Making the final decade of the Sustainable Development Goals count: an analysis of donors' subnational approaches to reaching the poorest people

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ACRONYMS

AGYW .... Adolescent girls and young women
COP .... Country Operational Plan
CPIA .... Country Policy and Institutional Assessment
DAH .... Development assistance for health
DHS .... Demographic and Health Surveys
DREAMS .... Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
EAI .... Equitable Access Initiative
GDP p.c. .... Gross domestic product per capita
GNI p.c. .... Gross national income per capita
HPN .... Health, population, and nutrition
HSS .... Health systems strengthening
IDA .... International Development Association
IPL .... International poverty line
JICA .... Japan International Cooperation Agency
LIC .... Low-income country
LMIC .... Lower middle-income country
MDGs .... Millennium Development Goals
MIC .... Middle income country
MICS .... Multiple Indicator Cluster Surveys
MOFA .... Ministry of Foreign Affairs of Japan
NTD .... Neglected tropical disease
ODA .... Official development assistance
OECD .... Organisation for Economic Cooperation and Development
PEPFAR .... President's Emergency Plan for AIDS Relief
SDGs .... Sustainable Development Goals
SNUs .... Sub-national units
TCA .... Targeted country assistance
UMIC .... Upper middle-income country
UN .... United Nations
UNDESA .... United Nations Department of Social and Economic Affairs
UNICEF .... United Nations Children's Fund
USAID .... United States Agency for International Development
WASH .... Water, sanitation, and hygiene
WHO .... World Health Organization

GLOSSARY

Aid targeting
The practice of allocating aid based on certain characteristics of a recipient. These characteristics may be related to a recipient's geographic region (national or subnational), poverty level, fragility level, or severity of disease burden. The intention of targeting is to send aid to those who need it the most, based on such criteria. However, many donors also factor in other dimensions to their aid allocation practices, such as geopolitical interests.

Key and vulnerable populations
We use the definitions for key and vulnerable populations put forth by the Global Fund to define a relatively specific group of people. "Key populations" are groups who meet three criteria: "a) increased [epidemiological] risk, vulnerability and/or burden due to biological, socioeconomic and structural factors; b) significantly lower access to services; and c) frequent human rights violations, systematic disenfranchisement and/or criminalization."[1] "Vulnerable populations" are groups who "experience a greater vulnerability to and impact of HIV, TB and malaria" yet are not captured by the "key populations" criteria.[2]

Pockets of poverty
A phenomenon where a country experiences development success but certain clusters of the population may be "left behind" despite their country's progress. These countries, often lower middle-income, are also those most likely to experience a transition from aid.

Poverty
We acknowledge that poverty is a complex social phenomenon that lacks a singular, universal definition. In this paper, we define "poverty" in terms of broad material deprivation and constrained access to resources. Our definition of poverty includes relative poverty, absolute poverty, extreme poverty, and "transitional" poverty, in which people may be living just above the poverty line or move in and out of poverty (as determined by international poverty lines).

Subnational
In this paper, we broadly define "subnational" as referencing all phenomena occurring within a country at a higher degree of granularity relative to the national level. Subnational, by this definition, encompasses the district, state, province, municipal, and local levels.

Transition from aid
Changing instruments, finances, and programming with the intention of shifting more responsibility to a recipient country in its preparation for an era beyond aid.

Vulnerability
As with poverty, we acknowledge vulnerability as a complex social phenomenon that is context dependent. We define vulnerability as social identities or circumstances that increase a group's likelihood of experiencing hardship, ill health, or deprivation, material or otherwise.

EXECUTIVE SUMMARY

Although the proportion of the world's population living in poverty has declined substantially over the last two decades, the absolute number of people that live in poverty or vulnerable conditions has remained high. Nearly 70% of the poor now live in countries classified as middle-income.[3] We conducted a document review and comparative analysis of six of the largest global health donors to better understand the extent to which they incorporate subnational poverty into their allocation decisions and programming. The donors we studied were Gavi, the Vaccine Alliance (Gavi); the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund); the President's Emergency Plan for AIDS Relief (PEPFAR); the United States Agency for International Development (USAID)—specifically, its Global Health Bureau; the World Bank's International Development Association (IDA); and the Government of Japan.

We found that most donor high-level strategy documentation allude to the relationship between poverty and health by, for example, noting the financial burden of specific diseases targeted or the disproportionate disease burdens that may fall on the poorest people. However, only two of these donors, Gavi and IDA, incorporate any subnational poverty indicators or broader subnational poverty focus that could be tracked and monitored over time. Gavi and IDA also integrate household level wealth or health expenditure data in their routine monitoring processes, though there is limited information about how much this integration influences how these two donors target aid toward the poorest communities. For the other four donors—Global Fund, PEPFAR, USAID, and Japan—subnational poverty is either not addressed or else is invoked in the context of other social or demographic factors that make certain groups of people vulnerable to disease (e.g., sex workers' vulnerability to HIV).

We draw five policy recommendations for how global health donors can more effectively work toward achieving the Sustainable Development Goals (SDGs) and leaving no one behind by improving the way they identify, prioritize, and target people living in poverty. We recommend that donors:

1. **Embed a specific focus on poverty elimination** in service of health outcomes. They could use geospatial data sources and methods, consult people living in poverty, and use multiple indicators to assess poverty to deliver on this focus.
2. **Create a clear action plan**, using specific language and clear metrics of progress, for populations labeled "key and vulnerable," "marginalized," or otherwise at risk of being left behind. Donors should also support data collection efforts for these populations.
3. **Expand beyond "value-for-money" approaches** that prioritize disease-specific indicators and may inadvertently neglect those most in need to include poverty-specific subnational indicators and approaches.
4. **Mainstream systems thinking across all donor activities and develop a clear set of indicators** for monitoring the impact of health system strengthening (HSS) investments or activities on protecting individuals and communities from illness-related poverty.
5. **Leverage disruptions caused by the COVID-19 pandemic and proactively respond to increasing rates of poverty** by leading a paradigm shift in the aid ecosystem. Adopt the "Re-imagined Aid model."[4]

1 INTRODUCTION

Since 2001, economic growth has led 33 countries to transition from low- to middle-income status.[5,6] This recategorization of country-level income status together with trends in international poverty and health point to global socioeconomic improvement in aggregate (Box 1). However, these aggregate data also mask the reality that there are still millions of people living in extreme and relative poverty, most of whom now live in middle-income countries (MICs).[5,7] As of 2017, an estimated 689 million people still lived on less than US$1.90/day while an estimated 1.8 billion lived on less than US$3.20/day.[8] And as of 2014, the latest year for which data are available, **68% of the people who were living below the international poverty line (IPL) of US$1.90 lived in countries classified as either lower MICs (LMICs) or upper MICs (UMICs)**.[3]

More people living in MICs (and elsewhere) may fall below the IPL in the coming decade: the World Bank projects that between 88 million and 115 million people could fall below the IPL in 2020 alone.[9] Among them, over 80% are people who live in MICs.[9] Estimates are much higher using LMIC and UMIC poverty lines (Box 1).[9] Combined with climate change and conflict, the next decade presents enormous challenges to social and economic development.[9] The COVID-19 pandemic is undermining decades of development progress, stalling economic growth worldwide, and disrupting essential health services.

MICs may have "pockets of poverty," or poor populations within a growing economy, which may be masked by national indicators of income. Therefore, **national indicators of poverty are insufficient for understanding who the poorest and most vulnerable people are within countries**.

Between 1990 and 2015, aggregate health outcomes improved substantially. For example, child mortality dropped 11 percentage points in low-income countries (LICs) and five percentage points globally between 1990 and 2017.[5] During this period, the number of people living below the international poverty line (IPL) of US$1.90/day decreased by nearly one billion, while the proportion of people living in poverty dropped from 35.9% to 10%.[6,7]

The IPL, which connotes extreme poverty, changed several times between 1990 and 2015, from US$1.00/day in 1990 to US$1.08/day in 2001 to US$1.25/day in 2008 and finally, in 2015, to the current IPL of US$1.90/day. The poverty numbers reported here use US$1.90/day to determine the number of people living in extreme poverty from 1990-2015. The World Bank recently introduced poverty rates of US$3.20/day and US$5.50/day for LMICs and UMICs, respectively, to better account for regional and national differences in purchasing power and consumption needs.[8] These poverty lines are not discussed in depth in this paper.

Box 1. Trends in international poverty and health

Along with these trends in health and poverty, there has also been a shift in global development goals. A growing, robust body of evidence now shows that **poverty has a bidirectional link with poor health**, linkages that were recognized both in the 2000-2015 Millennium Development Goals (MDGs) and the subsequent 2015-2030 Sustainable Development Goals (SDGs).[10,11,12] The inclusion of three health-related goals among eight total goals in the MDGs reflected, at the global level, recognition that poor health outcomes can inhibit poverty reduction and social development efforts.[11] The SDGs move beyond this recognition to place equal weight, through global-level targets, on socioeconomic, environmental, and political determinants that influence individual outcomes. The guiding principle of the SDGs is that "ending poverty and other deprivations must go hand-in-hand with" addressing health, education, economic growth, and climate change.[12] While only one goal, SDG 3, explicitly focuses on health, several other SDGs

have direct implications for health, such as those that encompass hunger and nutrition (SDG 2) and clean water and sanitation (SDG 6). The rhetoric of the SDGs suggests that "structural stratifiers" like income, occupation, and other social forces must be addressed to eliminate preventable differences in health outcomes among people.[13] The SDGs include an overarching pledge to "leave no one behind"—that is, to ensure that the poorest and most vulnerable people are not left out of global efforts to achieve the SDGs. The SDGs also reinforce the need for stronger health systems and more systems-level approaches to promote health, a need that was identified in the Alma-Ata Declaration of 1978 and in the Astana Declaration forty years later.[14]

To make progress towards the SDGs and leave no one behind, donors must understand who the poorest and most vulnerable people are, how poverty and other vulnerabilities may intersect or diverge in particular settings, and how best to reach these populations. While there is a substantial evidence base on whether official development assistance (ODA) is targeted to poor countries,[15,16] less is known about the allocation policies adopted by health donors to proactively target the poorest people within countries. To address this gap, we set out to identify whether health ODA donors consider sub-national poverty in their aid allocation system and, if so, how and why. We aimed to understand if countries in transition (i.e., those facing reductions in ODA as a result of economic growth) may be vulnerable to pockets of poverty after transition from ODA and if donors are living up to their commitments to leave no one behind through poverty-sensitive allocation processes.

Our working paper is divided into five main sections. In the first section, we briefly review the literature on approaches to measuring the linkages between poverty and health and on approaches to measuring donors' impact on poverty and health. We conducted this review to validate our starting assumption that improving health requires addressing poverty, and to ground our analysis in the existing evidence base on donors' impact on poverty and health. In the second section, we describe our methodology. In the third section we present the results of this analysis. In the fourth section, we discuss how we conducted an analysis of the policies of six major health donors in relation to targeting people living in poverty. In the final section, we offer five policy recommendations for how global health donors can more effectively work toward achieving the SDGs and leaving no one behind by improving the way they identify, prioritize, and target people living in poverty.

2 BACKGROUND: SITUATING AID TARGETING IN CONTEXT

Approaches to measuring poverty and health

Poverty and health have a strong bidirectional association. This link has been proven across many time periods, in many countries, and for a wide variety of health conditions (Appendix 1).[17] Wealth and income are important determinants of both poverty and health, but alone they insufficiently account for health and economic outcomes.[18] Other social determinants of health, such as socioeconomic status, gender identity and expression, sexual orientation, and race and ethnicity, interact in many ways to influence health and are all also mediated by place.[13] Improving health outcomes, then, requires attention to the particular needs and perspectives of intended beneficiaries of health programs, which in turn requires "more complex forms of intersectoral policy action."[13]

There are a variety of tools to measure poverty, including those that capture non-monetary dimensions of deprivation (see Appendix 1 for examples). However, many donors continue to rely on national-level monetary-focused poverty indicators, such as gross national income per capita (GNI p.c.), when determining which countries are eligible to receive aid. Yet donors themselves have acknowledged the major shortcomings of relying on monetary approaches and national-level poverty indicators alone to identify country needs, particularly for health.

For example, nine multilateral organizations, including Gavi, the Global Fund, the World Bank, and several United Nations (UN) agencies, convened the Equitable Access Initiative (EAI) to explore the relevance of GNI p.c. in their policy decisions and possible alternative measures. The EAI's report in 2016 concluded that GNI p.c. alone is insufficient for understanding specific countries' health needs and should be replaced with or complemented by more multidimensional indicators.[19] The report recommended "a multi-criteria framework" that accounted for "national income," "health needs," and "domestic capacity," while also being sensitive to "within country inequity."[19] However, since the report's publication in 2016, it is unclear the extent to which participating organizations have adopted its recommendations; for example, the Global Fund, Gavi, and the World Bank continue to use GNI p.c. in allocation decisions. Although the Global Fund references the EAI's recommendations in its 2017-2019 allocation methodology, the recommendation applies to its application of GNI p.c. rather than non-monetary considerations.[20]

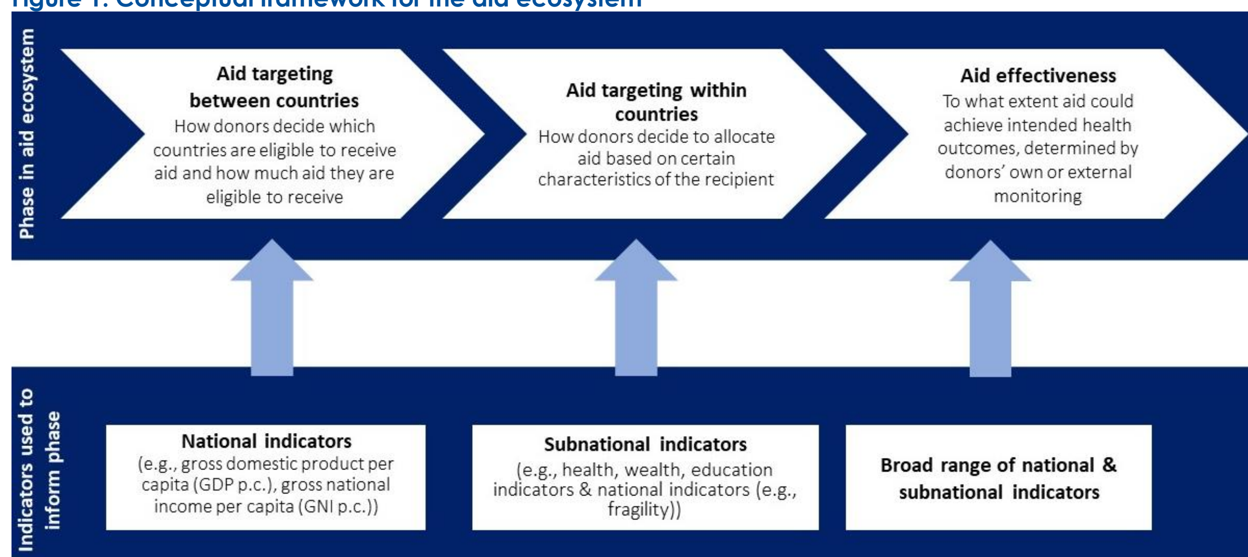
There is an array of non-monetary and hybrid approaches to measuring poverty that could help to create such a multi-criteria framework. At the same time, global calls for action such as the MDGs and SDGs help provide an agenda for taking a more holistic approach to poverty reduction and achieving health equity. Donors themselves acknowledge the need for a more multidimensional approach to health aid allocation decisions. Given this context, how well do donors draw from available indicators and methods, pursue in earnest the SDGs, and match their rhetoric with tangible policies and practices?

Approaches to measuring donors' impact on poverty and health

One approach to answering this question is to look at how donors allocate their funds. Donors target aid in particular ways depending on factors such as their organizational mandates, allocation policies, political interests, and normative values.[15,21–23] Our review of the literature identified three key areas in the aid ecosystem that have each been focal points of analysis aimed at better understanding aid allocation motivations, decisions, and impact (Appendix 2). We have consolidated these three areas into a three-phase aid ecosystem framework (Figure 1). These phases are: (i) aid targeting between countries, (ii), aid targeting within countries, and (iii) aid effectiveness.

Donors first must determine country eligibility and funding level (aid targeting between countries), which is most commonly based on national-level monetary poverty indicators and disease burden (e.g., HIV, malaria). Donors next make decisions on how to allocate aid based on certain characteristics of the recipient, such as disease burden or health needs (aid targeting within countries). Once donors have made these decisions, typically they then assess to what extent aid could deliver the intended impact (aid effectiveness). Alternatively, donors or external actors may assess aid effectiveness after aid has already been allocated and used. This framework is a simplification of a much more complex landscape but is useful for our analytical purposes (see methods section).

Figure 1. Conceptual framework for the aid ecosystem



Aid targeting within countries: the missing middle

Health aid is often targeted within countries to ensure ODA flows to people with specific diseases or populations vulnerable to specific diseases. Given health donors' focus on specific diseases and related health outcomes, donors tend to favor epidemiologic indicators that enable monitoring of disease burden and health status.[7] Given the conceptual link between poverty and health, it may be valuable for health donors to also track poverty-specific indicators. And since national income status inadequately reflects where people most vulnerable to diseases such as HIV or malaria may live (a large proportion live in pockets of poverty in MICs), donors should go beyond using national-level indicators.

In a 2017 report, AidData, a research laboratory at the College of William & Mary, analyzed donor activity using geospatial data to assess the extent to which donor funds met countries' specific health needs and other aid objectives. The report found that donors prefer maximizing "value-for-money,"[i] defined in terms of "economic efficiency," by spreading funds across the greatest number of people at the lowest possible cost per person. It further found that "subnational aid allocation decisions are governed by some mix of economic efficiency and political expediency criteria, depending on factors like the identity of the donor, national and local recipient institutions and needs, and types of aid."[7] Further, factors such as population

[i] "Value-for-money" is used often in the global health literature, but is not always clearly defined. What connotes good "value" is not always specified. It could encompass, for example, the number of people reached with a particular service or the number of deaths averted per dollar of ODA spent.

density, income, and road access were found to be predictive of where development finance is targeted.[7] These findings suggest that the people most deprived of resources may not be able to access the intended benefits of foreign aid, or may not be appropriately targeted.

With household surveys such as the Demographic Health Surveys (DHS) and the advent of "location-specific information" such as nighttime lights (luminosity), it is possible to collect and monitor subnational data.[7] Tracking such data will be critical for reaching the most vulnerable people. Yet recent analyses indicate that donors in practice generally do not leverage these tools to effectively reach the most vulnerable communities.[7] The evidence suggests that there is a risk that people living in poverty are being left behind. The rest of this paper explores the extent to which global health donors have explicit aid targeting policies for reaching people living in poverty.

3 METHODS

Donor selection

This analysis was conducted as part of a broader project called "Driving health progress during disease, demographic, domestic finance, and donor transitions." This project is examining the interplay of these four types of transitions in six MICs that are at different stages in their transition: Ghana, India, Kenya, Myanmar, Nigeria, and Sri Lanka.[24,25] A key component of this project is understanding how the major health donors to these countries are approaching aid transition and the potential implications of transition, such as addressing pockets of poverty within each country.

For this new study, we conducted a comparative analysis of six major global health donors, three bilateral and three multilateral (Table 1). We identified the major donors using the Organisation for Economic Development's (OECD's) Creditor Reporting System (CRS) database, which provides aid funding data by year, donor, recipient country, and sector.[26] Out of the official donors who report to the OECD, we identified the three bilateral donors and three multilateral donors that gave the most health ODA to our six focus countries: the World Bank's International Development Association (IDA); the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund); Gavi, the Vaccine Alliance (Gavi); the United States (US) government; the United Kingdom (UK) government; and the government of Japan. These six donors provide most of the total health aid to our six focus countries. Across all ODA recipients worldwide, these donors provided about 75% of all disbursed ODA for health in 2016. We calculated ODA for health using the sum of CRS sector codes 120 (health), 130 (population policies/programs and reproductive health), and 16040 (social mitigation of HIV/AIDS), as is common practice in other research that tracks health aid.[27] Additionally, this selection ensured variation in policies based on (i) the type of donor (bilateral versus multilateral) and (ii) whether a donor was focused on health ("health-centric donors" versus those that have health portfolios as one of a broad range of portfolios across multiple sectors).[26]

The UK Department for International Development (DFID) recently merged with the UK Foreign Office to become the Foreign, Commonwealth and Development Office.[28] The UK Government's future international development operations, policies, and practices are likely to change significantly through this merger. Consequently, the UK Government is not included in the present analysis. Within the US government, we looked at two agencies, the President's Emergency Plan for AIDS Relief (PEPFAR) and the United States Agency for International Development (USAID). We treated these two agencies as separate donors in our analysis given their significantly different scopes and mandates. Thus, the six donors included in the analysis were USAID, PEPFAR, IDA, the Global Fund, Gavi, and the government of Japan.

Table 1. Overview of donors selected for our analysis

Donor	Share of total DAH across six focus countries, 2016	Ranked contribution to ODA for health for all countries, 2016	Agency on which this paper focuses	Health-centric
Multilateral				
Global Fund	20%	#1 multilateral	N/A	Yes
Gavi	11%	#2 multilateral	N/A	Yes
World Bank, IDA	11%	#3 multilateral	N/A	No
Bilateral				
United States	37%	#1 donor government	PEPFAR, USAID	PEPFAR: Yes USAID: No
Japan	2%	#4 donor government	JICA	No

Our approach

We conducted a desk-based review of the six donors' key policy and strategy documents, websites, and relevant reports. We used a document analysis approach to identify and interpret donors' key policies related to aid targeting.[29] Our primary objective was to answer the question: *to what extent and in what ways do global health donors consider poverty in their aid allocation system, particularly in terms of reaching the poorest people?*

Through this process, we aimed to better understand how explicit global health donors are in addressing the relationship between poverty and health, as measured by their choice of indicators and articulated policies for allocating aid. Because national-level indicators of poverty may mask high poverty rates within countries, we paid special attention to the extent to which donors address subnational poverty. We acknowledge that there are many different ways to define and measure poverty, such as relative versus absolute poverty, extreme poverty, and "transitional" poverty in which people may be living just above the poverty line or move in and out of poverty over the course of one or more years. For this reason, we used a broad interpretation of the term "poverty" to assess to what extent donors take any nuanced or granular approach to poverty beyond national-level monetary poverty indicators such as GNI p.c.

Drawing from our aid ecosystem conceptual framework (Figure 1), we focused our analysis on the allocation of aid between countries (the first phase) and allocation within countries (the second phase). This framework helped focus our attention on which indicators donors use at national and subnational levels, if and when donors use poverty-related measures (i.e., at what phase and in what way), and at what phase in the allocation process donors use targeted approaches, if at all. Because of the centrality of the SDGs in shaping both the rhetoric and goalposts of the aid ecosystem, we also looked for donors' expressed commitment to and alignment with the SDGs and leaving no one behind, and how this rhetoric did or did not manifest in explicit policies.

The conclusions we have drawn about global health donors' treatment of poverty in their policies is limited only to the six donors under consideration, and do not necessarily reflect the policies or practices of other global health donors. The present study is limited to publicly available donor policy and strategy documents; it is possible that the global health donors discussed here do explicitly describe their approach to subnational poverty targeting elsewhere, though it seems unlikely that such an approach would be omitted from main guiding documents. We also did not complement the document analysis with qualitative interviews with key informants, which could yield important insights into donor practices that are not readily apparent in donor policies. Further exploration of donors' practices, including those that may not be documented in the public domain, would shed further light on the extent to which donors target poverty at the subnational level. Despite these limitations, the following findings are potentially important as collectively the six donors reviewed accounted for 66% of health ODA disbursements in 2018.

4 FINDINGS

Our study had four key findings. First, all health aid donors that we analyzed use national-level poverty indicators in their eligibility and/or allocation policies. Yet only two—Gavi and IDA—incorporate any subnational poverty indicators or broader subnational poverty focus in their allocation decisions or routine monitoring. Second, donors that focus on specific diseases monitor subnational disease-specific and coverage indicators for certain populations considered "key" and "vulnerable." Such populations may be an implied proxy for targeting the poorest people. Third, three donors—Gavi, the Global Fund, and USAID—allude to introducing "differentiated" and potentially subnational approaches to allocation and programming in their future strategies. Available details suggest, however, that these donors will continue using disease-specific rather than poverty-specific indicators in their subnational allocation and programming approaches. Fourth, all but one donor has either a standalone HSS window or cross-cutting HSS approach. Three donors use an HSS approach as an explicit strategy to reach the poorest people. We discuss each of these findings in more detail below.

Finding #1

All health aid funders rely on national-level monetary poverty indicators in their eligibility and/or allocation policies. Only Gavi and IDA, however, explicitly incorporate subnational poverty in their allocation decisions and/or routine monitoring.

The extent to which an explicit poverty focus is embedded within donors' core mandates or overarching strategies varies (Table 2). The World Bank's IDA exists for the express purpose of alleviating poverty in the poorest countries. The World Bank's strategy for health, population, and nutrition (HPN) underscores the Bank's commitment to and comparative advantage in poverty alleviation with a focus on improving the health of poor and vulnerable people.[30] Gavi's core mandate focuses on reaching the lowest-income countries with life-saving vaccines, reflecting a clear intention to reach the poorest people at the national level. PEPFAR has a relatively narrow focus on controlling the HIV/AIDS epidemic with little attention to poverty. In most cases, health donors articulate links between poverty and health—namely, poverty's impact on the health outcomes they seek to address—in their overarching high-level strategies. The Global Fund and PEPFAR, for example, both state in their strategies that poorer people generally bear a disproportionate disease burden or may be unable to access essential medical services. However, these funders' strategies and policies are grounded in epidemic control rather than poverty alleviation. Guidance for PEPFAR's Country Operational Plans (COPs) makes some links between HIV and socioeconomic determinants of HIV-related outcomes—for example, poverty's role in preventing people achieving virologic suppression—but does not go beyond acknowledgement of poverty as a contributing factor.[31]

Four donors—USAID, PEPFAR, Global Fund, and IDA—use language aligned with an economic efficiency approach in their strategies and allocation policies, which manifests as a prioritization of countries with high disease burdens and implementation of high performing and high impact programs. One of PEPFAR's main policy frameworks, PEPFAR 3.0, embodies these pillars, focusing on "geographic areas and populations where [PEPFAR] can achieve the most impact for [its] investments."[32] The Global Fund, USAID, and IDA all use similar language. USAID's Journey to Self-Reliance policy framework, for example, is guided by three interlocking principles: "(1) [advancing] country progress, by (2) making investments for impact, through (3) programs that sustain results."[33] The Global Fund, meanwhile, uses GNI p.c. and disease burden indicators for HIV, malaria, and TB in its allocation formula and then undertakes a "qualitative adjustment process" to determine final allocation amounts.[34] This qualitative adjustment process mediates the Global Fund's allocation decisions based on factors such as "programmatic performance" and "coverage gaps" and is intended to "maximize the impact of Global Fund resources."[34]

The extent to which donors align their strategies with the SDGs and in particular SDG 1, ending poverty everywhere, also varies. For example, the Global Fund's 2017-2022 strategy maps Global Fund investments to six of the 17 goals, including SDG 1. The Global Fund states that its investments will contribute to achieving SDG 1 by "[alleviating] the financial burden that the three diseases place on individuals, and governments thus freeing up resources to devote to other key drivers of health outcomes."[35] Gavi similarly links its activities to 14 of the 17 goals and suggests that Gavi will help achieve SDG 1 because immunization contributes to healthy childhood outcomes and "healthy children [and] families = increased prosperity."[36] Other donors such as PEPFAR do not make comparably explicit links to specific SDGs in their strategies.

Table 2. Summary of donors' high-level approaches to poverty.

	Core mandate includes poverty focus?	Uses economic efficiency approach?	Examples of donor's approach to addressing the link between poverty and health
Global Fund	No	Yes	The Global Fund says it will support SDG 1, ending poverty everywhere, through investments that "will alleviate the financial burden that the three diseases place on individuals, and governments thus freeing up resources to devote to other key drivers of health outcomes." (*2017-2022 Strategy*)[35]
Gavi	Yes	No	Equity is a "central organizing principle;" the first objective of the equity goal is to "reach under-immunised and zero-dose children" while the overall strategy is informed by the principle that "missed communities" lacking health services will be "first priority." (*Phase 5 Strategy, 2021-2025*)[44] Gavi also says it will support SDG 1: "healthy children & families = increased prosperity" (*Gavi website*)[36]
IDA	Yes	Yes	Poverty alleviation, improving the health of poor and vulnerable people, improving financial protection (*Strategy for Health, Population, and Nutrition, 2007*)[30]
USAID	Agency as a whole: Yes Global Health Bureau: varies by health area	Yes	"[Protect] poor and underserved people from illness, death, and extreme poverty" (*2015-2019 framework for health systems strengthening*)[60]; "The world's poorest, women, youth, the landless, persons with disabilities, politically and socially marginalized groups, and other vulnerable populations often face limited access to public services, political voice, and economic opportunity" (*Journey to Self-Reliance Framework*)[33]
PEPFAR	No	Yes	"Geographic areas at sub-national levels with the highest disease burden in every country" and "greatest need" (*PEPFAR 3.0, Impact Action Agenda*)[32]; Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) Partnership: "goes beyond the health sector to address the structural drivers that directly and indirectly increase girls' HIV risk, including poverty, gender inequality, sexual violence, and a lack of access to education" (*PEPFAR 2019 Annual Report to Congress*)[67]
Japan	No	No	The Ministry of Foreign Affairs of Japan (MOFA) commits to "pay attention not only to low-income countries but also to the poor in middle-income countries, as well as health disparities within a country" (*Basic Design for Peace and Health, 2015*)[38]

Of the six donors considered, four have explicit mechanisms in place for targeting aid toward LICs and LMICs (Table 3). GNI p.c. is the most commonly used measure to determine aid allocation between countries. Some donors such as the Global Fund and Gavi have engaged in discussions on the limitations of using measures like GNI p.c. to determine allocations.[19] Although these donors recognize that the poorest people mostly live in countries classified as middle-income, they and other health donors nevertheless continue to rely on GNI p.c. to make allocation decisions.[19,37] The Global Fund, Gavi, IDA, and Japan all use GNI p.c. in

their eligibility and/or allocation processes while USAID uses GDP p.c. and national poverty rates to assess countries' progress toward "self-reliance." Based on publicly available documents, PEPFAR does not explicitly include any poverty indicators in its eligibility or allocation policies. Donors often supplement GNI p.c. or GDP p.c. with other indicators, which tend to be disease-specific rather than poverty-specific.

Table 3. Donors' use of national and subnational poverty indicators

	National-level poverty indicator used (LIC/LMIC aid targeting mechanism)	Donor explicitly acknowledges limitations of national-level monetary poverty indicators?	Use of subnational poverty data in allocation and monitoring?
Global Fund	GNI p.c.	Yes	No
Gavi	GNI p.c.	Yes	Yes, monitoring
IDA	GNI p.c.	No	Yes, allocation
USAID	GDP p.c.	Yes	No
PEPFAR	None found	No	No
Japan	GNI p.c.	No, but commits to "pay attention not only to [LICs] but also to the poor in [MICs]"[38]	No

Several donors acknowledge the significant poverty levels within countries in their strategies and some also note the limitations of national-level monetary poverty measures. For example, the Global Fund's Strategy 2017-2022 states that "available metrics such as GNI or GDP p.c. provide insufficient insight into the issues of equity, access, and capacity that exist within diverse countries."[35] The Global Fund attempts to fill the gap by, in part, adopting "differentiating approaches to be more responsive to specific country contexts" (see Finding 3).[35] USAID's "Journey to Self-Reliance" framework also states that "all too often, economic growth is not inclusive and too many are left behind or left out."[33] The framework notes that "the world's poorest [...] and other vulnerable populations often face limited access to public services, political voice, and economic opportunity," precluding their ability to reap the benefits of economic growth.[33] Within USAID's Bureau of Global Health, its neglected tropical diseases (NTDs) portfolio is among the most explicit in linking poverty to health. In a 2019 factsheet, USAID states that NTDs "pose a crushing burden, particularly on the poorest, most marginalized and hard to reach populations."[39] Japan commits to "pay attention not only to low-income countries but also to the poor in middle-income countries, as well as health disparities within a country," though its explicit poverty focus seems to be limited to the Middle East and Latin America.[38]

Despite the Global Fund's and USAID's language around diverse country contexts and equity-related concerns, neither use subnational poverty data in their allocation policies. As mentioned previously, the Global Fund supplements its allocation formula, which is derived from GNI p.c. and disease burden indicators, with a qualitative adjustment process. The Global Fund's Strategy Committee oversees this adjustment process, which attempts to account for "country-specific considerations" beyond GNI p.c. and disease burden.[34] However, it is unclear the extent to which subnational poverty is factored in, if at all, in this process. As part of the Global Fund's funding application process that recipient countries must follow, the Global Fund also provides pre-filled "essential data tables" to help countries "develop a data-informed funding request."[40] These tables include indicators for resilient and sustainable systems for health, HIV, malaria, and TB, though the only poverty related indicators are national-level, including GNI p.c., GDP p.c., and poverty headcount ratio.[40] In its "Journey to Self-Reliance" framework, USAID uses national poverty rate (US$5/day), education quality, and child health to measure "citizen capacity" and GDP p.c., among two other indicators, to measure "capacity of the economy."[33]

Only two donors, IDA and Gavi, explicitly incorporate subnational poverty in either allocation decisions or routine monitoring. Both IDA and Gavi integrate household level wealth or health expenditure data in their policies. It is unclear, however, the extent to which the inclusion of these data influences these donors to

target aid toward the poorest communities. Gavi draws from household surveys for at least some of the indicators that it monitors, though these indicators revolve around immunization coverage. For example, Gavi's 2016-2020 strategy includes four core goals, one of which is uptake and coverage of vaccines. Under this goal, Gavi tracks three "equity" indicators, all of which relate to vaccine coverage.[41] District-level geographic distribution of coverage, average coverage difference across wealth quintiles at the country level, and average coverage difference across mother/female caretaker education levels comprise Gavi's equity indicators.[41,42] Gavi uses a mix of Demographic Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), and World Health Organization (WHO)/United Nations Children's Fund (UNICEF) data to track these indicators.[41] Gavi also has a standalone policy for fragile and emergency-affected states, which draws from other data sources.[43] Gavi's upcoming 2021-2025 strategy will also have at least one equity indicator, but in the most recent documentation available, the details of this indicator are limited.[44] Gavi's targeted country assistance (TCA), meant to "improve coverage rates and reduce equity barriers," provides another avenue for subnational targeting, "especially in specific geographical areas and/or population segments with large numbers and/or high percentage of un- or under-immunized children."[45] However, subnational poverty does not appear to be a primary factor for TCAs.

Of all donors considered, IDA incorporates the most comprehensive approach to measuring, targeting, and monitoring poverty. IDA's Country Policy and Institutional Assessment (CPIA), together with other IDA performance-based assessments, determine the IDA Country Performance Rating (CPR). This rating, together with countries' population and per capita income, in turn determines IDA's country allocation decisions.[46] "Policies for social inclusion and equity" is one among four clusters that comprise the CPIA.[47] Five criteria comprise this cluster, one of which is "equity of public resource use," which "assesses the extent to which the pattern of public expenditures and revenue collection affects the poor and is consistent with national poverty reduction priorities."[47] Under this criterion, IDA appraises "the extent to which vulnerable groups are identified, priorities are spelled out and budgets are aligned with those priorities, and **subnational allocation of public spending takes account of sub-national levels of poverty**" (emphasis added; Box 2).[47] For each criterion in the CPIA, IDA also lists "guideposts" for possible indicators, data sources, and resources for assessing said criterion.

> "The poor and vulnerable groups and their relevant characteristics are clearly identified. A comprehensive strategy, with well-defined and targeted interventions to assist the identified groups, is under full implementation. A wide range of consistent efforts is ongoing to ensure that poor and vulnerable groups are covered and are integrated into society. Public expenditures are fully aligned with poverty reduction priorities. Poverty is a key criterion used to allocate spending at sub-national levels."

Box 2. IDA CPIA description of highest score for Criterion 8, Equity of Public Resource Use.
Source: CPIA Criteria 2019, IDA.

It is unclear to what extent IDA's process for making allocation decisions applies to health-specific funding. However, IDA's HPN Results Framework does use subnational poverty-related indicators to measure progress. One of four strategic policy objectives of the HPN Results Framework is to prevent poverty from illness. Such poverty is measured by the percentage of out-of-pocket health expenditures as a proportion of total household income and the percentage of a country's population falling below the poverty line because of illness-related expenditures.[30]

Finding #2

Donors that target specific diseases monitor subnational disease-specific and coverage indicators for certain populations considered "key" and "vulnerable." Such populations may be an implied proxy for targeting the poorest people.

Most donors recognize that the subnational context in which they operate is complex and that within-country poverty rates are important. Nevertheless, as a general rule, donors mostly limit their focus to inequalities in health coverage and health outcomes rather than adopting a more multidimensional approach (e.g., one that addresses different dimensions of poverty). The multilaterals and specific health programs within USAID acknowledge the need to measure and monitor subnational data to better reach communities in need, yet typically they refer to disease-specific and coverage-related indicators rather than poverty-specific ones. The use of disease and coverage indicators is particularly apparent in the case of donors such as PEPFAR and the Global Fund, whose core mandates revolve around epidemic control for specific diseases. One way that donors attempt to bridge this gap is through targeting populations they identify as "key" and "vulnerable" who may be at a heightened epidemiological risk (Table 4). Donors define populations as "key" or "vulnerable" for reasons related to the disease on which the donor focuses (for example, heightened risk of exposure due to occupation), and not necessarily for financial or economic reasons.

Table 4. Comparison of relevant donors' definitions of key and vulnerable populations

	Key populations	Vulnerable populations	Other definitions
Global Fund	"Women and girls, men who have sex with men, people who inject drugs, transgender people, sex workers, prisoners, refugees and migrants, people living with HIV, adolescents and young people, orphans and vulnerable children, and populations of humanitarian concern, in each case based on epidemiological as well as human rights and gender considerations"[1]	"Orphans, street children, people with disabilities, people living in extreme poverty, mobile workers, and other migrants"	-
Gavi	-	-	"under-immunized children"; "zero-dose" or "zero-antigen" children; "missing millions"[44]; "those most marginalized"[54]
PEPFAR	"Men who have sex with men, transgender individuals, sex workers, people who inject drugs, and people in prisons and other closed settings"[50]	-	*Highest burden*: Children, including orphans and vulnerable children; adolescents; women under age 25 years; men under age 35 years; and key populations
USAID	-	-	*Across agency: "*The world's poorest, women, youth, the landless, persons with disabilities, politically and socially marginalized groups, and other vulnerable populations"[33]
IDA	-	-	-
Japan	-	-	-

Donors that focus on HIV such as the Global Fund and PEPFAR delineate population groups based on epidemiological risk and related factors. The Global Fund's allocation methodology for 2020-2022 directs funding to countries with higher burdens and countries with lower income, "specifically accounting for HIV epidemics among key and vulnerable populations, the threat of multidrug-resistant TB, and for the risk of

malaria resurgence."[37] Although many donors tend to use "poorest," "most vulnerable," and "most marginalized" either interchangeably or without clearly explaining how they are defining these terms, the Global Fund's Key Population Action Plan 2014-2017 is a notable exception. In this plan, the Global Fund defines "key populations" as groups who meet three criteria: "a) increased risk, vulnerability and/or burden due to biological, socioeconomic and structural factors; b) significantly lower access to services; and c) frequent human rights violations, systematic disenfranchisement and/or criminalization."[1] The Action Plan also describes special considerations for "vulnerable populations," or people who "experience a greater vulnerability to and impact of HIV, TB and malaria" yet are not captured by the "key populations" laid out in the criteria.[2] Countries submitting funding proposals to the Global Fund are required to include details on how they plan on reaching these key and vulnerable populations with Global Fund support. The interchangeability of these terms suggest that donors conceive of poverty and vulnerability to disease as synonymous.

PEPFAR relies heavily on subnational data to make allocation decisions and monitor progress. PEPFAR tracks subnational data on disease burden and health service use and needs; however, data on poverty are missing from this subnational monitoring. PEPFAR requires every country to develop annual COPs, which require details on how countries will reach target "sub-national units" (SNUs) and "priority sub-national units" (PSNUs).[31] Countries are required to report on SNUs "with age/sex/priority population disaggregates" and develop "SNU-level targets" for inclusion in their COPs.[31] In its guidance, PEPFAR exhibits a laser-like focus on epidemic control: the goal for identifying priority locations and populations is to "optimize resource allocation for maximum epidemiological impact."[31] PEPFAR 3.0's impact action agenda, one of five action agendas, further stipulates focusing on "geographic areas at subnational levels with the highest disease burden in every country" and "greatest need."[32] Key inputs for this process include "coverage of prevention services" and "estimated key and priority populations within high prevalence SNUs," though no poverty-specific indicators are tracked.[31] To inform COPs as well as other ongoing performance monitoring, PEPFAR draws from a range of data sources, including Population-Based HIV Impact Assessments (PHIAs) and other national household-level surveys.[48] PEPFAR uses these data to identify and target high-risk populations.[49,50] PEPFAR identifies the "vulnerable and poor" as those at risk of missing out on health care services.[48]

Finding #3

Three donors—the Global Fund, Gavi, and USAID—intend to introduce "differentiated" and potentially subnational approaches to allocation and programming in their future strategies. Available details suggest, however, that these donors will continue using disease-specific rather than poverty-specific indicators in their subnational allocation and programming approaches.

In response to significant disparities within countries, three donors—the Global Fund, Gavi, and USAID—have stated they will introduce or scale up subnational approaches to ensure that their services reach the people most in need (Table 5). These donors talk about "differentiated" or "targeted" approaches in their current or upcoming strategies or recent reports. They acknowledge that such approaches are needed to better address subnational differences in health needs and outcomes, thereby implicitly acknowledging that national income status may be an insufficient gauge of need. These donors, however, do not seem to fully operationalize this early thinking in their official policies and strategies, or identify how to meaningfully track subnational poverty more generally.

Both the Global Fund and Gavi use the language of "differentiated approaches" and specify large, federated states as the most likely or only candidates for subnational targeting. Gavi also articulates a vision to "leave no one behind" and reach the "missing millions" and "those most marginalized" in its upcoming Phase 5 Strategy for the period of 2021-2025.[44,54] The second of the four goals comprising Gavi's new strategy is to

"strengthen health systems to increase equity in immunization."[44] A key focus of this equity goal is to "reach under-immunised and zero-dose children."[55] The principle underlying Gavi's new strategy overall is that "missed communities" will be "first priority."[44] While Gavi notes that children located in these missed communities are likely in areas lacking "any basic health services," poverty-specific indicators are not mentioned.[55] Although MICs that have a GNI p.c. below Gavi's eligibility threshold of US$1,500[ii] may receive Gavi funding, some LMICs and all UMICs, which may have significant numbers of people living in poverty, are ineligible for Gavi support.[79] Under the sustainability goal in Gavi's new strategy, some of these "never eligible MICs" may be considered for "targeted, catalytic and time limited" support.[80]

Table 5. Comparison of relevant donors' descriptions of subnational allocation and programming approaches

	Global Fund	Gavi	USAID
Language used	"…At country level this may mean that the Global Fund invests through subnational grants in large federal states, adopts a pay for performance scheme in some contexts, or provides direct funding in support of a national strategy in others."	"More differentiated, tailored and targeted approaches for Gavi eligible countries"[51]	"More tailored and targeted approaches" using subnational and facility-level data
Indicated aim	Improved service coverage for key populations	Strategic Goal 2: Strengthen Health Systems to Increase Equity in Immunization	Responding to fragility and disruptions in health services
Geographic boundaries	Large, federated states	To include "working more extensively at subnational level in large, federated states"[52]	Not specified
Poverty focus	No explicit focus	Children who may "suffer from multiple deprivations," including inability to pay for illness	Not specified
Document	Global Fund 2017-2022 Strategy[35]	GAVI 5.0: The Alliance's 2021-25 Strategy: Report to the Board; Phase V 2021-2025 (webpage); GAVI 2021-25 Strategy One-Pager[44,51,52]	2020 Acting on the Call Report (Maternal and Child Health priority area)[53]

Gavi also recently published a landscape analysis and theory of change for using geospatial technologies in immunization programming to better identify areas with coverage gaps and to improve coverage equity.[58] The report states: "Geospatial technologies applied to immunisation programming can provide evidence of sub-national disparities to better support targeted allocation of resources and tailored strategies to improve equity in coverage."[58] The report further references "socio-economic status" and "socio-economic disparities" alongside geographic differences as important to track, though it is unclear which specific indicators comprise socio-economic status in this context.

The Global Fund's approach mirrors Gavi's approach. Details about what the Global Fund's "differentiated approach" might look like are in Key Performance Indicator 5: Service Coverage for Key Populations, Operational Objective 3, which states that the Global Fund may "[invest] through subnational grants in large federal states, [adopt] a pay for performance scheme in some contexts, or [provide] direct funding in support of a national strategy in others."[35] The Global Fund does not provide additional details regarding how it plans to or currently operationalizes this approach in practice, nor the extent to which this approach might encompass a focus on the poorest individuals or households within countries. The subnational grants described in Operational Objective 3 may, for example, only relate to health needs and outcomes rather than poverty or other vulnerabilities that potentially impact health.

[ii] The World Bank Atlas method classifies LMICs as having a GNI p.c. between US$1,036 and US$4,045. Consequently, some LMICs meet Gavi's eligibility requirements while others do not.

USAID's Bureau of Global Health, in its most recent Acting on the Call Report, repeatedly emphasizes an intention to draw from subnational- and facility-level data to better target its efforts. While this report is specific to its maternal and child health priority area, it emphasizes a "need to look beyond global and national mortality rates to measure […] progress" to "adopt more tailored and targeted approaches," which necessitates "an enhanced emphasis on analyzing sub-national- and facility-level data."[53] Other priority health areas do not have comparable reports. PEPFAR, by contrast, includes in its COP FY20 guidance the need to "focus resources on the highest prevalence areas, highest volume facilities, and highest prevalence population groups at the local level, with the highest performing SNUs."[31] Although PEPFAR's subnational focus appears highly targeted, economic efficiency rather than poverty alleviation is prioritized.

Finding #4

Most donors either channel funds through an HSS window or use a cross-cutting HSS approach. Three donors use HSS as an explicit strategy to reach the poorest people. These windows, however, tend to be comparatively small and to lack poverty-specific metrics. It is also unclear how an overarching HSS strategy is integrated into other programs.

All three of the multilateral donors considered in Table 6—the Global Fund, Gavi, and IDA—have either a dedicated window for HSS or a cross-cutting health systems focus, all with the stated intention of reaching the poorest and/or preventing illness-related poverty. USAID has a standalone Office of Health Systems Strengthening within its Bureau of Global Health, which similarly has an express purpose of protecting against illness-related poverty. Japan also includes HSS among its core priorities, along with universal health coverage, ensuring access to health services, and global health security. In Japan's case, the focus on poverty prevention or alleviation may be more implicit.

Table 6. Comparison of relevant donors' HSS mechanisms related to poverty reduction

	Global Fund	Gavi	IDA	USAID	Japan
HSS Mechanism/ Approach	Separate investment window	Separate investment window	Cross-cutting priority area	Cross-cutting standalone office	Priority area for investment
Mechanism name	Resilient and Sustainable Systems for Health	Health System and Immunization Strengthening	None	Office of Health Systems Strengthening, Bureau of Global Health	Unclear
Poverty focus	Improve health equity: reach all people, including the poorest	Reach the hardest to reach children (poverty not specifically mentioned)	Financial protection	Protect against poverty	Unclear

IDA's and USAID's approaches to HSS are the most institutionally embedded among the five donors that incorporate some focus on health systems. The World Bank's HNP strategy, for example, emphasizes the role of health systems, health financing, and health economics in promoting positive health outcomes.[30] The HNP strategy additionally promotes pro-poor results such as improving financial protection and emphasizes IDA's comparative advantage to deliver "policy and technical advice" at the health system level.[30] The stated purpose of USAID's cross-cutting Office of Health Systems in the Bureau of Global Health, meanwhile, is to "enable countries to address complex health challenges and protect against extreme poverty."[59] In USAID's 2015-2019 framework for HSS, the overarching goal of this office is to "[protect] poor and underserved people from illness, death, and extreme poverty" through "sustained, equitable access to essential, high-quality health services responsive to people's needs without financial hardship."[60] USAID frames HSS as playing a vital role in ensuring better health outcomes among poorer and more vulnerable

populations. It is unclear, however, to what extent this approach permeates other health areas within the Bureau.

Both the Global Fund and Gavi use standalone investment windows to channel their HSS support. The second guiding principle of the Global Fund's Building Resilient and Sustainable Systems for Health (RSSH) window is to "improve health equity" by "[designing] investments to reach all people," noting that "HIV, TB, and malaria disproportionately affect the poorest households."[61] The Global Fund also states that "improving equity requires robust measurement to identify those most at risk, where they live and how they are accessing services."[61] The Global Fund does not appear to provide additional guidance on what such measurement might entail, or how it will assess such measurement, though it does state that it is "working with partners to collect critical subnational data, including for key populations and specific sub-groups."[62] While the Global Fund states that it spends US$1 billion annually on RSSH, standalone RSSH that is not associated with a disease component is considerably less.[63] Disbursements for RSSH that are not linked to a specific disease component comprise less than 2% of Global Fund's cumulative disbursements as of 2020.[64] Of the Global Fund's investments linked to specific disease components, it is unclear how much is allocated for RSSH. It is also unclear what motivates or determines standalone RSSH investments versus RSSH investments encompassed by grants for specific disease components. Gavi's Health Systems Strengthening window appears to be the primary intended avenue for pursuing equitable vaccine delivery.[55] As with the Global Fund, Gavi's HSS window comprises a small fraction of Gavi's overall investment portfolio: between 2000 and 2018, HSS support represented only 11% of total Gavi disbursements.[65]

These approaches tend to lack indicators that would enable monitoring progress against the stated intention of protecting people from falling into poverty because of illness or ensuring the poorest have access to needed health services. Where indicators are listed, such as by Gavi, they tend to align with the WHO's core health systems building blocks and do not make a clear link between what the donors track and the overarching goal of protecting poor communities.

5 DISCUSSION

With another decade left to achieve the SDGs, health aid donors will need to move beyond invoking the rhetoric of the Global Goals to truly leave no one behind. Most health aid donors commit to addressing poverty in their high-level strategies and policies. These donors also acknowledge substantial domestic inequalities. However, unless they directly address and target subnational poverty as part of their core mandates and include specific subnational metrics for measuring progress, it will be hard for them to deliver on their promises to leave no one behind.

Based on the documents that we reviewed, health donors may implicitly target the poorest people within countries by targeting key and vulnerable populations, as defined by the donors. Donors that target specific populations within countries could, in practice, effectively result in targeting the poorest people, or possibly the poorest states or districts. Focusing on key and vulnerable populations gets closer to reaching people at risk of getting left behind. At the same time, there is evidence that the poorest may be missing out on the benefits of health aid. Donors need transparent metrics and methods for tracking the correlation of poverty, disease burden, and social stratifiers at the subnational level. Implying or assuming certain categories of people are poorer on average without these metrics and methods allows donors to avoid accountability while making attractive global commitments to reduce poverty. It is not universally accurate to infer that specific populations identified as vulnerable are indeed the poorest. It is also not clear how to assess whether donors intend to implicitly target the poorest people by targeting vulnerable populations. Poverty may track with disease burden or identity status in certain contexts, but it is not clear how, when, and what data donors use to assess this relationship.

While some donors like the Global Fund have developed standalone action plans for key and vulnerable populations and criteria used to determine who falls in this category,[2] the term "vulnerable" generally functions as a somewhat vague catch-all that is not well defined yet often used. For donors focused on specific infectious diseases such as HIV, malaria, or TB, vulnerability typically refers to epidemiological risk or constrained access to health services. However, health donors tend to use "poorest" and "most vulnerable" interchangeably, and sometimes also use terms like "the most marginalized" and "socially excluded" to connote populations that are vulnerable and/or impoverished. Although these categories may overlap, they do not always mean the same thing. Some of the hardest to reach people, the "missing millions" who may be mobile, disenfranchised, living with disabilities, or lack documentation, land, or a home, are among some of the many other populations that may be considered vulnerable.[7] All of these population groups require tailored approaches to reach, further highlighting the problems with ill-defined, blanket terminology.

In the context of poverty eradication and enabling people to live healthy lives everywhere, targeting poverty in practice or by proxy arguably does not go far enough when it comes to transparency and accountability for being pro-poor. Health donors already draw from sources that could better inform their allocation and monitoring processes. IDA, for example, includes Poverty Reduction Strategy Papers (PRSP) in its CPIA guideposts for criterion 8, "equity in public resource use." The WHO published a report in 2004 that looked specifically at the PRSP's relevance for health and found that PRSPs capitalize on the broad available options for measuring poverty, for example by using unmet basic needs (UBN), the Human Development Index, and qualitative poverty assessments.[66] To target poor populations, the most common strategy used by country governments and outlined in PSRPs as of 2004 was on the basis of residence (i.e., rural or urban), closely followed by regional or district-level targeting.[66] The report found, however, no consistent approach to targeting the poor or poorest populations, as well as "no discernible trend in either implicit or explicit poverty focus [in health] over time."[66] This analysis, while dated, is instructive for how donors might approach poverty targeting while pointing to a more deeply entrenched problem. Donors

such as IDA that expect country governments to produce analyses on poverty reduction in order to apply for funding should also themselves have transparent, data-driven plans for poverty reduction in the countries in which they operate. These plans should also be informed by and aligned with country plans.

PEPFAR's DREAMS program could also provide potential lessons for how to adopt a comprehensive multisectoral effort that addresses multidimensional lived realities of target populations. In this case, the DREAMS program aims to benefit adolescent girls and young women (AGYW) by "[going] beyond the health sector to address the structural drivers that directly and indirectly increase girls' HIV risk, including poverty, gender inequality, sexual violence, and a lack of access to education."[67] Programs like DREAMS acknowledge and incorporate important social determinants of health and more closely align with the values imbued in the SDGs, namely a "human-rights based approach that is rooted in giving all people the opportunity to achieve their right to life and dignity."[19] PEPFAR's monitoring and evaluation framework for DREAMS provides one example of how this approach might be operationalized. A key question guiding the evaluation of DREAMS is: "Are there changes in other outcomes important to the lives of AGYW (e.g., secondary school enrollment and completion, GBV, teen pregnancy)?"[68] Suggested data sources include survey and administrative data and "evaluative assessment of socio-economic, behavioral and health outcomes among AGYW and young men (before, during, after DREAMS interventions)."[68] The DREAMS logic model also aims to account for "AGYW vulnerabilities" such as "economic vulnerability" and "social isolation" and tracks "increased assets for AGYW and their families" among program outcomes.[68]

The scope, influence, and nature of external financing through health aid must evolve in the context of continued economic growth and social development in LICs and MICs. Donor funding in 2017 accounted for 28% and 12% of health spending in LICs and LMICs, respectively.[69] Ultimately, health aid should support countries on their paths towards self-reliance rather than perpetuate dependency on external support. More fundamentally, health donors should take steps to acknowledge and redress historical legacies of colonialism that contribute to the health inequities that health donors intend to address. In the context of growing attention to power imbalances within the aid sector between high-income, middle-income, and low-income countries, then, more fundamental shifts may be needed. The Incentives for Health (I4H) Alliance, a new health funding mechanism in MICs, was proposed in 2017 as an avenue for ensuring resources are funneled to the poorest people in MICs.[70] This mechanism recognizes the problematic dynamics created by the dominance of high-income countries in mediating health aid and the "disconnection between prevailing metrics and needs."[70] Part of this disconnect stems from institutions based in rich countries, such as the health donors analyzed in our review, dominating policy decision-making. Health donors can and should create more space for leaders from MICs and LICs to redress this dominance by finding ways to both leverage existing mechanisms and tools at their disposal and create new mechanisms that enable greater ownership and agency of country governments in allocation decisions.[71]

While a more explicit focus on subnational poverty in health donors' aid allocation processes and policies could accelerate progress toward the SDGs, donors may argue that there are potential drawbacks from such a shift. First, the scope of donors' mandates, particularly in the case of health-centric donors, may constrain them from targeting their funding at a sub-national level. For example, investing in data collection on subnational poverty or expanding their mandates and by extension the programmatic activities that they fund may come with high transaction costs and logistical challenges. There is at present no straightforward mechanism for most donors to target aid subnationally. Yet as the DREAMS program shows, it is possible to incorporate subnational components and shift toward a multisectoral approach.[72] Second, living in poverty, like many other social identities, can be stigmatized.[73] Greater attention to poverty may inadvertently increase stigmatization of people already marginalized. However, there is no evidence that donors' greater attention to subnational poverty in MICs would lead to greater stigmatization of people

living in poverty. Third, adding requirements for subnational targeting of donor assistance could compromise country sovereignty (donors typically engage with national governments of LICs and MICs who are often the implementing agency on the ground). Thus, centering countries and their representatives in any such process is critical.

Taking the long view, global health donors have meaningfully contributed to improving people's lives and opportunities. Through sustained investments in health programming, donors have helped reduce the burden of HIV, TB, malaria, and other preventable infectious diseases, increase access to and uptake of reproductive and sexual health services, and decrease rates of maternal and child mortality.[23] However, health does not exist in isolation of the broader socioeconomic and sociopolitical contexts of individuals, households, and communities. As demonstrated by the vision set forth in the SDGs, a more holistic approach to health—one that addresses the social determinants of health in a transparent and measurable way—is necessary. Working together with governments, civil society, and other sectors, global health donors should pursue "policies specifically crafted to tackle the social mechanisms that systematically produce an inequitable distribution of the determinants of health among population groups."[13]

Focusing only on disease burden or specific health or wealth metrics by themselves, as health donors tend to do, ignores the complex realities in which people live. This omission ultimately constrains the potential for transformative, long-lasting change. To make the final decade of the SDGs count and truly leave no one behind, global health donors will need to adapt their policies and practices to better suit the realities and needs of the people they intend to serve.

6 POLICY RECOMMENDATIONS: MAKING THE FINAL DECADE OF THE SDGS COUNT

The ambitious vision of the SDGs requires retooling policies and practices. It also requires specificity, nuance, and tailored approaches: "any effort to leave no one behind needs to begin with an assessment of which people are facing which problems in which places."[10] While health donors "talk the talk" on leaving no one behind, our study did not find evidence of the kinds of fundamental, systematic shifts that would be needed to achieve this vision. Only two donors incorporate poverty-specific subnational approaches or indicators in their allocation decisions or programming. Several donors are starting to adapt their policies to better respond to the reality of inequality in LICs and MICs yet they still maintain a relatively narrow disease-specific focus. All donors that we analyzed could benefit from a more nuanced allocation targeting process specific to poverty. To avoid replicating the existing model of focusing primarily on health-related measures as donors begin to incorporate a more subnational focus, health ODA donors would benefit from adapting their policies and practices such that there is a clear, measurable path to leaving no one behind, particularly the poorest people. We provide five specific policy recommendations.

Key recommendations to health donors

Recommendation #1

Embed a specific focus on poverty elimination in the service of health outcomes. Use geospatial data sources and methods, consult people living in poverty, and use multiple indicators to assess poverty to deliver on this focus.

To more effectively target the poorest people, health donors should embed within their mandate a focus on poverty elimination, if such a focus is not already explicit.[74] A United Nations Department of Economic and Social Affairs (UNDESA) report proposed to target people living in the poorest quintile in each country as one way to shift the conceptualization of poverty and better serve the needs of the poorest people.[74] This approach is one example of how to more accurately capture the reality of who the poor are and where they live. In 2014, a proposed framework for health financing produced by the Centre on Global Health Security Working Group on Health Financing called for increased efficiency, equity, and accountability from external donors and highlighted the need to "establish clear, well-founded and publicly available criteria to guide the allocation of resources."[75]

This recommendation remains highly relevant. Global health donors should leverage the growing availability of location-specific data sources and methods for measuring health and poverty as multidimensional and interrelated phenomena to create transparent metrics for tracking their progress toward commitments to reduce poverty. All six donors included in this analysis are also part of the Health Data Collaborative, a "collaborative platform" aimed "collecting, storing, analysing and using data to improve health outcomes, with specific focus on SDG targets and communities that are left behind."[76] Donors should act on these commitments by producing clear indicators for how they will measure progress.

National-level indicators still have value in identifying trends in macro-level poverty, fragility, and vulnerability, and evidence suggests that health ODA goes where it is most needed at the country level. A recent analysis by Development Initiatives found that in 2018, 46% of health ODA went to LICs, while 58% of health ODA went to least developed countries (LICs and least developed countries overlap).[77] These

macro-level trends should continue to be monitored to ensure that across levels, aid is reaching the people who need it most.

Some donors, such as the Global Fund and Gavi, require governments to include details for how vulnerable populations will be reached using their funds. Donors, however, should also incorporate the perspectives of people donors classify as vulnerable in allocation decisions, either directly or through implementation partners, and be transparent about who gets included in these population definitions (see Recommendation 2). IDA also requires governments to describe how they will reach people living in poverty through public expenditures and provides "guideposts" for possible data sources on subnational poverty trends. To go a step further, IDA could collect and report on evidence for how IDA's funds ultimately reach and impact people living in extreme poverty in the countries in which IDA operates.

We also echo Ferreira's assessment that one indicator alone will tell an incomplete story of poverty.[78] Donors should incorporate individual-level poverty or "deprivation measures" and a broader definition of poverty that draws from other available indicators of human development, inclusive of education, nutrition, and water, sanitation, and hygiene.[78] Donors should also be sensitive to gendered dimensions of poverty, which may be masked by household-level poverty indicators (i.e., female household members may be impoverished relative to male household members). And, most critically, global standards and measurements of poverty should not supplant local definitions and understandings of poverty. Global indicators fail to adequately capture, for example, people who may be living just above the poverty line or those may temporarily rise above the poverty line only to fall back below it within a short time span. Context-specific definitions of poverty shaped by those most affected, therefore, should determine the choice of indicators donors use to track subnational poverty as part of their future strategies and allocation decisions.

Recommendation #2

Create a clear action plan, using specific language and clear metrics of progress, for populations labeled "key and vulnerable," "marginalized," or otherwise at risk of being left behind. Donors should also support data collection efforts for these populations.

Donors should develop a clear action plan for targeted population groups and define to whom the action plan applies, how these populations will be reached, and how progress will be determined in reaching them and improving their lives. The Global Fund's 2014-2017 Action Plan provides one example of how to approach this process, though it is also now several years out of date. Regularly reviewing and revising existing guidelines and action plans as appropriate and in concert with country governments is also important for staying current with community needs and realities. Donors should also explicitly acknowledge that poverty is not homogenous and attempt to more clearly capture how poverty intersects with social identities that may make people living in poverty more vulnerable to disease. Resource deprivation, vulnerability, social exclusion, poverty, marginalization, and other terminology are all used somewhat interchangeably to connote some heightened risk to being left behind. This lack of clarity in terminology makes it difficult to know what progress looks like, which in turn precludes the possibility of meaningfully tracking and monitoring progress over time.

Quality data, particularly at the more granular subnational level, can be difficult to collect and monitor in some settings. Greater investments in and support of routine data collection at the subnational level is needed. This recommendation aligns with the EAI report's recommendation regarding "greater investments in data collection systems" that can better account for vulnerable populations by incorporating

"better quality and more reliable data that support the inclusion of relevant indicators."[19] In developing an action plan for key and vulnerable populations that encompasses data collection, donors must engage populations impacted in a meaningful way that will allow for accurate representation of their experiences and needs. This could mean at minimum half of any convening committee or commission involved in producing the action plan is composed of representatives of the key and vulnerable populations targeted. It could also mean making participatory poverty assessments (PPAs) and qualitative poverty assessments (PQAs) a key component of the allocation process to help ensure that the perspectives of people living in poverty are at the forefront of decision-making processes that have direct implications for their lives.

Recommendation #3

Expand beyond "value-for-money" approaches that prioritize disease-specific indicators and that may inadvertently neglect those most in need to include poverty-specific subnational indicators and approaches.

More granular and nuanced approaches to aid allocation are needed to better account for and respond to the highly variable contexts in which donors operate. Geolocated subnational data provide one possible avenue to better targeting and there are many other measures for poverty. We have come to similar conclusions as Custer et al., that using "spatially precise outcome measures" would be an efficient and effective means to better track progress towards achieving the SDGs.[7] While this approach should be particularly appealing to health donors oriented toward an economic efficiency approach, donors should also consider expanding the "value for money" paradigm. The emphasis on maximizing the number of lives saved per dollar, for example, potentially comes at the cost of leaving behind the most marginalized and hardest to reach communities. These communities may be on average more expensive to reach, and so would be deprioritized if the dominant concern remains maximizing value for money as it is currently understood.

Integrating subnational data into allocation decisions would also be a useful way to identify and target key and vulnerable populations and to ensure that these populations are getting value from health ODA.[7] Custer et al. further suggest mandating subnational project location disclosure, which we also recommend as a means to ensure external accountability.[7] Donors such as Gavi already draw from household surveys, WHO and UNICEF data, and other sources to construct indicators to monitor progress, and have even begun exploring the use of geospatial technologies.[58] Extending this process and expanding the scope of indicators used to ensure that subnational poverty is also included should be low-hanging fruit. A more equitable, accurate approach would be to partner with academic institutions based within countries to design and conduct studies that would help shed light on poverty-specific phenomena in contextually relevant ways.

Recommendation #4

Mainstream systems thinking across all donor activities and develop a clear set of indicators for monitoring the impact of HSS investments or activities on protecting individuals and communities from illness-related poverty.

Just as illness and poverty do not occur in separate vacuums, neither do individual donor practices. Five of the six donors analyzed here have either a specific HSS investment window or some form of cross-cutting integration of HSS into donor programming, with nearly all of those donors explicitly linking HSS to

protection from impoverishment. Clearly, donors understand the need for investing across the health system in recipient countries, yet in donors' own activities, they may miss the forest and see only the trees. As a recent Center for Global Development analysis put it, the guiding question should be "whether *the global system as a whole* allocates aid optimally, rather than whether the allocations of *individual* providers conform to the ideal distribution" (italics in original).[79]

The Institute for Health Metrics and Evaluation (IHME) recently found that less than 14% of total development assistance for health went toward broad-based HSS in 2019, while about 50% of all HSS funding was earmarked for more targeted health areas such as HIV/AIDS.[80] In a study co-authored by our own center, the Center for Policy Impact in Global Health, we found that in 2015, only US$2.5 billion out of a total of US$22.9 billion (10.9%) in DAH was directed to cross-cutting, system-wide HSS.[81] We also found that US$4.05 billion (17.7% of total annual DAH) was directed to what we called "program strengthening"; we defined program strengthening investments as those that "aim to improve the quality of a disease-specific program by strengthening just one or a few building blocks of the health system" (e.g., health information, supply chain). When donors limit their HSS investments, focusing mostly on strengthening specific disease programs, they miss the opportunity to strengthen health systems in ways that could build a strong primary health care delivery platform to tackle a wide array of health challenges.

A better and more meaningful shift would be to bolster HSS investment windows by incorporating indicators that monitor the impact of donor HSS investments on illness-related poverty. Donors should enhance both their commitment to and actions toward poverty reduction through HSS and financial protection by developing and implementing context-specific indicators that measure the direct impact of HSS investments or activities on people living in poverty. Potential indicators could include forgone services including preventative care or catastrophic health expenditures, though many other indicators are available.

Tracking indicators related to the WHO's six core health systems building blocks is essential for monitoring changes in structural barriers to health care that are out of individuals' control. However, it is difficult to ascertain the impact of changes in the health system without understanding the experiences people living at or below the poverty line have with the health system. Therefore, donors should endeavor to develop and implement a clearer link between HSS investments and activities through specific indicators informed by the experiences of people living in poverty.

Recommendation #5

Leverage disruptions caused by the COVID-19 pandemic and proactively respond to increasing rates of poverty by supporting a paradigm shift in the aid ecosystem. Adopt the "Re-imagined Aid model."[4]

A core challenge of the aid ecosystem as it is currently configured is that decision-making remains centered in HICs that are often far removed from the specific realities and needs of LICs and MICs. Donor approaches need to reach more effectively the poorest people, achieve poverty reduction, and support LIC and MIC governments in their paths toward prosperity and ownership over health programs. Consequently, "sustainably shifting financing and programmatic responsibility away from donors to domestic partners" serves as "a critically important underpinning of success in reaching the health SDGs."[26]

At the conceptual level, we recommend donors adopt the new model for aid proposed by Aid Re-imagined.[4] This model "advocates for aid programmes that are robustly analysed, relational [and] adaptive, and radically accountable," and provides a framework for how to approach aid projects from these vantage points.[4] As previously discussed, underlying power imbalances shape the current aid ecosystem. The Re-

imagined Aid model provides a framework for confronting these imbalances, recognizing and redressing injustices, and enhancing accountability of aid actors.[4]

To address the "disconnection between prevailing metrics and needs,"[70] health donors should endeavor to go to the root cause of this disconnect. Rather than imposing externally defined metrics, donors should transfer some of their decision-making power to countries themselves. External donors should work with country governments and their citizens to fundamentally reimagine the aid architecture, specifically the imbalanced power relations that define it. This shift could help enable a measurably country-specific, country-led process tailored to citizens' perspectives and needs that would be meaningfully responsive to subnational poverty.

Some donors do have specific mechanisms in place to better integrate the perspective of national governments, such as the Global Fund's Country Coordinating Mechanisms. However, to align with the Aid Re-imagined model and promote justice, country governments and citizens must be involved throughout the allocation decision-making process. This engagement should include involving not only the relevant policymakers in the government, but also civil society organizations and others that are responsible for service delivery and citizens themselves intended to benefit from donors' activities.

7 CONCLUSION

Poverty is a complex, socially embedded phenomenon that manifests in context-dependent ways. A wealth of monetary, non-monetary, and hybrid measures are available to help capture the extent of poverty in a given community, district, state, or country. Health donors, to varying degrees, acknowledge the important role poverty plays in shaping health outcomes and how poor health can lead to impoverishment. Despite this acknowledgement, most of the health donors we analyzed largely rely on national-level monetary poverty measures to understand and track poverty. Some donors, like Gavi and IDA, adopt a more nuanced approach in capturing poverty by drawing on household surveys and incorporating a subnational poverty focus in allocation decisions. In the context of a constrained global economy, strained health systems, and potentially diminished available external and domestic health financing, a more nuanced, comprehensive, and accountable approach to poverty is needed. There are steps health donors can take now to better prepare for new and worsening challenges to protect the world's most vulnerable, including people living in poverty.

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APPENDIX 1. POVERTY AND HEALTH SYNOPSIS

Macro-level, aggregated measures of deprivation or fragility tend to correlate with higher rates of poverty and poor health outcomes, but significant numbers of people living in poverty and/or with poor health exist in virtually every country in the world.[10] Poverty prevents people from accessing medical care and essential medicines, living in safe conditions, accessing clean water and adequate sanitation, having food security, and obtaining or meaningfully benefitting from education.[82] Ill health prevents people from working and can cause catastrophic health expenditures, both of which can have disastrous consequences for people's financial security and can contribute to generational poverty.[83] Conversely, evidence suggests a causal relationship between health and economic outcomes; good health can bring long-term economic benefits and stability, while economic security can facilitate better health and enable people to afford and survive bouts of sickness.[84] These benefits can translate to country-level economic and social gains. The Commission on Investing in Health's *Global Health 2035* report found that investing in better health yields (i) "instrumental value" in the form of greater productivity, as captured in national income accounts, and (ii) "intrinsic value," the value of being healthy and alive for longer in and of itself (unrelated to productivity).[85]

Poverty can be measured through monetary or non-monetary measures, or a hybrid approach using both (Table 1).[86] Monetary measures can be income- and consumption-oriented; examples include gross domestic product (GDP) per capita, gross national income (GNI) per capita, consumption levels, and poverty head count index. Examples of non-monetary measures include life expectancy and literary rates.[86] Multidimensional approaches to measuring poverty include the Human Development Index and the Multidimensional Poverty Index.[86] Poverty has been measured using a variety of other methods, indicators, and proxies (e.g., qualitative or participatory poverty assessments, health service use, catastrophic health expenditures, forgone services, household surveys such as the Demographic Health Survey, household-level unsatisfied basic needs, residence (rural versus urban), and nighttime lights [luminosity]).

Table 7. Examples of indicators, methods, and proxies for measuring poverty.

Monetary Measures	Non-monetary Measures	Hybrid Measures	Other Approaches
• GDP p.c. • GNI p.c. • Consumption levels • Poverty head count index • Catastrophic health expenditures	• Life expectancy • Literacy rates • Health service use & forgone services	• Human Development Index • Multidimensional Poverty Index • Unsatisfied basic needs	• Qualitative or participatory poverty assessments • Household surveys • Luminosity • Residence (urban, rural, etc.)

A barrier to using more nuanced approaches to measuring poverty is a lack of reliable data. This barrier makes it difficult to effectively leverage the "data revolution" and move beyond national-level indicators of poverty.[7] The availability and accuracy of data tends to decrease as the data becomes more granular (i.e., from national to subnational to household to individual), which may contribute to an overreliance on national-level indicators for identifying where the poorest people live.

Retrospective analyses of donors' impact on poverty and health

Country- and sector-specific analyses show that people most deprived of resources may not be able to access the intended benefits of foreign aid investments or may not be sufficiently targeted. For example, a recent AidData analysis found that in the Democratic Republic of Congo, areas with a higher malaria burden

were not sufficiently reached with malaria-specific resources relative to health need.[87] Another recent analysis found that areas with health facilities with lower capacity to provide services in Malawi similarly missed out, indicating that "donors may have inaccurate information about local population needs."[88] Evidence from Malawi also suggests that proximity to water, sanitation, and hygiene (WASH) aid projects correlated with fewer water-borne diseases, but "water availability, remoteness, and the income level of beneficiaries" mediated benefits of such projects.[89] In another example by Norwegian researchers, while aid in Nigeria resulted in reduced infant mortality and reduced inequalities between groups in regards to infant mortality, there is "evidence that aid projects are established in areas that on average have lower infant mortality than non-aid locations, suggesting that there are biases resulting in aid not necessarily reaching those populations in greatest need."[90]

Two other recent projects using geolocated subnational project data for the World Bank and the African Development Bank found that wealthier areas received more aid, indicating that "subnational aid allocations directly contradict donors' stated preferences."[91,92] There is also evidence that, while generally LICs with more substantial disease burdens receive more aid for health relative to MICs with smaller disease burdens, disease burden and economic status are not good predictors of the amount of aid for health received.[93]

APPENDIX 2. AID ECOSYSTEM PHASES

Aid allocation

While some donors are transparent about allocation criteria, recent analyses have found that the process by which donors in general determine eligibility and make allocation decisions lacks transparency in key dimensions such as guiding principles and specific criteria applied.[21] Greater transparency would improve accountability. A series of academic analyses borne out of the EAI focused on aid allocation. Collectively, the analyses found a general lack of transparency and accountability in donors' allocation processes: "little or no information [is] available on the values they embody, the exact criteria they include, the quantitative and qualitative considerations they use, or the results they produce."[21] The series also highlighted stakeholders' preferences of using measures other than GNI p.c. to inform allocation processes as well as the pervasive exclusion of country representatives in allocation decision-making processes. Looking at the nine convening agencies in the EAI, including the Global Fund, Gavi, and the World Bank, one paper in this series finds that publicly available information is insufficient for understanding allocation processes, and more important "choices relating to strategy, type of support, eligibility, and qualitative adjustments" are hidden from view.[21,22] An earlier analysis of quantitative allocation criteria and contribution norms of the Global Fund, Gavi, and IDA, among others, also found that only the Global Fund used allocation criteria explicitly emphasizing "underserved and most at-risk populations."[94]

Aid effectiveness

An aid effectiveness agenda, including country-owned and led processes, measurable outcomes of investments, donor coordination, and intersectoral approaches, characterize the current aid landscape.[95,96] There is a significant evidence base that explores the effectiveness of aid in achieving intended outcomes, with varying conclusions. Aid effectiveness, through this lens, attempts to capture the impact of foreign assistance on low- and middle-income countries. While the outcome of interest has historically been economic growth and poverty reduction, the literature has grown more diverse with more sector-specific analyses, including health and education.[97] Overall, the evidence broadly points toward positive overall impacts, though country- and sector-specific experiences have shown mixed results.[98] Despite the varying methods used to measure poverty—including across unit levels (e.g., individual, household, country) and across monetary and non-monetary measures—there is consensus in the literature that official development assistance is broadly effective at reducing poverty in aggregate.[86]