Juniper Online Journal of Public Health
ISSN: 2573-2153

Review Article
Volume 10 Issue 3 - December 2025
DOI: 10.19080/JOJPH.2025.10.555790

JOJ Pub Health

Agenda Distortion and the Politics of Aid: Shared Responsibility for Sustainable, Self-Determined Health Systems

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Submission: December 4, 2025; **Published:** December 17, 2025

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Abstract

Development assistance for health has contributed to major gains in disease-specific outcomes, yet persistent misalignment between donor priorities and national health needs continues to distort domestic policy agendas. As external financing plateaus and countries are increasingly expected to transition to domestic self-sufficiency, the limitations of existing aid-effectiveness and transition frameworks have become more visible. This study examines how national health agendas are reshaped by donor financing patterns and assesses the extent to which global policy instruments address or perpetuate these distortions. Using a hybrid methodology that integrates the Historical Integrative Policy-Epidemiology Synthesis approach with Critical Interpretive Synthesis, the analysis draws on evidence from diverse country transition experiences and major global policy frameworks to identify structural, political, and institutional gaps that impede sustainable, nationally led health financing and planning.

Findings show that the Paris, Accra, and Busan agreements established important principles of ownership, alignment, and harmonization, but lacked mechanisms to address the incentives driving vertical programming, short-termism, and the use of parallel systems. Transition frameworks created by global health donors have similarly focused on fiscal thresholds and program maturity while overlooking the political economy of donor- recipient power relations, the continuity of donor-financed system functions, and the effects of volatile or uncoordinated funding. Country assessments from Sri Lanka, Cambodia, Botswana, and others reveal that long-standing dependencies persist even when epidemiological and economic indicators suggest readiness for transition, and that gaps in supply chains, human resources, and information systems remain unaddressed.

The study proposes a set of policy recommendations aimed at correcting these gaps, including binding predictability standards for donors, integrated system-wide transition planning, and stronger mechanisms for domestic fiscal reform. These recommendations reframe sustainability as a process rooted in national autonomy, institutional resilience, and coherent system design rather than a siloed approach and a mere replacement of donor funds.

Keywords: Development Assistance for Health; Aid effectiveness; Agenda Distortion; Country Ownership; Health Financing Sustainability; Donor Transition

Abbreviations: DAH: Development Assistance for Health; HSS: Health System-Strengthening; NCDs: Non-Communicable Diseases; IHP: International Health Partnership; CIS: Critical Interpretive Synthesis; HIV: Human Immunodeficiency Virus; AIDs: Acquired Immune Deficiency Syndrome; WHO: World Health Organization; GFF: Global Financing Facility; GPEDC: Global Partnership for Effective Development Cooperation; AAAA: Addis Ababa Action Agenda; UHC: Universal Health Coverage; ACO: Aid Coordination Office

Introduction

The disjunction between donor priorities and national health needs has long shaped the discourse around Development Assistance for Health (DAH). While DAH has contributed to substantial gains in targeted health outcomes at the country level [1], particularly infectious diseases, the architecture of aid often reconfigures national health priority setting in ways that diverge from local epidemiological profiles and health system-strengthening (HSS) plans [2-6]. Despite global commitments to ownership and alignment with national needs, analyses reveal that donor funding is often only weakly correlated with country-level disease burden. Studies examining resource allocation patterns reveal substantial discrepancies between DAH distribution and national burdens of disease, including large differentials in funding for HIV, malaria, and immunization relative to non-communicable diseases (NCDs) and mental health [7,8].

Vertical, disease-specific programs, while highly effective in improving measurable outcomes for a small set of diseases, have been shown to redirect attention, human resources, and governance capacity away from primary health care functions and long-term HSS [4,9-11]. These dynamics have been documented across diverse contexts, where parallel supply chains, data systems, and supervisory structures created by aid initiatives can place additional demands on already constrained national systems [4,5,12]. It skews national policies towards some disease areas and less towards others. This phenomenon is described as agenda distortion-when donor funding priorities reorient national health policy focus away from local burden of disease or system needs towards donor-preferred programs [13,14]. This happens at both the global [15] and national level. This study focuses on the national level health agenda distortion since it is the locus of context-based sustainable policy action, which is especially pertinent given the current trend of declining aid and a trend towards national health sovereignty [16,17].

The friction between donor interest and recipient need constitutes one of the central tensions in global health aid governance [18] and continues to influence how recipient countries allocate resources, design programs, and conceptualize long-term health system planning [19]. Agenda distortion can occur through overt mechanisms, such as earmarked funding and performance measurement frameworks, or more subtly through the exercise of various forms of power by shaping norms and expectations about what constitutes an adequate health response.

DAH fungibility and substitution reinforce this concern; evidence from multi-country analyses indicates that DAH inflows reduce domestic public spending on health by substituting for national allocations rather than supplementing them, thereby weakening local accountability and long-term commitments to system financing [20-23]. Related studies demonstrate that fragmented and earmarked aid with short-term commitments aggravate the problem by generating volatility [24] and administrative burdens that divert limited governmental capacity toward donor-specific processes, reinforcing externally driven decision-making at the expense of unified sector strategies [25-28].

The global policy response to these challenges emerged through the aid-effectiveness agenda set out in the Paris Declaration (2005) [29], Accra Agenda for Action (2008) [30], and Busan Partnership (2011) [31] which articulated principles of ownership, alignment, harmonization, results, and accountability. Health-sector adaptations, such as the International Health Partnership (IHP) and later UHC2030, encouraged partners to align their support with a single national strategy and to use common assessment and review mechanisms [32,33]. Despite these efforts, evaluations show that fragmentation, misalignment, and agenda distortion persist, driven by institutional mandates, accountability requirements, power differentials, and divergent donor priorities [25].

These tensions have become more salient in the current era of declining DAH. Pressures to transition from donor financing to domestic self-sufficiency have intensified, with low- and middle-income countries encouraged to assume greater responsibility for sustaining the financing and planning of programs historically funded by external actors. Transition readiness assessments conducted across diverse contexts, including Cambodia, Sri Lanka, and Botswana, demonstrate that while countries may experience epidemiological improvements because of aid, external dependencies often remain embedded through governance arrangements and financing structures [34-39]. A historical analysis of more than six decades of data in Puerto Rico in a post-colonial environment concluded with similar findings [37,40,41]. The paradox is that health systems supported by donor investments may simultaneously be constrained by them, particularly where political, fiscal, or institutional capacity to absorb and sustain programs remains limited.

Against this backdrop, this study examines the gaps within global policy frameworks that aim to support national leadership and sustainability of health financing and planning but often fall short in addressing them. By synthesizing evidence on agenda distortion, power dynamics in donor-recipient relationships, and the limitations of existing aid effectiveness instruments, the study aims to illuminate the structural and procedural shortcomings of policies that fail to prevent misalignment and dependency. The study proposes policy recommendations to minimize agenda distortion while strengthening aid effectiveness, self-sufficiency, and sustainability.

Methods

Study design and analytic orientation

This study employed a hybrid methodological design integrating the Historical Integrative Policy-Epidemiology Synthesis (HIPES) [37] approach with Critical Interpretive Synthesis (CIS) [42]. The combination of these two methodological lenses enabled both a historically grounded assessment of how aid-related policies have evolved, their unintended effects, and an interpretive analysis of aid effectiveness frameworks.

HIPES analytic strand

HIPES provided the overarching structure for situating donor-recipient interactions within broader historical and political-economic trajectories, which shaped the aid effectiveness frameworks [37]. HIPES integrates three strands of inquiry:

1. Historical policy evolution: tracing shifts in health aid amounts, focus areas, channels, and global development frameworks from the early 2000s to the current era. This included analysis of major donor policy documents, aid-effectiveness frameworks, and transition readiness assessments.
2. Epidemiological alignment and health needs: examining

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whether donor-supported priorities reflect domestic disease burdens and system requirements, using a narrative literature review drawing on evidence from comparative studies on DAH allocation.

3. Political economy of aid and aid-effectiveness policy frameworks: interrogating how institutional incentives, governance arrangements, and asymmetrical power relations shape priority setting, program design, and implementation.

Critical Interpretive Synthesis

Critical interpretive synthesis guided the analysis by helping bring together findings from different types of literature and policy documents. Instead of only summarizing what each source says, this approach looked for patterns, assumptions, and gaps that shape how problems are understood. It allowed the study to compare different viewpoints, incorporate implicit researcher reflexivity, and identify where policy narratives may lead to distortions.

Data sources

- Peer-reviewed empirical studies on DAH flows, misalignment, fungibility, substitution, system effects, and power dynamics; theories of power in global governance [39,43].
- Donor policy instruments such as the Paris, Accra, and Busan agreements [29-31].
- Global health financing frameworks such as the Global Fund Sustainability, Transition and Co-financing policy (STC) [44], Gavi transition policies [45], PEPFAR Sustainability Index and Dashboard (SID) [46], and the Global Financing Facility (GFF) Strategy 2021-2025 [47].
- Policy and technical documents were reviewed, including the UHC2030 frameworks [32,33] and the Joint Assessment of National Health Strategies (JANS) [48].
- Other relevant documents, such as the WHA resolutions on sustainable financing [46,49].

Donor Funding Attributes, Role of Power, and Aid Effectiveness Frameworks

The evolution of DAH reflects a complex interplay of normative aspirations for national ownership and the reality of donor-driven influence [4]. Early commitments to aid effectiveness were grounded in the principles of alignment, harmonization, and mutual accountability, codified through the Paris Declaration (2005) [29], Accra Agenda for Action (2008) [30], and Busan Partnership for Effective Development Co-operation (2011) [31]. These agreements aimed to shift control over health policy and financing from donors to governments by promoting the use of national systems, national plans, and unified sector review mechanisms with the expectation of accountability, ownership, and fair use of resources [50-52]. Yet, while these frameworks established the vocabulary of autonomy, evidence suggests that their implementation has been limited, uneven, and undermined by broader political economy dynamics and power differentials [53-55]. The distribution, design, and conditionalities of aid reflect complex negotiations between donor agencies, global initiatives, and recipient governments. These negotiations are embedded in power relations that influence not only the allocation of resources but also the definition of priorities and acceptable interventions [56].

Evolution of DAH and its structural effects

The expansion of DAH from the early 2000s was characterized by rapid growth in vertical initiatives and global health partnerships [57]. A study on DAH trends noted that during roughly 2000-2010, health aid grew at about 11% per year on average, with much of this increase going to HIV/AIDS, TB, malaria, and vaccines, and being channeled through global health partnerships like the Global Fund and Gavi rather than traditional bilateral donors [58,59]. Global health partnerships and donor institutions such as PEPFAR introduced program architectures that relied heavily on earmarked funding, short-term performance metrics, and parallel implementation systems. Although these generated substantial gains in disease control and treatment coverage, they also created systemic dependencies [4,5,57,60-63]. For example, a study noted that Global Fund support improved Zimbabwe's procurement and supply chain efficiency through new infrastructure, data systems, warehouse optimization, and trained personnel. However, it also created a system where different donor-funded commodities followed separate protocols, leading to inefficiencies and dependence [64].

Another study analyzing DAH from 2005 to 2017 found that DAH was positively associated with the burden of HIV, TB, and malaria, and this alignment improved over time for these specific diseases. However, this focus excluded NCDs and other major burdens, which remain significantly underfunded by DAH relative to their disease burden [65]. For example, despite NCDs accounting for nearly 50% of global disease burden in 2015 and rising, DAH for NCDs remained very low, only increasing from 1% of total DAH in 1990 to 2% in 2022. Meanwhile, infectious diseases such as HIV/AIDS (26%), malaria (6.4%), and tuberculosis (3.5%) captured larger DAH allocations (2015 data) [5,66].

Moreover, DAH has been shown to underfund primary health care and HSS, with allocations for HSS declining from 19% in 1990 to just 7% in 2022 [5]. This reinforces vertical programming focused on specific diseases instead of cross-cutting systems functions, shifting national attention and resources toward areas prioritized by donors rather than the national health needs, including the rising burden of NCDs [65-69].

Vertical programs create incentives that can alter managerial attention and internal resource flows. Research on global health initiatives shows how parallel systems for reporting, sup-

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ply chain management, and supervision can divert capacity away from health system functions not covered by donor funds. Studies describe that reporting cycles, performance frameworks, and earmarked budgets influence national planning cycles and create incentives privileging donor objectives over locally determined needs [57,70-74]. Taking lessons from these experiences, a recent study concluded that declining aid is an opportunity to integrate vertical programs within the health system [75].

Financial substitution further complicates the sustainability landscape. Empirical evidence shows that DAH inflows can reduce domestic public health expenditure [20,76-78]. For every $1 increase in DAH channeled to governments (DAHG), there was a $0.62 decrease in government health expenditure (GHE), indicating displacement of domestic health spending. A study estimated that between 1995 and 2010, displacement of government health expenditure due to DAHG reduced total government health spending by $152.8 billion (90% CI: 46.9 to 277.6 billion) and concluded that only about 38% of every $1 of DAHG is truly additional to domestic health spending [79]. This implies that governments reduce their own health spending when receiving DAH, limiting fiscal effort, political commitment, and sustainability. It exposes health financing to risks when donor funding declines, as governments do not fully replace lost aid with their own funds. Countries often manage multiple donor-specific reporting cycles, audits, and performance frameworks, each reflecting different institutional priorities. Evidence shows these fragmented structures increase administrative burden and impede coherent national planning. A study by Spicer and colleagues showed that fragmentation persists despite successive aid-effectiveness agreements, driven by divergent donor mandates, weak coordination mechanisms, and inconsistent compliance with alignment principles [25]. Such parallel systems can produce distortions in human resources, data systems, and governance architecture. For example, staff may be allocated preferentially to donor-prioritized areas with salary supplementation or additional incentives, leaving underfunded parts of the health system understaffed [80,81].

Power and agenda setting

The persistence of agenda distortion is rooted not only in technical misalignment but also in the power asymmetries that shape donor-recipient relationships. The 'donor interest-recipient need' framework [18] highlights how health priorities emerge through negotiated processes in which donors typically retain disproportionate influence because of their control over financial and technical resources. The exercise of power in this space can be studied using Lukes' three dimensions of power [82,83]

1. The first dimension involves visible decision-making power: Direct conditionalities, earmarking, and performance-based funding mechanisms that explicitly shape program priorities.
2. The second dimension involves non-decision-making power, where donors shape the agenda by controlling which issues are considered or excluded from discussion, thereby preventing certain health needs from reaching the policy table. This hidden power limits the scope of national debates and sidelines topics that do not align with donor priorities.
3. The third dimension reflects ideological power, where donors influence the perceptions, beliefs, and preferences of national stakeholders, leading countries to internalize donor priorities as natural or inevitable. It involves the production of norms, metrics, and expectations such as "global best practices" or "evidence-based" interventions that align national strategies with donor preferences.

Power in donor-recipient interactions can also be studied using Barnett and Duvall's taxonomy of Power [39]:

- **Compulsory power** is the direct and observable control donors exert by providing or withholding funding, technical assistance, or sanctions, thereby compelling governments to adopt specific health policies and priorities. This manifests in explicit influence over decision-making and resource allocation.
- **Institutional power** is exercised through donors shaping the rules, norms, and procedures within global and national health governance structures, influencing which actors participate and how decisions are made on health agenda-setting. This indirect control creates lasting constraints on national policy options.
- **Structural power** lies in the underlying social and economic arrangements that define the positions and capacities of donor and recipient actors, such as the global aid architecture and economic dependencies that position donors as indispensable and shape recipient government behavior and interests.
- **Productive power** operates through discourses, knowledge production, and framing mechanisms by which donors influence what counts as legitimate health problems and appropriate interventions, shaping national health narratives and the identities of stakeholders to align with donor priorities.

These forms of power explain why agenda distortion persists even in contexts where aid-effectiveness norms promote ownership and alignment. Theoretical contributions from Lukes' three-dimensional view of power and Barnett and Duvall's taxonomy of power deepen understanding of how donor preferences are embedded within aid architectures. These dynamics manifest as preferential financing for interventions that align with donor mandates, privileging biomedical and quantifiable outcomes, and the diffusion of policy models that may not reflect domestic political or epidemiological contexts [84].

Aid-effectiveness frameworks and their limitations

Aid-effectiveness frameworks have been discussed and launched over the years with an aim to correct some of the structural issues discussed above by recommitting donors to country

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ownership, alignment, and harmonization. UHC2030 operationalized these principles through the "seven behaviors," emphasizing unified national plans and shared accountability frameworks [85]. Over just six years from 2005-2011, five aid effectiveness initiatives were launched: the Paris Declaration on Aid Effectiveness (2005) [29], the International Health Partnership plus (2007), the Accra Agenda for Action (2008) [30], the Busan Partnership for Effective Cooperation (2011) [31], and the Global Partnership for Effective Development Cooperation (GPEDC) (2011) [86]. More recently, in 2015, the Addis Ababa Action Agenda (AAAA) [87] was signed at the third international conference on financing for development, and the Universal Health Coverage (UHC) 2030 Global Compact was signed in 2017 [88]; see Table 1 for the key features of the selected aid effectiveness framework.

Empirical evaluations of aid effectiveness frameworks reveal persistent challenges in adherence to their recommendations, such as country ownership, alignment, harmonization, and mutual accountability. Studies demonstrate that donors often maintain parallel systems rather than fully integrating with recipient country systems, largely due to accountability pressures and mandate-driven priorities [89-92]. Some structural limitations and gaps in aid effectiveness frameworks and policies pronounce the effects of these factors on national agenda distortion, such as:

1. **Weak enforceability:** Principles of alignment and ownership lack mandatory compliance mechanisms.
2. **Fragmentation:** Multiple donor-specific tools such as Gavi transition criteria, Global Fund co-financing rules, and PEPFAR's Sustainability Index operate in parallel, producing a proliferation of policy instruments rather than coherent alignment.
3. **Oversimplified technocratic solutions:** Tools such as Joint Assessments of National Health Strategies (JANS) or annual health sector reviews emphasize procedural alignment but often fail to address political determinants of priority setting.
4. **Limited adaptation to changing donor landscape:** The frameworks were designed for bilateral and multilateral donors but are less suited to the growing influence of private philanthropic and non-state actors (NSA).
5. **Insufficient incorporation of political economy analyses:** Most frameworks treat misalignment as a technical issue rather than a manifestation of power asymmetries.

As DAH declines and transitions accelerate, these gaps become more apparent and increasingly important to bridge. Policy frameworks should be able to sustainably mitigate power asymmetries and structural dependency to prevent agenda distortion. The next section explores the policy gaps in aid effectiveness and transition frameworks in detail.

Policy Gaps in the Aid Effectiveness and Transition Frameworks

Despite the evolution of global aid-effectiveness and transition frameworks, several structural and functional gaps persist. Table 1 demonstrates the attributes of cross-sectoral compacts such as the Paris, Accra, and Busan agreements [29-31] institutionalized principles of ownership, alignment, and harmonization, yet in practice, they have been insufficient to counterbalance the stronger incentives for vertical, earmarked funding models. Evaluations consistently show that, despite donor accountability requirements to domestic constituencies, short funding cycles, and siloed program architectures, they continued to reproduce fragmentation and parallel systems [34-36]. As a result, the principles of "alignment" and "use of country systems" have not translated into donor practices. This creates a persistent implementation gap where normative commitments are not reflected in practiced behavior.

A second gap concerns the inability of both aid-effectiveness and transition frameworks to explicitly address the political economy of power imbalances that sustain agenda distortion. Neither the Paris-Accra-Busan agreements nor the UHC2030 mechanisms directly confront the structural incentives that drive donors to prioritize vertical programs, measurable short-term outputs, or geopolitical interests. Likewise, contemporary transition frameworks used by the Global Fund, Gavi, PEPFAR, or World Bank-affiliated mechanisms are heavily technocratic and focused on fiscal thresholds, co-financing ratios, or epidemiological benchmarks (summarized in Table 1).

They rarely consider how colonial legacies, institutional dependencies, or long-standing asymmetries in negotiation capacity shape priority-setting, even though evidence from Puerto Rico, Sri Lanka, Cambodia, and Botswana shows that structural dependence persists [34-37]. Transition tools often assess sustainability in terms of financial handover, not in terms of whether countries will be left with systems configured around donor legacies rather than national needs. This results in a narrow conception of transition that treats the process as a technical shift in financing rather than a political and institutional transformation requiring re-balancing of power and long-term system restructuring.

A third major gap is the limited attention to volatility, predictability, and long-term fiscal planning. Aid-effectiveness principles emphasize predictability, yet donors continue to implement abrupt funding changes and re-prioritize interventions. Furthermore, frameworks do not require donors to coordinate transition timelines or synchronize demands, resulting in cumulative shocks

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when multiple donors reduce support simultaneously.

Finally, neither set of frameworks adequately addresses the sustainability of health-system functions that donors themselves historically financed. Transition tools typically focus on HIV, TB, malaria, or immunization program sustainability but show limited engagement with supply chain integration, HRH absorption, laboratory networks, surveillance systems, or community-based services. These systems often lack a post-donor integration pathway, creating a transition risk that both aid-effectiveness and transition frameworks fail to address. The Cambodia Sustainability Roadmap, for instance, identified multi-layered dependencies in health information systems, procurement, and civil-society networks that require long-term domestic planning and technical restructuring rather than short-term handover [34].

Collectively, these gaps highlight the disconnect between the intended role of policy frameworks and their real-world effects. While the frameworks create a normative architecture of national ownership and sustainability, they lack the political, financial, and institutional mechanisms required to counterbalance donor incentives, correct historical asymmetries, or power imbalances. Addressing these gaps is essential for preventing agenda distortion and building nationally led, sustainable health financing ecosystems.

To make informed policy recommendations, Table 2 categorizes the key strengths and weaknesses of all the studied policy frameworks. However, evidence has shown that weak enforcement of their policy guidance has also been a key reason for suboptimal outcomes of these frameworks vis-à-vis their intended aims.

To illustrate how different actors could contribute to and gain from a more balanced policy process, Table 3 sets out the distinct roles and responsibilities of key stakeholders along with the benefits they experience when agenda distortion is avoided.

Policy Recommendations

Addressing the identified gaps requires a realignment of global and national policy instruments to shift from normative commitments toward enforceable, accountability-driven mechanisms that prioritize national autonomy, system strengthening, and sustainability. Table 3 lists the roles and responsibilities of various stakeholders and the benefits of preventing agenda distortion for them.

1. Governance and Aid Coordination

1.1. National Aid Coordination Office as Mandatory Single Gateway

Recipient countries should establish an Aid Coordination Office (ACO) with representation from the Ministry of Health and the Ministry of Finance, functioning as the mandatory entry point for all health financing negotiations with bilateral, multilateral, foundation, and private sector donors. This office would centralize the evaluation of all external financing proposals against the National Health Plan and the country's epidemiological priorities, issuing binding opinions that enable the government to reject or request modifications to misaligned proposals. The ACO would operate through legal mandate, requiring donors to submit proposals with sufficient lead time and include alignment analysis with national priorities, integration plans with existing systems, and transition strategies. This mechanism strengthens the recipient country's negotiating power and reduces the fragmentation that generates agenda distortion.

1.2. Official List of Top 10 National Public Health Priorities

Each country should publish and update annually an official list of the top 10 public health priorities based on disease burden, epidemiological analysis, and health system needs, developed jointly by the Ministry of Health and the WHO country office. This list becomes the mandatory reference standard against which all donor financing alignment is evaluated. The methodology for developing this list would integrate disease burden data (DALYs), mortality, health system capacity, and priorities expressed in national plans, published in a publicly accessible digital format with annual updates. Donors must demonstrate how their financing addresses at least one of the listed priorities, and the ACO uses this list as a central evaluation criterion. This explicit benchmark of needs makes it more difficult to impose external priorities misaligned with national epidemiological reality.

2. Long-Term Predictability and Financial Planning

2.1. Binding Multi-Year Financial Predictability Standards

Donors participating in pooled financing mechanisms or country compacts should publish binding multi-year financial commitments of at least 5 years, including projected annual amounts, phased reduction schedule, national co-financing expectations, and programmatic transition plan. A centralized platform under UHC2030 would register these commitments in a standardized format, allowing recipient countries to incorporate this information into their medium-term fiscal frameworks and multi-year budgets. Non-compliance with commitments without justification would generate graduated consequences: public reporting, financial penalties directed to the affected country's transition fund, and eventual temporary suspension of eligibility for new multilateral agreements. This mechanism reduces DAH volatility that impedes long-term planning and enables governments to develop sustainable policies based on predictable flows.

2.2. Mandatory Phased Exit Planning from Financing Inception

All donor financing agreements should include, from their conception, an explicit phased exit plan with a clear timeline for

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domestic financial substitution, regardless of the country's current income level. This plan would specify annual percentages of incremental co-financing by the recipient government, projected year of complete donor exit, and specific triggers (epidemiological and fiscal) for timeline adjustments. The recipient government would present annual evidence that projected budget increases are being executed, with analysis of additionality versus substitution through National Health Accounts. Plans would be reviewed every 2 years and could be adjusted under documented mutual consent. This approach corrects the problem of ad-hoc transition planning that generates sustainability crises when donors withdraw abruptly.

3. Systems Integration and Sustainable Transition

3.1. Comprehensive Health System Transition versus Programmatic Transition

Donor transition frameworks should expand from vertical programmatic criteria (disease elimination/control, fiscal thresholds) to a comprehensive evaluation of health system capacities to absorb functions historically financed by donors. "Transition readiness" would include mandatory assessment of capacities in procurement and supply chain, human resources, information and surveillance systems, laboratories, regulatory capacity, community networks, governance, and sustainable financing. A standardized Health System Transition Readiness Assessment would be conducted 3 years before the projected transition, identifying critical gaps requiring strengthening before exit. When this assessment identifies systemic weaknesses, the transition plan would include specific financing to strengthen capacities, and the timeline would adjust according to demonstrated progress. This approach recognizes that fiscal or epidemiological readiness does not guarantee system capacity to sustain functions autonomously.

3.2. Incentives for Country Systems Use and Penalties for Parallel Structures

Aid effectiveness principles should be operationalized through concrete financial incentives that link donor eligibility to participate in pooled financing mechanisms to demonstrated use of national procurement, budgeting, and information systems. Donors maintaining parallel structures without integration plans should face progressive disincentives, such as restrictions on access to multilateral funds or financial penalties directed to national system-strengthening funds. This approach would gradually realign financial flows toward national systems, reducing fragmentation and administrative burdens that perpetuate institutional dependencies and weaken domestic management capacities. Implementation would require mechanisms to verify effective use of country systems and clear criteria on when justified exceptions are admissible.

3.3. Domestic Fiscal Reform Commitments as Prerequisite for Aid Renewal

Recipient countries should demonstrate, as a condition for renewal of financing agreements, that they are implementing domestic fiscal reforms that increase fiscal space for health and that donor resources are truly additional and do not substitute national public spending. Each renewal would require evidence of a sustained increase in budgetary allocation to health, documented progress in eligible fiscal reforms (elimination of regressive subsidies, taxes on harmful products, improvements in tax collection, reduction of tax evasion), and an analysis in National Health Accounts demonstrating additionality. Countries demonstrating systematic substitution would face phased aid reduction until correcting the pattern, while those with proven additionality would receive timeline extensions or bonuses. This mechanism addresses the fungibility problem where DAH displaces domestic spending rather than supplementing it.

4. Accountability and Power Asymmetry Correction

4.1. Mandatory Integration of Political Economy Analysis in Aid Evaluations

All aid effectiveness tools (Joint Assessment of National Strategies, UHC2030 country compacts, co-financing reviews) and transition assessments should incorporate structured political economy analysis modules that identify power asymmetries, negotiation capacity, donor institutional incentives, and potential sources of agenda distortion. A standardized module based on HIPES methodology and power frameworks would be integrated as a mandatory section, including mapping of actors and institutional incentives, analysis of negotiation asymmetries, identification of structural power mechanisms, and evaluation of real versus nominal alignment. The analysis would be conducted by mixed teams (government, independent facilitator, civil society), and results would inform distortion risk mitigation plans incorporated into country compacts. This approach recognizes that misalignment is a product of political determinants and power asymmetries, not just technical miscoordination.

4.2. Public Donor Performance Ranking System

A global donor performance ranking system should be established, administered by an independent entity, that evaluates and publicly reports annual scores for each donor based on adherence to aid effectiveness principles, predictability, use of country systems, and track record of successful transitions. The methodology would evaluate donors across dimensions of alignment with national priorities, predictability of commitments, use of certified country systems, harmonization, sustainable transition track record, and transparency. Scores would be calculated using public data and surveys of recipient countries, published on an open-access platform. Countries would use these rankings as criteria to select and prioritize financing partners, while donors with poor performance would face reputational costs affecting their positioning. This mechanism generates incentives for donors to improve their aid effectiveness practices and strengthens recipient countries' negotiating power.

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Table 1: Key attributes of the aid effectiveness frameworks

Framework	Scope & level	Country ownership mechanisms	Alignment with national systems (PFM, M&E, plans)	Harmonization and coordination
Paris Accra Busan (PAB)	Cross-sector, global, normative	Strong in principle: ownership, alignment, mutual accountability	Strong emphasis on the use of country PFM, procurement, and monitoring systems	Strong: explicit on harmonization, joint missions, and reduced fragmentation
SWAps in health	Sector-wide, national	Medium to strong where government-led, weaker where donor-dominated	Strong alignment due to pooled funds and a single sector plan and budget	High: single sector dialogue, joint reviews, joint basket funds
IHP+/UHC2030 platform	Health sector, global partnership, and country-level engagement	Strong: compacts, seven behaviors, joint accountability, multi-stakeholder engagement	Strong emphasis on aligning behind national strategies, plans, and budgets	High: promotes joint assessments, joint reviews, shared analysis
Country compacts (under IHP+ / UHC2030)	Country-level, health sector-specific	Strong by design: government-led articulation of priorities and mutual commitments	Strong: usually ties partners to a single national plan and results framework	High: platforms for aligning partners, reducing duplication, and standardizing dialogue
JANS (Joint Assessment of National Strategies)	Country-level, strategy assessment tool	Medium: improves the quality of government strategies, which can enhance ownership	High: explicitly checks whether strategies are realistic about systems and financing	Medium: converges partners on one strategy and assessment
JAR / JAHR (Joint annual reviews)	Country-level, health sector review mechanism	Strong if the government chairs and sets the agenda, weaker if dominated by partners	High potential: The reviews monitor the implementation of the national plan and budget	High: a central coordination instrument in SWAps and UHC2030 context
Global Fund Sustainability, Transition Co-financing (STC) Policy	Programmatic disease-focused but system-relevant	Medium: uses country dialogue and Country Coordinating Mechanisms, but is still heavily donor-rule-bound	Medium: pushes for the use of national systems where feasible, but retains safeguards and parallel procurement in many places	Medium: some joint work with other partners, but still operates its own cycles and instruments
Gavi country processes and HSS/graduation policies	Programmatic, vaccines, and HSS	Medium to strong: country proposals, joint appraisals, but guided by Gavi policies	Medium: promotes integration of immunization into national plans, but often uses project-like channels	Medium: coordinates through ICCs and sector groups, but also runs specific processes
PEPFAR Sustainability Index and Dashboard (SID)	Programmatic, HIV, country-specific diagnostic	Medium: used in joint country dialogue but designed by PEPFAR	Medium: assesses the use of national systems and alignment as part of sustainability	Medium: encourages coordination with Global Fund, MOH, and others, but remains PEPFAR specific
PEPFAR Country Operational Plans (COPs)	Programmatic, HIV, annual planning, and budgeting	Medium: increasingly co-developed, but PEPFAR HQ retains significant control	Medium: can support alignment with national HIV strategies, but often retains PEPFAR reporting and procurement	Medium: engages with other partners, but processes are largely PEPFAR-specific
Global Financing Facility (GFF) Investment Cases	RMNCAH plus systems, country level	Strong: Government-led prioritization with multi-stakeholder platforms	High: investment case must reflect national plans and budget realities	High: deliberately links GFF, IDA, IBRD, and other partners to one plan and resource map
SDG3 Global Action Plan (GAP)	Cross-agency health collaboration, global and country	Medium: agencies commit to align behind country-led agendas but retain their mandates	Medium to high: one of its accelerators is sustainable financing that stresses alignment of DAH with national priorities, and using national systems	High on paper aims to reduce fragmentation and duplicative initiatives

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Framework	Sustainability & transition provisions	Flexibility vs earmarking of funds	Incentives for domestic resource mobilization
Paris Accra Busan (PAB)	Weak on explicit transition, stronger on long-term system alignment	No direct funding: acts through norms applied by donors, so de facto flexibility depends on donor practice	Indirect: encourages the use of DAH to leverage national budgets, but no hard instruments
SWAps in health	Moderate: The idea is long-term system funding, but without an explicit transition from DAH to domestic	Usually medium flexibility: some earmarks, but more fungibility than vertical projects	Moderate: often no explicit DRM, but DAH is supposed to complement, not substitute
IHP+/UHC2030 platform	Medium: promotes sustainable financing and transition discussions, but no binding rules	No direct financing, but encourages flexible, aligned DAH and discourages earmarked off-budget funding	Medium to high: encourages DRM and pro-poor fiscal policies as part of the sustainable financing accelerator
Country compacts (under IHP+ / UHC2030)	Medium: some compacts include sustainability and transition milestones, others less so	Medium: can constrain donors to fund agreed priorities, but some earmarking remains	Medium: some compacts include fiscal commitments, others are silent
JANS (Joint Assessment of National Strategies)	Medium: incorporates realism about fiscal space and implementation, but no binding transition plan	Neutral on flexibility or earmarking: does not govern money directly	Medium: can flag DRM gaps and unfunded mandates, but has no enforcement
JAR / JAHR (Joint annual reviews)	Medium: enables tracking of whether domestic funding is rising as DAH changes	Neutral to medium: can flag excessive earmarking and misalignment	Medium: can track domestic vs external finance and push for rebalancing
Global Fund Sustainability, Transition Co-financing (STC) Policy	High: explicit co-financing, eligibility thresholds, transition, and sustainability plans are core	Low to medium: funding is still disease earmarked, some flexibility within disease envelopes	High: clear co-financing rules and expectations for increasing domestic spend on HIV, TB malaria
Gavi country processes and HSS/graduation policies	High: explicit phases of co-financing, acceleration, and full self-financing, plus transition plans	Low to medium: strong earmarking to vaccines and immunization-related HSS	High: Co-financing curves are central to its model
PEPFAR Sustainability Index and Dashboard (SID)	High as an analytic tool: structured around sustainability domains, including financing, systems, and governance	Neutral to medium: does not change earmarking, but can encourage integration	Medium: explicitly includes domestic financing as an area of assessment
PEPFAR Country Operational Plans (COPs)	Medium: can include explicit transition or localization goals in some countries	Low to medium: highly earmarked budget lines and technical priorities	Medium: can set domestic financing benchmarks, but not always enforced
Global Financing Facility (GFF) Investment Cases	Medium to high: links grants and concessional loans to long-term reforms, but the explicit "DAH to domestic" transition is variable	Medium: still tied to RMNCAH focus, but promotes cross-cutting systems and budget support style operations	Medium to high: emphasis on crowding in domestic and private resources
SDG3 Global Action Plan (GAP)	Medium: promotes joint transition support where DAH is declining, but still quite new and evolving	Medium: aims to reduce off-budget and off-system DAH, but does not control individual donors	Medium: calls for DAH to leverage domestic resources and improve the efficiency of spending

Table 2: Strengths and weaknesses of the policy frameworks in preventing national agenda distortion

Policy Framework	Strengths	Weakness
Paris-Accra-Busan aid effectiveness compacts* [29-31]	• Clear normative principles on ownership, alignment, harmonization, and mutual accountability. • Explicit calls to use country systems and reduce parallel structures.	• Non-binding and unevenly implemented.
IHP+ / UHC2030 platform*[93]	• Directly promotes seven behaviors for effective DAH and country leadership, including alignment with national strategies, reduced fragmentation, and joint reviews.	• Depends heavily on voluntary partner behavior and government bargaining power.
Country compacts under IHP+/UHC2030*[94,95]	• Concrete instruments to translate Paris-Accra-Busan principles into enforceable mutual commitments at the country level.	• It can be ignored if donors or governments lack incentives to adhere.

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SWAps*[96]	• Pooled or basket funding, single sector plan and budget, joint reviews, and harmonized procedures. • They are one of the clearest practical models of non-distorted sector support.	• Not all donors signed on to SWAp arrangements. For example, Zambia's SWAp failed to serve as a common framework because several donors continued to use separate funding channels.
GFF Investment Cases*[97]	• Force explicit prioritization of RMNCAH and systems investments within a single country-owned investment case that aligns with national plans and budget. • Structure dialogue on domestic, external, and private financing in one place.	• Focused on RMNCAH, so risk of partial agenda shaping if not well integrated into the overall health strategy.
Joint annual reviews (JAR/JAHR)*[98]	• Central instrument for mutual accountability; if well used, they can surface misalignment, over earmarking, and donor-driven distortions.	• In many settings, JARs are largely technocratic and underused.
Global Fund STC Policy[99]**	• Explicit transition, sustainability, and co-financing logic. • Uses transition readiness assessments and encourages integration into national budgets and systems.	• Highly earmarked for three diseases. • Eligibility thresholds can push governments to reorient policy to "stay eligible".
Gavi HSS and graduation/transition policies[100,101]**	• Clear co-financing and transition path, with predictable expectations.	• Very strong vertical focus on vaccines can skew priorities away from broader PHC or NCDs in tight fiscal space.
PEPFAR SID[97]**	• Comprehensive diagnostic of sustainability, including governance, systems, and domestic financing.	• Improvements identified by SID are not always reflected in COP allocations or conditionalities.
SDG3 Global Action Plan[102-104]**	• Recognizes fragmentation and misalignment of global health initiatives and commits agencies to align with national priorities and strengthen sustainable financing.	• Despite engaging over 60 countries, the initiative struggled to translate global collaboration into meaningful national health outcomes. • Governments often felt the plan was agency-driven rather than country-owned, reducing local buy-in
PEPFAR Country Operational Plans (COPs)*[105]**	• Huge resources: can be aligned with national strategies if domestic actors are influential in the planning process.	• Annual, donor-driven planning cycle, heavy earmarking, and separate reporting can heavily shape HIV priorities and service models away from national preferences. • Creation of parallel delivery channels and HRH arrangements.
JANS*[48]**	• It can improve the internal coherence and realism of national strategies, which indirectly reduces susceptibility to donor-driven distortions.	• If dominated by external experts, it can imprint donor preferences in the very strategy that others are then expected to align with.

*These frameworks are explicitly oriented to country ownership, alignment, and harmonization, and are not themselves highly earmarked financial instruments; and have a high potential to prevent agenda distortion if implemented.

**These instruments are designed to manage transition and sustainability, but their vertical, disease, or intervention-specific nature carries inherent risk of agenda distortion and hence, have medium potential to prevent agenda distortion.

***These frameworks can contribute to the prevention of agenda distortion if used well, but carry a significant risk of reinforcing distortions.

Table 3: The roles and responsibilities of various stakeholders in preventing agenda distortion and its benefits for them

Stakeholder	Roles and Responsibilities	Benefits
National Governments/MoH	• Lead national priority-setting using epidemiological evidence, burden of disease, and health system needs. • Establish unified sectoral strategies, medium- long-term expenditure frameworks, and transparent budgeting processes. • Enforce the use of national systems for planning, procurement, M&E, and financial management. • Negotiate and accept donor compacts based on alignment, predictability, and coherence with national priorities. • Regulate private sector and non-state actors to ensure coherence with national plans.	• Improves sovereignty in decision-making and fiscal planning. • Builds long-term system resilience, efficiency, and reduces volatility associated with external flows. • Supports sustainable transition to domestic responsibility and reduces the risk of service disruption.

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Donor Agencies and Global Health Initiatives (Global Fund, Gavi, PEPFAR, World Bank, bilateral agencies)	• Move from vertical program initiatives to system-strengthening and transition-ready models. • Improve predictability of aid, reduce fragmentation, and avoid parallel systems. • Align investment with national plans and co-financing trajectories that are realistic and context-sensitive. • Avoid cliff-edge transitions and coordinate timelines to prevent simultaneous exits. • Offer technical support to governments in fiscal reform, efficiency improvements, and transparency.	• Ensures long-term impact of investments. • Ensures sustainability beyond donor exit, preventing service disruptions or program collapse • Enhances reputation and legitimacy by showcasing adherence to aid-effectiveness principles of Paris, Accra, and Busan, which they formally committed to.
World Health Organization	• Provide normative guidance, technical support, and tools such as the Health Financing Progress Matrix (HFPM). • Act as a neutral broker between donors and governments, reinforcing country ownership. • Promote systemwide transition planning and UHC-aligned allocation strategies. • Strengthen monitoring of equity, efficiency, and financial protection.	• Sustains progress towards UHC and reduces reversals when donors exit. • Reinforces WHO's mandate on system-strengthening, financial protection, and UHC.
Civil Society and Community Organizations	• Represent affected populations in national planning and donor coordination platforms. • Hold governments and donors accountable for transparency and alignment. • Provide essential services for key and vulnerable populations that may remain underfunded post-transition.	• Ensures continuity of services critical for key populations. • Expands space for rights-based policy and planning. • Reduces volatility in funding for community engagement.
Private Sector (including industry, suppliers, insurers, healthcare providers, corporate foundations)	• Participate in national priority setting and regulatory processes, becoming a public health partner, not merely a player. • Align their public health efforts with national priorities, enhancing their reputation. • Support strategic purchasing arrangements aligning with national systems. • Engage in co-financing or risk-pooling innovations within a nationally guided framework.	• Predictable regulatory and financing environment supports market stability. • Reduced duplication of efforts associated with parallel supply chains or reporting systems.
Philanthropic Organizations	• Invest in innovations and public health interventions without bypassing national systems.	• Local capacity and governance improvements enhance the long-term impact of their investments.
(Wellcome Trust, Gates Foundation, etc.)	• Support long-term institution-building, data systems, and research capacity. • Avoid influencing and skewing national agendas through single-issue funding.	• Stronger national institutions allow philanthropic projects to scale sustainably, enhancing their public image and furthering their cause.
Academic and Research Institutions	• Conduct independent assessments of aid alignment, fungibility, substitution, and effects on the health system and the health of the people. • Generate evidence for national planning. • Train the workforce in health financing, governance, and policy analysis.	• Access to better data and stronger national partnerships improves research quality. • Minimizes distortions in research priorities driven by donor-funded agendas.
Patients and patient groups	• Participate in social accountability, community oversight, and monitoring of service equity. • Voice demand for services aligned to real health needs.	• Ensures services reflect actual health needs rather than donor preferences. • Protects continuity of essential services during donor transitions. • Reduces financial hardship resulting from volatile funding.

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4.3. Binding Mutual Accountability Mechanisms

Mutual accountability should be operationalized through shared performance indicators, mandatory annual joint reviews, and linkage of compliance scores to financial allocation decisions by both parties. Each country compact would include a Mutual Accountability Framework establishing indicators for donors (predictability, alignment, use of country systems, harmonization) and governments (fiscal effort, implementation of reforms, transparency), with quantifiable annual targets and joint reviews facilitated by a neutral entity. Non-compliance would generate graduated consequences: public reporting, percentage withholding of next disbursements, and eventual full review of agreement terms. The scores would feed into the donor ranking and parliamentary reports on aid management. This enforcement mechanism converts normative accountability principles into operational commitments with real consequences for both parties.

4.4. Multi-Stakeholder Governance Platforms and Civil Society Sustainability

Countries should establish formal multi-stakeholder dialogue platforms that institutionalize the participation of civil society, patient organizations, medical societies, academia, the private sector, non-state actors, and donors in the planning, monitoring, and evaluation of health aid and transition processes. These platforms would operate as permanent consultation spaces linked to the ACO, with balanced representation of actors, clear advisory mandates on health needs prioritization, and the capacity to raise alerts about misalignments or sustainability risks. Special coordination mechanisms should be established for non-state actors and philanthropic organizations operating outside traditional bilateral/multilateral architectures, requiring their alignment with national priorities and participation in accountability platforms. This mechanism expands the base of actors involved in aid governance beyond the donor-government dyad, incorporates perspectives of those who directly experience the effects of agenda distortion, and strengthens legitimacy and national ownership of health policies.

Conclusion

The current study demonstrates that while global aid-effectiveness agreements and donor transition frameworks were created to promote national ownership, alignment, and sustainability, they have been unable to counteract the structural incentives that continue to drive agenda distortion. Evidence across multiple countries shows that the principles articulated in Paris, Accra, and Busan remain aspirational because the donor financing landscape is dominated by vertical programs, short funding cycles, and parallel system requirements that often override national priorities. Transition frameworks developed by major global health initiatives have similarly focused on fiscal thresholds and program maturity while overlooking the political, institutional, and historical factors that embed long-term dependency. As countries approach transition in a period of declining development assistance for health, these gaps become even more visible, increasing risks to health system stability, governance, and the sustainability of health gains.

Addressing these challenges requires action from all stakeholders, as it is in their interest that health interventions in a country remain nationally led and population health-driven without any fragmentation and duplication of efforts. For this to happen, a decisive shift from normative statements toward enforceable mechanisms that strengthen country leadership, improve predictability of funds, and ensure donors participate in coordinated, system-wide planning is needed. Embedding political economy analysis, system integration requirements, and civil-society sustainability into policy frameworks is essential. Likewise, governments must advance fiscal reforms and strengthen institutions to absorb responsibilities historically managed through donor-funded architectures. In doing so, countries and donors can move toward health systems that are nationally steered, financially sustainable, and aligned with population health needs. The recommendations of this study highlight a practical path toward reshaping global aid governance in ways that minimize agenda distortion and help achieve the desired state: *DAH should operate as a catalyst that strengthens nationally led health systems, aligns fully with epidemiological needs and national priorities, supports predictable financing to ensure long-term planning, and enables a smooth transition to sustainable self-reliance without distorting national agendas or creating long-term structural dependencies*.

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How to cite this article: Gonzalez AR, Mehto AK, Vignoli L. Agenda Distortion and the Politics of Aid: Shared Responsibility for Sustainable, Self-Determined Health Systems. Juniper Online Journal of Public Health, 10(3). 555790. DOI: 10.19080/JOJPH.2025.10.555790

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How to cite this article: Gonzalez AR, Mehto AK, Vignoli L. Agenda Distortion and the Politics of Aid: Shared Responsibility for Sustainable, Self-Determined Health Systems. Juniper Online Journal of Public Health, 10(3). 555790. DOI: 10.19080/JOJPH.2025.10.555790