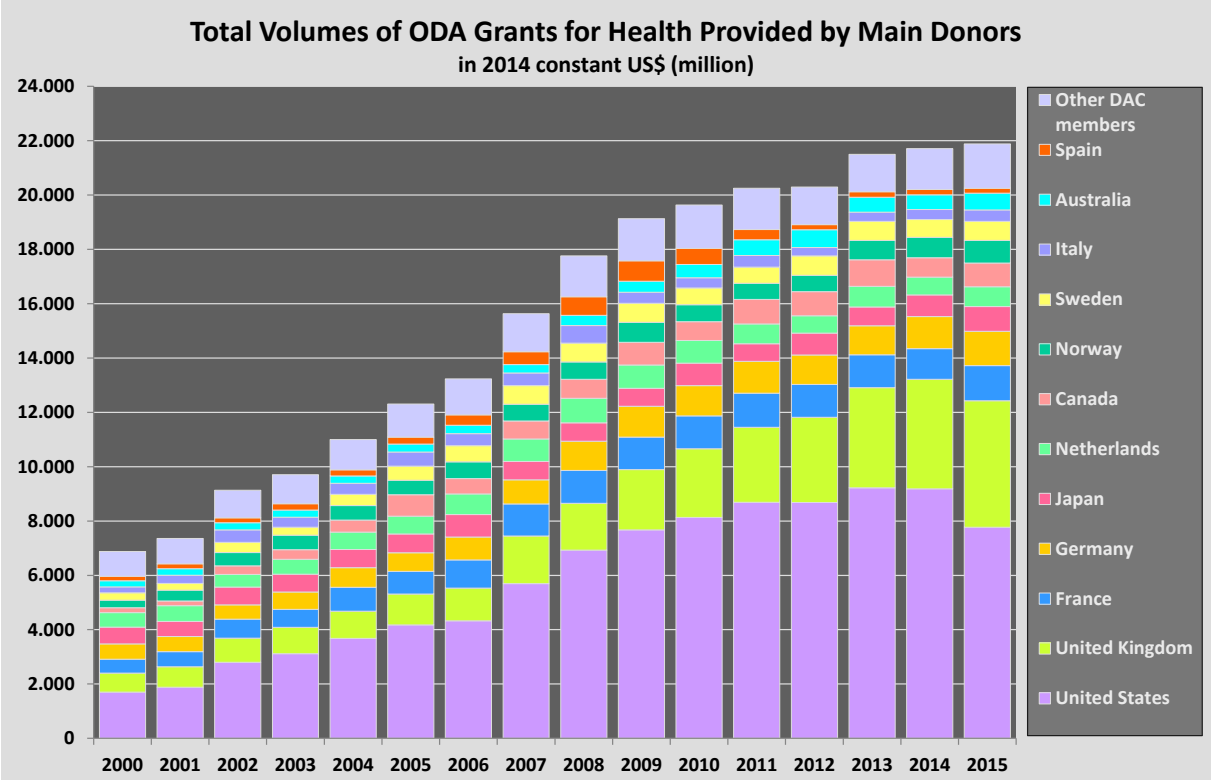


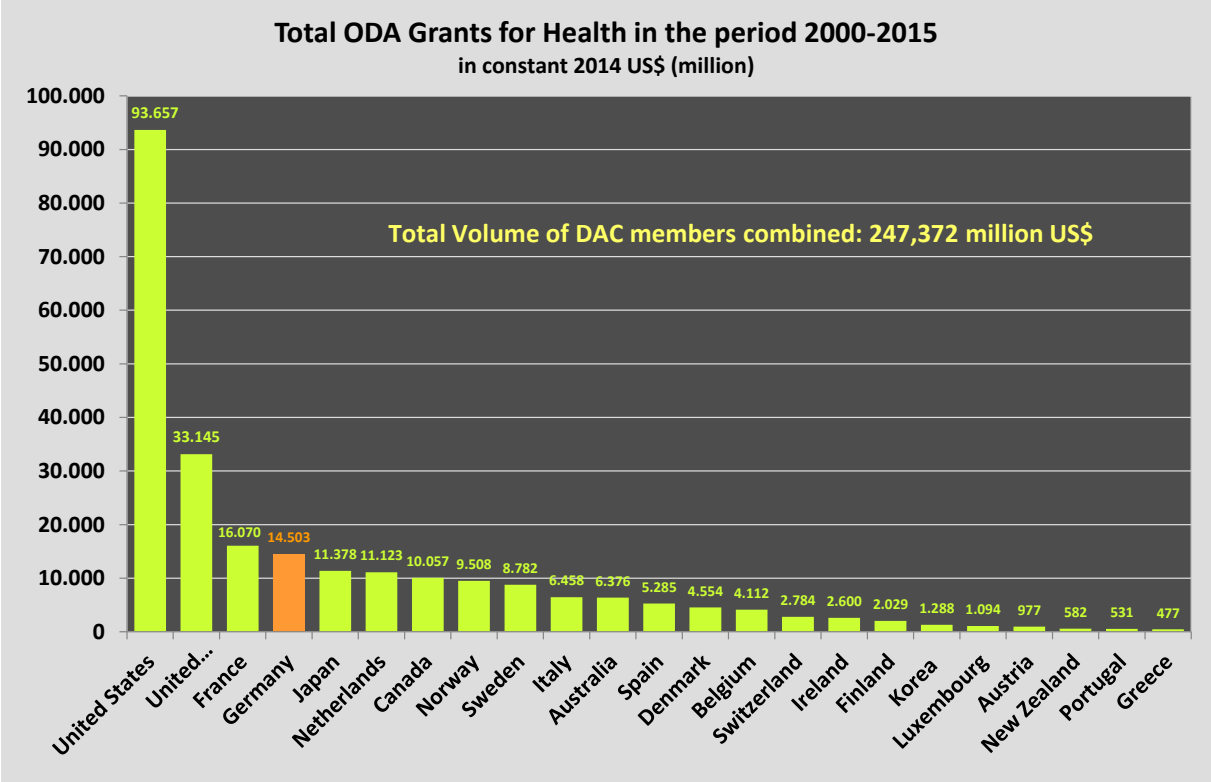
The collective efforts by the European donor countries for global health were well above average, but they considerably lagged behind the recommended minimum level. According to the preliminary estimates, Europe's overall ratio in 2015 reached close to two thirds of the health-specific financing target. This expected increase is mainly due to the foreseen additional efforts by the United Kingdom. In this context, the estimated resources provided to confront the Ebola crisis played quite a significant role, whereby it still remains uncertain to what extent these contributions are actually representing additional funds for the health sector or whether they have merely been shifted within the sector. On the basis of the available data and under favourable assumptions regarding the percentage of the funds made available for this purpose in addition to already committed health financing, the overall contributions for 2014 and 2015 can be estimated at close to 1.5 billion US$, of which Europe has provided 840 million or almost 57 percent. The current insufficient availability of data regarding the special need to deal with this disease outbreak as well as the overall contributions for health is creating a significant uncertainty.



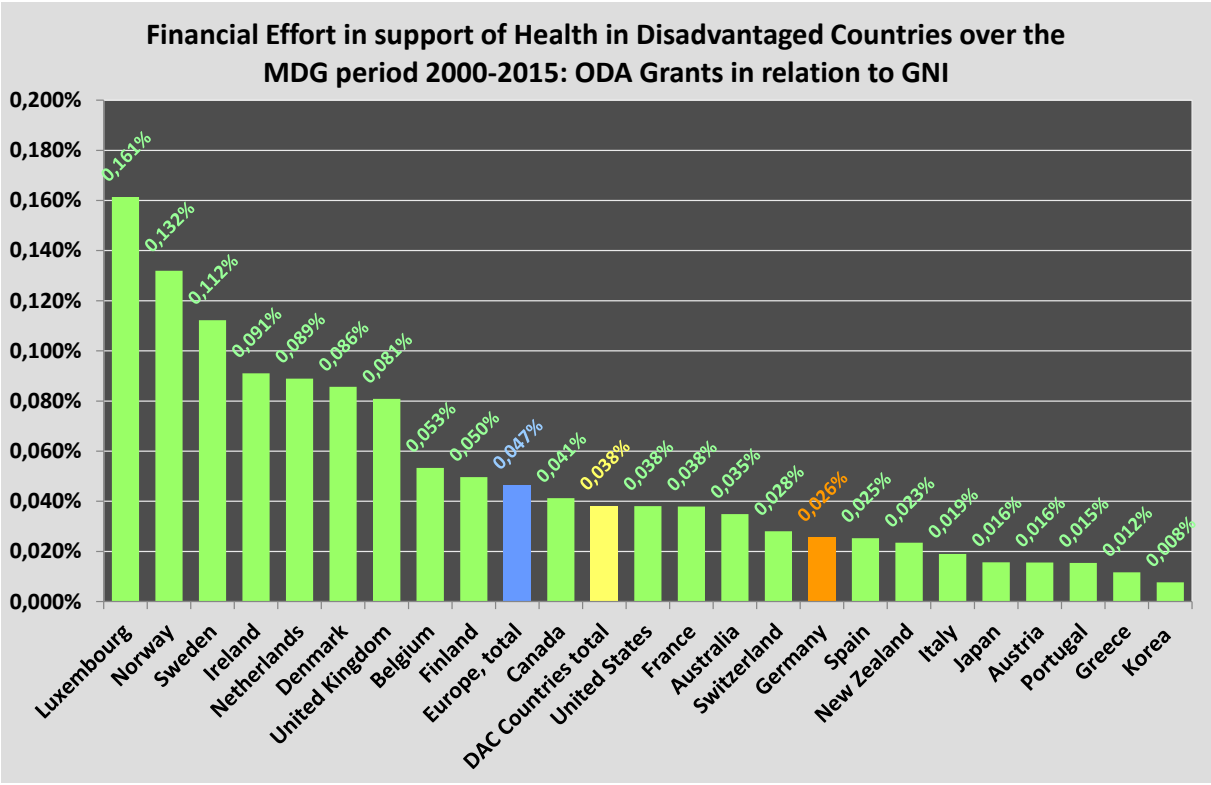
Global health financing primarily depended on the G7 Countries as well as Australia, the Netherlands, Norway and Sweden. These 11 countries provided close to 90 percent of the overall ODA grants for health throughout the MDG era. For most donor countries, this is simply the result of their exceptional economic capacity. But Norway, Sweden and to a lesser extent even the Netherlands, have become important contributors because their financial efforts are considerably above average. In recent years, the United Kingdom has shown particularly impressive increases. After the USA, with the by far largest economy, the United Kingdom has established itself as the second most important donor country. The British grant volumes are meanwhile well above the annual financial resources paid by all other donor nations, despite the fact that some of them have a higher GNI.

Not only the United Kingdom, but also France is ahead of Germany regarding the amount of contributions for the realisation of the health-related MDGs. Germany's genuine total contribution of 14.5 billion US$ corresponded to merely a share of less than 6 percent of the grant disbursements made by the DAC countries combined and thus it was considerably lower than the share of the GNI of 8.7 percent. The European DAC countries taken together contributed over half of the amount, while they account for roughly 41 percent of the total economic potential.





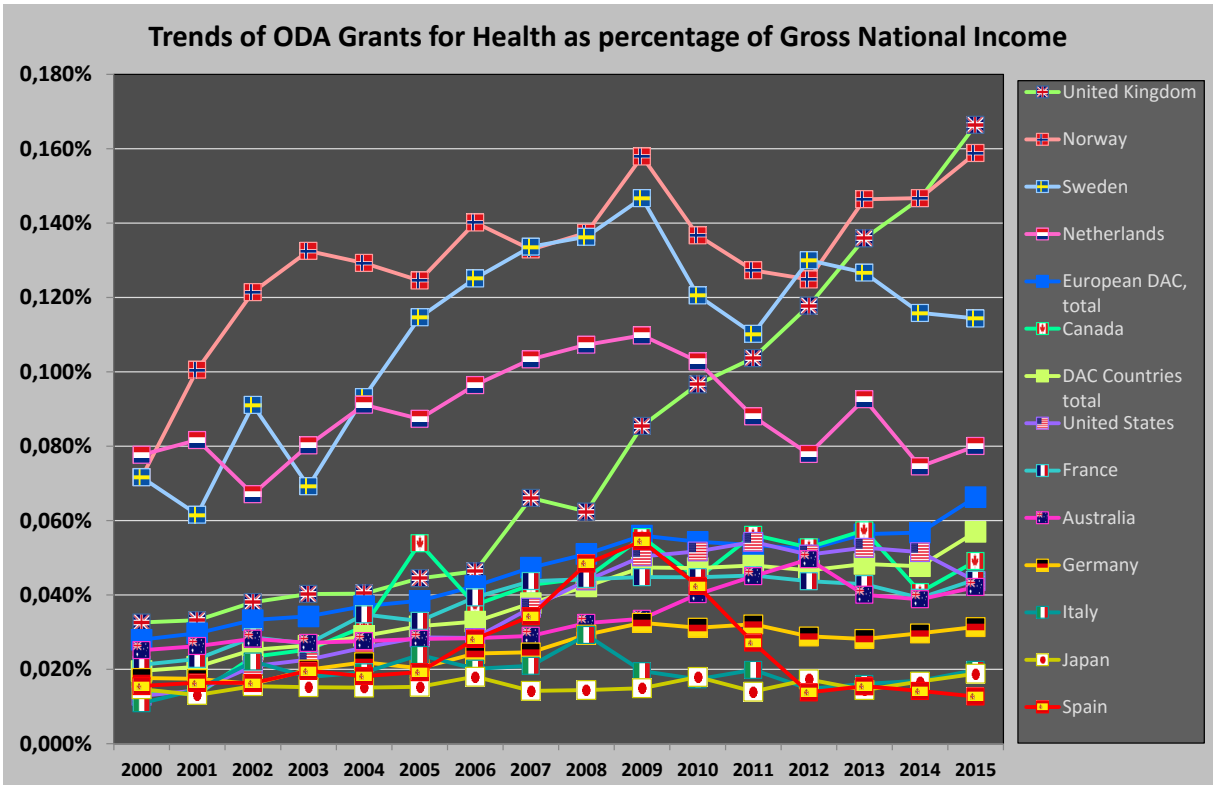
There is quite a large span when looking at the contributions for health in relation to the economic capacity. Only three DAC countries have exceeded the threshold value of 0.1 percent of the GNI. The United Kingdom is the only G7 member among the 9 DAC countries that have achieved at least half of the target value during this

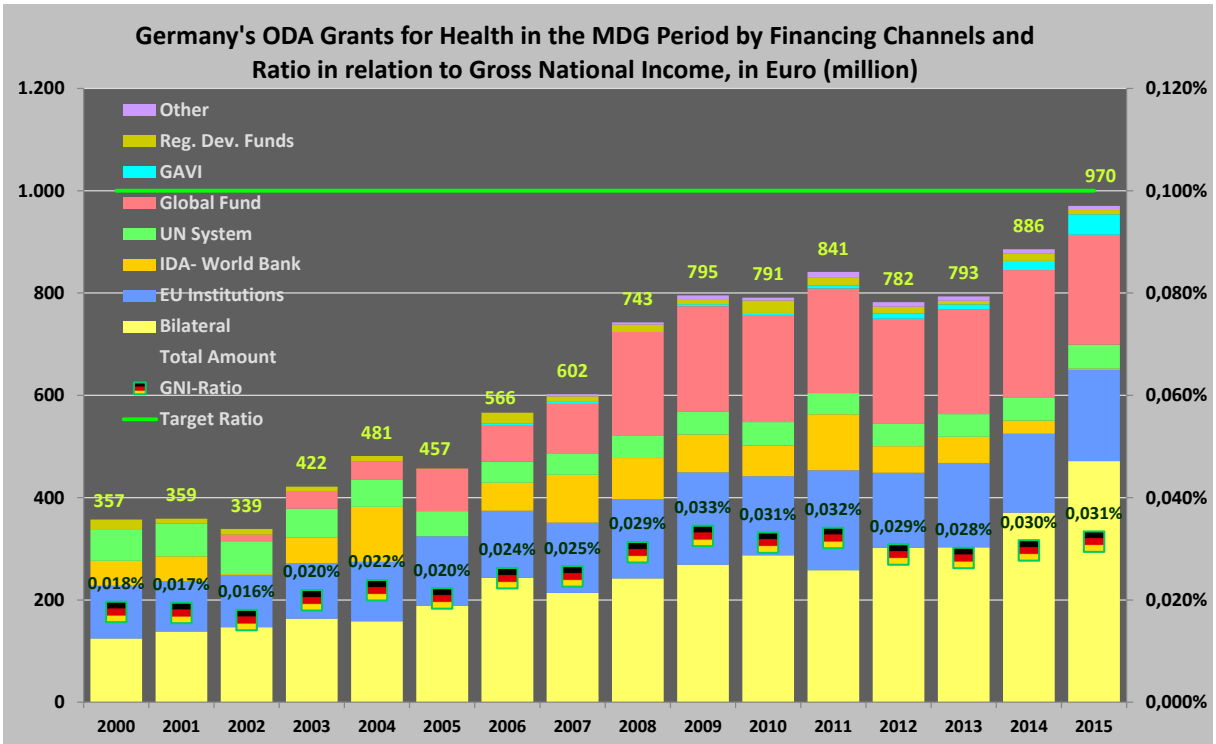


timeframe. Most countries, among them those with the largest economies, provided only a mere fraction of the recommended level of contribution. This leads to an enormous deficit and to an increased fragility of health financing.

Germany can be found at the end of the ranking list. When putting aside countries that were particularly affected by the debt crisis and the special case of Korea (that had joined the DAC more recently in 2010), only the ratios for Japan, New Zealand and Austria are even lower.

A glance at the development of the financial efforts over the MDG period clearly reflects that only a few countries have attempted to meet the target value for contributions in support of health at an early stage. Norway exceeded the recommended ratio already in 2001 and Sweden followed in 2005. It is quite remarkable that both countries reached the minimum level on a continuous basis after that, and in most years their efforts went well beyond that threshold. The United Kingdom joined this leading group in recent years with an outstanding increase of the ODA contributions for health. The United Kingdom is also the only G7 member that has achieved the recommended contribution level, which it has considerably exceeded in the meantime, whereby all other member countries are far from reaching this goal. The small group of exemplary contributors is up against the majority of DAC countries where the ODA grants range hardly between one fifth and half of the target value, without a prospect of appreciable improvement.

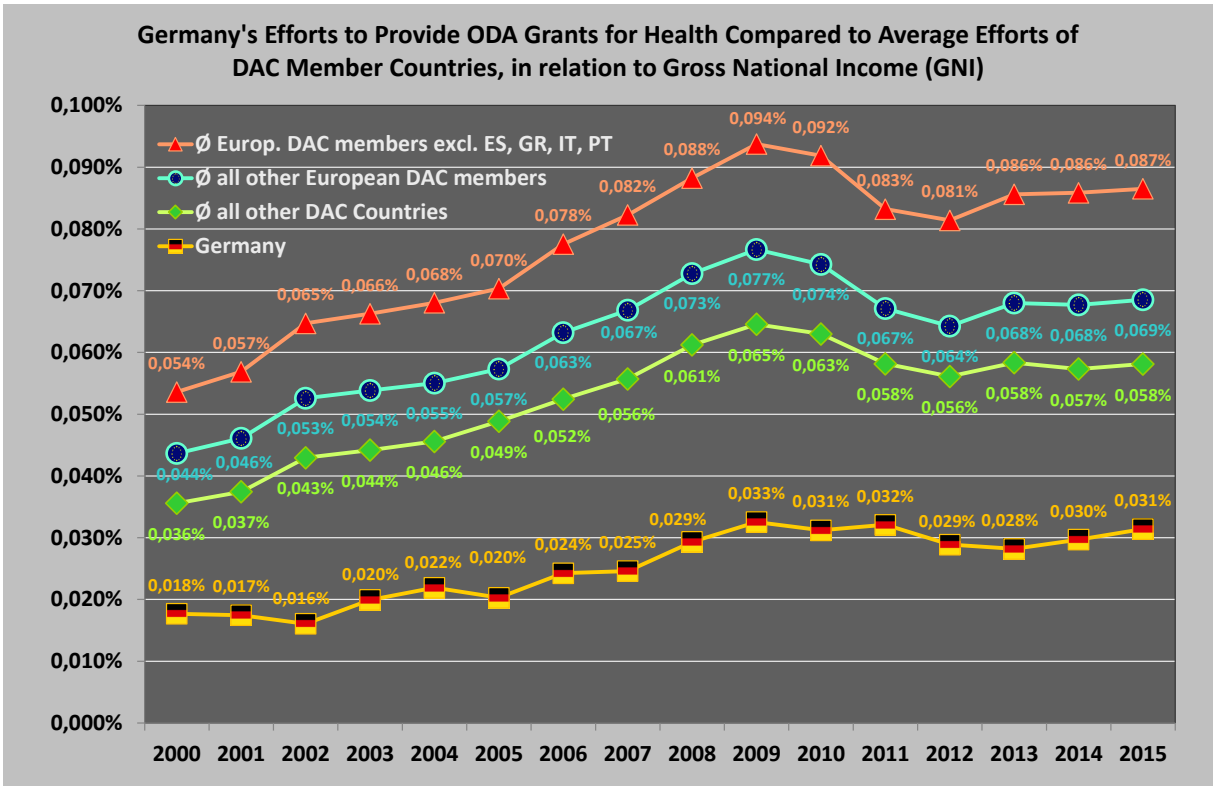




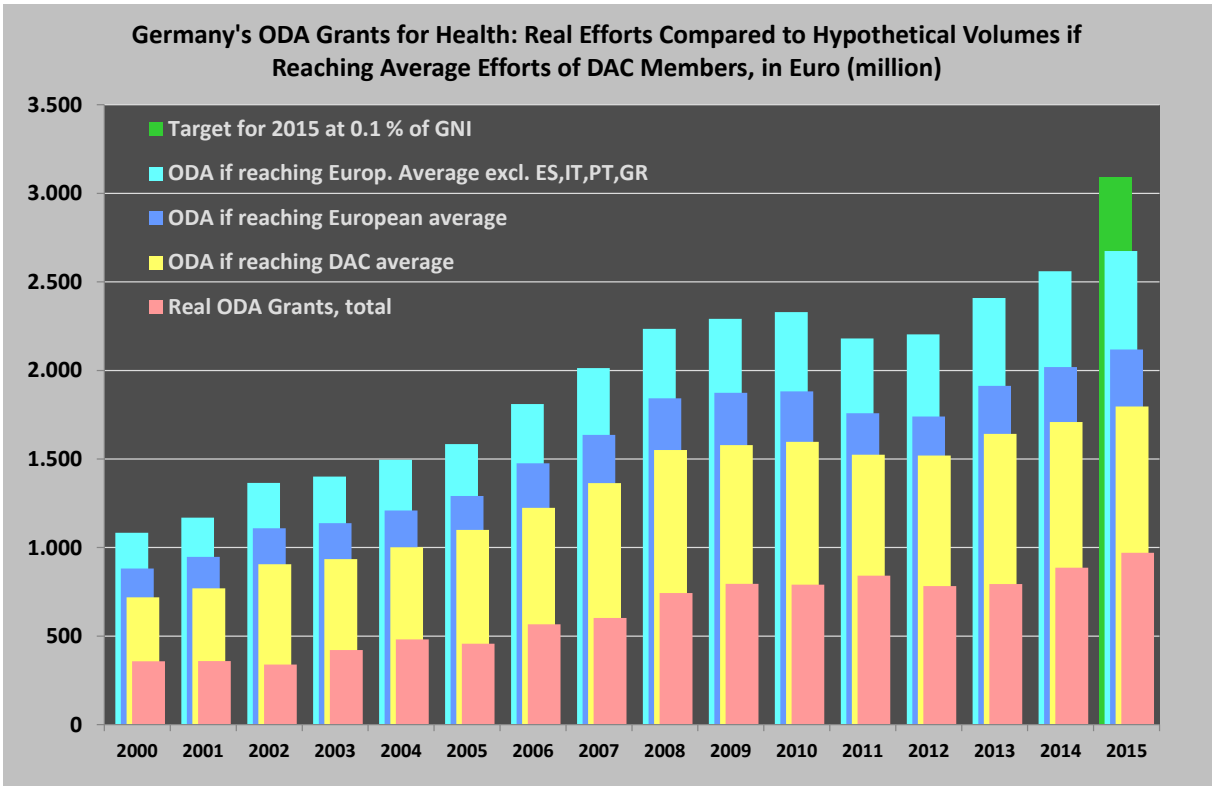
When looking at Germany's ODA grants for global health, a significant growth from 2006 to 2009 can be noted in parallel with the trend of overall contributions for genuine development aid. A large part of this increase was due to the considerably higher contribution to the Global Fund. However, the efforts in relation to the GNI never achieved even one third of the target value. Thus, the ODA grants for health are even considerably more inadequate, as was already observed when assessing the total aid flows, compared to the respective financing targets. Regarding the last five-year period, it has to be stated that the efforts were stagnating. The predicted increase of the contribution in 2015 is based on the favourable assumption that the financial resources for the control of the Ebola crisis and the consequently created special programme "Health for Africa" will be made available in addition to the existing financial commitments for health projects. In view of the limited increase of the total budget of the Ministry for Development Cooperation (BMZ) amounting to hardly 100 million euros or 1.5 percent compared with the previous year, this is questionable at least.

In relation to the average value of financial efforts for global health that have been made by other European DAC countries with comparable economic conditions, Germany's insufficient level of contribution becomes apparent. In nearly every year of the MDG period, this comparative figure was three times higher than Germany's GNI ratio. Even if the four countries hit especially by the crisis are in-

cluded in the calculation, the European average was twice as high as the German contribution level. And even the average efforts by all DAC countries including the six non-European member countries in most years was twice the size of the contribution level recorded for Germany.



If Germany had achieved the average level of the economically comparable European DAC countries over the timeframe of the realisation of the MDGs, this would have amounted to an overall contribution of almost 31 million euros. In reality, Germany's contribution for the realisation of health-related goals totalled little more than 10 billion euros, resulting in a shortfall of almost 21 billion euros. Thus, Germany does bear a special responsibility for the improvement of the living and health conditions in the economically deprived regions of the world, not only with regard to the fact that it represents the largest economy in Europe, but it has every reason to compensate for the cumulative contribution shortfall during the MDG period by making increased efforts in the coming years for the realisation of the 2030 Agenda.

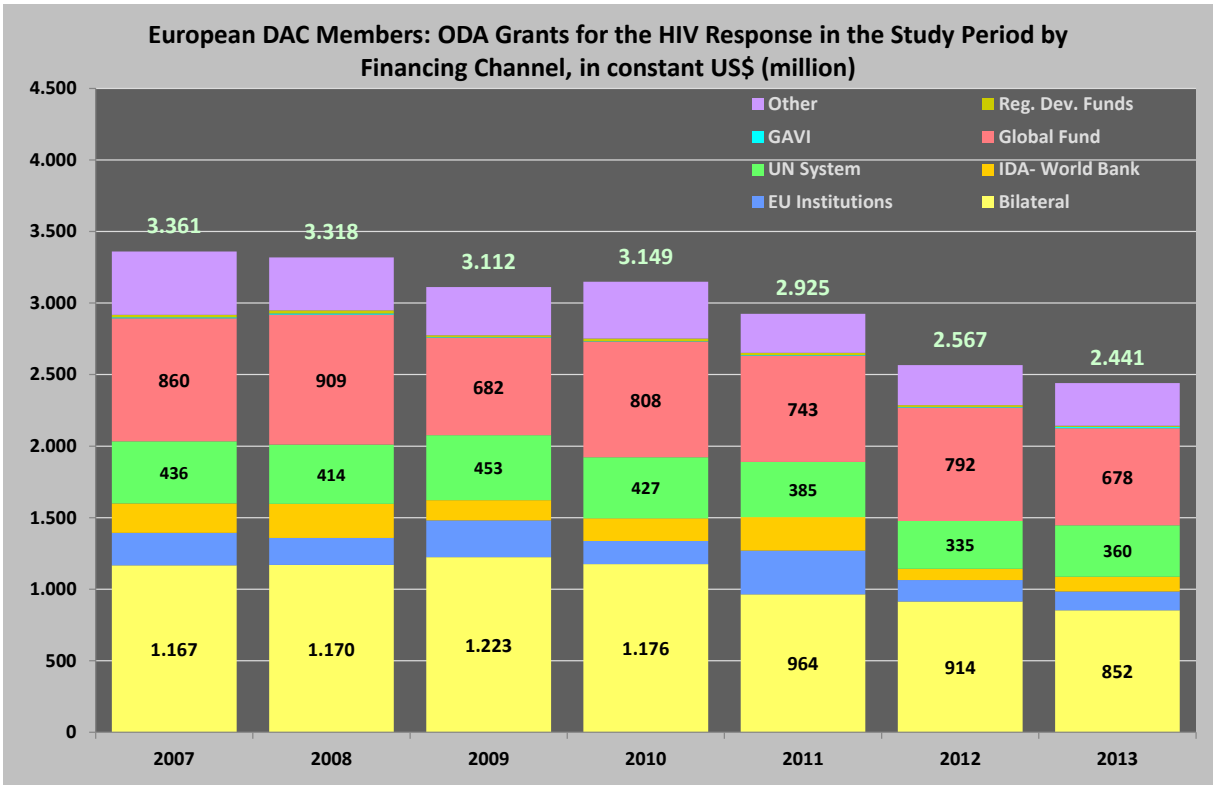


ODA Contributions for the Control of the HIV-Epidemic

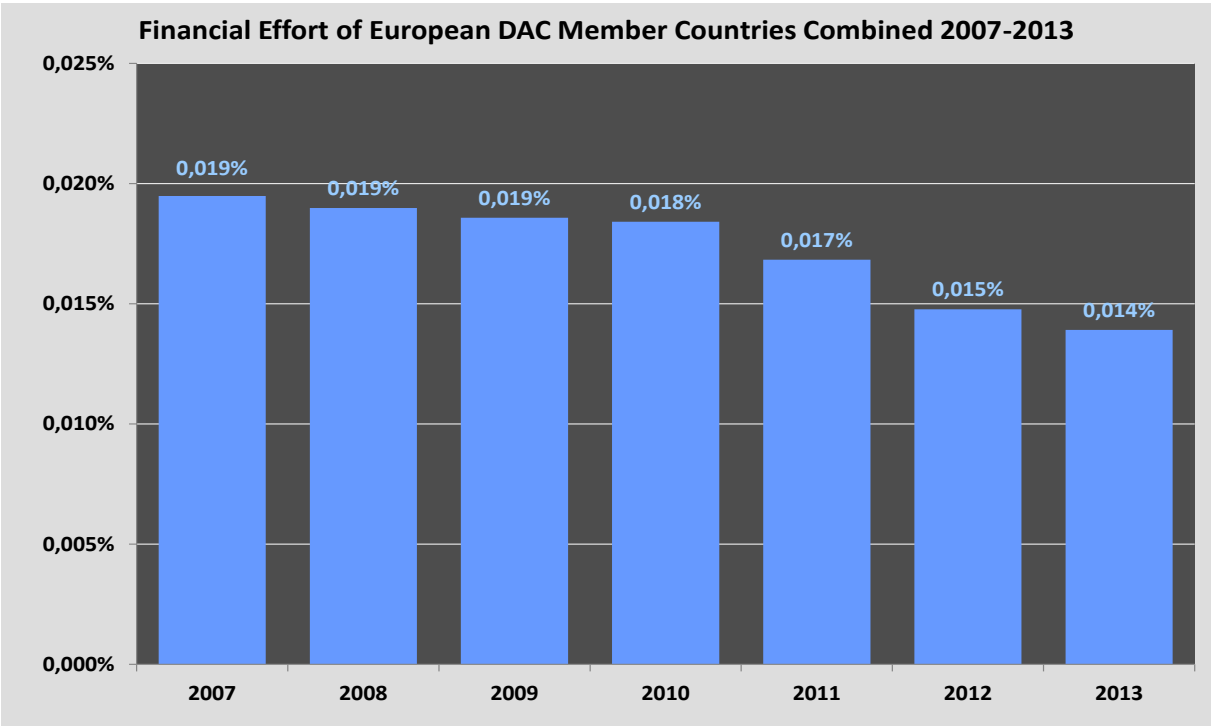
In contrast to the trend observed for Europe's ODA grants for the health sector as a whole, showing a renewed increase (especially caused by the higher contributions from the United Kingdom) in the year 2013, the genuine contributions for the global response to the HIV epidemic persistently decreased during the study period. However, during the past two years, this negative tendency could be partially reversed due to an increase of the amount of contributions to the Global Fund provided by European donor countries combined, mainly due to increased grants by the United Kingdom. The cancellation of payments to the Global Fund by Italy and Spain following the debt crisis had caused at least a significant portion of the overall decrease of contributions made available by Europe.

It is obvious nevertheless, that the significance of the response to the HIV-epidemic in the framework of bilateral cooperation has noticeably declined. This is based on a comprehensive estimate, which does not only include specific HIV interventions, but also HIV components in projects of reproductive health and sector-wide health programmes. In addition, there has been a declining tendency of the share of HIV interventions in relation to total disbursements in the case of important multilateral financing mechanisms, such as the European Union and IDA.

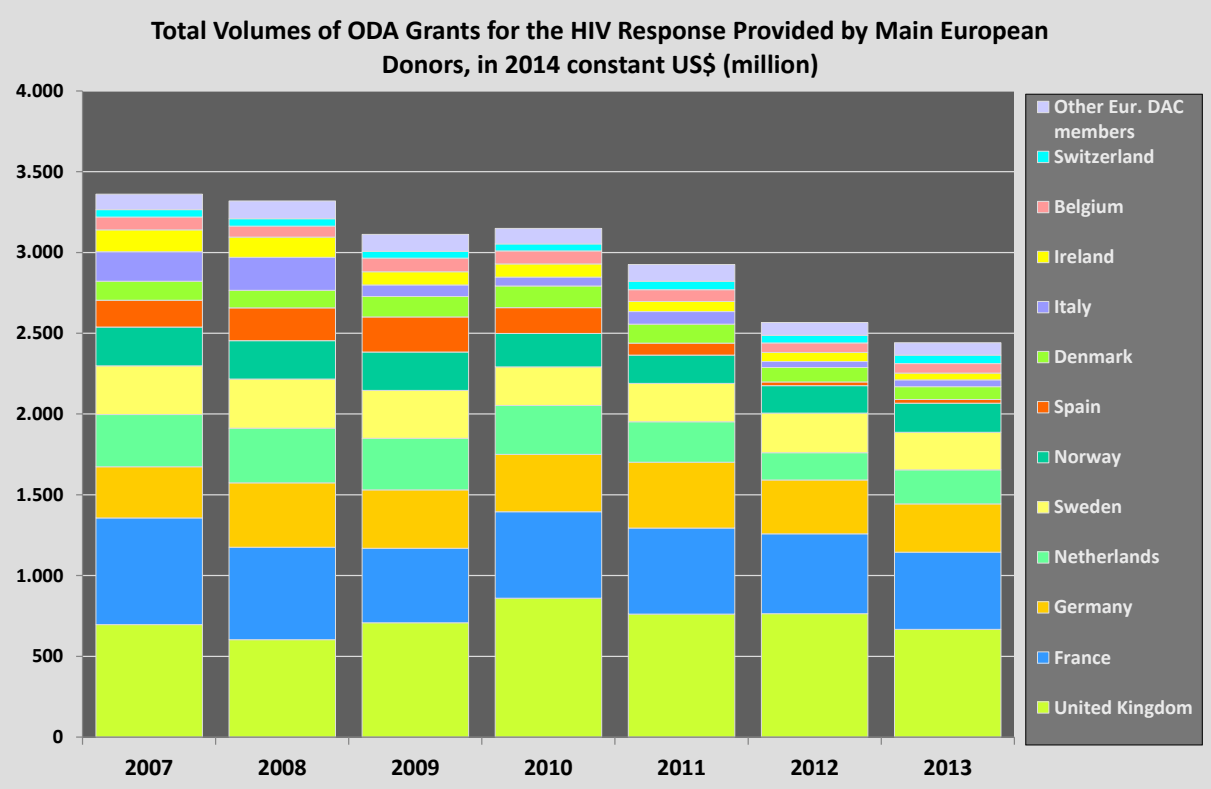
Urgent countermeasures have to be taken in this respect in order to fulfil the respective target of the 2030 agenda, namely to end the AIDS epidemic.



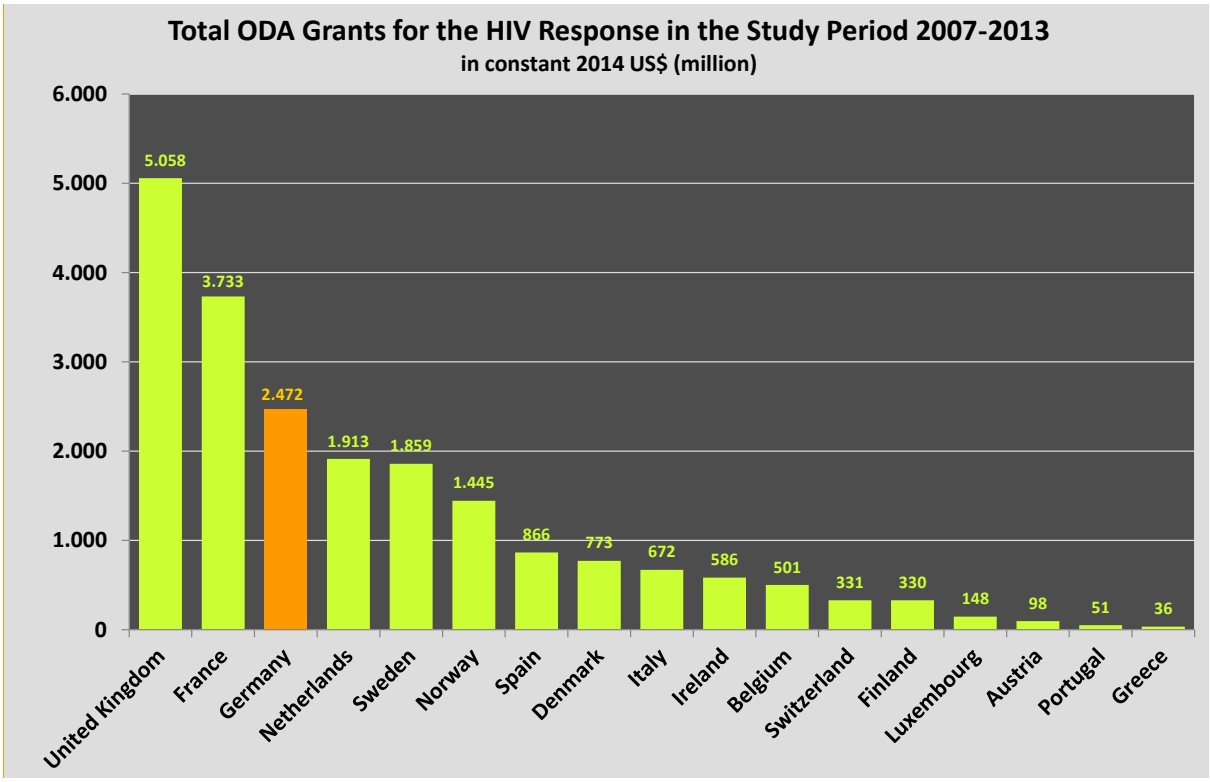
Accordingly, Europe's collective ratio in relation to the GNI after 2010 has diminished considerably. In addition to the cuts made by the above mentioned crisis-stricken



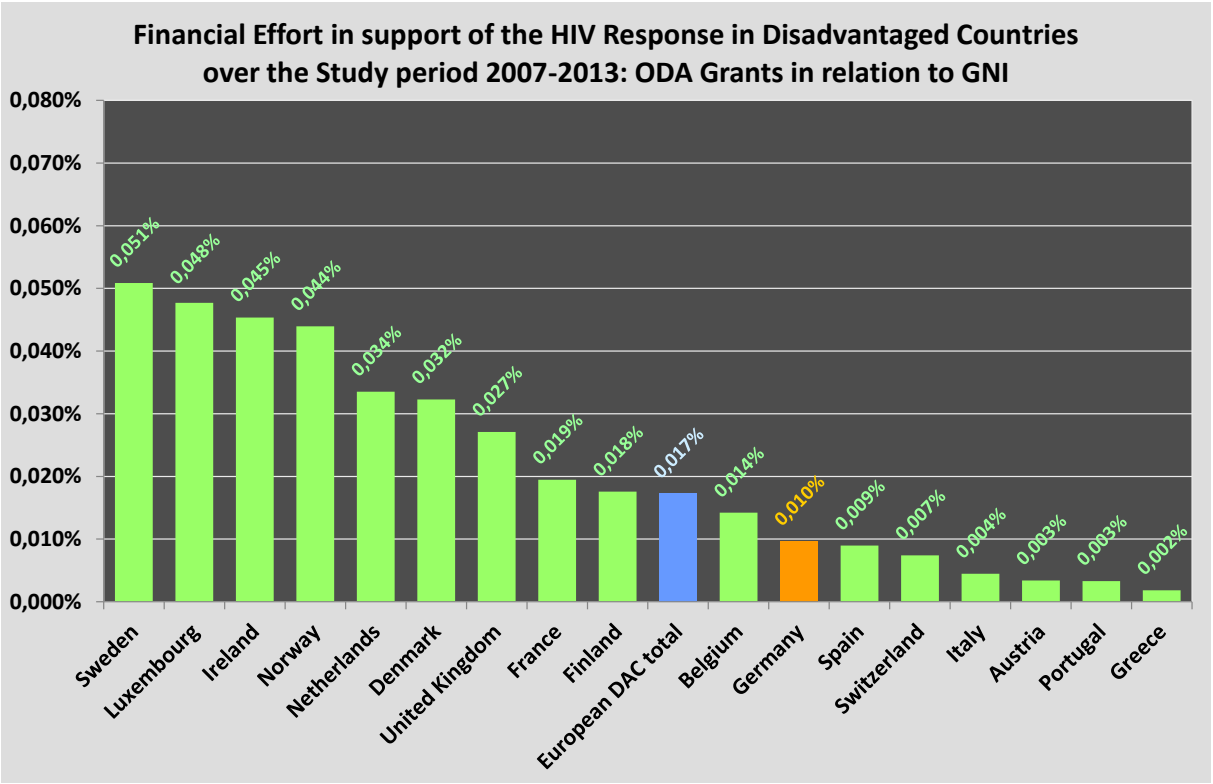
countries, the grant volumes of France (especially due to falling contributions to UNITAID) and the Netherlands (first of all due to declining bilateral contributions) also dropped by more than 100 million US$ and thus below the level of 2007, after adjusting for price levels.



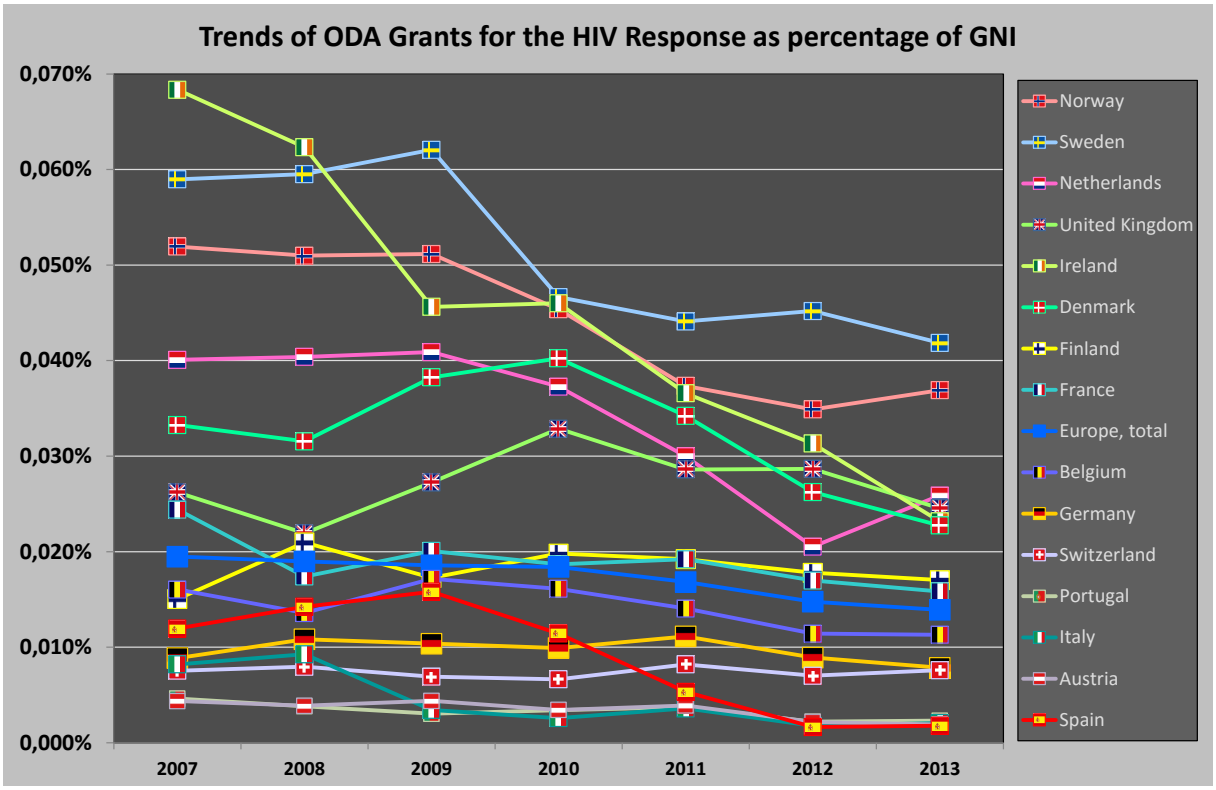
Similar to the overall health promotion, Germany only ranks third among European donors with respect to the absolute amount of the contribution provided during the period reviewed to date, although the country has the largest economy by far. In this time period, the contributions by the United Kingdom were twice as high as Germany' grants and France also contributed about 50 percent more. The amount made available by Sweden, Norway, and the Netherlands taken together, was more than twice as high as the contribution provided by Germany for the global HIV response, even though the combined economic capacity of all three countries corresponded to hardly half of the German GNI.



Despite the position shifts of some countries, the differences in the financial efforts for the global response to the most devastating epidemic are quite similar than for the overall improvement of the health situation. Germany ranks far behind in the lowest places and reduces the European overall volume due to its low contribution

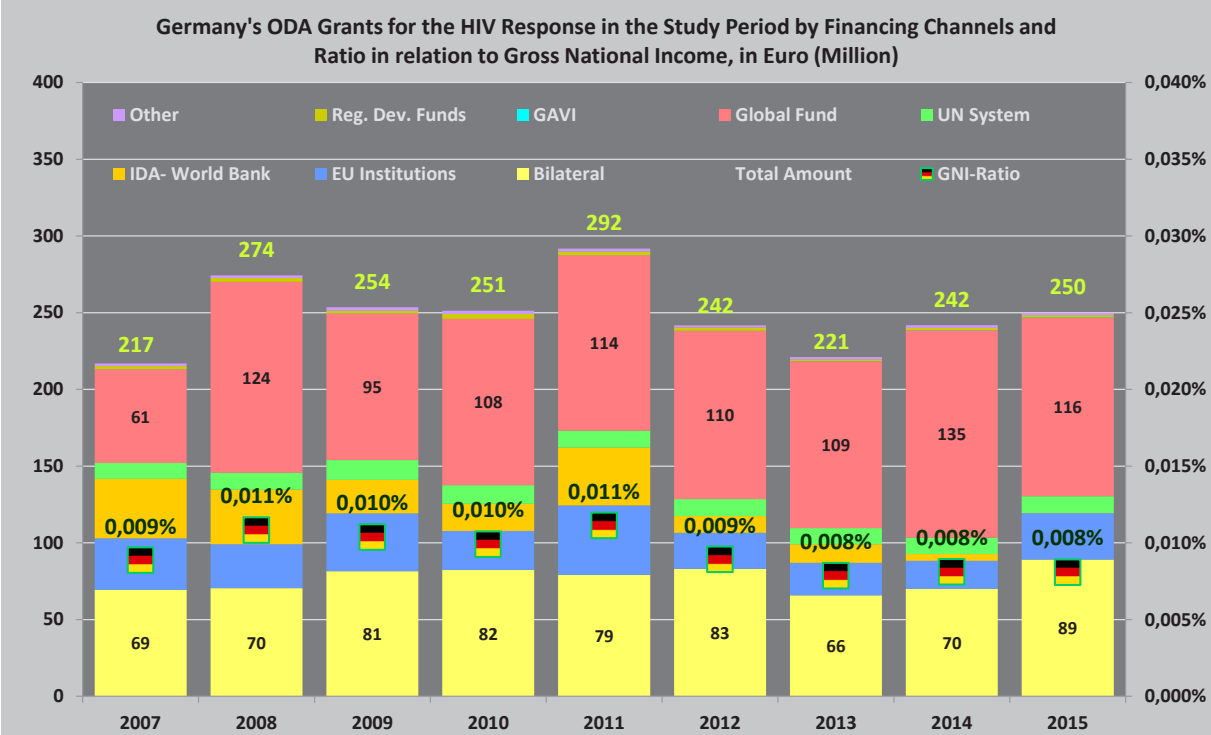


level. Apart from the crisis-hit countries, only Switzerland and Austria were even less generous in the support of the HIV response in economically deprived countries.

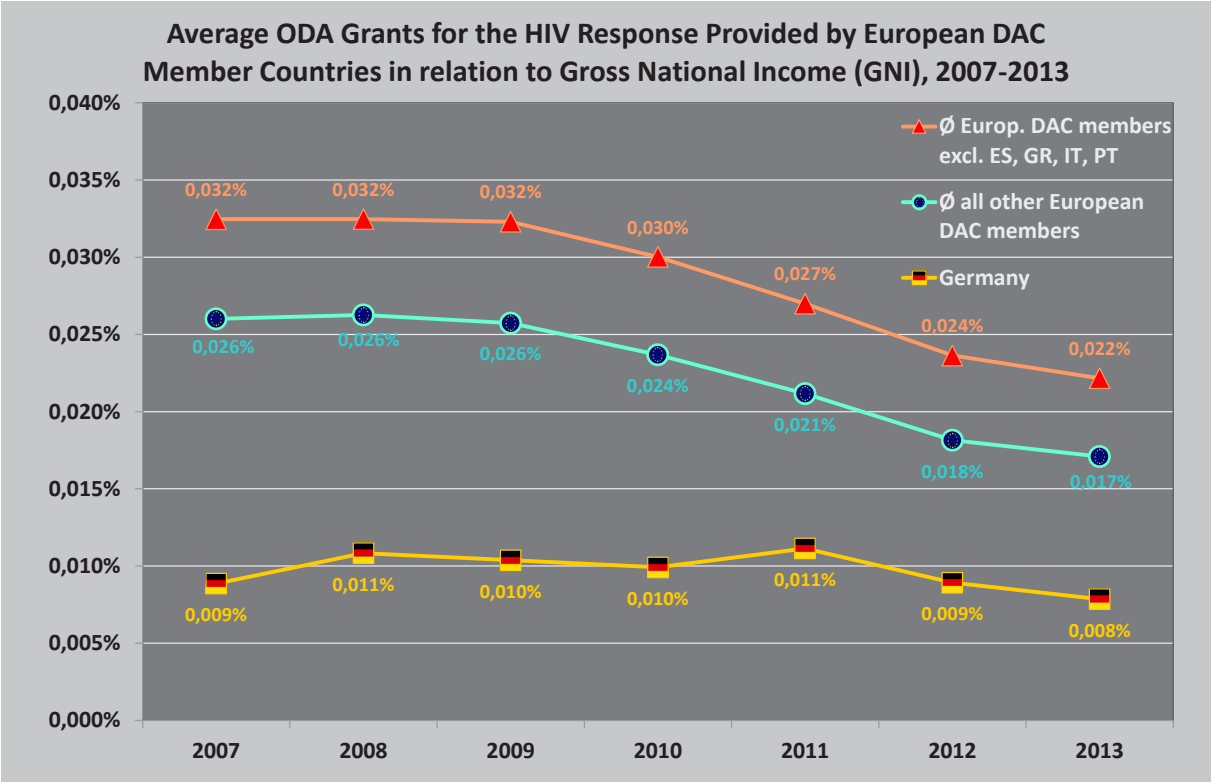


A glance at the development of grants in relation to the economic capacity of individual countries shows, that in the course of the study period there has been a reduction especially in those countries with the highest performance. The United Kingdom is once again one positive exception in this case, even though the increase of the efforts for the global response to the HIV epidemic – mainly due to the varying contributions to the Global Fund over the years – did not show a linear tendency.

The volume of grants provided by Germany has been stagnating since 2008 when the last significant increase of the contribution to the Global Fund had taken place. The fluctuations of the total amount can mainly be attributed to the varying HIV proportion of the total disbursements made by EU institutions and IDA over the years. The bilateral grants remained at a quite constant level of 70 up to little over 80 million euros. The growth projected for 2015 is based on the favourable assumption that the funds for the special programme "Health for Africa" will be provided in addition to the commitments previously made for health projects. According to the analysis that had been carried out in the course of the 2015 ODA study and which is based on WHO data on national health accounts in combina-



tion with the scope of HIV interventions as documented in the project-level database of the DAC/OECD, about 15 percent of external financial resources for health sector programmes in sub-Saharan Africa is being used for HIV interventions.

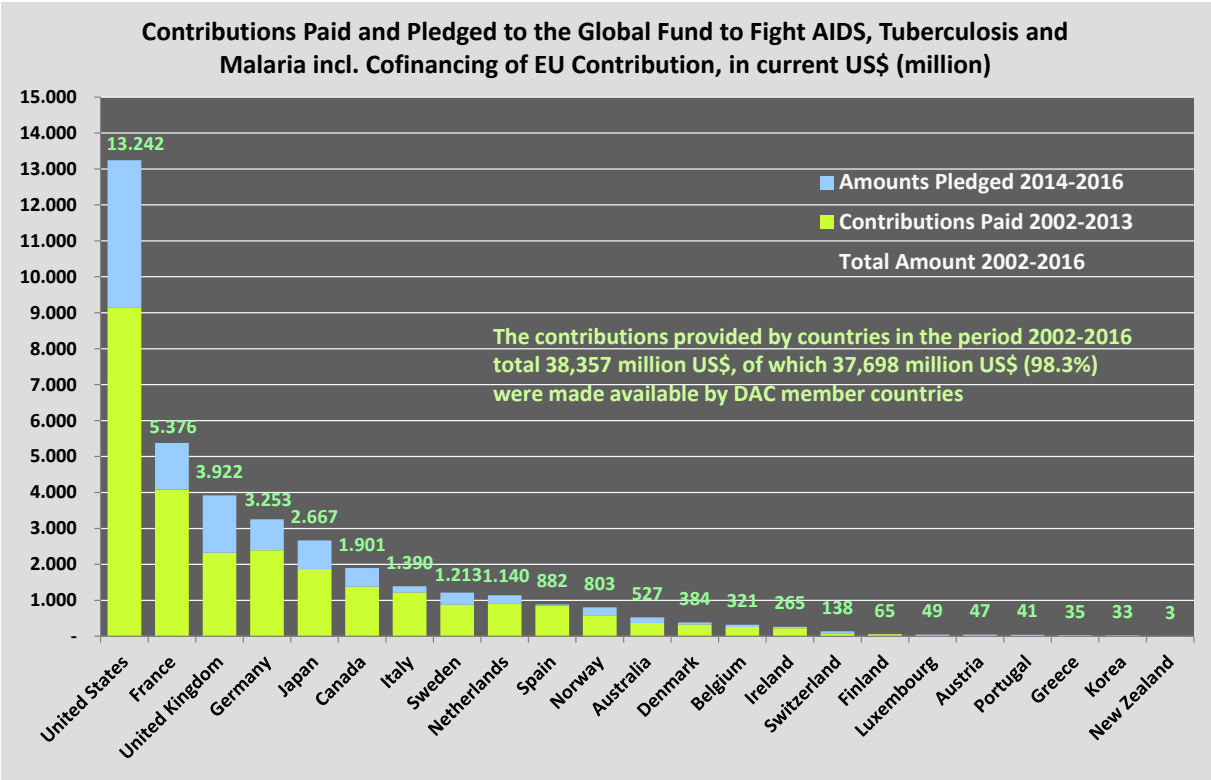


The remainder of the European DAC countries, which are comparable in economic terms, on average made contributions that were three times as high as the German contribution for the global response to HIV. Even when including those countries that were considerably affected by the debt crisis, Germany still ranks far below Europe's average financial efforts. The gradual narrowing of the gap between the ratios in the last years of the study period unfortunately could not be attributed to the increased effort by Germany, but to the declining contributions by other European donors.

Contributions to the Global Fund to fight AIDS, Tuberculosis and Malaria

The Global Fund is the most important financing instrument for the control of the most devastating infectious diseases and the improvement of the health situation in the particularly deprived countries overall. The grants by the Global Fund have created the possibility to plan and to implement prevention and treatment programmes that are at least approximately commensurate to the dimensions of the challenges. The Global Fund has set new standards regarding the involvement of self-help initiatives and civil society organisations which are indispensable for reaching key populations made vulnerable to HIV due to social conditions, the protection of human rights, and, ultimately, for the effectiveness of programmes. Furthermore, the programmes supported by the Global Fund, have substantially contributed to the strengthening of central elements of the health systems in recipient countries. A suitable and reliable participation in the financing of the Fund is a central task of the economically better-off countries in order to fulfil their obligation for global health.

Even when looking at the absolute overall amounts of the contributions, Germany ranks fourth of all donor countries behind France and the United Kingdom. In the period up to 2013, Germany was still in third place, but due to the insufficient increase during the current replenishment period, Germany fell far below the British contribution. In this overview the EU contribution has been attributed to the respective member countries according to their share in financing of the total of ODA resources administered by EU institutions (budget and European Development Fund).



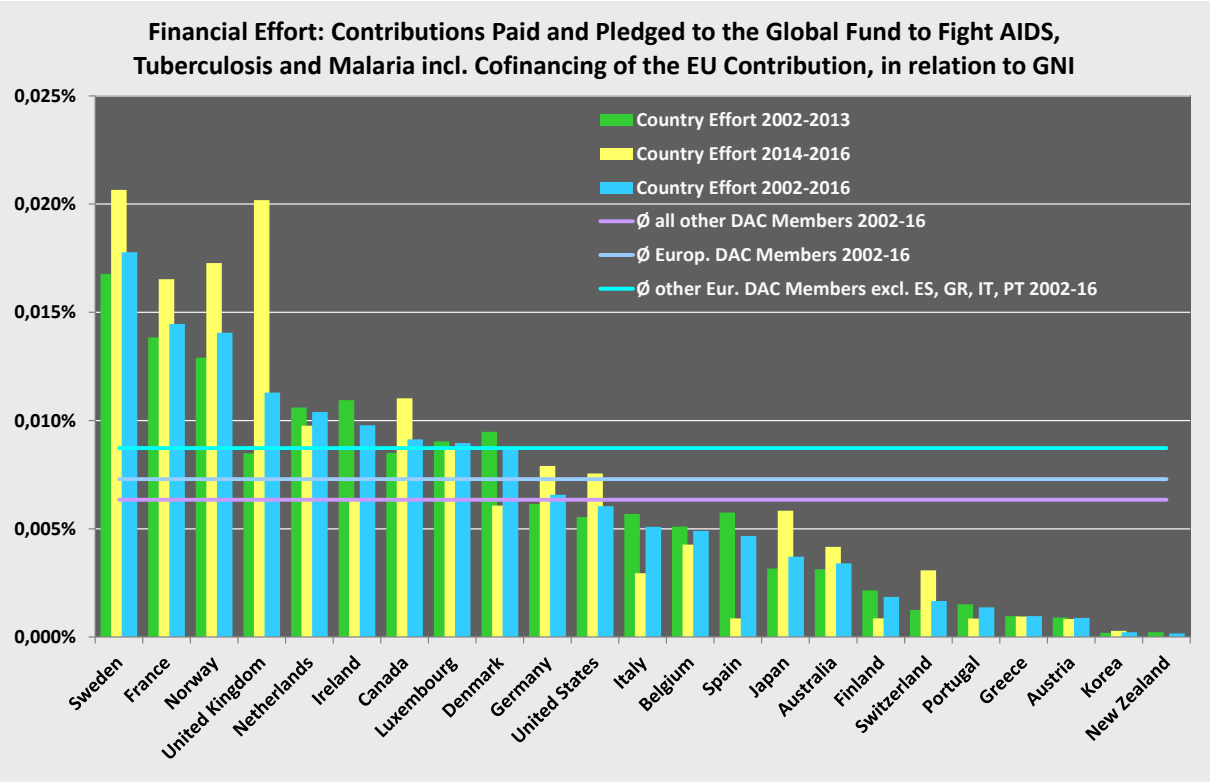
For the whole period since the inception of the Fund till the foreseen contributions this year, an average contribution ratio in relation to the collective GNI of 0.0087 percent can be calculated for the economically comparable countries in Europe. With 0.0066 percent or in other words 66 cent per 10,000 Euro of the economic capacity, Germany's contribution was considerably below this level. For the current replenishment period of 2014 to 2016 the gap is expected to decrease somewhat, but it still will remain significant. According to the economic outlook of the IMF and the pledged contributions, the European countries with similar economic characteristics, will raise on average 0.0095 percent of their joint GNI for the Fund, whereas Germany's contribution level can be estimated at 0.0079 percent or 79 cent per 10,000 Euro of the GNI.

At the same time, however, the fund represents the most important financing channel for Germany's aid in support of this critical area for human development, accounting for 43 percent of the total volume of ODA grants provided for the HIV response in the period from 2007 to 2015. Regarding the contributions for the health sector as a whole the Global Fund received one fourth of the overall volume, which represented the second highest share following bilateral cooperation.

When evaluating the financial efforts in favour of the Global Fund, Germany ranks tenth when considering the total timeframe. In the current replenishment

period Germany's contributions relative to GNI will presumably rank in eighth place.

In order to achieve the average contribution level of comparable European countries in the total period reviewed, Germany would have to raise an additional 825 million euros for the Fund. Just like all other financing deficits described in the above chapters, this shortfall should be taken into account, if we turn to the question which contributions Germany should be making in the future in order to fulfil its obligation for the promotion of global health.



Germany's Imperative Way to a Fair Contribution for Health

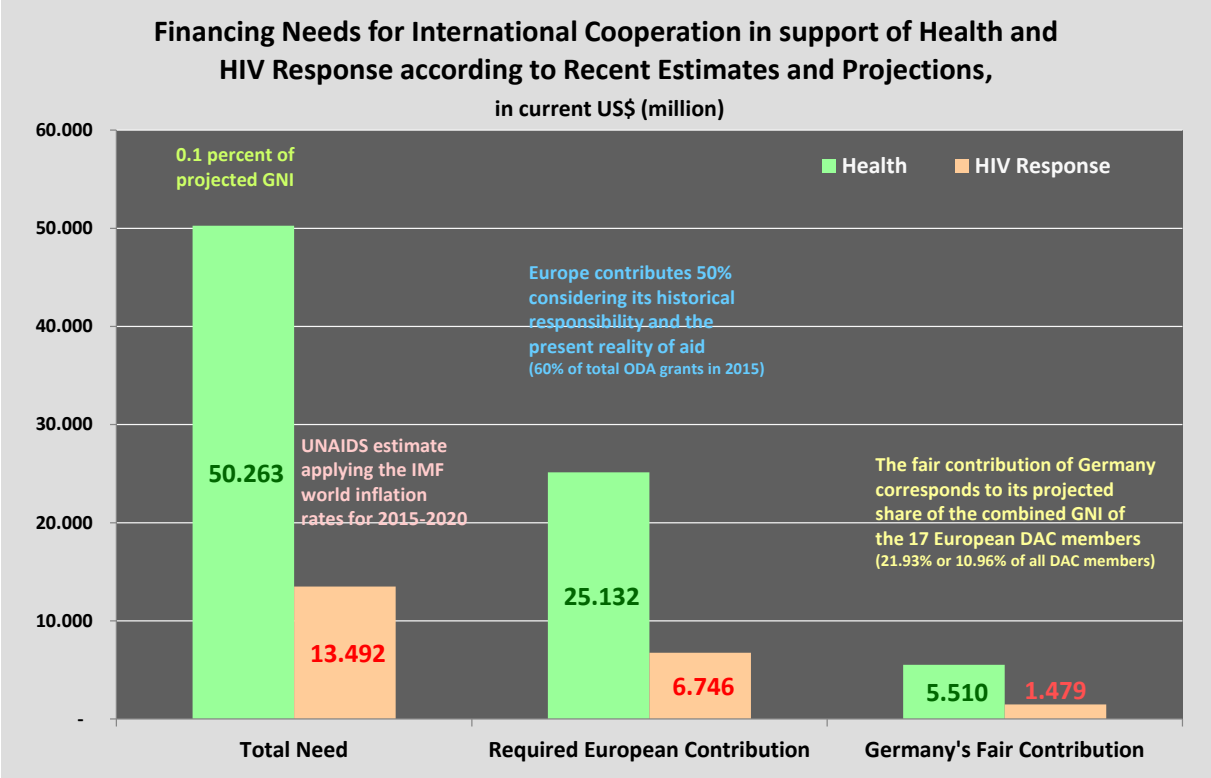
The realisation of universal health coverage and the end of AIDS and other devastating infectious diseases represent cornerstones of the 2030 Agenda for Sustainable Development. The improvement of the still completely unsatisfactory health situation in many economically deprived countries is indispensable in order to meet the primary objective to enable people to lead a long, creative and self-determined life. Health is the yardstick for the social advancement and is closely interconnected with all other dimensions of human development. Thus, health promotion is of exceptional importance in global development cooperation and politics.

In order to provide life-saving health and HIV services also and especially in locations, where the structural vulnerability and economic hardship are the worst, the contribution level of most economically privileged countries including Germany has to be raised considerably. In connection with the enhanced own efforts by the developing countries, it will be possible to close the enormous financing gaps. Due to their involvement in colonial exploitation, which has caused immense suffering for the affected people and produced structural barriers for development and health, the European countries have a special responsibility. Furthermore, according to the current reality of development aid, Europe raises almost 60 percent of the total ODA grants. Thus it can be assumed that European contributions in the years to come will have to amount to at least 50 percent in order to have a realistic chance to mobilise the additionally needed financial resources as quickly as necessary.

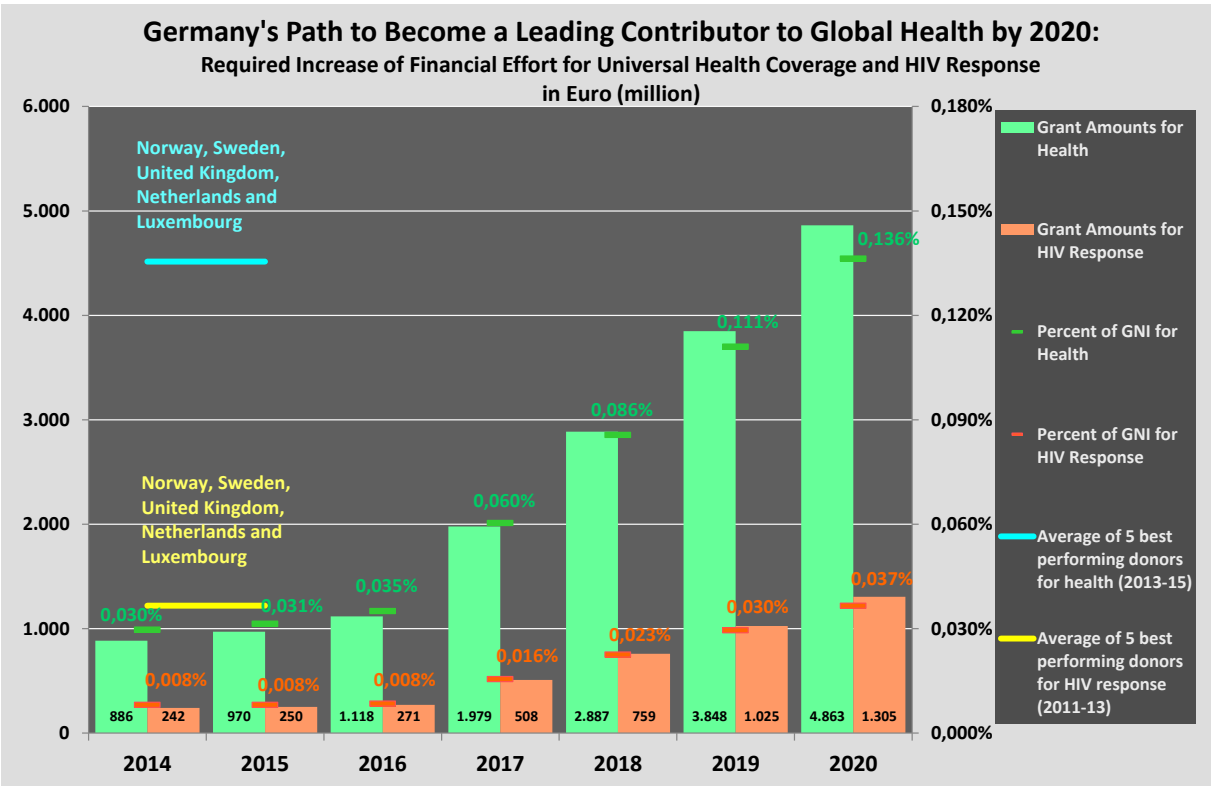
The realisation of the UN agreed target ratio by 2020 has to be the basis. This means that this global financing target will finally be achieved half a century after the original obligation and a decade and a half since the renewed commitment by the European Union. Then it will be possible to overcome the prevailing bottlenecks that have provoked unbearable conflicts about objectives. This is the necessary prerequisite in order to move forward in all areas of human development, i.e. not only directly tackling the enormous health problems, but also making significant progress to overcome their structural causes and social consequences.

The elaborated estimate of the fair contribution for health promotion as well as the end of the AIDS epidemic as a public health threat is based on these criteria and brings together the current needs assessments with the latest economic forecasts. For this purpose, a projection of ODA grants for health in the current year has been compiled, which is based on the study results and assumptions already mentioned above as well as the respective titles in the federal budget of 2016.

In case of this scenario, Germany would achieve Europe's required average contribution level by 2020. The impression that the planned rates of increase appear to be quite significant, is simple due to the fact that the starting level is so far below the European benchmark. If Germany would implement these increases, it would be able to achieve the contribution level which has already been reached on average by the leading European contributors. This is without taking into account the enormous deficits of Germany cumulated during the MDG period.



A central component is the increase of the contribution to the Global Fund to a suitable level. For the upcoming replenishment period for 2017 to 2019, a fair overall contribution in the amount of 1,428 million US$ has to be calculated, which would



correspond to about 1,275 million euros. When deducting the co-financing of the already pledged EU contribution, a bilateral contribution of close to 1,200 million would have to be paid over the period of three years.

The suggested increase of ODA contributions for global health is to be regarded as an investment in the future. Thus, Germany would be providing the chance to take a great step forward for the global efforts in the improvement of the health and living conditions for the deprived majority of the world population. Thus, it would help to prevent immense human suffering and to create decisive prerequisites for sustainable development. Furthermore, with this important sign of human solidarity, Germany would gain a new kind of credibility, which is of crucial importance in the political dialogue to overcome international conflicts as well as the formation of a more just and future-oriented world order. One part of this new order should also include a global plan of action, with the goal to secure universal access to essential health services for all people without pushing them into poverty. This requires a funding model, which will overcome the uncertainty of voluntary contributions and which will instead be based on a fair system of obligatory contributions.

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