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Development assistance for health: critiques, proposals and prospects for change

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Abstract: After a ‘golden age’ of extraordinary growth in the level of development assistance for health (DAH) since 1990, funding seems to have reached a plateau. With the launch of the Sustainable Development Goals, debate has intensified regarding what international financing for health should look like in the post-2015 era. In this review paper, we offer a systematic overview of problems and proposals for change. Major critiques of the current DAH system include: that the total volume of financing is inadequate; financial flows are volatile and uncertain; DAH may not result in additional resources for health; too small a proportion of DAH is transferred to recipient countries; inappropriate priority setting; inadequate coordination; weak mechanisms for accountability; and disagreement on the rationale for DAH. Proposals to address these critiques include: financing-oriented proposals to address insufficient levels and high volatility of DAH; governance-oriented proposals to address concerns regarding additionality, proportions reaching countries, priority setting, coordination and accountability; and proposals that reach beyond the existing DAH system. We conclude with a discussion of prospects for change.

Introduction

The past 15 years have witnessed unprecedented global attention to health challenges in developing countries.¹ There has been extraordinary growth in the level of development assistance for health (DAH) and the breadth of new actors engaged in global health initiatives [Institute for Health Metrics and Evaluation

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¹ We use the term developing country to refer to all LICs and MICs, as classified by the World Bank. The most recent year for which data were relatively complete and available was 2014.

(IHME), 2016].² This rapid expansion has contributed to impressive achievements such as a dramatically scaled-up response to the HIV pandemic (UNAIDS, 2015), improved control of malaria in many endemic countries [World Health Organisation (WHO), 2014] and reinvigoration of research and development of medicines for diseases that primarily affect the world's poor (Pedrique *et al.*, 2013), among others. While increased DAH does not necessarily translate into health impact, and the causal pathways connecting the two are complex, there have been a number of rigorous evaluations suggesting that at least some interventions have had significant and positive health effects (Glassman and Temin, 2016). There has also been a departure from the traditional modes of DAH that characterized the second half of the 20th century – that is, a near-complete reliance on public sector funding channeled through the UN system and bilateral aid agencies – replaced by the emergence of new actors and significant experimentation with new institutional forms such as public–private partnerships (Szlezak *et al.*, 2010).

These developments have raised key questions about the current DAH system: Are the resources sufficient and sustainable? Are they being spent in the right way and on the right thing? Who should pay and who should receive, and how much? Who should decide these matters, and how? These questions have been sharpened by the flattening of DAH since 2011 (IHME, 2016).

At the same time, the system is being challenged by at least two major transitions: first is the 'health transition', in which many developing countries are wrestling with both communicable and non-communicable diseases (NCDs) as well as new health threats linked to processes of globalization (Frenk *et al.*, 2014). Second is an economic transition with the rise of many middle-income countries (MICs) – such as the BRICS (Brazil, Russia, India, China, South Africa) and MINTS (Mexico, Indonesia, Nigeria, Turkey, South Korea) – leading to increasing multipolarity in the global system. This phenomenon has at least two components: some formerly low-income countries (LICs) are developing quickly and are increasingly able to finance their own health needs; and some MICs are both continuing to grow and exerting increased influence in the global system, whether by joining established institutions or creating novel arrangements that may better serve their interests (Kickbusch, 2016). These transitions are taking place in the context of ongoing economic, social and political globalization, characterized by the intensified movement of people, goods, resources, ideas and microbes across

2 The IHME has defined DAH as 'financial and in-kind contributions made by ... institutions whose primary purpose is providing development assistance to improve health in developing countries (2011)'. We adopt the term DAH, as it is currently widely used in the literature, but note that other terms may also be used, such as global health financing, health aid or foreign aid. Alternative terms include external financing or international financing for health, but these could imply a broader field of enquiry that would encompass all health financing that crosses borders, such as remittances. The term global health financing could, arguably, include both national and international financing. These latter terms are not used in this paper for the sake of clarity.

borders. Finally, with the 2015 launch of the Sustainable Development Goals (SDGs), debate has intensified regarding what international financing for health should look like in the post-Millennium Development Goals era. The moment seems ripe to take a hard look at the DAH system, and to take stock of the many proposals that have been advanced to improve the *status quo*.

In this review paper we sought to respond to the following four questions:

1. What does the system for DAH look like today?: A brief description of the landscape.
2. Should the system be changed, and, if so, why?: A summary of the major critiques of the existing DAH system, based on a literature review.
3. What might be done?: A summary of proposals that have been advanced to address these critiques.
4. What are the prospects for change?: A discussion of recent trends and implications for reform.

In answering these questions, we seek to provide a systematic overview of problems and potential solutions, but considered advocating for any particular solution to lie outside the scope of this article.

Landscape

As of 2014, developing countries accounted for 84% of the global population and 84% of the burden of disease, but only 36% of gross domestic product (GDP) and 21% of health spending.³ DAH has increased dramatically over the past two decades, almost doubling from \$6.9 billion in 1990 to \$11.6 billion in 2000, and tripling again to \$33.9 billion by 2010 with growth leveling out since then (IHME, 2016).⁴ In 2013 DAH reached its peak at an estimated \$36.9 billion (IHME, 2016). Notably, this amount was equivalent to only about 4.4% of total public spending on health in LICs and MICs, estimated at \$840 billion in 2014, and an even smaller proportion (2.3%) of total health spending (public and private) in lower-middle-income countries (LMICs), estimated at \$1.612 trillion. However, disaggregating developing countries reveals wide variability in the relative importance of DAH by income group, with external financing accounting for a hefty 33.2% of total health expenditure in LICs, but only 3.3% in LMICs and 0.2% in upper-MICs (see Table 1).⁵ It is therefore likely that many of the shortcomings of the existing DAH system hit LICs the hardest.

3 This sentence updates the calculation by Gottret and Shieber that “Developing countries account for 84 percent of global population, 90 percent of the global disease burden, and 20 percent of global GDP, but only 12 percent of global health spending” (2006). Updated population, GDP and health expenditure data are from the World Bank, and burden of disease estimates from the Global Burden of Disease 2013.

4 Note that all IHME figures are expressed in 2014 dollars.

5 Authors’ analysis of 2014 data from the World Health Organization Global Health Expenditure database, as included in the World Development Indicators database of the World Bank. Note that these data differ from the IHME database, and provide a slightly different picture of the role of external financing.

Table 1. Health expenditure (2014, current \$)^a

	Population (%)	GDP (%)	Per capita GDP (\$)	Health expenditure (billions \$/% of GDP)	Health expenditure per capita (\$)	External resources for health (% health expenditure)	Proportion of health expenditure public/private/out of pocket (%) ^b
World	100	100	10,748	7743/10.0	1073	0.003	60/40/18
					By income group		
High-income countries	16.4	64.4	42,330	6131/12.3	5251	0.0	62/38/13
Upper-middle-income countries	35.1	27.5	8430	1326/6.2	516	0.2	55/45/32
Lower-middle-income countries	40.0	7.6	2033	263/4.5	90	3.3	36/64/56
Low-income countries	8.6	0.5	654	23/5.7	37	33.2	42/58/37
					By geographic region		
East Asia and Pacific	31.2	27.5	9492	1457/6.9	643	0.3	66/34/25
Europe and Central Asia	12.5	29.9	25,846	2187/9.5	2420	–	76/24/17
Latin America and Caribbean	8.6	8.0	9975	447/7.2	714	0.5	51/49/32
Middle East and North Africa	5.7	4.5	8470	180/5.3	433	0.8	61/39/31
North America	4.9	24.5	53,982	3187/16.5	8990	–	50/50/11
South Asia	23.7	3.3	1501	115/4.4	67	2.3	31/69/61
Sub-Saharan Africa	13.4	2.2	1801	95/5.5	98	11.2	43/57/35

Note: GDP = gross domestic product.

^aAll country categories and data from the World Bank World Development Indicators database.

^bOut-of-pocket expenditure is a subset of private expenditure; it is shown here as a proportion of total health expenditure.

Governments remain by far the largest source of DAH, accounting for about 73% of the total. However, private sources of funding (including foundations, NGOs and corporations) have grown in importance, increasing from 6.5% of total DAH in 1990 to 16.5% in 2000 and 17.3% in 2014, with the largest single contributor being the Bill & Melinda Gates Foundation. International financing was directed toward a range of health issues, with HIV/AIDS receiving the largest total amount, followed by maternal, newborn and child health. Malaria, health sector support and tuberculosis ranked lower in terms of total funding received, but each of these areas saw rapid increases in recent years. Non-communicable diseases received the least funding of the disease categories tracked by IHME (2016).

To put these trends in perspective, it may be useful to consider what has been taking place more broadly in development assistance. The most authoritative figure available is the Organisation for Economic Cooperation and Development (OECD)'s estimate of official development assistance (ODA), which includes only government contributions from OECD members. A comparison with DAH is necessarily imperfect, since DAH includes both public and private sources from both OECD and non-OECD countries, but still useful to understand broad trends. Total ODA increased by 77% from 2000 to 2014 (OECD, 2015), while DAH grew by 332% in the same time period. Looking only at health ODA, the proportion of health within total ODA also grew over the same period, from less than 2% in 1990 to 8% in 2000 and to 17% in 2014 (OECD, 2015; IHME, 2016). In short, development assistance targeted at health has grown faster than development assistance overall.

Eight critiques of the DAH system

Many of the critiques regarding the existing DAH system mirror those regarding the development aid system more broadly, while others are specific to the health sector. We categorize the critiques under eight themes, with brief summaries of each:

1. *Inadequate total volume of financing*: existing financial resources dedicated to health fall short of needs, and significant international resources will be required particularly to support the poorest countries (Committee of Experts to the Taskforce on International Financial Transactions and Development, 2010; McCoy and Brikci, 2010; Clift, 2011).
2. *Volatility and uncertainty of financing*: aid disbursement is irregular and information on future financial flows is uncertain, which is particularly detrimental when DAH funds recurring costs in the health sector such as salaries, drugs and transport; volatility can also undermine longer-term efforts to build health systems (Lane and Glassman, 2009).
3. *Additionality of financing*: external financing may displace rather than augment domestic financing for health (Frag et al., 2009; Lu et al., 2010; Dieleman et al., 2013). Critiques have been raised regarding fungibility between health and

non-health spending (such as between health and road building), and between various priorities within health spending (such as between HIV and NCDs). However, it should be noted that there is considerable disagreement in the literature regarding the degree to which DAH is in fact additional (or fungible), the reasons behind it, and whether it is necessarily negative (Ooms *et al.*, 2010a, 2010b; Roodman, 2010; Sridhar and Woods, 2010; Stuckler *et al.*, 2011; Garg *et al.*, 2012; Roodman, 2012a, 2012b; Dykstra *et al.*, 2015).

4. *Proportion transferred to recipient countries*: the proportion of DAH that is transferred to or spent in developing countries is unclear and/or inadequate. There have been longstanding critiques that a significant proportion of ODA is ‘phantom aid’ that remains in the donor country, for example, through administrative costs, grants to donor-linked NGOs, or debt relief. The OECD estimates that the proportion of ODA that qualifies as Country-Programmable Aid (targeted at specific countries and ‘over which partner countries could have a significant say’) was 78% in 2014 (OECD, 2016a). We did not find an estimate for the proportion of DAH that remains in donor countries, but studies narrower in scope support the overall critique. For example, a 2009 study of the Gates Foundation’s grants from 1998 to 2007 estimated that 40% of grant funding went to supranational organizations and 82% of the remaining amount went to US-based organizations (McCoy *et al.*, 2009). A 2013 study on PEPFAR found that only 8% of funds went directly to governments in LMICs (Fan *et al.*, 2013).
5. *Priority setting*: critiques on priority setting in DAH center around three distinct but interrelated questions: *how* priorities actually get set, with disagreement on whether donor interests, recipient needs or other factors determine final priorities (Shiffman, 2006; Glassman *et al.*, 2012); *who should* set priorities, with concern that donors continue to drive decision making at the cost of meeting recipients’ greatest needs or highest priorities, which also undermines country ownership (Kickbusch, 2002; Ollila, 2005; Kipiriri, 2012); and *how* priorities *should* be set, with concern that spending is not allocated based on objective indicators such as disease burden or through fair, transparent processes (Sridhar and Woods, 2010; Glassman *et al.*, 2012).
6. *Coordination*: the proliferation of actors involved in DAH, particularly over the last decade, has exacerbated the problem of coordination among them, with the predictable consequences of system fragmentation, inefficiencies, confusion, gaps and transaction costs. The total number of major global health actors (donors, foundations, initiatives, etc.) was estimated in 2015 to exceed 200 (Hoffman *et al.*, 2015).
7. *Accountability*: the existing DAH system has weak mechanisms of accountability, particularly for strengthening the accountability of stronger actors toward weaker ones. Critiques encompass a diverse set of issues regarding *who* should be accountable to *whom*, and for *what*. While discussions of accountability have tended to focus on relationships between donor and recipient governments, also significant are accountability relationships between governments and their own constituents (Hudson and GOVNET Secretariat, 2009; Sridhar and Woods, 2010) and those between donors and recipients across societies as increasing amounts of DAH are channeled outside governmental channels (Jordan and

van Tuijl, 2006). In particular, concerns have been raised regarding the lack of accountability mechanisms governing the Gates Foundation, given its tremendous financing power and influence in global health (*The Lancet*, 2009).

8. *Rationale*: debates have arisen regarding what *is* and what *should be* the rationale or justification for DAH. The foundations of the existing system of DAH and ODA were built after the Second World War and decolonization, and were initially framed as ‘foreign aid’, with recipients in a hierarchical relationship of dependence on donors. Alternative framings have since emerged, including ‘cooperation’, which implies a more equal relationship based on the principle of mutual benefit; ‘national security’, based on the argument that infectious diseases or other health threats arising in a foreign country may spread back to the donors’ country unless managed at the source; ‘global public goods’, which emphasizes the responsibility of all states to contribute to the shared benefit of health; ‘health diplomacy’, which can include the use of DAH to achieve a donor’s other foreign policy goals; ‘investment’, eyeing future commercial relationships to be built between a donor and recipient country; ‘restitution’, which emphasizes obligations to remedy past and/or ongoing wrongs; ‘global solidarity’, based on the notion of the emergence of a global society bound together by relationships of interdependence (Commission on Macroeconomics and Health, 2001; Mackintosh *et al.*, 2006; Frenk and Moon, 2013; Heymann *et al.*, 2015; Kickbusch, 2016). Each of these framings implies different institutional arrangements for DAH and is reflected in various reform proposals for the DAH system.

Proposals for reforming the DAH system

We roughly divided proposals for reform of the DAH system into three categories: those that primarily seek to address financing issues (e.g. volumes, volatility); those that seek primarily to address governance issues within the existing DAH system (e.g. additionality, proportion, coordination, priority setting and accountability); and those that reach beyond the DAH system. (Some proposals cover more than one category.)

1. *Financing-oriented proposals (e.g. volumes and predictability)*: in response to critiques regarding insufficient levels and high volatility of DAH, a number of proposals for innovative financing mechanisms have been advanced – both specifically for health and more broadly for development. These include international taxes such as a levy on financial transactions (such as trade in equities or currencies), ‘sin taxes’ on products that are (potentially) harmful to health (such as tobacco, alcohol, fossil fuels or some foods), a tax on every individual earning more than \$1 billion per year, or expanding the tax on air tickets currently used to fund the global health initiative UNITAID. Estimates of total amounts that could be raised range from \$5 billion to \$400 billion per year, depending on the tax rate, the taxed item and which countries implement it (deFerranti *et al.*, 2008; Leading Group on Innovative Financing for Development, 2010; World Bank and GAVI Alliance, 2010; WHO SEARO, 2012).

Finally, earmarked contributions from the sale of products by the private sector have been proposed to generate additional funds for health, such as (Product) Red for the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). While Product Red has raised important sums (\$306 million from 2001 to 2015), it remains a very small proportion (0.8%) of the \$38 billion contributed to the GFATM, 95% of which came from governments (\$36.2 billion).⁶

One estimate found that innovative financing mechanisms had raised \$94 billion for development between 2000 and 2014 (Global Development Incubator, 2014). It should be noted, however, that there is no clear consensus on what kinds of financing deserve to be labeled ‘innovative’, and that financial flows from traditional governmental sources continue to dwarf those from innovative sources (Atun *et al.*, 2012).

Other proposals involve novel mechanisms for managing financial flows (rather than generating new financial flows), including: leveraging the International Monetary Fund (IMF)’s Special Drawing Rights to back bonds for development purposes; building on the GAVI Alliance’s International Finance Facility for Immunization, which frontloads financial flows by using long-term pledges from donor governments to sell ‘vaccine bonds’ in capital markets; designating a ‘swing donor’ or donor of last resort that would counterbalance unpredictable disbursements by individual donors to smooth out resource transfers; and building on the GFATM’s (or Global Fund) Debt2Health initiative, which redirects funds for debt repayment by recipient countries to domestic health investments.

Finally, advocates have long urged OECD donor governments to live up to their commitments to allocate 0.7% of gross national income for development assistance and to extend their planning horizons to make aid more predictable (see e.g. Millennium Development Goals (MDG) Gap Task Force, 2013). As of May 2016, however, only seven governments had ever achieved the 0.7% target (OECD, 2016b).

2. *Governance-oriented proposals within the DAH system (e.g. additionality, proportion, priority setting, coordination and accountability)*: at national level, proposals to improve coordination (many of these at least partially implemented) have included: Sector-Wide Approaches, General Budget Support or donor specialization in one sector, referring broadly to the principle that donors coordinate within a given country and with its government to harmonize aid with country priorities, and with each other; the Three Ones approach for HIV/AIDS, referring to one action framework, one national coordinating authority and one monitoring and evaluation system for all actors involved in a country’s response to HIV/AIDS; and the One UN/Delivering as One initiative to improve coordination among UN organizations within a country based on six principles – One Leader, One Budget, One Programme, One Office, One Voice for advocacy and One Fund.

6 Authors’ calculations based on data from GFATM.

At the international level, initiatives and proposals include: the 2005 Paris Declaration on Aid Effectiveness, signed by more than 100 countries and international organizations and based on the five principles of ownership, alignment, harmonization, results and mutual accountability, with the follow-up 2008 Accra Agenda for Action putting additional emphasis on ownership, ‘inclusive partnerships’ and results; the International Health Partnership, started in 2007 to apply the Paris Declaration principles to the health sector, and provide better coordination for donor countries and agencies; the H8, an informal group of eight health-related organizations (WHO, UNICEF, UNFPA, UNAIDS, GFATM, GAVI, the Bill & Melinda Gates Foundation and the World Bank) formed in 2007 to improve coordination, especially on the health-related MDGs; and the H4+ for maternal and child health, created in 2010 (WHO, UNFPA, UNICEF, UNAIDS, UN Women and the World Bank) to coordinate support for countries with the highest infant and maternal mortality rates. It is beyond the scope of this article to assess how well each of these initiatives have fared, but clearly, many have recognized that improved coordination is necessary. Despite these many initiatives, recent assessments of the overall quality of DAH have found that much room for improvement remains (Duran and Glassman, 2012).

In addition to these organizational approaches, priority setting methodologies can also be seen as efforts to improve coordination at an ideational rather than organizational level. For example, the development of the Disability- (or Quality-) Adjusted Life Year and the Disease Control Priorities Project both aimed to make priority setting more rational, objective and evidence based. Other initiatives, such as the UN Commission on Information and Accountability for Women’s and Children’s Health, sought to improve accountability of DAH actors through transparency and the use of information and evaluation. Lastly, some proposals have urged restructuring of existing institutions rather than new coordination efforts: for example, calls to expand the mandates of the GFATM and UNITAID beyond HIV, tuberculosis and malaria; or to merge Gavi, GFATM and the World Bank’s health financing into a consolidated global ‘Principal Financier(s)’ to channel funding to national health strategies (Dybul *et al.*, 2012).

3. *Proposals reaching beyond the existing DAH system:* some proposals reach at least one step beyond the existing set of actors and institutions in DAH. These include the proposal for a Global Social Protection Fund for long-term resource transfers (or redistribution) to poorer countries or populations to meet basic health needs, based on an expansion of the notion of social protection beyond the nation state and possibly a transformation of the GFATM (Ooms *et al.*, 2010a, 2010b). Many have also argued for the increased use of formal international law for global health (including but not limited to the purpose of resource generation), building on the precedent established by the 2005 WHO Framework Convention on Tobacco Control. Proposals include those for a treaty on antimicrobial resistance (Hoffman and Behdinan, 2016), research and development of new medicines focusing on the needs of the poor (Røttingen and Chamas, 2012), an alcohol

convention (Sridhar, 2012), a chronic disease ‘global compact’ (Magnusson, 2009), a ‘fake drugs’ treaty (*The Lancet*, 2011a), an obesity convention (*The Lancet*, 2011b) and a Framework Convention on Global Health (Gostin, 2007). The track record of international law in achieving its intended effects is both mixed and difficult to assess, however; therefore, both the problems to be targeted by treaties and treaty design itself merit careful consideration (Hoffman and Røttingen, 2014).

Discussion and conclusions

Significant and rapid changes have taken place in the system for DAH since 2000, and we are now entering an era of major transition with the launch of the SDGs. There is no shortage of critiques or proposals to reform the DAH system. What should we look for in reform proposals?

Proposals should lead to adequate, or at least additional (at national and/or international level), resources to provide a basic minimum package of services. They should reduce the volatility of financial flows to provide more predictable, sustainable financing. Proposals should offer legitimate processes for decision making, such that those most affected by these decisions are substantively involved in making them. They should incorporate both objective evidence and legitimate political processes into priority setting. Proposals should provide robust arrangements for better coordination, including merging or restructuring existing organizations if needed. And they should offer accountability mechanisms for results, and for compliance with commitments on financing, monitoring and coordination.

No single proposal will be able to address all major critiques of DAH. Most aim to address only one or two. This is not necessarily problematic, but suggests the need for multiple reforms over many years. Furthermore, many of the proposals we identified are characterized by a ‘big idea’, but remain nascent and would benefit from more detailed justification. In particular, many proposals do not address basic governance questions, such as how decisions would be made, or how new initiatives would fit within a complex ecosystem of actors and interests.

What are the prospects for reform? The ‘golden age’ of rapid increases in DAH may be over, with DAH increasing only 1% per year since 2010, compared with over 11% annual growth in the decade prior (IHME, 2012; IHME, 2016). Political attention in the traditional donor OECD countries may be shifting to other global challenges, such as climate change, refugees and terrorism. No major new financing commitments were made at the 2015 Financing for Development summit in Addis Ababa. Though difficult to predict, major increases in the amount of DAH seem unlikely (Dieleman *et al.*, 2016). Emerging powers are often mentioned as potential new sources of DAH. But, while some MICs have funded bilateral and multilateral DAH initiatives, data are scarce and overall do not suggest that this group of countries will provide DAH at a scale comparable with

the OECD countries (Fan *et al.*, 2014). Neither has innovative financing been adopted on a large scale, beyond the initial major experiment with UNITAID. Nor is health spending in most LICs and many MICs projected to increase to cover basic needs before 2040 (Dieleman *et al.*, 2016). Thus, without significant changes in mindset, significant increases in the levels of DAH seem unlikely, and major gaps between actual and total financing needed seem likely to persist.

Given a relatively fixed resource envelope, it becomes even more important, then, to improve other aspects of DAH. The emerging powers may have an appetite for reform. Within the global financial institutions, they have sought a weightier decision-making role at the World Bank and IMF, or created alternate arrangements such as the Asian Infrastructure Investment Bank and New Development Bank (formerly known as the BRICS Development Bank). Determined leadership from one or more countries could champion any of the reform proposals above. However, as demonstrated in Table 1, DAH accounts for a small proportion of health financing in MICs. It is the LICs that have the greatest stake in strengthening the system, and will need to push for change. While LICs, in general, will have fewer levers of influence than MICs, leadership and political alliances with like-minded development actors can wield significant power. In addition, many LICs are undergoing rapid economic growth which may change the nature of the donor–recipient relationship. Furthermore, the rationale for DAH may shift with the increased health interdependence that results from the intensified movement of people, goods, pathogens, ideas and financial resources across borders (Frenk *et al.*, 2014). The closer the health of one country’s population is tied to that of another, the stronger the interest in ensuring healthy populations on both sides of the border. The recent Ebola and Zika health emergencies have reminded the world of these realities.

Reforming a complex, entrenched DAH system will never be easy. While there are numerous problems, there is also no shortage of promising proposals for change, or of political possibility. What is needed are determined leaders who will champion reforms and invest the political capital needed to build better institutions for DAH in the SDG era.

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