Sovereign Debt News Update No. 165: Health Sovereignty in an Era of Debt Distress: Financing Africa's Right to Health Amid Shifting Aid Landscape

By:

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Across Africa, the financing and governance of health systems have long been intertwined with foreign assistance. For decades, bilateral donors, multilateral institutions, and global health initiatives have played a central role in funding disease control, health workforce salaries, medicines procurement, and research infrastructure. In recent years, however, there's been a global trend in the reduction of aid to Africa since 2018. Donors such as America, Germany, France and Norway, are shifting their funding priorities to focus on domestic agendas. These aid cuts have had a significant impact on African countries that relied heavily on development assistance for health (DAH). According to the African Union's Health Financing Reform Handbook titled "Financing Africa's

Health Security and Sovereignty", Africa bears *approximately 22 % of the global burden of disease, yet accounts for 1 % of global health expenditure.*

The United States' "America First Global Health Strategy" announced in 2025 and now in its early stages of implementation has since accelerated this debate. Through a series of bilateral Memoranda of Understanding (MOUs) with African governments, the strategy seeks to reshape global health cooperation by replacing traditional aid structures with co-investment arrangements between the United States and partner governments. These agreements have sparked intense debate across the continent. Supporters argue they encourage self-reliance and national ownership of health systems. Critics warn they may deepen asymmetries in global health governance, particularly where agreements involve data sharing, financial commitments, and geopolitical conditions. This update examines the emergence of the strategy, the countries that have signed agreements under it, those that have refused to sign, and the broader implications for Africa's pursuit of health sovereignty in an era of constrained fiscal space and debt distress.

The America First Global Health Strategy and the Transformation of U.S. Health Assistance

The America First Global Health Strategy represents a major shift in the United States' approach to international health cooperation. Announced by the U.S. government in September 2025, the strategy aims to transition global health partnerships away from donor-driven aid and toward bilateral agreements grounded in co-investment, accountability, and domestic ownership of health systems. The initiative emerged in the context of broader restructuring within the U.S. foreign assistance architecture, including the dismantling of the United States Agency for International Development earlier in 2025. Under the new model, health programs previously implemented through international NGOs or development agencies are increasingly routed through national governments.

The U.S. Department of State has described this shift as a decisive move away from what it calls "*dependency-creating aid structures*" toward partnerships that encourage governments to assume greater responsibility for their health systems. According to U.S. Secretary of State Marco Rubio, the strategy aims to ensure that global health funding "strengthens partner governments and

eliminates inefficiency and waste from our foreign assistance architecture." Programs funded under the strategy primarily focus on infectious disease control, including HIV/AIDS, malaria, tuberculosis, and maternal and child health initiatives. The agreements generally span five years and require participating countries to commit significant domestic co-financing, signaling a structural transition toward shared responsibility for health outcomes.

Kenya's Landmark Agreement and the First Implementation of the Strategy

Kenya became the first African country to sign an agreement under the America First Global Health Strategy on 4 December 2025, marking the beginning of the new bilateral framework between the United States and African governments. The five-year agreement, covering the period from 2026 to 2030, is valued at approximately US$2.5 billion. Under its terms, the United States committed up to $1.6 billion in support for Kenya's health programs, while the Kenyan government pledged to increase domestic spending by approximately $850 million over the same period. The agreement targets priority diseases including HIV/AIDS, malaria, tuberculosis, and polio while strengthening Kenya's health workforce and disease surveillance systems. Officials in both governments described the agreement as a new model for health partnership. Speaking at the signing ceremony, Secretary Rubio was confident that the arrangement would ensure that funding flows directly through Kenya's government rather than through external intermediaries. Kenyan President William Ruto welcomed the partnership, emphasizing that U.S. support had historically played a critical role in saving millions of lives through HIV/AIDS treatment and prevention programs. The Kenya agreement also signaled the broader ambitions of the strategy, with U.S. officials indicating that similar deals would be pursued with dozens of countries around the world.

Legal Challenge and Data Sovereignty Concerns in Kenya

Despite being celebrated as a landmark partnership, the Kenya agreement quickly became the subject of legal and political controversy. On 11 December 2025, the Kenyan High Court temporarily suspended implementation of the deal after receiving a petition from the Consumers Federation of Kenya and other civil society actors. The petition argued that the agreement raised serious

concerns regarding data privacy and constitutional oversight. Specifically, petitioners, led by the Consumers Federation of Kenya, feared that the arrangement could allow the transfer of sensitive health data, including pathogen samples and patient information, to foreign entities without adequate safeguards inconsistently with the 2010 Kenyan Constitution. Civil society groups argued that Kenya's constitution requires transparency and parliamentary oversight for international agreements that involve national resources and public data. The legal challenge also reflected broader anxieties across the continent about health data sovereignty. In an era defined by global pandemics and rapidly evolving biomedical research, health data and pathogen samples are increasingly recognized as valuable strategic resources. Justice Bahati Mwamuye therefore ordered a temporary halt to the sharing of health data while the court reviews the legality of the agreement.

Civil Society Mobilization Across Africa

The Kenyan court challenge unfolded alongside a wider mobilization by African and international civil society organizations concerned about the implications of the new agreements. In December 2025, nearly fifty organizations from Africa and around the world issued an open letter addressed to African heads of state and government urging caution in negotiating health agreements with the United States. The letter was coordinated by several advocacy networks including the Universities Allied for Essential Medicines and Public Citizen. It warned that the new agreements could reshape global health governance in ways that disadvantage African countries if safeguards were not introduced. The organizations raised several key concerns. First, they argued that provisions requiring the sharing of health data and pathogen samples could enable foreign institutions to develop vaccines, diagnostics, or treatments without guaranteeing fair access or technology transfer to the countries providing the data. Second, the letter highlighted concerns about financial conditionalities that require countries to significantly increase domestic spending at a time when many African governments are already facing debt distress and fiscal constraints. Third, the groups warned that replacing multilateral mechanisms with bilateral agreements could fragment global health coordination and weaken institutions such as the World Health Organization that play a central role in disease surveillance and pandemic preparedness. The organizations urged African leaders to negotiate collectively

and insist on transparency, equitable access to medical technologies, and strong protections for health data.

Why Civil Society Concerns Matter

For many observers, the concerns raised by civil society groups reflect deeper structural issues in global health governance. At their core, the debates surrounding the America First Global Health Strategy revolve around who controls health resources, knowledge, and decision-making authority. Health data, pathogen samples, and epidemiological surveillance systems are essential for developing vaccines, diagnostics, and treatment protocols. When countries share such data with external partners, they often expect reciprocal benefits such as access to medical technologies, capacity building, and technology transfer. Critics of the new agreements argue that without explicit benefit-sharing provisions, African countries may contribute valuable data while receiving limited long-term advantages. Another key concern relates to financial sustainability. Many African governments already rely heavily on external funding to support essential health programs. If bilateral agreements require large increases in domestic spending without addressing underlying fiscal constraints, countries may struggle to meet these obligations. In simple terms, civil society groups fear that African governments may be entering agreements that require them to spend more money while simultaneously giving up control over strategic health resources. For ordinary citizens, these concerns translate into questions about whether such agreements will ultimately strengthen national health systems or create new forms of dependency.

African Countries That Have Signed Agreements Under the Strategy

Despite these concerns, several African governments have moved ahead with signing bilateral health cooperation agreements with the United States under the America First Global Health Strategy. Kenya’s agreement in December 2025 was quickly followed by similar deals across multiple regions of the continent. Rwanda signed its agreement on 5 December 2025 with U.S. funding valued at approximately US$157.8 million and a domestic contribution of about US$70.6 million over five years. Uganda signed on 18 December 2025 under a deal valued at approximately US$2.3 billion, including US$1.7 billion in U.S. support

and about US$500 million in domestic co-investment. Nigeria signed an agreement on 20 December 2025 valued at approximately US$2.1 billion, accompanied by a domestic co-investment commitment of around US$3 billion over five years. Nigeria's agreement is quite interesting as it is being described "faith-based healthcare" (with a strong emphasis on Christian-based healthcare providers) and is actually the largest under the US Strategy thus far. Liberia concluded a smaller agreement valued at approximately US$176 million, including US$125 million from the United States and US$51 million from Liberia. Lesotho signed a US$364 million deal combining $US232 million in U.S. funding and US$132 million in domestic financing. Sierra Leone joined the initiative on 22 December 2025 with a package valued at approximately US$173 million. A timeline giving key events and the countries that have signed thus far can be found here. At the time of the publishing of this update, twenty-four countries have since signed agreements, worth a total of $20 billion in health aid over five years.

African Countries That Have Not Signed the Agreements

While a significant number of African governments moved quickly to sign bilateral agreements under the America First Global Health Strategy, several countries have either declined to participate or delayed negotiations pending further review. Governments that have not signed agreements include Zimbabwe, South Africa, Tanzania, Zambia, and the Democratic Republic of Congo, among others. Officials in these countries have cited a range of concerns, including questions about data sovereignty, fiscal commitments, and the broader implications of replacing multilateral global health cooperation with bilateral arrangements. In several cases, governments have emphasized that while they remain open to health partnerships with the United States, they prefer frameworks that align more closely with existing regional or multilateral systems.

According to Think Global Health (policy trackers monitoring the agreements), some governments expressed unease about the long-term financial commitments required under the "co-investment model", particularly given the fiscal pressures many African countries currently face. While these deals have been described as operating under a "co-investment model", they largely reflect an 'extractivist' element, as argued by Professor Sophie Harman. The

Zambia-US bilateral health deal was supposed be signed in December, but it faltered after America linked the billion-dollar deal to access to Zambian minerals, particularly copper and cobalt. The US was linking the five-year deal (which was intended to combat HIV/AIDS and malaria) to a "bilateral compact" involving copper and cobalt access. Effectively, according to Health GAP's Asia Russell, this deal would slash US funding to life-saving programs while prioritizing mining corporations over Zambians with HIV. Zambia confirmed requesting "revisions" to the memorandum, with President Hakainde Hichilema viewing aid cuts as opportunity to "*take care of our own affairs.*" Meanwhile, America remains resolute on withholding health aid, as a draft of a memo prepared for Secretary of State Marco Rubio by the department's Africa Bureau staff says "*We will only secure our priorities by demonstrating willingness to publicly take support away from Zambia on a massive scale*".

Zimbabwe also declined to sign. In a public clarification, Zimbabwe's Secretary for Information, Publicity and Broadcasting Services, Nick Mangwana, said the government's decision followed an inter-ministerial review and reflected concerns that the draft agreement did not reflect an equitable partnership. Zimbabwe was being asked to share its biological resources and data over an extended period, with no corresponding guarantee of access to any medical innovations such as vaccines, diagnostics, or treatments that might result from that shared data. According to one source, the Zimbabwe College of Public Health Physicians however urged re-engagement, warning HIV treatment for 1.2 million people could be at risk.

Thus, while some governments view the agreements as an opportunity to secure predictable funding, others have adopted a more cautious approach, arguing that such arrangements require careful scrutiny to ensure that they do not compromise national interests. Dr Jean Kaseya, Director General at Africa Centers for Disease Control and Prevention (Africa CDC) has since expressed support for countries renegotiating, stating "*We want to own our data in Africa. We want to own our future. We cannot accept not owning our data.*"

The Right to Health and its Financing in Africa

The debates surrounding the America First Global Health Strategy unfold against the broader backdrop of Africa's ongoing struggle to adequately finance

health systems. The right to health is recognized as a fundamental human right under international law and regional human rights instruments, including the African Charter on Human and Peoples' Rights. In a draft study on the Right to Health and Its Financing in Africa, the African Commission on Human and Peoples' Rights has emphasized that governments have an obligation to ensure accessible, acceptable, and quality health services for their populations. Yet despite these commitments, many African countries continue to allocate relatively small portions of their national budgets to health care. In 2001, African Union member states adopted the Abuja Declaration, committing to allocate at least 15% of their annual national budgets to the health sector. More than two decades later, however, most countries on the continent still fall far short of this benchmark. Studies of health financing patterns show that many governments allocate between 5% and 10% of their national budgets to health, leaving significant gaps that are often filled by external donors. It is equally important to situate the reality of many Africa countries in the menace that is debt servicing, which is often carried out at the expense of key sectors as healthcare, education and social services. According to analysis by Debt Justice, debt repayments for countries in the global south hit 19.2% of government revenue in 2025. These structural problems explain why foreign assistance continues to play a crucial role in sustaining health programs across the continent.

The Growing Debate on Health Sovereignty

The rollout of the America First Global Health Strategy has generated significant debate among public health experts, advocacy organizations, and academic researchers. Several analysts have argued that the bilateral agreements risk creating a fragmented global health landscape where different countries operate under distinct partnership frameworks rather than unified international systems. Critics also warn that replacing multilateral funding channels with bilateral agreements could weaken global institutions that play critical roles in pandemic preparedness and disease surveillance. Writing on the emerging agreements, global health researchers have emphasized that while increased domestic investment in health systems is essential, the transition must be carefully managed to avoid destabilizing programs that currently rely on external funding. Advocacy organizations have also raised concerns about equity and access to medicines. They argue that without strong safeguards, the

sharing of health data and pathogen samples could lead to the development of new pharmaceutical products that remain inaccessible to the countries that provided the underlying research materials. These debates underscore the complex trade-offs involved in reshaping global health cooperation. While the push for national ownership aligns with longstanding calls for greater African leadership in health policy, it also raises important questions about fairness, transparency, and long-term sustainability.

Further, the controversy surrounding the America First Global Health Strategy has evolved into a broader debate about health sovereignty in Africa. For many policymakers and scholars, the concept of health sovereignty refers to the ability of countries to design and finance health systems that reflect national priorities rather than external donor agendas. Achieving this vision requires both financial independence and strong institutional capacity. Yet the reality for many African states is that external funding remains essential for sustaining key health programs. The bilateral agreements introduced under the new strategy illustrate the tensions inherent in this situation. On the one hand, they encourage governments to assume greater responsibility for health financing and program management. On the other hand, they raise concerns about unequal negotiating power and the potential for external actors to influence national health policies and reach for a country’s natural resources (as in the case of Zambia). Civil society organizations argue that African governments must approach such agreements with caution, ensuring that they include clear provisions for transparency, technology transfer, and equitable access to medicines. Without such safeguards, critics warn that new partnership models could reproduce many of the inequalities that have historically shaped global health governance.

Conclusion

The emergence of the America First Global Health Strategy marks a significant turning point in the relationship between African countries and one of their most important global health partners. By replacing traditional aid structures with bilateral co investment agreements, the United States has signaled a new approach to international health cooperation. For some African governments, these agreements offer an opportunity to secure predictable funding while strengthening national ownership of health programs. For others, the initiative

raises important concerns about financial sustainability, data sovereignty, and the broader implications of reshaping global health governance through bilateral arrangements.

Ultimately, the debate surrounding the agreements highlights a deeper structural challenge. African countries remain committed to realizing the right to health for their populations, yet many continue to operate with limited fiscal space and underfunded health systems. Bridging this gap will require sustained domestic investment, innovative financing strategies, and equitable international partnerships that respect national sovereignty while supporting global health solidarity. The unfolding discussions around the America First Global Health Strategy therefore represent more than a dispute over a particular policy initiative. They reflect the broader struggle to redefine Africa's place within the global health architecture and to build resilient health systems capable of meeting the needs of the continent's people.

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