RESULTS FOR DEVELOPMENT

RAPID ASSESSMENT TO IDENTIFY 'ON THE GROUND' EFFECTS OF 2025 UNITED STATES GOVERNMENT FUNDING CUTS ON IMMUNIZATION PROGRAMS IN THREE COUNTRIES

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Executive Summary

Purpose and context
In early 2025, sweeping reductions to U.S. government (USG) global health funding created an urgent need to understand how these cuts were affecting immunization service delivery. Across many countries, USAID played both a direct and indirect role supporting immunization service delivery, depending on the country; in some countries USAID supported broad integrated health service delivery strengthening at the community-level that included immunization, and in others, projects had an immunization mandate at the local-level.[1] For countries already dependent on external support to sustain outreach, vaccine transport, and health worker incentives, the potential negative consequences of abrupt funding withdrawal was clear: rapid reversals of progress on immunization coverage, toward reaching zero-dose children, and preventing outbreaks.

To understand and document the effects of USG funding cuts on immunization programs and last-mile service delivery, GiveWell funded R4D to conduct a rapid assessment focused on three priority countries: the Democratic Republic of Congo (DRC), Madagascar and Nigeria. These countries were selected due to their heavy reliance on donor support, high burdens of vaccine-preventable disease, and diverse health system delivery approaches. The assessment aimed to generate rapid, actionable insights on the impacts "on the ground" to expand GiveWell's immunization evidence base and inform grantmaking strategies so that their investments remain impactful even as aid flows shift. By examining trends across these diverse contexts, the assessment also sheds light on dynamics and challenges likely emerging in other countries that previously depended on USG support for their immunization programs.

Methodology
The assessment drew on over 200 interviews and focus groups with vaccinators, health facility managers, district and provincial officers, and national stakeholders. Participants described how immunization service delivery functioned before the funding cuts, the disruptions that followed, and the consequences for coverage, equity, and system performance. Quotes throughout this synthesis memo reflect majority views and capture the causal chain that respondents traced — from loss of partner support to downstream effects on missed children.

Of note, our assessment's qualitative design means that our findings are not statistically generalizable, and the results may be influenced by bias from participants as well as challenges during analysis and interpretation.

Major findings
Across all three countries, respondents consistently described a marked "before-and-after" shift following the withdrawal of U.S. government support. Specifically, according to stakeholders, the abrupt withdrawal of funding for a range of community-level activities, including transport, stipends, data bundles, form printing, and other incremental costs have created the following shifts:

- Outreach teams that once traveled monthly to remote villages are now grounded,
- Health volunteers who once mobilized caregivers and traced missed children have dropped out,
- Vaccine transport is slower and more expensive, and;
- Data needed for planning is delayed or incomplete.

[1] Examples include: KFF, 2024; US Department of State, 2018, MRITE, 2023

Front line actors assert that these disruptions are leaving more children unreached and threatening to erase years of progress.

Yet respondents also described resilience and adaptation. They noted that many fixed-post services continue to run, even with fewer staff. Health workers are pooling personal resources, walking long distances to collect vaccines, and rescheduling sessions instead of canceling them. These examples suggest that systems are strained but not broken — and that targeted, catalytic investments could stabilize services and reach more under-immunized or zero-dose children.

What follows are the most salient findings from the key informants and facilities sampled in our assessment - a synthesis of where the gaps seem most severe and where investments could help reduce the number of missed children, further summarized in the appendix (Table 3). These findings are presented temporally, in terms of immediate cause and effect, cascading into broader implications that stakeholders are grappling with today:

1. Funding withdrawal created shockwaves at the last mile.
Respondents almost universally described the withdrawal of USAID and other donor support as disruptive and harmful, slowing down a system that previously had momentum. They warned of rising zero-dose numbers, declining coverage, and higher outbreak risk if gaps remain unfilled.

2. The loss of stipends and partner support triggered widespread workforce attrition, demotivation, and declining service delivery capacity – particularly for the volunteer health workforce and vaccinators.
Prior to funding cuts, volunteer and ad hoc workers were described as the backbone of outreach due to health systems' heavy reliance on volunteer labor for health service delivery at the community level. Volunteers performed a variety of key roles, including community mobilization, defaulter tracing, and door-to-door visitation in rural communities. The abrupt loss of financial incentives for these individuals has reportedly meant that many have left their roles in the health system, leaving the remaining permanent staff overburdened. As a result, workforce morale has plummeted and service delivery has suffered, with fewer outreach and mobilization activities being carried out.

3. Service delivery has shifted dramatically away from outreach and mobile strategies toward fixed-post sessions.
Interview participants explained that mobile strategies have largely collapsed, and outreach is now irregular or absent in many districts, leaving entire villages unreached for months. Fixed sessions are maintained but reach fewer children without community mobilization to drive demand.

4. Last- mile vaccine transport and distribution have become more unreliable, causing more frequent stockouts and session cancellations.
Health facility staff described a change in vaccine availability due to challenges with last-mile vaccine transport: previously predictable vaccine deliveries to the health facility level are now delayed or dependent on facilities identifying their own funds to collect stock. Resulting stockouts at the facility level were described as causing an increase in missed sessions as well as discouraging caregivers from returning when they find no vaccine available.

5. Coverage rates are already declining, with evidence of reversals in recent gains.
With reductions in outreach and mobile strategies, and increasing stockouts of key antigens, respondents cited both measured drops in coverage and observed increases in zero-dose

children. In Madagascar, for example, one respondent cited a four-point decline in Penta 1 coverage within a year.[2] Many expressed fear that measles, polio, and other outbreaks are imminent if gaps in coverage are not closed.

6. Progress made in reaching zero-dose children is being lost.
Stakeholders described a clear causal chain: when partners funded transport, stipends, and mobilization, facilities could systematically identify and vaccinate zero-dose children. Without those supports, children in remote areas are increasingly missed, and some facilities report slipping back into "zero-dose facility" status.[3]

7. Rural sites are disproportionately affected by funding cuts.
Because rural facilities are typically most dependent on funded outreach, transport, and volunteer labor, they are reporting disproportionately more negative and severe impacts as compared to their counterpart urban facilities. Respondents reported entire communities going unreached for months, while noting that comparatively, urban facilities maintained at least fixed sessions.

8. Data and reporting systems became more fragmented, expensive, and prone to delays after the cuts.
Without donor-funded data clerks, printing, and internet connectivity, facilities report delayed submissions and missing tools. Data now arrives late or incomplete, making it difficult for districts to track coverage gaps and plan catch-up activities.

9. Microplanning[4] and coordination processes have stalled, reducing the system's ability to optimize and adjust coverage strategies.
Stakeholders highlighted that quarterly and monthly review meetings–used for data review, coordination, microplanning, performance management, integrated health service delivery planning–were once routine but are now canceled or shortened, leaving fewer opportunities to course-correct or target resources for missed populations.

10. Broader health system services have weakened, with respondents citing family planning, malaria, HIV and maternal and child health programs and outcomes at greatest risk.
Respondents reported stockouts of antimalarials, contraceptives, and other primary care commodities, leaving facilities "empty-handed." They explained that, when caregivers no longer expect services to be available, community trust erodes and demand for immunization decreases. These dynamics are further compounded by strain on the health workforce: given the integration of health services and commodities, reported reductions in the immunization

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[2] Respondents often described or cited coverage drops from the perspective of their own facility's data and coverage calculations but typically did not elaborate on specific data sources. Descriptions of visible increases in zero-dose children are based on facility estimates and coverage targets and, in the perspective of the respondent, corroborated to them by a new lack of ability/funds to physically visit communities that were previously targeted by outreach and mobile visits.

[3] Facilities designated as 'zero-dose' serve areas where many children have not received any routine vaccines; facilities can move in or out of this status as coverage worsens or improves. In Nigeria specifically, facilities are currently designated as zero-dose when they fail to reach 80% of their target for Penta 1 in their catchment areas.

[4] Per Gavi, microplanning is an intervention that bundles planning activities, community engagement, and mapping — among other strategies — at the local level and has been suggested as a critical intervention to identify and research zero-dose children and missed communities.

workforce mean reductions in the health workforce in general. Increasing stockouts across multiple commodities, plus a shrinking and/or overstretched health workforce, contribute to the described weakening of broader health services.

These findings suggest that the effects of donor withdrawal are cascading down to the last mile of the immunization system, revealing large, systemic vulnerabilities. Simultaneously, they highlight clear leverage points where targeted, well-designed investments could rapidly restore coverage and prevent further backsliding. Beyond these immediate actions, our findings suggest there are deeper systemic dynamics – like workforce sustainability and supply chain vulnerabilities – in each of these countries that could be addressed with large-scale investment and innovation to redesign broader systems. In this memo, however, we have chosen to focus our recommendations on addressing acute challenges identified by stakeholders with the most impactful and cost-efficient solutions.

By acting on the insights shared in this report, GiveWell and other donors can play a catalytic role in reconnecting immunization systems with missed children and generating evidence to help governments, Gavi, and other partners re-prioritize funding toward proven, high-impact interventions.

Introduction

Background

In early 2025, the new United States presidential administration implemented significant reductions to the U.S. Agency for International Development (USAID) budget, at one point estimated to be over 90% of USAID foreign contracts (AP, 2025). Prior to 2025, USAID supported a wide range of immunization activities, including vaccine procurement and introduction, health worker training, outreach and community mobilization, supply chain logistics, data systems, and technical assistance to Ministries of Health, to strengthen routine immunization and expand equitable access to life-saving vaccines (US Department of State, 2018, Dahl et al., 2024). In a 'worst case scenario' some of these cuts could disproportionately affect routine immunization, health worker support, vaccine supply chains, and outreach programs, but more information is needed to understand how funding cuts are translating and affecting vaccination services at the last-mile (CGD, 2025; KFF, 2025).

The implications of these reductions are particularly severe in countries where domestic health budgets are already constrained and where international support has historically underpinned critical elements of immunization systems. Interruptions in this funding carry the potential to trigger rapid, localized breakdowns in vaccine delivery and to reverse hard-won gains in coverage, especially in hard-to-reach and underserved areas. The impacts are expected to be most acute at the "last mile" in facilities and communities where service delivery is already fragile and heavily reliant on external support. Yet, there is limited data on how these reductions are materializing at facility and district levels.

Within this context, GiveWell and R4D decided to undertake an assessment focused on understanding the impacts of USG funding cuts at the last-mile across three priority countries–DRC, Madagascar and Nigeria–to address gaps in available data. Findings from this work are intended to inform GiveWell's near-term and future grantmaking decisions in immunization.

Study objectives and learning questions

R4D designed this assessment to generate rapid, actionable insights on the impacts of recent USG funding cuts—including reductions from USAID, Centers for Disease Control and Prevention (CDC), and other agencies—on last-mile immunization service delivery in three priority countries. Our primary aim was to understand what was happening 'on the ground' in each country, in order to strengthen GiveWell's immunization evidence base and inform their internal strategy development.

Specifically, the assessment gauged how funding reductions affected health system functionality at the subnational level, focusing on facility and district dynamics and drawing on national-level insights for context. It examined six key technical domains to understand how these reductions affected immunization service delivery systems:

- Workforce, especially for vaccinators and other frontline healthcare workers
- Supply chain performance, particularly at the subnational level
- Service delivery, including disruptions to vaccination sessions
- Data and reporting systems
- Planning and prioritization, including coordination and decision-making among national and subnational actors (including resource allocation and new vaccine introduction, NVI, planning)

- Broader health system impacts, for other health services and commodities

Across these domains, the assessment explored:

- The ways in which vaccinators and other frontline health workers were affected by funding cuts, including changes in workload, staffing, incentives, and remuneration.
- New vaccine supply chain issues that emerged at facility and district levels, such as stockouts, procurement delays, and cold chain challenges.
- How fixed-site and outreach vaccination sessions were maintained or reduced, and which populations were placed at increased risk of being missed due to changes to sessions.
- Gaps that emerged in the collection and use of immunization data.
- How district and national actors adjusted planning, budgeting, and coordination to respond to new financial constraints, including implications for NVI planning.

These areas provided a structured lens for understanding how funding reductions translated into frontline disruptions and adaptation strategies in Nigeria, Madagascar, and DRC.

Country selection and rationale

Country selection was determined during the concept note phase (i.e., detailed in the linked Google Doc), based on where R4D could most feasibly operationalize, GiveWell's strategic interests, and the potential magnitude of impact from USG funding cuts. This ensured coverage of diverse contexts while keeping the work practical for rapid assessment. The final countries selected were: **DRC**, **Madagascar**, and **Nigeria**.[5]

While the countries were determined at the outset of the project, regional and facility selection took place between the concept note phase and after project launch, depending on the country:

- **DRC**: After the project launch, R4D and the DRC-based sub-awardee identified eight regionals previously supported by USAID and used Expanded Program on Immunization (EPI) input, coverage data, and variety of settings to align on two provinces – Sankuru and Kasai Oriental.
- **Madagascar:** During the concept note phase, R4D identified 14 regions previously supported by USAID, with plans to select two. Once the project started, we used coverage data, EPI input, and security status to align on two regions – Boeny and SAVA.
- **Nigeria:** R4D aligned with GiveWell during the concept note phase on conducting the assessment in four states: Jigawa, Kano, Niger, and Taraba. Ultimately, Taraba lacked an Internal Review Board (IRB) that could approve a study exemption for our assessment, so R4D and GiveWell aligned on Adamawa as an alternative.

Methodology

Research design

This qualitative assessment employed Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs), using semi-structured guides tailored to stakeholder groups (e.g., facility staff, district managers, national EPI stakeholders). Guides were adapted to each country and language to ensure contextual relevance.

[5] For additional detail on the country selection rationale, see the concept note here.

Sampling and study participants

A purposive sampling strategy was used to ensure diverse, context-rich insights. Participants included national and subnational health officials, facility managers, vaccinators, and community health volunteers. At least two regions and two districts per country were selected based on U.S. government engagement, immunization coverage, and facility performance. A mix of KIIs and FGDs were conducted to enhance accessibility and depth. A breakdown of selected stakeholders by country and role is in Table 1 below:

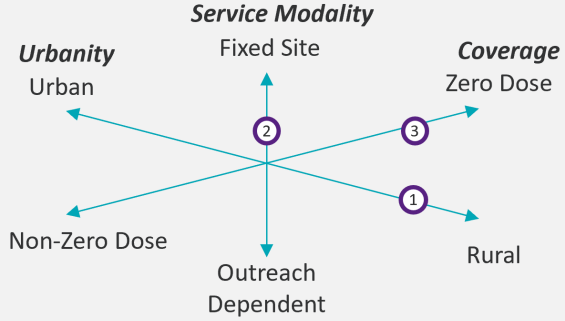
Table 1. Stakeholder Distribution by Country and Role:

Stakeholder type	Madagascar	Nigeria[6]	DRC
National Gov't	1 KII, 1 FGD	N/A	2 KIIs
National implementing partner/donor/Civil Society Organizations (CSOs)	1 KII, 2 FGDs	N/A	2 KIIs, 1 FGD (8 total)
Provincial/Regional/ State Gov't official	2 KIIs	16 KIIs	10 KIIs
Health district gov't official	2 KIIs	24 KIIs	13 KIIs
Health Facility level	8 KIIs	24 KIIs	22 KIIs
Vaccinators	20 total (KIIs + FGDs)	24 KIIs	25 KIIs
Community Agents (MG) Members of the health committee area (DRC)	4 total (KIIs + FGDs)	N/A	83 total (FGD)

Facility archetypes // Comparative vaccination site criteria

For this assessment, we initially planned to sample five immunization service delivery archetypes rather than pursue geographic representativeness.[7] Our aim was to focus on facility types most likely impacted by USG funding cuts and to capture key structural and operational features influencing last-mile delivery. We proposed covering between two and four archetypes per country, depending on government input, budget, and safety. The final list of site types was confirmed with national governments and GiveWell before data collection.

Example: Archetype Axes and Potential Facility Coding



While the archetype-based approach aligned with our objectives, several challenges in practice limited its feasibility: the archetypes were not mutually exclusive, their definitions varied across

[6] In Nigeria, we included more subnational areas than in DRC or Madagascar (4 states vs. 2 provinces/regions) and elected to focus on specific state-level vs. national stakeholders.

[7] For additional detail on the originally envisioned archetypes, see the original concept note here.

contexts, and they were inconsistently classified across countries. The example graphic on page 9 how decentralized coding resulted in divergent interpretations. We reflect on these challenges and offer recommendations for what we would do differently in the future in the Appendix (Table 4, on R4D learnings).

In addition to the practical challenges described above, Table 2 below shows that our facility sample skewed rural. While this limited our ability to compare archetypes as planned, it supported a core design element of the assessment: engaging vaccinators and health system actors working in harder-to-reach, under-resourced settings far beyond, for example, capital cities.

Table 2. Facility sampling by archetype

Archetype	Total site types	% of total site types	MG sites	NG sites	DRC sites
Remote, Rural	31	56%	13	14	8
Semi-Remote	5	9%	2	3	*
Zero-Dose	1	2%	*	1	*
Urban, Peri-Urban	16	29%	5	6	7
Fixed Site	2	4%	2	*	*
Total	**55**	**100%**	**22**	**24**	**15**

**archetype not included in final coded sampling*

Rather than relying on the archetype framework for comparisons in this memo, we have instead identified key comparative factors across site types that offer valuable insights, including: service delivery modalities (e.g., fixed, outreach, mobile), urbanity distinctions (particularly rural vs. urban), state-level trends in Nigeria, and transcript analyses referencing zero-dose sites and/or populations. Wherever possible, comparisons by site characteristics are captured within our domain-specific findings. State-level differences in Nigeria are also embedded in our domain-specific learnings and represented visually in the Appendix (Table 5).

Data collection partners, tools and procedures

To implement our rapid assessment, we partnered with organizations and/or consultants with country-level expertise; relationships with respective ministries of health; and capacity to conduct data collection, coding and analysis. In all countries, data collection took place between July and August 2025. In DRC, we partnered with the Department of Tropical Medicine at the University of Kinshasa, where the team was led by Trésor Zola Matuvanga; in Madagascar, we worked with TA4ID, a consulting group with a local presence; in Nigeria, we collaborated with a team of consultants, led by Dr. Mariya Saleh, with support from Dr Ibrahim A Ahmad, Dr. Omololuoye Majekodunmi, and Dr. Tijjani Hussaini.

In all countries, ethical protocols were reviewed and approved by the relevant authorities: in DRC, ethical approval was secured from the Ethics Committee at the Kinshasa School of Public Health, University of Kinshasa; in Madagascar, from the Secretary General of the Directorate of Expanded Program on Immunization; and in Nigeria, from the Ministries of Health in Kano and Jigawa, the Ministry of Primary Health Care in Niger, and the Ministry of Health and Human Services in Adamawa.

For data collection, all ethical protocols, including the collection of informed consent, were followed. All data collected through KIIs and FGDs were transcribed and coded in NVivo, with

quality control measures to ensure relative consistency and enable comparison across countries. Country-led teams were responsible for reviewing coded data for consistency; for the cross-country comparison, R4D completed coding spot-checks, sometimes resulting in additional conversations with country teams for clarification and/or requests for re-coding.

Data analysis

A multi-step qualitative analysis was conducted using NVivo. Theme frequency and intensity were examined by country and archetype, with file counts indicating topic spread and reference counts indicating depth. Within each country and archetype, domain-level findings were summarized using AI tools (e.g., Microsoft Co-Pilot) with specific prompts to use only imported text (i.e., interview transcripts). We validated AI-assisted summaries by reviewing the associated transcripts. This exercise was repeated for specific codes within the domains with comparatively high file and reference counts. For additional depth in our analysis, we also pulled all references to specific phrases and codes (e.g., zero-dose) in transcripts by country.

R4D also held a three-day, in-person workshop to review all of the data available and to generate and iteratively refine the preliminary findings of our cross-country analysis by domain and archetype. We developed country-specific summaries based on the data, independent of those produced by the country-teams, to validate or challenge our conclusions. These summaries were compared to state/region-specific memos developed by country teams to ensure alignment in themes identified. In this report, findings are synthesized across countries, archetypes, urban/rural divides, subnational categories, and zero-dose status to identify both shared and unique insights. Country-specific findings have been reviewed and validated by country teams.

Limitations

This rapid assessment was intentionally designed to gather qualitative data from purposively sampled key informants. As a result, the data are contextually rich but not statistically generalizable. However, the mechanisms and system behaviors observed appear transferable to similar contexts experiencing comparable disruptions, offering insights to strengthen preparedness and health system resilience to future shocks.

The findings are subject to potential bias from both participants and researchers. Participants may have shaped their responses to align with social expectations—either emphasizing or downplaying the effects of funding cuts. Researcher bias was also possible, including in interviewer conduct and interpretation, across both country-led teams and R4D. To mitigate these risks, we implemented standardized interviewer training and follow-up, and used multiple measures to assess the relevance and salience of findings (described above in Data Analysis).

Several other limitations emerged during analysis. The large volume of qualitative data collected complicated data management and cross-country comparisons. Interview participants also varied in their familiarity with the funding sources of immunization activities, making it difficult to attribute impacts to specific donors such as USAID and the study did not systematically fact-check or triangulate these accounts. Finally, the study intentionally oversampled rural facilities—typically the most negatively affected by funding cuts—which may have skewed findings toward more adverse experiences and limited representativeness.

Results and Insights

In the following sections, we present results and insights from our assessment across and within DRC, Madagascar and Nigeria. First, we present our cross-country analysis via ten key themes supported by illustrative quotes from interview transcripts. Next, we provide an overview of similarities and differences across the countries. And finally, we share country-specific findings organized by domain with additional sections on relevant analytical frames (e.g., references to nomadic/displaced populations in DRC and zero-dose children in Nigeria).

Cross-country analysis: overall project findings

Across all three countries, respondents consistently described a marked before-and-after shift following the withdrawal of U.S. government support. To reflect this experience as directly as possible, we included quotations throughout our summaries below that capture the majority findings and views across the assessment. These quotes were selected because they illustrate the causal chain respondents traced—from the loss of partner support, to specific disruptions, to the downstream consequences for coverage, equity, and health system performance. Our findings are presented in a similar fashion, moving temporally through immediate cause and effect to broader implications that stakeholders are navigating today. Together, these findings create a mosaic of how funding cuts reshaped service delivery, workforce, supply chain, data, planning, and other key topics across diverse settings. *Note that all findings described below are specific to the key informants and facilities sampled in our assessment.*

1. **Funding withdrawal created shockwaves at the last mile.**

Respondents almost universally characterized the cuts as deeply harmful, describing the system as slowed, fragmented, or stalled without the support of partner funding. Prior to funding cuts, systems were functional and seen as strengthened by USAID. In DRC, a Nurse Supervisor described extensive support provided by USAID under the PROSANI project for logistics, vaccine supply and transport, even providing bicycles for health aids to conduct outreach and mobile strategies; however, without this support, they said, “We no longer carry out mobile strategies in the health areas. Even outreach strategies are not fully implemented as planned.”

System shocks, many emphasized, pose the risk of declining coverage and rising risk of mortality. In Nigeria, for example, a state-level government official reported drops in all indicators evaluated between May 2024 and May 2025, including the number of outreach and mobile sessions, as well as coverage of PENTA 3. In DRC, a community health worker lamented, “Since their [USAID] departure, due to the disruption, we in the community have lost our children.”

2. **The loss of stipends and partner support triggered widespread workforce attrition, demotivation, and declining service delivery capacity – particularly for the volunteer health workforce and vaccinators.**

Respondents described facilities before funding cuts as being fully staffed, supported by partners in the form of training or financial incentives[8]. These supports kept key roles like vaccinators, data clerks, and community volunteers engaged and able to meet coverage targets. A Head Nurse in DRC, for example, described, “When [USAID] were here, there was

[8] Financial incentives may include, but are not limited, to the following: stipends, as a form of compensation paid by a partner or facility; transport stipends or allowances, to cover the cost of transport, including fuel, for outreach/mobile activities/vaccine transportation; and, outreach allowances, similar to a per diem, to cover the cost of food or incidentals while conducting outreach activities.

never a staff shortage, nor instability." In Jigawa, the USAID-funded M-RITE project expanded the workforce and its reach in hard-to-serve areas by hiring 27 "M-RITE" consultants to support "targeted outreach in the hard-to-reach areas, underserved settlements, zero-dose LGAs."

The loss of financial inputs and stipends caused great losses in the participation of community health volunteers[9], which increased the burden and workloads of remaining salaried staff and volunteers. As one facility manager in Adamawa explained, in a manner consistent with other interviews: "We have just two staff in the facility, and those staff are expected to attend to all units. The workload is too much even though we are trying our best, but it affects service delivery negatively."

Respondents repeatedly emphasized that this attrition caused both service gaps and a visible drop in morale. A CHW in Madagascar, for example, described a 40% drop in vaccination-related activities alongside decreasing enthusiasm among CHWs due to the loss of financial incentives. On the whole, stakeholder accounts across countries illustrate a vicious cycle: as stipends and partner support vanished, volunteers dropped out, remaining staff were overburdened, and coverage fell — further demotivating the workforce and worsening attrition.

3. **Service delivery shifted dramatically away from outreach and mobile strategies and toward fixed-post sessions.**

Prior to the cuts, immunization relied on a balanced mix of fixed sessions, outreach visits, and mobile teams that extended services to hard-to-reach areas. Respondents felt that the blend of service delivery options allowed for maximization of coverage, with donors placing particular emphasis on reaching underserved populations. After funding was withdrawn, respondents reported that mobile teams stopped almost completely, and outreach sessions became irregular. A Vaccinator in Madagascar explained this shift as follows, "Advanced strategies [i.e., outreach sessions] are the most important in vaccination, as they involve going directly to the sites to identify those who have been lost to follow-up and those who have received zero doses. In 2024, many donors funded [outreach], which allowed us to achieve good results. Today, the [ACs] are not very motivated without a donor, because currently, there are only UNICEF and the Unité de Coordination des Projets [donor coordination group]. This is why the results have declined."

Without stipends or transport, staff often cannot reach remote villages, leaving caregivers without access to services. While fixed-post sessions have continued and are prioritized, they are also impacted by funding cuts by way of reduced attendance due to product stockouts and the absence of community mobilization. As described by an Officer-in-Charge in Nigeria, "…because like I told you, when they come and don't get the vaccine, that will discourage them from coming back and that will affect the turnout of the fixed sessions."

4. **Last- mile vaccine transport and distribution have become more unreliable, causing more frequent stockouts and session cancellations.**

Before the funding cuts, respondents described vaccine distribution as comparatively predictable and well-supported by partners. USAID and other donors funded fuel, transport

[9] Proxies in this report for Community Health Workers include: Agents Communautaires (ACs) in MG, Relais Communautaires (RECOs) in DRC, and Community Health Workers (CHWs) across countries. In Nigeria, CHWs are distinct from Community Health Extension Workers (CHEWs), in that CHEWs have formal healthcare training and are regulated by the National Primary Health Care Development Agency. While analogous to CHWs in that they are volunteer or lay health workers, some roles in Nigeria are more descriptive - e.g., community mobilizers, town criers, etc.

stipends, and emergency deliveries, ensuring that vaccines arrived on time and that outreach sessions could be implemented as planned. Since the withdrawal, surveyed facilities are struggling to fund and organize vaccine collection, leading to transport delays and inconsistent supply. In Nigeria, for example, vans used for distribution are sitting idle due to lack of fuel funding, and health facilities must pay out of pocket to collect vaccines.

This is resulting in growing service disruption and increasing the risk of missed children. Stakeholders described delivery staff as less willing to travel without fuel support and warned that repeated stockouts are discouraging caregivers from returning, fueling increases in under-vaccinated and zero-dose children. In DRC, a Regional Immunization Program Manager described this dynamic as follows: "You imagine a mother who brings her child for an appointment and finds …the vaccines are not yet available. When she comes back, it's very likely that she won't be able to come back. And already, this child is lost from sight. They won't come here. What they are going to do is what will increase the number of zero-dose and under-vaccinated children." Stakeholder accounts show how a breakdown in transport and delivery has turned what respondents felt like was a predictable supply system into a fragile, costly, and unreliable one — with direct consequences for coverage and equity.

5. Coverage rates are already declining, with evidence of reversals in recent gains.[10]
Across the three countries, respondents said that as outreach and mobile strategies stopped and stockouts increased, coverage dropped. Before cuts, the perception was coverage was strong and progress was being made. Respondents linked falling coverage numbers and outbreaks to disruptions in service delivery, warning that gains made in recent years are being lost. In Nigeria, a Cold Chain Officer connected the reduced and de-motivated workforce to poorer immunization service delivery, stating, "In the immunization section we have a large number of dropouts because we are unable to reach the number of targeted children due to the fact that there are hard to reach areas where one has to trek or commute with motorbikes all due to the funds cut."

Since the cuts, coverage has started to slip, with respondents citing concrete declines. A Regional Immunization Program Manager in Madagascar reported: "For Penta 1, in May 2024, we were at 80%, and in May 2025, at 76%. For Penta 3, in May 2024, we were at 68%, and in 2025, at 64%." Respondents worry these drops, and the failure to meet vaccination coverage targets in general, will translate into preventable disease outbreaks and child deaths. A Vaccinator in Madagascar summarized the impact of funding cuts on coverage as follows: "The impact I see is that the vaccination coverage target may not be met. Vaccination prevents certain diseases, so unvaccinated children are exposed to these diseases. In public health, this can cause many casualties and make it difficult to control the negative effects due to the lack of vaccination, due to the departure of USAID." With coverage declines already measurable in some areas, there is concern that if not remedied quickly, they could negatively impact progress toward reducing zero-dose children and preventing outbreaks.

6. Progress made in reaching zero-dose children is being lost.
Building on the concluding point from the previous paragraph, across all three countries, respondents consistently reported that gains in reaching zero-dose children are eroding since

[10] Respondents often described or cited coverage drops from the perspective of their own facility's data and coverage calculations but typically did not elaborate on specific data sources. Descriptions of visible increases in zero-dose children are based on facility estimates and coverage targets and, in the perspective of the respondent, corroborated to them by a new lack of ability/funds to physically visit communities that were previously targeted by outreach and mobile visits.

the withdrawal of U.S. government support. They described a clear causal chain: when partners funded transport, stipends, and community mobilization, facilities could systematically find and vaccinate children with no prior doses. Without these supports, outreach has become irregular or stopped, and children in remote areas are increasingly missed.

Before the funding cuts, partner support was credited with transforming facility performance and allowing teams to reach beyond their usual catchment areas. A Regional Immunization Program Manager in Madagascar remarked, “We worked with USAID on the search for zero-dose children. USAID's presence really improved the performance of the [primary health centers], as they supported them in all areas: travel, compensation for stakeholders, etc.…Moreover, they didn't just support the [primary health centers]in the communes, but also extended to the outskirts, such as [primary health centers]…This was a real asset.” In DRC, another Regional Immunization Program Manager credited support from PROSANI-USAID with the ability to “intensify” their vaccination activities, specifically for zero-dose and undervaccinated children.

Once funding was withdrawn, respondents described delays or cancellation of outreach sessions, and some facilities fear that they are sliding back toward high-zero-dose status. For example, an Officer-in-Charge in Nigeria tied the rise in zero-dose children directly to the reduction or lack of outreach sessions: “It is not long we managed to move out of zero-dose facility that the fundings stopped, and I’m afraid now we are back to the status of zero-dose facility. And this was a result in the negligence in terms of outreach sessions, if it is not negligence, it will be as a result of delay, which that delay is caused by skipping outreach session.” In DRC, stakeholders connected the rising numbers of zero-dose and undervaccinated children to a resurgence in epidemics, like Acute Flaccid Paralysis, among others. These accounts suggest that progress made in finding and vaccinating zero-dose children is at risk of being lost — with direct consequences for equity, coverage, and outbreak prevention.

7. **Rural sites are disproportionately affected by funding cuts.**

Respondents emphasized that rural sites are harder-to-reach and more dependent on funded outreach, transport, and volunteer support. When funding stopped, these areas were disproportionately affected, with outreach canceled and entire villages left without visits for months. In Nigeria, a Facility Manager described a 50% reduction in manpower - i.e., the number of outreach teams dropping from ten to five teams - for visiting hard-to-reach settlements. In Madagascar, a CSO detailed the impacts of reduced outreach in rural areas: “The first visible impact is the sharp increase in the number of unvaccinated children. Many parents were used to home vaccination, so they wait at home. But now, since door-to-door is no longer done, the children are not vaccinated, and infant mortality risks increasing.”

Last-mile distribution also takes on new challenges in rural zones, where transportation across vast and sometimes difficult terrain is a major barrier, and the absence of fuel or functioning cold chain equipment has led to vaccine spoilage and session cancellations. These disruptions have not only reduced coverage but also eroded community trust. In areas where outreach was once routine, the sudden absence of services has led to skepticism and disengagement, further complicating efforts to recover lost ground.

8. **Data and reporting systems became more fragmented, expensive, and prone to delays after the cuts.**

Data collection and reporting systems have felt the impact of funding cuts, severely limiting visibility into the health of the immunization system and undermining the ability to monitor coverage in real time. Before the withdrawal, partners funded data clerks responsible for

uploading data, plus the printing of data collection and reporting tools and internet subscriptions, enabling timely weekly reporting. This infrastructure allowed for consistent, standardized data flows that supported planning and accountability. In Nigeria, a state-level government official described USAID support via stipends for data clerks in 226 facilities, characterizing data delivery as "efficient and without delay, unlike now [after USAID's withdrawal]."

Without this support, surveyed facilities have had to purchase or photocopy their own tools, and some ask caregivers to buy their own child health booklets, which is a barrier for many families. As detailed by a Vaccinator in Madagascar, "Patients are asked to bring a booklet, even though they were always free during the USAID era, and some people can't even afford to buy one. Without management tools and without funding, it's really difficult!"

Reporting is now often delayed or incomplete, with staff bringing reports in non-standard formats that must be adapted before they can be entered into national systems, creating additional work and risking data errors. When reporting tools are stocked out, stakeholders across all three countries report using photocopied forms, notebooks or scraps of paper. In DRC, a Nurse Supervisor described challenges with non-standardized reporting and data quality, stating, "At the end of the month, we take the registers and see how many children we have vaccinated, to make a summary report that we will submit to the central office. Now, if we don't have the tools, everything is already biased."

These disruptions have fragmented the data ecosystem, increased operational costs, and made it more labor-intensive to maintain data flows. But more critically, they have obscured visibility into who is being reached and who is being left behind. Incomplete records and inconsistent reporting make it difficult to track immunization coverage, monitor commodity and logistics data, identify geographic or population-level disparities. This information is essential for local, state and national governments to make strategic, evidence-based decisions about where to direct resources (e.g., commodities, personnel) to improve coverage. When data systems falter, it becomes harder to hold health system actors accountable for coverage outcomes. This weakens the feedback loop between service delivery and policy and erodes trust in the system.

9. **Microplanning[11] and coordination processes have stalled, reducing the system's ability to optimize and adjust coverage strategies.**

Respondents described that quarterly or monthly planning meetings were once routinely funded and enabled course corrections throughout the year. Now, without resources for transport, printing, or stipends, these meetings are shortened, postponed, or canceled, leaving health teams without the tools or forums to identify gaps or plan catch-up campaigns. Microplanning and coordination processes have effectively stalled, significantly reducing the system's ability to optimize and adjust coverage strategies. A Nurse Supervisor in DRC explained the importance of having support for microplanning: "[USAID departure] had an impact because developing a microplan requires support. With local resources alone, we can't make a proper microplan. You need to invite the ITs, the CODESA [Comité de Développement Sanitaire] president—those on the ground who know the villages and the distances between villages and health centers. That requires resources—to bring these people together, train them, and do everything we've always done for microplanning. But since we lack resources, it has an impact—we struggle to develop the microplan."

[11] Per Gavi, microplanning is an intervention that bundles planning activities, community engagement, and mapping — among other strategies — at the local level and has been suggested as a critical intervention to identify and research zero-dose children and missed communities.

Stakeholders are continuing to piece together microplans, but report struggling without donor support. A Head Nurse in Nigeria stated, “With USAID, we were required to conduct supported microplanning. But this time, it’s really painful. We do the microplanning without support. We are forced to push ourselves—along with the central office team—to organize proper microplanning.”

10. **Broader health system services have weakened, with respondents citing family planning, malaria, HIV and maternal and child health programs and outcomes at greatest risk.**

Respondents noted that the withdrawal of USAID support also disrupted other primary health services. Stockouts of antimalarials, contraceptives, and HIV tests were reported, with maternal health services and commodities hit hardest. A Head Nurse in DRC lamented, “If you dare enter the pharmacy, you’ll cry. It’s almost empty. There’s nothing. No mosquito nets. No antimalarials. Everything—everything—is at zero.” In Nigeria, stakeholders described unavailability of commodities for biannual Maternal Newborn and Child Health week campaigns and reported, “So, generally speaking now, all health services have deteriorated because all units are affected like labor and delivery, family planning, immunization and the rest.”

Integration of immunization with other health services means that stockouts of immunization or other key commodities negatively impact caregiver and client trust and confidence in the health system overall. Describing this dynamic in Madagascar, a CHW said, “People come to me, but I can’t help them. I used to have medicines, and that built trust. Now, I have nothing to give. My reputation is declining.” Reduced supportive supervision, including that which used to be provided for integrated services, was also reported. In Nigeria, a Routine Immunization Officer provided an example of how he approached supportive supervision in the past, using the opportunity to visit to assess and provide coaching for multiple, integrated services (e.g., immunization and antenatal care). By the same token, multiple health areas are impacted negatively by reduced funding for supportive supervision.

These dynamics are exacerbated by strain on the health workforce: given the integration of health services and commodities, reported reductions in the immunization workforce equal reductions in the health workforce available for other health services as well. Stockouts across multiple integrated commodities, plus a shrinking and/or overstretched health workforce, contribute to the described weakening of broader health services.

Similarities and differences across countries

Across DRC, Madagascar, and Nigeria, respondents described a remarkably similar before-and-after trajectory: partner withdrawal led to the loss of stipends, transport support, and data system inputs, which together reduced outreach frequency, delayed vaccine transport, and left districts less able to plan and monitor coverage. In all three countries, respondents warned of declining coverage, more missed children, and increased outbreak risk, underscoring how fragile last-mile immunization systems are without partner support. Urban facilities across countries generally maintained fixed sessions but noted reduced demand, while rural facilities were often unable to perform outreach and mobile sessions, leaving rural communities–which had become accustomed to those types of service delivery–unreached by the immunization system for extended periods.

Across countries, some differences emerged in immunization topic emphasis and intensity:

- In DRC, respondents most frequently highlighted the loss of volunteer stipends and the collapse of microplanning and data review meetings, which left health areas without active community mobilization and with unvalidated or delayed data.
- In Madagascar, stakeholders stressed the near-complete halt of outreach and mobile strategies, describing entire fokontany[12] going months without visits and warning that remote households are increasingly missed.
- In Nigeria, one dominant theme was the breakdown of the partner-supported "push" system for vaccine distribution[13], forcing LGAs and facilities to collect their own vaccines and contributing to stockouts of vaccines. Notably, in Nigeria respondents cited the collapse of its push system for vaccines distribution, but it has been difficult to independently verify where and when USAID was or was not funding elements of the push system.

Country specific findings

Democratic Republic of Congo

Overall findings

The abrupt end of USAID's PROSANI[14] project marked a clear turning point for immunization delivery in the two study provinces, Sankuru and Kasai Oriental. Under PROSANI, core operational inputs were consistently funded — transport and fuel for vaccine distribution, stipends for Relais Communautaires (i.e., RECO – a voluntary community health relay, or the community health worker analog in DRC) or RECOs, per diems for facility staff to join supervision and outreach, data tools and internet connectivity for DHIS2 reporting, and quarterly planning and review meetings. Urban and rural communities reported receiving similar levels of substantial partner support. Respondents repeatedly contrasted this period with the present, describing the system as slower, less coordinated, and less able to reach children.

Across interviews and group discussions, three themes emerged as most consequential: workforce disruption, the sharp reduction of outreach and mobile delivery, and weakening of data reporting and planning systems. RECOs, once the frontline for mobilization and tracing missed children, are now unpaid in many areas and have stopped home visits. Facility staff, whose salaries were already delayed, lost partner-funded supplements and reported fewer outreach sessions and greater difficulty maintaining coverage.

Respondents consistently described outreach and mobile strategies as the hardest hit modalities: teams once held outreach sessions monthly, but now run them sporadically, and have had to suspend mobile strategies entirely. They report that fixed-site services continue but

[12] Madagascar-specific term that refers to the smallest administrative unit within a commune, similar to a village or neighborhood

[13] In Nigeria as well as other countries, commodity distribution - including for vaccines - is typically described in terms of "push" or "pull" systems. In this context, the "push" system means that commodities are pushed from a centralized location to the LGA or the last-mile, with partners or donors typically covering the costs of transport to the last-mile. In a "pull" system, facilities at the last-mile must pick up commodities from a centralized location and bring them to the last-mile, often at their own cost.

[14] Projet de Santé Intégré (PROSANI) was a large-scale USAID-funded health service delivery program implemented across 78 health zones in DRC from 2010-2025. PROSANIplus, implemented from 2015-2018, expanded coverage to 168 health zones. USAID's Integrated Health Program (USAID-IHP) followed with an expanded mandate beyond service delivery, and was implemented from 2018-2025.

serve fewer children, particularly in remote areas where mobilization has lapsed. Several zones reported measles outbreaks coinciding with these gaps.

Interviews revealed that data systems have also weakened with the loss of partner funding for tools and forms, VSAT internet subscriptions, and coordination meetings. Health zones described related challenges that have emerged including having to use ad hoc report formats, lengthening delays in reporting data, and struggles to validate and analyze data for decision-making.

While these patterns were reported in both provinces, respondents in Kasai Oriental most often emphasized service delivery disruptions – especially the loss of RECO stipends and its impact on CHW involvement – whereas Sankuru respondents highlighted the challenges of data reporting, microplanning, and maintaining services within the broader health system in a highly remote setting.

Domain findings

Perception of Funding Cuts

Across DRC, respondents overwhelmingly characterized the withdrawal of USAID/PROSANI support as disruptive. They described a clear "before and after": prior to the cuts, partners routinely funded core enablers of vaccination, and now those supports are irregular or absent. The tone of interviews was strikingly urgent as respondents spoke of "lethargy," "loss of motivation," and described the health system as having "no one to push it forward."

Stakeholders consistently said that the funding gap has not been filled by other partners, and several expressed concern that no new support is forthcoming. Although a few respondents noted that vaccination remains a priority despite reduced funding, these comments were rare compared to the prevailing sense that the system is slowing down.

Workforce

Stakeholders consistently described the workforce as the domain most affected by the USAID/PROSANI withdrawal. Before the cuts, partners funded stipends for RECOs, as well as allowances and per diems for facility staff, which both supplemented delayed government salaries and covered outreach costs. RECOs mobilized caregivers, identified zero-dose children, and submitted community-level reports. According to interviews, these supports kept both community and facility teams engaged and able to meet session targets.

Respondents said these supports "stopped suddenly" and have not been replaced. RECOs are now unpaid, rely on personal funds or community contributions, and, in many areas, have reduced their participation in the health system or stopped work altogether. Respondents reported that this loss led to fewer outreach visits and fewer home visits to find missed children.

As described in interviews, both facility staff and RECOS have lost reliable financial support. Many RECOS were reported to have stopped attending meetings, mobilizing households, or conducting home visits. Reports even highlight that some staff have turned to farming to replace a once-reliable source of compensation. As a result, interviews emphasize, outreach sessions have declined, leaving many households unreached. Supervisors report a rise in zero-dose and underimmunized children since January 2025. The removal of incentives for tracing missed children has further reduced RECO engagement, according to interviewed stakeholders. Without follow-up, children who miss sessions often remain unreached for months. Health zone managers warn that unless support for community tracing resumes, coverage will continue to

fall and equity gaps will widen. One health committee member summarized: “Since the partners stopped supporting us, the RECOS have stopped working. Community activities are no longer done as before.”

Supply Chain
Respondents identified vaccine distribution as one of the most disrupted areas following withdrawal of USAID/PROSANI support. USG partners previously funded fuel and per diems for health zone and facility staff to collect vaccines from depots and, in some cases, they organized deliveries during stockouts:

- In Kasai Oriental, USAID provided support by transporting vaccines from regional/provincial level to 10 out of 19 total central health district offices in the province.
- In Sankuru, USG partners supported the transport of vaccines from the national EPI Directorate to the regional depot, and in cases of stockouts at the health zone and facility level, USG partners hired vehicles to transport vaccines from the depot to facilities.

This transportation support was described as essential to keeping sessions on schedule and preventing shortages.

Post-funds withdrawal, most zones reported that vaccine transport now depends on occasional district meetings or ad hoc funding. Facilities pool personal resources, borrow motorcycles, or walk long distances to collect vaccines. Several zones linked these delays to stockouts of DTP-HepB-Hib, OPV, and measles vaccines, noting that children are sometimes turned away and do not return. While stakeholders clearly connected transport gaps to the loss of partner funding, some emphasized that certain stockouts are due to upstream procurement delays, making attribution of all stockouts to funding cuts difficult to verify.

Cold chain equipment was rarely flagged as a major constraint; however, several zones reported growing difficulty repairing broken fridges due to lack of funds or transport for technicians. Respondents said USAID’s role in the cold chain was largely indirect; previously, support included supervision, training for preventive checks, and limited deployment of technicians to conduct diagnostic assessments and repair nonfunctional equipment.

Service Delivery
Respondents consistently described the reduction of outreach and mobile sessions as one of the most damaging effects of the funding cuts. Under USAID/PROSANI support, outreach sessions were scheduled regularly in both urban and rural areas, with RECOs mobilizing caregivers and tracing children who had missed doses. Partner funds covered fuel and per diems, allowing teams to travel long distances and reach most villages, including remote sites that sometimes required travel by motorcycles or pirogues.

Since funding withdrawal, outreach and mobile activities have shrunk dramatically, with rural areas reporting a sharper decline, as outreach sessions are frequently canceled due to lack of fuel or per diems, leaving some catchments unreached for months. Other notable findings included:

- Health workers reported walking long distances or crossing rivers by canoe to deliver vaccines, efforts many said are not sustainable.
- Respondents said community-based tracing and catch-up efforts have largely stopped.
- In urban areas, outreach has been reduced but rarely described as completely halted.
- In all areas, mobile teams were rarely mentioned and appear largely inactive.

As a result, respondents say zero-dose and underimmunized children are increasing, particularly in hard-to-reach areas. Several health zone managers reported measles outbreaks that coincided with these outreach lapses and warned that more outbreaks could occur if services are not restored.

Fixed-site sessions have largely continued but are occasionally disrupted by staff or vaccine shortages, resulting in delayed or canceled sessions. According to stakeholders in urban settings, fixed sessions still run regularly, and several facilities have adapted by shifting session times to maintain attendance. Several respondents said that when caregivers arrive and find no session or no vaccine, they often do not return. The loss of RECO incentives, particularly in rural areas, and awareness campaigns has further reduced demand, with fewer parents bringing children unless actively mobilized. While impacts are described with the greatest severity\in rural areas, urban sites also reported disruption (e.g., stockouts, demotivation, skipped meetings) but also more service continuity overall.

Data and Reporting Systems

Before the funding cuts, respondents described functioning data flows supported by PROSANI. At the community level, RECOs and health committees had notebooks, registers, and monthly activity report forms to prepare reports — all supplied under partner support. At the facility and health zone level, USAID/PROSANI financed the reproduction of reporting tools and internet connectivity for District Health Information System 2 (DHIS2) entry, including VSAT internet subscriptions that kept zones online. They also funded multi-day monitoring and review meetings that allowed head nurses to analyze and validate data before transmission, which respondents credited with ensuring accuracy and fixing errors early.

After the withdrawal, respondents reported tool shortages and connectivity gaps that disrupted timely reporting. “We even write small reports on scraps of paper… Before, they had notebooks, registers, calculators… now… it’s really catastrophic,” one health worker said. Community actors now buy paper or photocopy forms themselves. Facility staff said printing reporting tools has become their responsibility, and VSAT internet subscriptions and data packages have stopped. Head nurses bring reports “in a format that is not suitable,” and data clerks struggle to adapt them for DHIS2 entry. Some must travel long distances to buy data bundles, delaying submissions. Urban sites described more adaptations and resilience than rural; urban teams more often reported improvising workarounds such as buying registers or traveling to submit DHIS2 reports. Routine review meetings have been shortened or canceled, which respondents said leaves less time to check errors.

Several managers said these challenges coincided with declines in reported coverage and weaker monitoring. “Coverage has dropped… we have seen a regression,” one data manager observed, linking the loss of reporting tools, connectivity, and review time to reduced ability to track performance and plan sessions.

These impacts appear most strongly in rural areas, where microplanning and data validation meetings have largely stopped, and staff often pay out-of-pocket for forms and transport. Respondents linked these gaps to preventable deaths and worsening child and maternal outcomes.

Planning and Prioritization

Before the USAID/PROSANI withdrawal, USG partners funded the core processes for immunization planning and coordination, including the preparation of Annual Operational

Plans[15] and detailed microplans[16] for each health area. Respondents said this support covered the costs of gathering health area staff and community representatives to review population data and prepare outreach schedules. These meetings also served as a venue to validate data and make mid-year adjustments to ensure coverage targets were met.

Since the cuts, many health zones, particularly in rural areas, have been unable to conduct or update microplans, citing lack of funds for meeting logistics, printing templates, and transport reimbursement for participants. Several respondents reported that quarterly data validation and steering meetings have stopped altogether. As one EPI supervisor put it, “We have not been able to finalize our microplans because there is no funding to bring the teams together,” a view echoed by others who said this has slowed decision-making and left gaps in outreach planning.

Respondents consistently warned that the absence of microplanning will have direct consequences for immunization performance, with outreach becoming less targeted and coverage expected to decline in the coming months.

Broader Health System Impacts

Stakeholders repeatedly emphasized that the effects of USAID’s withdrawal extended well beyond immunization, describing the destabilization of other primary health care services. Before January 2025, PROSANI-funded support provided essential medicines, including antimalarials, rapid diagnostic tests, HIV tests, and treatments for severe malnutrition. These inputs were consistently described as critical to maintaining service coverage and keeping households from paying out-of-pocket, as several services and commodities were free under PROSANI support. For example, antimalarial drugs and other essential medicines used to be provided at a reduced cost through an internal hospital pharmacy system, where a “moderating ticket” was issued to lower the price for adults while maintaining free access for children. This system also helped discourage perceptions that “free” medicines were ineffective.

Since the cuts, facilities report months-long stockouts of antimalarials, HIV tests, and routine essential drugs. One facility head explained: “Before, we received free medicines through the partners. Since their departure, there are no more medicines. Patients must buy everything, even paracetamol.” Several respondents linked these shortages to increased mortality, particularly among children and pregnant women. Since the end of PROSANI/USAID funding, the commodity subsidy mechanism has disappeared. Patients must now take their prescriptions to external pharmacies and purchase medicines at full price. Similarly, patients are now charged for malaria diagnostic tests (i.e., RDT and thick smear), whereas tests were previously free.

Participants claimed that the cuts have also weakened community health structures. Health area development committees, or CODESA committees, no longer meet regularly, and RECOs, who previously conducted door-to-door sensitization and mobilization, are largely inactive. CODESA committees are viewed as important links between communities and health facilities, playing key roles in community mobilization, oversight, resource mobilization, and health service improvement. Without funds for transport or supervision, community engagement activities have stopped, leaving gaps in health promotion and demand generation.

[15] Annual Operational Plans (AOPs) are planning documents summarizing all activities to be implemented throughout the year, which also include a synthesis of key immunization indicators achieved during the previous year.

[16] Microplans summarize key activities that health facility staff have planned to implement during the period, serving as a reference document for the health facility to guide immunization service delivery and monitoring.

Respondents warned that these combined effects threaten broader health system performance and could reverse previous gains in maternal and child health. One chief medical officer summarized: “Many indicators have turned red… truly, there are no medicines. It’s a major challenge.”

Comparative site characteristics findings

Nomadic and/or Displaced Populations
Mentions of displaced or camp-based populations were limited in the transcripts. One national-level partner noted that USAID funding was key to reaching displaced populations in humanitarian provinces such as North Kivu, South Kivu, and Ituri. A rural head nurse described serving a remote forest settlement that functions like a camp, requiring motorcycle travel followed by walking to reach a few thousand targeted for vaccination.

While these examples confirm that USAID played a role in extending vaccination services to displaced and remote populations, they were rare in the dataset. Overall, the impacts of USAID’s withdrawal on these groups cannot be assessed in depth from available transcripts but are likely to mirror the broader reductions in outreach and access seen in rural areas.

Madagascar

Overall findings

The withdrawal of U.S. government support, specifically through USAID’s ACCESS[17] program and PSI/IMPACT[18] has disrupted multiple parts of Madagascar’s immunization system, with the strongest and most consistent effects at the community level. The loss of stipends, transport support, and supervision for Agents Communautaires (ACs) left many demotivated or caused them to stop entirely. Without these actors, facilities lost their primary mechanism for mobilizing caregivers and conducting outreach, leading to fewer sessions and rising numbers of zero-dose children.

Across interviews and group discussions, four themes dominated stakeholder concerns: workforce losses, the reduction of outreach and mobile delivery, supply chain issues, and weaknesses in data systems. These were consistently described as urgent problems, viewed as the biggest threats to coverage and equity. While fixed-site vaccination has largely been maintained, outreach and mobile campaigns have shrunk dramatically, reducing access for remote households.

These patterns in Madagascar were consistent across both focus regions, suggesting that the impacts reflect the systematic nature of USAID support across Madagascar rather than region-

[17] Accessible Continuum of Care and Essential Services Sustained (ACCESS) was a USAID-funded community health and vaccination program implemented in 14 regions in Madagascar from 2018-2025. Note that it was originally supposed to end in 2023 but had been extended through March 2025.

[18] PSI/Improving Market Partnerships and Access to Commodities Together (PSI/IMPACT) was a USAID-funded project focused on logistics and supply chain support, vaccine distribution, cold chain management, and transportation systems. It covered the same 14 regions as ACCESS and operated 2018-2024. Note that it was originally funded through 2023 but had been extended through December 2024. Note also that for both projects, R4D’s data collection partner TA4ID, emphasized that even with projects expected to end, stakeholders did not expect a complete cessation and disruption to USAID funding and instead expected that new USAID-funded projects would come online.

specific vulnerabilities. Both regions experienced universal community agent demotivation and attrition, significant supply chain disruptions, and reductions in outreach and mobile vaccination strategies. The SAVA region appeared to experience more dramatic facility-level workforce reductions while the Boeny region experienced more systematic destabilization of disease tracking and facility surveillance. Stakeholders noted a 13% decline in site visits and attributed a measles outbreak to the lack of monitoring. Generally, however, these minor differences suggest that the impacts are systemic rather than region-specific.

There was broad consensus in interviews that the combined effects of lost transport, mobilization, and supervision have led to fewer children being reached overall. Respondents repeatedly predicted declines in coverage and cited increases in missed vaccination opportunities as evidence that the system is no longer keeping pace with demand.

Domain findings

Perception of Funding Cuts

Nearly all respondents characterized the funding withdrawal as a major setback. Stakeholders traced a clear chain: ACCESS withdrawal ended AC incentives and community engagement support, and PSI/IMPACT withdrawal removed vaccine transport and emergency distribution capacity. District managers expressed skepticism that remaining partners (WHO, UNICEF, Gavi) could fill these gaps, citing their differing mandates and more limited capacity. Only one central stakeholder described the withdrawal as an opportunity for government ownership; most warned that coverage would decline and outbreak risk would rise, noting that surveillance is now irregular and delayed.

Workforce

Workforce impacts were the most frequently mentioned consequence of the cuts, raised in nearly every interview and often described with urgency. Interviewees emphasized that the funding withdrawal disrupted support for both community health volunteers (ACs) and facility-based staff, though in different ways.

At the community level, ACs played a central role in outreach and mobilization: they conducted home visits, organized sensitization activities, identified and referred zero-dose children, and followed up with families who missed sessions. Several ACs explained that during the ACCESS period they had access to resources that made this work possible — such as monthly activity report forms for recording village-level data, registers, sensitization materials (e.g., booklets or backpacks), and communication credit for reporting. Some ACs also mentioned receiving small stipends or transport reimbursements tied to monthly coordination meetings, which allowed them to bring reports to the primary health center.

When this support ended, ACs lost both the resources and the incentives that enabled them to maintain regular community contact. Many reported that they could no longer afford phone credit, transport, or photocopying and therefore delayed or skipped reporting. Others said they reduced or stopped outreach and mobilization altogether, leaving large parts of some catchments without sensitization or follow-up of missed children.

At the facility level, primary health center staff reported that they lost funded supervision visits, quarterly performance review meetings, and external logistical support for outreach. These visits often included on-site coaching, data quality checks, and even preventive cold chain maintenance. In retrospect, quarterly reviews were especially valued as a forum to analyze coverage data, identify missed children, and coordinate catch-up activities.

One primary health center head in SAVA described walking hours to deliver vaccines after the outreach team shrank from 27 to seven staff, noting that “we do what we can, but many villages have not been visited for months.”

Together, these changes have reportedly weakened both tiers of the workforce: AC participation has dropped, community-to-facility data flow has become less timely and complete, and facilities have less oversight and fewer opportunities for course correction. Stakeholders warned that without renewed support for AC engagement, training, and supervision at the facility level, coverage gaps will widen, and equity will deteriorate.

Supply Chain

The clearest reported supply chain shift since the withdrawal of PSI/IMPACT and ACCESS support has been in vaccine distribution, primarily affecting the final distribution node where vaccines move from higher-level storage to service delivery points. Prior to funding cuts, PSI/IMPACT provided transportation from regional vaccine depots to district health offices and directly to health facilities for routine and emergency vaccine supplies. Several facilities reported that during the ACCESS period, stockouts were rare, and distribution was timely and well-coordinated. Respondents recalled that, “before, supply arrived without much delay,” and a primary health center in the Boeny region noted, “when ACCESS was here, there were no stockouts,” specifically referencing consistent availability of vaccines like BCG.

At present, the lack of reliable transportation, lowered capacity for emergency response, and breakdown of systematic distribution scheduling and coordination have been particularly severe for remote facilities that were entirely dependent on PSI/IMPACT transportation. Respondents frequently cited transport and delivery challenges as major bottlenecks. Several facilities reported intermittent stockouts of BCG, DTC/DTP, PCV10, and Penta District managers and primary health center heads described needing to collect vaccines themselves, sometimes without fuel or a functioning vehicle, slowing replenishment and delaying vaccination sessions. Stakeholders generally linked these disruptions to funding shortfalls and the end of partner support, However, not all respondents explicitly named USAID as the cause of current stockouts, and some spoke more broadly about declining financing or logistics capacity. After the fact, when trying to confirm the linkage between USG fund withdraws and stockouts cited in interviews, it’s difficult to fully separate the effects of USAID withdrawal from other contributing factors, such as delayed government deliveries or general resource constraints.

Cold chain equipment itself was not frequently described as a current barrier. Most facilities reported that solar refrigerators installed in recent years remain functional, though a few cited delays in repairing or installing regional cold rooms since donor funding ended. USAID’s contribution to the cold chain was indirect, primarily through equipment functionality checks, maintenance coordination, quality assurance of vaccine storage protocols, installation support, and training on cold chain management. However, several respondents pointed to stalled maintenance and installation as consequences of losing external support.

Service Delivery

Before the funding cuts, fixed-site, outreach, and mobile sessions together formed a balanced service delivery model according to those we interviewed. ACs mobilized caregivers ahead of vaccination days, and fuel and per diems for outreach teams were regularly funded, enabling monthly visits to remote communities. Several facilities reported that this combination of fixed and outreach services was crucial for maintaining high coverage and keeping zero-dose numbers low.

After the withdrawal, respondents consistently said that outreach was the first activity to be reduced or stopped, with rural facilities reporting the most acute impacts. This has led to:

- Monthly outreach sessions being suspended for extended periods;
- Entire villages being left without vaccine access; and,
- Services provided by mobile teams, which were once essential for reaching remote populations, being suspended.

This shift has forced caregivers to travel long distances to fixed sites, where stockouts and canceled sessions often discourage return visits. Respondents have linked these changes to declining coverage and the rising number of zero-dose and under-immunized children.

While fixed-site vaccination services have largely continued, especially in urban areas, stakeholders have reported changes, including:

- Operating with fewer staff and heavier workloads;
- Challenges in reaching informal settlements and peri-urban populations; and,
- Loss of mobilization efforts.

The transition from a mixed-service model to a predominantly fixed-site approach has significantly reduced service reach, and was one of the most consistent and concerning themes in the dataset. Stakeholders warn that without restored resources for outreach and mobile services, coverage will continue to deteriorate and inequities between urban and remote populations will deepen.

Data and Reporting Systems

Data functions were among the most frequently cited concerns, with the clearest changes seen at the community and primary health center level. Before the withdrawal, ACCESS funding supported a functional reporting pipeline from the community to the district. ACs received RMA forms and communication credit, allowing them to document village-level immunization activities and submit reports on time. Monthly meetings served as a touchpoint for turning in RMAs and coordinating outreach. Facilities used these reports to update registers and plan catch-up sessions, and ACCESS also funded quarterly review meetings that allowed data to be validated and analyzed for decision-making. In some districts, CommCare was in use as a digital reporting tool, and several facilities had support for DHIS2 data entry and troubleshooting.

After ACCESS withdrew, respondents described a steady breakdown of these functions. RMAs became scarce, phone credit and transport reimbursements disappeared, and AC reporting became more delayed or incomplete. Some ACs stopped reporting altogether, while others resorted to scratch-paper tallies or photocopying forms at their own expense. Facility staff reported that without ACCESS-funded printing and communication support, they faced delays or paid out of pocket to maintain reporting. Managers said mismatches between paper and digital data have become more common, and quarterly review meetings have stopped, leaving fewer opportunities to spot gaps or coordinate corrective actions.

Stakeholders repeatedly said these changes leave them unable to see coverage gaps in time to act: data now arrive late, are incomplete, or are not validated, which slows outreach planning and makes it harder to identify missed children. Several facility heads said they could no longer track coverage progress or plan outreach effectively because of delayed or missing data. Several primary health centers also noted that the loss of ACCESS support and quarterly review

meetings has made it harder to identify missed children and organize catch-up activities, allowing zero-dose cases to accumulate.

Planning and Prioritization
Planning and coordination were raised less frequently than workforce or outreach issues but still emerged as a concern in several districts. Without ACCESS support, managers reported having only limited and inflexible local funding[19], making it difficult to adjust plans mid-year. Quarterly planning meetings have been suspended, further reducing the system's ability to identify priority areas. Respondents said this has delayed updates to microplans and stopped the identification of zero-dose "hotspots." One district head reported that malaria vaccine introduction planning is currently on hold, with no timeline for resumption.

These disruptions have constrained the system's ability to plan proactively, update microplans, and introduce new vaccines. Stakeholders expressed concern that the absence of quarterly reviews leaves emerging coverage gaps unidentified and unaddressed.

Broader Health System Impacts
Respondents consistently emphasized that the withdrawal of USAID support affected not just immunization but the broader primary health care system. Facility heads and district managers described a "void" left in service delivery and coordination, with several saying the system now feels "asleep."

The loss of quarterly review meetings was a central theme for this domain. These reviews covered all major health programs — immunization, maternal health, malaria, family planning, and others — and served as the primary venue for joint problem-solving and performance monitoring. Their absence has left primary health centers "working alone" and reduced the ability to identify and respond to gaps across programs. Several district managers warned that, without these reviews, problems persist longer and there is no mechanism to keep facilities accountable or motivated to improve.

Impacts were particularly severe in maternal and child health. Respondents reported that programs for safe delivery, maternal death review, and community case management of childhood illness are no longer supported, leaving facilities to fund partogram printing and supervision from their own budgets. Some noted that maternal deaths are no longer consistently reported, increasing the risk that preventable deaths go unaddressed. Malaria and family planning services were frequently mentioned as suffering from stockouts or reduced outreach, with one district leader naming malaria as the program most affected by funding losses.

Across these domains, respondents described a health system at risk of backsliding. One district manager summarized the situation starkly: "the car is still rolling, but without someone to push, it rolls backward." Several noted that without external support, key services risk continued deterioration, with some activities already described as "asleep" or completely stopped.

[19] The described inflexibility stems from Madagascar's annual budget allocation system and centralized financial management. With no dedicated budget line for emergency vaccine transport or mobile vaccination activities, no allocation for community health worker incentives, and no rapid-disbursement mechanism for urgent needs, local funding lacks the flexibility previously offered by ACCESS.

Nigeria

Overall findings

The withdrawal of U.S. government funding negatively impacted immunization programs, with varying levels of severity, across the four states assessed in Nigeria: Jigawa, Kano, Adamawa and Niger. Prior to funding cuts, USAID funding supported core delivery functions in several states, including logistical support for outreach and vaccinator stipends, vaccine transport and distribution, cold chain maintenance, data collection, analysis, validation and reporting. Absent US support, states report significant workforce reductions, supply chain disruptions, compromised data quality and timeliness and ultimately, drops in immunization coverage and a rise in the number of zero-dose children. State-by-state impacts are discussed within the domain-specific findings below and represented visually in Table 5 in the appendix.

Across interviews, stakeholders consistently identified three pain points impacting immunization programs: workforce challenges, primarily resulting from the elimination of stipends for volunteers responsible for key immunization activities, disruptions to service delivery modalities, including a sharp reduction in outreach services, and strains on the supply chain, particularly the change from “push” to “pull” systems for vaccine distribution and difficulties maintaining cold chain due to faulty or non-existent equipment.

While these key challenges are largely shared across states, the intensity of their impact varies by geography. For example, stakeholders in Jigawa and Kano spoke most frequently about workforce disruptions and service delivery challenges. Respondents from Adamawa noted challenges across the domains but discussed impacts on immunization planning relatively more than others. In Niger, references to data systems were common and salient. In many respects, however, Niger appeared to be an outlier in comparison to Jigawa, Kano and Adamawa. In general, the challenges discussed in Niger were fewer and described with less urgency. We suspect that additional partner support in Niger – via SYDANI and New Incentives, as of late 2024, along with a new MOU signed with UNICEF and Gavi in January 2025 – may explain the lesser impact. Similarities and differences across states are discussed in more detail in the section on domain-specific findings.

Unlike the DRC and Madagascar, attribution of funding cuts and their associated negative impacts – whether that belongs to USAID or other donors (e.g., Gavi) – was ambiguous in many transcripts from Nigeria and varied by state. Based on what we can ascertain from the data, as well as follow-up conversations with stakeholders at the state-level, our understanding is as follows:

- In **Jigawa**, the closure of USAID’s M-RITE project is clearly and directly tied to the loss of stipends for outreach and support for data collection, analysis and validation.
- In **Niger**, stakeholders refer to previous funding from USAID prior to 2025 for support with COVID-19 vaccination, but linkages to more recent USAID funding are not clearly made.
- In **Kano** and **Adamawa**, USAID funding is described in more generic terms as supporting vaccine availability and cold chain. Stakeholders in **Adamawa**, however, also reference previous support from USAID for COVID-19 vaccination prior to 2025.
    - In a follow-up conversation with the State Primary Health Care Development Agency in **Adamawa**, we learned that USAID provided support for the Emergency Operations Center and outreach activities, but the specific mechanism of support is unclear.
    - In a follow-up conversation with the State Emergency Routine Immunization Coordination Centers in **Kano**, we learned that there was no direct support from

USAID for immunization. Gavi was the principal donor for routine immunization from June 2024 until February 2025, which aligns with the challenges and timeline flagged by respondents as well as the larger withdrawal of USAID support for immunization programs.

Wherever possible, we have linked the negative impacts of funding cuts to the withdrawal of U.S. government support. In cases where the connection is unclear, we have noted our uncertainty. Triangulation of impacts directly linked to US support is complicated by respondents' own limited or potentially inaccurate understanding of the funding sources of specific immunization activities. However, we do think it is important to acknowledge and reiterate that respondents answers were given after they were explicitly asked about US government funding cuts; they entered into interviews with our data collection teams following an informed consent process that detailed the purpose and context of the conversations, which was to discuss impacts to immunization programs following the withdrawal of U.S. government support.

Domain findings

Perception of Funding Cuts

Most respondents described USG funding cuts in overwhelmingly negative terms, with a subset of stakeholders in Niger State holding more neutral views. While no donor or partner has fully replaced the support previously provided by USAID, all states report some level of partial gap-filling. In this regard, Niger appears to be faring better the best, with more consistent support across key areas. Of note, Niger signed an MOU with Gavi and UNICEF in January 2025 to support immunization which is likely helping to buffer the impact of any other funding cuts. Otherwise, New Incentives' All Babies Are Equal, which operates in Jigawa, Kano and Niger, is helping to offset reductions in outreach by continuing to offer stipends to community mobilizers for these efforts in those states. UNICEF, the World-Bank funded IMPACT Project and SYDANI (in Niger State only) offer additional support for cold main maintenance, vaccine distribution and outreach. Funding from the federal government, via the Basic Health Care Provision Fund (BHCPF), as well as from LGAs and facilities themselves provide supplemental funding for immunization, though it is inconsistent and often delayed.

Workforce

Workforce impacts were the most consistently cited by respondents, with some variation in Niger. Specifically, stakeholders linked funding cuts to the reduction or elimination of stipends for volunteer staff. In transcripts from Jigawa, some stakeholders described the loss of stipends within the context of funding cuts from both USAID and Gavi, suggesting that both donors supported programs with financial incentives for volunteers. In Adamawa, respondents only refer to USAID in the context of providing stipends. Volunteer staff, sometimes referred to as ad hoc or casual staff, comprise a large part of the immunization workforce in Nigeria and are primarily responsible for outreach activities. Permanent staff, who are salaried government employees, have not seen their compensation impacted by funding cuts. However, due to the loss of the volunteer workforce, permanent staff report being overburdened and taking on additional responsibilities. Low morale and demotivation are pervasive among the limited volunteer staff who remain working without financial incentives as well as overextended permanent staff.

Supply Chain

Respondents from Jigawa, Kano and Adamawa reported severe impacts to the immunization supply chain as a result of funding cuts. Specifically, stakeholders described the collapse of the

push system for vaccine distribution: previously, vaccines were distributed down the supply chain – from the federal to the state, from the state to the LGA, and from the LGA to facilities. In cases where distribution was not possible via the push system, transport stipends were available for the collection of vaccines from centralized stores. Respondents stated that, post-funding cuts, vaccine distribution has transitioned to a pull system and financial responsibility for vaccine transport has shifted to LGAs, facilities and individuals. They cited skyrocketing costs of fuel in Nigeria as an additional barrier to vaccine transport. While not explicitly stated by stakeholders, the inability to source funds, or to do so quickly, for vaccine transport and distribution likely impacts the availability of vaccines for service delivery.[20]

Stockouts of the Rota vaccine were reported across all states, followed by BCG and Penta in Jigawa, Kano and Adamawa. Stockouts of consumables were mentioned in Kano and Adamawa, with Kano specifically describing inappropriately bundled commodities (e.g., not enough syringes to match BCG doses) contributing to stockouts.

Generally, stakeholders linked vaccine stockouts to failures of and loss of funding for of the push system, rather than national vaccine shortages; however, one state-level respondent in Jigawa referenced rationing of vaccines at the national level, noting that despite sharing forecasts, "[vaccines] are not distributed based on requirement, but based on availability." If there is indeed a linkage between vaccine stockouts and the USAID funding withdrawal, which is certainly implied because of how the interviews were structured, the main pathway would be via reduced funding for vaccine transport. However, the link both in the transcripts and in trying to externally verify funding flows is difficult to make with certainty. In Jigawa, for example, USAID and Gavi were reported to support vaccine distribution via the push system by a single stakeholder, but it seems possible that the distribution challenges were exacerbated by other funding issues that coincided with the timeline of USAID's departure.

In Jigawa, Kano and Adamawa, respondents report non-functional cold chain equipment as a result of funding cuts and in one case, specify that funding for cold chain maintenance has not been available since January 2025. In some cases, equipment has gone unrepaired for months due to the lack of funds for maintenance. For example, in Adamawa and Kano, stakeholders reported ongoing delays - from six months to one year - in repairing cold chain equipment. Another stakeholder from Kano reported that in the past, preventive cold chain maintenance was completed on a quarterly basis; since January 2025, there had been no maintenance due to the lack of funding and they were concerned about the impact on the life and performance of the equipment as a result. In other cases, funding is not readily available for the increasingly expensive diesel required to fuel generators. Given challenges in maintaining the cold chain, some respondents cite concerns about vaccine safety and efficacy. To mitigate cold chain challenges, respondents from all three states describe moving vaccines to facilities with functional cold chain storage, despite the associated logistical challenges.[21]

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[20] In Jigawa and Niger, attribution of support for vaccine delivery was confidently made to USAID by state-level officials. In Kano and Adamawa, the attribution is not direct but implied. In all cases, we are continuing to investigate whether and what activities were funded by USAID in each of the states, and whether the timing aligns for negative impacts following the withdrawal of US support in early 2025. As of now, for example, we have been unable to positively establish USAID support in Niger, including for vaccine transport, in early 2025.

[21] In Jigawa, preventive cold chain maintenance was previously covered by Gavi and USAID, according to officials from the Jigawa State Primary Health Care Development Agency and at the state-level, respectively. USAID's previous role in cold chain activities in the other states is unclear. In Jigawa and Adamawa, stakeholders have looked to UNICEF for support with repairing non-functional cold chain equipment.

Service Delivery
Prior to funding cuts, interviewers described a mix of fixed and outreach services working in tandem to carry out immunization activities. Vaccinators conducted fixed sessions on a regular basis, often weekly, and conducted outreach services targeting underserved communities within 2-5km from facilities. Outreach services, primarily staffed by the volunteer workforce, were integrated with other health services (e.g., malaria, family planning), and included various forms of community mobilization, including home visits. Mobile services, which were more resource-intensive and served hard-to-reach communities further than 5km from facilities, were discussed less frequently by stakeholders. In Kano specifically, multiple respondents confirmed that the state does not conduct mobile sessions.

Post-funding cuts, respondents highlighted that fixed sites remain intact and prioritized in all states, though they are undermined by varying degrees of supply chain disruption, workforce reductions, and a lack of community mobilization to drive demand for immunization services. Stakeholders expressed concern that, with reduced community engagement, caregivers – especially in remote settlements – are left without reminders or opportunities to vaccinate outside facility walls, contributing to growing numbers of zero-dose children.

Since the withdrawal of USAID support, respondents consistently reported that outreach and mobile sessions, where applicable, have been the most severely affected service delivery modalities. Without stipends or transport funding, many health workers reported reduced or stopped outreach entirely. One provider said outreach frequency dropped from twice per month to once, and some facilities said that they are now limited to fixed-post sessions only. Transportation costs were cited as a major barrier: staff now rely on facility managers to find ad hoc resources for fuel or motorcycle hire, or they pay out of pocket when they can.

Respondents consistently described rural LGAs as bearing the brunt of the funding cuts, citing longer distances, fewer health workers, and heavier reliance on donor-funded logistics. Rural facilities frequently reported missed or severely delayed outreach sessions. While fixed services persist, rural facilities reported reduced hours for service provision, longer wait times for clients, and stockouts of key antigens. As a result of these challenges, stakeholders in rural facilities are concerned about decreasing levels of engagement from caregivers and the resulting impact on coverage. Urban facilities also experienced staff demotivation, supply shortages, and outreach disruptions, but generally maintained more consistent fixed-site services and were better able to self-fund small operational costs.

There were some state-specific differences:

- In Jigawa, Kano and Adamawa, outreach services have been reduced significantly. Niger reports mixed impacts on outreach activities.
- In Jigawa, Kano and Adamawa, stakeholders report drops in coverage, and rising numbers of zero-dose children, due to reduced outreach activities.
- In Adamawa, for example, respondents report reduced numbers of outreach sessions per month – from 2-3 times to once per month for one rural, hard-to-reach facility – and have observed sharp drops in coverage as a result. As observed by one respondent: “Fully immunized children had reduced; it was 85% but it is now 54%, while zero dose has increased, all because of the lack of conducting outreach sessions as before.”

Reduced outreach services stemming from USAID’s funding withdrawal are clearest for Jigawa:

- In Jigawa, USAID funded up to 150 teams “supporting targeted outreach in the hard-to-reach, underserved settlements, zero-dose LGAS...” prior to the abrupt cancellation of the M-RITE project.

- In Kano, Adamawa and, to the lesser extent it was impacted, Niger, the cause of funding cuts impacting outreach is unclear. For instance, all Nigerian states were subject to delayed payments to facilities from the federal government via BHCPF, potentially impacting resources available for outreach.[22]
- New Incentives' All Babies Are Equal partially offsets reductions in outreach where the program operates, in Jigawa, Kano and Niger states. The IMPACT project and SYDANI also support outreach in Jigawa and Niger, respectively.

Data and Reporting Systems

Prior to funding cuts, respondents described key aspects of data collection and reporting as functional and essential for quality data collection, analysis and reporting at both the LGA and state-levels. In both Adamawa and Jigawa, stakeholders described receiving support from USAID-funded programs for technical assistance and capacity building support for data analysis and reporting, including transmission from facilities to LGAs and from LGAs to the DHIS2 (with the exception of at least one facility in Adamawa, which reported uploading their data directly to to the DHIS2). Respondents in Jigawa, Kano and Adamawa also described data review and validation meetings at both the LGA and state-level.

Following funding cuts, however, stakeholders across Jigawa, Kano and Adamawa reported the absence of data collection tools (e.g., registers, utilization forms) and insufficient funds for the transmission of data. Only one respondent in Niger described stockouts of data tools. Furthermore, respondents from Jigawa, Kano and Adamawa reported no longer holding regular meetings to review or validate data. In Jigawa, USAID via M-RITE, alongside Gavi and WHO, previously supported monthly data review meetings. M-RITE also provided stipends to LGA consultants for their support with data analysis and reporting. A state official in Jigawa referred to the departure of the LGA consultants as a loss of "critical manpower" with impacts on data collation, analysis and dissemination. In Adamawa, the loss of USAID stipends for data clerks has led to delays in the delivery of data from facilities and LGAs.

Given shortages of data collection tools, the loss of human capital for data analysis and transmission, and reduced opportunities to review and validate data, stakeholders have significant concerns about data quality, timeliness, and its ability to accurately reflect the drops in coverage due to reduced outreach services and supply chain disruptions. While stakeholders in Jigawa and Adamawa explicitly tied reduced capacity for data collection, analysis and reporting to USAID funding cuts, the source of data-related challenges in Kano is unclear. On the whole, Niger reported very few challenges related to data.

Planning and Prioritization

Across Jigawa, Kano and Adamawa, stakeholders described varying degrees of disruption to immunization planning and coordination; respondents from Niger did not report significant challenges. In Jigawa, LGA-level planning and coordination meetings have ceased; previously, LERICC met on a weekly basis with funding related to supportive supervision. At the facility level, stakeholders described reallocation of funds for urgent needs, like vaccine transport and stipends for vaccinators. In Kano, microplanning meetings were previously held on a biannual basis and supported by WHO, the Kano State Primary Health Care Management Board and Gavi. In Adamawa, respondents cited challenges with the execution of microplans due to a lack of funds to convene relevant stakeholders prior to implementation. Stakeholders in Niger did not report significant challenges with immunization planning or prioritization, though they noted a

[22] Following the completion of data collection in August 2025, we have since learned that BHCPF payments have resumed in many states.

desire to increase domestic funding to bridge any funding gaps. A desire to mobilize domestic resources was also discussed in Adamawa.

Compared to Madagascar and DRC, NVI was discussed more frequently in Nigeria–though overall, as a topic, NVI was discussed infrequently. Upon closer review of the transcripts, however, stakeholders primarily discussed vaccines introduced within the last five years, including rotavirus, HPV (Kano, Adamawa), and MCV2 (Adamawa). No stakeholders reported introduction of the malaria vaccine and in Jigawa, a state-level official hypothesized that USAID funding cuts may have impacted its rollout. Multiple stakeholders acknowledge potential challenges with future vaccine rollout, particularly the reduced capacity of the immunization workforce.

Broader Health System Impacts
Across all states, there is consensus that other health services and commodities have been more severely impacted by funding cuts than immunization programs. Specifically, respondents mentioned that family planning, malaria, tuberculosis (TB) and maternal and child health fared worse and, in some cases, were essentially non-operational. For example, a stakeholder in Jigawa described, “Yeah I think the worst hit is malaria and family plan[ing], even though the vaccines, the effect can be 30 percent, so like family planning it is like total blackout. When we receive for quarter, it only lasts for a month or less than that. And even for malaria the effect is also... You will see that when the supply reach the facility within no time it dries up. I think we are not getting what we require, we are just getting what is given to us”.

However, because immunization programs are often integrated with other health services, there are some shared impacts. For example, a state official in Niger remarked, “So, compared to other programs, other programs have taken a hit. They have taken a hit from things like malaria, HIV, and, in particular, the ATMs. We call them the AIDS, Tuberculosis, and Malaria programs have also been impacted significantly, and these are programs that we integrate immunization services with, so they tend to also indirectly affect immunization.” Multiple stakeholders reported that when immunization programs or other integrated health areas experience challenges - such as stockouts - the other services are impacted by proximity; this suggests that disruptions to one or more integrated health services have the potential to undermine community trust and confidence in the health system as a whole.

Comparative site characteristics findings

Zero-Dose Populations
Before the USG/USAID cuts, respondents across states linked donor support — particularly from USAID (through M-RITE in Jigawa, outreach and cold chain support in Kano and Adamawa, and capacity building and logistics support in Niger, as reported by respondents) — to progress in reducing zero-dose children. They emphasized that USAID’s role in funding outreach teams, transport allowances, stipends for vaccinators and volunteers, and data clerks (notably in Adamawa) made it possible to reach children in remote or underserved settlements, and in zero-dose LGAs. A facility manager in Jigawa, for example, highlighted how external financing enabled their facility - previously classified as “zero-dose” - to move out of that status, as outreach and routine sessions were conducted more consistently.

After the cuts, stakeholders in Jigawa, Kano, and Adamawa described increases in zero-dose children, citing the collapse of USAID-supported outreach and distribution systems, the end of

stipends for community mobilizers, transport barriers, and frequent vaccine stockouts. State specific differences emerged:

- In Jigawa, there is fear that areas that had recently graduated from “zero-dose” status have slipped back after USAID-funded outreach teams and supervision ended.
- Kano officials also linked rising zero-dose numbers to the loss of stipends, the dissolution of UNICEF-supported Volunteer Community Mobilizers who conduct door-to-door outreach and track defaulters, and the breakdown of the push distribution system.
- In contrast, Niger showed a more mixed picture: some respondents said they had not seen an increase in zero-dose children, while others described a persistent “high level burden” in hard-to-reach LGAs. This relative resilience was attributed to the state’s reliance on solar cold chain, a pull distribution model, and continued support from Gavi, UNICEF, and SYDANI, with New Incentives also active in some areas.

Conclusions and recommendations

Key actionable findings

Our assessment across Madagascar, Nigeria, and DRC revealed clear, consistent patterns across interviews: the withdrawal of USG funding caused a steep decline in outreach, mobile strategies, and community engagement — the very activities that keep coverage high and zero-dose numbers low. Data systems and microplanning have slowed, making it harder for districts to track gaps or plan corrective actions. Respondents repeatedly warned that coverage losses are mounting, especially in rural and hard-to-reach areas, and that measles and other outbreaks are already emerging.

The findings point to specific operational levers that, if restored, could rapidly recover coverage and prevent further backsliding. They also reveal a critical need for better, more granular data to target investments where they avert the most missed children.

Furthermore, these findings and recommendations are most applicable in settings where immunization systems have been similarly impacted by abrupt funding withdrawals. While the patterns observed are consistent across the three countries assessed, their relevance may vary in contexts with different funding structures, service delivery models, or baseline systems resilience.

From the perspective of stakeholders we interviewed, the most actionable findings include:

- Outreach and mobile strategies have collapsed, leaving many remote areas unreached for months and undoing years of progress toward reaching zero-dose children.
- Volunteer and ad hoc workforce participation has plummeted after stipends and transport allowances ended, driving sharp drops in community mobilization.
- Vaccine distribution is underfunded and unreliable, forcing facilities to self-finance transport and causing frequent stockouts of key vaccines and consumables.
- Microplanning and data review processes have stalled, reducing districts’ ability to target outreach or plan catch-up activities.
- Rural sites are the hardest hit, with outreach fully suspended in some areas and entire communities going unreached for months.
- Coverage is declining, with growing numbers of zero-dose children and early signs of outbreaks in multiple countries.

Please note that for the public-facing version of this document, the remaining content of this section has been removed, as the detailed recommendations were intended to help GiveWell shape their internal grantmaking strategy.

Appendix

Table 3. Major Findings from Rapid Assessment

In Table 3, we have a snapshot of the major, cross-country findings from our rapid assessment. These findings are described in more detail, accompanied by illustrative quotes, within the narrative report in the section on "cross-country analysis: overall project findings."

Table 3. Major Findings from Rapid Assessment

Theme	Specific Points & Details
1. Systemic Disruption and Challenges at the Last-Mile	**1. Funding withdrawal created shockwaves at the last mile.** Withdrawal of USAID and other donor support disrupted the system, risking rising zero-dose numbers and declining coverage. **2. The loss of stipends and partner support triggered widespread workforce attrition, demotivation, and declining service delivery capacity – particularly for the volunteer health workforce and vaccinators.** Volunteer and ad hoc workers left; permanent staff are overburdened and morale has dropped. **3. Service delivery has shifted away from outreach and mobile strategies toward fixed-post sessions.** Outreach is irregular or absent, leaving entire communities unreached. **4. Last- mile vaccine transport and distribution have become more unreliable, causing more frequent stockouts and session cancellations.** Delayed deliveries and reliance on facility-collected stock result in missed sessions and discouraged caregivers.
2. Declining Coverage and Population Reach	**5. Coverage rates are already declining, with evidence of reversals in recent gains.** Measured drops in coverage and increases in zero-dose children signal outbreak risk. **6. Progress in reaching zero-dose children is being lost.** Without funded transport, stipends, and mobilization, children in remote areas are increasingly missed. **7. Rural sites are disproportionately affected by funding cuts.** Rural facilities, most dependent on outreach and volunteers, face extended service gaps.
3. Weakening Systems and Processes	**8. Data and reporting systems became more fragmented, expensive, and prone to delays after the cuts.** Delays and incomplete data hamper planning and tracking of coverage gaps. **9. Microplanning and coordination processes have stalled, reducing the system's ability to optimize and adjust coverage strategies.** Review meetings are canceled or shortened, limiting course correction. **10. Broader health system services have weakened, with respondents citing family planning, malaria, HIV and maternal and child health programs and outcomes at greatest risk.** Stockouts immunization and other integrated health commodities erode caregiver trust and demand for immunization.

Table 4. R4D Project Learnings

Please note that for the public-facing version of this document, Table 4 on R4D's project learnings and reflections has been removed, as it was primarily intended for discussion between GiveWell and R4D.

Table 5. Nigeria State Comparison by Domain

In the table below, we have provided a visual representation of the state-by-state findings in Nigeria by domain, as reported by stakeholders. For most domains, Jigawa, Kano and Adamawa reported similar challenges and in similar levels of frequency and saliency, with exceptions noted in the summary column. Across nearly all domains, Niger fared better reporting fewer challenges overall and with less urgency. We hypothesize that alternative sources of funding helped shield Niger from the level of difficulties faced in the other states.

Legend

Severely impacted

Moderately impacted

Marginally impacted

Table 5. Nigeria State Comparison by Domain

	Jigawa	Kano	Adamawa	Niger	Summary
Perception					Very negative perceptions, with a subset of neutral views in Niger
Workforce					Most consistently cited negative impact, due to loss of financial incentives and overextension of remaining workforce; salience of workforce impacts strongest in Jigawa and Kano
Supply Chain					Challenges in vaccine distribution and stockouts widespread, with difficulties in maintaining cold chain and other supply chain disruptions reported most in Kano. Of note: In April 2025, Kano initiated a new integrated delivery mechanism run by the state's Drug Management Agency to improve supply chain challenges; improvements due to this initiative were not yet visible during our data collection in July 2025 but this may change in the future.
Service Delivery					Reduction in outreach services, most acutely reported in Jigawa followed by Kano; Jigawa, Kano and Adamawa reported decrease in # of vaccines delivered
Data and Reporting Systems					Loss of technical assistance, regular data review and validation meetings, and stockout of data tools reported across Jigawa, Kano and Adamawa; significantly fewer and more routine challenges reported in Niger
Immunization and Planning					Jigawa and Kano describe significant challenges in planning and coordination, whereas Adamawa described difficulties in execution; Niger reported few challenges
Broader Health System Impacts					Consensus among states that other health services and commodities (FP, malaria, HIV, TB, MNCH) are more severely impacted, with recognition of knock-on effects to immunization given integration of services

Acronyms

AC - Agents Communautaires (MG)
ANC – Antenatal Care
BHCPF - Basic Health Care Provision Fund (NG)
CDC – Centers for Disease Control and Prevention (US)
CHW – Community Healthcare Worker
CODESA - Comité de Développement Sanitaire (DRC)
CSO – Civil Society Organization
DRC – Democratic Republic of the Congo
EPI – Expanded Program on Immunization
FGD – Focus Group Discussion
IRB – Institutional Review Board
KII – Key Informant Interview
LERICC - Local Government Emergency Routine Immunization Coordination Center (NG)
LGA – Local Government Area (NG)
MNCH – Maternal Newborn and Child Health
NVI – New Vaccine Introduction
RECO - Relais Communautaires (DRC)
RI – Routine Immunization
TB - Tuberculosis
USAID - United States Agency for International Development
USG – United States Government

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