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THE OTHER STORY BURIED IN THE HEADLINES: HEALTH FUNDING OR DATA EXTRACTION?

The ongoing US-Israel conflict with Iran and its impact on Africa, especially driving up the price of oil, gas, and fertilisers, has captured our attention. The impact will be severe on communities and already fragile African economies that are already struggling. We know the impact will be harsh and can only hope the war will end soon (by the time of publication). There is, however, another issue that has not received the same international sheadlines and been overlooked in the news agenda: That is, the impact of US health MOU's that numerous African nations have signed in recent time and the resulting effects on already fragile African healthcare systems. According to Health Policy Watch, Africa is not the only continent to have inked deals; several Latin American countries have also signed.

Several African nations, including Rwanda, Uganda, Nigeria, Lesotho, and Eswatini, have already signed the controversial health funding agreements.

> AFRICA CDC, AND LOCAL HEALTH EXPERTS HAVE ALSO RAISED SERIOUS CONCERNS ABOUT THESE HEALTH DEALS

Donald Trump's "America First" global health strategy will grant the U.S access to crucial health data from African nations, potentially assisting big pharmaceutical companies in developing new vaccines. However, these countries may not gain access to these vaccines once they become available, which raises concerns about equity in global health and the potential for increased health disparities between wealthy and African nations.

Additionally, some health deals are also linked to mineral agreements, which may prioritize resource extraction over equitable health access. Twenty African nations have so far signed the “health collaboration MOUs,” which represent more than $18.3 billion in new health funding and include more than $11.2 billion in US assistance alongside $7.1 billion in co-investment from recipient countries.

The Africa Centre for Disease Control, Africa CDC, and local health experts have also raised serious concerns about these health deals. Is this the new scramble for Africa’s health resources? The new agreements raise significant questions about who controls the funding, who safeguards the data, and who will be held accountable if issues arise.

Remembering COVID vaccine access

Remember the COVID pandemic when many poorer countries were left frustrated with the access and then subsequent unequal roll-out of the vaccines? Well, this prompted African nations to develop their own vaccines. Africa only produces about 1% of the vaccines it needs and has to import them. Led by the Africa CDC and the African Union, the goal is to produce 60% of the continent’s vaccine needs locally by 2040 and has led to Africa developing pan-African vaccine hubs to ensure a level of self-reliance and build regional vaccine capacity.

There are now concerns that the new deals will lock countries into external partnerships that are not very transparent. According to the memo released by the Department of State, the US says the deals will support, “[...] amongst other things, Data Systems: The funding will support the scale-up of health data systems for partner governments, ensuring that key programmatic data for HIV/AIDS, TB, malaria, polio, and disease outbreaks can be tracked at scale over the long term, while also encouraging countries to increase their domestic health expenditures duringthe agreement period.”

However, given the state of local healthcare systems, there is really no guarantee that countries will have the money and/or resources to ensure their overburdened healthcare systems can handle this, especially considering the potential increase in demand for services due to the scale-up of health data systems and the ongoing challenges posed by diseases like HIV/AIDS, TB, and malaria.

Undermining trust

Bioethicists have also entered the debate and have raised concerns about the health deals and warned that the national health data for healthcare funding risks undermining trust in research and care.

Writing in the Journal of Medical Ethics, Prof. Keymanthri Moodley, in the Department of Medicine at Stellenbosch University, and Associate Professor of biomedical ethics, Brian Earp, at the National University of Singapore, argued that tying essential healthcare access to data-sharing could erode public trust in both healthcare and research in African nations.

“When access to healthcare is linked to large-scale data-sharing agreements negotiated under conditions of unequal power, patients and communities may perceive health systems as serving external interests rather than primarily protecting their own,” they wrote in the journal.

> PATIENTS AND COMMUNITIES MAY PERCEIVE HEALTH SYSTEMS AS SERVING EXTERNAL INTERESTS RATHER THAN PRIMARILY PROTECTING THEIR OWN

They further argue that perceptions—especially where longstanding histories of extractive research and resource exploitation remain salient— “can weaken confidence in consent processes, blur the boundary between care and data extraction, and reduce willingness to engage with healthcare or research initiatives over time.”

Pushback by some?

For years, the US was one of the largest bilateral healthcare donors in Africa. It is estimated that since 2001, the US has invested close to $200 billion in several health care programmes, including HIV (human immunodeficiency virus), TB (tuberculosis), and malaria prevention. One of Trump's first actions upon taking office in 2025 was to halt US aid and other healthcare programmes, including PEPFAR, the President's Emergency Plan for AIDS Relief, which provided funding for HIV/AIDS treatment and prevention.

This immediate shutdown and sudden of aid cuts caused widespread panic across Africa, with many countries losing crucial funding for healthcare programmes. A few months after the aid cuts, the US announced the America FIRST health policy, which focuses on prioritising American interests in health initiatives. However, there has been pushback. In February, Zambia and Zimbabwe announced they have rejected the health deals.

Zimbabwe rejected the deal that would have provided $367m in funding over five years. President Emmerson Mnangagwa expressed dissatisfaction with the 'lopsided' nature of the deal. A government spokesman told media outlets that the US was demanding access to biological samples for research and commercial gain but said it was not willing to share the benefits for future vaccines and treatments, which raised concerns about equity and fairness in the proposed agreement.

Zambia, one of the world’s largest copper producers, said it would no longer go ahead with the US deal that was worth around $1 billion because it "[...] does not align with the country’s interests," a government spokesperson said. The Zambian deal hinged on gaining access to the country's mineral wealth. In December, the US said that it had committed, with Zambia, to “a plan that aims to unlock a substantial grant package of US support in exchange for collaboration in the mining sector and clear business sector reforms.”

In the East African powerhouse, Kenya, in December, a High Court suspended the $1.6 billion US health deal, citing serious concerns over data privacy, lack of parliamentary oversight, and constitutional violations. According to reports, one of the groups that took the case to court, the Consumer

Federation of Kenya, argued that the country risked “ceding strategic control of its health systems if pharmaceuticals for emerging diseases and digital infrastructure (including cloud storage of raw data) are externally controlled.” The court case resumed in February and has been postponed to April.

Conclusion

Health activists have expressed grave concern that the new US strategy is overly transactional, extractive in nature and lacking clarity in the decision-making processes.

Data sovereignty also raises serious questions about the implications: when your data funds medicines that you cannot easily access and when priorities are influenced by another country without a true partnership? Activists maintain that any future agreements should incorporate clear limits on data use, independent oversight, fair benefit-sharing, safeguards against re-identification, and ongoing community engagement. Without these protections, agreements that look good on the surface might actually worsen the situation by taking advantage of local resources and harming both local health systems and global health cooperation, which most certainly increase health inequalities in Africa and the global south.

For those countries that have already signed the MOU's, there are several issues that remain unclear; for instance, have there been clear limits on data use to ensure the protection of individual privacy? What independent oversight exists to guarantee accountability in how data is handled and shared? With whom exactly will the data be shared? There are many unanswered questions and details missing. This is where one hopes the African Union and the Africa Centre for Disease Control will assist countries in understanding what this means for their health sovereignty.

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