When Aid Becomes Empire: The Silent Recolonisation of Global Health

What the America First Global Health strategy means for the Global South.

FÒS FEMINISTA

WHAT IS THE AMERICA FIRST GLOBAL HEALTH STRATEGY

Officially launched in September 2025, the America First Global Health Strategy (AFGHS) lays out a plan "that uses global health diplomacy and foreign assistance to make America safer, stronger, and more prosperous" while also looking to "end the inefficiencies, waste, and dependency of our current system".[1] The strategy lays out three core approaches to global health that are meant to guide American thinking and action around global health intervention and global health advocacy going forward. These are: (1) addressing and preventing future outbreaks and epidemics; (2) developing bilateral agreements as a mechanism for overseas health assistance; and (3) promoting and exporting American health innovation globally to advance global health outcomes. Taken together, the strategy looks to "save millions of lives around the world and assist other countries in developing resilient and durable health systems."

The United States has historically been the world's largest donor to global health.[2] While U.S. assistance policies have often done enormous good, a fact acknowledged in the AFGHS, they have also been used to exert political pressure through tools such as the Global Gag Rule, with women, girls, and gender-diverse people across the Global South bearing the brunt of these abuses. Nonetheless, global health assistance, and the broad commitment to advancing global health outcomes, have traditionally received largely bipartisan endorsement, supported across administrations regardless of political ideology. The AFGHS marks a sharp departure from this bipartisan legacy, signaling a rupture with the longstanding foreign assistance consensus that placed global health above partisan agendas. Paradoxically, even as the AFGHS claims to reaffirm U.S. leadership, the administration's fiscal year 2026 budget anticipates a 62% cut to foreign assistance for health—deepening the rupture it has created with the bipartisan norms of foreign aid.[3]

With the launch of the AFGHS, global health has been reframed as an explicit political strategy to pursue American national advantage, rather than a public-health first technical issue. The AFGHS preserves U.S. priorities that do not conflict with the populist and anti-rights perspectives championed in other guiding documents such as the Project 2025[4] and the Protego[5], and deliberately excludes those that do. For example, the strategy continues to emphasize infectious diseases such as HIV, tuberculosis, malaria, polio, outbreak surveillance, competition with China, the interests of U.S. corporations, and the expansion of bilateral aid. At the same time, it pointedly omits areas such as climate-related health risks, childhood vaccines, women's health, including maternal and reproductive health, support for U.S.-based NGOs, and engagement with regional or multilateral institutions. This selective approach underscores the administration's intent to reshape global health priorities around ideology and domestic political alignment rather than evidence-based need or global equity.

1 United States Department of State. (2025). America First Global Health Strategy. https://www.state.gov/wp-content/uploads/2025/09/America-First-Global-Health-Strategy-Report.pdf

2 KFF. (2025). U.S. is the Largest Donor of International Health Assistance. U.S. global health budget figures. https://www.kff.org/global-health-policy/u-s-global-health-budget-figures/#Figure2

3 Bollyky, T. J. (2025). The new America Fir**st Global Health Strategy goes back to the future. The Lancet.** https://doi.org/10.1016/s0140-6736(25)02264-0

4 In 2023 the Heritage Foundation – a conservative think-tank in the United States – produced Mandate for Leadership: The Conservative Promise (also known as Project 2025), a document that is meant to serve as a policy blueprint for the next Republican administration, "emphasizing white, Christian ethno-nationalist ideals." Drafted by several former Trump Administration officials, including Valerie Huber, the document is anti-democratic and centres on anti-LGBTQI+, anti-immigrant, anti-DEI (diversity, equity, and inclusion), and anti-SRHR rhetoric. In addition, the document proposes a strategy for utilizing U.S. foreign assistance and foreign policy to restore the centrality of family to American life and "returning America to glory and leadership on the global stage." For more information about Project 2025 and it's harms, see: https://fosfeminista.org/wp-content/uploads/2025/02/Beyond-the-Global-Gag-Rule_V2-1.pdf

5 The Protego is a program designed to promote "high-impact, low-cost, evidence-based" health interventions primarily to operationalize the Geneve Consensus Declaration by providing a structured framework for action that is, in fact, based neither on evidence nor on rights. For more information about Protego and its harms see: fosfeminista.org/wp-content/uploads/2025/02/Beyond-the-Global-Gag-Rule_V2-1.pdf

WHAT WE KNOW

THE DISAPPEARING ACT – MATERNAL AND CHILD HEALTH AND FAMILY PLANNING

First, the strategy omits any reference to sexual and reproductive health and rights, maternal health, or family planning, despite these being central pillars of U.S. global health assistance for decades. While the AFGHS claims that the U.S. has provided over $204 billion in foreign assistance for global health since 2000, other sources show that between 2000 and 2023, the U.S. was responsible for as much as $278.1 billion in funding as foreign assistance for global health, with 11.5% of that going towards maternal health outcomes.[6] In 2024 alone, the U.S. provided $1,916 million dollars to maternal and child health, family planning, and reproductive health programs, which marked approximately 15% of their global health spending.[7] By excluding these areas entirely, the strategy effectively erases the country's own history of leadership and sidelines the needs of women, girls, and gender-diverse people globally.

In fact, in keeping with the anti-gender[8] and anti-DEI[9] mandates of the current U.S. administration, the word "gender" appears zero times across the text. It also avoids mentioning women, girls, or any other systematically excluded communities in the discussion of priorities that are included in the strategy, despite the evidence showing the differentiated impacts of outbreaks like Ebola on women[10], or the feminisation of HIV/AIDS[11]. This omission has already begun to shape U.S. positions in political spaces; for example, the U.S. blocked a UNGA resolution on non-communicable diseases in September 2025 solely because it included "gender" language.[12] Similarly, the U.S. opposed the adoption of a number of Third Committee resolutions in November 2025 on the basis of "irrelevance" to the mandate of "maintaining international peace and security" and the continued "use of problematic language."[13]

BIG BROTHER BILATERALISM – THE OPPOSITION TO MULTILATERALISM

The strategy explicitly prioritizes bilateral assistance, arguing that foreign aid is "not just aid – it is a strategic mechanism to further our bilateral interests around the world." It proposes the development of time-bound, 2-5-year bilateral agreements with countries across the Global South, with the stated aim of transitioning most of them to "full self-reliance" within the term

6 Dieleman, J. L., Apeagyei, A. E., Hay, S. I., Mokdad, A. H., & Murray, C. J. L. (2024). The USA's role in global development assistance for health, 2000–30. The Lancet, 404(10469), 2258–2260. https://doi.org/10.1016/s0140-6736(24)02266-9

7 KFF. (2025). U.S. Global Health Funding (in millions), By Program Area. U.S. global health budget figures. https://www.kff.org/global-health-policy/u-s-global-health-budget-figures/#Figure4

8 The White House. (2025). Defending women from gender ideology extremism and restoring biological truth to the federal government. https://www.whitehouse.gov/presidential-actions/2025/01/defending-women-from-gender-ideology-extremism-and-restoring-biological-truth-to-the-federal-government/

9 The White House. (2025c, January 21). Ending radical and wasteful government DEI programs and preferencing. https://www.whitehouse.gov/presidential-actions/2025/01/ending-radical-and-wasteful-government-dei-programs-and-preferencing/

10 Davies, S. E., & Bennett gendered, B. (2016). A human rights analysis of Ebola and Zika: locating gender in global health emergencies. International Affairs, 92(5), 1041–1060. https://doi.org/10.1111/1468-2346.12704

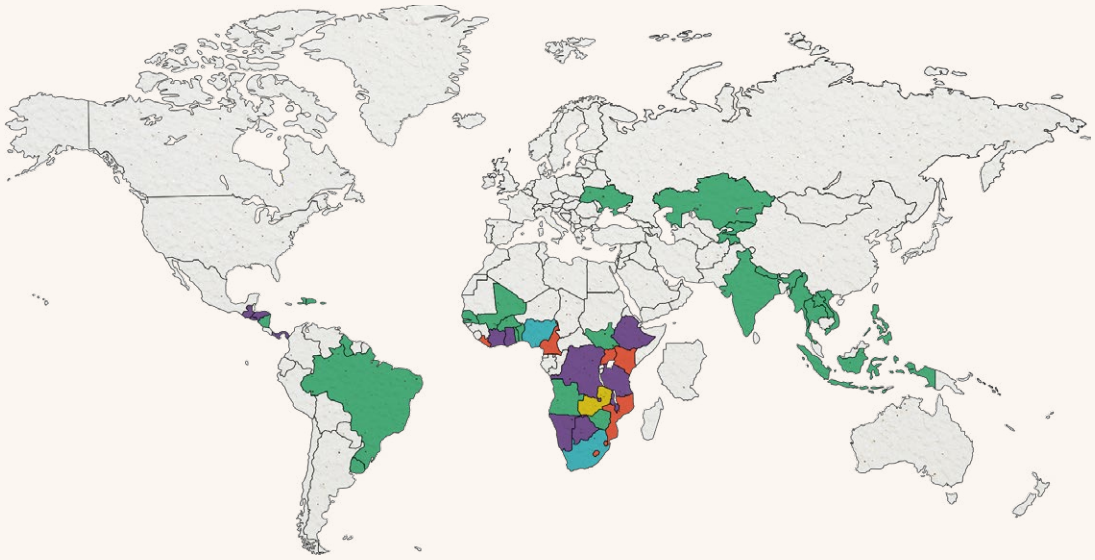
11 Girum, T., Wasie, A., Lentiro, K., Muktar, E., Shumbej, T., Difer, M., Shegaze, M., & Worku, A. (2018). Gender disparity in epidemiological trend of HIV/AIDS infection and treatment in Ethiopia. Archives of Public Health, 76(1), 51. doi.org/10.1186/s13690-018-0299-8

12 Choat, I. (2025, September 27). US refuses to back UN declaration on noncommunicable diseases. The Guardian. https://www.theguardian.com/society/2025/sep/26/us-refuses-to-support-un-health-declaration-on-noncommunicable-diseases

13 U.S. Mission to the United Nations. (2025, October). Remarks for the General Debates of the Third Committee of the United Nations General Assembly [Press release]. Retrieved December 13, 2025, from https://usun.usmission.gov/remarks-for-the-general-debate-of-the-third-committee-of-the-united-nations-general-assembly/

of the agreement. While it still remains unclear which countries will be offered bilateral deals, they are likely to be those countries that have already signed bridge agreements through March 2026, save a few. Early intel from civil society watchdog groups suggests that while the bulk of the negotiations will be happening in Africa in December 2025, there are a few countries in Latin America and the Caribbean that have also started negotiating bilaterally. Please replace this text with: It is worth noting that of all the Memoranda of Understanding signed under the AFGHS, the government of Kenya remains the only one to have publicly released both its MoU and accompanying data-sharing agreement. While copies of draft or leaked versions of the Ugandan, Rwandan, and Liberian MoUs are in circulation, none have been officially published. This absence of transparency raises critical questions about what provisions are being shielded from public scrutiny, and whose interests are being prioritized in agreements that reshape national health systems and data governance frameworks.

The turn toward bilateralism itself is deeply concerning, particularly when read alongside the Protego strategy and the Trump Administration's championing of the Geneva Consensus Declaration, as it suggests that aid will be conditional on the acceptance of non-evidence-based approaches to women's health and reproductive rights, including the prohibition of abortion.[14] These approaches risk profound rollbacks in longstanding global health norms, including hard-won gains in maternal health, sexual and reproductive health and rights (SRHR), and gender equality. Further, with the GGR expanded to now cover bilateral funding as well[15,16], the implications for these MoUs remain uncertain, particularly since co-financing requirements are embedded in bilateral agreements. These mandates risk constraining how recipient governments can deploy their own public resources once these are committed to bilateral agreements, further narrowing national policy space for agenda-setting in health.



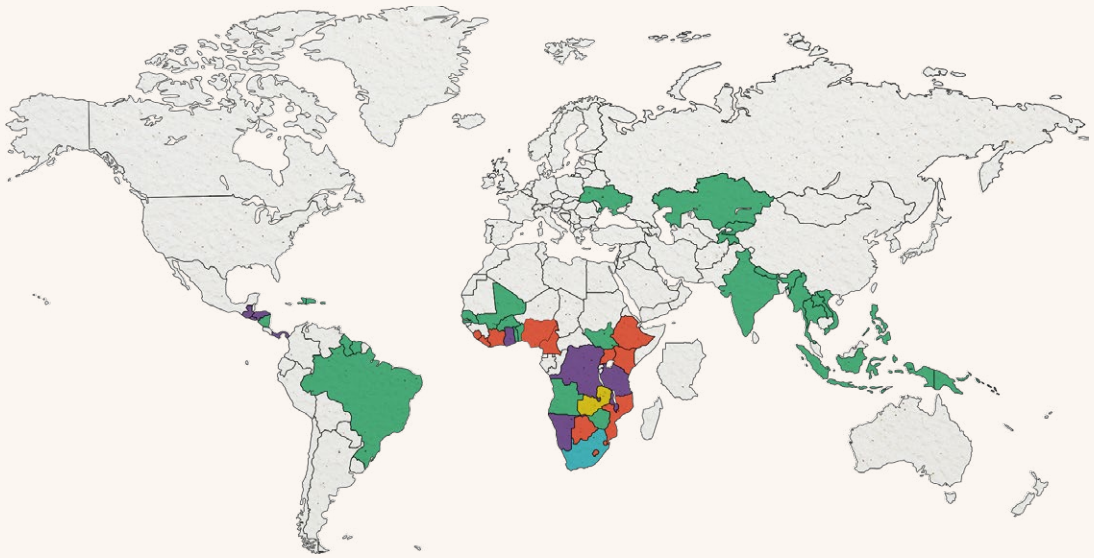
STATUS OF NEGOTIATIONS
December 2025

- Countries where bilateral negotiations have stalled.
- Countries supported by PEPFAR until January 2025.
- Countries that have already signed bilateral agreements on Global Health Cooperation.
- Countries where bilateral agreements on Global Health Cooperation are being negotiated.
- Countries supported by PEPFAR that have been "disqualified" from further funding.

14 Fos Feminista. (2025). Beyond the Global Gag Rule: A Feminist, Global South-led Analysis of Anti-Rights and Anti-Gender Action from America. https://fosfeminista.org/news-and-stories/beyond-the-global-gag-rule/

15 IPAS. (2024). Project 2025: An Anti-Gender Promise to Upend Foreign Assistance and Multilateralism. Retrieved January 14, 2026, from https://www.ipas.org/wp-content/uploads/2024/07/Project2025OPRAGE24b.pdf

16 Fos Feminista. (2025a). Beyond the Global Gag Rule: A Feminist, Global South–led Analysis of Anti-rights and Anti-gender Action from America. In Fos Feminista. Retrieved January 14, 2026, from https://fosfeminista.org/wp-content/uploads/2025/02/Beyond-the-Global-Gag-Rule_V2-1.pdf



STATUS OF NEGOTIATIONS
January 2026

- Countries that have already signed bilateral agreements on Global Health Cooperation.
- Countries that have already signed bilateral negotiations have stalled.
- Countries where bilateral agreements on Global Health Cooperation are being negotiated.
- Countries supported by PEPFAR until January 2025.
- Countries supported by PEPFAR that have been "disqualified" from further funding.

Compounding these risks is the fact that the ideological conditions attached to bilateral assistance are not necessarily rooted in stable, codified policy positions on health, but are instead highly vulnerable to the personal views and political calculations of the sitting U.S. president. Under this model, access to essential health financing can be jeopardized by ad hoc grievances or unsubstantiated claims that bear little relation to health need or human rights standards. For instance, despite both Nigeria and South Africa having received short-term bridge funding for PEPFAR-supported programs until March 2026 to manage the immediate fallout from large-scale funding cuts, the U.S. State Department confirmed in early December that they will not be eligible for further funding under the bilateral health compacts, over widely discredited allegations that the South African government is violently persecuting its white Afrikaner minority and that the Nigerian government is abetting discrimination and violence against Christian communities.[17,18] In early December, the State Department also wrote that the "ongoing repression of religious freedom and free speech, the presence of persistent obstacles to U.S. investment," meant that they would be revaluating their longstanding partnership with Tanzania[19]. However, despite these public statements, Nigeria and the US signed a bilateral agreement on the 20th of December, that was "negotiated in connection with reforms the Nigerian government has made to prioritize protecting Christian populations from violence"[20] and intel from watchdogs suggests that Tanzania and the US are negotiating an MoU, highlighting the unpredictability of the policy positions that underpin these MoUs.

17 Lee, M., & Imray, G. (2025, December). Rubio and Kenyan President Ruto speak after signing 'America First' global health deal. PBS News. www.pbs.org/newshour/world/watch-rubio-and-kenyan-president-ruto-speak-after-signing-america-first-global-health-deal

18 Cullinan, K. (2025, November 24). South Africa may be excluded from future US grants for HIV amid political row – Health Policy Watch. Health Policy Watch. healthpolicy-watch.news/south-africa-may-be-excluded-from-future-us-grants-for-hiv-amid-political-row/

19 U.S. Department of State. (2025, December). Review of U.S.-Bilateral Relationship with Tanzania [Press Release]. Retrieved January 13, 2026, from www.state.gov/releases/office-of-the-spokesperson/2025/12/review-of-u-s-bilateral-relationship-with-tanzania/

20 U.S. Department of State. (2025, December). Expanding Faith-Based Healthcare in Nigeria Through the America First Global Health Strategy [Press release]. Retrieved January 13, 2026, from www.state.gov/releases/office-of-the-spokesperson/2025/12/expanding-faith-based-healthcare-in-nigeria-through-the-america-first-global-health-strategy/

The strategic choice of bilateralism is not accidental; it grants the U.S. sole authority over how funds are used and to what ends, authority it cannot exercise within multilateral institutions. This logic is made explicit in the strategy's criticism of the WHO and other multilateral bodies, which it frames as constraining U.S. influence during global health emergencies and acting against American national interests. This mirrors arguments in Project 2025[21] and signals an effort to weaken shared governance structures, undermine collective preparedness, and replace consensus-driven, evidence-based cooperation with unilateral U.S. control. One clear example of the sidelining of multilateral health action is the manner in which the bilateral agreements actively undermine the WHO Pandemic Treaty[22] negotiated in 2025, with clauses imposed by the U.S. being in clear contravention of the Pathogen Access and Benefit Sharing (PABS) system being negotiated.[23,24]

LIFE-SAVING AID AS LEVERAGE FOR THE MILITARY-INDUSTRIAL COMPLEX

Beyond weakening multilateral institutions and eroding global consensus on health, the move toward interest-driven bilateralism is being used as a vehicle for advancing U.S. military and commercial interests through increasingly coercive tactics, reshaping who receives aid and on what basis. The strategy makes clear that U.S. foreign assistance should flow only to "strategically aligned" partners – a framing lifted directly from Project 2025 and one that effectively redefines need as secondary to ideological and geopolitical alignment.

This logic is reinforced in the AFGHS's rationale for prioritizing Africa, which it describes as "a continent of strategic importance to U.S. national interests," citing amongst other advantages, its deposits of "key minerals and rare earth elements needed as inputs into advanced technologies that fuel critical military and commercial applications." Never has this been clearer than in the abrupt halt in negotiations between the U.S. and Zambia. The Memorandum of Understanding between the two countries was scheduled for signing on December 11, 2025 but stalled after the U.S. indicated that health assistance would not be released until Zambia agreed to terms for "collaboration in the mining sector" and other business-sector reforms.[25] Similarly, negotiations with the Democratic Republic of Congo (DRC) have yet to produce a concrete health MoU, despite ongoing talks on mineral trade.

This asymmetry suggests that the U.S. may be withholding health assistance as leverage to secure more favourable access to the DRC's mineral resources, particularly in an effort to counter China's current dominance in the country's mineral markets[26].

21 Fos Feminista. (2025). Beyond the Global Gag Rule: A Feminist, Global South-led Analysis of Anti-Rights and Anti-Gender Action from America. https://fosfeminista.org/news-and-stories/beyond-the-global-gag-rule/

22 World Health Organization. (2025). WHO Pandemic Agreement. Seventy-eighth World Health Assembly. apps.who.int/gb/ebwha/pdf_files/WHA78/A78_R1-en.pdf

23 Cullinan, K. (2025, December). Africa is stuck between global Pathogen-Sharing talks and conflicting US bilateral agreements. Health Policy Watch. healthpolicy-watch.news/africa-stuck-between-global-pathogen-sharing-talks-and-conflicting-us-bilateral-agreements/

24 Patnaik, P. (2025, November). Transactional U.S. bilateral contracts seeking biological data complicates multilateral negotiations on pathogen access & benefit sharing; unlocking PABS puzzle could hinge on conditional access. Geneva Health Files. genevahealthfiles.substack.com/p/transactional-us-bilateral-contracts-seeking-biological-data-complicates-multilateral-negotiations-pathogen-access-benefit-sharing-unlocking-pabs-puzzle-hinges-on-conditional-access

25 U.S. Mission to Zambia. (2025, December). President Hichilema and visiting senior U.S. official agree to a new way forward for the U.S.-Zambia bilateral relationship - U.S. Embassy in Zambia [Press release]. U.S. Embassy in Zambia. Retrieved December 13, 2025, from zm.usembassy.gov/hichilema-orr-agree-to-a-new-way-forward-for-the-u-s-zambia-bilateral-relationship/

26 Cullinan, K. (2026). US signs bilateral health agreements with 14 African countries – with some key exceptions -. Health Policy Watch. Retrieved January 14, 2026, from healthpolicy-watch.news/december-deals-us-signs-bilateral-health-agreements-with-14-african-countries/

While arguably soft power has always been deployed in national interest, as Savior Mwambwa, Program Manager at Open Society Foundations observes, “The curtain has risen on a new era in which access to African resources is not merely a consideration in American foreign policy but the organizing principle that supersedes all others, including saving lives.”[27]

PROFITS FIRST; NOT PEOPLE – THE WORLD AS AMERICA’S MARKETPLACE

Furthering this fundamental realignment of global health away from a rights-based agenda and toward a commercial one, the AFGHS envisions U.S. health assistance as a vehicle to expand markets for American technologies, ensuring U.S. products “become a cornerstone of health systems around the world.” There are many examples that illustrate how health interventions are being repurposed to generate future commercial advantage, such as the rollout of lenacapavir, which was framed as a “market-shaping investment”[28] to secure early dominance for Gilead. The push for lenacapavir deployment is also embedded in the bilateral agreements signed with Mozambique[29] and Eswatini[30], effectively locking public health cooperation into a strategy that serves Gilead’s early market capture.

We’re also seeing from the Kenyan[31] agreements how this is playing out in the context of vaccines and epidemic management: under these agreements, pathogen data sharing is being mandated with the explicit understanding that this data will then be passed on to “non-U.S. Government U.S. entities (“U.S. Recipients”), each of whom must have the capability to assist in developing diagnostics and/or medical countermeasures” with the intention of then making these medical countermeasures available for sale back to the country at a price. Put plainly, the agreement extracts data for free from partner countries, then monetizes it, forcing them to buy back solutions built from their own information.

A similar logic is evident in the agreements with Rwanda, where U.S. support for disease surveillance and health system “innovation” is explicitly tied to the deployment and entrenchment of U.S.-developed technologies[32], rather than strengthening public health capacity on sovereign terms.

27 Mwambwa, S. (2025., December). America Just Said the Quiet Part Out Loud in Zambia. Facebook. Retrieved December 19, 2025, from https://www.facebook.com/share/p/1KkqKqTwmJ/?mibextid=wwXIfr

28 U.S. Department of State. (2025, September). Department of State, Gilead Sciences, and The Global Fund Announcement of Lifesaving and Innovative PEPFAR Initiative. Retrieved December 18, 2025, from www.state.gov/releases/office-of-the-spokesperson/2025/09/department-of-state-gilead-sciences-and-the-global-fund-announcement-of-lifesaving-and-innovative-pepfar-initiative/

29 U.S. Department of State. (2025b, December). Empowering resilience in Mozambique under the America First Global Health Strategy [Press release]. Retrieved December 19, 2025, from https://www.state.gov/releases/office-of-the-spokesperson/2025/12/empowering-resilience-in-mozambique-under-the-america-first-global-health-strategy/

30 U.S. Department of State. (2025, December). Supporting breakthrough health advancements in Eswatini under the America First Global Health Strategy [Press release]. Retrieved December 19, 2025, from www.state.gov/releases/office-of-the-spokesperson/2025/12/supporting-breakthrough-health-advancements-in-eswatini-under-the-america-first-global-health-strategy/

31 U.S. Department of State. (2025, December). Cooperation Framework between The Government of the Republic of Kenya and The Government of the United States of America on Health. Retrieved: December 13, 2025, from online.flippingbook.com/view/860002012/

32 U.S. Embassy in Rwanda. (2025, December). Continuing to Deliver on the America First Global Health Strategy with the Signing of the United States-Rwanda Bilateral Health Cooperation Memorandum of Understanding. Retrieved December 19 2025 from rw.usembassy.gov/united-states-rwanda-bilateral-health-cooperation-memorandum-of-understanding/

In addition to repositioning the Global South as a marketplace, this approach treats the Global South as a laboratory and a testing ground for U.S.-led research aimed at generating commercially exploitable data under the guise of health intervention. The strategy explicitly calls for the establishment of a "first-of-its-kind innovation fund to support American-led research, market-shaping and other dynamic advancements in global health,"[33] embedding the prerogatives of U.S. capital into the architecture of global health funding and research rather than prioritizing community needs, informed consent, and equitable benefit sharing. By design, this fund would enable U.S. actors to refine technologies and interventions in low- and middle-income settings and then leverage those insights to capture Asia's projected $5 trillion and Africa's $250 billion healthcare markets as "opportunities" for U.S. commercial diplomacy. Framing global health research in this way echoes troubling precedents where commercial priorities have overridden ethical protections.[34]

HOLLOWED OUT HEALTH SYSTEMS

The AFGHS argues that the global health architecture has been fundamentally mismanaged, citing alleged "inefficiencies" and "mission creep" to justify sweeping restructuring. It presents the proportion of spending on technical assistance and program management as evidence of waste, selectively highlighting instances of corruption or commodity diversion to reinforce this narrative. On this basis, the strategy asserts that training, quality assurance, and program management should be rapidly shifted to "local ministries of health," and that U.S. funds should, in the near term, be directed almost exclusively toward frontline costs (health workers and commodities) which are framed as a pathway to "health sovereignty" and accelerated country ownership.

Such a framing fundamentally misunderstands how health systems work. The WHO identifies six 'building blocks' that make up functional health systems[35] - health services, health workforce, a health information system, medical products, vaccines and technologies, health financing, and leadership and governance. Yet the model championed by the AFGHS concentrates narrowly on workforce development, select system capacities, and commodified health products, sidelining the broader ecosystem required for sustainable systems strengthening.

This imbalance is compounded by an overemphasis on health security – prioritizing epidemic prevention and infectious disease control at the expense of the full range of services health systems are meant to deliver. In practice, this means that routine and essential services such as routine childhood immunization, antenatal and postnatal care, maternal and child nutrition programs, access to contraception and safe abortion care, cervical and breast cancer screening, menstrual health services, and the prevention and response to gender-based violence are sidelined in favor of narrowly defined outbreak preparedness.

33 U.S. Department of State. (2025, November). Driving global health progress through American innovation and burden sharing: The first doses of Lenacapavir arrive in Eswatini and Zambia [Press release]. Retrieved December 19, 2025, from https://www.state.gov/releases/under-secretary-for-foreign-assistance-humanitarian-affairs-and-religious-freedom/2025/11/driving-global-health-progress-through-american-innovation-and-burden-sharing-the-first-doses-of-lenacapavir-arrive-in-eswatini-and-zambia/

34 Eboh, C. (2009, July). Pfizer, Nigeria sign $75 mln Trovan settlement. Reuters. https://www.reuters.com/article/world/africa/pfizer-nigeria-sign-75-mln-trovan-settlement-idUSLU52274/

35 WHO. (2007). Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action. World Health Organisation. Retrieved December 19, 2025, from https://iris.who.int/server/api/core/bitstreams/809f813f-5b90-4187-861b-3953bb54e244/content

BUT WHY DOES IT MATTER

Although the AFGHS claims that these measures are a means to advance health sovereignty, freeing Global South countries from "the current U.S.-funded global health delivery system and the culture of dependency", its actual provisions do the exact opposite. The strategy affirms national ownership only rhetorically while simultaneously dictating how Global South countries should design their health strategies, set priorities, and implement programs. In other words, the AFGHS uses the façade of health sovereignty to hollow out national health systems in the Global South, to the benefit of private capital interest in the U.S. At a moment when Global South countries are asserting their leadership on setting and implementing health agendas – through mechanisms such as the 2025 Accra Initiative in Africa or through strategic regional coordination in the ORAs-CONHU and the COMISCA in Latin America – and on committing to deploy domestic capacity and govern their systems around resilience, equity, and dignity, the conditions embedded in the AFGHS threaten to roll back this momentum.

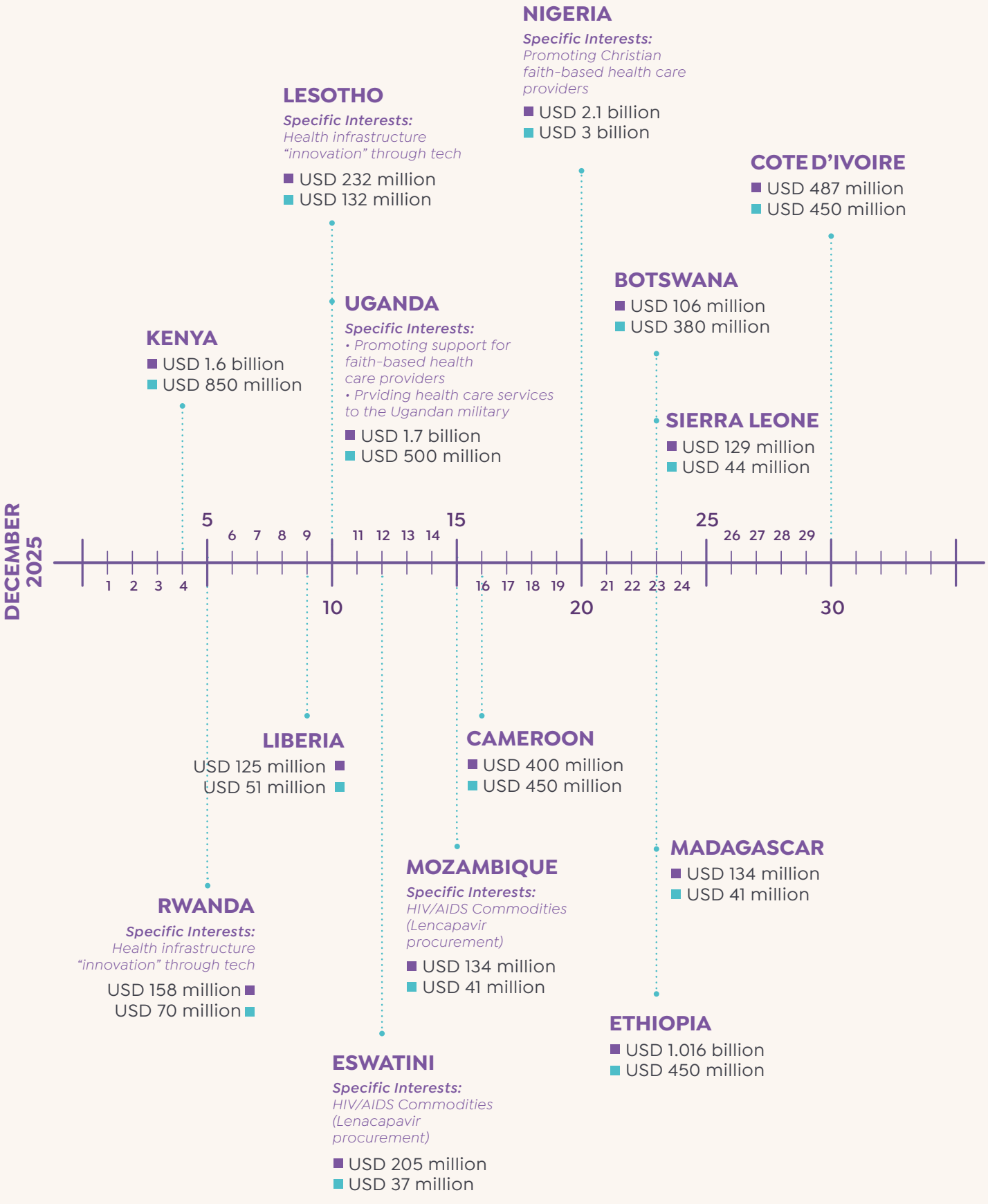
First, the AFGHS places the United States firmly in the driver's seat of other countries' national health agendas by determining which services and cadres of health workers will be supported, for how long, and under what ideological constraints. As noted earlier, health systems exist to meet multiple and overlapping needs; yet the Memoranda of Understanding (MoUs) implementing the AFGHS prioritise health security to the detriment of broader systems strengthening.

The bilateral MoUs preserve only limited continuity with disease-specific investments, with the bulk of funding under the commodities and health-worker categories directed toward life-saving treatment, particularly for HIV/AIDS. At the same time, available reporting suggests a relatively rapid drawdown of U.S. investments in tuberculosis and malaria, even as support for surveillance and outbreak response remains comparatively stable.[36] Most strikingly, the compacts would all but eliminate maternal and child health funding, signaling a clear prioritization of preventive and routine services that form the backbone of primary health care.

The MoUs also emphasize an ambitious co-financing model for healthcare workers, with the U.S taking on the bulk of the costs in the early years (even though domestic appropriations haven't yet been raised to support these bilateral commitments[37]), and national governments absorbing all workforce costs by year 5. On the surface of it, the tapered national absorption of frontline health workers appears progressive, signaling country ownership and a transition from donor-funded project staff to permanent public-sector cadres. In practice, however, given the priority areas of the MoU, this framing reduces frontline workers to instruments of epidemic prevention, obscuring their central role in delivering essential routine services, such as family planning, routine immunization, nutrition support, and community-based primary care.

36 Estes, J., & Keller, J. M. (2025, December). What We Know—and Don't Know—About the Trump Administration's Global Health Agreements. Centre for Global Development. Retrieved December 19, 2025, from https://www.cgdev.org/blog/what-we-know-and-dont-know-about-trump-administrations-global-health-agreements

37 Bass, E. (2025). Lessons from America's Health Agreements with Kenya and Rwanda. To End a Plague . . . Again. https://emilysbass.substack.com/p/lessons-from-americas-health-agreements


NIGERIA
Specific Interests:
Promoting Christian faith-based health care providers
USD 2.1 billion
USD 3 billion
LESOTHO
Specific Interests:
Health infrastructure "innovation" through tech
USD 232 million
USD 132 million
COTE D'IVOIRE
USD 487 million
USD 450 million
BOTSWANA
USD 106 million
USD 380 million
UGANDA
Specific Interests:
• Promoting support for faith-based health care providers
• Prviding health care services to the Ugandan military
USD 1.7 billion
USD 500 million
KENYA
USD 1.6 billion
USD 850 million
SIERRA LEONE
USD 129 million
USD 44 million
DECEMBER 2025
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
LIBERIA
USD 125 million
USD 51 million
CAMEROON
USD 400 million
USD 450 million
MADAGASCAR
USD 134 million
USD 41 million
RWANDA
Specific Interests:
Health infrastructure "innovation" through tech
USD 158 million
USD 70 million
MOZAMBIQUE
Specific Interests:
HIV/AIDS Commodities (Lencapavir procurement)
USD 134 million
USD 41 million
ETHIOPIA
USD 1.016 billion
USD 450 million
ESWATINI
Specific Interests:
HIV/AIDS Commodities (Lenacapavir procurement)
USD 205 million
USD 37 million
US Commitment
Country Co-financing Commitment

The negotiation of the AFGHS bilateral MoUs has been rushed and largely non-consultative, privileging U.S. priorities over country and sub-national needs. In Kenya, county health directors reported being summoned to Nairobi with almost no notice to review the MoU[38]; a bizarre decision considering that health in Kenya constitutionally devolved. These rushed negotiations are made more coercive by the structure of the financing itself. Funding timelines under the MoUs are intentionally short-term and explicitly "subject to the availability of funds,", creating persistent uncertainty for governments seeking to sustain essential services. The stalled negotiations in Zambia illustrate this dynamic vividly: bridge funding under PEPFAR is only guaranteed until March 31, 2026, and unless Zambia accedes to U.S. conditions – including demands related to mining and broader business-sector reforms, it risked being unable to finance critical life-saving health services from April 1 onward[39]. This structure turns rather than a predictable foundation for system strengthening.

Against this background of coercive and rushed decision-making, the AFGHS, and by extension the bilateral MoUs for its implementation, emphasizes performance-based targets. Yet based on what we know from the Kenyan MoU, the baseline figures and outcome indicators included in the document show inconsistencies between national and global data and, in some cases, oversimplify key epidemiological measures, calling into question whether they can meaningfully measure progress or justify performance-linked financing.[40] At the same time, long-standing sources of health data such as the USAID-funded Demographic and Health Surveys (DHS), which have underpinned credible baselines for decades, have been interrupted because of the lack of funding, leaving countries without nationally representative benchmarks.[41] Without such reliable data infrastructure, it is unclear who will produce the credible baselines needed to assess performance under these financing mechanisms.

Second, despite the rhetoric on sovereignty, the AFGHS hardwires dependency into bilateral agreements through conditional procurement guidance. Roughly a quarter of U.S. global health funding that is promised until 2030 is earmarked for commodities with procurement that privilege U.S.-made products. MoUs such as Rwanda's explicitly prioritize U.S.-based digital and technological solutions for the delivery and management of health services.[42] Together, these provisions extend dependency beyond medicines to include health technologies, data systems, and service-delivery platforms, raising serious questions about where this leaves indigenous capacity to manufacture, adapt, or govern these tools. This directly undermines long-standing demands from African governments and civil society for local manufacturing, regional procurement, and South–South supply chains, including collaboration with India and China. It also contradicts transformative continental initiatives like the African Medicines Agency (AMA), the Partnership for African Vaccine Manufacturing (PAVM), and the 2021 Innovation and Regional Production Platform anchored by Pan-American Health Organization (PAHO). This reliance on the U.S. for commodities and financing is a part of the commercial diplomacy strategy that is also outlined in Project 2025 to oppose the growing influence that China exerts on the African continent through the Belt and Road Initiative (BRI). Consequently, the strategy cements U.S. commercial advantage at the expense of regional autonomy and the result is a global health order where African governments remain buyers, not producers, precisely the opposite of the sovereignty agenda they have articulated.

38 Okeyo, V. (2025, December 9). Counties Alarmed Over Kenya's $2.5 Billion Health Deal with US. DeFrontera. https://defrontera.org/features/counties-alarmed-over-kenyas-25-billion-health-deal-us

39 Bass, E. (2025a, December 11). U.S. delays Zambia health agreement as signing becomes contingent on mining deal. To End a Plague . . . Again. https://emilysbass.substack.com/p/us-delays-zambia-health-agreement

40 Bass, E. (2025, December). US-Africa health agreements targets don't add up. To End a Plague . . . Again. https://emilysbass.substack.com/p/us-africa-health-agreements-targets

41 Rebuilding Global Health Data: scale, risks, and paths to recovery. (2025, November 2). Open Data Watch. opendatawatch.com/publications/rebuilding-global-health-data-scale-risks-and-paths-to-recovery/?utm_source=chatgpt.com

42 U.S. Embassy in Rwanda. (2025, December). Continuing to Deliver on the America First Global Health Strategy with the Signing of the United States-Rwanda Bilateral Health Cooperation Memorandum of Understanding. Retrieved December 19 2025 from rw.usembassy.gov/united-states-rwanda-bilateral-health-cooperation-memorandum-of-understanding/

Third, beyond its financial leverage, the U.S. is asserting a new form of regulatory dominance through clauses such as those in the Liberian[43] and Kenyan[44] bilateral agreements, which require that medicines and health technologies be FDA-compliant rather than WHO-compliant. This may seem like a technical distinction, but it has profound consequences, especially given the increasingly politicized nature of U.S. domestic debates over essential medicines.

For example, the recent 2025 decision to place mifepristone under FDA review, despite more than two decades of global evidence confirming its safety for medication abortion and miscarriage care, exposes just how vulnerable essential reproductive commodities are to domestic ideological debates within the U.S. Similarly, the FDA's proposed warnings on acetaminophen use during pregnancy, citing an ill-verified association with neurodevelopmental conditions such as autism and ADHD[45], reflects an increasingly politicized regulatory environment. Similarly, the broader assault on vaccines, including high-profile calls to revisit or restrict long-established immunizations like measles or MMR, illustrates how deeply scientific consensus is being undermined for political gain.

Under the terms of the AFGHS-aligned funding agreements, if the FDA ultimately restricts or withdraws any of these commodities, they will automatically become non-procurable, non-compliant, and no longer considered essential, even if WHO continues to endorse them, and even if global scientific evidence remains unchanged. Countries would be forced to align with the shifting ideological terrain of U.S. domestic politics rather than with global health norms.

Fourth, the AFGHS's insistence that partner countries share surveillance, laboratory, and pathogen data in exchange for aid is essentially data extraction for private, commercial gain. While pooling public-health data across borders can be a powerful tool for epidemic control (as recognized in the aftermath of COVID-19 and reflected in the ongoing negotiations around the Pathogen Access and Benefit-Sharing system) it is only effective and legitimate when governed by transparent, reciprocal arrangements and independent oversight. Under the new bilateral model, however, recipient countries are being asked to open up their health systems and hand over sensitive programmatic and genomic data to external actors while the agreements provide little clarity on who gets access to this data, how the data may be used, who will control secondary uses, and what redress exists if data are misused. And critically, even though the MOU itself can be terminated with notice, the obligations around data transfer and access continue beyond the life of the agreement, meaning that once countries open their surveillance systems, pathogen samples, or health records, the U.S. can retain and continue using that data long after the partnership is dissolved. Because the AFGHS ties data access to funding, countries may feel compelled to comply even where national law would otherwise prevent data sharing. All of these are concerns that were brought up by Kenyan civil society actors in the run up to the signing of the bilateral agreement between the U.S and the Kenyan government, and they were only partially addressed before the agreement was signed.[46] Furthermore, organizations like MSI warn that combining Helms with the AFGHS's sweeping data-sharing requirements could create a vast anti-abortion surveillance apparatus, where U.S. agencies gain unprecedented access to programmatic health information under the guise of compliance monitoring.[47]

43 U.S. Department of State. (2025, December). Memorandum of Understanding between the United States and the Government of Liberia. https://healthpolicy-watch.news/wp-content/uploads/2025/12/US-Liberia-MOU-2025.pdf

44 U.S. Department of State. (2025, December). Memorandum of Understanding between the United States and the Government of Kenya on Health. https://online.flippingbook.com/view/860002012/

45 U.S. Food and Drug Administration. (2025). FDA Responds to Evidence of Possible Association Between Autism and Acetaminophen Use During Pregnancy [Press release]. Retrieved December 10, 2025, from www.fda.gov/news-events/press-announcements/fda-responds-evidence-possible-association-between-autism-and-acetaminophen-use-during-pregnancy?utm_source=chatgpt.com

46 Bass, Emily. (2025). Lessons from America's Health Agreements with Kenya and Rwanda. substack.com/home/post/p-180640773

47 MSI Reproductive Choices. (2025). The Trump Administration's Weaponisation of U.S. Foreign Assistance. MSI.

Fifth, and related to this question of surveillance and data sharing, the lack of reciprocity built into these bilateral agreements raises a critical and unresolved question: what happens when the epidemiological threat moves in the opposite direction? There is no provision requiring the U.S. to share surveillance data, commodities, or countermeasures with its partners if outbreaks originate within its borders and spread outward – a scenario that is increasingly plausible given the resurgence of measles and polio in the United States, diseases that many countries in the Global South have worked for decades to eliminate.

Taken together, these elements make clear that the AFGHS does not advance health sovereignty but instead repackages it as compliance with U.S. political, commercial, and regulatory priorities. The strategy closely mirrors the logic set out in Project 2025, which explicitly positions global health assistance as a tool of commercial diplomacy, designed to secure U.S. supply chains, expand markets for American firms, and counter China's influence, particularly in regions rich in critical minerals and rare earths, as seen in U.S. engagement across countries such as Rwanda and the Zambia. This approach stands in direct contradiction to the path African governments have already articulated through the Accra Initiative and the Lusaka Agenda, which prioritize regional manufacturing, coordinated procurement, and nationally governed health agendas. Rather than enabling regional coherence, it fragments it, creating parallel pathways that subordinate health policy to U.S. strategic interests and hollow out the very notion of sovereignty it claims to uphold.

WHAT CIVIL SOCIETY CAN DO IN THIS MOMENT: RECOMMENDATIONS FOR RESISTANCE AND ACTION

1. DEMAND FULL TRANSPARENCY IN NEGOTIATIONS AND INSIST ON MEANINGFUL CIVIL-SOCIETY PARTICIPATION.

Civil society must press governments to make the contents of all AFGHS-related negotiations and draft MoUs public, including annexes on financing, data access, procurement, and regulatory alignment. Civil society organizations (CSOs) should push for formal, structured roles in negotiation processes, not just as observers, but as contributors with the power to shape the content, safeguards, and limitations within these agreements. National-level consultation spaces should be created where feminist groups, health-rights advocates, and affected communities can review, critique, and propose alternative language. Equally important is clarity from governments on both what the transition to 2030 will look like and what priorities they intend to protect or expand until 2030, to ensure that the AFGHS does not derail long-term national health strategies. We know this strategy works based on the Kenyan example; despite being the first MoU to be signed, the High Court has temporarily suspended the implementation of of the agreement following a petition by civil society and consumer groups raising constitutional and data-privacy concerns.[48]

2. BUILD CROSS MOVEMENT SOLIDARITY AROUND SHARED HARMS

Civil society actors working across maternal and child health, family planning, HIV/AIDS, SRHR, vaccine equity, data privacy, economic justice, and good governance and transparency should actively invest in cross-movement coordination to resist the shared harm of the AFGHS and identify shared risks created by the MoUs. By mobilising as a united pressure group rather than as isolated constituencies, CSOs can more effectively challenge inequitable provisions, push for the removal of harmful conditionalities, and hold national governments accountable.

48 Rukanga, B. (2025, December 12). Kenyan court suspends US health aid deal over data privacy concerns. Retrieved January 13, 2026, from https://www.bbc.com/news/articles/ce91degnelko

3. ACTIVELY RESIST THE DE-PRIORITIZATION OF SRHR AND THE ROLLBACK OF HEALTH RIGHTS.

CSOs must reject any effort to dilute, sideline, or criminalize SRHR under the guise of AFGHS compliance, including the insertion of restrictive clauses relating to the Helms Amendment, Genva Consensus Declaration, or the broader Protego framework. Feminist and SRHR organizations can lead coordinated advocacy to reaffirm SRHR as a core national priority, demand funding protection for reproductive care and safe abortion, and expose how U.S. conditionalities threaten national commitments to gender equality, maternal health, and bodily autonomy. This includes monitoring MoUs, budget reallocation, and service-level changes that could restrict access or undermine community-led care models.

4. DEFEND MULTILATERALISM AND CALL OUT ATTEMPTS TO SIDELINE GLOBAL HEALTH ARCHITECTURE.

The AFGHS seeks to replace multilateral coordination with bilateral, U.S.-designed systems of oversight and control. CSOs must highlight the dangers of fragmenting global health governance, undermining WHO, and bypassing continent-wide initiatives such as the African Medicines Agency and regional epidemic surveillance platforms. Advocates can jointly call for governments to commit to multilateral rules-based systems, resist clauses that erode global norms, and publicly expose how bilateral deals weaken shared global health security.

5. PRESSURE GOVERNMENTS TO PROTECT RECIPROCITY, INVEST IN LOCAL PRODUCTION, AND DEEPEN SOUTH–SOUTH COLLABORATION.

CSOs should demand that any agreement with the U.S. include clear reciprocity, including clarity on U.S. obligations beyond funding. At the same time, civil society can advocate for national policies that prioritize local manufacturing, regional supply chains, and South–South procurement arrangements, resisting U.S.-mandated dependence on U.S. commodities. This includes pushing for budget allocations, legislative reforms, and regional alliances that strengthen domestic capacity and prevent long-term lock-in to U.S. supply routes, regulatory preferences, or proprietary surveillance systems.

6. RAISE URGENT QUESTIONS ABOUT RISKS ORIGINATING FROM THE U.S. AND DEMAND ACCOUNTABILITY FOR CROSS-BORDER HARM.

Given the resurgence of measles, polio, and other preventable diseases in the U.S., CSOs must openly question why agreements impose strict reporting and data-sharing obligations on partner countries while remaining silent on outbreaks originating in the U.S., thus recreating colonial power structures and understandings of disease. Who carries the burden if the next epidemic spreads from the U.S. into the Global South? Who is liable for health, economic, and social harm? Civil society can pressure governments to demand commitments, and independent oversight mechanisms to ensure that the U.S. is not exempt from the very obligations it imposes on others.

7. ADVOCATE FOR GOVERNMENT COMMITMENT TO EVIDENCE-BASED SERVICE PROVISION AND HEALTH SYSTEMS PLANNING

Civil society should push governments to anchor all health policy, procurement, and service delivery decisions in globally recognised, evidence-based standards such as WHO normative guidance, essential medicines lists, and peer-reviewed public health research, rather than politically contingent (such as the GCD) or externally imposed regulatory frameworks such as the FDA or the CDC. This includes resisting the substitution of multilateral scientific consensus with unilateral standards, and demanding transparency around how evidence is assessed, weighed, and applied in national decision-making.

8. PUSH GOVERNMENTS TO STRATEGICALLY DEPLOY DOMESTIC FUNDING AND BROADEN PARTNERSHIPS BEYOND FAITH-BASED ACTORS.

Civil society should encourage governments to use their own health financing to intentionally prioritize areas deprioritized or excluded under the AFGHS including SRHR, maternal and child health, routine immunization, and community-based services. At the same time, CSOs can press governments to leverage this moment to build more inclusive coalitions and partnerships with a diverse range of civil society actors, including feminist organizations, rights-based groups, professional associations, and community-led organizations, rather than relying predominantly on the faith-based implementers centered in the AFGHS. Doing so can help rebalance influence within national health systems and strengthen accountability.