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Nigeria's HIV Response after the 2025 PEPFAR Funding Shock: Service Vulnerabilities and Priorities for a Sustainable Transition

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Abstract

Nigeria's HIV response illustrates both the benefits of sustained external investment and the fragility of a system dependent on that funding. This critical narrative review and policy analysis examines the 2025 disruption to PEPFAR and develops a transition agenda for Nigeria. Targeted retrieval and verification through October 2026 drew on peer-reviewed research and official sources covering treatment, prevention, maternal and child health, the workforce, laboratories, supply chains, information systems, and community delivery. Nigerian reports described a complete disruption of community services, uncertainty among providers, and declining laboratory capacity, despite initially stable ARV stocks. A multi-country facility analysis reported an 18% decline in HIV testing, a 33% decline in PEP initiations, a 24% decline in direct service workers, and a 1% decline in treatment totals. These figures are not Nigeria-specific effect estimates. Modelling studies identified significant risks from a sustained interruption; but they did not document an observed increase in infections or deaths in Nigeria. The policy context has since shifted with renewed US funding, a bilateral health agreement, and the adoption of Nigeria's National Strategic Plan 2026-2030. Implementing this new framework will require far more than the funding announced so far. This review proposes a framework for costing a function-based transition compact that links funding releases to institutional responsibilities, workforce arrangements, and opera-

tional readiness to achieve equitable service coverage. It also proposes two policy matrices outlining vulnerabilities, safeguards, accountability arrangements, and phased milestones. The transition must also preserve trusted community platforms, protect the full care cascade, and provide corrective support if performance deteriorates. Sustainable ownership should be measured by service quality and patient outcomes—not by spending shares or the scale of administrative transfers.

Keywords

HIV, PEPFAR, Nigeria, Health Financing, Health-System Sustainability

1. Introduction

Expanding treatment through PEPFAR support has been a significant achievement for Nigeria's HIV response. But sustaining the response takes more than paying for drugs. It also depends on health workers, laboratories, transport, information systems, and community-level organisations. A Nigerian review found that ART coverage rose from about 15,000 in 2002 to over 1.78 million in 2023 [1]. The challenge now is to maintain that progress as the external funding and support we have come to rely on change.

It's absolutely critical to draw the line between programme growth and its sustainability, especially in a very large and dispersed health system. There is a whole range of actors at the federal, state, facility and community level all delivering care, and they all do it in very different ways. National funding has to be a reliable source of funding at the point of care. The transition is all about the service functions: who buys the consumables, who pays the staff, who moves the specimens, who keeps the records and who helps the patient back into care. That is the lens through which we will be looking at this.

The January 2025 suspension of US foreign assistance (plus the stop work orders and partial waivers) made this a very urgent issue [2]. Reports from Nigeria were that community testing and specialist services were all but stopped, despite the initial stability of ARV stocks [3]. That really does challenge the idea that preparedness is simply about having the medicine. There can be medicine in the clinic and still have absolutely nothing else: no staff, no specimen transport, no access to the community.

Vulnerability to HIV is also unevenly distributed across population groups. The Nigeria Integrated Biological and Behavioural Surveillance Survey reported HIV prevalence of 25.0% among men who have sex with men and 10.9% among people who inject drugs. Analysis across the 12 states surveyed also revealed considerable gaps in service coverage [4]. Although these prevalence estimates are specific to the populations surveyed and should not be generalised to Nigeria as a whole, they highlight persistent disparities in HIV burden and demonstrate why aggregate treatment coverage alone is insufficient to assess equity in the national response.

These differences also have an impact on how the disruption should be measured. The loss of a community access point may not immediately impact national treatment numbers, but it can have a massive impact on the ability of certain groups to access care. Financial sustainability needs to be factored in alongside accessibility, confidentiality and quality of service. Otherwise, a transfer of responsibility may look like a success on paper but, in reality, could shift the cost onto the patient, the unpaid worker, or the community group.

The policy landscape has changed since the initial shock. The bilateral health cooperation agreement announced in December 2025 did include the prospect of renewed U.S. support and increased Nigerian health financing. Nigeria has since put in place its National Strategic Plan 2026-2030, and UNAIDS has welcomed a new U.S. HIV funding package in February 2026 [5]-[7]. The current challenge is therefore not a funding cut that is purely hypothetical or a scenario of complete donor exit. It is a more realistic partnership and a tangible step towards domestic responsibility.

Mansour and colleagues have described how US policy developments have an impact on health systems and research beyond their direct fiscal impact (*i.e.* on workforce, supply chain and governance functions) [8]. The editorial makes the point about the wider disruption. The present review goes on to develop a Nigeria-specific implementation response by synthesising the evidence and policy developments with clearly defined responsibilities, readiness milestones and safeguards for service continuity.

This review pinpoints which service functions the 2025 shock has impacted, separates the evidence from the projected risks and sets out a practical transition plan for Nigeria. The fundamental point is that ownership should be determined by the ability to fund, manage and deliver each of the key functions whilst maintaining appropriate coverage. It proposes a function-based transition plan to turn the broad promise of sustainability into specific functions, milestones and actions for correction.

2. Review Approach and Analytical Scheme

This is a critical narrative review and policy analysis. The targeted searches and source verification for this revision were updated on 18-19 October 2026 using the publisher records, PubMed and PubMed Central records and official records of UNAIDS, NACA and Nigeria's Federal Ministry of Health and Social Welfare. The search concepts were Nigeria, HIV, PEPFAR, funding interruption, donor transition, sustainability, service delivery, prevention, workforce, laboratory systems and supply chains. Sources were selected on the basis of relevance to the argument rather than through a full systematic review process.

An illustrative search string was: ("Nigeria" OR "Nigerian") AND ("HIV" OR "HIV/AIDS" OR "antiretroviral therapy" OR "ART" OR "PrEP" OR "PMTCT") AND ("PEPFAR" OR "foreign aid" OR "funding interruption" OR "donor transition" OR "health financing" OR "sustainability" OR "service delivery"). We

adapted search terms to each database's requirements and supplemented them with searches of official institutional repositories and reference lists.

We included sources that provided relevant evidence on any of the following: Nigeria's HIV response, PEPFAR-supported service delivery, HIV financing, service disruption, health system capacity or transition arrangements. We focused on Nigerian empirical studies and official policy documents. We included multi-country programme analyses and quantitative models where they provided relevant evidence on service disruption or potential impact, and we took account of their geographic scope and study design in our interpretation of the results. We excluded sources that were not directly relevant to HIV service delivery or financing, sources which were duplicative of evidence we had already captured and sources which simply didn't contain enough accessible information to underpin the claims we were making. As this was a targeted narrative review, we selected sources on the basis of their relevance to the conceptual framework and their contribution to it rather than on the basis of a pre-defined systematic screening protocol.

We looked at the implementation and financing studies in Nigeria. We included the multi-country programme analyses and the quantitative models where those were useful in terms of illuminating the 2025 shock (and in keeping with the original geographic scope of the studies). We used the official statements to record the policy choices and the reported programme conditions; we didn't independently verify implementation. We only used the abstract-level evidence where the evidence we had access to actually supported that. We didn't do any pooled effect estimate or any formal risk of bias score.

The synthesis was structured around three interlinked questions: What was PEPFAR's contribution to service delivery? What vulnerabilities were revealed by the funding shock? And what would be the sequence of a transition agenda? Within those sections, we looked at the evidence across treatment, prevention and case finding; maternal and child services; enabling system functions and community access. Where possible, we have retained the earlier Nigerian studies as they did a good job of illustrating the pre-existing implementation constraints. This is a thematic account of the material that we used, not a claim that we used a prospectively registered extraction protocol or a duplicate screening process.

Health system resilience is the conceptual underpinning of the exercise: the ability to respond to disruption and still deliver core services [9]. For this review, we have operationalised that through four questions for each function: Is the finance appropriated and released? Is responsibility assigned to an institution and workforce that is capable of responding? Are the operational inputs in place? Is coverage maintained across the affected populations? Those are the questions we have put forward as part of our analytical framework (it is not a validated instrument of readiness). We need to be very clear that recommendations are distinct from interventions, which have been documented and are intended for use in national and state planning.

We can use three quite different types of evidence. A programme report can record an allocation or a reported service interruption but can't tell how long it was or what the impact was. An observational study can identify associations and can capture the implementation experience. It can't, however, isolate the funding shock from other pressures which may have been going on at the same time. A model can produce an estimate of the outcome based on a set of assumptions, without actually observing it. Table 1 sets out the main forms of evidence. Table 2 and Table 3 use these different forms of evidence to set out the proposed safeguards and the implementation responsibilities; they are not the results of a tested intervention.

Table 1. Summary of principal evidence informing the analysis of Nigeria's HIV response after the 2025 PEPFAR funding shock.

Evidence source	Setting	Design/source type	Principal contribution
Salihu *et al.* [1]	Nigeria	Programme review	Describes the expansion of ART and the role of key-population service delivery platforms.
UNAIDS [3]	Nigeria	Official program assessment	Reports interruptions to community testing and specialised services following the funding disruption.
Mugo *et al.* [10]	Northern Nigeria	Observational program study	Describes differentiated ART delivery and service outcomes during COVID-19.
Iliyasu *et al.* [11]	Northern Nigeria	Qualitative provider study	Identifies uncertainty, workforce and operational vulnerabilities during funding disruption.
Honermann *et al.* [12]	Multiple PEPFAR-supported countries	Facility-level program-data analysis	Documents changes in treatment, testing, PrEP, PMTCT and workforce indicators, accounting for reporting patterns.
Hontelez *et al.* [13]	Seven sub-Saharan African countries	Mathematical modelling	Projects possible infections and deaths under specified interruption scenarios; Nigeria was not included.
Brink *et al.* [14]	26 countries, with LMIC extrapolation	Mathematical modelling	Estimates potential additional infections and deaths under alternative funding-interruption scenarios.
Zakumumpa *et al.* [15]	Uganda	Qualitative implementation study	Provides comparative evidence on service changes following shifts in PEPFAR funding.
Aji *et al.* [16]	Indonesia	Qualitative case study	Illustrates institutional and stakeholder factors associated with program sustainability after donor support.

3. PEPFAR's Structural Contribution to Nigeria's HIV Response

3.1. Treatment Expansion and Differentiated Delivery

ART expansion was contingent upon an implementation platform and commodities. The range of services available (decentralised services, mentoring, data review, adherence support and public involvement) was the key to moving from policy to access [1]. All of those are assets in the transition phase. Sustainability planning therefore needs to look at which of the functions can be taken into the public sector and which will have to remain as contracted services rather than simply assume that consolidation of the organisation will lead to the preservation of performance.

The platform that results has capabilities that simply aren't there in a commodity budget. Mentoring assists facilities with the resolution of clinical and operational issues; data review allows the identification of those who have missed contact; and differentiated delivery leads to a reduction in both the number and cost of facility visits. A good example of a key population programme in Nigeria is how a local organisation can go from a prevention-only programme to one that provides full treatment [1]. The transition plan has to ensure that the capacity that's been built is maintained, with the appropriate levels of management and supervision to maintain it.

Nigeria's experience with Covid-19 is a textbook example of adaptation under pressure. In 63 of the northern facilities serving 84,776 people living with HIV, Mugo and colleagues saw an increase in uptake of multi-month dispensing and an increase in viral suppression amongst those who were tested (from 91% to 93%). There was also an increase in both missed visits and laboratory turnaround time, indicating that resilience was not equally distributed across the different outcomes [10]. A separate programme among children and adolescents saw multi-month dispensing increase from 23% to 88% [17]. The observational data do support the continued use of differentiated delivery options, without any assumption that one model will necessarily lead to better outcomes.

The practical lesson is to be flexible without losing clinical oversight. A multi-month supply can reduce the need for travel and help protect refills for the eligible patient, but it still requires good forecasting, sufficient stock, and clear arrangements for clinical review. The patient with symptoms, treatment problems or changing clinical needs will need an alternative. The approach therefore needs to maintain a menu of delivery options and ensure that the right people can access them rather than simply use reduced frequency of facility visits as the measure of success [10] [17].

3.2. Prevention and Trusted Community Platforms

Community platforms can deliver HIV services to people who might otherwise be put off by stigma, lack of transport or discrimination in the more conventional settings. The Nigerian experience with comprehensive services for key populations is a prime example of the value of locally based organisations and a client-centred approach [1]. The prevention coverage gaps seen across the 12 states also underline the fact that simply maintaining the services that already exist is not sufficient; there also needs to be a focus on the populations that haven't yet been reached [4].

For these services, continuity is mainly about the relationship between the organisation and the client. Peer workers can assist with the client's decision to come forward, help them through the referral process and provide information in a context where the normal service would be regarded as unsafe or unacceptable. Moving a service into a public setting may alter those dynamics even if the service package in name is the same. The proposed approach to the transition therefore

treats the delivery of the service in the trusted community setting as a capability which can be funded and measured rather than as an organisational form which has to go [1] [4].

Continuity is key to prevention. A Nigerian retrospective cohort study of 43,788 initiators of oral PrEP found that only 11.5% were still on treatment at six months [18]. This is prior to the 2025 disruption, so we can't use it to assess the impact of that. It does, though, point to an existing implementation challenge which funding instability would undoubtedly exacerbate. Procurement of prevention products therefore needs to be matched with an appropriate follow-up, counselling and convenient access rather than simply being measured by the number of people who initiate.

Low recorded continuation must lead to an investigation into both the service design and the measurement. Some people will stop because their perception of exposure has changed; others will stop for reasons such as transport cost, stigma, inconvenient delivery or loss of contact. A single programme retention metric will not tell us which of those pathways people have actually taken. For transition planning, we need to look at initiation, continuation, documented discontinuation and opportunities to restart together. That is the only way to avoid equating a product purchase or a first prescription with sustained access to prevention [18].

3.3. Laboratories Supply Chains and Information Systems

The degree of operational dependence revealed in 2025 is not new. Itiola and Agu identified the domestic financing, governance and HR challenges to ownership of Nigeria's HIV supply chain [19]. Ogbuabor and colleagues documented unpredictable budget releases and weak engagement by financing institutions in the HIV response [20]. That is why it is entirely possible to have nominal domestic ownership and still have donor-supported implementation.

National ownership of a laboratory network requires funding for specimen transport, QA, maintenance, reagents, information systems and staff. If equipment moves or the reporting authority changes without funding service's recurrent functions, we're moving the assets without moving the ability to operate them. The planning should therefore be on the complete service function rather than on individual inputs.

Information Systems are operational assets. There is a need to be able to detect missed refills, link specimens to results, and distinguish transfers from loss to follow-up. All of that requires good records and good staff. The consolidation exercise has to preserve that capability whilst tidying up the reporting and clarifying the maintenance responsibilities. Of course it's very expensive to keep two platforms running in parallel forever. However, we don't want to retire one prior to having tested the migration, as that could lead to a loss of information which is absolutely critical for both patient care and programme monitoring [20].

Diagnostic capacity also has benefits for programmes beyond a single disease. A study of febrile HIV patients in South-East Nigeria looked at dengue and ma-

laria using both assays and microscopy and provides a very clear demonstration of the value of being able to diagnose co-existent endemic infections [21]. It doesn't look at PEPFAR financing or prove that integration saves money, but it does provide a good basis on which to assess how laboratory and referral transitions can maintain shared capacity.

4. What the Funding Shock Revealed

4.1. Disruption Can Precede Commodity Shortages

The UNAIDS March 2025 Nigeria assessment found the ART supplies initially quite stable, although community testing and specialist services at over 80 of the one-stop shops had been disrupted [3]. A qualitative study of 15 providers at a major ART facility in the north of the country found the situation to be extremely uncertain, with patients in a state of panic, staff unpaid and lab capacity in a state of terminal decline, even though the medicines were still there [11]. It's a local study, so it doesn't give us the national picture, but it does demonstrate the impact of operational uncertainty on care even prior to the medicines actually running out.

The same study looked at panic visits, information gaps and precautionary restrictions on dispensing [11]. Crisis comms is therefore a complete operational necessity. Patients need to know where they can get their meds, whether their appointments have changed and what services are actually available. Staff need to know what they can and can't do and what the escalation routes are. The proposed solution is a coordinated comms plan in line with service status so that it's the facts of the situation that provide reassurance rather than some vague, generic statement.

4.2. Treatment Protection Can Conceal Losses Elsewhere

A facility-level analysis of 31,628 facilities and community service sites across the PEPFAR-supported programs looked at the Q4 2024 and Q4 2025 data [12]. Overall, across the entire reporting dataset, there was a 1% decrease in the number of people on treatment, an 18% decrease in HIV testing, a 33% decrease in PrEP initiations and a 24% decrease in direct service health workers. These are overall program-level estimates and do not represent the change in the number of people on treatment, etc., in the subset of facilities that reported continuously. The analysis split the facilities by level of reporting continuity (71.5% reported in all 8 quarters and 16.7% reported intermittently). Treatment numbers were up by around 0.3% in the facilities that reported continuously but down 6% in the facilities that reported intermittently [12]. This data is from a number of PEPFAR-supported countries and should not be interpreted as Nigeria-specific effect estimates.

For Nigeria, the appropriate monitoring response is a service cascade dashboard rather than a single ART total. We look at test review, new diagnoses, PrEP continuation, VL coverage, infant diagnosis, referral completion and staff availa-

bility all in one. A fall in diagnoses during a testing interruption should not be interpreted as a fall in transmission. Suppression amongst those who are tested can be very high, and the people who aren't being tested are effectively invisible.

Interpretation is very much dependent on the completeness of the reporting. In the multi-country analysis, the sites that reported continuously were very different from those that reported intermittently, and some sites simply stopped reporting [12]. If those sites are removed, the rest of the programme can look far more stable. If every missing report is treated as a zero, then the level of service loss will be overestimated. Nigerian monitoring should show the reporting status alongside the outputs and look at site closures, delayed reporting, and client transfers separately. That's the only way to ensure that the recovery seen is, in fact, recovery of access rather than just better visibility.

Maternal and paediatric continuity is absolutely vital, and there is a need to protect the entire pathway. That includes antenatal testing, maternal treatment, infant prophylaxis, sample transport, early infant diagnosis, and mother-infant follow-up. Programme assessment should be able to identify where the contact is lost and whether that loss is different by age, by pregnancy or by geography. This is a proposed monitoring priority rather than an estimate of the additional Nigerian vertical transmissions that would be attributable to the shock.

Children, adolescents and pregnant women all have their own specific protections within that monitoring framework. An infant result that comes in after a long delay is not the same as a result that is returned in a timely fashion. A maternal prescription in no way demonstrates that the mother and infant have actually gone down the pathway. The metrics of interest are sample collection, lab receipt, result return and linkage to clinical action. In the multi-country facility analysis, we saw a 6% drop in infant testing at the continuously reporting facilities and a 60% drop at the intermittently reporting facilities. Again, those are not Nigerian figures; they're just an example of what can be learned from looking at the continuity of reporting and the age-specific pathways [12].

4.3. Workforce and Equity Require Distinct Transition Arrangements

The emergency response was the approval of ₦4.8 bn for 150,000 treatment packs and an assessment of the affected workers for possible absorption into the public sector. UNAIDS has also reported the recall of some of the community workers [3]. This is clear evidence of capacity to respond, but approval for allocation or recall in itself is not sustainable financing or restored coverage. A sustainable arrangement would have to deal with the issues of payroll/contract, supervision, deployment and retention.

Different roles will have different institutional homes, of course. The core clinical and lab posts would probably be best in a public body where both the work and the money are available. Specialist services could be procured via accountable contracts. Peer navigation and community work would probably be best in a

trusted organisation with a reliable flow of public money. Forcing every single role into the civil service would be a massive missed opportunity for community delivery and a very expensive way to do it. Equally, if peer and community work were optional, then that would be a form of under-access for the very people who are already the most disadvantaged.

A proper workforce register should be about functions, not job titles. It should set out the location, the workload, the competencies, the employer, the pay source and the services that would be affected if that post were to go. The transition costs would be the recruitment/contracting, the supervision and retention and the salary. Public absorption may be an option in some circumstances, but that would require a public establishment and a public payroll. For community roles, a predictable service contract may be a better way of ensuring access than a change of employer [11].

4.4. Projections Define Risks Rather than Observed Nigerian Losses

Mathematical models do demonstrate the scale of potential disruption over a long period under the various assumptions that go into them. Hontelez *et al.* did a 90-day funding interruption scenario for 7 SSA countries and projected a huge number of excess deaths and infections under the various interruption scenarios [13]. Nigeria wasn't one of the 7 countries that they modelled, so their estimates should be viewed as an indication of the potential scale of disruption in an interdependent system rather than as a prediction for Nigeria per se.

Ten Brink and colleagues modelled 26 countries and then extrapolated out to the LMICs. In the scenarios that combined a reduction in international aid with the end of PEPFAR support, they estimated 4.43 to 10.75 million additional infections and 0.77 to 2.93 million additional HIV related deaths between 2025 and 2030 [14]. Those are the ranges for the scenarios and the extrapolated populations. Of course, subsequent funding decisions will change the policy context and so will change the actual outcomes; they don't in any way retrospectively wipe out the value of the modelling in terms of assessing the risk of interruption.

Model interpretation should also be evolving as policy evolves. An interruption scenario should identify the sensitive functions and, in that way, prevent the very interruption from being assumed. It's not sufficient simply to take the existing worst-case estimate and carry that into a period of new commitments. Nigeria's current planning should incorporate these risk scenarios with actual local service indicators and with actual documented financing releases. **Table 2** brings the identified vulnerabilities, the potential consequences and the proposed safeguards all in one place.

5. A Transition Agenda for Nigeria

5.1. Stabilising Essential Services and Measure Recovery

Action must be immediate to ensure continuity of treatment and of the full

Table 2. Principal vulnerabilities and proposed safeguards.

System function	Vulnerability exposed	Potential consequence	Priority safeguard and supporting sources
ART continuity	Dispensing, monitoring, and tracing depend on funded operational support.	Missed refills, delayed review, and loss of contact; risk to suppression.	Protect the complete delivery pathway; retain appropriate multi-month dispensing. [3] [10] [11] [17]
Testing and prevention	Outreach and prevention delivery can contract despite stable ART totals.	Fewer diagnoses and reduced access to PrEP and other prevention.	Protect a prevention funding floor; support continuation and accessible restart. [3] [4] [12] [18]
Maternal and pediatric care	Testing, prophylaxis, infant diagnosis and result return require linked contacts.	Delayed diagnosis and clinical action; risk of preventable transmission.	Fund and monitor the full mother-infant pathway and age-specific access. [12] [17]
Health workforce	Partner-funded staff can lose pay, contracts or supervision.	Overload, attrition and loss of institutional knowledge.	Cost posts by function; finance absorption, contracting or community delivery. [3] [11] [12]
Laboratories and supply chains	Transport, maintenance, quality assurance and forecasting require recurrent resources.	Stock imbalances, delayed results and interrupted monitoring.	Fund validated transport routes, maintenance, quality systems and risk-based buffers. [11] [19]
Data and accountability	Staff loss and reporting disruption reduce program visibility.	Apparent stability can conceal missing services or patients.	Track reporting completeness; test migration; verify access with communities. [12]
Community and key-population access	Trusted providers rely on short-term awards and flexible non-state delivery.	Loss of confidential access and greater travel or disclosure burdens.	Use predictable public contracts with safeguards for confidentiality and community monitoring. [1] [3] [4]
Financing and governance	Appropriations and partnership announcements may not become operating funds.	Nominal ownership without delivery capability.	Publish function-level costs, releases, responsibilities, and corrective triggers. [5]-[7] [20]

ART, antiretroviral therapy; PrEP, pre-exposure prophylaxis. The potential consequences are plausible pathways rather than actual measured national effects. The safeguards are the authors' own interpretation of the evidence presented, not interventions that they assessed.

maternal-infant pathway with a view to restoring testing, prevention, lab transport and community access. Buffer stock requirements should be based on consumption, lead times and supply risk rather than some arbitrary universal target. Multi-month dispensing should remain an option for eligible patients and alternative arrangements should be in place for those who require more intensive review.

Measure recovery against pre-disruption trends and against expected need. Simply comparing a recovering quarter to the worst disrupted quarter will overstate the recovery. The dashboards should show the denominators, the level of reporting completeness and the differences between population groups where administrative data are incomplete; use independent community feedback. Any apparent decline should be investigated for both delivery loss and reporting loss prior to any conclusion being reached as to the cause.

A good dashboard should separate the inputs from the service processes and the outcomes. The inputs would be things like payment delays, stockout days and

staff availability. The process measures would be testing, specimen turnaround, refill completion and referral completion. The outcomes would be retention and viral suppression (with their denominators and reporting completeness). They're on very different timescales, with an unpaid post or a delayed transport run potentially being the first indication of a problem before any change in suppression occurs. Local thresholds and escalation responsibilities need to be agreed prior to transfer.

5.2. Implementing a Costed Transition Compact

The Dec 2025 Nigeria-US agreement provides nearly $2 bn of US support from April 2026 to Dec 2030, with Nigeria making corresponding health sector financing commitments [5]. These are general health sector commitments rather than a verifiable HIV-specific allocation or any evidence of actual disbursement. In conjunction with the National Strategic Plan 2026-2030 and the renewed US HIV financing, this creates a policy window for a costed implementation compact [7].

The Global Fund is a complementary financier in the Nigerian HIV response and should be formally included in the transition compact. As part of its 2024-2026 grant cycle, Nigeria has received funding for HIV prevention, testing, treatment and care (including for key and vulnerable populations) as well as for health system strengthening [22] [23]. The Global Fund's Reach, Expand and Sustain (REACH) project is a clear example of how it can support the national HIV programme's objectives of progress towards the 95-95-95 targets and the prevention of vertical transmission. The Global Fund also provides funding through national institutions and implementing partners, which is another source of financing and delivery.

The compact should therefore map Global Fund, PEPFAR and domestic contributions against service functions, geographical areas, population groups and time periods. This would allow for the identification of complementary investments, overlapping responsibilities and functions that are not supported. PEPFAR provided support for implementation and technical capacity; the Global Fund provided support for programme activities and health system investment, and domestic recurrent financing should be treated as part of a coherent financing architecture rather than as one source of funding to be substituted for another. Where funding streams support the same activity, they should be clearly assigned responsibility for procurement, staffing, reporting and service delivery to avoid duplication and financing gaps.

The compact would map every key HIV function to the responsible institution, the recurrent cost, the workforce arrangement, the financing source and the transfer milestone. It would be built into the existing national and state plans rather than creating a parallel coordination structure. A public finance matrix would separate out appropriation, release, expenditure and delivery and would also identify which of the obligations are external and which are ones that a domestic institution would take on.

Each entry should separate out the full recurrent cost from any temporary donor contribution. Lab costs would be transport, equipment servicing, QA, power and data handling and reagents. Community service costs would be supervision, admin and encounters. A compact which omits those costs would understate the resources required for transfer. The financing evidence from the Nigerian stakeholders supports a focus on the timing and predictability of releases rather than on the budget labels themselves [20].

The compact should also ensure that decisions are taken at the level where they can be implemented. National co-ordination can set the standards and establish a common reporting framework; the states and the service providers will have to agree on what is realistic in terms of workforce, contracting and delivery arrangements. Finance and procurement authorities should be involved prior to any commitments being made. There should be a clear link to the existing plans to avoid the risk of creating a new form of co-ordination with no authority or resources to deal with the inevitable operational bottlenecks that will arise.

5.3. Finance Prevention and Community Access as Core Functions

Public funding should of course be about protecting prevention, testing and trusted community access as much as treatment. Community contracts should have clear selection criteria, clear reporting requirements and predictable payment. We also need to consider coverage, quality, and confidentiality alongside expenditure. The funding arrangements should allow the organisations working with marginalised populations to retain the trust and flexibility that enables them to deliver services.

Domestic financing should come from a well-coordinated mix of federal and state budgetary allocations, appropriate NHIA benefit arrangements, eligible BHCPF mechanisms, state co-contribution and transparent private sector participation. The various options have different mandates, different eligibility criteria and different administrative requirements and should not be treated as equivalent sources of HIV programme financing. Insurance mechanisms may well cover the cost of eligible clinical services but are not likely to be sufficient to fund population-level prevention, community outreach and other public health functions. Of course budgetary allocations are of no use at all unless they are actually released on time and turned into expenditure. Private sector contributions may provide some additional support but should not be viewed as a substitute for predictable public finance. The transition compact should therefore clearly define the functions that are to be covered by each of the financing streams, the institutions that are responsible for the release and management of the funds and the recurrent costs which are unfunded [20].

Public contracting for HIV services targeting key populations must carefully consider Nigeria's legal and social context. Existing national and state-level legislation may create legal, operational and safety challenges for organisations and individuals involved in delivering these services. Such considerations are im-

portant when designing contracting arrangements that ensure confidentiality, protect service users and support equitable access to HIV prevention and treatment [24]. The Act and such legislation should not be read as a total ban on all HIV services or on civil society contracting in general. They may well create a situation of legal uncertainty, lead to organisations being less visible and will in any event complicate the delivery of confidential, community-led services. Contracting arrangements will therefore need to be subject to legal review and will need to contain appropriate safeguards around confidentiality, data protection, non-discrimination in access and the safety of both service providers and clients. Community organisations should be able to deliver clinically appropriate services in a way that is compliant with the law without necessarily exposing clients or staff to undue risk of disclosure or security breaches.

Community involvement needs to go way beyond consultation. Community reps can be involved in the very definition of accessible hours of service, the nature of confidential communication and the nature of acceptable referral arrangements. They can be the ones to report on closures or informal charges that a standard dashboard would miss. Public contracts should have appropriate reporting requirements and ensure that payment is made on time (including for the reasonable cost of operating which is necessary for a service to be reliably delivered). The organisation's performance should be judged on who it reaches and the quality of the access it provides rather than just on the volume of service it delivers.

5.4. Transferring Operational Capability with the Budget

Workforce transition has to start with a properly verified register of posts, functions, workload, competencies and finance. The decision around transition has to be clear as to whether it's absorption, renewable contracting or continued community delivery. A transfer is not complete until supervision and remuneration are in place. Temporary arrangements must have a clear end point and a funded successor so that we don't end up with emergency volunteerism as the operating model.

Lab and procurement transition must of course maintain QA, maintenance and performance. The info systems integration will require secure data migration, interoperability, ownership and a funded support function. Local manufacture may go some way to improving supply security for certain products, but procurement decisions will have to be made on the basis of quality, price, lead time and continuity. The operational requirements must be costed out in full rather than simply being absorbed into a general sustainability pot.

For the lab, the handover should be evidenced by working specimen routes, working equipment service arrangements, trained operators, participation in external quality assurance and reliable result return. A machine that has been handed over with no maintenance or reagents is not an operational service. For procurement, we should have forecast and buffer levels that take into account consumption and lead times, and there should be clear responsibility for emergency redis-

tribution. The integration should maintain accountability for HIV performance and should be assessed in terms of where the shared systems are in fact of benefit [19].

For data systems, the move has to define who owns the records, who has access to the records, who owns the software and who is responsible for fixing any failures. The test migration has to confirm that the patient IDs, the treatment histories and the lab results are all still usable before implementing and switching off the legacy systems. There has to be a funded support function as part of the transfer. Interoperability has to enable continuity of care and reliable reporting rather than be an interoperability objective in itself.

5.5. Making Transition Conditional on Readiness and Reversible When Necessary

Experience elsewhere supports a degree of caution around abrupt institutional change. A qualitative study in two districts in eastern Uganda described a decline in service following the removal of site-level PEPFAR support, followed by the re-establishment of support and further changes in the way services were delivered [15]. That doesn't mean the study provides a causal estimate for Nigeria. It does, however, highlight why a transfer of support should be viewed as a process over time rather than a single administrative event.

Aji and colleagues' Indonesian study looked at sustainability after the donor support had ceased via interviews and discussions with a wide range of district- and community-level stakeholders. The key finding was that sustainability was a function of collaborative capacity, sustained commitment, coordination and local financing [16]. The programme in question was MCH, not HIV, but the point is that the sustainability issue is about the existence of an enduring institutional relationship. For Nigeria, the compact should therefore be negotiated with the state implementers and the community organisations rather than be a national finance compact.

For each function, Nigeria and its partners should agree on readiness milestones relating to released financing, appropriate staffing, operational inputs and sustained equitable coverage. Responsibility can be handed over in stages as the milestones are achieved. The Compact should designate the National Agency for the Control of AIDS (NACA) as the national coordinating institution responsible for reviewing performance alerts and recommending the activation of temporary bridging support (in consultation with the Federal Ministry of Health and Social Welfare, the Federal Ministry of Finance and the relevant State authorities). Activation would be on the basis of clearly defined triggers (e.g. a sustained disruption of essential services, failure to release an agreed amount of financing, critical staffing gaps or a deterioration in access amongst the most vulnerable).

The bridging mechanism would be funded via a pre-authorised contingency allocation within the Federal HIV response budget. The allocation would be targeted to the cost of the bridging mechanism and would be funded through contributions from the participating state governments where state functions are af-

fected. Any use of the allocation would be subject to documented justification, time-limited approval, public reporting and a recovery plan which would identify the responsible institution and the date on which regular funding would be restored. Where appropriate, existing partner commitments could provide complementary short-term support but would not in any way replace the public funding mechanism. This is a proposed safeguard which would require formal agreement, budgetary provision and operational arrangements; it is in no way a current NACA-administered fund.

Readiness should be demonstrated for each function and each location. A state with working payroll and specimen transport may be at a very different stage of the game than one with delayed releases or incomplete contracts. The compact should identify all outstanding dependencies, and each transfer should have a clear decision-maker. Contingency support should have a clear trigger, a time limit, and a recovery plan so corrective action is taken to protect the patient, while still incentivising the institution to complete the reform.

The roadmap has distinct immediate, medium-term, and longer-term phases, with planning horizons of course from compact adoption. The indicators include actual disbursements, staffing, services in operation, equity, and independent review. A national average should not trump continued failure in a particular state or population. Table 3 therefore links the proposed accountability to both the monitoring indicators and the evidence required to justify further transfer.

Table 3. Proposed phased roadmap for a resilient national HIV response.

Indicative horizon	Priority actions	Proposed accountability	Core monitoring measures	Evidence needed for further transfer
First 6 months	Protect treatment and maternal-infant care; restore testing, prevention, outreach and specimen transport; map posts, stocks and contracts.	Federal and state health authorities, NACA, partners and community representatives.	Refill continuity; stockout days; testing and PrEP activity; infant testing; reporting completeness.	Released bridging funds; paid staff; working transport and service routes; an agreed recovery baseline.
6 - 24 months	Implement the costed workforce plan; establish predictable community contracts; transfer laboratory and data responsibilities; strengthen pooled procurement.	Health and finance authorities, NACA, NHIA where relevant, procurement and laboratory agencies, civil society.	Disbursement timeliness; paid or contracted posts; viral-load coverage and turnaround; community access and patient costs.	Functioning payroll or contracts; sustained supplies and quality assurance; tested data transfer; maintained equitable coverage.
2 - 5 years	Progressively transfer ready functions; increase predictable domestic financing; assess supply options; institutionalise independent evaluation and contingency support.	National and state institutions, finance and health ministries, legislatures, donors and community oversight bodies.	Financing reliability; retention and suppression with valid denominators; equity; audits; milestones achieved.	Sustained performance across populations and locations; functioning review and corrective action before further transfer.

Periods run from the date of adoption of the transition compact and are proposed planning horizons rather than agreed government deadlines. NACA (National Agency for the Control of AIDS), NHIA (National Health Insurance Authority). Accountabilities and readiness thresholds should be established via the existing national and state structures. Time elapsed in itself is not sufficient to justify a transfer.

6. Discussion

The major contribution of this review is the identification of functional continuity as the missing link between financing arrangements and sustainable ownership. Nigeria has a huge amount of programme assets in the form of a large treatment platform, experienced institutions, a host of local implementing organisations, laboratory capacity and community networks. The issue is: how do we maintain that performance as we change who is funding and who is in charge? That's the interpretation that makes sense of PEPFAR's contribution without in any way equating reliance on external implementation arrangements with the inevitable demise of national capacity.

The distinction is important because the same delivery arrangement can be the basis for very rapid expansion and can lead to a very difficult handover. External implementation capacity can be used to plug urgent gaps in procurement, staffing or supervision, but those functions still need a successor. The policy response should be to maintain the partnership's ability to deliver in the short term while making the successor explicit. A transfer that changes the funding label without funding the operational obligations of the successor leaves the original vulnerability in place [14].

This is in the wake of, rather than a repetition of, the Mansour *et al.* editorial [8], which looked at the international implications of a shift in US policy. This is a synthesis of how a national response might be implemented in the light of a different financing scenario. It maps each of the proposed transfers to resource release, workforce responsibility, functioning inputs and equitable coverage. The added value is making the implementation obligations explicit, while still distinguishing between a proposal that is evidence-informed and one assessed as a transition intervention.

The evidence is all over the place. The Nigerian qualitative work identifies operational and financial constraints [11]. The programme evidence identifies differentiated delivery as an adaptation [17]. The multi-country data show that prevention and workforce loss can be offset by relative stability in treatment totals [12]. They answer different questions, and we can't aggregate them to give a single national effect size. Taken together, they do support the monitoring of the enabling functions, which the clinical indicators don't.

These findings also go some way to explaining the gap between national treatment performance and the actual local service experience. Treatment figures move very slowly and can remain static whilst testing, outreach and staffing all go

down. Those people already on treatment may be temporarily shielded from the impact, whilst the very people who need diagnosis and prevention are increasingly invisible. The proposed compact is the mechanism which brings the enabling services into the definition of programme continuity and provides the implementation response to the cascade-wide losses which are so clearly apparent in the programme data [12].

The framework has a funding dimension to it: the issue is how much reliable delivery can be achieved given the resources at hand rather than which source is going to claim the larger slice of the pie. Unpredictable domestic funding may be less useful to a service than a smaller but more reliable amount. A transitional partnership, on the other hand, can support the move to national ownership by funding the handover, transferring the management capability and clarifying the future obligations. Greater domestic responsibility and continued international partnership can thus be mutually reinforcing.

Equity is at the heart of this. A transition can maintain the total number of people on ART at the national level while compromising confidentiality, increasing travel, or passing the cost on to the patient. Community delivery should therefore be viewed as a core access function rather than as a one-off donor project. Measures of continuity must identify who is being left behind (adolescents, children, pregnant women and key populations) as well as the performance of the services that remain.

Equity needs to be looked at in terms of the burden of accessing care as much as the number of contacts. Moving community services into a facility could have an impact on travel, waiting times, confidentiality and out-of-pocket costs for both the patient and the carer. The apparent efficiency gains at a programme level need to be examined to see whether the increased cost to the patient and the carer more than makes up for them. Community-led monitoring is a very useful complementary source of evidence; it too will require resourcing and clear pathways for action, and it cannot in any way replace the statutory duties of the public body.

Integration will require a similarly careful selection of options. Shared procurement, shared lab transport or shared reporting may go some way to reducing the fragmentation. Integration is of no use at all if it doesn't deliver timely and appropriate services. There may still be circumstances in which specialist and community delivery arrangements are required where they provide access that general delivery doesn't. The Uganda experience is a good example of what happens in the aftermath of withdrawal and the Indonesian experience is a good example of the importance of having durable stakeholder relationships [16]. Neither of those provides any evidence as to the effectiveness of the proposed Nigerian compact, which will have to be assessed at the local level.

This is a selective and interpretative review. It is not in any way an exhaustive evidence census, a formal quality assessment or a causal estimate of the Nigerian post-shock epidemiological outcomes. Programme reporting will of course change as staffing and finance change, and announced commitments may well not in fact

be disbursed. Multi-country models are based on assumptions that subsequent policy developments may well alter. These limitations are in favour of transparent triangulation and updated local measurement rather than the rejection of the disruption or the presentation of projected regional losses as actual Nigerian outcomes.

Future research should look at state-level access, outcomes and patient costs in relation to pre-shock trends, taking into account reporting completeness and economic pressures. Comparative studies should look at whether workforce and community contracting arrangements can sustain coverage. The costing should incorporate maintenance, data stewardship and peer services. That would make the proposed compact a testable implementation strategy.

A practical evaluation could kick off in a number of states with a baseline of the functions, costs and service performance. We could then use prospective monitoring to track the timing of the functions, the arrangements for workforce, the level of reporting and patient access as the functions move. The qualitative work with patients, staff and community groups would be absolutely central to understanding why the indicators go up or down. Where possible, a comparative design would be used to separate out the impact of the transition arrangements from the impact of the economic and security pressures. That would turn the roadmap into an actually assessable implementation plan rather than just another statement of intent.

7. Conclusions

The 2025 PEPFAR funding shock has highlighted the gap between the availability of ARVs and the operational systems required to deliver a full range of HIV services in Nigeria. The new policy commitments and the renewed international support are an opportunity, but they will only be of use if they result in predictable funding, working workforce arrangements, working lab and information systems and equitable access for the community.

The priority is to safeguard the continuity of treatment and the full maternal and infant care pathway as we rebuild the prevention, testing, lab and community services. This will require a coherent financing approach which explicitly maps the contributions of the domestic government, PEPFAR and the Global Fund to the functions and populations they serve. A framework for costing a function-based transition compact would be useful in terms of assigning the recurrent costs, institutional responsibilities, workforce arrangements and readiness milestones and would also provide a mechanism for corrective action should any of the essential services start to slip.

The framework proposed is an evidence-informed policy recommendation rather than an evaluated intervention. Its feasibility and effectiveness will need to be tested in a prospective evaluation across states and service settings (including the impact of financing releases, service continuity, workforce retention, access equity, patient cost and viral suppression). Sustainable national ownership will ulti-

mately be a function of the ongoing provision of accessible, high-quality HIV services and improved patient outcomes rather than the handover of administration or the announcement of funding.

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Conceptualisation, NFE, and EIO; methodology, NFE, MK and AT; investigation, NFE, EIO, AT, and MA; data curation, NFE, MK; writing—original draft preparation, NFE and EIO; writing—review and editing, MK, AT, MA and BM; visualisation, MA; project administration, NFE and EIO. All authors have read and agreed to the published version of the manuscript.

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Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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