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# Africa and the America First Global Health Strategy: Critical Reflections

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The United States, under the leadership of President Donald Trump, has withdrawn from the World Health Organization (WHO) and dramatically cut health and humanitarian aid to Africa, including support for key non-governmental organizations (NGOs). It has replaced a mix of bilateral and multilateral approaches to global health with the America First Global Health Strategy (AFGHS), which foresees bilateral agreements with 71 recipient countries worldwide.<sup>1</sup> This paper focuses on the motivation and impact of this approach on important areas such as African digital sovereignty and the ability to contain emergent diseases, including the current Ebola outbreak.

## INTRODUCTION

Digital sovereignty is the ability for a nation to maintain control over its data and its digital assets, infrastructure and technologies. The concentration of big tech in a few countries has created power asymmetries and sovereignty challenges for many nations.<sup>2</sup> The African continent faces the most significant threats from China and the United States.<sup>3</sup> Chinese telecom companies have constructed much of Africa's digital backbone, including mobile networks and national data centres, leading to widespread concerns about the degree of African dependency on Chinese technology and potential threats to the control of data.<sup>4</sup> The United States also threatens the digital sovereignty of other nations through its corporate-owned cloud infrastructure, which hosts massive amounts of data. Under the 2018 Cloud Act, US authorities can order firms to hand over data from operations domestically and abroad, including Canada and African countries.<sup>5</sup>

A newly emerging threat to digital sovereignty is the AFGHS. On January 20, 2025, citing undue political influence from China in the WHO, Trump signed Executive Order 14155, which initiated formal US withdrawal, one year later, from the health organization.<sup>6</sup> As indicated by Trump's early criticisms of China during Covid-19, this withdrawal was on his list of priorities well before his second term,<sup>7</sup> and occurred along with massive cuts to public health assistance through the closure of the United States Agency for International Development (USAID) in February 2025.<sup>8</sup> The question became: what would Trump's new global health agenda look like?

In September 2025, the State Department answered with the publication of the AFGHS. The strategy's bilateral health agreements, completed or under negotiation with 71 countries around the world, have offered health assistance in exchange for access to health data. These agreements threaten each country's digital sovereignty and patient privacy, while opening economies to US health-related goods and services.

In the case of Zambia, negotiations have been held up due to US insistence that the Memorandum of Understanding (MOU) be tied to the signing of a critical mineral accord.<sup>9</sup> Clinical experimentation, including the medical use of artificial intelligence (AI), has been embedded in the accord with Rwanda and closely aligned with a US-sponsored agreement to bring robotics into delivery systems.<sup>10</sup> This continues a long tradition of using the continent's population for potentially unethical experimentation.<sup>11</sup>

The AFGHS, this paper argues, is less about improving global health and more about utilizing bilateral approaches and the cover of global health to advance US strategic and corporate interests.<sup>12</sup> The paper begins with some general reflections on the problematic nature of taking a bilateral approach to global health. The second section links the current Ebola outbreak in the Democratic Republic of the Congo (DRC) and surrounding countries to the shift in US global health policy, including the closure of USAID and its associated cuts to health and humanitarian assistance. The third section examines other problems with the AFGHS, including the loss of digital sovereignty for African countries. The fourth section

looks at the US-Nigeria health MOU to examine how the AFGHS plays out in an actual accord. The conclusions provide recommendations on how the global community should respond to the AFGHS.

## BILATERALISM AND GLOBAL HEALTH

The AFGHS, from a global health perspective, is disquieting.<sup>13</sup> The name itself is an oxymoron. A widely accepted definition of global health is “an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide.”<sup>14</sup> Prioritizing one country in global health is an anathema to the very nature of the discipline, which is about equitable access to health worldwide. But the highest priority of the AFGHS is not global health: its first priority is to cover the advancement of US strategic and corporate interests.

Shifting power dynamics are at the core of moving from a mix of bilateral and multilateral programs to a strict bilateral approach. The US withdrawal from key international fora that are driven in part by norms of equity and fairness, and in the absence of negotiating options in geographically linked or politically aligned blocs, African nations and others find themselves alone in the ring with the United States. Newly asymmetric power relations have emerged, and isolation through bilateralism is by design.

With its “leverage-based order,” the United States can demand multiple concessions that have nothing to do with public health.<sup>15</sup> The demands to make health care support contingent on accessing minerals, for example, is signalled in the original document. Pillar 2 of the AFGHS, “Making America Stronger,” contains a section called “Leveraging U.S. Global Health Leadership to Compete with China.” It states that the program has the potential to be an important counterweight to China in Africa, which is a “continent of strategic importance to U.S. national interests,” because Africa “contains several of the large deposits of key minerals and rare earth elements needed as inputs into advanced technologies that fuel critical military and commercial applications.”<sup>16</sup> This could be the first time a public health assistance document contains a discussion of leveraging health aid to gain access to critical minerals for military applications.

Leveraging has blatantly played out in real time, with the United States holding up its US\$1.5 billion bilateral health agreement with Zambia until the African country signs a mining accord giving the United States access to Zambian minerals.<sup>i</sup> Unlike many other African countries, Zambia also pushed back on the unfettered access to Zambian health information.<sup>17</sup> Kenya suspended its health MOU, one week after it was signed in December 2025, due to the agreement’s unlawful sharing of patient data, which was inconsistent with Kenya’s Data Protection Act of 2019.<sup>18</sup>

The demand for “co-investments” or “shared responsibility,” which is purportedly aimed at enhancing ownership of aid programs, has put an onerous burden on governments and undercut sovereignty over vast sums of African money that is now tied to problematic health agreements with asymmetric

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<sup>i</sup> All figures in US dollars.

conditions.<sup>19</sup> The section on recipient contributions in the AFGHS highlights a problem with bilateral agreements: “Going forward, the United States will implement health assistance through multi-year bilateral agreements between the U.S. government and recipient countries that require both parties to follow through on key terms in order to facilitate accountability and unlock future U.S. funding.”<sup>20</sup> Notice the ambiguity of the terminology of “to facilitate accountability” and “unlock future US funding,” which places all power on the US side to determine when governments are not “accountable,” and with no time dimension on “future US funding.”

The programs can be cancelled for a variety of reasons, at the whim of the White House, and without any connection to the country’s health needs or policies. The president’s abrupt cutting of health aid to South Africa in 2025 because of his dislike of South Africa’s land policies, for example, has been described as the United States showing “how political alignment now overrides epidemiological logic.”<sup>21</sup> The exigencies of public health have become subservient to the unilateral demands of the United States. We will see how this plays out in the latest Ebola outbreak.

Pillar 1 of the document, “Making America Safer,” emphasizes that the AFGHS makes “every effort to prevent deadly diseases from reaching our shores or harming American citizens abroad.”<sup>22</sup> As stated, this approach is not about *global* public health. And what exactly is the strategy to accomplish this goal? The document asserts what nobody with even rudimentary training in epidemiology could possibly state with confidence: the system the United States aims to build in each country will “enable detection of an outbreak with epidemic potential within seven days of its emergence.”<sup>23</sup> Every successful intervention in emergent disease outbreaks has required international cooperation. In the case of Covid-19, China released the genetic code that was needed to generate mRNA vaccines in early January 2020.<sup>24</sup> Pulling out of the WHO, which places severe restrictions on international communications and collaboration, undermines the imperative of international cooperation.

So how will this dramatic seven-day goal of detection be achieved? The key is to “engage bilaterally” “to strengthen global surveillance” by assigning “U.S. government staff with a health portfolio to every country with a U.S. mission.”<sup>25</sup> The United States plans to withdraw from investing in global laboratory capacity and data systems around the globe in order to focus on single-country surveillance and laboratory operations that the United States can monitor.

## THE AFGHS, US AID AND THE EBOLA OUTBREAK

On the surface, the potential success of this bilateral approach to global health seems dubious. We can examine the impact in practice with the current outbreak of the Ebola Bundibugyo strain. The DRC signed the new AFGHS agreement in February 2026. The first known case of Ebola in the DRC was detected in a nurse on April 24, 2026, in Bunia, Ituri Province, but the outbreak was not confirmed until May 15.<sup>26</sup> By then, infections had already spread across at least nine health zones in Eastern DRC and

into neighbouring Uganda. By July 30, there were more than 3,605 confirmed cases and 1,587 deaths in the DRC, 20 cases and two deaths in Uganda, and one case in France. It is already the third largest Ebola outbreak in history, with the potential to become the largest, according to the Africa Centres for Disease Control and Prevention.<sup>27</sup>

What happened to the seven-day detection promised by the AFGHS? The WHO emphasized that the outbreak had surpassed the critical four-week detection gap, allowing Ebola to rapidly spread in Eastern Congo. By early May, Doctors Without Borders had documented some 55 deaths from viral hemorrhagic fevers since the beginning of April, but identification of the causal disease did not occur until nearly the end of that month.<sup>28</sup>

While there is little doubt that the ongoing violence in Eastern Congo played a role in the delayed detection of the virus,<sup>29</sup> so did shifting US policy.<sup>30</sup> Following the closure of USAID, US government support of health and humanitarian aid to the DRC plummeted from \$1.28 billion in 2024 to \$405 million in 2025, to a mere \$135 million through July 1, 2026.<sup>31</sup> Prior to 2025, the United States funded a wide range of preparedness measures in the DRC that have been dramatically curtailed, including surveillance and response systems. The United States previously funded air transportation and trained people to properly handle and preserve samples for testing. The WHO has indicated that the lack of transportation impeded its ability to move such samples for testing.<sup>32</sup>

A key component of the AFGHS is to curtail support of NGOs due to their purported inefficiencies.<sup>33</sup> The US cutbacks to NGO support in the DRC have had a severe impact on the course of the Ebola outbreak. Testing is only one small part of surveillance. Someone needs to be in place to observe a mysterious new disease cluster, which leads to potential testing. USAID invested heavily in local communities and workers, often through NGOs that built trust with communities that were weary of outsiders, particularly given the conflict-ridden nature of the region.<sup>34</sup>

The 70 percent cut in humanitarian and health aid to the DRC has had a huge impact. For example, the International Rescue Committee, a humanitarian organization, reduced its coverage from five to two zones in Ituri Province, where the outbreak originated. According to Ana Bodipo-Mbuyamba, former USAID Health Office Director for the DRC from 2018 to 2023, “When you dismantle those programs, you no longer have your frontline eyes and ears on the ground that can alert you. Not having that, you lose precious time, and then precious lives get lost because of that.”<sup>35</sup>

The US withdrawal from the WHO has also impacted the course of the Ebola outbreak. US officials dealing with Ebola have been barred from directly communicating with the WHO. The essence of global health emergencies is the sharing of data and information. US officials complain they have been hobbled by these unprecedented barriers, which have constrained their ability to properly respond to the outbreak. The inability to fill senior posts, and cutbacks of infectious disease staff, have also impeded efforts. Current vacancies include the director of the infectious disease agency, surgeon general, head of the Food and

Drug Administration, deputy health secretary and head of the US Centers for Disease Control and Prevention (CDC). As Jeremy Konyndyk, former head of the National Institute of Allergy and Infectious Diseases, has stated, “If there were multiple US government health partners seeing clusters of unexplained viral hemorrhagic fever, they would have been sending that up the chain. Except that they didn’t really have anyone to send it up the chain to anymore.”<sup>36</sup>

The CDC webpage on Ebola sums up the priorities of the Trump Administration embedded in the AFGHS: “To date, no cases of Ebola disease have been confirmed in the United States because of this outbreak.”<sup>37</sup> To help maintain this and to undoubtedly illustrate the “success” of its global health strategy, the United States has tried to keep all exposed Americans out of the country by sending them to Europe. On May 27, the US government announced the creation of a new facility at the Laikipia Air Base in Nanyuki, Kenya, for quarantining and treating Americans exposed to Ebola, although its creation has been held up by a court challenge.<sup>38</sup> In all outbreaks in the past, US citizens were given access to fully equipped facilities in US hospitals.<sup>39</sup> The US strategy, as measured by its impact on this current global health emergency, has been disappointing.

## ADDITIONAL REFLECTIONS ON THE AFGHS

There are other issues with the AFGHS. The heavy emphasis on bilateral relations and working with state health programs does not mean that the United States is abandoning its long-term neoliberal health agenda.<sup>40</sup> The document contains a section entitled “Utilize the Private Sector to the Maximum Extent Practical,” with a focus on privatizing health commodity procurement, distribution of health commodities, service delivery and health systems.<sup>41</sup>

The real aim of this approach becomes apparent in Pillar 3 of the AFGHS document, “Making America More Prosperous.” The emphasis is not on local private sectors within recipient countries, but rather on opening recipient countries to US corporations. This will be done by ensuring that health foreign assistance funds will be used “to procure supplies from U.S. companies, creating opportunity for those companies to grow their presence in emerging markets.”<sup>42</sup> They also require that they “heavily utilize American logistic companies to transport commodities internationally” and facilitate new partnerships that will “increase access to emerging markets for U.S. healthcare and pharmaceutical companies.”<sup>43</sup>

Centralizing country health data is required: “As part of each bilateral agreement, the United States will partner with recipient countries to develop a streamlined and robust performance monitoring system.”<sup>44</sup> This helps facilitate a key component of the AFGHS, that is, unfettered access to all health data, which is also found in every accessible bilateral agreement: “The U.S. government will also ensure long-term data sharing agreements are in place to provide the United States necessary data.”<sup>45</sup> The consequences of not providing the data are clearly spelled out: “Specific performance requirements will be negotiated with each country as part of its bilateral agreements. Performance on all these metrics will be required to trigger future year US health assistance funding.”<sup>46</sup> This is specified in all eight agreements accessed.<sup>47</sup>

## AFGHS AND BILATERAL AGREEMENTS: THE EXAMPLE OF NIGERIA

The United States hoped to have 71 bilateral health MOUs completed between December 2025 and March 2026, but only 33 had been signed as of July 23, partly due to resistance to the terms being demanded. The MOUs under the AFGHS are difficult to locate and only eight of the 24 signed African bilateral agreements (Cameroon, Ethiopia, Kenya, Liberia, Mozambique, Nigeria, Rwanda and Uganda) are available in the public domain.<sup>48</sup> The structure and focus of all agreements are similar. They are a clear reflection of the demands of the Trump administration, rather than the result of careful, long-term negotiations.<sup>49</sup> For example, all eight documents begin with a focus on surveillance and outbreak responses to potential pathogens that could affect the United States. Such pathogens represent a tiny portion of the sources of mortality in African countries, compared to the plethora of other infectious and chronic diseases in African countries that do not threaten the health of the United States.<sup>50</sup>

A review of one document provides insight into the degree of correspondence between the stated goals of the AFGHS and the MOUs. This paper examines the Nigerian agreement, as it has the most significant co-financing requirements and Nigeria has the largest population in Africa.

The accord was signed on December 19, 2025, covering the period from 2026 to 2030. The document, like many of the others, begins with broad health objectives, such as decreasing the maternal mortality rate by five percent per year. However, nowhere in the main document does it specify how these goals are to be achieved. The real focus begins on page 7 of the document, which repeats the promise of the AFGHS: Nigeria is to detect all disease outbreaks with epidemic potential within seven days (reaching a success level of greater than 95 percent within five years), with reports to the US government by the next day and a plan for effective interventions in consultation seven days later (reaching a success level of greater than 85 percent in five years).<sup>51</sup>

It should be noted that all sections on co-financing contain the following rider on US funding: “subject to the availability of funds.”<sup>52</sup> Nigeria has no recourse to curtailing its funding if the United States does not meet its spending obligations. However, the United States has put in place a punishing formula for reducing its co-financing if Nigeria does not provide sufficient funds. For example, Nigeria is expected to increase its base spending by roughly \$845 million in 2030, compared to \$720 million in 2029. The United States is expected to increase its spending over the same period from \$137 million to \$237 million. If Nigeria kept the same level in 2030 as in 2029, the United States would do the same; spending would be \$100 million less in 2030, matching the 2029 level. However, this is patently unfair, since it would mean that the United States would cut its planned level by 42 percent (100/237), whereas Nigeria would cut its levels by only 15 percent (125/845).<sup>53</sup>

Overall, Nigeria is expected to come up with 60 percent of the \$4.93 billion budget between 2026 and 2030, which is the second highest level of contribution among the 33 agreements and by far the largest sum in absolute dollars.<sup>54</sup> There is an additional dimension that creates an even more onerous burden on Nigeria. By banning the inclusion of funding in Nigeria’s share from outside sources, the US maximizes its leverage since it does not need to bargain with other parties.

Section 2.3 of the MOU deals with the commodity supply chain systems to provide goods and services and has an interesting clause not found in other accords. This clause reflects a Nigerian priority, that is, the aim to source 30 percent of commodities from local providers. However, it contains an important delimiting clause that Nigeria is “expected to cover any price differentials.”<sup>55</sup> The United States is to be tapped for commodities not produced in Nigeria or those that “do not meet quality and quantity standards.”<sup>56</sup> Without setting targets or programs, the US suppliers are simply “encouraged” to develop plans to enable local production of health-related commodities.<sup>57</sup>

Despite the addition of clauses not found in other agreements, it is almost certain that US healthcare manufacturers will be the main beneficiaries of this program, in line with the priorities set out in the AFGHS. This is made fairly explicit in the MOU, with the US government planning to “ensure availability of ARVs [antiretrovirals], HIV test kits, nutrition ... and malaria commodities” and to “provide newborn units, emergency obstetric equipment, health workforce enhancement technologies,” etc.<sup>58</sup> The provision of these products will be a boon to US manufacturers. Additional opportunities for US private health care companies will arise from US support for partnerships between an expanded National Health Insurance Authority and US companies, in areas such as data warehousing and insurance claims. All US-supported contractors, sub-contractors and suppliers are exempt from Nigerian taxes.<sup>59</sup>

The lengthy section on data systems reflects the prioritization of accessing data, as set out in the AFGHS. This category is the most heavily funded by the United States, which agrees to cover two-thirds of the nearly \$300 million total. The aim is to move toward a centralized digital medical records system, with the goal of reaching 100 percent participation by 2030. Heavy emphasis is on software systems that facilitate US monitoring.

The largest item of US support was the allocation of \$51 million to build a national health data warehouse to centralize the deposit of all this data. The MOU contains a clause on the negotiation of a five-year renewable agreement providing the US full data access, a key priority of the AFGHS.<sup>60</sup> With regard to “specimen sharing and data sharing arrangements,” it states that “failure to fulfill any commitments in these arrangements could result in changes in the planned assistance contemplated under this MOU and/or discontinuation of this MOU by the U.S. Government.”<sup>61</sup>

In sum, the Nigerian bilateral MOU closely aligns with the priorities of the AFGHS aimed at advancing US interests on multiple levels. These include expanding the market for US health companies, gaining unfettered access to citizens’ health data, and keeping epidemics away from the United States. Recipient countries such as Nigeria must absorb the large financial burdens and asymmetric risks associated with non-compliance.

A key focus of the AFGHS is accessing the digital health information of Africans and the citizens of other recipient countries.<sup>62</sup> This complements broader American attempts at “virtual jurisdiction” of the cloud, which is contested by laws asserting “territorial jurisdiction” over localized data. An example is the

European General Data Protection Regulation.<sup>63</sup> Other countries, including Canada, have done little to counter the US Cloud Act.<sup>64</sup> Few African countries have asserted “territorial sovereignty” over their data. Ghana passed the Data Protection Act in 2012, creating a Commission for Data Protection that has the capacity and authority to enforce the law. Replicating this can be challenging, given capacity and regulatory limitations in most African countries.<sup>65</sup> This is recognized with ongoing efforts to address technical issues at the regional level.<sup>66</sup> All of this points to the need for the creation of an international coalition of the willing, including Canada, to create alternative platforms that guarantee digital sovereignty for all participating countries while working with African governments (and others) to develop the services and manufacturing to build viable autonomous health care systems.

## CONCLUSIONS

For too long the health care of Africans has relied heavily on American financial support. Hints of potential vulnerability to the capricious winds of American politics have always been present, as seen in the Helms Amendment, the Global Gag Rule, and problematic policy conditionality associated with foreign aid, such as user fees in primary care.<sup>67</sup>

Recent massive cuts in health and humanitarian aid, and the shift from a mix of multilateral and bilateral health delivery to bilateral assistance only, are aimed at the instrumental exploitation of that vulnerability. The new health MOUs arising from the AFGHS reflect the US shift from soft to hard power. They undercut African digital sovereignty, including the control of health-related information.

Public health has no boundaries in the interconnected world of the 21st century. The sharing of health data is a vital element of creating strategies to deal with emerging health challenges; it should be the product of cooperation, not coercion. Yet health data also contains sensitive personal information that must be protected, and shared carefully, sparingly and with adequate degrees of anonymization. It should not be a bargaining chip for vital healthcare funding support.

Canada, which is also struggling to secure its own digital sovereignty, should work with international partners to provide alternatives for African countries aimed at generating local health care goods and services that can be produced by and for Africans. Those goods and services should include health information management systems that will guarantee autonomy from the coercive arm of the US government and its private sector partners, while at the same time respecting patient privacy and data sovereignty.

To quote Prime Minister Mark Carney: “When we only negotiate bilaterally with a hegemon, we negotiate from weakness. We accept what’s offered.”<sup>68</sup> The MOUs of the AFGHS are *prima facie* evidence of this. Perhaps it is time for a bit of “variable geometry”<sup>69</sup> to create a new coalition around the common values and interests associated with building African digital sovereignty, health sovereignty and sustainability.

## Author's Note

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## END NOTES

<sup>1</sup> US Department of State, *America First Global Health Strategy (AFGHS)*, September 2025, <https://www.state.gov/wp-content/uploads/2025/09/America-First-Global-Health-Strategy-Report.pdf>.

<sup>2</sup> Julia Pohle and Thorsten Thiel, “Digital Sovereignty,” *Internet Policy Review* 9, no. 4 (2020), <https://policyreview.info/concepts/digital-sovereignty>.

<sup>3</sup> The two countries command more than 90 percent of revenue and profits in the African markets. Tyler Venske, “Navigating Digital Sovereignty in Africa: A Review of Key Challenges and Constraints,” *The Africa Governance Papers* 1, no. 4 (October 2023), [https://www.africa-usforum.africa/wp-content/uploads/2024/07/1-TAGP-4\\_1\\_Research\\_Venske\\_US-China-techwar\\_FINAL.pdf](https://www.africa-usforum.africa/wp-content/uploads/2024/07/1-TAGP-4_1_Research_Venske_US-China-techwar_FINAL.pdf).

<sup>4</sup> Venske, “Navigating Digital Sovereignty in Africa.”

<sup>5</sup> Neal Kushwaha, Przemysław Roguski and Bruce W. Watson, “Up in the Air: Ensuring Government Data Sovereignty in the Cloud” in T. Jančárková, L. Lindström, M. Signoretti, I. Tolga and G. Visky (Eds.), *20/20 Vision: The Next Decade: 12th International Conference on Cyber Conflict* (May 26–29, 2020): 43–61.

<sup>6</sup> The White House, *Executive Order 14155—Withdrawing the United States from the World Health Organization*, January 2, 2025, <https://www.govinfo.gov/content/pkg/DCPD-202500122/pdf/DCPD-202500122.pdf>.

<sup>7</sup> BBC, “Coronavirus: Trump accuses WHO of Being a ‘Puppet of China’,” May 20, 2020, <https://www.bbc.com/news/health-52679329>.

<sup>8</sup> Warren Parke and Alan Whiteside, “HIV and the Volatile New World Order: From Declining Pandemic to One Crisis Among Many,” *Balsillie Papers* 7, no. 1 (2025), <https://uwspace.uwaterloo.ca/items/340d983b-045a-4fac-af9c-063f8c19f450>.

<sup>9</sup> Nelso Aghogho Evaborhene, “Protecting Global Health in the Era of the America First Strategy,” *The Lancet Global Health* 14, no. 4 (April 2026): E485–87.

<sup>10</sup> Thomas Pigott, “Continuing to Deliver on the America First Global Health Strategy with the Signing of the United States-Rwanda Bilateral Health Cooperation Memorandum of Understanding,” *The American Times*, December 5, 2025, <https://www.america-times.com/continuing-to-deliver-on-the-america-first-global-health-strategy-with-the-signing-of-the-united-states-rwanda-bilateral-health-cooperation-memorandum-of-understanding>; US Department of State, *Memorandum of Understanding Between the Government of the United States of America and the Government of the Republic of Rwanda on Health Cooperation*, December 5, 2025, <https://build.thinkglobalhealth.org/wp-content/uploads/2026/03/Rwanda-MOU.pdf>.

<sup>11</sup> Howard Stein, Samantha Cunningham and Pádraig Carmody, “The Rise of ‘Behavioral Man’: Randomized Controlled Trials and the ‘New’ Development Agenda,” *Human Geography* 14, no. 1 (2026): 62–75.

<sup>12</sup> The United States has always had self-interest embedded in its aid strategy, although it was not as blatant and extreme. In areas such as humanitarian aid, which has a strong health dimension, others have argued that the need of countries was the dominant motivation. (Rob Kevlihan, Karl DeRouen Jr and Glen Biglaiser, “Is US Humanitarian Aid Based Primarily on Need or Self-Interest?” *International Studies Quarterly* 58, no. 4 (2014): 839–85.)

<sup>13</sup> The author of this paper has been involved with graduate global health programs at the University of Michigan for more than two decades.

<sup>14</sup> Jeffrey Koplan, Christopher Bond, Michael Merson, Srinath Reddy et al., “Towards a Common Definition of Global Health,” *The Lancet* 373, no. 9679 (2009): 1993–95.

<sup>15</sup> Evaborhene, “Protecting Global Health in the Era of the America First Strategy.”

<sup>16</sup> US Department of State, *AFGHS*, 17.

<sup>17</sup> Ben McGregor, “U.S.-Zambia Critical Minerals Deal: What It Means for Mining Investors,” *Canadian Mining Report*, May 6, 2026, <https://www.canadianminingreport.com/blog/u-s-zambia-critical-minerals-deal-what-it-means-for-mining-investors>.

<sup>18</sup> Basillioh Rukanga, “Kenyan Court Suspends ‘Landmark’ US Health Aid Deal Over Data Privacy Concerns,” *BBC*, December 12, 2025, <https://www.bbc.com/news/articles/ce91degnelko>.

<sup>19</sup> Evaborhene, “Protecting Global Health in the Era of the America First Strategy.”

<sup>20</sup> US Department of State, *AFGHS*, 27.

<sup>21</sup> Evaborhene, “Protecting Global Health in the Era of the America First Strategy.”

<sup>22</sup> US Department of State, *AFGHS*, 16.

<sup>23</sup> US Department of State, *AFGHS*, 16.

<sup>24</sup> Lisa Schnirring, “China Releases Genetic Data on New Coronavirus, Now Deadly,” *CIDRAP News*, January 11, 2020, <https://www.cidrap.umn.edu/covid-19/china-releases-genetic-data-new-coronavirus-now-deadly>.

<sup>25</sup> US Department of State, *AFGHS*, 13.

<sup>26</sup> Di Caelers, “Month-long Detection Gap Complicates Ebola Containment in DRC,” *Nature Africa News*, May 19, 2026, <https://www.nature.com/articles/d44148-026-00130-y>.

<sup>27</sup> World Health Organization, “Ebola disease caused by Bundibugyo virus - Democratic Republic of the Congo B,” August 1, 2026, <https://www.who.int/emergencies/disease-outbreak-news/item/2026-DON614>; Daniel Khalili-Tari and Reuters, “Ebola outbreak in DR Congo could become worst in history, Africa CDC warns,” *Al Jazeera*, June 16, 2026, <https://www.aljazeera.com/news/2026/6/16/ebola-outbreak-in-dr-congo-could-become-worst-in-history-africa-cdc-warns>.

<sup>28</sup> Caelers, “Month-long Detection Gap Complicates Ebola Containment in DRC.”

<sup>29</sup> Jean B. Nachega et al., “Ebola Outbreak Caused by Bundibugyo Virus: Challenges and Priorities for Epidemic Preparedness and Response,” *The Lancet* 407, no. 10547 (June 20, 2026): 2474–78.

<sup>30</sup> Alex Mirugwe, “The Cost of Blind Spots: How the 2025 USAID Closure Weakened Global Outbreak Detection,” Makerere University School of Public Health, Kampala, Uganda, May 26, 2026, <https://medium.com/@mirugwejalex/the-cost-of-blind-spots-how-the-2025-usaid-closure-weakened-global-outbreak-detection-d4efae6352a2>.

<sup>31</sup> US support for international health fell by 33 percent in 2025. Aid to sub-Saharan Africa fell by 47 percent in 2025. (US Department of State, “US Foreign Assistance” <https://foreignassistance.gov>.) One model estimates that US cuts have led to the deaths of 781,000 people, including more than 500,000 children (many in sub-Saharan Africa) that would have been prevented if expenditures and programs were maintained. (Impact Counter, “Death Toll One Year after USAID Cuts,” 2026, <https://www.impactcounter.com/dashboard?view=table&sort=title&order=asc>.) There is little evidence that other countries are picking up the slack and even seem to be following a similar pattern. Worldwide, financing for global health fell by 21 percent in 2025. (Anya Hirschfeld, Allison Krugman, Thomas Bollyky, Stephanie Psaki and Joseph L. Dieleman, “Tracking the ‘America First’ Bilateral Health Agreements,” July 23, 2026, <https://www.thinkglobalhealth.org/article/tracking-the-america-first-bilateral-health-agreements>.)

<sup>32</sup> Lauren Kent and Jenifer Hansler, “US Funding Cuts Have Hampered Response to the Deadly Ebola Crisis, Aid Workers Say,” *CNN*, May 26, 2026, <https://www.cnn.com/2026/05/22/africa/ebola-us-aid-cuts-drc-uganda-intl>.

<sup>33</sup> As stated in the introductory letter to the AFGHS by Secretary of State Marco Rubio: “our foreign assistance programs are deeply broken” and have created NGOs with “perverse incentives to self-perpetuate.” There is little doubt there is some truth to NGO inefficiencies. A better approach would have been to come up with strategies to improve their operation, not to halt all funding with the consequences we describe. There are examples of alternative management strategies. See, for example, André A. de Waal and Diana Adongo Olale, “Analyzing the Effectiveness of a Kenyan NGO with the HPO Framework,” *Global Business and Organizational Excellence* 38, no. 2 (2019): 31–42.

<sup>34</sup> The closure of NGOs in the DRC had a high impact in part due to the challenging situation, compared to Uganda where detection and tracking is much easier. (Nachega et al., “Ebola Outbreak Caused by Bundibugyo Virus.”)

<sup>35</sup> Jonathan Lambert, “U.S. Aid Cuts May Have Delayed Detecting this Ebola Outbreak,” *NPR*, May 21, 2026, <https://www.npr.org/2026/05/21/nx-s1-5828951/aid-cuts-may-have-contributed-to-delay-in-identifying-current-ebola-outbreak>.

<sup>36</sup> Sarah Oweremohle, “Trump Admin Shutting Key US Researchers Out of Global Virus Response Talks, Documents and Sources Reveal,” *CNN*, May 26, 2026, <https://www.cnn.com/2026/05/25/politics/global-virus-response-trump-administration>.

<sup>37</sup> US CDC, “Ebola Outbreak: Current Situation,” June 26, 2026, <https://www.cdc.gov/ebola/situation-summary/index.html>.

<sup>38</sup> Nanyuki is a problematic location. It is a prime agricultural town and tourist gateway to Mt. Kenya National Park. The Katiba Institute, a constitutional law organization, filed suit to challenge the arrangement because it was considered “constitutional recklessness.” Hearings are being held. The approach is another example of the asymmetries of power embedded in bilateralism. The United States has promised \$13.5 million in return and can be as using financial leverage on a country under economic strain. Washington is clearly attempting to transfer a biological risk to a less powerful country. (Jane Munga, “The Bigger Problem with the U.S.-Kenya Ebola Deal,” Carnegie Endowment for International Peace, June 16, 2026, <https://carnegieendowment.org/emissary/2026/06/kenya-us-ebola-facility-deal-foreign-policy-china>.)

<sup>39</sup> Under the new policy, the United States now requires a three-week quarantine for all US citizens from an Ebola area in a third country. In mid-July 2026, seven US aid workers were sent to the new Kenyan facility, despite the ongoing court case. (Reuters, “Seven Americans Quarantining at Kenya Ebola Facility After US Travel Ban, Says Aid Group,” *The Guardian*, July 17, 2026, <https://www.theguardian.com/us-news/2026/jul/17/ebola-us-aid-workers-kenya>.)

<sup>40</sup> Rebecca Ridell, “Why is the U.S. Trying to Export its Flawed Health-care Policies Around the World?” *The Washington Post*, January 1, 2026, <https://www.washingtonpost.com/opinions/2022/01/10/usaid-private-health-systems-kenya>.

<sup>41</sup> US Department of State, *AFGHS*, 25.

<sup>42</sup> US Department of State, *AFGHS*, 32.

<sup>43</sup> US Department of State, *AFGHS*, 33.

<sup>44</sup> US Department of State, *AFGHS*, 22.

<sup>45</sup> US Department of State, *AFGHS*, 22.

<sup>46</sup> US Department of State, *AFGHS*, 22.

<sup>47</sup> There was also no evaluation of the challenges in obtaining the data for monitoring compliance. This could be an advantage to the United States, since it could be used selectively to curtail assistance when politically expedient.

<sup>48</sup> Hirschfeld, Krugman, Bollyky, Psaki and Dieleman, “Tracking the ‘America First’ Bilateral Health Agreements.”

<sup>49</sup> Anonymous conversation between the author and a US official involved in the negotiations.

<sup>50</sup> Between 2000 and 2021, African mortality from chronic diseases such as high blood pressure, diabetes and heart disease doubled to 20 percent. No zoonotic hemorrhagic diseases appear in the top 20 sources of mortality in either time period. The only zoonotic disease appearing in both lists was HIV, which declined from 13.6 percent to only 4.6 percent, largely due to generous US support. (“WHO, Global Health Estimates: Leading Causes of Death: Africa Region,” <https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates/ghe-leading-causes-of-death>.) The decline in HIV as a source of mortality is under threat due to US cuts to the President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund. (Charles Kenny, “Millions Lost Access to PEPFAR-Supported HIV Drugs During the US Foreign Assistance Pause,” Center for Global Development, February 24, 2026, <https://www.cgdev.org/blog/millions-lost-access-pepfar-supported-hiv-drugs-during-us-foreign-assistance-pause>; Elise Lankiewicz, “Measuring PEPFAR Disruptions at Scale: Results from a 46-country Implementing Partner Survey,” Paper Presented at AIDS 2026 conference, Rio de Janeiro, Brazil, July 26–31, 2026). Not everyone is so pessimistic. Some authors see the cuts as an opportunity to improve efficiency, reduce reliance on donors and better embed HIV programs into domestic health systems. (Evelyn Foster-Pagaebi, Bartholomew Ndulue, Johnson E Awe., Olanrewaju Bonyo et al., “Declining Donor Funding for HIV Programmes in Sub-Saharan Africa: Implications for HIV Incidence, Mortality, and Domestic Financing,” *Journal of Life Science and Public Health* 2, no. 1, 2016, <https://journals.stecab.com/index.php/jlsph/article/view/1944/898>.)

<sup>51</sup> The MOU (Section 2.2) provides detail on how this is to be accomplished. Implementation includes the funding of an assessment of the existing system, the commitment to fill existing gaps, large-scale US technical support, the provision of technical and financial support for response commodities such as personal protective equipment, and the commitment to Nigeria to provide salaries to hundreds of field epidemiologists and a specimen agreement with the United States for five years, renewable for another five. Along with the surveillance and outbreak response system was the creation of a dozen national specialized labs with capabilities to characterize pathogens, 23 regional labs and 1,500 clinical and public health labs for activities such as screening. Nearly 15 percent of total spending in the MOU (\$660 million) was to deal with this US high priority, in which Nigeria was expected to cover nearly two-thirds of the cost. (US Department of State, *Memorandum of Understanding Between the Government of the United States of America and the Government of the Federal Republic of Nigeria on Health Cooperation*, December 19, 2025, 7, <https://build.thinkglobalhealth.org/wp-content/uploads/2026/03/2026-0009QN-Nigeria-Health-12.19.2025.pdf>.)

<sup>52</sup> US Department of State, *MOU between USA and Nigeria on Health Cooperation*, 9.

<sup>53</sup> US Department of State, *MOU between USA and Nigeria on Health Cooperation*, 28–29.

<sup>54</sup> There is a fundamental disconnect between the financial promises in this document and plans for Nigerian expansion in other government documents, which *ipso facto* creates questions about the operational significance of the MOU. Nigeria plans to increase its health spending as a proportion of its national budget only marginally, from five percent as proposed in its 2025 budget to only six percent from 2026 to 2030. (Hirschfeld, Krugman, Bollyky, Psaki and Dieleman, “Tracking the ‘America First’ Bilateral Health Agreements.”) This is highly unlikely. In 2025, the Nigerian government spent only \$1.7 billion on the health sector, which was a decline from \$2.02 billion in 2024. In 2026, it was expected to come up with \$345,000, rising to \$845,000 in 2030. Even if it managed to keep the same budget in real terms, the proportion allocated to the MOU projects would need to rise from 20 to 50 percent of the total. What would happen to other health care needs that were covered by 30 percent of the budget in 2026? There is no analysis of this consequence. (Development Research and Project Centre of Nigeria, “Understanding the Nigeria 2025 Proposed Budget: The Healthcare Sector in Focus, <https://drpcngr.org/wp-content/uploads/2025/01/Understanding-the-Nigeria-2025-Proposed-Health-Budget-.pdf>.)

<sup>55</sup> US Department of State, *MOU between USA and Nigeria on Health Cooperation*, 13.

<sup>56</sup> US Department of State, *MOU between USA and Nigeria on Health Cooperation*, 13.

<sup>57</sup> US Department of State, *MOU between USA and Nigeria on Health Cooperation*, 14.

<sup>58</sup> US Department of State, *MOU between USA and Nigeria on Health Cooperation*, 22.

<sup>59</sup> US Department of State, *MOU between USA and Nigeria on Health Cooperation*, 25.

<sup>60</sup> This seems to be a common feature of the other MOUs. For example, Cameroon’s agreement states: “The United States and the Government of Cameroon intend to negotiate a data sharing arrangement for the purpose of exchanging data... Both Participants expect this data sharing arrangement to continue for ten (10) years, renewable by mutual agreement every five (5) years thereafter.” They are encouraged to use software by American companies such as ScanForm, which is an AI health care recording system and a potential challenge to digital sovereignty. (US Department of State, *Memorandum of Understanding Between the Government of the United States of America and the Government of the Republic Cameroon on Health Cooperation*, December 16, 2025, 4, [https://build.thinkglobalhealth.org/wp-content/uploads/2026/04/Cameroon\\_MOU.pdf](https://build.thinkglobalhealth.org/wp-content/uploads/2026/04/Cameroon_MOU.pdf).)

<sup>61</sup> US Department of State, *MOU between USA and Nigeria on Health Cooperation*, 27.

<sup>62</sup> The interest in accessing the personal health data of Africans can be seen as part of a larger American project being undertaken by the giant corporation Palantir in cooperation with the Trump Administration. Palantir is a software company that compiles data and uses AI algorithms to pinpoint patterns in a variety of sectors, including military, immigration and health care. In March 2025, Trump generated an executive order facilitating sharing of data between government agencies. The Trump Administration has signed agreements with Palantir to introduce its software, Foundry, into multiple agencies, including Homeland Security, with the aim of centralizing information on US residents and helping track down illegal immigrants for US Immigration and Customs Enforcement (ICE) as part of the development of the technocratic surveillance state. Its healthcare software is used in hospitals in 46 states and multiple countries overseas. Palantir is not just a run-of-the-mill software company. It is owned by right-wing billionaire Peter Thiel, who funded J.D. Vance, and by his close associate Alex Karp, whom *Time* magazine characterized as “an unashamed techno-nationalist who evangelizes Western power.” Palantir also works closely with the CDC on disease outbreaks, mines data to assess market opportunities for health companies and is actively involved with health risk scores because “it is imperative” that people “are appropriately classified and scored to prevent untenable financial risk” to maximize private health care profits. (Palantir, “CDC and Palantir Partner to Deliver ‘Common Operating Picture’ to Advance Public Health Preparedness,” December 7, 2022, <https://investors.palantir.com/news-details/2022/CDC-and-Palantir-Partner-to-Deliver-Common-Operating-Picture-to-Advance-Public-Health-Preparedness>; American Friends Service Committee, “Palantir in Healthcare — Factsheet, June 2026, [https://afsc.org/sites/default/files/2026-06/palantir-in-healthcare\\_final\\_0.pdf](https://afsc.org/sites/default/files/2026-06/palantir-in-healthcare_final_0.pdf); Sheera Frankel and Asron Krolik, “Trump Taps Palantir to Compile Data on Americans,” *The New*

*York Times*, May 30, 2026; Rachel Rowe, “How Risk Scores Encode Financial Logics in Health,” *Economy and Society* 55, no. 1, 144–65; Nikhal Kumar, “The 100 Most Influential People of 2025: Alex Karp,” *Time*, April 16, 2025, <https://time.com/collections/100-most-influential-people-2025/7273812/alex-karp>.)

<sup>63</sup> Syed Ahmed, “Jurisdictional Challenges in Cloud Computing: Data Sovereignty and International Agreements,” *TILS Law Review* III, no. 2, 2025.

<sup>64</sup> Barry Appleton, “Whose Law Governs Canadian Data? The CLOUD Act, Executive Agreements and Digital Sovereignty,” Special Report, BSIA, March 11, 2026, <https://balsilliepapers.ca/canadian-data>.

<sup>65</sup> Godswill Owoche Antai, Shishitileugiang Aniashe Akpanke, Alex Olajide and Victory Omali Obule, “Digital Trade and Data Sovereignty: Comparative Legal Frameworks in the EU, US, Africa and China,” *International Journal of Economics and Business Management* 2, no.1 (2025): 1–18, [https://ijebm.kiu.ac.ug/assets/articles/1768803300\\_digital-trade-and-data-sovereignty-comparative-legal-frameworks-in-the-eu-us-africa-and-china.pdf](https://ijebm.kiu.ac.ug/assets/articles/1768803300_digital-trade-and-data-sovereignty-comparative-legal-frameworks-in-the-eu-us-africa-and-china.pdf).

<sup>66</sup> The East African Community has been moving in that direction, with cooperative frameworks to build local AI capacity. (Akim Benamara, “East African Community Unveils Regional Framework to Accelerate Artificial Intelligence Development,” *Tech Africa News*, May 6, 2026, <https://techafricanews.com/2026/05/06/east-african-community-unveils-regional-framework-to-accelerate-artificial-intelligence-development>.)

<sup>67</sup> The Helms Amendment, passed in 1973, bans the use of US aid to fund abortions. The Global Gag Rule, pushed by Republican administrations since President Ronald Reagan enacted it in 1984, prohibits US-funded NGOs from promoting or discussing abortion, even if other funds are used.

<sup>68</sup> World Economic Forum, “Davos 2026: Special address by Mark Carney, Prime Minister of Canada,” January 20, 2026, <https://www.weforum.org/stories/2026/01/davos-2026-special-address-by-mark-carney-prime-minister-of-canada>.

<sup>69</sup> World Economic Forum, “Davos 2026: Special address by Mark Carney.”



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