PATH

TECHNICAL BRIEF

Aid at a crossroads: How countries in sub-Saharan Africa are responding to cuts in donor funding for maternal, newborn, and child health

October 2025

Introduction

Key messages

1

Financing constraints undermine MNCH programs, as foreign support could be poised to drop by nearly half in 2025.

Declining donor support, rising debt burdens, and low domestic allocations have weakened the sustainability of MNCH services, leaving health budgets vulnerable to ongoing cuts and increasing the risk of setbacks in maternal and child survival. Our analysis estimates a 49% reduction in foreign assistance for MNCH across ten focus countries in 2025.

2

Alternative financing mechanisms are emerging but limited.

Some countries are piloting earmarked taxes, cost-sharing schemes, and more, but scale and coverage remain modest.

3

Governments are adopting coping strategies.

Countries are exploring various strategies including integration of donor-funded vertical programs (e.g., *one budget, one plan, one M&E*), public-private partnerships (PPPs), and the use of high-level advocacy and evidence to prioritize health financing and strengthen accountability.

4

Policy priorities moving forward.

Governments, African Union agencies, partners, and civil society must collaborate to: safeguard and expand MNCH funding from all sources; strengthen domestic resource mobilization for MNCH and build resilient systems to withstand funding shocks; integrate donor-funded programs into national systems; expand prepayment and pooling mechanisms such as national health insurance; ensure accountability and efficient fund absorption; and prioritize equity-focused interventions to reduce maternal and newborn deaths.

Maternal, newborn, and child health (MNCH) services have been one of global health's best investments for decades. They help women live healthier lives, give children a stronger start to grow up healthy and thrive, and generate tremendous economic benefits. Since 2000, highly effective and low-cost MNCH solutions have helped cut preventable maternal deaths by nearly 40% and child deaths by more than half, helping more children than ever before reach their fifth birthday.

Despite this progress, too many mothers, newborns, and children die from preventable causes. Every two minutes, approximately 18 children die before their fifth birthday and one woman dies from complications in pregnancy and childbirth. The majority of maternal deaths—70%—happen in sub-Saharan Africa, where women and girls face a 1 in 66 chance of dying due to maternal causes in their lifetime.

Bold leadership and increased investment by country governments are urgently needed to end these preventable deaths, especially as many donor countries reduce their investment in foreign assistance, also called official development assistance (ODA). A recent report found that ODA has dropped by 21% from 2024 to 2025, following years of incremental decline. If other funding sources do not fill these gaps, it's estimated that between 2025 and 2040, the maternal mortality ratio, the under-five mortality ratio, and the stillbirth rate could increase by 29%, 23%, and 13%, respectively, with nearly 8 million more children under age five and over 1 million more women dying due to a lack of available health care services. To protect decades of progress, countries in sub-Saharan Africa must dedicate more domestic resources to MNCH, spend smarter, and identify new sources of funding within a limited fiscal space.

Methodology: This brief summarizes insights from a mixed-methods study by PATH on how countries are mitigating the impact of ODA cuts. While many global analyses have assessed the impact of funding gaps, a country-oriented perspective was lacking. To draw insights from the country level, we combined quantitative analysis of financing data (from the World Health Organization Global Health Expenditure Database [WHO GHED] and the Institute for Health Metrics and Evaluation [IHME] Financing Global Health data released in 2025, among others) with direct analysis of country budgets, where available. We further conducted a series of interviews with national-level policymakers, implementers, and civil society actors from ten countries with high child and maternal mortality rates selected to capture a diverse set of regions and socio-cultural and political contexts (e.g. fragility and conflict): **the Democratic Republic of the Congo (DRC), Ethiopia, Kenya, Malawi, Mozambique, Nigeria, Somalia, South Sudan, Tanzania, and Uganda.** Participants reflected on the impact of decreased foreign funding on the ability of the various countries to provide MNCH services and the adaptations countries are making to continue this work. This research aims to help country stakeholders adapt, optimize, and strengthen their health systems in the new funding reality.

Financial analysis findings

Limited fiscal space for health

Between 2020 and 2025, most of the ten countries experienced stagnant or decreasing tax-to-gross domestic product (GDP) ratios—in other words, less revenue—and rising debt-to-GDP ratios—representing greater reliance on borrowing to fund public services (Figure 1).

Especially in Ethiopia, Nigeria, South Sudan, and Somalia, a surge in debt has not been accompanied by increasing tax revenues, constraining the fiscal space to sustain MNCH financing as donor support declines.

Underinvestment in health in national budgets

Between 2015 and 2022, the ten countries spent an average of 4.9% of their total government budgets on health, or 1% of their GDP—well below the 15% target African leaders agreed to in the Abuja Declaration in 2001 (Figure 2).

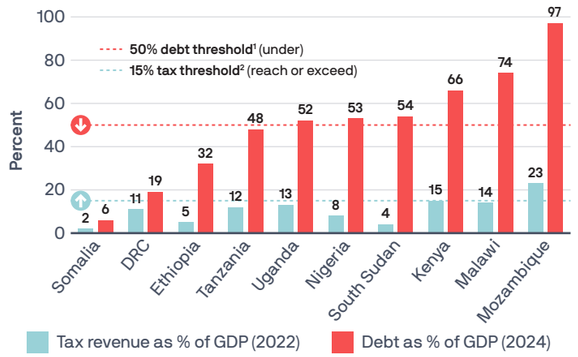
Government health spending as a share of GDP remains low, particularly in the DRC, Nigeria, Somalia, and South Sudan. Furthermore, across Africa, most countries allocate less than 10% of their total government budget to health, and only four countries have met the Abuja target of 15%. Of our ten focus countries, Kenya, Mozambique, and Ethiopia allocated the greatest portions (5.7%–8.7%). These figures highlight a limited fiscal commitment to health within the broader economy.

Most health funding in the countries came from nongovernmental sources

Of every $10 of health funding spent in the ten focus countries, $2.10 came from domestic government resources, $3.90 came from donors, and $3.30 represents out-of-pocket costs paid by patients (Figure 3).

Reduced donor funding risks disrupting MNCH services and increasing out-of-pocket costs, leading to financial hardship and widening inequities.

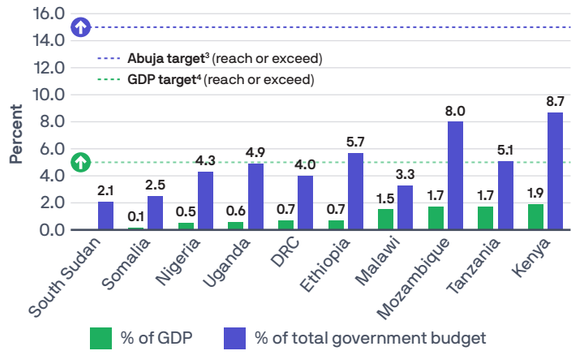
FIGURE 1. **Country revenue balances: inflows (tax) and outflows (debt) as a percent of GDP.**



Source: World Bank, WHO GHED, International Monetary Fund.

1. The East African Community (EAC) has established a target for its member states to limit gross public debt to 50% of their GDP.
2. The World Bank recommends that a 15%+ tax-to-GDP ratio is a key ingredient of economic growth and poverty reduction.

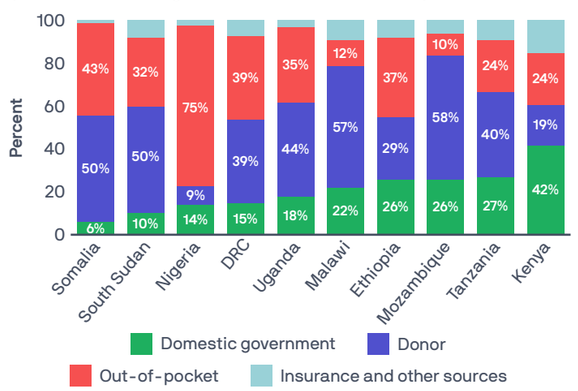
FIGURE 2. **How countries prioritize health: spending as % of GDP and % of total national government budget (vs targets).**



Source: WHO GHED.

3. The 15% Abuja target was a 2001 agreement by AU member states to allocate at least 15% of their annual national budgets to the health sector.
4. The recommendation to spend 5% of GDP on health is supported by evidence suggesting it can help limit out-of-pocket costs and promote universal health coverage.

FIGURE 3. **Distribution of health spending by source of funds (donor, domestic government, other sources) since 2015.**



Source: WHO GHED.

Likewise, most MNCH funding in the countries came from nongovernmental sources

From 2015 to 2022, countries spent an average of US$2.83 per capita on MNCH services—$0.76 (27%) of which came from domestic government resources (Figure 4).

Though MNCH financing across the sampled countries has fluctuated, government funding on average supported between 8% (South Sudan) and 46% (Tanzania) of the total spent on MNCH services per country. Those countries with the highest average annual spending of domestic government funds on MNCH services were Nigeria ($1.50 per capita) and Kenya ($2.28); those with the lowest were South Sudan ($0.10) and the DRC ($0.18).

Total ODA was already trending down before 2025

Total ODA in the ten focus countries has decreased since 2021; ODA allocated specifically to MNCH has fluctuated over the years but remains a small portion of the overall ODA total (Figure 5).

From 2019 to 2024, just over $1 of every $6 of all ODA provided by donors went to MNCH services. Over this period, donors provided US $9.98 billion for MNCH (17%) and $44.78 billion for other services (83%) to the ten countries.

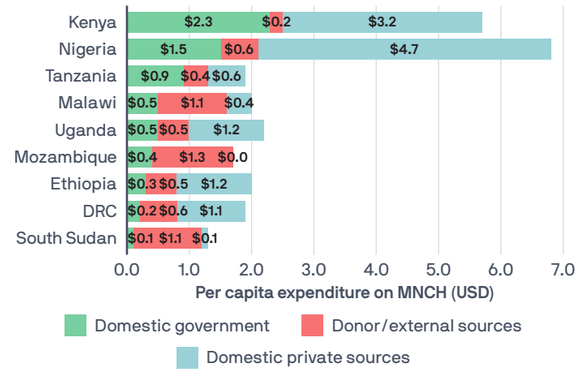
In 2025, countries' ODA for MNCH could reduce by half

The ten focus countries on average received $1.66 billion in ODA for MNCH each year between 2019 and 2024, but we estimate that in 2025, ODA for MNCH could reduce by 49% (Figure 6).*

Our analysis found that in 2025, the ten countries may receive an estimated total of $850 million in ODA for MNCH—a reduction by nearly half (49%) from the average annual ODA received since 2019. The biggest decreases are in South Sudan (58% decrease), Kenya (55%), Uganda (52%), and Malawi (51%); even the countries least affected, Somalia and Tanzania, may see significant drops in ODA, of 41% and 44% respectively.

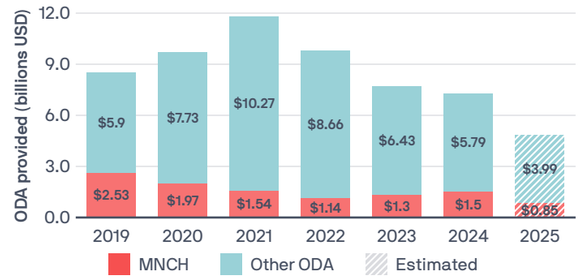
*ODA data from the IHME does not include recipient country or topic detail for 2025. To estimate 2025 MNCH ODA, we distributed each donor's total 2025 ODA to countries using time-weighted recipient share rates (2019–2023), then each donor-recipient pair's time-weighted rate of MNCH ODA as a share of total ODA. A time-trend regression approach produced similar results, so we report the parsimonious weighted-share estimates.

FIGURE 4. **Countries' average spending on MNCH services per capita, by source of funding (2015–2022).**



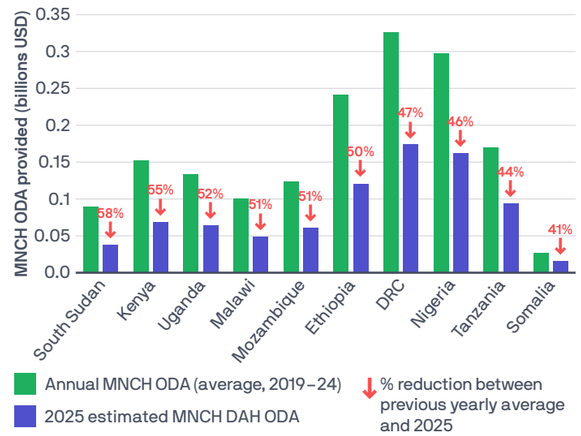
Source: Calculations using WHO GHED financing data and UN Population Prospects population data. Data for Somalia not available.

FIGURE 5. **Trends in total ODA for MNCH and other health priorities across the ten focus countries (2019–2025).**



Source: Analysis of IHME Financing Global Health data.

FIGURE 6. **Estimated 2025 reduction in annual MNCH ODA received by focus countries.**



Source: Analysis of IHME Financing Global Health data.

Qualitative analysis findings

From qualitative interviews conducted with 13 stakeholders from 10 focus countries across sub-Saharan Africa, we identified the following perceived effects of ODA cuts.

Though in recent years—including 2025—many countries have increased health allocations to address ODA reductions, currency devaluation has undermined impact. Country-level factors such as inflation, currency devaluation, and delayed disbursements mean these increases have not always translated into equivalent purchasing power at the facility level.

> "The budget has increased, but because commodities are procured in dollars, the devaluation in [Ethiopian] currency means the money buys much less."

Some of the most visible impacts of ODA reductions affect community outreach and health education services, which have historically relied on external funding. Populations in rural, insecure, or displaced settings, as well as youth, are often missed unless dedicated outreach is conducted. As such, cuts to outreach services deepen access inequities. In Kenya, for instance, the suspension of donor support disrupted a planned measles campaign in Turkana County. In Malawi, reductions in donor-funded family planning contributed to a reported rise in teenage pregnancies and new HIV infections. In South Sudan, decreased donor aid particularly impacted conflict- and flood-affected communities, which rely heavily on support from nongovernmental organizations.

> "The badly affected aspect is the community-based activities and services [such as] education, awareness, and outreaches. [Therefore], the impact [of donor withdrawal] on the disease burden among vulnerable communities and hard-to-reach [areas] is even triple."

Many countries have seen significant supply disruption in the procurement and distribution of essential MNCH drugs and commodities—many of them lifesaving. Mozambique, Nigeria, Kenya, South Sudan, and Somalia have already reported shortages. Mozambique has estimated it faces a $70 million annual gap in medicines procurement, and Somalia projects that therapeutic foods for child malnutrition could run out by the end of 2025 without additional financing. These pressures heighten risks of preventable illness and mortality. Because donors have played a major role in the procurement of medicines and supplies, further stockouts are expected as budget gaps widen.

> "Once vaccines are procured [through Gavi], implementing partners would support with last-mile vaccine delivery from national stores to region stores then to health facilities…but this was disrupted."

Human resources have also been affected where donor-supported staff could not be absorbed into national or subnational payrolls. ODA cuts have led to the termination of contracts for health workers previously employed through donor-supported projects, straining already fragile health workforce systems. Health workers funded by donor programs were often on separate contracts and payrolls, meaning they needed to be transitioned into the public system. Malawi, Uganda, South Sudan, and Tanzania all report gaps in MNCH services arising from the loss of health workers.

ODA cuts have also stressed underlying systems such as health information and monitoring systems. Data platforms relied on donor funding for upkeep and management, most notably DHIS2, the world's largest health information management system used by more than 70 countries. Respondents also reported impacts to Nigeria's reporting system for prevention of mother-to-child transmission of HIV, South Sudan's maternal and newborn death surveillance system, Kenya's health information system, and Somalia's electronic logistics management information system. Funding cuts have frozen updates and disrupted system availability, which will make it harder in the long term for countries to track progress, identify problems, and make decisions based on evidence. In Nigeria, the donor-funded 2023–24 Demographic and Health Survey could not be completed due to cuts, leaving the country reliant on outdated 2018 data.

> "The other significantly affected area [is evidence generation and use]. Most of the health information systems were donor-funded…even the human resources that were supporting the systems."

In some countries, quality assurance and learning efforts were put on hold due to resource constraints, which may affect service performance over time. In Nigeria and Kenya, respondents noted that previously donor-supported platforms to improve care—such as quality-of-care committees and joint supervision forums—have not convened regularly, reducing opportunities for shared learning and joint accountability across programs.

> "I lead the quality-of-care program for the country, and we have not held any meetings this year […] not because of tight schedules, but funding."

Countries reported difficulties integrating parallel donor-driven programs into national systems, leading to duplication and fragmentation. For example, vertical donor-led programs for MNCH in Malawi and Nigeria operated with separate staff, budgets, and logistics, making it challenging to transition these services into routine primary care. Similarly, in Kenya, donor funding had previously supported last-mile vaccine delivery; when this stopped and the national distribution system had to try to absorb the function, there were temporary gaps in service continuity.

In the face of ODA cuts, many global partner organizations have faced restructuring and major changes to their workflow. Respondents noted that the tendency to prioritize the institution's survival and workforce retention could sometimes come at the cost of poorer service delivery to populations.

Responses to ODA cuts and adaptation strategies

While funding cuts have already posed significant challenges and ramifications may continue to surface as projects wrap and funds dry up, respondents described positive steps countries have begun taking to adapt to ODA cuts. These include:

1. **Expanding and earmarking existing domestic health budgets:** Of the 10 countries, 5 increased health budgets since 2023. Countries are also taking steps to safeguard resources for health; for instance, Malawi is developing a new law to establish a national health fund and channel earmarked revenues directly to health, and Nigeria is reviewing its Basic Health Care Provision Fund to strengthen financing for primary health care. Uganda, Ethiopia, and Kenya have also committed supplementary allocations during shocks.
2. **Identifying new sources for health financing:** Ethiopia is working to enroll more households in community-based health insurance in order to help share costs for MNCH services, which in the past have depended on high out-of-pocket payments and donor subsidies. Tanzania, Ethiopia, Mozambique, and Somalia are leveraging earmarked sin taxes on tobacco, alcohol, and/or sugar for health, and Somalia is considering using telecom levies. Several governments have pursued efficiency measures, like Kenya's effort to allow facilities to retain and reinvest the funds they generate, improving flexibility and efficiency.
3. **Leveraging new and emerging partnerships:** Partnerships beyond traditional donors, such as PPPs, public-private contracting (a more agile version of PPPs), and new multilateral funds, are beginning to bridge financing gaps. For instance, Tanzania's *m-mama* program with the Vodafone Foundation provides emergency transport for pregnant women. Kenya, Tanzania, Malawi, Ethiopia, and Uganda are beneficiaries of the recently launched Beginnings Fund for MNCH, a new philanthropic approach that unites African countries, donors, and multilaterals to jointly strategize and invest in a comprehensive package of systems-strengthening products and services. Kenya has reallocated some Global Fund resources to MNCH, and South Sudan has partnered with the Susan Buffett Foundation to support MNCH interventions. Several countries are also piloting PPPs such as private wards or pharmacies to generate additional revenue while safeguarding core services. While promising, these efforts still cannot fill the gap left by traditional donors.
4. **Integrating donor programs into national systems:** Countries are working to integrate formerly vertical donor-funded programs into national systems to improve efficiency and sustainability. For example, the *one plan, one budget, one M&E* approach used by several countries aligns all partners under a single strategy and financing pool; Tanzania's *One Plan 4* offers a unified roadmap for MNCH and adolescent health; and Uganda, Kenya, and Nigeria are integrating MNCH and HIV services into primary care.
5. **Transitioning the health workforce:** In Malawi and South Sudan, governments are beginning to plan for the absorption of donor-funded health workers into the public payroll. Efforts include reviewing laws and financing mechanisms to create new channels for facility-level or pooled funding, earmarking funds for the health workforce in national budgets, improving weak payroll systems, and shifting workers under different budget lines so their salaries can continue to be paid. However, early progress is uneven due to the workforce challenges described in the section above.
6. **Advocating for accountability and funding:** Civil society organizations (CSOs) have mobilized to maintain oversight mechanisms and advocate for increased government funding for MNCH. In Ethiopia, national and regional CSO-led workshops contributed to a 325% increase in budget allocations for MNCH. In Uganda, CSOs have continued to track budget releases and press for transparency, while in South Sudan, they have kept quality-of-care review mechanisms active despite reduced donor support. Furthermore, as the AU and its agencies are playing an increasingly important role in facilitating regional coordination in the face of donor transitions, meetings of these agencies are important advocacy opportunities. For example, at an August 2025 meeting, AU member states made a commitment to prioritize MNCH services across the continent.
7. **Generating evidence:** Governments are commissioning studies to better understand financing gaps and guide policy responses. Tanzania and Ethiopia did rapid assessments of the fiscal impact of donor transitions, and Kenya and Nigeria initiated sector reviews to reallocate resources within constrained budgets. In several cases, these assessments have been used to inform cabinet-level debates, demonstrating growing political recognition of donor transition risks.
8. **Making cost-saving operational shifts:** Some governments and partners are replacing out-of-town program planning meetings with virtual platforms or meeting in partner facilities rather than hotels, thus balancing the benefits of large in-person meetings with cost-cutting needs.

Recommendations

Based on these findings, PATH recommends the following urgent actions to safeguard decades of progress for mothers and children:

For governments

- Increase domestic allocations to health, moving toward the Abuja 15% target and recent renewed commitments, and safeguard those funds by earmarking in budgets.
- Explore alternative financing mechanisms (e.g., health taxes/levies, insurance and cost-sharing programs, and fund retention by facilities) and earmark those revenues for health to sustainably reduce dependence on donors.
- Strengthen accountability mechanisms to ensure earmarked revenues are directed to health and fast-track disbursements to avoid service interruptions.
- Integrate donor-supported MNCH programs (e.g., last-mile distribution, outreach, quality monitoring, and supervision) within national systems to foster continuity in financing and service delivery. Prioritize absorption of donor-funded health workers by creating interim budget lines or reallocating underused funds.
- Conduct financial analyses to inform reallocation of domestic resources toward MNCH and health.
- Build institutional capacity in health planning, governance, and local manufacturing.

For civil society and advocates

- Sustain advocacy for increased and equitable domestic health financing and monitor disbursements to ensure timely provision and use of earmarked health revenues.
- Keep oversight platforms active (e.g., quality-of-care committees, review meetings), even with low-cost adaptations such as virtual meetings.
- Document and amplify (including via media) community-level effects of ODA reductions, especially for remote, displaced, and youth populations, to support health equity and global solidarity for health.
- Provide targeted short-term support to government where critical gaps arise, including by exploring innovative partnerships with the private sector and philanthropies.

For the African Union and other regional bodies

- Facilitate continental advocacy for, and monitoring of, MNCH financing commitments, including by encouraging member states to share lessons on domestic resource mobilization.
- Facilitate building regional drug and vaccine manufacturing capacity to enhance supply chain sustainability for health commodities.

For global partners

- Ensure predictable and phased transition planning to minimize shocks.
- Align support with national priorities and provide pooled, flexible funding that can be used as needed.
- Fund financial and gap analyses, as well as capacity strengthening, to guide countries in addressing limited fiscal space and reallocating domestic resources.
- Focus on strengthening crosscutting systems (payroll/human resources, supply chains, information systems) rather than narrow vertical programs.
- Organize institutional reforms within multilateral organizations to prioritize maximizing benefits to populations in parallel with wider goals of institutional survival.

Conclusion

While the ten countries we studied have taken laudable steps toward addressing ODA cuts, limited fiscal space and competing priorities will continue to present tough choices. Advocacy is essential to ensure that women and children are not left behind.

The impacts of ODA cuts outlined here underscore long-standing aid dynamics: donor support has driven major health gains, but siloed programs have fostered over-reliance and complicated transitions. The recent shifts in global health funding patterns offer an opportunity for governments, civil society, and global partners to work together to strengthen domestic financing, integrate core systems, and build resilience. Sustained donor engagement alongside these efforts is vital to protect hard-won progress and advance equitable health for women, children, and communities across sub-Saharan Africa.

For further information, contact PATH at advocacyandpolicy@path.org

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