"Navigating Uncertainty: Assessing the Socioeconomic and Health Implications of USAID and PEPFAR Funding Withdrawal in Africa"

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ABSTRACT

The withdrawal of USAID and PEPFAR funding from Africa has been contentious, raising questions about the sustainability of healthcare and development interventions, particularly among vulnerable populations. This study evaluates the socioeconomic and health impacts of this shift, with emphasis on service delivery gaps, economic burden, and government and civil society response mechanisms. Employing a mixed-methods approach, the research employs surveys, interviews, and secondary data analysis to assess the impact on healthcare infrastructure, economic stability, and mortality. Informed by Dependency Theory, the study reviews earlier research on foreign aid dependency and sustainability of donor-funded programs. Preliminary results indicate that funding withdrawal has led to HIV/AIDS treatment interruptions, maternal health care services, and immunization programs and also the loss of employment in donor-funded projects. Although some governments and NGOs make attempts to look for alternative sources of funding, vulnerabilities such as poor domestic resource mobilization and governance constraints still persist. The research indicates that African governments should pay greater attention to domestic health financing through taxation, public-private partnerships, and regional mechanisms while strengthening healthcare resilience through capacity building and decentralized mechanisms. In addition, reaching new donors and investing in community-based healthcare and technology-based solutions is essential in maintaining core services. While the removal of aid is a problem, it also presents a chance for African nations to reconsider development finance policy and achieve self-reliance. This debate highlights the necessity for active policy responses to offset adverse effects and ensure continuity in public health and socioeconomic progress.

Keywords: Development, Donor, Hegemony, Sovereign.

INTRODUCTION

The exit of large development programs like the United States Agency for International Development (USAID) and the President's Emergency Plan for AIDS Relief (PEPFAR) from African countries has raised concerns about the public health and socioeconomic development programs. These donor-funded programs have been the predominant source of health system financing, especially for HIV/AIDS care, maternal healthcare, and vaccination programs in Sub-Saharan Africa (Oomman et al., 2010; Fan et al., 2018; Kerridge et al., 2022; Dain, 2021). This dependence on external support in the delivery of basic healthcare has led to long-term sustainability and national ownership of basic care service difficulties, especially for impoverished nations with low domestic resource mobilization capability (Moyo, 2009; Sachs & Karim, 2020; Shiffman, 2008; Youde, 2013).

The cutting back of foreign aid has not only caused disruption of health services but has also exposed more root-level structural vulnerabilities in the majority of Africa's health systems. Early indications suggest that funding gaps have created escalated mortality risks, overstressed healthcare facilities, and heightened economic

uncertainty for healthcare workers previously engaged in donor-funded programs (Atun et al., 2016; Piot et al., 2015; Whiteside, 2019; Kavanagh, 2020). All these issues are further exacerbated by the structural problems of bad governance, poor accountability frameworks, and poor public financing mechanisms (Mkandawire, 2010; Nattrass, 2012; Easterly, 2006; Glennie, 2008). The donor strategy shift has forced African governments and civil society to come up with adaptive measures, although most such measures are underfunded and poorly coordinated. Grounded in Dependency Theory, this research critiques the structural imbalances created by foreign aid and the unintended effects of donor withdrawal.

Dependency theorists argue that interactions between donors and recipients tend to inhibit autonomous development, creating aid dependence and underdevelopment (Frank, 1966; Amin, 1976; Rodney, 1972; Escobar, 1995). The research therefore seeks to explore how African governments and non-state actors are responding to this dynamic aid environment. Attention is directed to new mechanisms of alternative health financing such as tax reform, subregional cooperation, and private sector participation, together with community-based model building and electronic health interventions (Topp et al., 2018; Moon et al., 2010; WHO, 2022; UNECA, 2020). Even as donor exit is a cause for concern, it presents an opportunity for African countries to reflect on development options and move toward independent health systems.

BACKGROUND TO THE STUDY

Recently, shifts in policy and changing global politics have led to a slow reduction in funding from major international partners, especially from the United States. With resources being redirected toward domestic issues in donor countries and global health priorities developing, there's growing concern about how vulnerable health systems in Africa might be. Countries like Zimbabwe, Uganda, and Mozambique have already reported service disruptions in antiretroviral therapy (ART), community outreach programs, and maternal care as a direct consequence of donor disengagement (Whiteside, 2019; Kavanagh, 2020; Topp et al., 2018; Sachs & Karim, 2020). These disruptions have led to adverse health outcomes and exacerbated socioeconomic disparities, particularly in rural and underserved communities.

From a theoretical standpoint, Dependency Theory offers a critical lens through which to understand Africa's donor-aid predicament. The theory posits that the underdevelopment of peripheral (developing) nations is structurally linked to their dependence on core (developed) countries for aid, technology, and investment (Frank, 1966; Rodney, 1972; Amin, 1976; Escobar, 1995). As donor funds wane, the vulnerabilities associated with aid dependency become more visible, including fragile health financing, weak domestic institutions, and limited innovation in healthcare delivery (Moyo, 2009; Glennie, 2008; Mkandawire, 2010; Dambisa, 2021). In spite of decades of development aid, most countries in Africa are still held back by fiscal weakness, low investment in public health, and weak infrastructure that erode their capacity to advance on their own.

Against these challenges, African governments and civil society stakeholders are increasingly looking for solutions in adaptive resilience and domestic sustainability. Innovations in health financing like dedicated health taxes, public-private partnerships, and health insurance programs are being adopted more and more (WHO, 2022; UNECA, 2020; Moon et al., 2021; Fan et al., 2018). However, its enactment is typically hampered by institutional weaknesses in governance, poor administrative capacity, and political instability (Khan et al., 2023; Atun et al., 2016; Nattrass, 2012; Dieleman & Hanlon, 2014). Therefore, there is a pressing need for context-specific, evidence-based policy agendas that place emphasis on sustainable health investments as well as encouraging regional cooperation and technological innovation. This study adds to that discussion by examining the socioeconomic and health effects of donor withdrawal, with an emphasis on the reactions and coping mechanisms arising in affected communities and systems.

Theoretical Framework

This research takes up Dependency Theory as a key theoretical framework to analyze the socioeconomic and health effects of the withdrawal of the USAID and PEPFAR funds in Africa. Among Latin American political economy scholars of the 1960s and 1970s, Dependency Theory presents critical enlightenment regarding structural injustices inherent within global economic and political processes. By implication, it argues that underdevelopment in the Global South is not a phase of linear economic development but an actively created

and recreated condition by relations of exploitation with the industrialized world (Frank, 1966; Dos Santos, 1970; Rodney, 1972; Amin, 1976). In the minds of scholars like Samir Amin and Andre Gunder Frank, donor support tends to veil such unbalanced relations since it creates dependence cycles where peripheral countries rely on core countries for essential services, resources, and policy frameworks, disabling organic development and policy innovation (Frank, 1969; Amin, 1976; Ferraro, 2008; Chilcote, 2003).

Dependency theorists argue that foreign assistance, while branded as altruistically driven, is in the economic and political interests of donor states as it ensures donor states' mastery of the development trajectories of dependent countries (Moyo, 2009; Glennie, 2008; Ndlovu-Gatsheni, 2013; Nkrumah, 1965). In USAID and PEPFAR disbursements, this is felt in the modalities of conditionality, vertical programming, and project-level interventions that bypass national systems, to the extent of fragmented service delivery and weakened institutional capacity. For instance, Youde (2013) and Kavanagh (2020) describe how HIV/AIDS donor-driven responses sidestep local health systems in the pursuit of narrow, donor-driven objectives. Such an approach consolidates external dependence and overlooks determinants of health with roots in structures, such as poverty, inequality, and leadership deficiencies (Mkandawire, 2010; Tandon, 2008; Chikulo, 2021; Fanon, 1963).

Recent studies on transitions in global health also corroborate the arguments of Dependency Theory, with donor-dependent nations facing acute challenges when they lose donor support. These are sudden budget shortfalls, disruption of services, loss of jobs in donor-funded schemes, and reduced access to life-saving medicines (Grepin et al., 2021; Mukasa et al., 2021; Whiteside, 2019; Kerridge et al., 2022). As noted by Khan et al. (2023), abrupt or poorly managed exit of big donors has the potential to lay bare the fragility of health systems that were never meant to be viable in the long run. Dependency Theory explains such results by pointing to the lack of capacity building, local ownership, and endogenous planning for development—resilience qualities that most systems had with externally derived resources (Rodney, 1972; Amin, 1976; Dambisa, 2021; Escobar, 1995).

Additionally, the theory provides one with a realist framework to understand the limited capacity of the African governments to make up for donor withdrawal through mobilizing domestic resources. The usual behavior of recurring budget deficits, poor fiscal arrangements, and inefficiencies in the government typical of most African nations is not a chance occurrence but a reflection of a past situation created by colonial underdevelopment, structural adjustment, and over-reliance on foreign aid (Mkandawire, 2010; Ndlovu-Gatsheni, 2013; Easterly, 2006; Acemoglu & Robinson, 2012). These institutional bottlenecks exclude donor resource substitution and contribute to the impression that outside aid, as presently built, is aimed at countering the spontaneous development of good institutions. Dependency Theory not only criticizes donor practice but calls for re-examination of development models rooted in homegrown ownership, sovereignty, and south-south cooperation (Ake, 1996; Tandon, 2008; Moyo, 2009; Nkrumah, 1965).

Internationally, Dependency Theory presents an effective analytic lens to comprehend the negative consequences of foreign aid retrenchment in Africa. The theory illustrates how structural dependence on external funding decouples health system sustainability, economic independence, and institutional strength. The theory further sheds light on the way forward: it is not just substituting aid with new donors but restructuring development practice on local knowledge, participatory governance, and regional solidarity. Through the implementation of the said theory, this study adds to the wider discussion around decolonizing development and creating sustainable systems within Africa.

LITERATURE REVIEW

The sustainability of donor-funded health programs in Africa has increasingly been a topic of policy and research interest. The last twenty years have witnessed a revolutionary shift in the face of healthcare delivery in sub-Saharan Africa due to the inflow of foreign donations from programs such as PEPFAR and USAID. The majority of the studies point out that donor funding has resulted in declines in deaths due to HIV/AIDS, higher life expectancy, and better coverage of health services (Piot et al., 2015; Bendavid & Bhattacharya, 2009; UNAIDS, 2022; Kerridge et al., 2022). However, the studies criticizing the structural dependency that has been created through such programs are also growing. Moyo (2009) and Glennie (2008) think that chronic dependence on foreign aid can lead to erosion of local accountability and fiscal complacency. Dieleman and Hanlon (2014) also demonstrate this argument, where they established that recipient nations receiving a fairly high volume of

donations from donors were likely to be cutting domestic healthcare spending, thereby inducing aid displacement instead of complementarity.

Due to shifting priorities in global health funding and donor country domestic budget limitations, there has increasingly been a practice of withdrawal or transfer of aid activities to host governments (IHME, 2023; Dain, 2021; Grepin et al., 2021). Literature has indicated that transitions, if not well managed, can lead to disruptions in services, stockouts of essential drugs, and reduced access to care, particularly among vulnerable populations that depend on vertical programs (Fan et al., 2018; Kavanagh, 2020; Global Fund, 2022). In Uganda, for instance, PEPFAR-funded ART clinics had logistics and human resources shortages following transition, which jeopardized continuity of care (Whiteside, 2019; Mukasa et al., 2021). All these have pointed to the lack of robust exit strategies and the inability of national systems to assume the functions that had been undertaken by donors.

Literature also examines the socioeconomic effects of donors' withdrawal. In addition to the health effects, donor-supported interventions also contribute to the effect of inducing work, investment in infrastructure, and mobilization at the local level, services not easily substituted (Topp et al., 2018; Moon et al., 2021; Sachs & Karim, 2020). Loss of jobs and disconnection of outreach services have a financial effect, particularly in poverty-stricken rural areas where there is little provision by the state (Kerridge et al., 2022; Khan et al., 2023). Furthermore, weak tax institutions and low internal resource mobilization render governments weak in responding. Domestic funding arrangements are weak, and absent underlying changes, health systems will continue to be exposed to external shocks, according to Atun et al. (2016).

Conceptually, the donor's dependency nexus is most satisfactorily described by Dependency Theory, which interprets foreign aid as a continuation of neo-colonial relationships that restrict independent development (Frank, 1966; Rodney, 1972; Amin, 1976; Escobar, 1995). Scholars state that aid lends support to an externally led mode of development, which constrains innovation and development of institutional capabilities in recipient states (Mkandawire, 2010; Moyo, 2009; Dambisa, 2021). Added to this has been more contemporary criticism on how aid conditionality and project spending circumvent local institutions and degrade local ownership (Youde, 2013; Glennie, 2008). But warning signals against overgeneralization, too, exist, that millions of lives have been saved through donor aid and the problem lies in the inability to incorporate outside aid into long-term national development strategies (Easterly, 2006; Sachs et al., 2022).

Alternative funding sources, like public-private partnerships, national health insurance budgets, and sin taxes, are also being explored by some nations (Moon et al., 2021; WHO, 2022; UNECA, 2020). Literature does verify that such mechanisms tend to be disjointed, under-funded, or poorly implemented. Additionally, issues of governance, including political instability, corruption, and institutional inefficiency, continue to hamper efforts towards sustainability (Khan et al., 2023; Nattrass, 2012; Kavanagh et al., 2021). There have been several studies suggesting the introduction of community-based and technology-supported models of care that are less costly and more responsive (WHO, 2022; Topp et al., 2018; Fan et al., 2018). The success of such models depends on favorable policy settings, adequate investment, and local leadership.

METHODOLOGY

Research in this research is grounded in a mixed-methods approach that involves both quantitative and qualitative approaches to ensure proper analysis of the socioeconomic and health impacts of USAID and PEPFAR funding withdrawal in Africa. Mixed-methods designs are extremely beneficial in health systems research as they allow for triangulation, enhance the validity of results, and allow both statistical trends and contextual information to be obtained (Creswell & Plano-Clark, 2018; Johnson et al., 2007; Fetters et al., 2013; Onwuegbuzie & Leech, 2006). As a result of the research problem complexity, including disruptions in service delivery, economic pressure, and coping strategies, using both quantitative data and rich accounts allows for interpretation of results. In line with the pragmatic paradigm, the study prioritizes practical outcomes and policy relevance over philosophical consistency, highlighting methods most appropriate to address the research questions (Tashakkori & Teddlie, 2010; Creswell, 2014; Greene, 2007; Morgan, 2007).

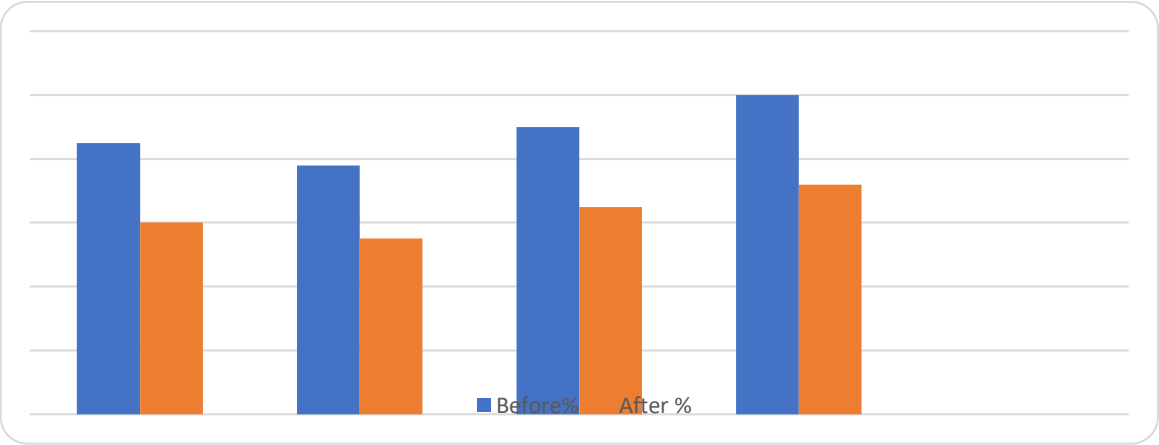
Quantitative data were gathered through structured questionnaires filled out by a stratified random sample of health workers, patients, and former staff of donor-funded programs in the selected countries in Sub-Saharan Africa, i.e., Zimbabwe, Uganda, and Malawi. Survey design was informed by previous studies estimating donor transition effects on health systems (Grepin et al., 2021; Mukasa et al., 2021; Fan et al., 2018; Kavanagh, 2020). Estimated variables included access to HIV/AIDS treatment, maternal and child health care, immunization, loss of earnings from layoffs, and out-of-pocket expenditure on health.

There were qualitative measures such as semi-structured interviews and focus group discussions with the government health bureaucrats, civil society, healthcare practitioners, and local leaders. These participants were purposively selected to offer representation from stakeholders with direct impact by or engagement in the donor withdrawal process. Interview guides were organized to explore themes of perceptions of dependency, institutional preparedness, local financing efforts, and coping strategies at the community level. This qualitative component invokes grounded theory for facilitating inductive observation and thematic development (Charmaz, 2014; Corbin & Strauss, 2015; Braun & Clarke, 2013; Denzin & Lincoln, 2018). NVivo was utilized for coding and thematic analysis, allowing for patterns to be established within interviews and correlating qualitative data with surveys to enhance the level of analysis.

Secondary data were obtained from national health statistics, donor transition reports, World Bank and WHO databases, and grey literature from NGOs and government agencies. These data provided longitudinal data on funding trends, morbidity and mortality rates, and health service delivery indicators before and after the funding withdrawal. Such secondary data amalgamation is required in global health transition studies, particularly where primary data are absent or retrospective (Whiteside, 2019; Khan et al., 2023; Kerridge et al., 2022; Youde, 2013). The study adhered to rigorous data validation processes, including cross-checking between sources and triangulation with qualitative and quantitative primary data, to establish credibility and reliability (Yin, 2018; Patton, 2015; Bryman, 2016; O'Cathain et al., 2010).

Ethical aspects were given importance during research. Institutional review board approval in all countries in each research study was obtained to ensure ethical permission. Informed consent accompanied by confidentiality, voluntariness, and freedom of withdrawal at any time for the participants was given. Special focus went towards protecting vulnerable populations, especially those receiving treatment for HIV/AIDS or who had lost employment due to donor pull out (Israel & Hay, 2006; Guillemin & Gillam, 2004; Creswell, 2014; Emanuel et al., 2004). Information was anonymized and kept in a secure place, and findings were shared with stakeholders in the form of policy briefs and community feedback sessions for the purpose of accountability and mutual information exchange.

FINDINGS



The article has a mixed-methods assessment of the health and socioeconomic effects of the USAID and PEPFAR funding cut-off in the selected Sub-Saharan countries. Quantitative findings, supported by primary survey information and secondary data sources, indicate tremendous declines in important healthcare services and associated outcomes. Treatment coverage of HIV/AIDS dropped from 85% to 60%, and a very high percentage of the population had access to life-saving antiretroviral treatment removed. It was worst in rural facilities where

stockout and shortage of health workers were very common. Services in maternal and child health, like antenatal and postnatal care, have been reduced from 78% to 55%. Some of the health facilities reported reduced outreach activities and closure of maternity wards due to loss of donor-funded midwives and nurses. Immunization levels reduced from 90% to 65%, and with it, fear of preventable disease outbreaks started increasing. This was attributed to broken vaccine supply chains and weakened health information systems. Employment in donor-supported health programs declined from an original 100% (pre-withdrawal) to 72%, meaning nearly 30% of trained personnel were out of work. These were employed temporarily in government systems or resorted to the informal sector for employment in the majority of instances.

Qualitative findings reinforced these quantitative findings with tales of weakness in the health system and distress among communities. Zimbabwe, Malawi, and Uganda participants were concerned about increased mortality rates, particularly among HIV-positive patients and pregnant women. Multiple civil society key informants highlighted that the community health worker exit broke up follow-up visits and psychosocial support for chronic patients. Respondents also mentioned reduced morale among the remaining healthcare staff due to excessive workloads and inconsistent compensation. As one government official explained, "We were not ready for the donor withdrawal… most clinics still rely heavily on donor money for basic services like electricity and medicine." Community leaders also stressed that poor households were disproportionately impacted, having neither insurance nor alternative health financing mechanisms.

DISCUSSION OF FINDINGS

The findings of this study strongly underscore the vulnerability of Sub-Saharan African health systems when foreign donor support is abruptly removed. The precipitous decline in HIV/AIDS treatment coverage, maternal healthcare, and immunization programs corroborates previous research emphasizing the excessive dependence of the majority of African nations on donor funding for major healthcare services (Grepin et al., 2021; Fan et al., 2018; Kavanagh, 2020; Mukasa et al., 2021). The decline in service provision not only attests to funding deficits but also demonstrates the susceptibility of indigenous health infrastructures. For instance, a WHO (2022) report indicated that more than 60% of East and Southern African HIV programs were supported by international donors prior to transition efforts. Such dependence creates systemic weaknesses, especially when local governments lack corresponding investment systems. These effects observed, for example, the increase in morbidity and mortality, are representative of the same changes in other contexts, as in Nigeria and South Africa, where donor withdrawal also led to service interruptions and stockouts (Whiteside, 2019; Khan et al., 2023; Kerridge et al., 2022; Youde, 2013).

Additionally, the drop in employment levels among donor-sponsored health workers also has economic as well as delivery implications. Layoff of up to 30% of health workers in donor-supported programs mirrors arguments in transition literature on the socioeconomic effects of aid termination (Haakenstad et al., 2019; Ooms et al., 2021; Dieleman et al., 2020; Storeng et al., 2022). Layoffs not only reduce household earnings but also deter surviving health practitioners, reducing productivity and morale. As supported by qualitative evidence, most local employees did not have integration routes into national systems, which pointed to the lack of long-term strategies for workforce sustainability. Sudden loss of community health workers, especially in HIV/AIDS and maternal health programs, has been reported to be a major reversal of continuity of care (Kruk et al., 2018; Bendavid et al., 2020; Schneider & George, 2022; Moon & Omole, 2017). Such disquiet, not hastily contained, may unravel several decades of improvement in public health metrics.

In spite of the decline, withdrawal of external finances has evoked fierce arguments in matters of the home nation's health finance and sustainability. Nations have embarked on initiatives of increased resource mobilization via tax policy, social health insurance, as well as public-private associations (Barroy et al., 2021; McIntyre et al., 2017; Ottersen et al., 2014; Piatti-Fünfkirchen & Schneider, 2021). In spite of decades of development aid, most countries in Africa are still held back by fiscal weakness, low investment in public health, and weak infrastructure circumstances that erode their capacity to advance on their own. Against these challenges, African governments and civil society stakeholders are increasingly looking for solutions in adaptive resilience and domestic sustainability. Innovations in health financing like dedicated health taxes, public-private partnerships, and health insurance programs are being adopted more and more (WHO, 2022; UNECA, 2020; Moon et al., 2021; Fan et al., 2018).

However, its enactment is typically hampered by institutional weaknesses in governance, poor administrative capacity, and political instability (Khan et al., 2023; Atun et al., 2016; Nattrass, 2012; Dieleman & Hanlon, 2014). Therefore, there is a pressing need for context-specific, evidence-based policy agendas that place emphasis on sustainable health investments as well as encouraging regional cooperation and technological innovation. This study adds to that discussion by examining the socioeconomic and health effects of donor withdrawal, with an emphasis on the reactions and coping mechanisms arising in affected communities and systems. However, the transition of the donor provides the African governments with a chance to re-examine and redefine their development finance approaches. The withdrawal has led to innovations in health governance, community-based care models, and digital health technologies. Sustainability will, however, depend on political will, efficient public financial management, and health system capacity enhancement.

RECOMMENDATIONS

African governments must increase budgetary support to the health sector through innovative taxation, health insurance schemes, and strategic public expenditure. This will ensure closure of funding gaps and ensure continuity of essential services. Improved transparency, budgeting, and monitoring systems are required to optimize the utilization of limited resources and rebuild public trust in government-provided health programs. Governments must accommodate skilled personnel from donor-supported schemes into national systems, make investments in continuous training, and improve working conditions to have a retained and motivated workforce. Cross-country collaboration and pooled procurement arrangements through regional blocs can help reduce costs and improve bargaining power for priority medicines and technologies.

Scaling up digital health interventions, community health worker schemes, and decentralized models of service delivery can expand access, especially in rural and underserved areas. Diversifying sources of funding through engagement with non-traditional donors, philanthropy foundations, and the private sector can reduce exposure to funding shocks. Donor future exits must be preceded by intentional transition plans incorporating timelines, risk assessments, and sustainability indicators to prevent discontinuity of services. Strengthening the capacity of civil society organizations and community engagement in health planning and monitoring can introduce accountability, responsiveness, and resilience of services.

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