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MINKA | AFD AGENCE FRANÇAISE DE DÉVELOPPEMENT

The Suspension of USAID Activities and its impact on Nigeria Health Ecosystem

The Implication for HIV and Malaria Program Sustainability, Health Workforce and Domestic Financing in Nigeria.

10 décembre 2025

Public

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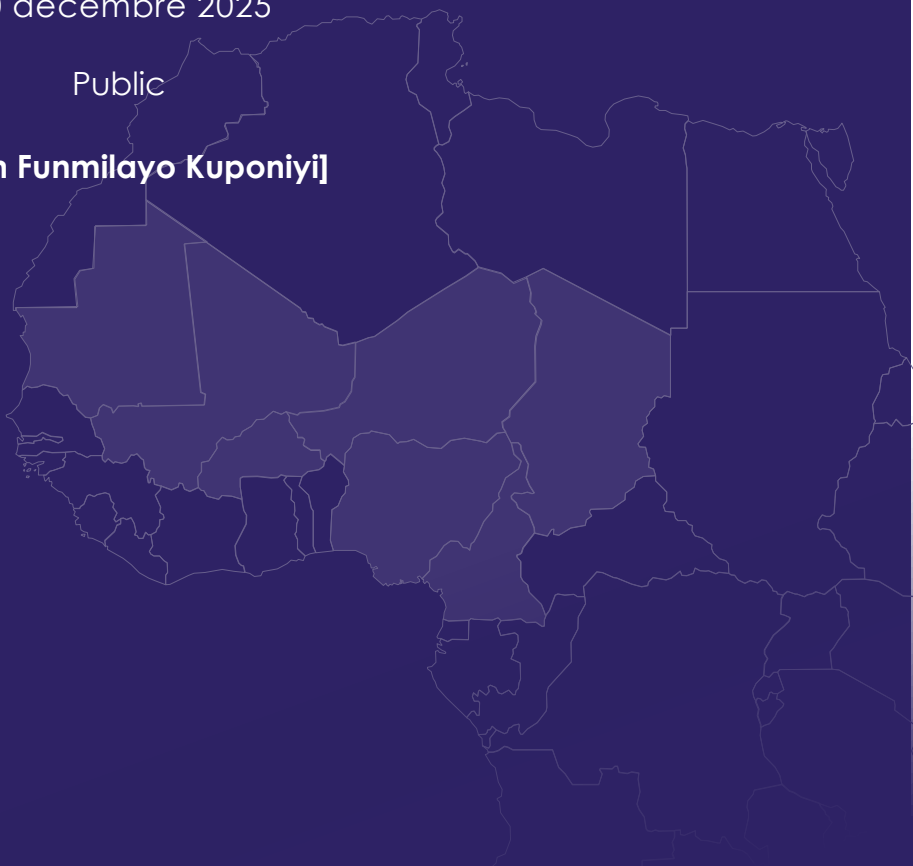

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Suggested Citation :

Kuponiyi, S. F. (2025). *The Suspension of USAID Activities and its Impact on Nigeria's Health Ecosystem*. PASAS/AFD

https://pasas-minka.fr

ACKNOWLEDMENTS

The author gratefully acknowledges the contributions of the many individuals and institutions who supported the development of this policy brief. Special appreciation is extended to the former USAID managers, federal and state government officials, leaders of civil society organisations, and representatives of international and local implementing partners who generously shared their time, insights, and lived experiences through key informant interviews and survey participation. Their reflections provided critical grounding for understanding how the suspension of USAID global health activities has affected programmes, systems, and communities across Nigeria.

The author also thanks colleagues and technical experts within Nigeria's broader health ecosystem whose perspectives helped clarify operational realities and contextualise emerging policy implications. While their contributions informed the analysis, all interpretations and conclusions presented in this brief remain the sole responsibility of the author.

To protect confidentiality, the names of respondents are not listed individually. The author is deeply appreciative of their openness, candour, and commitment to strengthening Nigeria's health system during a challenging period of uncertainty and transition.

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ACRONYMS & ABBREVIATIONS

AfCFTA / ACFCTA	African Continental Free Trade Area
ACT	Artemisinin-based Combination Therapy
AFD	Agence Française de Développement
AfDB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrome
APIN	AIDS Prevention Initiatives in Nigeria
ARV / ARVs	Antiretroviral / Antiretroviral Drugs
ART	Antiretroviral Therapy
ATM	AIDS, TB and Malaria
BHCPF	Basic Health Care Provision Fund
CADRI	Capacity for Disaster Reduction Initiative
CBHI	Community-Based Health Insurance
CDC	Centers for Disease Control and Prevention (U.S.)
CHW	Community Health Worker
COP	Country Operational Plan (PEPFAR)
CSO / CSOs	Civil Society Organization(s)
CSR	Corporate Social Responsibility
DAC	Development Assistance Committee (OECD)
DALY	Disability-Adjusted Life Year
DRR	Disaster risk reduction
DMoC	Differentiated Models of Care
DRM	Domestic Resource Mobilization
DRPC	Development Research and Projects Center
EU	European Union
ECOWAS	Economic Community of West African States
FBO	Faith-Based Organization
FCDO	Foreign, Commonwealth & Development Office (UK)

FEWS-NET	Famine Early Warning Systems Network
FMoH	Federal Ministry of Health
FP	Family Planning
FCT	Federal Capital Territory
GAVI	Global Alliance for Vaccines and Immunization
GCCC	Government Cash Counterpart Contribution
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GNI	Gross National Income
HIV	Human Immunodeficiency Virus
HMB	Heavy Menstrual Bleeding
HRH	Human Resources for Health
INGO / INGOs	International Non-Governmental Organization(s)
IP / IPs	Implementing Partner(s)
IPTp	Intermittent Preventive Treatment in Pregnancy
ITN	Insecticide-Treated Net
KII / KIIs	Key Informant Interview(s)
KP	Key Population
LGA	Local Government Area
LLIN	Long-Lasting Insecticidal Net
LON	Local Organization Network (TB LON project)
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MTCT	Mother-to-Child Transmission
NACA	National Agency for the Control of AIDS
NASA	National AIDS Spending Assessment
NDRMSS	National Domestic Resource Mobilization for Sustainable Development Strategy
NERICC	Nigeria Expanded Programme on Immunization Coverage and Quality
NEMCHIC	Nigeria Expanded MCH Immunization Coverage
NGO / NGOs	Non-Governmental Organization(s)
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
NiBUCAA	Nigeria Business Coalition Against AIDS

ODA	Official Development Assistance
OOP	Out-of-Pocket (expenditure)
OSS	One-Stop Shop
OVC	Orphans and Vulnerable Children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PFM	Public Financial Management
PHC	Primary Health Care
PMI	President's Malaria Initiative
PMTCT	Prevention of Mother-to-Child Transmission
PrEP	Pre-Exposure Prophylaxis
PPP	Public–Private Partnership
PSM	Procurement and Supply Management
SDG	Sustainable Development Goal
SHI	Social Health Insurance
SMC	Seasonal Malaria Chemoprevention
SRH / SRHR	Sexual and Reproductive Health / Sexual and Reproductive Health and Rights
SSA	Sub-Saharan Africa
SWAp	Sector-Wide Approach
TB	Tuberculosis
TWG / TWGs	Technical Working Group(s)
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
USG	U.S. Government
VMMC	Voluntary Medical Male Circumcision
VL	Viral Load
WHO	World Health Organization

1 - EXECUTIVE SUMMARY

Nigeria's health financing system is marked by deep structural vulnerabilities. More than 90% of Nigerians pay for healthcare out of pocket, with health expenses consuming up to 70% of household expenditure for many families and pushing vulnerable households further into poverty. National health insurance currently covers less than 40% of the population, leaving donor funding and a small share of tax-based financing to fill critical gaps.

USAID has been a dominant actor across multiple health sectors. Between 2020 and 2024, USAID invested approximately $2.8 billion in Nigeria, with PEPFAR and PMI accounting for about 70% of total investments. In 2024, USAID provided roughly $12 billion in foreign aid to sub-Saharan Africa, with Nigeria being one of the countries where USAID represented more than half of all Official Development Assistance.

Nigeria's HIV response illustrates the level of donor dependence. The country has over 1.8 million people living with HIV, with about 1.7 million receiving PEPFAR-supported antiretroviral therapy. By 2023, PEPFAR's cumulative investments in Nigeria exceeded $7 billion. Between 2018 and 2023, annual HIV expenditures ranged from $330 million to $406 million, with PEPFAR and the Global Fund financing 85–90% of total spending. National AIDS spending assessments have consistently shown that more than 90% of HIV funding comes from external partners. Before Nigeria's renewed domestic commitments in 2015, the country directly covered less than 10% of people living with HIV. Budget execution for NACA has also been variable, averaging between 47% and 76% from 2016 to 2021. Weak engagement between the health and finance sectors, the absence of a structured donor transition plan, and fragmented procurement systems further undermined sustainability.

1.1 - Impact of the USAID Funding Suspension

The January 2025 suspension of US foreign aid triggered immediate and cascading shocks. By August 2025, an estimated 65% of PEPFAR-funded awards were terminated, disrupting treatment for about 2.3 million patients and reducing the scale of prevention services, including PrEP, VMMC, and HIV testing. Malaria and HIV programmes were affected across multiple states, with LLIN distribution halted in eight states. More than 1,200 frontline workers lost their jobs, and some partner organisations saw operational capacity fall to as low as 40–45%.

Projections indicate that disruptions to ART could lead to as many as 2.9 million additional HIV deaths globally by 2030 and significantly increase mother-to-child transmission. A 44% cut to PMI funding could result in an additional 67 million malaria cases and nearly 300,000 malaria-related deaths. Workforce impacts were severe: organisations reported stop-work orders issued within 24 hours, mass layoffs, and the permanent loss of institutional memory as donor-funded staff left the system.

1.2 - Government and Stakeholder Response

The Federal Government mobilised ₦7.1 billion in emergency funding and secured roughly $200 million through legislative approval, though this remained insufficient to offset the scale of disruptions. NACA doubled its drug allocation from ₦5 billion to ₦10 billion, and several state governments procured commodities as interim measures. New actors—including the Global Fund, World Bank, AfDB, and ECOWAS—stepped in as temporary stabilisers, signalling a shift toward a more diversified aid architecture.

Governance mechanisms were strengthened through the establishment of an ATM technical working group and an inter-ministerial coordination committee. The government accelerated policy reforms promoting integrated service delivery, expanded health insurance coverage,

and enforced government-led warehousing. Domestic resource mobilisation efforts intensified, including revitalisation of the HIV Trust Fund and the expansion of faith-based financing models.

However, medium-term fiscal absorption capacity remained weak, and without structural domestic budget integration and workforce retention strategies, Nigeria risks deeper instability by 2026. Governance weaknesses, including documented cases of fraud, underscored the need for stronger accountability frameworks.

1.3 - New and Emerging Health Financing Actors

The Global Fund continues to play a central role, although it faces its own fiscal pressures, partly due to high reliance on US contributions. Nigeria's TB programme, financed 70–80% by the Global Fund, has experienced less severe commodity disruptions.

Philanthropy and the private sector are expanding their footprint, including through the redesigned HIV Trust Fund and initiatives supporting local NGOs. Faith-based financing continues to grow as a domestic funding stream. South-South partners, particularly China, have shown early interest in supporting multilateral or community-level engagements. However, no single donor or grouping appears able to fully replace USAID's footprint. Nigeria must therefore blend smaller and more fragmented external flows with increased domestic resources.

The landscape is shifting from donor-driven to shared-ownership models, but sustainability will depend on whether Nigeria institutionalises accountability and financing reforms through a structured Transition Compact.

1.4 - Recommendations

Immediate Actions

1. Establish a Transition Compact with defined roles for national and global funders.
2. Develop a national HR transition plan for donor-funded workers.
3. Secure uninterrupted commodity financing through diversified funding mechanisms.
4. Protect frontline outreach services through ring-fenced domestic allocations.

Medium-Term Reforms

5. Implement mandatory quarterly releases for HIV and malaria budget lines.
6. Formalise a 2026–2030 domestic financing compact with clear percentage targets.
7. Institutionalise donor coordination under a Joint Health Financing Platform aligned with a single national plan.

Long-Term Reforms

8. Invest in local manufacturing of essential health commodities.
9. Increase national health allocations toward the 15% Abuja target with protected sub-allocations.
10. Develop ECOWAS pooled procurement for ARVs, antimalarials, and diagnostics.
11. Strengthen South-South financing mechanisms, including diaspora bonds and solidarity levies.
12. Institutionalise community-led monitoring and accountability across HIV, TB, and malaria programmes.

2 - INTRODUCTION

Overview of USAID's role in Nigeria's health ecosystem

Over the past decade, the United States has emerged as Nigeria's most significant bilateral donor, providing $7.8 billion in foreign aid between 2013 and 2023, with funding reaching a peak of $1.3 billion in 2022 alone [15].

A significant portion of these disbursements have been to the health sector. More than half of the funding allocated in 2024 was allocated to the health sector particularly targeting Nigeria's critical disease burden through flagship programs such as PEPFAR (President's Emergency Plan for AIDS Relief) for HIV/AIDS treatment and the President's Malaria Initiative (PMI) for malaria control [16,17]. Nigeria, with the second-highest HIV prevalence globally, has been a major beneficiary of life-saving antiretroviral medications, diagnostic services, and prevention programs funded by US assistance [18]. These funds are typically allocated through multi-sectoral partnerships involving the Nigerian Federal Ministry of Health, State Primary Health Care Development Agencies, and implementing partners including international NGOs and local civil society organizations [19]. The allocation process involves direct budget support, procurement of medical commodities, technical assistance, and capacity-building initiatives across federal and state government health systems [20].

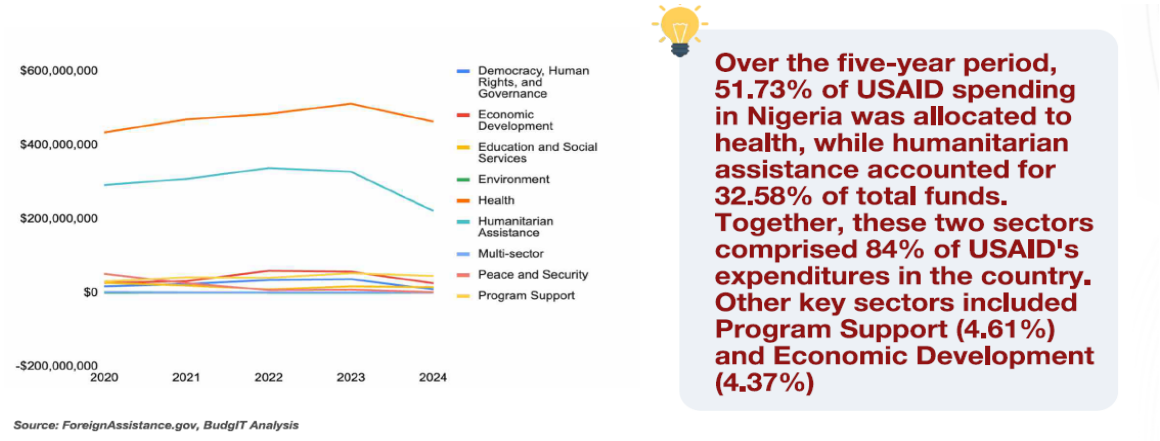


Fig 1: USAID funding across key sectors in Nigeria in 2024. Health received the most funding.

Context of global aid retraction

Globally international aid from donors fell by 7.1% in real terms in 2024 compared to 2023. In 2024, the Official Development Assistance (ODA) from OECD Development Assistance Committee (DAC) member countries was USD212.1 BN amounting to just 0.33% of DAC combined countries gross national income [21]. The Development Assistance Committee (DAC) is an international forum of many of the largest providers of aid, including 33 members, with the overarching objective of promoting development cooperation and policies that contribute to sustainable development, poverty eradication, and improvement of living standards [22]. The US was the largest member of the DAC ODA accounting for 30% of the total DAC ODA in 2024 and has led this retrenchment [21].

On his first day in office, President Donald Trump issued an executive order pausing US foreign development assistance for 90 days for assessment of programmatic efficiencies and consistency with United States foreign policy and subsequently announced plans to terminate 92% of foreign assisted grants-nearly 10,000 contracts and USAID grants worth $60billion [23,24].

Nigeria's ODA dependence

These cuts have disproportionately affected low and middle-income countries. It is estimated that bilateral ODA to least developed countries could drop by 13-25% in 2025 while countries in sub-Saharan Africa could see a drop in funding of up to 16-28% (25). Nigeria received approximately $5.0 billion in Official Development Assistance (ODA) in 2022 making it the 5th largest ODA recipient globally [26]. USAID to Nigeria has exceeded $600 million annually since 2018. In 2023 over 24% of ODA received in the country was from USAID', while in 2024 a total of $738.7 million was disbursed [27]. The table below highlights the disbursements of USAID funding to Nigeria from 2016 to 2024.

Year	Disbursements (in Millions USD)
2016	361M
2017	492M
2018	714M
2019	620M
2020	701M
2021	798M
2022	789M
2023	824M
2024	739M

Table 1: USAID funding to Nigeria from 2016 to 2024

Health programs at risk: PEPFAR and PMI

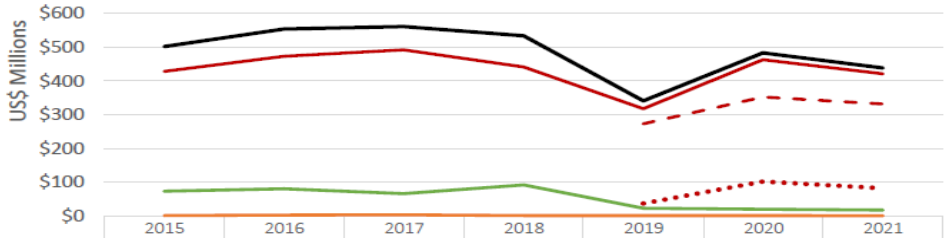
The health sector has consistently received the lion share of USAID funding in Nigeria. Between 2022 and 2024, the sector received over 53% (approx. $1.47B) of $2.8B USAID funding to Nigeria [28]. Over the past 5 years, this funding has been distributed through the global health supply chain program which has significantly enhanced healthcare infrastructure, medicine accessibility and disease response especially for malaria, HIV/AIDS and maternal health [29]. Two significant programs supported by USAID funding for healthcare are the President's Emergency Plan for AIDS Relief (PEPFAR) and the President's Malaria Initiative for States (PMI)

PEPFAR Scope and Overview

The President's Emergency Plan for AIDS Relief (PEPFAR), was established by President George Bush in 2003 and represents the largest commitment by any nation to address a single disease in history [30]. PEPFAR has provided a cumulative funding of $100 billion for HIV/AIDS treatment prevention and research since its inception saving an estimated 25 million lives as at December 2024 [30,31]. Since its inception in Nigeria in 2004, PEPFAR has led the country's HIV response, funding 75% of HIV programming in Nigeria, training health workers and providing treatment to millions of Nigerians living with HIV and AIDS [29].

Since inception to 2023, the PEPFAR program has contributed over $7.8BN to Nigeria's HIV and AIDS response through organisations like National Agency for the Control of AIDS (NACA) and the Aids Prevention Initiatives in Nigeria (APIN)(32). In 2023 Nigeria was one of the top 10 recipients of USAID funding globally receiving over $600million in health assistance directed toward HIV, vaccines and to prevent outbreaks. PEPFAR is Nigeria's largest HIV donor supporting 90% of the country's treatment burden.

PEPFAR was estimated to support 1.9 million Nigerians with access to antiretroviral treatment (ART). In addition to ARVS, PEPFAR provided HIV testing and counselling services for over 83.8million people by 2024 [33] and supported comprehensive HIV treatment services in more than 1450 health facilities across all 36 states in Nigeria and the FCT [34]. PEPFAR also leads the provision of prevention of mother-to-child transmission (PMTCT) supporting over 600 PMTCT clinics [32] and providing provider-initiated testing and counseling during antenatal care, ARVs during pregnancy and delivery, early infant diagnosis and post-partum family planning [33]. In addition PEPFAR provided additional support services including laboratory services and quality assurance, health workforce development and capacity building, community outreaches, health system strengthening and policy development.



	2015	2016	2017	2018	2019	2020	2021
FE.01 Public	73,299,196	79,543,466	66,045,257	91,477,782	23,110,492	19,869,076	17,106,073
FE.02 Private	760,194	1,559,340	2,936,398	197,273	236,616	732,884	146,480
FE.03 International	427,677,071	471,936,348	491,314,743	440,696,444	316,989,764	461,462,928	420,504,065
GFTAM					36,504,534	101,554,554	81,445,795
PEPFAR					272,460,166	351,681,244	330,641,645
Total	501,736,461	553,039,154	560,296,399	532,371,499	340,336,872	482,064,889	437,756,619

Fig 2: HIV expenditure trends in Nigeria by financing entity, 2015-2021, US$ million, source : NASA

PMI Overview

The Presidents Malaria Initiative (PMI) is an interagency initiative by the United States government under president Bush and launched in 2005 [35]. The PMI is the largest international source of funding for treatment against malaria. PMI supports malaria control activities in 11 of 36 states in Nigeria to reach approximately 56 million people [36]. A key focus of the PMI was to pregnant women through preventative treatment of malaria and strengthen digital surveillance of malaria.

In 2024, the PMI program received $20.7 million in USAID for the support of its activities in Nigeria as part of a total $795 million congressional allocation for malaria activities by the US government [37].

PMI activities include the provision and distribution of insecticide treated nets(ITN), distributing over 300 million ITNs in Nigeria [38]. It has also provided seasonal malaria chemoprevention, a flagship program implemented in Nigeria , Senegal and Burkina Faso amongst others [39]. It was announced that 28.7 million children in Nigeria were covered by SMC in 2023 and was implemented in all eligible 21 states in Nigeria [39, 40]. Other key programs by the PMI include distribution of indoor residual sprays using insecticides, case management and treatment, intermittent treatment in pregnancy and health system strengthening and capacity. It was estimated that the PMI program had achieved 100% preventative coverage in Nassarawa state and distributed over 595000 treatment doses to 200,000 women in Oyo.

Funding Cuts

The suspension of USAID funding has created severe disruptions across Nigeria's health sector, which previously relied on approximately $2.8 billion in USAID investments between 2020-2023, with PEPFAR and PMI accounting for roughly 70% of the country's health portfolio. The funding freeze has caused disruptions to essential health services across Nigeria. Core HIV and malaria programs have been suspended in 12 states, while long-lasting insecticidal net (LLIN) distribution has been interrupted in 8 states, with coverage falling to just 40%. The suspension has also created significant commodity stockouts and halted the normal LLIN distribution cycle, directly impacting millions of Nigerians who depend on these life-saving interventions. [3]

Over 1,200 front-line health workers have been laid off. These layoffs threaten the continuity of community-based HIV testing, antiretroviral therapy (ART) services, viral load monitoring, and supply chain management. The loss of skilled personnel represents a critical vulnerability in maintaining health service delivery and could have long-term consequences for program sustainability. [3]

Impact of funding cuts on PEPFAR

By August 2025 an estimated 65% of PEPFAR's awards were terminated affecting 16% of "life-saving" programmes [10]. Terminated awards directly supported approximately 2.3 million patients on antiretroviral therapy (ART), representing roughly 1 in 10 patients across the entire PEPFAR program. Beyond treatment services, 39% of planned new pre-exposure prophylaxis (PrEP) initiations, 31% of voluntary medical male circumcision (VMMC) procedures, and approximately 31% of HIV testing were encompassed under terminated awards. This signals immediate risks extending well beyond commodity supply issues to include critical prevention services and at least 1.5 million orphans and vulnerable children (OVC) supported through these programs [10].

The operational handoff of PEPFAR programming from USAID to the State Department introduces significant implementation constraints. The State Department has limited in-country staffing and lacks USAID's established contracting and financial management systems, complicating award modification, procurement, and field-level monitoring. This reduced operational capacity creates uncertainty around program reallocation and threatens the continuity of technical oversight that has historically underpinned PEPFAR's effectiveness [10].

Several local NGOs such as APIN and Caritas Nigeria have been forced to close down clinics or suspend drug supplies creating a significant gap in care chain. This has resulted in multiple care interruptions, increased risk of epidemic rebound and loss of control over prevalence indicators. The funding cuts have also placed the most vulnerable groups receiving HIV treatment at risk including women, children, sex workers, drug users and men who have sex with men.

Impact of Funding Cuts PMI

The 2025 USAID funding freeze poses significant risks to PMI programs in Nigeria. Suspended US contracts for PMI have halted hundreds of millions of dollars annually, threatening an increase of nearly 15 million additional malaria cases and 107,000 additional deaths globally in just one year of disrupted malaria control supply chain [41]. For Nigeria, which has the world's highest malaria burden and where PMI has been instrumental in achieving progress, the withdrawal of this support threatens to reverse decades of gains and condemn millions of children and pregnant women to preventable illness and death. Since the suspension of the PMI funding, several campaigns have been halted undermining the progress in perinatal prevention and exposing mothers and children as well as other vulnerable populations to an increased risk of malaria resurgence.

An internal USAID memo has estimated that an additional 12.5-17.9 million malaria cases and an additional 71,000-166,000 deaths could occur annually if PMI was halted permanently [42]. Modeling studies from the Malaria Atlas Project have estimated that a halt of PMI-funded programs for 90 days would result in 1.7 million additional cases and 17,000 additional deaths. A freeze for 1 year would result in 14.9 million additional cases and 107,000 additional deaths [43].

Training for health workers in malaria diagnosis, clinical care and preventive treatment in pregnancy will be significantly impacted as these have been led by the PMI initiative undermining decades of investments [43]. This undermines the capacity-building efforts that took decades to establish. The cuts also threaten Reductions investments in new and improved malaria prevention, diagnostic, and treatment interventions [42].

Purpose and objectives of this policy brief

This policy brief aims to achieve the following objectives:

1. Analyse the impact of the suspension of USAID projects and the reduction in funding for flagship programs in Nigeria (PMI, PEPFAR) on the health ecosystem
2. Gathering and studying the positions and discourse of political authorities, civil society and beneficiaries regarding the consequences of aid suspension
3. Observing if new actors are emerging to replace USAID.

These objectives would be met through a combination of desk research, documentary sources (such as academic publications, press articles, official documents and research papers). It would also include expert interviews with national and international actors in Nigeria's health ecosystem. Using insights from these sources, it would seek to answer the following questions

- What major risks does the suspension of the USAID pose to Nigeria's health situation (current and in the future)? Is there evidence of deterioration?
- How has aid governance in Nigeria been organised since the suspension and what visible effects have the funding gap produced?
- What local perceptions accompany the announcement of USAID funding suspension, depending on stakeholder groups (national and regional authorities, civil society, development actors)?
- Are adaptation strategies being implemented or considered by these actors?
- Has the suspension triggered the emergence of new aid actors? If so, how is the landscape of international aid in Nigeria being redefined?

3 - METHODOLOGY

This policy brief is based on a structured qualitative analysis of evidence drawn from multiple sources within Nigeria's health ecosystem. The overall aim is to generate a grounded understanding of how the USAID global health funding cuts affected programmes, systems, and communities, and to identify feasible policy options for sustaining essential services and managing transition beyond 2026.

Data Sources

Four complementary data sources were used:

Literature and Document Review

A targeted review was conducted of:

- Academic publications on aid dependence, HIV/TB/SRHR financing, and health systems in Nigeria and sub-Saharan Africa;
- Official documents including national health and HIV/TB/SRHR strategies, budget and expenditure reports, National AIDS Spending Assessment (NASA) reports, and state-level policy documents;
- Donor and programme reports, such as PEPFAR and USAID public statements, Global Fund materials, and implementing partner reports;
- Press articles and analytical commentaries on the USAID funding freeze, its political context, and reported effects on services.

This literature provided the contextual baseline for understanding USAID's role in Nigeria's health sector before the funding cuts and informed the development of the analytical framework.

Key Informant Interviews (KIIs)

Semi-structured KIIs were conducted with national and sub-national actors, including both Nigerian and international stakeholders working in the health ecosystem:

- Federal Ministry of Health (FMoH) directors and senior officials;
- National Agency for the Control of AIDS (NACA) senior officials and technical leads;
- State AIDS and public health programme managers;
- Leadership and senior staff of international and local implementing partners (IPs);
- Representatives of civil society and networks involved in HIV, TB, SRHR and OVC programming.

A total of nine KIIs were conducted via in-person meetings, phone, or virtual platforms. Interviews followed a semi-structured guide covering programme disruptions, workforce and commodity issues, financing, governance, adaptation strategies, and perceptions of risk.

Online Surveys with Government Counterparts

A structured open-ended survey was administered to government counterparts (federal and state level; n = 9). Questions explored:

- Observed programme disruptions and service changes;
- Human resources and workload issues;

- Commodity and stock-out experiences;
- Budget gaps and interim measures;
- Perceived impacts on patients and communities;
- Lessons learnt and recommendations for government and partners.

Online Surveys with Implementing Partners (IPs)

A parallel open-ended survey was administered to implementing partners working on USAID-supported health programmes (n = 10). This survey covered similar domains, with additional emphasis on:

- Operational changes within projects;
- Effects on case management, outreach, and OVC/KP services;
- Staff losses, burnout and organisational resilience;
- Ongoing effects of the cuts at facility and community levels;
- Suggested policy and operational responses.

Analytical Approach

All qualitative data (KII transcripts/notes and survey responses) were organised into a single qualitative dataset and analysed using a NVivo-style thematic analysis.

1. Development of the coding framework
    - A deductive framework was first constructed from the research questions and literature review, focusing on:
        - Programmatic disruptions and health outcomes;
        - Workforce impact;
        - Commodity and stock-out issues;
        - Financial constraints and budget gaps;
        - Service access challenges for patients/communities;
        - Stakeholder perceptions and lived experiences;
        - Adaptation and resilience strategies (short-term and post-2026);
        - Pre-funding freeze context (USAID's baseline role);
        - Recommendations from respondents.
    - As analysis progressed, inductive sub-themes were added to capture emerging issues such as OVC vulnerability, staff burnout, and differential impacts on key populations and humanitarian settings.
2. Coding process
    - Each KII and survey response was read multiple times and coded manually against the above parent nodes and sub-themes as follows:

        1. Programmatic Impact and Health Outcomes

            a. Service disruptions

b. Coverage decline
c. Epidemic risks
d. Commodity shortages

2. Workforce Impact

a. Layoffs and HR shortages
b. Redeployment and CHW gaps

3. Financial Adaptation and Governance Response

a. Budget relocations
b. Domestic resource mobilization
c. Coordination with donors/IPs
d. Policy shifts

4. Stakeholder Discourses and Perceptions

a. Government narratives
b. CSO perspectives
c. Beneficiary/community concerns

5. Adaptation and Resilience Strategies (2025-2026 + Post-2026)

a. Short-term stopgaps
b. Long-term sustainability plans
c. Post- 2026 donor transition preparedness

6. Emerging/New Aid Actors

a. Global Fund, GAVI, EU, AFD
b. Philanthropy/private sector
c. South-South partnerships

7. Context: USAID funding before freeing

a. Dependency on PEPFAR/PMI and role in service delivery
b. Pre-2024 progress
    - A respondent was coded under a theme if they referred to it anywhere in their responses (e.g., a single mention of stock-out was sufficient to code that response under "Commodity & Stock-Out Issues").
    - Coding frequency was used to gauge which themes were most prominent, but interpretation focused on the depth and consistency of patterns, not on numbers alone.

8.Cross-case comparison

- The analysis compared themes across respondent groups (government vs IPs; national vs state; national vs international actors) and across programme areas (HIV, TB, SRHR/FP, OVC, health systems).
- Particular attention was paid to convergence and divergence between government narratives and implementer/frontline perspectives.

Triangulation and Validation

To strengthen rigour and credibility, three layers of triangulation were used:

- Data triangulation: Findings from KIIs, government surveys, IP surveys, and the literature/document review were compared and integrated.
- Perspective triangulation: Views of federal actors, state managers, international and local implementing partners, and community-facing staff were analysed side by side to avoid a single-institution bias.
- Thematic triangulation: Reported effects on services, workforce, commodities, financing, and governance were cross-checked against each other to build a coherent picture of the system-wide impact.

Ethics, Confidentiality and Reflexivity

- Participation in interviews and surveys was voluntary, and respondents were informed that their contributions would be used in aggregated form for a policy analysis.
- No names or identifying details are reported in this brief; quotations are anonymised using generic labels (e.g., "Government respondent", "IP respondent").
- The analysis was guided by principles of confidentiality, respect, and non-attribution, particularly given the sensitivity of funding and governance issues.
- Reflexively, the author acknowledges their own position within the SRHR and health policy community and has sought to balance system-level interpretation (policies, financing, governance) with grounded narratives from frontline workers and affectedcommunities.

Limitations

This methodology has several limitations that should be considered when interpreting the findings:

- Sample scope: KIIs and surveys covered a purposive group of federal, state, and implementing partner actors; not all Nigerian states, facilities or CSOs are represented.
- Depth of survey responses: As online, open-ended instruments, some survey responses were brief and varied in detail.
- Time-bounded perceptions: The evidence reflects perceptions and experiences during and shortly after the USAID funding cuts; the situation may evolve as new funding decisions, domestic responses, or donor transitions unfold.
- Qualitative focus: The analysis is qualitative and exploratory; it does not provide statistically representative estimates of impact but rather rich, contextual insights.

Strengths of the Approach

Despite these limitations, the methodology offers several strengths:

- It captures frontline lived experiences and operational realities that are often missing from routine monitoring data and high-level budget discussions.
- It integrates multiple perspectives – government, international and local partners, and community-facing staff – providing a more complete view of how funding shocks are experienced in practice.
- It combines literature and document review with primary qualitative data, grounding the analysis in both existing evidence and fresh, context-specific testimonies.
- It uses a transparent thematic framework, making it clear how conclusions were derived and how they link back to the views and experiences of respondents.

4 - FINDINGS AND ANALYSIS

Pre-Funding Freeze Context

Nigeria's health financing system has been characterized by substantial out-of-pocket expenditure, with over 90% of Nigerians paying for healthcare services directly, alongside limited public pooling and significant dependence on donor funding [44]. The national health insurance scheme (NHIS) currently covers less than 40% of the population, with the remaining funding deficits met by donor funds and a small percentage from taxes [1].

Within this broader context, Nigeria's HIV response has long been donor reliant, with domestic funding remaining low or volatile. USAID has been a major contributor, providing approximately $12 billion in foreign aid to sub-Saharan Africa (SSA) in 2024, with Nigeria being one of the countries in the SSA region where USAID accounted for over 50% of Official Development Assistance (ODA) [4]. From 2020 to 2024, USAID funding to Nigeria amounted to $2.8 billion, with PEPFAR and PMI contributing roughly 70% of total investments [3].

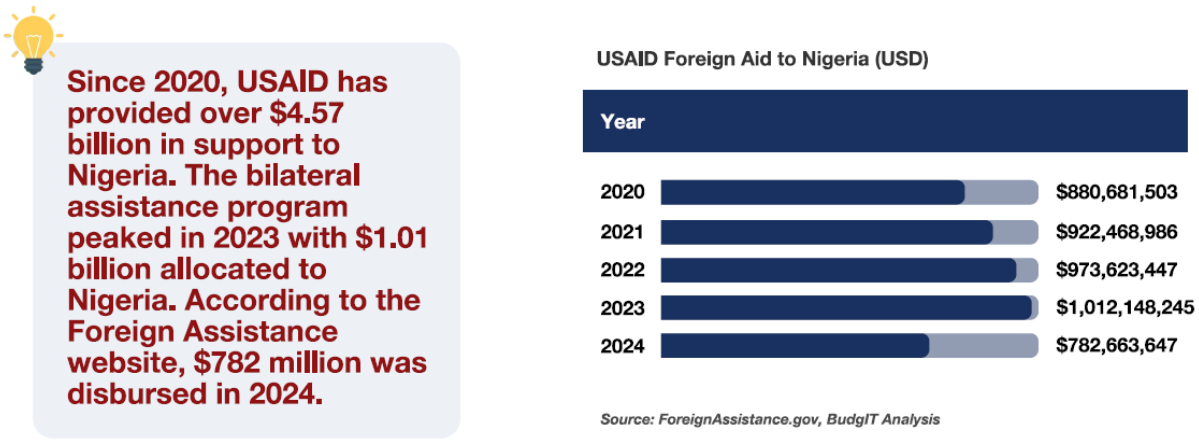


Fig 3: USAID Funding to Nigeria, 2020-2024,

PEPFAR funding specifically decreased from $387 million in 2016 to $331 million in 2021. However, by 2023, PEPFAR had invested over $7 billion in Nigeria, with significant spending on antiretroviral therapy (ART), laboratories, and supply chain expenditure [6]. PEPFAR funded 75% of HIV programming in Nigeria through 10 funding channels and 59 prime partners [8]. Nigeria has over 1.8 million people living with HIV and AIDS, with 1.7 million people on PEPFAR-supported ART [5].

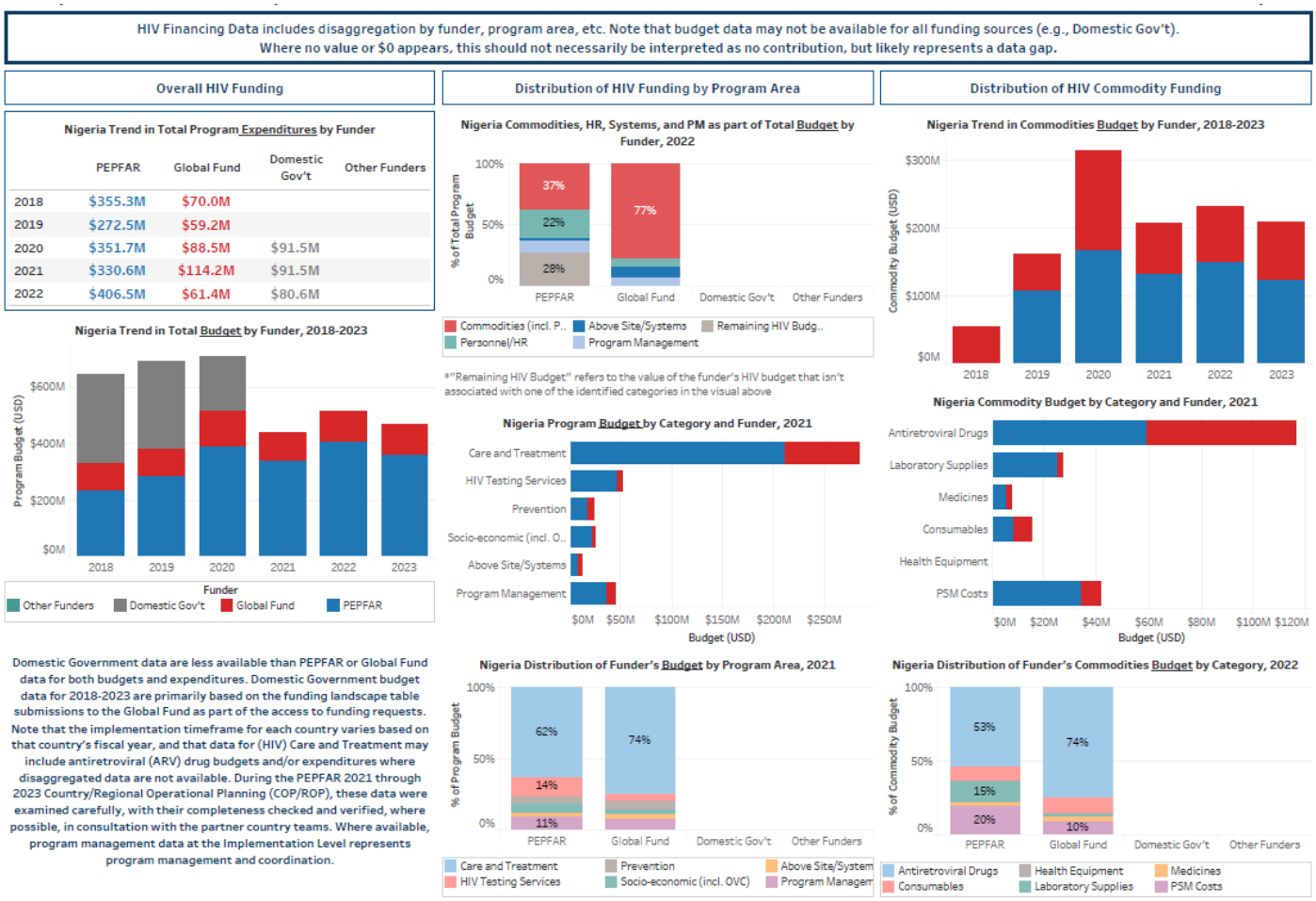


Fig 4: HIV Financing Disaggregated Data, Source, UNAIDS. 2024. ***HIV Sustainability Planning****,*

Purchasing inefficiencies characterized the system, with no integrated national procurement and supply management (PSM) strategy, heavy spending on non-programmatic items, user fees emerging when supply gaps occurred, and the private sector remaining under-utilized [9]. Pooling mechanisms lagged behind policy intentions: while a national social health insurance (SHI) integration blueprint existed, implementation was slow due to antiretroviral (ARV) cost fears and static premiums, and Basic Health Care Provision Fund (BHCPF) HIV benefits remained under-implemented [9].

The Nigeria HIV Sustainability Planning Executive Summary in 2024 showed that significant funding for HIV came from USAID/PEPFAR and the Global Fund. Between 2018 and 2023, annual HIV expenditure ranged from approximately $330 to $406 million, with PEPFAR and the Global Fund financing 85-90% of this expenditure [7]. In 2020 specifically, 67% of HIV spending was donor funded. The execution of the NACA budget was approximately 47-76% between 2016 and 2021 [9].

Challenges have persisted throughout this period, including weak Ministry of Health-Finance engagement and the absence of a time-bound donor transition plan. The integration of HIV services into the basic health care provision fund has been slow due to fears of the rising costs of ARVs and static premiums. Procurement and supply management have also been weak, with no nationally integrated strategy, heavy spending on non-programmatic items, user fees emerging in supply gaps, and the role of the private sector remaining underutilized [9]

The table below shows the distribution of USAID funding across different sectors in 2024:

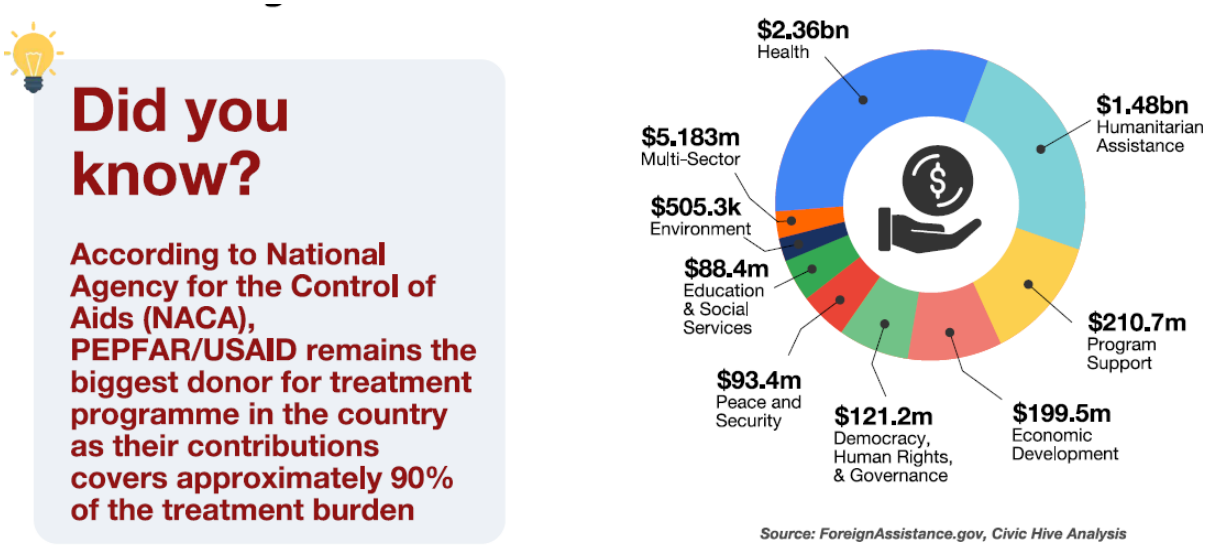


Fig 5: USAID funding across key sectors in Nigeria in 2024. HIV/AIDS received the most funding.

Fig 6: Total USAID funding to Nigeria from 2001 till date. Funding progressively increased till 2023 with a sharp decline in 2025

Key Indicators of HIV Spending In Nigeria

NASA data also highlights the key service spending indicators. The majority of HIV resources were directed to care and treatment (57–64%), with antiretroviral therapy (ART) alone accounting for 30–36% of all spending a category almost entirely supported by PEPFAR. Spending on HIV testing and counselling (HTC) rose to as high as 12% of total expenditure, reflecting intensified case-finding efforts. Meanwhile, PMTCT spending sharply declined to less than 1%, signalling a growing vulnerability in maternal and infant HIV prevention. Investments in prevention for key populations increased significantly from 1.3% to 8.9% of spending, driven largely by donor-funded PrEP scale-up. Overall, the spending pattern demonstrates that Nigeria's HIV response, especially ART, testing, prevention, and PMTCT remains financially unsustainable without continued donor support. [8]

Table 2: Key Spending Indicators, source NASA.

Indicator	2019	2020	2021
Total HIV spending in million Naira (NGN)	NGN104,361	NGN172,063	NGN174,822
Total HIV spending in million US Dollars (US$)	US$340	US$482	US$438
Total spending on HIV in millions of constant dollars (2015 values)	US$365	US$558	US$515
Total spending on HIV in current international dollars (PPP)[1]	US$772	US$1,199	US$1,122
Public financing as a percentage of total HIV spending (%)	6.8%	4.1%	3.9%
Private financing as a percentage of total HIV spending (%)	0.1%	0.2%	0.0%
International financing as a percentage of total HIV spending (%)	93.1%	95.7%	96.1%
HIV spending as a percentage of GDP (%)	0.072%	0.112%	0.099%
Spending on HIV as a percentage of national health spending (%)[2]	2.40%	3.30%	n/a
HIV spending per capita in dollars	US$1.67	US$2.31	US$2.05
Total spending on HIV per PLHIV in US$	US$189.1	US$283.6	US$230.4
HIV Prevention[3] in million US Dollars (US$)	US$9.17	US$11.76	US$39.45
HIV Prevention as percentage of total spending (%)	2.7%	2.4%	9.0%
HIV testing and counselling (HTC) in million US Dollars (US$)	US$23.57	US$57.69	US$50.85
HIV testing and counselling (HTC) as a percentage of total spending (%)	6.9%	12.0%	11.6%
HIV care and treatment in million US Dollars (US$)	US$193.98	US$309.36	US$261.38
HIV care and treatment as a percentage of total HIV expenditure (%)	57.0%	64.2%	59.7%
HIV Prevention spending on key populations (including HIV testing and counselling) in million US Dollars (US$)	US$4.32	US$10.73	US$38.80
HIV Prevention spending on key populations, including HIV testing and counselling, as a percentage of total HIV spending (%)	1.3%	2.2%	8.9%
Prevention of vertical transmission of HIV infection (PMTCT) including HIV testing and counselling in million US Dollars (US$)	US$4.99	US$2.74	US$1.60
Prevention of vertical transmission of HIV infection (PMTCT) including HIV testing and counselling as a percentage of total HIV expenditure (%)	1.5%	0.6%	0.4%
Antiretroviral therapy in million US Dollars (US$)	US$105.10	US$175.64	US$129.74
Antiretroviral therapy as a percentage of total HIV expenditure (%)	30.9%	36.4%	29.6%

Evidence Synthesis From KIIs and Surveys

This section summarises insights from both the Key Informant Interviews (KIIs) and the survey responses, capturing how the USAID funding cuts were experienced at the frontline. While earlier sections outlined national-level financing trends, the evidence below reflects the operational realities within programmes, facilities, and communities. The tables highlight recurring themes across respondents, areas where government and implementing partners converged or differed, and direct excerpts illustrating how the cuts affected service delivery, workforce capacity, and stakeholder perceptions. These findings ground the policy recommendations in the lived experiences of those most directly impacted.

Table 3: Insights from surveys

Previous partnership intensity Respondents contrasted the current situation with previous levels of support, highlighting significant reductions in partnership engagement and programmatic reach. One implementing partner (IP) summarized the change as: "*No more partnership support as it used to be, reduced outreaches*" (IP1). **Baseline of training and support** Several references to "not much training" now occurring implicitly point to earlier periods characterized by more frequent capacity-building activities under USAID support. Respondents implicitly describe a "*before and after*" picture: previously more training, broader outreach, and stronger partnerships; now shrunk and weakened.

Table 4: *Insights From KIIs*

The pre-freeze context was characterized by heavy dependency on USAID across multiple health sectors, with over 90% of HIV funding from external sources and extensive integrated service delivery reliant on USAID support. This created significant vulnerability when the freeze occurred, requiring rapid pivots toward domestic resource mobilization and alternative funding sources. **USAID's role and scope of support** Before the freeze, USAID was a major financier across multiple health and development sectors in Nigeria, including HIV, tuberculosis (TB), malaria, family planning (FP), health systems, governance, democracy, human rights, and nutrition (KII 5). USG funded key parts of the HIV response, including one-stop shops (OSS) and key population (KP)-friendly facilities, commodities, and supply chain systems (KII 1). USAID was identified as "*one of the major funders*" for partners such as the World Health Organization (WHO) and United Nations Population Fund (UNFPA), especially for FP commodities and logistics, with many other UN-funded and USAID-funded partners critically dependent on this support (KII 2). **Extent of donor dependency** The National AIDS Spending Assessment (NASA) revealed that over 90% of HIV programme funding came from donors, primarily USG and the Global Fund (KII 5, KII 4). Of approximately 1.6 million people living with HIV (PLHIV), Nigeria previously covered less than 10% directly before the 2015 commitments to ramp up domestic financing (KII 3). Extensive donor-funded community outreach and integrated services, combining HIV with sexual and reproductive health (SRH),

FP, and maternal health, were heavily reliant on USAID support, especially in humanitarian settings (KII 4).

*"…National AIDS Spending Assessment… shows that more than **90%** of the funding for HIV programs comes from the donor." -KII 5*

Pre-freeze progress and momentum

All respondents implicitly acknowledged that before the freeze, the scale-up agenda for FP, HIV, and child health was moving forward, with programmes expanding and services reaching more beneficiaries (KII 1, KII 2, KII 3). The cuts forced Nigeria to slow scale-up plans and shift urgently toward domestic financing mechanisms, disrupting the momentum that had been building in the years leading up to 2025.

Programmatic Impacts on Health Outcomes

The US funding freeze and prospective dismantling of USAID, PEPFAR, and PMI, amid parallel UK and EU Official Development Assistance (ODA) cuts, poses system-level risks to health and nutrition across sub-Saharan Africa (SSA), with Nigeria being one of the top recipients where US aid accounts for over 50% of ODA [9]. The disruption is magnified in Nigeria due to weak pooling, high out-of-pocket (OOP) spending, and constrained fiscal space [46]. The crisis occurs within the context of Nigeria's low human-resource density of 4 physicians per 10,000 people [45]. The suspension disrupted core HIV, malaria, and maternal and child health (MCH) programs, affecting service continuity across 12 states, interrupting long-lasting insecticidal net (LLIN) distribution in 8 states, and forcing layoffs of over 1,200 front-line workers [3]. These disruptions threaten infectious disease control and MCH gains, while increasing preventable deaths. Cuts to foreign-aided oncology services will also cause backlogs and mortalities, with cascading effects on MCH, oncology, and surgical care [45].

The impact on HIV and related programs has been quite severe. By August 1, 2025, an estimated 65% of USAID's PEPFAR awards were terminated (approximately 24% of planned funding), with 16% of programming that meets the administration's own "lifesaving" definition sitting under terminated awards. Terminated awards encompassed approximately 2.3 million treatment patients (approximately 1 in 10 across PEPFAR), 39% of planned new pre-exposure prophylaxis (PrEP), 31% of voluntary medical male circumcision (VMMC), and approximately 31% of HIV testing, signalling immediate risks beyond commodities alone. Although some large programs, including Nigeria, still retain the majority of budget under active awards, reallocation is uncertain [10]. As of 2024, 3.3 million people living with HIV (PLHIV) depend on USAID-funded antiretroviral therapy (ART); the funding halt jeopardizes the 95-95-95 targets [4]). The disruption of PEPFAR has key likely impacts including ART interruptions critical for newborn protection, stock-outs, drug resistance, and weakened prevention of mother-to-child transmission (PMTCT), PrEP, testing, and viral load (VL) monitoring, with an expected 60% rise in mother-to-child transmission (MTCT) from ART disruption [6]. PEPFAR supports approximately 20 million people on ART globally [46]. The Lancet HIV scenario projects up to 2.9 million extra HIV deaths by 2030.

Nigeria's past experience with PEPFAR funding changes illustrates the real-world consequences of such disruptions. A survey of 30 PEPFAR-supported APIN comprehensive clinics [25] responses; Lagos, Oyo, Plateau) compared pre-change (October 2013–September 2014) versus post-change (October 2014–September 2015) periods after PEPFAR's policy shift toward "country ownership." While antiretrovirals (ARVs) and CD4 support largely continued, there were sharp reductions in viral load testing (92%→64%), routine monitoring labs (100%→0%), patient-tracking (100%→44%). Ninety-six percent of clinics introduced user fees (median US$40/year), with reported quality-of-care compromises, staff attrition, and patient dissatisfaction [46].

Funding cuts have also had a similar impact on malaria programs. It's estimated that a 44% cut to the President's Malaria Initiative (PMI) in Nigeria would add approximately 67 million cases and 291,000 deaths. PMI's portfolio of long-lasting insecticidal nets (LLIN), indoor residual spraying (IRS), artemisinin-based combination therapy (ACT), and intermittent preventive treatment in pregnancy (IPTp) is highly cost-effective at approximately US$94 per disability-adjusted life year (DALY) and reduces costs on health systems. Without these buffers, systems may not absorb surges, causing an additional approximately 69,000 deaths. For Nigeria, PMI investments of approximately $345 million since 2010 were linked to approximately 13.8 million cases and approximately 129,000 lives averted. [10].

Nutrition programs have also suffered catastrophic setbacks. Helen Keller International halted the Advancing Nutrition programme in Nigeria, affecting 5.6 million children [9]. If US and other donor cuts persist, global severe acute malnutrition (SAM) treatment faces a $290 million gap, leaving 2.3 million children untreated and causing approximately 369,000 extra child deaths annually, with Nigeria directly exposed as a high-burden country. Donor cuts of $290 million for SAM leave 2.3 million children untreated, adding 369,000 child deaths yearly. The US share alone of $128 million leaves 1 million children untreated, adding 163,500 deaths [9]. Overall nutrition funding contractions total $704 million, with systems risks including Famine Early Warning Systems Network (FEWS-NET) disruption [13].

Insights from Surveys with Ips

Reduced or halted services

Implementing partners (IPs) report widespread service disruptions following the funding cuts. One IP stated that "some activities were halted, while some were done with no funding at all," while another described entire programmes being "abandoned." Key population (KP)-friendly services and capacity-building initiatives stopped entirely, with one IP noting that facilities experienced longer client wait times as a result of these cutbacks.

"Everything was abandoned." (IP respondent on service delivery after cuts)

Coverage declines and quality gaps

Government respondents identified HIV/AIDS, prevention of mother-to-child transmission (PMTCT), family planning (FP), gender, and key population services as the most affected areas, summarizing the impact as affecting "HIV/AIDS services, Gender and key population." One IP described a substantial reduction in case management processes for those infected and affected by HIV. While readiness assessments for pre-exposure prophylaxis (PrEP) were conducted, downstream gaps including lack of partner services and antimalarial drugs for intermittent preventive therapy (IPT) limited the effectiveness and benefits of these initiatives.

"No KP friendly services, no capacity building activities for the staff and it increased patient/client wait time at the facility." (IP respondent)

Effects on vulnerable groups and outcomes

The cuts had particularly severe consequences for vulnerable populations. Orphans and vulnerable children (OVC) support programs designed "to help them stay in school and medically" were "cut short," according to one IP social worker. In children's services, another IP explained: "It affects the funding for children's care in our supported facilities," directly linking the cuts to serious illness or death, noting instances where "sick children were being taken home by their parents" due to funding shortfalls.

"The aid given to OVC to help them stay in school and medically was cut short." (IP social worker)

Illustrative respondent evidence

IP1 (Technical quality improvement specialist) reported that after the cuts, there were no KP-friendly services, no capacity building, and increased client wait times. IP3 (Social worker with OVC) noted that educational and medical aid for OVC "was cut short," later emphasizing that "everything was abandoned" in terms of service delivery. IP10 (senior IP staff overseeing HIV/OVC services) described the comprehensive impact as "treatment interruption, stock out of ART regimens, reduced coverage, reduced resources."

Insights from KIIs

Service disruptions

The funding freeze triggered immediate and widespread service disruptions across multiple health sectors. The most concerning disruption was to prevention services for key populations, particularly affecting one-stop shops (OSS) and KP-friendly facilities that shut down suddenly when US Government (USG) funding stopped (KII 1). While core facility-based services continued, "adjunct or additional activities by civil society groups" supported by USAID had to pause until implementing partners (IPs) were allowed to resume (KII 3). From a policy perspective, many partners had planned 2025 activities that had to be stepped down due to lack of funding, affecting multiple programmes including family planning, child health, micronutrient supplements, tuberculosis (TB)/leprosy, and immunisation (KII 2).

"Because before the funding gap or before the change in the funding policy, a lot of our patient community members accessed services from the one-stop shop… A lot of the resources from U.S. government went into some of these facilities. And because of the funding gap, some of these facilities closed almost immediately." -KII 1

At the community level, "most of the community outreaches came to a halt," especially for key populations and less privileged community members, including those in humanitarian settings (KII 4). The situation was described as a "complete blackout" across the 36 states plus Federal Capital Territory, with panic, no information, staff asked to return laptops, and outreach work stopping "for a long period of time" (KII 4). While antiretrovirals (ARVs) and other essential HIV medicines were exempted and in-country stock could last for the initial three-month stop-work period and its extension, the freeze "crippled service provision" because IP staff conducting supervision, data entry, and clinical work were told to "stop work," leading to empty clinics (KII 5).

"Most of the community outreaches came to a halt," especially for key populations and less privileged community members, including humanitarian settings. - KII 4

The TB LON project in Rivers State, part of a 5-year, 14-state intervention, stopped within 24 hours of the Trump order due to a USAID stop-work directive. Community outreach for TB case finding dropped drastically, reducing cases detected because outreach activities were heavily donor-funded and incentivised (KII 8). At the macro level, programme closures occurred across multiple sectors, with "a lot of international non-governmental organisations (INGOs) closing down" in northeastern, north-central, and northwestern humanitarian settings, accompanied by staff

reductions and service shutdowns, especially in health and education (KII 9). Essential drugs became inaccessible for some HIV patients when the freeze hit, leading to missed doses and risk of casualties (KII 9).

"To be very frank, in all sincerity, one cannot overemphasise the impact the funding cuts had on Nigerian healthcare systems generally, not just the TB LON project… there was a funding gap… there was a huge funding gap that I think at some point the lawmakers in Nigeria had to quickly approve $200 million to support the health care system. But it wasn't enough." -KII 8

Coverage declines and quality deterioration

While most respondents noted it was "too early" to quantify declines since the freeze started around February 2025 with some relaxation after April (KII 1, KII 3), there were clear warnings that key population prevention access was at risk and that without services "you're reversing the gains from over the years" (KII 1). Reported spikes in new infections occurred due to disrupted prevention services including condoms, sexual and reproductive health (SRH), and family planning (FP), with children orphaned in Oyo State because ARV stockouts and deaths were reported from some facilities (KII 4).

"Most of the community outreaches came to a halt… complete blackout across the 36 plus 1 states… there was a significant spike in the rate of new infections… we also got numbers like from Oyo state… some mortalities… children… orphaned." -KII4

Reduced TB detection resulted from fewer outreaches leading to fewer TB cases found in communities, even though the TB programme overall is 70–80% Global Fund–funded (KII 8). While there was no sign yet in 2024 HIV cascade data because ARVs were protected, longer-term effects could show later when annual targets are assessed (KII 5). Real coverage decline was anticipated to become visible by December or early the following year, once organisations fully exhausted reserves and stopped "suspending from their research hoping funds can be raised" (KII 9).

"Already where we were before was at least trying to make sure we scale up services so that more people will get. But because of the cuts… the scale up will now need more money locally." -KII 2

Epidemic risks (HIV, malaria, maternal and child health)

The greatest risk to HIV epidemic control centred on key population access to HIV prevention and treatment, with failure to maintain services threatening to reverse epidemiological gains (KII 1). The risk was framed against Nigeria's 95–95–95 HIV targets: with approximately 2 million people living with HIV, the aim is for 95% to know their status, 95% of those to be on ART, and 95% of those to be virally suppressed. Current achievement stood at approximately 87% for the first 95 and "90-something" for the second and third 95; while the freeze had not yet affected these metrics, the risk was clear if staffing collapse continued (KII 5). Missed ARV doses risked more casualties and weakened the HIV response, while referral pathways were also disrupted due to lack of test kits and technical skills (KII 9).

For maternal and child health and family planning, commodities were identified as "the most hit of all" in Family Health, with knock-on risks for maternal health, newborn health, and child survival, as newborn commodities and immunisation were also affected (KII 2). Community outreach shutdowns affected condom distribution, SRH programmes, FP interventions, and some maternal health programmes, since these were integrated into HIV community activities (KII 4). For tuberculosis, while the programme was 70–80% Global Fund–funded, USAID cuts still hurt community case finding and the speed of diagnostic scale-up (KII 8). More broadly, USAID had historically supported HIV, TB, malaria, MCH, and health systems including data quality,

reporting, and harmonisation, so the freeze exposed how over-reliance on those funds had distorted domestic health financing (KII 8).

Commodity shortages

The commodity situation revealed both immediate shocks and medium-term risks. There was no immediate drug stock-out because Nigeria had recently received a large consignment of HIV commodities; the problem was supply chain access, with commodities stuck in warehouses because of frozen operational funds (KII 1). The first major shock was zero access to warehouses. Even though commodities were physically available, the public-private partnership (PPP) 4PL warehousing arrangement meant the government couldn't access them initially (KII 6).

"From the policy or the programmatic point of view of a country, the family planning commodities is the most hit of all." -KII 2

All technical working groups (TWGs) convened to understand which services would stop and what commodity gaps existed. Orders for essential medicines and diagnostics were halted, and for a period they could not even access the warehouses managed under PPP 4PL arrangements (KII 6). The gaps for HIV, TB, and malaria were quantified and taken to the government, resulting in an intervention fund of USD 200 million for AIDS, TB, and malaria (ATM) commodities (KII 6). "*Lawmakers had to quickly approve $200 million, but it wasn't enough" (KII 8*).

Commodity stockouts and rationing also occurred at facility level, including instances where ARVs were reportedly sold to those who could pay (KII 4). A period existed where essential drugs could not be accessed by regular beneficiaries (KII 9). To prevent medium-term shortages, there was a strong focus on preventing stock-out of all "life-saving commodities" (such as FP commodities, HIV/TB/leprosy medicines, micronutrient supplements, and multimicronutrient supplements) by raising the issue to the Coordinating Minister and pushing internal mechanisms to fill financial gaps (KII 2).

"…we could not even access the warehouse… even orders for essential interventions… medicines… and diagnostics, were halted." -KII 6

From the finance perspective, Nigeria had progressively raised commodity budgets between 2015–2024 and doubled the commodity allocation from ₦5 billion to ₦10 billion in 2024 to cover more of the 1.6 million people living with HIV, where previously Nigeria covered less than 10% of patients, demonstrating some readiness to take ownership (KII 7).

Workforce Impacts

The multifaceted impacts on Nigeria's health workforce, threatened the sustainability of critical health programmes and reversed years of capacity-building investments. Disruptions to HIV, tuberculosis (TB), malaria, and broader health system functions have implications for service continuity, quality of care, and epidemic control.

Immediate Workforce Losses and Service Disruption

An analysis of the multi-layered repercussions documented the layoffs of over 1,200 front-line workers, threatening continuity in community testing and supply chains [3]. These workforce reductions exposed critical vulnerabilities in programmes that depend heavily on donor-funded human resources for health (HRH). A 2025 systematic review synthesizing 34 publications across 12 African countries, with Nigeria the most represented (n=6), found that workforce retention is precarious, as staff hired on project funds are often lost post-funding, along with institutional knowledge [11].

Modelling on the President's Malaria Initiative (PMI) contribution to malaria control demonstrated that cuts would result in reduced donor-funded posts, affecting health-system capacity and leading to capacity-related excess deaths, with implications for operations and maintenance (O&M) essentials [10]. The workforce impact encompasses project-funded HRH, incentives, task-shifting arrangements, and both retention and absorption capacity [47].

Structural Vulnerabilities and Systemic Risks

The funding cuts have also exposed deeper structural vulnerabilities in Nigeria's health workforce architecture. Analysis of high development assistance for health (DAH) dependence for HIV and immunization programmes revealed multiple workforce impacts: reduced donor-funded posts, decreased retention and absorption capacity, and tensions between technical capacity needs and political appointments [48]. The freeze also stresses workforce exposure and public financial management (PFM)/corruption risks [4].

Projections on how PEPFAR funding cut could affect Nigeria's HIV response identified significant HRH exposure, warning that cuts would jeopardize training, retention, and motivation, with possible job losses [6]. A review on the impact of the January 20, 2025 U.S. foreign-aid suspension on HIV programmes in Nigeria highlighted workforce risks including PEPFAR-funded cadres at risk, potential layoffs, non-governmental organisation (NGO) closures, and hospital saturation. The analysis underscored HRH risks if the suspension extends past the 90-day window and emphasized the need for post-2026 fiscal and supply-chain buffers [5].

Historical Precedent and Recurring Patterns

Nigeria's current workforce challenges echo previous experiences with donor funding transitions. A survey of 30 PEPFAR-supported APIN comprehensive clinics comparing pre-change versus post-change periods after PEPFAR's policy shift toward "country ownership" revealed dramatic reductions in staff supports with stipends dropping from 72% to 8% and hiring falling from 80% to 20%, alongside reduced outreach capacity (from 84% to 16%). These cuts resulted in staff attrition, morale decline, longer wait times, and reported quality-of-care compromises [49]. PEPFAR supports approximately 20 million people on antiretroviral therapy (ART) globally, and Nigeria's past experience highlighted clinic challenges and staff shortages when funding declined [46].

An 89-study scoping review (1990–2018) examining donor transitions, many involving USAID/PEPFAR and Global Fund/Gavi, found that such transitions affect every health-system building block, leading to service disruptions and human resources shortages. The workforce impact manifested as HRH losses and planning/management capacity gaps [50].

Insights from Surveys

Staff losses, burnout, and morale

The funding cuts had a significant impact on health workforce capacity and wellbeing. One implementing partner (IP) summarized the impact as: "It reduced manpower at the facility, increased burn out on the staff and the economic well-being of my team because some lost their job" (IP1). Respondents noted reduced supervision and outreach teams, with particular effects on community and key population (KP) services as well as child health services.

"It reduced manpower at the facility, increased burn out on the staff… some lost their job." (IP respondent)

Reduced outreach and supervision capacity

Several IP responses highlighted diminished programme reach and quality oversight due to workforce constraints. Respondents mentioned fewer outreaches, reduced supervision visits, and loss of partnership support, with one noting: "No more partnership support as it used to be, reduced outreaches" (IP1).

"No more partnership support as it used to be, reduced outreaches." (IP respondent)

Insights from Key Informant Interviews

Human resources shock came with two critical consequences: [1] a shift towards *"facility-only"* models, undermining community reach; and (2) a loss of institutional memory and skills that will be costly and slow to rebuild.

Layoffs and human resources shortages

The funding suspension triggered human resources decline, particularly for staff whose salaries were 100% donor-funded. Stop-work orders were issued within 24 hours for USAID-supported projects, such as the TB LON project, with field and facility staff told to stay home. Some staff were unpaid for approximately one to two months before being redeployed or losing their jobs, as *"services were not provided"* (KII 8). Stop-work orders from the US government (USG) to implementing partners (IPs) meant some staff lost jobs and others stopped work because they were not being paid, which *"crippled service provision"* (KII 5).

"with the stop work order… some people lost their jobs… So… it didn't affect essential medicines that much, but it affected staffing… That means on a clinic day, they won't see me." -KII 5

"…immediately after the announcement by Trump, there came a stop work order by USAID… staffs were… relieved of their responsibilities… asked to… stay back at home… They were not paid… for a month or so." -KII 8

Many staff at one-stop shops (OSS) and key population (KP)-friendly facilities had to stop work almost immediately because their salaries were entirely funded by the USG (KII 1). OSS and KP-friendly facility staff *"stopped almost immediately"* once salaries ceased, with numbers described as "a lot of them" across the 36 states plus Federal Capital Territory (FCT), though exact figures were not yet fully available. Implementing partners "stopped work as they were directed and they were not talking to anybody," indicating abrupt suspension of field staff activities (KII 3).

"The funding freeze also meant that a lot of the healthcare workers needed to stop almost immediately… a lot of the OSS and KP friendly facilities pulled a lot of their staff, because the funding for them was coming from the US government." -KII 1

The scale of the crisis was documented through multiple channels. Network of people living with HIV and AIDS in Nigeria (NEPHWAN) conducted a rapid survey across all 36 states plus FCT to quantify staff affected and the degree of disruption, though specific numbers were not available at the time of interview (KII 5). A mass layoff of IP-supported staff occurred, with staff asked to submit laptops and tools, leaving states "in limbo" with no one trained to take over many functions (KII 4). The response document also addressed staff at service delivery points who lost their jobs, and there was a commitment by the Federal Ministry of Health (FMoH) to re-engage them on different terms, although implementation remained unclear (KII 6). However, government informants noted that implementation remains uneven, and community-based cadres

including peer educators, outreach teams, and KP navigators appear less protected than facility-based professionals (KII 6).

At the ecosystem level, civil society organizations described widespread human resources shocks. Many organizations cut staff, reallocated staff, or shut down entirely, with some running at only 40–45% of previous capacity (KII 9). Staff were laid off without severance, causing livelihood crises and mental health issues among founders, executive directors, and staff (KII 9). While USAID was just one of the Knowledge Network for Disease Control and Vigilance KNCV's projects and some operations continued using Global Fund and KNCV International funds plus organizational reserves, USAID-funded posts were directly hit (KII 8).

Redeployment and community health worker gaps

Some staff were reabsorbed under different funders including Global Fund and government positions, but not at previous scale, leaving community outreach teams thinned out. The closure or scale-down of OSS and KP-friendly sites meant immediate loss of cadres critical for KP outreach, case finding, adherence support, and data entry (KII 1). While formal redeployment was not always mentioned, there were efforts to redirect KP clients from OSS and IP-run centres to government facilities, which implicitly requires shifting workload onto government health workers (KII 1). NACA redirected KP clients from closed OSS and KP sites to government facilities and tried to integrate services under AIDS, TB, and malaria (ATM) programmes.

"Of course they reduced, they stopped work as they were directed and they were not talking to anybody… a lot of the adjunct or additional activities by civil society groups… stopped. So had to pause until they came back." KII 3

However, states had no oversight capacity for many donor-run facility staff; when IPs withdrew, states were "like a fish drawn out of water" and didn't know what to do (KII 4). Some staff moved to other donor-funded projects, such as Global Fund–financed roles, but field outreach teams shrank due to limited funds and reprioritization towards life-saving interventions (KII 8). Where organizations had multiple donors, some staff were moved from USAID projects to other grants. Where funding was concentrated 100% in USAID organizations, they often closed or ran skeletal services (KII 9).

A state-led pilot for last-mile delivery was initiated, with plans to shift warehousing and distribution to state Drug Management Agencies and reduce reliance on donor-funded fourth-party logistics (4PL) and third-party logistics (3PL) arrangements, piloting over the next two supply cycles (KII 6 Mr.). While community health worker (CHW) cadres were not explicitly discussed by all respondents, the loss of IP-funded outreach and civil society organisation (CSO) activities suggests significant community-level gaps.

3.6 Financial Adaptation and Governance Responses

The USAID funding freeze and prospective dismantling of major health financing streams necessitated immediate financial and governance responses from Nigeria. While the Federal Government and development partners mobilized stopgap resources and invoked commitments to self-reliance, these interventions remain largely temporary. The challenge now centres on translating emergency measures into structural reforms that can sustain health programmes beyond 2026 if donor diversification stalls or the freeze persists.

Immediate Fiscal Buffering and Emergency Resource Mobilization

Nigeria's initial response focused on mobilizing domestic resources to prevent immediate service collapse. The Federal Government mobilized ₦7.1 billion in stopgap funding, comprising

₦4.8 billion in contingency allocation and ₦2.3 billion from the Basic Health Care Provision Fund (BHCPF) [3]. Additionally, Nigeria secured $200 million through legislative approval to offset aid cuts in the near term [13]. A ₦4.8 billion domestic allocation combined with a US$1.07 billion Sector-Wide Approach (SWAp) framework was used to stabilize the HIV response [51]. Stop-gap domestic moves included NGN 4.9 billion in reforms, $3.2 million for 150,000 packs, and the $200 million 2025 allocation, all important but time-limited bridges [5].

The Federal Government invoked the Renewed Hope Agenda rhetoric of self-reliance to frame these interventions. However, the patch remains temporary, and without structural domestic budget integration and human resources for health (HRH) retention plans, Nigeria faces cascading commodity and workforce shocks by 2026 if the freeze persists or donor diversification stalls [3]. While Nigeria's near-term mitigation efforts are significant, medium-term fiscal absorption and execution capacity remain weak [13].

Emerging Multi-Donor Architecture and Diversification

Beyond domestic mobilization, the crisis accelerated engagement with alternative development partners. The Global Fund, World Bank, African Development Bank (AfDB), and Economic Community of West African States (ECOWAS) intervened as interim funders, underscoring a nascent multi-donor transition model and signaling a new South-South aid architecture by 2026 [3]. These interventions represent important steps toward diversifying Nigeria's health financing base away from overwhelming dependence on USAID.

Proposed adaptation strategies urge domestic budget increases, public-private partnerships (PPPs) and innovative finance mechanisms, community-led delivery models, and leveraging non-US funders to diversify support [6]. The Nigeria HIV Trust Fund, established in 2022, alongside the Global Fund for AIDS, Tuberculosis and Malaria (GFATM), PPP arrangements, regional pooling, and community-led monitoring, represent near-term levers for sustaining services [46]. However, the transition from US State Department coordination, with limited staffing and absent USAID systems, complicates award modification, financial management, and monitoring (10).

Domestic Resource Mobilisation Strategies

Multiple analyses point to domestic resource mobilization (DRM) and expansion of risk pooling mechanisms as the credible path to post-2026 sustainability [44]. Tax-based financing offers opportunities to expand pooling and risk-sharing, with value-added tax (VAT) and import duties proposed to broaden the revenue base [44]. Additional DRM levers include VAT and excise taxes, mobile solidarity levies, and diaspora bonds to expand health fiscal space [52].

The domestic financing playbook centres on expanding the National Health Insurance Scheme (NHIS) and community-based health insurance (CBHI), enforcing employer co-financing requirements, fixing reimbursement mechanisms, and coordinating donors to backfill paused external funding lines and cap out-of-pocket (OOP) spending through 2026, with concrete governance and measurement frameworks [1]. Studies identify political commitment, governance reform, and domestic resource mobilization, including the ₦50 billion trust fund and the National Domestic Resource Mobilization for Sustainable Development Strategy (NDRMSS) 2021–2025, as critical to transitioning ownership [53].

Structural Reforms and Resilience Strategies

Beyond immediate resource mobilization, longer-term resilience requires structural reforms across multiple dimensions. Import-substitution strategies, regional pooling through the African Continental Free Trade Area (AfCFTA), and strengthened engagement with the President's Malaria Initiative (PMI) represent important resilience lenses for post-2026 planning in Nigeria [4]. However, experiences from other countries suggest caution: aid graduation often shifts composition toward loans, and governments tend to borrow less for health, risking sectoral drift

toward infrastructure. Pakistan's experience illustrates this risk, with health-aid share declining from 6% to 1% and domestic health spending falling from 3.5% to 3% [54].

Programmatic Innovations and Efficiency Gains

Financial sustainability also depends on programmatic innovations that deliver better outcomes with available resources. Resilience innovations such as community pharmacy antiretroviral therapy (ART) models and differentiated models of care (DMoC) improved outcomes and could offset donor exit impacts [53]. Practical models including community ART delivery, differentiated care, and ART surge initiatives can inform USAID exit adaptation and sustainability planning for post-2026 health financing strategies [53].

Governance Challenges and Implementation Gaps

Despite these strategies, significant governance and implementation challenges remain. While the framework for domestic resource mobilization exists, execution capacity is weak. Drawing on prior Nigerian evidence from PEPFAR cutbacks which led to service reductions and user-fee introduction, and stakeholder studies emphasizing domestic resource mobilization, the current crisis underscores the need for stronger governance mechanisms [5]. The review literature provides a strategy playbook and measurement agenda to design post-2026 resilience, focusing on domestic financing, embedded systems, capacity development, and context-specific sustainment indicators [11]. However, translating these frameworks into operational reality requires sustained political commitment and institutional reform that extends beyond emergency rhetoric to structural transformation of health financing architecture.

Insights from Surveys

Loss of donor funds and absence of funding for activities

Implementing partners (IPs) repeatedly stated that activities had "*no funding at all*" or simply: "*No funding*" (IP1). Orphans and vulnerable children (OVC) support and other social support packages were described as "cut short" due to funding loss (IP1).

Temporary stopgap funding

Government respondents described immediate emergency measures to maintain basic operations. One government respondent noted: "*State government temporal funding pending budget approval and the staff resilience*" (G1). Another stated they had "*submitted a budget to the state and leveraging on available funding from other sources*" (G2).

Budget reallocation and domestic financing

Respondents proposed structural solutions to address funding gaps. One government respondent recommended: "*Nigeria should include HIV funding into the state budget and monitor implementation*" (G1). Implementing partners recommended "*budget cashback*" and improved Government Cash Counterpart Contributions (GCCC) (IP1).

The cuts translated into sharp budget gaps at facility and project level, with no funds for activities, staff, or OVC support, prompting ad-hoc stopgaps including temporary state funding and attempts to tap other sources.

Insights from KIIs

Budget reallocations

The funding freeze triggered immediate emergency budget reallocations at federal and state levels to prevent service collapse. The most significant intervention was a USD 200 million emergency health envelope that Nigerian lawmakers "*quickly approved*" to address immediate and intermediate gaps created by the freeze (KII 1). This intervention fund was specifically designated for AIDS, TB, and malaria (ATM) commodities as an emergency measure, with the government securing the funding approximately one to two weeks after the gaps were presented (KII 5, KII 6). The USD 200 million was released and approved for HIV, TB, and malaria commodities as an immediate buffer (KII 4), though it still did not close the funding gap entirely (KII 8).

"There was a government funding, emergency funding that the Nigerian government approved. I think it was $200 million to immediately address the immediate gaps and the intermediate gaps while we work towards a more sustainable framework…" – KII 1

Beyond the emergency envelope, NACA's allocation for drugs doubled from ₦5 billion in 2024 to ₦10 billion in 2025, specifically to enable the government to take more responsibility for commodities (KII 1). This represented an almost 100% increase and reflected a long-term trend of budget growth for NACA commodities, building on President Buhari's 2015 commitment to add 10% of people living with HIV (PLHIV) to those covered by the government (KII 7, KII 5).

"Over the last 3–4 years, we've been working to actually try to mitigate some of the possible results of a policy shift in funding. So when this pause came on, we had already started working on a sustainability plan for the country." – KII 1

Some states also took independent action. States like Yobe and Jigawa procured their own HIV, TB, and malaria commodities as stopgaps (KII 4). However, many planned activities, especially coordination, innovation, and data systems, were de-prioritised to free up resources for antiretroviral (ARV) procurement (KII 4). One government respondent called for budget line readjustment, increased appropriations, and pushing states to cut from their own funds to prevent stock-outs (KII 2).

Domestic resource mobilization

The funding crisis served as a catalyst for accelerating domestic resource mobilization strategies that had been developing for several years. National AIDS Spending Assessment (NASA) findings revealed that over 90% of HIV funding comes from donors, mainly USG and the Global Fund, making the funding freeze a "wake-up call" to build domestic financing and transition funding to government and communities via state-level sustainability plans (KII 5). For three to four years before the freeze, NACA had already been working on a sustainability plan and an "ownership to sustainability" approach at country level, anticipating donor policy shifts (KII 1). Nigeria was positioned as "prepared even before Trump" to take ownership of the HIV response, with ongoing engagement between NACA management, Budget Office, and Accountant-General for releases (KII 7).

"…out of the 1.6 million patients in the country, I think Nigeria was just taking maybe less than 10%. But… in 2015… [Buhari]… promised… Nigeria is going to be adding 10%… So, that budget has been increasing since 2015… Like last year 2024… there was almost 100% increase in terms of commodities allocation, from 5 billion to 10 billion." -KII 7

The National and State Domestic Resource Mobilisation Strategy, established around 2021, was being reviewed to respond to new realities, with focus on efficiency, sustainability, and leveraging existing actors (KII 3). The HIV Trust Fund was being revamped to be more responsive to programme needs and reality, serving as part of a broader sustainability plan (KII 4). Mid-term state

strategies for 2025–2027 specifically focused on domestic resource mobilisation from government, private sector, and philanthropy (KII 4). There was also heightened emphasis on health insurance to integrate HIV into the National Health Insurance Authority (NHIA) and state schemes (KII 3).

"We've had a resource mobilized, domestic resource mobilization strategy since 2021… Government… is thinking of, can we use our system and stop verticalizing services… states too are keying into [health insurance]… there is an increase, a kind of more consciousness to enlist more people to benefit from health insurance." -KII 3

Innovative financing mechanisms were being explored, including faith-based organization (FBO) mapping and creation of a faith-based funding mechanism to channel church and mosque resources to HIV, TB, malaria, and emerging diseases (KII 4 e). At the civil society level, many small non-governmental organizations (NGOs) that never accessed USAID survived through family donations, local philanthropic giving, and small public fundraising, demonstrating that local philanthropy and diversified domestic funding already underpin resilience for a large part of the sector (KII 9).

Coordination with donors and implementing partners

The crisis necessitated strengthened coordination mechanisms across government, donors, and implementing partners. The Coordinating Minister created an ATM technical working group to integrate disease responses as a cost-saving, sustainable approach (KII 1). The Procurement and Supply Management (PSM) technical working group served as the apex coordination platform for supply chain and immediately met after the stop-work order to determine affected services and commodities (KII 6). An inter-ministerial committee involving Health, Finance, Budget and Planning, and other ministries, along with the ATM technical working group, was created to coordinate financial and programmatic responses to the cuts (KII 4).

Coordination meetings continued even when USG implementing partners stayed away, with the government and Global Fund covering coordination costs (KII 1 KII 3). However, the Global Fund also requested "*de-prioritisation*" because the US is its main donor, forcing Nigeria to trim budgets and reinforcing the reality that donor funding trends are shifting away from direct service provision (KII 5). After USAID was merged into the US Department of State on 3 February 2025, some projects like TB LON 1 and 2 resumed under a different US financing arrangement, now focusing mainly on life-saving interventions with a reduced funding envelope (KII 8).

One ATM technical working group mandate was to develop a joint integrated strategic plan for HIV, TB, and malaria from 2026 onward, plus a policy requiring that any implementing partner must have a local partner or be locally registered (KII 4). USAID was positioned as a major funder across governance, human rights, democracy, nutrition, and health, with funding cuts from other multilaterals such as the UK Foreign, Commonwealth and Development Office (FCDO) making the US role even more prominent in the landscape (KII 9).

Policy shifts

The funding crisis accelerated several policy shifts that had been under consideration but gained urgency and political support. All respondents strongly reinforced a shift away from vertical programmes toward integration. Integrated services through government facilities were framed as the "most cost-effective and efficient way" for long-term provision (KII 1). The policy direction emphasized bringing AIDS, TB, and malaria together, integrating HIV into insurance, and promoting local production of commodities, all strengthened by the crisis (KII 3).

An integrated ATM strategic plan for post-2026 was being developed, with a push requiring all implementing partners to have a local partner or be locally registered, alongside a joint ATM plan from 2026 onward and aggressive expansion of health insurance for PLHIV, TB, and malaria

(KII 4). The ATM technical working group was set up to design a "new health system not exposed to external shocks," including an integrated ATM strategic plan, expansion of health insurance, and roles for states to budget for 5,000–10,000 PLHIV on insurance per state from 2026 (KII 4).

The crisis triggered enforcement of existing supply chain policy stipulating that the government should lead warehousing and distribution, reducing dependence on donor-funded fourth-party logistics (4PL) and third-party logistics (3PL) arrangements such as Cabonic (KII 6). Pilots were underway to shift from donor-funded 4PL/3PL to state Drug Management Agencies for last-mile delivery (KII 6). The crisis also triggered re-negotiation of public-private partnership (PPP) contracts so the government has end-to-end visibility and control over warehouse access (KII 6).

At the organizational level, civil society organizations were exploring governance and financial model shifts. Some NGOs were considering movement from incorporated trustees to limited by guarantee structures, others were launching apps or consulting arms to generate revenue, and many were rethinking fundraising models to be less grant-dependent (KII 9). However, from the finance perspective, no new finance policy changes had been observed yet, with expectations that true effects and perhaps further shifts would appear "*in the next two years*" not immediately (KII 7).

Stakeholder Discourses and Perceptions

Pre-Freeze Context: Vulnerabilities and Governance Challenges

Before the funding freeze, stakeholder discourses revealed deep structural vulnerabilities in Nigeria's health financing architecture and governance systems. Catastrophic out-of-pocket (OOP) payments dominated health care financing discussions in Nigeria, with awareness gaps and fairness concerns [1].

Governance weaknesses were evident, with donor-driven coordination undermining NACA's leadership and limiting country ownership and long-term planning [53]. The vertical governance structure, with multi-agency U.S. coordination, created fragmentation and weakened national ownership [55]. This systemic dependency on heavy donor reliance risked sustainability and health-system resilience [55]. Weak integration of services was also apparent, as PEPFAR funding neglected family planning and primary prevention, focusing narrowly on treatment and psychosocial support. Donor-led vertical programs hindered capacity building and national ownership, risking long-term system fragility [55].

Equity concerns were already prominent, particularly regarding key populations. Government reluctance to fund one-stop shops, outdated KP estimates that hindered targeting, and the substantial KP burden created equity risks that stakeholders frequently highlighted [49]. The limited progress toward universal health coverage [UHC] suggested that without stronger domestic financing coordination, Nigeria's mixed financing model risked reversing health gains when foreign aid declined [56]. The fragility narrative and reliance on long-term donor investment dominated stakeholder perspectives [10], with donor vulnerability indicators showing heavy reliance on external technical and funding inputs mirroring the fragility that would worsen under USAID withdrawal [56].

Despite these challenges, there were some positive elements in the pre-freeze discourse. Political support was evident through the Abuja Declaration, Renewed Hope Agenda, and presidential directives [53]. Emerging themes of self-reliance such as African Continental Free Trade Area (AfCFTA) engagement, and import-substitution strategies were also present [4]. However, the evidence gap was substantial: outcomes were rarely measured (only 6 of 89 studies,

approximately 7%), highlighting the need for countries to embed monitoring in transition plans (50).

Post-Freeze Impact: Service Disruptions and Heightened Vulnerabilities

Following the January 2025 U.S. pause on PEPFAR funding, stakeholders shifted focus dramatically to immediate risks and systemic vulnerabilities exposed by the crisis. A recent study showed that the freeze risked antiretroviral therapy (ART) interruptions, stock-outs, rising drug resistance, and equity setbacks, including a modelled 60% increase in mother-to-child transmission (MTCT) risk if ART was disrupted [46]. There have been renewed conversations on Sustainable Development Goal (SDG) principles of "leave no one behind" and highlighting difficult trade-offs between competing priorities [54].

The global ARV market instability and pre-exposure prophylaxis (PrEP) procurement gaps also threaten to undermine post-2026 HIV response sustainability unless domestic financing and supply-chain independence increased immediately [53]. Logistics dependence on Chemonics and other PEPFAR partners threaten last-mile delivery and data systems [53].

Governance risks gained renewed attention in stakeholder discussions. Documented $3.8 million in PEPFAR funds fraud in Nigeria in 2018 underscored the need for tighter public financial management (PFM) and accountability mechanisms as funding domesticizes [13]. Public trust became a critical concern, with NACA managing risk through communications countering rumors of paid ART services [53]. The importance of early, transparent planning and communication, alongside domestic ownership, became central themes [50].

Transition Readiness and Domestic Ownership

In response to the crisis, stakeholders emphasized transition, compact readiness and institutional reforms. The National AIDS Spending Assessment (NASA) demonstrated Nigeria's financing fragility before the crisis, reinforcing arguments that the compact must now institutionalize domestic ownership [8]. The Renewed Hope Agenda rhetoric of self-reliance was invoked to frame the government's response [3], though stakeholders remained cautious about the gap between rhetoric and implementation.

Stakeholder narratives increasingly focused on concrete strategies for resilience and sustainability. Self-reliance, AfCFTA engagement, and import-substitution narratives gained prominence as pathways forward [4]. The importance of early, transparent planning and communication, combined with genuine domestic ownership, became central to stakeholder advocacy [50]. There was recognition that policies existed but implementation lagged, with particular emphasis on BHCPF engagement gaps and the urgent need for transition readiness [48].

The crisis served as a catalyst for stakeholders to demand more robust governance frameworks, accelerated pooling mechanisms, and genuine integration of vertical programs into comprehensive health systems. While acknowledging the severity of immediate impacts, stakeholders increasingly emphasized that the funding freeze represented both a crisis and an opportunity, a chance to build the self-reliant, domestically financed, and sustainably governed health system that had been discussed but not fully realized in the pre-freeze era.

Insights from Surveys

Emotional responses and hope

Survey responses revealed significant emotional strain and psychological impact on implementing partners and health workers. One IP expressed cautious optimism despite the challenges: "*We still hope it gets better*" (IP1). Respondents discussed serious illness, death, financial strain, and burnout, implicitly expressing stress, concern, and compassion for both affected staff and

patients. The emotional toll extended beyond programmatic concerns to encompass the human cost of service disruptions and workforce instability.

Everyday stories and lived realities

The Broader Context question elicited short but powerful anecdotes that illustrated the human impact of the funding cuts. One particularly poignant example described sick children being taken home due to lack of care: *"The sick children were being taken home by their parents leading to serious illness or death"* (IP1). Other respondents noted the disconnect between preparedness and resource availability, describing facilities that were ready for new interventions such as pre-exposure prophylaxis (PrEP) but lacked the necessary commodities and partner services to implement them effectively.

Insights from KIIs

Stakeholder perceptions diverged sharply along institutional lines. Government narratives emphasized preparedness and downplayed immediate disruption, while civil society organizations documented devastating immediate impacts. Community-level concerns centered on fear, confusion, and concrete service gaps, revealing a disconnect between official reassurances and lived realities on the ground.

Government narratives

Government stakeholders presented a complex narrative balancing preparedness messaging with acknowledgment of significant challenges. Finance and NACA voices emphasised that Nigeria had been preparing since 2015 to take over the HIV response, increasing budgets and integrating HIV into health insurance (KII 7, KII 1, KII 3). The *"prepared but under pressure"* storyline was prominent, with one respondent framing the response as proactive, stressing that NACA had anticipated a US policy shift and was already developing sustainability and integration plans (KII 1). From the finance perspective, there was emphasis on preparedness and ownership: Nigeria had long planned to *"take ownership of the HIV response"* increasing budget since 2015, leading to the assertion that *"we are ever ready to take ownership of the response"* (KII 7).

"Nigeria has been prepared even before Trump to take ownership of the HIV response… So far, so good, we are ever ready to take ownership of the response… the pullout, the effect will not be just immediate… maybe in the next two years we start to be seeing those effects. But for now, there wasn't any disruption, there wasn't any changes."-KII7

A *"frame of no decline... yet"* characterized many government responses. Some officials stated *"for now, there wasn't any disruption"* on commodities, with real impacts expected to show after approximately two years (KII 7). Both government respondents repeatedly said they had not seen evidence of service decline yet, emphasizing mitigation efforts and the need for proper assessment later (KII 1, KII 3). One respondent articulated a *"no vacuum"* but serious stress position, acknowledging the scale of the challenge in a 200+ million population but insisting the government was working to cushion the effect and avoid commodity gaps (KII 2).

"…an organization that is funded 100% by USAID will be affected, they may have closed and some may be doing skeletal services… However, those who may have multiple donors… still have some projects running… However… we have more small non-profits doing their own thing, raising resources from family and the public… without depending on foreign funding…"-KII9

However, government narratives also acknowledged vulnerabilities. The funding freeze was interpreted as a *"wake-up call"* and signal that donors are not forever. Officials noted that donors

are there to fill gaps temporarily and build capacity; they are "*not supposed to be here forever*", with the funding freeze serving as a strong signal to prepare for eventual donor exit (KII 6, KII 5). One government official called the cut a "shock" that exposed data, supply chain, and human resources systems as highly donor dependent, risking near collapse without immediate domestic interventions (KII 4).

Civil society organisation perspectives

Civil society organizations provided a critical counter-narrative that starkly contrasted with some government messaging. CSOs observed severe immediate shock and unequal resilience across the sector. They documented closures, deep cutbacks to 40–45% capacity, mass layoffs, and burnout (KII 9). Multiple international non-governmental organizations (INGOs) and NGOs closed or slashed operations to 40–45% of previous capacity. Many founders and executive directors experienced burnout, mental health challenges, and financial distress (KII 9).

Organizations with 100% USAID dependence were the most devastated, while those with multiple donors, domestic philanthropy, or earned income survived better (KII 9). This unequal vulnerability meant that organisations 100% USAID-funded were devastated, while those with diversified funding streams could reallocate staff and keep some services running (KII 9). Civil society and faith-based adjunct services were described as particularly hard-hit, especially outreach and key population (KP) and community-facing work (KII 3).

Civil society networks also played important documentation roles. NEPHWAN, the network of people living with HIV (PLHIV), conducted a rapid survey to quantify service disruption and staff stop-work impact (KII 5). Faith-based organisations (FBOs) were highlighted as under-utilized actors with substantial resources. NACA mapped FBO health and non-health infrastructure in all 36 states plus Federal Capital Territory (FCT) and was designing a faith-based funding mechanism (KII 4).

Beneficiary and community concerns

At the community level, the funding freeze triggered immediate panic, confusion, and tangible harm. There was panic, lack of information, hoarding behaviour, and in some facilities antiretrovirals (ARVs) were reportedly sold when supplies felt insecure (KII 4). Panic among recipients of care was notable, with negative rumours that drugs would no longer be bought leading patients to seek extra refills and engage in hoarding behaviour (KII 6).

Key population community anxiety was particularly acute. Government respondents described engaging the patient community to reassure them, build capacity, and encourage access via general facilities when one-stop shops (OSS) closed, implicitly acknowledging fear, stigma, and uncertainty among KPs (KII 1). People in humanitarian settings lost access as INGOs shut down, with risk of hospitals and schools closing (KII 9). The emotional and physical impact at community level was severe, with no outreach, no information, and deaths reported in Oyo State leading to children being orphaned (KII 4).

Specific service gaps created tangible health consequences. Patients were missing essential drugs, with closed hospitals and schools in some areas expected to shut down by December because of funding loss. Services for ordinary citizens were "*shutting down*", particularly in humanitarian zones (KII 9). Service gaps in tuberculosis (TB) outreach and community case finding implied delayed diagnosis and continued transmission when outreach was halted or reduced (KII 8).

Adaptation and Resilience Strategies

Short-term strategies and immediate responses

Nigeria's immediate adaptation focused on emergency resource mobilization and service stabilization. The near-term mitigation included $200 million approved by lawmakers to offset aid cuts, though medium-term fiscal absorption and execution capacity remain weak [13]. The Global Fund, World Bank, African Development Bank (AfDB), and Economic Community of West African States (ECOWAS) intervened, underscoring a nascent multi-donor transition model that provides near-term cushioning if paired with public financial management (PFM) reforms to improve execution and credibility [3,12]. The UNAIDS Sustainability Roadmap positions Nigeria's "new business model" for government-led resourcing, while Global Fund stockpiles and World Bank co-financing offer near-term cushioning [12].

The analysis showed a recognition of the need for rapid transitions of lifesaving services, explicit financing for prevention, and multi-partner backstops if systems are to remain stable into 2026 [4]. Community-led delivery models and community-led monitoring emerged as critical short-term levers to maintain service access during the transition [6]. Practical innovations such as community pharmacy antiretroviral therapy (ART) models and differentiated models of care (DMoC) improved outcomes in previous donor transitions and could offset donor exit impacts in the immediate term [53].

Long-term structural reforms and sustainability mechanisms

For post-2026 sustainability, comprehensive structural reforms across financing, service delivery, and governance were recommended. Domestic resource mobilization (DRM) strategies like value-added tax (VAT) and excises, mobile solidarity levies, and diaspora bonds have been highlighted to expand health fiscal space [52]. It also encompassed domestic budget increases, public-private partnerships (PPPs) and innovative finance mechanisms, efficiency gains, community-led delivery, and leveraging non-US funders to diversify support [6]. The authors specifically propose domestic budget increases, PPPs, regional pooling, Global Fund engagement, the Nigeria HIV Trust Fund (2022), and community-led monitoring as mitigation levers [4].

Concrete implementation levers such as burden-based budgeting, social health insurance (SHI) integration, primary health care (PHC) task-shifting, private-sector HIV Trust Fund with transparent governance, procurement and supply management (PSM) integration, and aligned donor purchasing have also been recommended [48]. This also includes frameworks such as domestic resource mobilization, import-substitution, and regional pooling through the African Continental Free Trade Area (AfCFTA) as resilience strategies useful for post-2026 planning, while also addressing workforce exposure and PFM/corruption risks [4].

Service delivery innovations provide scalable models for sustainability. Evidence shows that institutionalization can work: the Nigeria Expanded Programme on Immunization Coverage and Quality (NERICC) in 18 states and the Nigeria Expanded MCH Immunization Coverage (NEMCHIC) demonstrate scalable routines for routine immunization (RI) and maternal and child health (MCH), with HIV integration into the National Health Insurance Scheme (NHIS) under discussion [48]. Other Practical models include community ART delivery, differentiated care, and ART surge can inform USAID exit adaptation and sustainability planning for post-2026 health financing strategies [53].

Institutional frameworks and coordination mechanisms

Long-term resilience requires institutional frameworks that embed sustainability principles. The PEPFAR–Global Fund–UNAIDS "Resource Alignment" initiative represents a sustainability mechanism that Nigeria can leverage for post-2026 coordinated financing and local ownership of HIV services [7]. The health ecosystem is transitioning from a donor-driven to a shared-ownership model, but legal, human resources for health (HRH), and financing bottlenecks threaten sustainability post-2026 unless the proposed Transition Compact institutionalizes domestic accountability [14]. Without structural domestic budget integration and HRH retention plans, Nigeria faces cascading commodity and workforce shocks by 2026 if the freeze persists or donor diversification stalls [3].

Insights from Surveys

Adaptation was described as mostly defensive. It involves shrinking coverage, narrowing focus, and using temporary state funds or collaborations with partners. There is recognition of the need for community ownership and domestic funding, but these efforts are still at early stages.

Short-term Adaptations
Government respondents describe reliance on temporary state funding while waiting for budget approval and note staff resilience. They also mentioned submitting budgets to the state and drawing on available funds from other sources. IPs report that after the funding cut they adjusted their reach, limited some services, and relied on collaborations and partnerships with facilities.

Community ownership and sustainability language
Several IPs stress community ownership and sustainability. They call for community empowerment and communal farming as mitigation strategies.

Reduced but maintained core services
Some respondents explain that they have continued essential services but at a reduced scale. Activities are limited and targeted to specific populations.

Insights from KIIs

Short-term stopgaps (2025–2026)

Government actors used existing government channels to distribute commodities stuck in USG-managed warehouses. Emergency federal funding of about USD 200 million was approved to cover immediate and intermediate gaps (KII 1). Rapid quantification exercises were conducted to identify commodity gaps and prevent stock-outs across FP, HIV, TB and leprosy, newborn, and micronutrient supplies (KII 1).

"…if it's established that the states can do their last mile delivery… then the need to have the donor-funded fourth-party logistics… will be cut off… the government must be at the driver's seat…" - KII 6

A USD 200 million intervention fund for ATM commodities was also set aside. A government waiver allowed continuation of critical life-saving interventions, although some prevention

commodities were excluded, indicating a change in donor funding priorities (KII 6). States like Yobe and Jigawa procured their own commodities as stopgap measures (KII 4).

At organizational level, KNCV used other active projects such as Global Fund grants, international KNCV funding, and organizational savings to keep some operations functioning while USAID-funded TB LON work was halted (KII 8). Other organizations relied on reserves, rationed resources, cut or reassigned staff, and ran skeletal services while waiting for future funding (KII 9).

"The government is also looking at local production of commodities, including medications… when we start producing, it provides opportunities for jobs… It also will strengthen our system." – KII 3

b. Long-term sustainability plans

A multi-disease sustainability framework is being developed under the ATM TWG, with state-level plans to integrate HIV, TB, and malaria funding into regular government budgets (KII 1). The Domestic Resource Mobilization Strategy (2021–2024, under review) emphasizes efficiency, leveraging existing resources, and expanding the HIV Trust Fund and private sector engagement (KII 3). Expanding national and state health insurance is seen as a path to absorb HIV and other conditions and reduce out-of-pocket costs.

The Ownership to Sustainability Plan for HIV provides states with a structure to create state-specific sustainability plans and shift management and financing from donors to government and communities (KII 5). NACA is rolling out this plan in phases, starting with seven states and then expanding nationally, using co-creation workshops to map service delivery costs, absorption of IP staff, and prioritization of essential services (KII 4). Supply chain reform is being tested through a pilot of state-led warehousing and last-mile delivery, with the goal of reducing reliance on donor-funded 4PL and 3PL logistics if states perform well (KII 6).

"These measures… are long-term measures, because if we're integrating service provision… that is a long-term measure… everything we are doing now under the ATM umbrella… is for a long-term sustainability of the response." – KII 1

Civil society organizations are diversifying by rethinking funding models, developing apps and consulting services, and adopting legal forms such as companies limited by guarantee to support revenue generation (KII 9). System-level shifts include increasing NACA's commodity budget and the emergency USD 200 million national allocations, which are presented as steps towards greater domestic responsibility for HIV and broader health financing (KII 7, KII 8).

c. Post-2026 donor transition preparedness

Respondents stress that changes underway are long-term. The ATM TWG is mandated to create a multi-disease sustainability framework and work with states to build ownership beyond 2026 (KII 1). USAID's contraction is pushing the government and states to lead, including pursuing local production of HIV and other commodities with system-strengthening and employment benefits (KII 3).

At system level, the ATM TWG and sustainability plans aim to integrate HIV, TB, and malaria, reduce duplication, and embed services within primary health care and insurance schemes. The Federal Government and several states are expanding health insurance enrolment and budgeting to cover 5,000–10,000 PLHIV per state in NHIA and state schemes from 2026 onward (KII 4).

"…integrated strategy plan… Across the 36 plus one states, most… have made budgetary

*allocation for about **5 to 10,000** People Living with HIVs… to be on the health insurance beginning for 2026." - KII6*

At organizational and CSO levels, NGOs with diversified funding such as Global Fund, other bilateral, and philanthropy are reallocating staff, using reserves, and rationalizing services. Some are changing legal status, and adding digital tools, consulting services, and fee-for-service models to generate revenue (KII 4) . DRPC's NSI, funded by the Gates Foundation, is providing localization grants to NGOs affected by the cuts (KII 4).

"…the organization is not just implementing the USAID project. It has a couple of other projects… Global Fund is one of them… funding was also coming in from all those… And let's not forget, some organizations have their own way of… saving for the rainy day… somehow they were able to go back to the purse to still keep operations moving." -KII 4

It would take a two-year lag before the full financial impact is visible, making medium-term planning for 2026–2027 crucial (KII 7). This also calls for a whole-of-sector approach and enabling regulations that support diversification and encourage greater involvement from local donors and philanthropy (KII 9)

Emerging and New Aid Actors

The funding crisis has resulted in a shift in Nigeria's development partner landscape, with new actors stepping in to fill gaps left by USAID reductions. The Global Fund, World Bank, African Development Bank (AfDB), and Economic Community of West African States (ECOWAS) are now acting as interim funders, signalling a new South-South aid architecture by 2026 [3]. The Global Fund has emerged with particular prominence, with stockpiles and World Bank co-financing offering near-term cushioning [12], alongside new bilateral partnerships that diversify the donor base [7]. The emergence of Global Fund dominance, alongside continued engagement from the UK Department for International Development (DFID)/UKAID and donor coordination mechanisms such as the "*ops-room concept*" reflects the evolving partnership landscape [10].

Beyond traditional multilaterals, Nigeria is leveraging non-US funders and exploring innovative domestic and regional financing sources [6]. Emerging actors now include the Nigeria Business Coalition Against AIDS (NiBUCAA) and private philanthropy [53], while the HIV Trust Fund, Zakat-based financing, and expanded private sector engagement represent important domestic mobilization channels [47]. The need for pooled baskets and comprehensive donor-mix mapping and coordination has become critical as multiple donors engage simultaneously in what are often parallel transitions [48, 13]. This emerging multi-partner ecosystem-spanning the Global Fund, ECOWAS, South-South partnerships, and domestic actors-offers both opportunities for diversification and challenges for coordination as Nigeria navigates the post-USAID landscape [55].

Insights from KIIs

Global Fund and traditional multilaterals

The Global Fund remains central to Nigeria's health financing, especially for tuberculosis (TB) and parts of the HIV response, but is also under fiscal pressure (KII 5). The TB programme in Nigeria is 70–80% funded by the Global Fund, so USAID cuts hit outreach and innovation, but "*the impact wasn't really felt as much*" on core TB commodity funding (KII 8). However, respondents noted a "*domino effect*" on other donors, especially the Global Fund, because the US government contributes "*about 30 or more percent*" to the Global Fund, prompting de-prioritization and budget trimming (KII 1). The Global Fund is already de-prioritising and asking Nigeria to trim

budgets because of US cuts (KII 5). While Gavi, the European Union (EU), and Agence Française de Développement (AFD) were not explicitly named in most interviews, there was repeated reference to "*other partners*" and "other funding sources" (KII 1, KII 3).

"…by and large, the TB program in Nigeria is largely funded by the Global Fund. So even though Nigeria did not have so much of heat from the USAID project… programs like the HIV programs… were hugely affected. But the TB program somehow is largely funded by the Global Fund." -KII 8

Philanthropy and private sector engagement

Philanthropy and the private sector are becoming more prominent through mechanisms such as the HIV Trust Fund and innovative financing initiatives. Private sector engagement and the HIV Trust Fund redesign aim to generate domestic private resources for HIV and related services, with the fund now being "*revamped to generate resources*" (KII 3). Philanthropists are stepping in to bridge gaps, with the "*big four*" foundations (such as Gates) revising strategies and potentially expanding programme support in Africa (KII 9). Domestic philanthropy already sustains many grassroots NGOs that were never USAID-funded (KII 9). The Development Research and Projects Centre (DRPC)–Gates Nigeria Sustainability Initiative (NSI) represents a new mechanism linking philanthropy and local leadership, channelling support to local NGOs affected by the cuts as a localization model (KII 9). There was also strong emphasis on faith-based financing as an emerging domestic resource stream (KII 4).

South-South partnerships and new geopolitical actors

While South-South partnerships were not extensively discussed in all interviews, some respondents identified emerging opportunities in this space. China is "really leading multilateral conversations," providing leadership and discussing rule of law and global reforms, and may start supporting civil society directly in coming years (KII 9). Saudi government support in health was mentioned as a possible future engagement area (KII 4). However, concrete health-sector commitments from these actors remain limited so far.

"…an important initiative being done by DRPC… with funding from Gates Foundation… to support nonprofits that may have been affected by the cuts… We've also seen philanthropists… And… don't be surprised that… you might find China providing support to civil society… now that China is also talking about rule of law and the need for reforms within the global architecture."-KII 9

Uncertainty and domestic primacy

A dominant theme was the uncertainty about which external actors will fill the USAID gap. One respondent explicitly stated "it is not clear yet" who will emerge to replace USAID, noting that the only actor they are strongly looking to is the Nigerian government, with a recommendation that the government target 60–70% domestic allocation and releases for HIV (KII 4). No single donor is poised to replace USAID's footprint. Instead, the landscape is evolving into a patchwork of actors, with the Global Fund remaining central but under pressure, philanthropy and private sector engagement growing through new mechanisms, and potential future roles for non-traditional actors including China and Gulf states, although concrete commitments remain limited (KII 5, KII 9).

For Nigeria, this implies a future in which no single external actor provides the security blanket once offered by USAID. Instead, the country will need to blend smaller, more fragmented external flows with expanding domestic resources to maintain gains in HIV, TB, malaria, family planning (FP), and maternal and child health (MCH).

5 - POLICY IMPLICATIONS AND RECOMMENDATIONS

Immediate Actions

Adopt a Transition Compact with multi-stakeholder governance

Establish a formal Transition Compact involving the Global Fund, World Bank, US Centers for Disease Control and Prevention (CDC)/State Department, Federal Ministry of Health (FMoH), and National Agency for the Control of AIDS (NACA), defining clear roles, financing commitments, and accountability mechanisms. Convert emergency measures into a codified AIDS, TB, and Malaria (ATM) Sustainability Framework with legal backing, domestic resource mobilization targets, and dedicated budget lines for coordination, data systems, and community platforms. Include quarterly review mechanisms and escalation procedures to address implementation bottlenecks rapidly before they translate into service failures or commodity stockouts.

Develop a comprehensive human resources transition plan

Create a national human resources transition plan for donor-funded health workers, including absorption pathways into state and federal schemes, task-shifting arrangements, and retention incentives for high-burden local government areas (LGAs). Prioritize community-based cadres-peer educators, outreach teams, and key population (KP) navigators-who are most vulnerable yet essential for community-level access. Include bridge funding for salaries during transition (12–18 months), clear absorption criteria based on programme criticality and geographic need, and special provisions for civil society organization (CSO) staff employment pathways.

Secure uninterrupted commodity financing for essential health products

Guarantee financing for antiretrovirals (ARVs), pre-exposure prophylaxis (PrEP), and long-lasting insecticidal nets (LLINs) through multi-source mechanisms that prevent single-point failures. Front-load the approved USD 200 million intervention fund, accelerate Global Fund and World Bank disbursements, and establish quarterly release schedules. Develop a commodity security dashboard with real-time monitoring and trigger mechanisms that initiate emergency procurement when stock levels fall below three months' supply.

Protect frontline workforce funding through ring-fenced allocations

Ring-fence and domestically fund a minimum community outreach package for HIV, TB, and family planning (FP), including key population and humanitarian services. Finance through dedicated state budget lines supplemented by the HIV Trust Fund and faith-based organization (FBO)/corporate social responsibility (CSR) co-financing. Cost the minimum package using actual service delivery data, including stipends, transportation, test kits, and peer-led organization grants, with quarterly performance reviews linking financial releases to coverage and outcome indicators.

Medium-Term Reforms

Ring-fence HIV and malaria budgets with guaranteed quarterly releases

The Nigerian Government should establish legally protected budget lines at federal and state levels through appropriation legislation amendments, with mandatory quarterly releases to prevent execution delays. Link releases to performance indicators measuring coverage, commodity availability, and workforce retention. Create an independent budget tracking mechanism involving civil society and National Assembly health committees, publishing quarterly scorecards by state and programme area to identify bottlenecks.

Adopt a medium-term HIV/ATM financing compact with domestic share targets

Formalize a 2026–2030 compact with explicit domestic financing targets (60–70% by 2030) and annual National Assembly reporting. Include provisions for efficiency gains, waste reduction, and public financial management reforms to improve budget execution from 47–76% to minimum 85%. Identify specific revenue sources-budget allocations, National Health Insurance Authority (NHIA) contributions, HIV Trust Fund, solidarity levies-with realistic targets based on fiscal space analysis.

Institutionalize donor coordination through a Joint Health Financing Platform

Establish a permanent platform bringing together government ministries, development partners, the Global Fund, philanthropic actors, and private sector under formalized governance structures. Implement "one plan, one budget, one monitoring and evaluation (M&E) framework" principles, managing a unified financing dashboard tracking all flows with real-time visibility. Include CSO and community representatives in governance, meeting quarterly for operational coordination and annually for strategic planning.

Long-Term Structural Transformation

Promote local manufacturing of essential health commodities

Invest in domestic and regional manufacturing capacity for ARVs, long-lasting insecticidal nets, and diagnostics through public-private partnerships, technology transfer agreements, and African Continental Free Trade Area (AfCFTA) regulatory harmonization. Provide targeted incentives including tax holidays, subsidized credit, guaranteed purchase agreements, and regulatory capacity support. Partner with regional bodies to establish quality assurance frameworks and coordinate investments, initially focusing on high-volume products like first-line ARVs.

Increase national health budget allocation and embed HIV/AIDS financing

Work toward the Abuja Declaration 15% target through binding annual increments (e.g., 1% increases per year) with explicit HIV/AIDS, TB, and malaria sub-allocations. Gradually integrate HIV financing into core health budgets, beginning with shared costs while maintaining dedicated financing for HIV-specific commodities. Develop a health financing strategy identifying revenue enhancement measures-improved tax collection, earmarked health taxes on tobacco and alcohol, mobile money levies-with realistic projections.

Build regional resilience through Economic Community of West African States (ECOWAS) pooled procurement

Lead establishment of an ECOWAS Pharmaceutical Procurement Service achieving economies of scale, enhanced negotiating power, and diversified supply chains. Begin with high-value standardized commodities (ARVs, antimalarials, vaccines) where aggregated demand creates leverage. Include emergency procurement provisions with pre-positioned stocks and rapid deployment protocols enabling member states to access supplies within 48–72 hours.

Foster South-South collaboration and African-led funding mechanisms

Strengthen partnerships with emerging South-South donors and African-led institutions, including the African Development Bank, regional development banks, diaspora bonds, and solidarity levies. Position Nigeria as a leader in African-owned health financing models demonstrating sustainability through domestic resources and regional cooperation. Engage strategically with China, Gulf states, and middle-income countries, negotiating partnerships respecting national ownership. Create knowledge-sharing platforms for African countries to exchange experiences on health financing transitions.

12. Institutionalize community-led monitoring and accountability frameworks

Embed community-led monitoring into all HIV, TB, and malaria programmes with formal roles for people living with HIV networks, CSOs, and community health committees in oversight, budget tracking, and service quality assessment. Link to national M&E frameworks through standardized tools and regular reporting. Train community monitors in budget literacy and data collection with stipends for participation. Publish findings in accessible formats (scorecards, dashboards) presented in public forums where programme managers must respond. Extend monitoring beyond service quality to budget tracking and equity assessments for marginalized populations.

6 - CONCLUSION

Nigeria stands at a critical juncture in its health financing journey. The January 2025 USAID funding freeze has exposed deep structural vulnerabilities, including over 90 percent out-of-pocket health expenditure, 85 to 90 percent donor dependency for HIV programmes, and fragmented procurement systems. These weaknesses threaten decades of progress in HIV, tuberculosis, malaria, and maternal and child health. The immediate impacts have been severe: 2.3 million treatment patients affected, more than 1,200 frontline workers laid off, 5.6 million children losing nutrition support, and civil society organizations operating at only 40 to 45 percent capacity. Yet the crisis also presents an opportunity to build a self-reliant and sustainably financed health system that Nigeria has long envisioned.

The government's early response shows political will by mobilizing ₦7.1 billion in stopgap funding, doubling NACA's drug budget to ₦10 billion, and securing 200 million dollars in emergency appropriations. The Global Fund, World Bank, African Development Bank, and ECOWAS have stepped in as interim funders, signaling the emergence of a new multi-donor architecture. Policy shifts toward integrated service delivery, government-led supply chain management, and mandatory local partnerships indicate growing commitment to national ownership. New domestic financing mechanisms, such as revitalization of the HIV Trust Fund, resource mobilization through faith-based organizations, and expanded health insurance, offer promising pathways.

Emergency measures alone cannot ensure sustainability. Medium-term fiscal absorption remains weak, with budget execution rates between 47 and 76 percent. Without structural reforms such as legally protected budget lines with guaranteed quarterly releases, comprehensive human resources transition plans, and institutionalized donor coordination platforms, Nigeria risks commodity and workforce shocks by 2026. Achieving resilience requires binding commitments to increase health budget allocations toward the Abuja Declaration target of 15 percent, rapid expansion of the National Health Insurance Scheme beyond its current 40 percent coverage, investment in local manufacturing for essential commodities, and community-led monitoring that strengthens accountability and equity.

The transition from donor dependency to domestic ownership will be difficult and will require political commitment that endures beyond electoral cycles, transparent financial management that rebuilds trust after documented fraud, and genuine partnership with civil society organizations and communities. Nigeria must blend shrinking and fragmented external flows with growing domestic resources while maintaining service continuity for 1.8 million people living with HIV, protecting maternal and child health, and preventing malaria in vulnerable groups. Success depends on moving from parallel emergency responses to a unified national health financing compact with clear targets, accountability mechanisms, and embedded community participation. The health and lives of millions depend on whether Nigeria can make the difficult decisions that genuine transformation requires.

> *Most of the community outreaches came to a halt… complete blackout across the 36 plus 1 states… there was a significant spike in the rate of new infections… we also got numbers like from Oyo state… some mortalities… children… orphaned.*

KII4

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8 - ANNEXES

ANNEX 1 Thematic Coding Framework

This thematic coding framework guided the qualitative analysis of Key Informant Interviews (KIIs) and survey responses. It was developed through a combined deductive–inductive approach:

- **Deductive nodes** were drawn from the research objectives, literature review, and USAID/PEPFAR transition discourse;
- **Inductive sub-themes** emerged directly from patterns observed during coding.

The framework enabled systematic comparison across respondent groups (government, IPs, CSOs) and across programme areas (HIV, TB, SRHR, OVC, health systems) to understand the operational, financial, and governance implications of the USAID funding suspension.

1. Programmatic Disruptions & Health Outcomes

1.1 Service disruptions
Changes in service continuity across HIV, TB, malaria, SRHR, KP and OVC services; reduction in outreach; facility closures; scale-back of community programmes.

1.2 Coverage declines
Reductions in ART enrolment, PrEP initiation, VMMC, HTC volumes, ANC/PMTCT access, LLIN distribution, and other essential health services.

1.3 Epidemic risks
Increased HIV transmission, MTCT risk, malaria resurgence risk, treatment interruption, loss to follow-up, and emergence of drug resistance.

1.4 Commodity shortages
Stock-outs or stock-risk for ARVs, PrEP, HIV test kits, LLINs, ACTs, lab reagents, and logistics bottlenecks.

2. Workforce Impact

2.1 Layoffs and contract terminations
Loss of donor-funded staff, community health workers, case managers, and outreach personnel.

2.2 Redeployment
Movement of staff to other programmes or non-health sectors due to funding termination.

2.3 HR shortages
Vacancies, reduced coverage, weakened facility functionality, and burnout due to increased workload on remaining staff.

2.4 Community health worker (CHW) gaps
Loss of KP outreach agents, adherence counsellors, OVC caseworkers, and volunteers.

3. Financial Adaptation & Governance Response

3.1 Budget reallocations
Federal/state emergency funds, internal reprogramming, use of contingency budgets.

3.2 Domestic resource mobilisation
Increased reliance on national programmes, HIV Trust Fund contributions, state procurement of commodities, faith-based financing.

3.3 Coordination with donors/IPs
Global Fund, WHO, WB, AfDB, ECOWAS involvement; interim funding mechanisms; TWG coordination.

3.4 Policy shifts & reforms
Movement toward integrated ATM services, warehousing reform, PHC expansion, medium-term financing frameworks.

4. Stakeholder Discourses & Perceptions

4.1 Government narratives
Framing of the freeze as a call for sustainability; emphasis on sovereignty, domestic financing, and transition readiness.

4.2 CSO perspectives
Concerns about shrinking civic space, reduced KP access, accountability gaps.

4.3 Community/beneficiary concerns
Fear of ART interruption, rising mortality risk, inability to afford services, distrust in health system continuity.

4.4 Implementing partner (IP) perspectives
Operational uncertainty, shrinking programme scope, organisational restructuring, and risk to long-term programme performance.

5. Adaptation & Resilience Strategies (2025–2026 + Post-2026)

5.1 Short-term stopgaps
Emergency funding, rationing services, prioritising critical patient categories, pausing non-essential activities.

5.2 Long-term sustainability plans
HIV integration into insurance schemes, domestic manufacturing, state co-financing models, performance-based allocations.

5.3 Post-2026 donor transition preparedness
Scenario planning, risk mitigation, redesign of governance structures, joint financing platforms.

6. Emerging / New Aid Actors

6.1 Multilateral donors
Global Fund, GAVI, EU, AfDB, World Bank responses and their capacity to fill gaps.

6.2 Philanthropy & private sector
HIV Trust Fund, Gates Foundation NSI, CSR contributions, private-level health investments.

6.3 South–South partnerships
China, regional blocs (ECOWAS), AU frameworks, regional pooled procurement opportunities.

7. Pre-Funding Freeze Context (Baseline USAID Role)

7.1 Dependency on PEPFAR/PMI
USAID as financier of ART, PrEP, PMTCT, KP programmes, supply chain, HRH, governance, and community systems.

7.2 USAID's role in service delivery
OSS, KP-friendly centres, logistics and supply chain systems, training, and integrated outreach models.

7.3 Pre-2024 programme progress
Scale-up achievements, service expansion, and momentum before the freeze.

8. Recommendations From Respondents

8.1 Short-term responses
Emergency buffer financing, commodity procurement, temporary staffing solutions.

8.2 Medium-term reforms
Ring-fenced budget lines, TWG strengthening, transition compact, improved financial accountability.

8.3 Long-term sustainability measures
Domestic financing benchmarks, regional collaboration, local manufacturing, institutionalised community monitoring.

Application of the Framework

The coding framework was applied across:

- 9 KIIs (federal, state, IPs, CSOs);
- 2 structured surveys (Government n=9; IPs n=10);
- Supplementary documents (NASA 2022, PEPFAR reports, GF documents, national health policies).

Each respondent was coded under a theme whenever they mentioned or implied it. This allowed for cross-comparison, frequency mapping, and triangulation of findings across data sources.

ANNEX 2 Consent Form for Key Informant Interview

Project Title: *Policy Brief on the Impact of USAID Global Health Funding Cuts on Nigeria's Public Health System*
Researcher: Sarah Kuponiyi, Lead Consultant

Interviewer: Ifeoma C. Dowe

Purpose of the Study

You are invited to participate in this interview because of your knowledge and experience in Nigeria's health sector. The purpose of this study is to understand the impacts of USAID funding cuts on public health programs, identify lessons for resilience, and generate policy recommendations.

What Participation Involves

- The interview will take approximately **30–45 minutes**.
- You will be asked questions about your observations and perspectives on how the funding cuts have affected services, coordination, and policy responses.
- Participation is **voluntary**, and you may decline to answer any question or withdraw at any time.

Confidentiality

- Your responses will be kept confidential.

- Findings will be summarized in a policy brief, but **your name, position, or organization will not be quoted** without your explicit consent.
- Notes and recordings (if applicable) will be stored securely and used only for the purpose of this study.

Risks and Benefits

- There are no known risks to participating.
- While you may not directly benefit, your input will help inform evidence-based recommendations for Nigeria's health system and future donor coordination.

Voluntary Participation

Your participation is entirely voluntary. You may refuse to take part or choose to stop the interview at any point without consequence.

Consent Statement

Please check the option that applies:

☐ I consent to participate in this interview.
☐ I do not consent to participate in this interview.

☐ I consent to the interview being recorded (audio/virtual).
☐ I do not consent to the interview being recorded.

Name of Participant: _____
Signature/Initials: _____
Date: _____

Interviewer's Name: _____
Signature: _____
Date: _____

ANNEX 3: DATA COLLECTION INSTRUMENTS

This annex presents the tools used to collect qualitative data for the policy brief, including the **Key Informant Interview (KII) Guide** and the **Implementing Partner (IP) and Government Survey Instrument**. These instruments ensured consistency across respondent groups and supported systematic thematic analysis.

9 - A. Key Informant Interview (KII) Guide

Reflections on USAID Global Health Funding Cuts in Nigeria

Introduction for Participants

Thank you for agreeing to this interview. This study aims to understand the impact of the USAID funding freeze on Nigeria's public health system. Your insights will inform a policy brief focused on resilience and sustainability.
All responses will remain confidential and will not be attributed by name.

10 - Section 1: Respondent Context

1. Please introduce yourself and your role within the Ministry/Agency.

2. How long have you been engaged in the health sector, particularly in donor-supported programmes?

11 - Section 2: Institutional Response & Programme Impact

3. How did your Ministry/Department respond to the USAID funding cuts?
    - **Probes:**
        - Were any budget reallocations or emergency funding lines approved?
        - Were these measures intended only for 2025–26, or also post-2026?
4. Which programmes under your responsibility were most affected (HIV, malaria, SRHR/FP, MCH, TB, immunisation)?
    - **Probe:** Any figures on affected clinics/services or beneficiaries lost?
5. What specific disruptions occurred (e.g., stock-outs, outreach reduction, staffing issues)?
    - **Probes:**
        - Approximate number of workers laid off or redeployed?
        - Any quantifiable service declines?

12 - Section 3: Adaptation, Policy, and Governance

6. What short- and long-term measures were taken to ensure continuity of essential services?
    - **Probe:** Amount of emergency funding mobilised?
    - **New Probe:** What is the plan for sustaining services after 2026?
7. How did the cuts affect coordination with development partners (IPs, CSOs, donors)?
    - **Probe:** Changes in partner numbers or roles?
8. Did the cuts trigger policy or financing shifts (e.g., domestic resource mobilisation, new taskforces)?
    - **Probes:**
        - Quantify reallocations where possible
        - Are medium-term financing plans being developed for 2026 and beyond?

13 - Section 4: Strategic Lessons & Broader Implications

9. What major risks do these cuts pose now and in the future?
    - **Probes:**
        - Figures on service declines
        - Expected risks post-2026 if donor reductions continue
10. What lessons should guide Nigeria in managing future donor shocks?

- **Probe:** Policies to reduce reliance on external funding post-2026?

11. Are new actors emerging to fill the funding gap?
    - **Probe:** Any concrete percentage contributions or funding amounts?

14 - Section 5: Closing Reflections

12. What key message would you send to policymakers about sustainability?
13. Are there documents or data you can share to support analysis?
    - Examples: layoff numbers, budget reallocations, M&E data
14. Any final reflections, stories, or messages relevant to this brief?

15 - B. Survey Instrument: IP & Government Respondents

Reflections on USAID Global Health Funding Cuts in Nigeria

Section 1: Respondent Profile

- Name & Position
- Institutional Affiliation / Project
- Role within USAID-supported initiatives
- State/Region
- Years of Public Health Experience
- Phone Number
- Age
- Gender

Section 2: Understanding the Funding Cuts

1. How did the cuts affect your work operationally or resource-wise?
2. What changes did you witness in service delivery (coverage, stock-outs, halted services)?
3. Did your project's impact extend beyond its original scope?
    - If yes, please specify.

Section 3: Adaptation, Resilience & Strategic Lessons

4. What measures helped mitigate negative impacts?
5. What could have been done differently?
6. Are you still seeing effects of the cuts today?
    - If yes, please explain.

Section 4: Broader Context & Narratives

7. Please share an example/story showing how the cuts affected people or systems.

8. What are your recommendations (policy, operational, donor-level) to strengthen resilience?

Section 5: Final Notes

9. Any additional reflections you believe should be included?

PASAS

PLATEFORME D'ANALYSE,
DE SUIVI ET D'APPRENTISSAGE
AU SAHEL

PORTÉ PAR

MINKA | AFD AGENCE FRANÇAISE DE DÉVELOPPEMENT

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Ce rapport a été élaboré dans le cadre d'un financement du Fonds Paix et Résilience Minka.

Le Fonds Minka, mis en œuvre par le groupe AFD, est la réponse opérationnelle de la France à l'enjeu de lutte contre la fragilisation des États et des sociétés. Lancé en 2017, Minka finance des projets dans des zones affectées par un conflit violent, avec un objectif : la consolidation de la paix. Il appuie ainsi quatre bassins de crise via quatre initiatives : l'Initiative Minka Sahel, l'Initiative Minka Lac Tchad, l'Initiative Minka RCA et l'Initiative Minka Moyen-Orient.

La Plateforme d'Analyse, de Suivi et d'Apprentissage au Sahel (PASAS) est financée par le Fonds Paix et Résilience Minka. Elle vise à éclairer les choix stratégiques et opérationnels des acteurs de développement locaux et internationaux, en lien avec les situations de crises et de fragilités au Sahel et dans le bassin du Lac Tchad. La PASAS se met en œuvre à travers d'un accord-cadre avec le groupement IRD-ICE après appel d'offres international dont le rôle est double : (i) produire des connaissances en réponse à nos enjeux opérationnels de consolidation de la paix au Sahel et (ii) valoriser ces connaissances à travers deux outils principaux : une plateforme numérique, accessible à l'externe, qui accueillera toutes les productions et des conférences d'échange autour des résultats des études. La plateforme soutient ainsi la production et le partage de connaissances, en rassemblant des analyses robustes sur les contextes sahéliens et du pourtour du Lac Tchad.

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