Rapid assessment to identify ‘on the ground’ effects of 2025 United States government funding cuts on immunization programs in 3 countries

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Submitted April 25, 2025

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Background and Introduction

In early 2025, the new United States presidential administration implemented significant reductions to the U.S. Agency for International Development (USAID) budget, resulting in steep cuts from the United States government (USG), at one point estimated to be over 90% of USAID foreign contracts (AP, 2025). 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 especially severe in countries where domestic health budgets are already constrained, and where international support has historically covered core components of the immunization system—including supply chains, campaign logistics, and per diem payments for health workers. Funding disruptions have the potential to trigger rapid, localized breakdowns in vaccine delivery and to reverse recent progress on improving vaccine coverage, particularly in hard-to-reach and historically underserved areas.

The effects are expected to be most acute at the "last mile"—facilities and communities where service delivery is already fragile and highly dependent on external financing. Yet, there is currently limited data available on how these cuts are materializing in real time at facility and district levels. *This assessment seeks to fill that gap through a rapid assessment in three priority countries: Nigeria, Madagascar, and Democratic Republic of the Congo (DRC). The goal is to surface qualitative insights on service disruptions, adaptation strategies, and emerging risks—especially those that may influence current and future GiveWell grantmaking in the immunizations space.*

Objectives and Learning questions

This assessment seeks to generate rapid, actionable insights on the impacts of recent USG (e.g., USAID, CDC, others) funding cuts on last-mile vaccine delivery in three countries, in order

to inform GiveWell's immunization fact base and internal strategy development. Specifically, the assessment will document how these funding reductions are affecting health system functionality at the sub-national level with a focus on the facility and district levels (and national-level insights for critical context), with an emphasis on the following:

- Vaccinators and other frontline healthcare workers
- Sub-national vaccine supply chain performance
- Vaccination session disruptions
- Management information systems (MIS) and data use
- Planning, coordination, and prioritization, and decision-making among national and subnational actors (including resource prioritization, new vaccine introduction (NVI) planning and prioritization, etc.)

Learning Questions: These focal topics directly inform five core learning questions for this assessment:

- How are vaccinators and other frontline health workers affected by funding cuts (e.g., workload, staffing, incentives, remuneration)?
- What new vaccine supply chain issues are emerging at the facility and district levels (e.g., stockouts, procurement delays, cold chain)?
- How are fixed-site and outreach vaccination sessions being maintained or reduced, and which populations are at increased risk of being missed?
- What gaps have newly emerged in the collection and use of immunization data?
- How are district and national actors adjusting planning, budgeting, and coordination to respond to new financial constraints (including how plans for NVI are being affected)?

Country Selection and Rationale*

The proposed countries (below) were chosen to represent a range of contexts, reflecting factors such as including a desire to gather data points across multiple countries, strategic interest of

country to GiveWell, historical USG support levels, potential diversity of vaccine service delivery archetypes that can be explored, and operational feasibility for R4D of conducting rapid assessment. At a baseline, these countries generally represent high vaccine-preventable disease (VPD) burden, low immunization coverage contexts.

Country	**Magnitude of USAID funding cut**[1]	**Rationale for selection**	**Potential engagement strategy and focal regions (where known)**
Nigeria (73% coverage[2], 3.8% VPD burden[3])	23% cut / $178M	Nigeria is Africa's most populous country (~223 million) and a large recipient of USG global health funding, including for immunization system strengthening and supply chain logistics through bilateral programs (USAID, 2023). Immunization coverage is highly unequal, with DTP3 rates below 60% in several northern states as of 2022–2023 (WHO/UNICEF, 2023). The presence of GiveWell-recommended implementer New Incentives in several USG-supported states offers an opportunity for complementary insight into local service disruptions.	Engage federal government through the existing R4D office, and set up engagement in 4 states by engaging consultants and CSOs. They will conduct KIIs with LGA and health facility (/outreach) staff. States we're considering include: Niger, Kano, Jigawa and Taraba. We will avoid Bauchi and Gombe due to other investments GiveWell is potentially making.

Madagascar (80% coverage, 2.6% VPD burden)	54% / $62M	Madagascar's immunization system is highly dependent on donor financing for outreach and mobile services in rural and hard-to-reach regions (Gavi, 2023[SS1]). Fewer large donor-funded partners operate here compared to Nigeria, Ethiopia, or DRC, making it an important "signal" country for direct observation of how funding shifts affect last-mile delivery. Coverage has been inconsistent and vulnerable to operational disruptions, with DTP3 dropping below 70% in several years (WHO/UNICEF, 2023,[SS2] Gavi).	Engage through a sub-award to current R4D consultant (TA4ID) on a different project who has deep Madagascar experience and network. Engagement in 2 regions; KIIs with district and health facility (/outreach staff). Our understanding is that there are 14 regions that were supported by USAID: Atsimo-Andrefana, Menabe, Melaky, Boeny, Sofia, Diana, Sava, Analanjirofo, Atsinanana, Vatovavy, Fitovinany, Vakinakaratra, Amoron'i Mania, and Haute Matsiatra. Preliminarily, we were considering selecting two previously USAID-supported regions that, pre-2025, had 'high' and 'low' vaccine coverage (i.e., Menabe and Vakinakaratra). However, we are also considering other characteristics, such as difficult to reach regions (i.e., Anosy). If this grant is approved, we would plan to use the time between grant approval and kickoff to propose two regions to GiveWell, and align on region selection.

DRC (69% coverage, 1.8% VPD burden)	34% / $387M	DRC has historically been one of the largest recipients of immunization-focused external assistance globally, including significant USG support for cold chain, logistics, and supervision (USAID, 2023). The country also faces one of the highest global burdens of vaccine-preventable diseases and wide disparities in DTP3 coverage, which has stagnated around 60% nationally since 2019 (WHO/UNICEF, 2023). Structural challenges such as geographic isolation, conflict, and frequent stockouts make DRC an important setting for observing warning signals of system shocks.	Engage through a sub-award (hired by R4D) based in Kinshasa. Engagement in 2 formerly USAID-supported regions; KIIs with LGA and health facility (/outreach staff). Propose region selection and rationale to GiveWell, and jointly align on region selection before data collection starts.

Optional country add-on: scope & conduct assessment in Niger

R4D has identified a team of two highly-qualified consultants who can lead work in Niger, if this is of interest to GiveWell. However, because Niger is a generally higher risk environment (i.e., military escort must be hired to accompany any international organization traveling outside of Niamey, though this does not apply to a local consultant), R4D expects needing 1-2 additional months to scope this opportunity and confirm that, in view of the security situation and risk profile of the country, we could conduct this work in a meaningful way. Preliminarily and excitingly, the consultants who we've spoken with in Niger, including a senior consultant with an extensive track record of leading Global Fund and GHSC-PSM engagements, believe that they could carry out this work with the support of the immunization program, potential in Niamey and another region with low(er) security risks. Our contacts are open to jointly assessing feasibility and scope if we and GiveWell want to move this assessment forward there.

Approach to Data Collection, Analysis, and Synthesis

The assessment will use a qualitative, rapid-assessment design that combines national-, district-, and facility-level perspectives. This will allow us to explore systemic impacts, local adaptations, and signals of risk across contexts.

- Key Informant Interviews (KIIs) at national, regional, subnational, and facility levels - conducted by R4D staff and/or consultants when possible. *Note: national and regional*

level KIIs will be critical for obtaining relevant permissions and matrixing our cross-country synthesis. We are committed to upholding our duty of care policy and ethical standards and will obtain necessary local and/or national approvals prior to initiating our work.

- (where needed) collaboration with CSOs, local researchers, and implementing partners to support site selection and data collection.

- Emphasis on understanding how systems are adapting under new resource constraints.

Analysis and Synthesis Approach

We will draw on established qualitative research methods to ensure that findings are credible, relevant, and comparable across diverse contexts. Our analysis will center on identifying convergent themes, unique contextual factors, and implications for service delivery and access to vaccines/vaccination, especially at the last mile.

Key components of our approach include:

- **Standardized data collection instruments:** We will develop a semi-structured interview guide tailored to each respondent group (e.g., facility staff, district managers, regional/state stakeholder, national extended programme on immunization (EPI) stakeholders. Before developing the guides, we will identify specific data points and insights needed to answer this study's learning questions to inform KII structure and content. These guides will ensure that all key domains are consistently explored across facility types and contexts, enabling structured comparisons. Each tool will be piloted and refined for clarity, relevance, and symmetry of data collection, ensuring clarity and cross-contextual relevance.

- **Recording, transcription, and coding:** Where consent is obtained and recording is feasible, interviews will be audio-recorded and transcribed verbatim. Transcripts will be coded thematically using a framework grounded in the core research questions, facility archetypes, and the five impact domains (workforce, supply chain, service delivery, data/MIS, and planning). We anticipate using NVivo or a similar platform to support coding and synthesis.

- **Note-based analysis where recording is not possible:** In cases where consent cannot be obtained or recording is not feasible (e.g., due to time constraints or respondent comfort), interviewers will use a structured note-taking template to document responses. These notes will be reviewed and synthesized using the same thematic framework to preserve consistency.

- **Synthesis across facility archetypes and system levels:** We will analyze findings by archetype and health system level (facility, district, regional, national), looking for both cross-cutting trends and outlier cases that offer insight into adaptation or emerging vulnerabilities. This will allow us to triangulate findings across different country contexts and delivery models.

- **Cross-country synthesis and comparative framing:** Final analysis will draw out patterns across the three countries while preserving attention to context. We will use archetype-level synthesis (e.g., what's happening across remote rural outreach-dependent settings) to highlight recurring constraints and potential risk signals, while also surfacing country-specific nuances and innovations.

- ***(where possible, district/regional health officers feel comfortable, & not requiring IRB approval)*** **Opportunistic use of informal channels and rapid pulse checks:** Examples of qualitative data collection through informal channels in workplaces has been established, such as by Healy, Ostrich & Means in their paper "Leveraging Informal Qualitative Data Collection and Use at Syringe Services Programs." Based on their methodology, we are hoping where possible to leverage district health officer's existing communication channels (most likely WhatsApp) with community health workers and other frontline workers who provide vaccines to obtain consent and then collect informal data (messages, voice memos, etc.) from these workers as qualitative data from a broader sample to supplement the more rigorous but smaller sample collected through standardized KIIs. The goal is to validate emerging themes or identify new areas of concern thanks to the larger sample size. These insights will be clearly flagged as informal and used to guide follow-up interviews or thematic probes.

This mixed qualitative strategy ensures both rigor and adaptability, enabling us to generate timely insights that are grounded in real-world service delivery challenges without imposing excessive burden on field teams or health workers.

Target Facility / Service Delivery Archetypes and Sampling Approach

Rather than aiming for geographic representativeness, we propose sampling facility and service archetypes that we hypothesize are likely to be affected by USG funding cuts and that reflect key structural and operational characteristics affecting last-mile immunization delivery. These archetypes capture how service delivery is organized, who is being served, and what constraints are likely most binding—especially in the context of recent USG funding cuts. We assume we can roughly cover 2-4 archetypes per country, pending government input, budget, and safety considerations (i.e., archetypes proposed below in this concept note, to be confirmed and finalized with country government approval). We expect that as we finalize the data collection plan, including matrixing sub-national areas and service delivery archetypes, we will refine and confirm the list of planned regions and archetypes with GiveWell before we conduct data collection.

mmunization service elivery archetype	**ey Characteristics**	**hy It Matters**	**ata Collection onsiderations**	**riority for this ssessment**
emote Rural, Fully utreach-Dependent (Facility ith high % of outreach ervices)	lo nearby facility; eliant on mobile eams or campaigns	uts often reduce ransport budget; opulations easily issed	Phone or in person nterviews with facility taff/CHWs -Collect insights and erify data via DHO or SO partner	igh
emi-Remote with Mixed ervice Delivery	artial access to xed site; remainder ia outreach	isruptions may educe catchment or rop frequency	Phone or in-person KIIs Include district upervisors	igh

Recently Integrated Zero-Dose Communities	Previously unreached, just recently added to outreach rounds	Fragile trust and access—early service interruption could reverse progress	In person interviews if feasible Remote interviews with EPI focal points WhatsApp surveys with outreach staff	*High, but may already be represented by other archetypes in this table*
Urban or Peri-Urban, Mobile/Temporary Sites, including urban slums	Densely populated areas lacking permanent infrastructure	High population vulnerability; hard to track disruptions	In-person if safe Phone or in-person with CSO workers	Medium
Routine Facility-Based Site with Stable Demand	Consistent fixed-post services, accessible to catchment	Useful as a 'control' to compare outreach-dependent sites	In-person visits usually feasible Phone interviews with health facility staff	Medium

Timeline and Deliverables

Target Timelines

Milestone	**Target Timeline**	**Details**
Assessment kickoff	Late May / Early June	Internal launch with R4D team; confirm roles, finalize work plan, initial alignment with GiveWell
Country engagement kickoff	Early to mid-June	Initiate discussions with Ministries of Health, key partners, and CSOs; confirm feasibility and focal geographies. R4D set up contracts with any vendors (i.e., consultants, sub-awards, etc.)

Permissions and coordination	Mid to late June	Secure any required written permissions from government stakeholders or implementing partners to proceed with data collection
Site and archetype sampling finalized	Mid to late June	Confirm which regions, districts, and facilities to visit or reach remotely in each country, using archetype framework
Data collection tools drafted	Late June	Develop and refine semi-structured interview guides, note-taking templates, and rapid poll questions for WhatsApp groups
Data collection tool iteration and finalization	Early July	Feedback from GiveWell incorporated, and tools finalized and translated into local language (as needed)
Data collection (rolling across countries)	Mid July	For national and regional stakeholders - in-person and phone interviews, remote data gathering, and informal polling; begin transcription and cleaning in parallel
	Mid July to Mid August	For district- and facility level stakeholders: in-person and phone interviews, remote data gathering, and informal polling; begin transcription and cleaning in parallel
Ongoing synthesis and internal check-ins	July - August	Weekly internal synthesis meetings to identify emerging themes, course-correct if needed, and coordinate across countries
Cross-country synthesis and memo drafting	Early August - Mid August	Identify converging risks and adaptations by archetype and system level; draft findings and visual materials
Final deliverables shared with GiveWell	Late August	Submit cross-country memo, country summaries, and slide deck; optional blog post shared in draft form if applicable

Deliverables

The assessment will produce a combination of ongoing and final deliverables to support GiveWell's internal decision-making, with flexibility in format (e.g., memos or slides):

Deliverable	**Description**	**Timing**	**Format Options**
Data collection plan and qualitative data tools drafted and shared with GiveWell	Qualitative data tools shared for review/input by GiveWell	end-June	Word document
Qualitative data tools finalized		Early July	
Synthesis memo outline	Outline of main sections and structure of final cross-country synthesis memo	Early July	
Biweekly email updates during data collection	Includes brief overview of progress made, successes, challenges, emerging themes, and any interesting or surprising learnings	July and August	1-2 page email updates
Cross-country synthesis memo with annexed country vignettes	High-level synthesis across countries and archetypes, summarizing key patterns, risks, and decision-useful insights. Includes vignettes for each country highlighting country-specific key takeaways	Late August	Memo (max 10-15 pages) and presentation slides
Slide deck	Presentation-ready summary of final findings and strategic takeaways	Late August	PowerPoint slide deck

Anonymized qualitative raw data (optional)	R4D can share all qualitative data collected (anonymized) if we can confirm that this poses no IRB concerns.	August	Word doc
Contribute to / review draft GiveWell blog post as requested (optional)	Provide input and/or review to draft GiveWell blogpost, if requested	August (if appropriate)	Decided by GiveWell

Budget Summary

Preliminary estimated total for this assessment across 3 countries: $271,445 USD, at approximately $82K for Nigeria (sampling from 4 states), $75K for Madagascar, and $115K for DRC, with program management and cross-country analysis proportionately included. R4D can provide a more detailed cost breakdown of main cost categories by country with this concept note.

Nigeria	
Description	**Total Cost**
R4D in-country staff	$14,380
Travel/ODC costs	$2,643
Consultants	$37,934
R4D Program Mgmt	$27,151

Subtotal, Nigeria	**$82,108**
Madagascar	
Description	**Total Cost**
R4D in-country staff	$-
Travel/ODC costs	$2,517
Subaward	$45,000
R4D Program Mgmt	$27,151
Subtotal, Madagascar	**$74,669**
DRC	
Description	**Total Cost**
R4D in-country staff	$-
Travel/ODC costs	$2,517
Subaward	$85,000
R4D Program Mgmt	$27,151

Subtotal, DRC	**$114,669**
PROJECT TOTAL	**$271,445**

Risks / Assumptions

- **Facility-level conversations:** Facility-level conversations in some countries (e.g., Nigeria) may require facility-specific letters of invitation from the government. We're currently working to understand where this is required, the potential lead time to obtain these letters, and possible alternative approaches if the timeline is too long for this rapid assessment (e.g., district-level conversations, CSO engagement, etc.).

- **R4D contracting timelines:** Once a qualified team or individual has been selected for consultant / CSO engagement, we should assume it will take 10 business days for R4D to set up a contract with an established vendor, and 15-20 business days for R4D to set up a contract with a "new" (i.e., "newly doing business with R4D") vendor. This timeline would start once R4D has a signed contract from GiveWell. Consultants for DRC and for state-level data collection in Nigeria would be vendors new to R4D.

- **R4D engagement of consultants and sub-awards:**

    - For Madagascar, we plan to forego a competitive procurement process in favor of setting up a sub-award with the consultant referenced in the Madagascar engagement process (unless, of course, GiveWell has concerns about this).

    - For DRC, R4D has already posted a funding-contingent RFP on our website, so the consultant or firm selected will have gone through a competitive process.

    - For Nigeria, we plan to forego a competitive procurement process and contract directly with state-level consultants and data collectors who are already in the R4D network .

- **Differing IRB requirements**: Country's IRB processes can vary, and some countries we engage with have stricter thresholds for what needs IRB approval than others. As this work is not human subjects research, we have done our best to design this assessment, including our selection and planned engagement with consultants, in a way that will allow us to carry out the work rapidly and will not require IRB approval. If we encounter unforeseen complications or requests for IRB review, we will raise this to GiveWell and agree on a contingency plan.

End Concept Note.

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[1] **USAID cuts by country (% + Absolute)**

[2] Proportion of children in the target population who would be vaccinated in the absence of the program, aggregated across vaccines, based on GiveWell's preliminary internal country-level cost-effectiveness analysis.

[3] Probability that an unvaccinated person will die of a vaccine-preventable cause before reaching age 5, including mortalities indirectly attributable to vaccine-preventable disease. Calculations based on GiveWell's preliminary internal country-level cost-effectiveness analysis.
