PATH

TECHNICAL BRIEF

Resilience in action: How countries in sub-Saharan Africa are responding to cuts in donor funding to protect women and children

December 2025

Introduction

Key takeaways

1

Maternal, newborn, and child health and immunization programs have already been undermined by financing constraints—and we estimate that foreign support for these programs may further drop by nearly half in 2025.

Declining donor support, rising debt burdens, and low domestic allocations have weakened the sustainability of these lifesaving programs, increasing the risk of setbacks in maternal and child survival. Further exacerbating the problem, across the ten focus countries we analyzed, we estimate a 49% reduction in foreign assistance for maternal, newborn, and child health and a 32% reduction for immunization in 2025.

2

Alternative financing mechanisms are emerging but limited.

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

3

Governments are adopting coping strategies to maximize limited funds.

Countries are exploring various strategies including integration of donor-funded vertical programs (e.g., the *One Plan, One Budget, One Report* approach), 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 (AU) agencies, partners, and civil society must collaborate to: safeguard and expand maternal and child health and immunization funding from all sources and especially domestic resource mobilization; build resilient systems to withstand funding shocks; integrate donor-funded programs into national systems, particularly around workforce and last-mile delivery; 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, including immunization, 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 one woman and 18 children under the age of five die from complications of pregnancy and childbirth. Sub-Saharan Africa bears a disproportionate burden of maternal and child deaths; for example, women and girls living there 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 total 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 and immunization, 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 and immunization 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 and immunization 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).

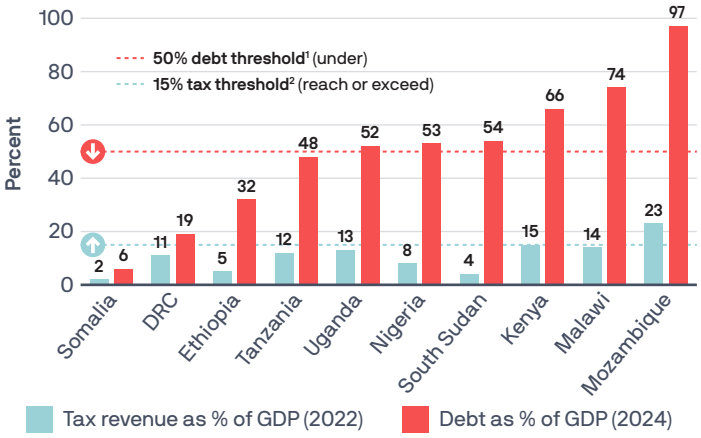
Government health spending as a share of GDP remains low, particularly in the DRC, Nigeria, Somalia, and South Sudan. Furthermore, across Africa, most countries allocate less than 10% of their total government budget to health, and only four countries have met the Abuja target of 15%. Of our ten focus 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 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.

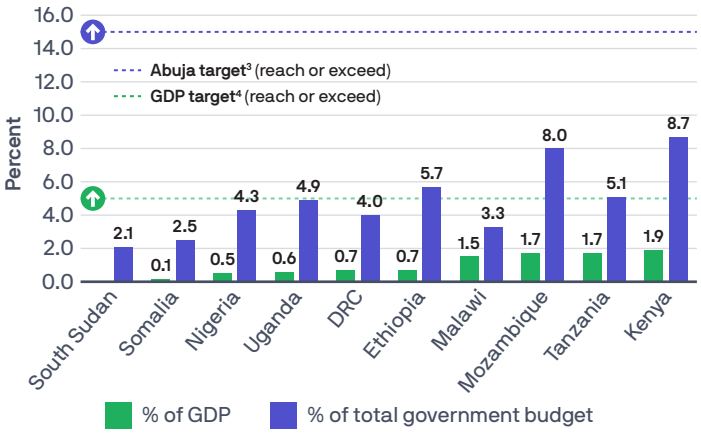
FIGURE 1. **Country revenue balances: inflows (tax) and outflows (debt) as a percent of GDP.**



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.

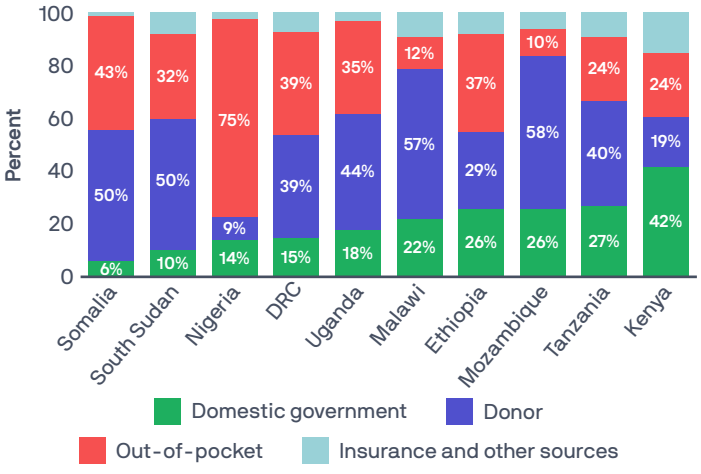
FIGURE 2. **How countries prioritize health: spending as % of GDP and % of total national government budget (vs targets).**



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 and immunization 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).

Inconsistent trends in government funding for immunization

In the focus countries, government funding of routine immunization has varied significantly over time. As donor funding reduces, consistent domestic funding will be even more important (Figure 5).

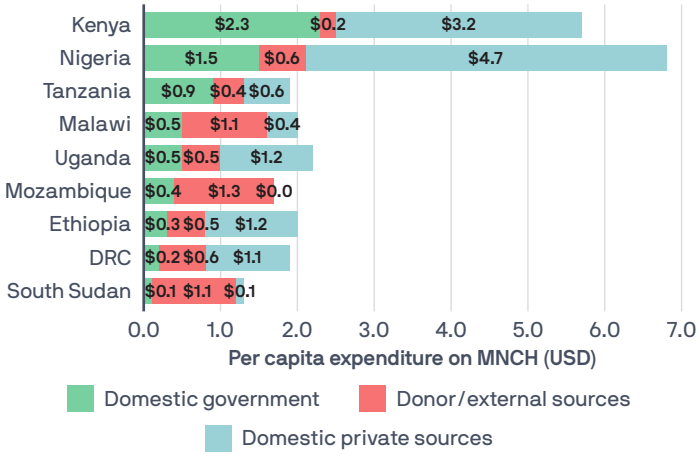
As of 2024, government funding for routine immunization was highest in Malawi and Kenya (58%), and lowest in DRC (5%) and Mozambique (8%). From 2022 to 2024, Tanzania had the biggest increase in proportion of immunization funding coming from the domestic government (from 11–56%), while Nigeria saw the greatest decline (from 55%–11%).

By the end of 2025, countries' ODA for MNCH may have been reduced 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).[5]

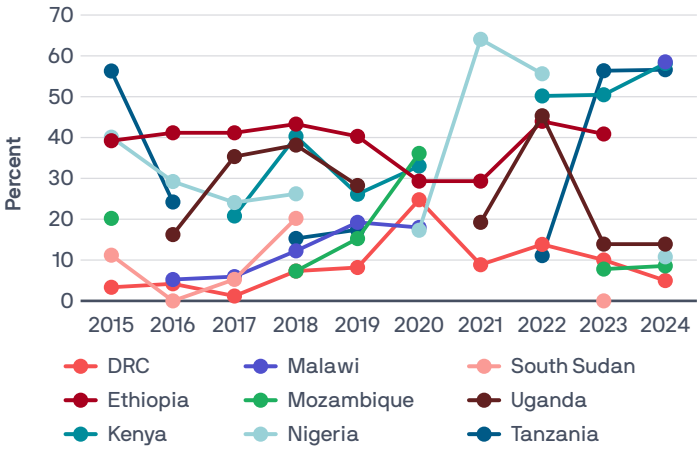
Our analysis found that in 2025, the ten countries may receive an estimated total of $850 million in ODA for MNCH—a reduction by nearly half (49%) from the average annual ODA received since 2019. The biggest decreases are in South Sudan (58% decrease), Kenya (55%), Uganda (52%), and Malawi (51%); even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

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



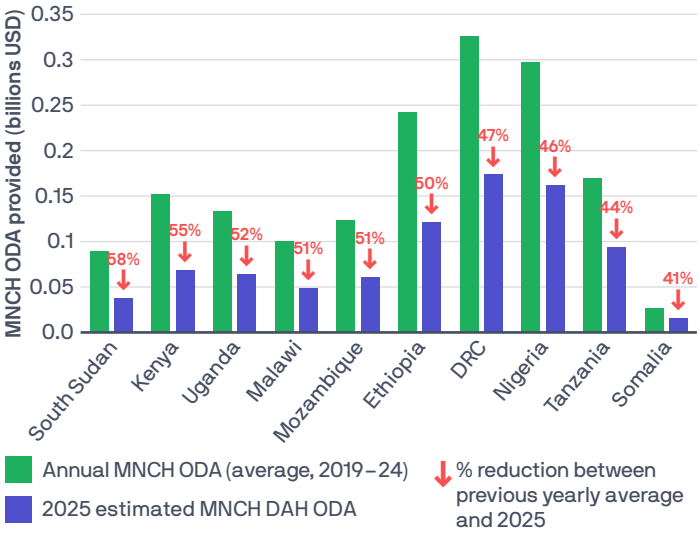
Source: Calculations using WHO GHED financing data and UN Population Prospects population data. Data for Somalia not available.

FIGURE 5. **Government funding as a share of total routine immunization financing (2015–2024).**



Source: Analysis of WHO/UNICEF immunization expenditure data.

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



Source: Analysis of IHME Financing Global Health data.

By the end of 2025, countries' ODA for immunization may have reduced by a third

From 2019 to 2024, the ten focus countries on average received $0.56 billion annually in ODA for immunization. However, we estimate that in 2025 the countries may receive $0.38 billion in immunization ODA—a reduction of 32% from that annual average (Figure 7)[5].

The countries with the biggest relative decreases in immunization ODA are Kenya (38% decrease), Tanzania (36%), and Nigeria (36%). Even the countries least affected, Mozambique and South Sudan, may see significant drops in ODA, of 19% and 16% respectively.

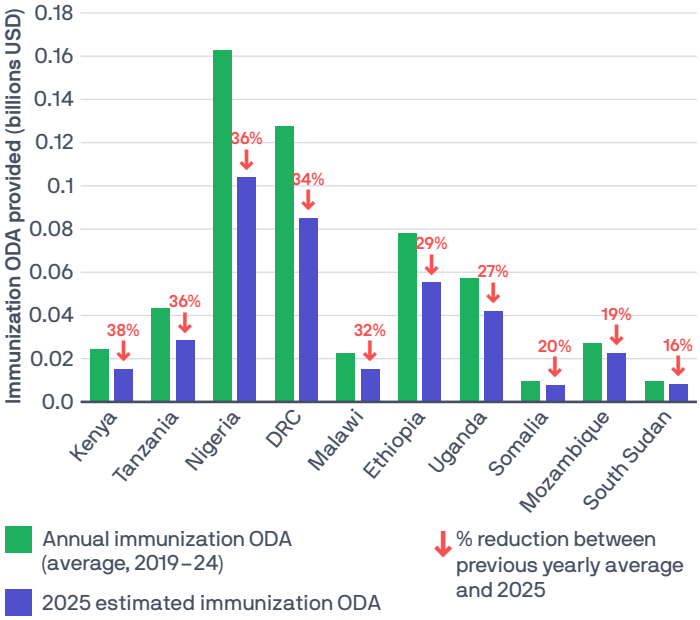
Total ODA was already trending down before 2025

Total ODA in the ten focus countries has decreased since 2021; ODA allocated specifically to MNCH and immunization has fluctuated over the years but remains a small portion of the overall ODA total (Figure 8).

From 2019 to 2024, of all ODA provided by donors, approximately $1 of every $6 went to MNCH services and $1 of every $16 went to immunization. Over this period, donors provided the ten countries with US$3.38 billion for immunization (6%), $9.98 billion for MNCH (17%) and $41.40 billion for other services (76%).

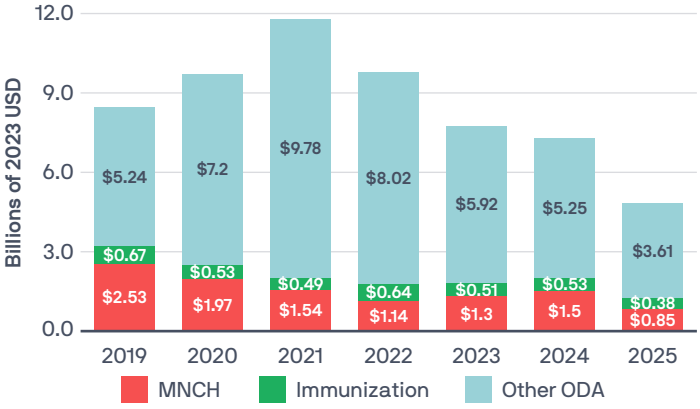
5. ODA data from the IHME does not include recipient country or topic detail for 2025. To estimate 2025 MNCH ODA, we distributed each donor's total 2025 ODA to countries using time-weighted recipient share rates (2019–2023), then each donor-recipient pair's time-weighted rate of MNCH ODA as a share of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

FIGURE 7. **Estimated 2025 reduction in annual immunization ODA received by focus countries.**



Source: Analysis of IHME Financing Global Health data.

FIGURE 8. **Focus country cluster—MNCH vs. immunization vs. other ODA (2019–2025).**



Source: Analysis of IHME Financing Global Health data.

Qualitative analysis findings

The qualitative interviews conducted with 13 stakeholders from the ten focus countries identified the following perceived effects of ODA cuts:

Though in recent years—including 2025—many countries have increased health allocations to address ODA reductions, "double inflation" and currency devaluation have 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. In particular, many supplies for routine immunization delivery (such as cold chain equipment and fuel) are priced in US dollars, making immunization especially vulnerable to the "double inflation" of currency depreciation alongside donor withdrawal.

> "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 vaccine 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 (NGOs). Several respondents also noted that halted immunization campaigns, disrupted digital tracking systems, and the withdrawal of NGO mobile teams has been contributing to growing pockets of children who have never received a vaccination (zero-dose children), particularly in remote and conflict-affected areas.

> "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 vaccines, drugs and other commodities—many of them lifesaving. Mozambique, Nigeria, Kenya, South Sudan, and Somalia have already reported medicine 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 and delivery of medicines and supplies, further stockouts are expected as budget gaps widen. Respondents also stated that even when vaccines were available nationally (often through support from Gavi), the biggest disruption to routine immunization was in the operational backbone—transport, cold chain upkeep, distribution planning, and outreach—functions which have previously depended on donor support.

> "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. Kenya, Malawi, Tanzania, Uganda, and South Sudan all report gaps in MNCH and immunization services arising from the loss of health workers and outreach vaccinators.

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 outbreaks, identify the areas of highest need, and make decisions based on evidence. Immunization is particularly reliant on digital systems; for instance, in Somalia, disruptions to the electronic logistics management system reduced visibility into vaccine stocks, expiry dates, and distribution needs. In Nigeria, the most recent donor-funded Demographic and Health Survey could not be completed due to cuts, leaving the country reliant on outdated 2018 data.

> "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 quickly integrating parallel donor-driven programs into national systems, with short timelines 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 health care (PHC) systems. Similarly, in Kenya, donor funding had previously supported last-mile vaccine delivery; when this halted and the national distribution system had to try to absorb the function quickly, there were temporary gaps in service continuity. When donor-supported programs end abruptly, service gaps are unavoidable because the systems carrying them cannot be rebuilt in a single budget cycle.

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.

PATH/Georgina Goodwin

Head nurse Fatuma Bititi managing patient records at Kenya General Hospital in Lubumbashi, DRC.

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 have 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 PHC. 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 and immunization 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*, 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 to improve maternal and newborn survival. Kenya has reallocated some Global Fund resources to MNCH, and South Sudan has partnered with the Susan Buffett Foundation to support MNCH interventions. Kenya and Ethiopia are exploring partnerships with private logistics firms to strengthen cold-chain capacity and support last-mile vaccine transport, while Somalia has engaged digital health partners to enhance visibility of vaccine stocks through simplified electronic tools. 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 Budget, One Plan, One Report* 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, immunization, and HIV services into PHC. Several countries are using this transition to clarify logistics roles; for instance, Kenya's integration of last-mile vaccine delivery has clarified government responsibilities for distribution, cold-chain repair, and immunization microplanning.
5. **Transitioning the health workforce:** In Malawi and South Sudan, governments are planning the absorption of donor-funded health workers into the public payroll—including reviewing laws and financing mechanisms to create new channels for facility-level or pooled funding, earmarking national funds for the health workforce, improving weak payroll systems, and shifting workers under different budget lines so their salaries can continue to be paid. However, early progress is uneven.
6. **Advocating for accountability and funding:** Civil society organizations (CSOs) have mobilized to maintain oversight mechanisms and advocate for increased government funding for MNCH and immunization. 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. As the AU and its agencies take on a greater role in regional coordination during donor transitions, their meetings offer important advocacy opportunities. For example, at an August 2025 meeting, AU member states committed to prioritize MNCH services, and the AU is also advancing a Continental Immunization Strategy to improve immunization access through regional vaccine manufacturing, stronger accountability, and resilient PHC systems.
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:** 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 Declaration's 15% target and recent renewed commitments, and safeguard those funds through budget earmarks.
- 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 immunization and 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. Use this opportunity to advance integration across siloed health areas.
- Conduct financial analyses to inform reallocation of domestic resources toward immunization, MNCH and health.
- Build institutional capacity in health planning, governance, and local manufacturing.
- Support pooled procurement mechanisms that give African countries greater bargaining power, predictable supply, and better value for money spent.

For the African Union and other regional bodies

- Facilitate continental advocacy for and monitoring of health, MNCH, and immunization financing commitments (e.g., the Abuja Declaration, the Addis Declaration on Immunization, the Continental Immunization Strategy, and the Lusaka Agenda), 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 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.

- Strengthen independent, evidence-based accountability mechanisms to track MNCH and immunization financing, policy implementation, and service delivery, to promote efficient spending, transparency, and health impact.
- Keep oversight platforms active (e.g., quality-of-care committees, review meetings), 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 prevent zero-dose hotspots and support health equity.
- Provide targeted short-term support to government where critical gaps arise, including by exploring innovative partnerships with the private sector and philanthropies.

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, last-mile delivery, and 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