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Beyond the Headlines: Reclaiming health equity and sovereignty from the America First Health Deals

1. Background

Between September 2025 and April 2026, the Government of the United States, acting through the State Department under Secretary Marco Rubio, rolled out the America First Global Health Strategy (AFGHS) which is a coordinated programme of five-year bilateral Memoranda of Understanding (MoUs) that has reshaped the architecture of US health cooperation with the African continent. As of late April 2026, the State Department reported 31 MoUs signed globally, worth USD 20.6 billion of which USD 12.8 billion is US assistance and USD 7.8 billion is country co-investment¹. The majority of these agreements are with African states, with at least nineteen confirmed signatories from the continent². The AFGHS are noted to provide funds for health commodity purchases, health care workers, extension of health insurance and outbreak responses for African countries³. The absence of detail on what each provide, however, is a consequence of the individual MoUs not being in public domain, a lack of transparency that violates rights to informed participation in health.

The headline financial figures conceal a structural concern. An independent analysis by the Center for Global Development calculates that, relative to United States Financial Year 2024 health obligations, the AFGHS bilateral framework represents an average 49 % annual decrease in US financial support to signatory states, with country-level cuts reaching 69% in Rwanda, 61% in Madagascar, 42% in Liberia and 34% in Eswatini⁴. The MoUs simultaneously embed obligations that extend far beyond their financial duration, including data-sharing arrangements with up to ten years of post-termination access, transfer of biological specimens and genetic sequence data within five (5) days of detection of pathogens with epidemic potential, twenty-five-year (25) horizons on specimen-sharing obligations under the model Specimen-Sharing Agreement, US audit rights over national health facilities and financial systems and clauses requiring recognition of US Food and Drug Administration approvals by national medicines regulators^{5,6,7}.

¹Press Release, Office of the Spokesperson. Washington, DC: US Department of State, 21 April 2026 - <https://www.state.gov/releases/office-of-the-spokesperson/2026/04/trump-administrations-america-first-global-health-strategy-fights-infectious-diseases-through-bilateral-health-memorandum-of-understanding-with-bolivia>

²Press Release, Office of the Spokesperson. Washington, DC: US Department of State, 22 December 2025 - <https://www.state.gov/releases/office-of-the-spokesperson/2025/12/delivering-on-president-trumps-commitment-america-first-global-health-strategy-and-bilateral-health-mous>

³Okoiti v Prime Cabinet Secretary & Cabinet Secretary for Foreign and Diaspora Affairs & 3 others; Katiba Institute (Interested Party); Kenya Medical Practitioners, Pharmacists and Dentists Union & 6 others (Intended Interested Party) (Constitutional Petition E816 of 2025) [2026] KEHC 1271 (KLR) (Constitutional and Human Rights) (12 February 2026) (Ruling) <https://www.kenyalaw.org/ken/ke/judgment/kehc/2026/1271/eng@2026-02-12>

⁴Estes, J. and Madan Keller, J. (2025). *What We Know—and Don't Know—About the Trump Administration's Global Health Agreements*. Blog Post. Washington, DC: Center for Global Development, 18 December 2025 - <https://www.cgdev.org/blog/what-we-know-and-dont-know-about-trump-administrations-global-health-agreements>

⁵Letter to African Heads of State and Government: Urgent Need to Protect Sovereignty by Demanding Fair Terms in Health Agreements with the U.S. Government. Open Letter, 10 December 2025. Washington, DC: Public Citizen - <https://www.citizen.org/article/letter-african-and-global-civil-society-call-on-to-african-heads-of-state-and-government-to-demand-fair-terms-in-u-s-health-agreements/>

⁶Health Policy Watch (2025). *Exclusive: US Ties Global Health Aid to Data Sharing on Pathogens – Undermining WHO Talks*. Health Policy Watch, 7 November 2025 - <https://healthpolicy-watch.news/exclusive-us-ties-new-health-funding-to-pathogen-sharing-disrupting-who-talks/>

⁷Munga, J. and Mosero, R. (2026). *Kenya's Health Deal Is a Stress Test for the America First Global Health Strategy*. Washington, DC: Carnegie Endowment for International Peace, 30 March 2026 - <https://carnegeieendowment.org/russia-eurasia/research/2026/03/kenya-data-protection-america-first-global-health-strategy>

The fact that the AFGHS explicitly notes that the region has amongst the world's largest reserves of globally-demanded critical minerals used in a range of energy, military, information technologies and of biodiversity suggests why the region is being singled out, with no other global region similarly targeted⁸.

Notably, the MoUs are being applied in a region that faces significant challenges in meeting debt, fiscal demands and the globally agreed health-related goals set in the Sustainable Development Goals, exacerbated by the cliff-edge withdrawal of USAID funding in 2024/5. The East and Southern African (ESA) region carries both the heaviest historical US health investment (through PEPFAR, the President's Malaria Initiative, and USAID Maternal and Child Health programmes) and subsequent to the withdrawal of USAID funding, the biggest exposure to AFGHS terms. Within the East African Community, Kenya (with MoU signed 4 December 2025, for a USD 1.6 billion US contribution against an estimated USD 850 million co-investment) and Uganda (MoU signed 10 December 2025, for USD 1.7 billion against USD 500 million co-investment) led the regional rollout. They were followed by Rwanda (USD 228 million), Burundi, and the Democratic Republic of Congo (USD 1.2 billion, signed 26 February 2026 only after a separate US–DRC strategic minerals agreement)⁹. Within the Southern African Development Community (SADC), the bilaterals were signed by Botswana (USD 487 million), Mozambique (up to USD 1.8 billion), Lesotho (USD 364 million), Eswatini (USD 242 million), Madagascar (USD 175 million), Malawi (USD 936 million) and Angola (USD 121 million)¹⁰.

Critically, the region is also the principal site of documented African resistance to the AFGHS template. In Kenya the High Court suspended implementation of the data-transfer provisions of the Kenya–US Strategic Health Cooperation Framework by way of a conservatory order issued on 11 December 2025, seven days after signature. A petition dated 8 December 2025 alleges that the AFGHS was executed unilaterally by the Executive, without the requisite parliamentary approval, an inclusive public consultation or transparent fiscal impact assessment and/or without due consideration for data protection. It is thus alleged to be arbitrary and unconstitutional in contravening constitutional principles and applicable statutes¹¹.

In Zimbabwe on 23 December 2025, by Presidential directive, the Government of Zimbabwe was reported to have formally discontinued negotiations on a USD 367 million bilateral MoU. A public statement, reported on 25 February 2026 framed the refusal in explicit pan-African terms, highlighting that the agreement was as asymmetrical and tying the decision to the protection of African solidarity in multilateral fora, particularly the World Health Organization Pathogen Access and Benefit-Sharing (WHO PABS) process, where the Zimbabwean Permanent Representative serves as African Group Coordinator for Health Matters speaking on behalf of fifty (50) African Member States¹².

In Zambia on 4 May 2026, the Minister of Foreign Affairs, publicly confirmed that negotiations had stalled because the US side had tied the conclusion of a USD 2 billion health package to a critical-minerals agreement that sought to grant preferential US access to Zambian copper, cobalt and lithium.

⁸ Africa Centre for Strategic Studies. *Africa's critical minerals at a Critical Juncture, Spotlight*. 2025; Accessed November 19, 2025
<https://africacenter.org/spotlight/africas-critical-minerals-at-a-critical-juncture/>

⁹ Press Release, 27 February 2026. Washington, DC: US Department of State - <https://www.state.gov/releases/office-of-the-spokesperson/2026/02/fostering-health-sovereignty-in-the-democratic-republic-of-the-congo-through-the-america-first-global-health-strategy>

¹⁰ *Advancing the America First Global Health Strategy Through Landmark Bilateral Global Health MOUs with Botswana, Madagascar, Sierra Leone, and Ethiopia* - <https://www.state.gov/releases/office-of-the-spokesperson/2025/12/advancing-the-america-first-global-health-strategy-through-landmark-bilateral-global-health-mous>

¹¹ *Okoti v Prime Cabinet Secretary & Cabinet Secretary for Foreign and Diaspora Affairs et al*, 2026 *ibid*

¹² Xinhua (2026). *Zimbabwe Stops Negotiations with U.S. on Health Funding Deal*, 26 February 2026 - <https://english.news.cn/africa/20260226/2ae12092eff94423a8b10a8f4f78f9c/c.html>



Zambian Minister Haimbe’s statement is the clearest articulation of a delinking principle made by an African government: ‘the agreements must be considered separately on their respective merits’¹³.

Indeed, the name ‘America first’ reflects the intention to use the MoUs and the leverage of funds for health to promote American political economy interests in the ESA region, to counter other global actors, specifically noting China, and, as will be described later, without giving jurisdiction to African courts over its terms, or any disputes arising. While the MoUs explicitly state ‘America first’, they also implicitly convey an erosion of African health sovereignty.¹⁴

Resistance is also visible outside the ESA region. In April 2026, the Government of Ghana through the Data Protection Commission allowed the deadline on a USD 109 million MoU to lapse, citing ‘unprecedented access to national health records, metadata and backend dash-boards’. President John Dramani Mahama used the moment to consolidate the ‘Accra Reset’ framing of an African alternative¹⁵. In contrast, Nigeria signed a USD 5.1 billion MoU on 19 December 2025 with a USD 200 million carve-out for Christian faith-based facilities providing a comparative West African example illustrating how AFGHS terms are politicised along different lines¹⁶.

2. The interlocking problems to address

The AFGHS rollout, taken together with the regional resistance it has already provoked, presents six interlocking problems for Eastern and Southern Africa. These problems, detailed below, motivate a call for regional engagement, supported by legal and policy analysis, to make these problems visible in the public sphere and to engage diplomacy and collective action to protect health equity, health sovereignty and Africa’s rightful benefit from its own health, genetic, and data resources.

2.1 Undermining of African jurisdiction on public health.

The Kenyan High Court’s Conservatory order on 11 December 2025 demonstrates that the concerns with the AFGHS are not theoretical, but live constitutional questions. The substantive hearing on 25 May 2026 may set a doctrinal template applicable across the region. There is no evidence of any health impact assessment having been done of the MoU by public authorities or of the findings having been publicly reviewed prior to signing. This negates public health and democratic duties for inclusive public consultation and parliamentary approval, based on transparent fiscal and public health impact assessment.

The requirement in Section 2.1.2 of the published Kenya text that the Kenyan medicines regulator recognise US FDA approvals by 31 December 2026 displaces the regulatory autonomy that the African Medicines Agency was established to consolidate. The AMA Treaty (2019) expressly confers that continental harmonisation mandate. A bilateral MoU requiring national regulators to defer to US FDA approvals without reference to the AMA framework is in direct tension with a binding treaty obligation and erodes the continental regulatory sovereignty architecture the AMA was designed to consolidate. This legal conflict between bilateral AFGHS obligations and the AMA Treaty deserves explicit treatment in any constitutional and legal analyses of the MoUs.

¹³Statement by Hon. Mulambo Haimbe, SC, MP, Minister of Foreign Affairs and International Cooperation of the Republic of Zambia, 4 May 2026.

¹⁴AO Sule (2026) *America First, Africa last: Data extraction from Africa’s bodies and the erosion of health sovereignty*, *Pambazuka news*, 22 January 2026

¹⁵Cullinan, K. (2026). *Ghana Rebuffs US Health Deal – But South Africa and Zambia Struggle Without Aid*. *Health Policy Watch*, 29 April 2026 - <https://healthpolicy-watch.news/ghana-rebuffs-us-health-deal-but-south-africa-and-zambia-struggle-without-aid/>



The MoUs limit the application of the precautionary principle to include measures to protect public health where future impacts are uncertain. They further undermine African jurisdiction in a range of aspects:

1. The MoU requires African states to apply the USA Food and Drug Administration (FDA) approvals and USA emergency use authorizations as the basis for authorizing corresponding health products. Not only does this deny African country public health and medicine control regulatory authorities, it subjects African countries to processes on medicines and health technologies to regulatory failures and company influence of the FDA, evident in past examples of the export of HIV contaminated blood products to Latin America and Asia, and approval of oxytocin despite early warnings of addictive features. It also poses a risk of US blocks to African emergency use authorizations such as in pandemics, given US commercial interests.
2. It sets a number of African country liabilities on time bound information, audit, notifications and digital systems noted in the subsequent sections where any dispute with or defaults by African countries are subject to US jurisdiction, without any reciprocal liabilities from the USA or their resolution under African law.
3. It includes no recognition of constitutional/legal provisions or regional or international standards and conventions African countries have duties to comply with, including those of the World Health Organisation (such as the International Health Regulations), and those of AU, SADC, EAC, and COMESA. The USA withdrawal from the WHO and other UN bodies makes resolution of any legal conflicts problematic through international dispute mechanisms, given that for African countries these obligations and commitments are binding in international and domestic law.

In the Kenya constitutional challenge, the government argued that the MoU itself stipulates that it is a non-binding arrangement between the participants and does not create legal obligations under international law. Notwithstanding this claim, the courts sustained the petition on grounds that the court must prioritize protection of *the Constitution* since there can be not greater public interest than to demand compliance with *the Constitution*¹⁷. The outcome of this case will be instructive for all countries that have signed or are resisting signing the MoU, for the USA and for regional and international law. Should the non-binding nature of the MoU as asserted by the Kenya Government be upheld by the courts, this has implications for national, regional and international law having precedence over *all* the MoUs signed. Should a breach of constitutional procedure and standards be upheld, this equally has implications for countries examining the MoU against their constitutional provisions. Both outcomes suggest a precedent for further legal and public scrutiny of the MoUs before they can be applied in the ESA region.

2.2 Bilateral fragmentation of an African continental position

By design, AFGHS engages each African state individually, on US-defined terms, in parallel time-windows that prevent regional coordination. Of the nineteen confirmed African MoUs signed, few have been made public. This means that the majority of African parliaments and publics have not been given sight of what their executives have signed in their names. This fragmentation directly undermines transparency and African unity in diplomacy, as, for example, raised in the African Group's collective position at the WHO IGWG on the Pathogen Access and Benefit-Sharing (PABS) Annex, where approximately one hundred (100) low- and middle-income countries continue to insist on mandatory benefit-sharing as the price of rapid pathogen-data sharing. Each bilateral signature of the AFGHS weakens that collective leverage. Each government that signs a bilateral MOU embedding unilateral five-day pathogen-transfer obligations is, in effect, pre-empting the WHO IGWG outcome that the African Group is collectively negotiating.

¹⁷ *Okoiti v Prime Cabinet Secretary & Cabinet Secretary for Foreign and Diaspora Affairs et al* [2026] KEHC 1271 (KLR), *op. cit.* (fn3).

Neither AU, SADC, nor EAC have issued a formal institutional position on the AFGHS. A May 2026 AU-UN joint communiqué, however, reaffirmed commitment to "health sovereignty" without naming the strategy, and a SADC Foreign Ministers retreat that same month committed to coordinated regional responses to geopolitical shifts.¹⁸

This silence is not solely a political gap. Under Article 3(h) of the AU Constitutive Act, the AU is obliged to promote and protect human and peoples' rights in accordance with the African Charter. The failure of AU institutions to formally respond to an agreement that implicates the right to health of fifty-four member states invites civil society to press the AU Commission directly for a formal institutional position, framed in the language of the AU's own constitutional obligations.

2.3 Asymmetric data and pathogen extraction.

A leaked model Specimen-Sharing Agreement provides under its Article 5 for obligations that 'shall remain in force for [twenty-five (25)] years', while the financial window is five (5) years and the post-termination data-access tail is up to ten (10) years. Pathogens and Digital Sequence Information (DSI) must be transferred within five (5) days of detection and receiving the request from the USA. The United States is permitted to share these specimens with up to ten (10) non-US-Government entities that is, with private pharmaceutical and biotechnology firms without reciprocal benefit-sharing or DSI traceability.

This means that biological samples and genomic data drawn from ESA populations may be commercialised by entities whose corporate ownership is now opaque. African states stand to forfeit the revenue contributions that would otherwise flow to them from this through the CBD Cali Fund mechanism.¹⁹ The risks of unspecified/unregulated business use of such pathogen specimens are not noted in the agreement, nor how they will be addressed. For example, there is reported to be no statement of exclusion of use of such pathogens for biological weapons, or of an exclusion of use of genetic material for ethnic specific screening for work, migration and other discriminatory purposes²⁰.

2.4 Erosion of national data sovereignty.

The digital health systems, surveillance infrastructures, genomic intelligence, and cross-border data-sharing embedded in these agreements constitute an emerging "digital colonialism." They exchange African health and population data as strategic assets for health financing, while undermining local ownership, governance capacity, and public benefit.²¹ AFGHS data-sharing provisions are difficult to reconcile with the data-protection statutes of every major ESA jurisdiction, viz: Kenya's Data Protection Act 2019 and Digital Health Act 2023; Uganda's Data Protection and Privacy Act No. 9 of 2019; South Africa's POPIA 2013; Zambia's Data Protection Act 2021; and Tanzania's Personal Data Protection Act 2022²².

¹⁸ i. African Union Commission and United Nations (2026). *Joint Communiqué of the Tenth African Union–United Nations Annual Conference*. Addis Ababa: ii. African Union Commission / United Nations, 13 May 2026 - <https://au.int/en/pressreleases/20260513/joint-communiqué-tenth-african-union-united-nations-annual-conference> iii. Southern African Development Community (2026). *SADC Ministers of Foreign Affairs Retreat, Skukuzza – Outcome Statement*. Issued 24 May 2026. Skukuzza, Kruger National Park, South Africa: SADC Secretariat - <https://www.sadc.int/latest-news/sadc-ministers-foreign-affairs-retreat-skukuzza-outcome-statement>

¹⁹ *Convention on Biological Diversity* (2011) CBD Secretariat. [Adopted 29 October 2010 at COP-10, Nagoya, Japan; entered into force 12 October 2014.] <https://www.cbd.int/abs/default.shtml>

²⁰ AO Sule (2026) *ibid*

²¹ Sekalala, S. and Chatikobo, T. (2024). *Colonialism in the New Digital Health Agenda*. *BMJ Global Health*, 9(2), e014131 - <https://gh.bmj.com/content/9/2/e014131>

²² i) Republic of Kenya — *Data Protection Act No. 24 2019* - www.kentrade.go.ke/wp-content/uploads/2022/09/Data-Protection-Act-1.pdf, *Digital Health Act No. 15 2023* - <https://nhts.dha.go.ke/api/file-download/?filename=Digital%20Health%20Act%2015%20of%202023.pdf>

ii) Republic of Uganda — *Data Protection and Privacy Act of 2019* - <https://ict.go.ug/site/documents/Data-Protection-and-Privacy-Act-2019.pdf>

iii) Republic of South Africa — *Protection of Personal Information Act (POPIA) 2013* -

www.gov.za/sites/default/files/gcis_document/201409/3706726-11act4of2013protectionofpersonalinforcorrect.pdf iv) Republic of Zambia — *Data*

The MoU is reported to include use of US digital and Artificial intelligence (AI) systems provided by US businesses, and to facilitate commercial use of the data obtained for US interests. The data covered includes what is obtained from the audit of health facilities, genetic sequencing, pathogen surveillance and biobanking, with notification of outbreaks to the USA within one day of their occurrence. In each ESA jurisdiction listed, this incompatibility with domestic data-protection law means that aggrieved persons and civil society organisations may lodge complaints with the national data protection authority and, where constitutional provisions protect privacy and data rights, bring constitutional petitions challenging MoU implementation.

The MoUs make no reference to relevant domestic and international reporting duties and standards. They are reported to exclude any information flow back to African countries from the USA, including notification of outbreaks in the USA that may affect African populations, nor accounting for how African data is used. Beyond the constitutional duties of African states to generate, use, and report health data for equitable and effective public health, health data is a growing economic resource for the development of new technologies, AI models and systems. An asymmetric agreement with a unidirectional flow to the USA undermines both the reciprocity needed to address global health risks, and the principle of equitable benefit sharing from biological resources, as negotiated under the UN Convention on Biological Diversity (CBD) and the Nagoya Protocol on Access to Genetic Resources²³.

2.5 The conditioning of health on trade, minerals and geopolitics.

The Zambian case has placed beyond reasonable dispute that AFGHS health funding is being explicitly conditioned on non-health concessions minerals access in Zambia's case, separate strategic-minerals agreements in the DRC's case and broader bilateral alignment elsewhere. The exclusion of South Africa and Tanzania for reasons of foreign-policy posture rather than health need and the religious carve-out in the Nigeria MoU indicate that AFGHS operates as an instrument of US geopolitical and commercial policy, rather than of health solidarity.

This conditioning violates the spirit of Article 4 of the African Union (AU) Constitutive Act on respect for state sovereignty. It raises a strong argument under the good faith principle in Article 26 of the Vienna Convention on the Law of Treaties (VCLT), read alongside the WHO Constitution's foundational commitment to the enjoyment of the highest attainable standard of health as a fundamental right of every human being. Where health agreements are deployed instrumentally to extract trade and minerals concessions, that principle is engaged and provides a basis for domestic and regional legal challenge, including by states currently resisting or renegotiating AFGHS terms. It directly contradicts the Lusaka Agenda and the Accra Reset, both of which affirm the indivisibility of African health policy from African development policy²⁴. It deploys health as a tool of soft diplomacy to lever conditional agreements on US commercial access to strategic and critical mineral resources in the region, at precisely the moment when African countries require the widest latitude in minerals negotiation to secure more equitable benefit-sharing with both local communities and ESA countries across the global critical mineral value-chain, that carry with them institutionalised duties to assess, prevent, and control the health and environmental risks associated with extractive activities.

Protection Act 2021 -

www.parliament.go.tz/sites/default/files/documents/acts/Act%20No.%203%20The%20Data%20Protection%20Act%202021_0.pdf v)

United Republic of Tanzania — Personal Data Protection Act 2022 - <https://tanzlii.org/en/akn/tz/act/gn/2023/395b-1/eng@2023-06-13>

²³ UN CBD (2014) *The Nagoya Protocol on Access and Benefit-sharing* <https://www.cbd.int/abs/default.sbtm>

²⁴ *African Union Constitutive Act (2000), Articles 3 and 4 on the promotion of African unity, solidarity, and common positions; AU Agenda 2063, Aspirations 1 and 2; Lusaka Agenda on the Future of Global Health Initiatives (2023); Accra Reset on African Health Sovereignty, hosted by H.E. President John Dramani Mahama, August 2025.*

Conditioning health financing on minerals concessions assigns the benefits of Africa's extractive wealth to US commercial interests, with potentially intergenerational consequences for African population wellbeing.^{25,26}

2.6 Forfeited industrial and benefit-sharing dividends and precedents for future health negotiations.

AFGHS MoUs emphasise commodity procurement and ISO 15189 laboratory accreditation but are thin on local pharmaceutical manufacturing, technology transfer and DSI traceability. This is directly inconsistent with the EAC Regional Pharmaceutical Manufacturing Plan of Action (2017–2027), the SADC Protocol on Health and Pharmaceutical Business Plan, the AfCFTA-anchored African Pooled Procurement Mechanism and the Africa CDC New Public Health Order and AHSS Agenda's 60% by 2040 manufacturing target²⁷. It is also inconsistent with the unmet Abuja Declaration commitment to which all AU Member States subscribed in 2001 that 15% of national budgets be allocated to health, a target that, in the most recent reporting period, only Cabo Verde and South Africa had met^{28,29}

By prioritising the purchase of externally produced commodities over investment in African productive capacity, the AFGHS forfeits a generational opportunity to advance the continent's pharmaceutical self-reliance at precisely the moment when post-COVID consensus had aligned political will behind it. The AFGHS sets a benchmark for health diplomacy that poorly advances or protects the public health policy interests of ESA countries, and in contract significantly disadvantages African health diplomacy in future negotiations with international partners.

In summary, without understating the necessary role of increased domestic and regional investment and spending on health, including through addressing resource losses in trade, financial flows and tax systems, global health requires health diplomacy that prioritises public health and is based on principles of collective responsibility, transparency, reciprocity, equity and benefit sharing if the major challenges to health are to be addressed. African countries have demanded this in health diplomacy to date.

As noted in the various areas discussed in this section, the AFGHS breaches these principles in ways that pose a risk to future health diplomacy for the region, raising further burdens on ESA countries to affirm and not erode such multilateral principles that have been hard-won in prior negotiations in bilateral negotiations with other countries, regions and powerful private actors. Without a coordinated continental response, the terms of the AFGHS risk becoming a default architecture for health cooperation, raising the burden on ESA countries to defend multilateral principles of transparency, reciprocity, equity, and benefit-sharing in future negotiations. Without a coordinated continental response, the terms of the AFGHS risk becoming a default architecture for health cooperation, raising the burden on ESA countries to defend multilateral principles of transparency, reciprocity, equity, and benefit-sharing in future negotiations.

²⁵ Weng, L. (2025). *Unlocking the Potential of Critical Minerals Extraction for Africa's Structural Transformation*. CSST Working Paper No. 005. London: Centre for Sustainable Structural Transformation (CSST), SOAS University of London, 2025 -

https://www.soas.ac.uk/sites/default/files/2025-02/Unlocking%20the%20Potential%20of%20Critical%20Minerals_WP5.pdf

²⁶ UN Secretary-General's Panel on Critical Energy Transition Minerals. (2024) *Resourcing the energy transition principles to guide critical energy transition minerals towards equity and justice*, UN. 11 September 2024 -

https://www.un.org/sites/un2.un.org/files/report_se_panel_on_critical_energy_transition_minerals_11_sept_2024.pdf

²⁷ i. EAC Regional Pharmaceutical Manufacturing Plan of Action (EAC-RPMPOA) 2017–2027; SADC Protocol on Health (1999, entered into force 2004) [https://industrialization.go.ke/sites/default/files/2023-](https://industrialization.go.ke/sites/default/files/2023-08/2nd%20EAC%20Regional%20Pharmaceutical%20Manufacturing%20Plan%20of%20Action%2020172027.pdf)

[08/2nd%20EAC%20Regional%20Pharmaceutical%20Manufacturing%20Plan%20of%20Action%2020172027.pdf](https://industrialization.go.ke/sites/default/files/2023-08/2nd%20EAC%20Regional%20Pharmaceutical%20Manufacturing%20Plan%20of%20Action%2020172027.pdf)

ii. SADC Pharmaceutical Business Plan; AfCFTA Protocol on Trade in Services and ongoing negotiations on health. iii. *Africa's Health Security and Sovereignty agenda: a new way forward* - <https://kbub.africacdc.org/storage/uploads/publications/06ee6f8ee057869f65e6d4f11a1f0f8b.pdf>

²⁸ Organisation of African Unity (2001). *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*.

OAU/HEA/ABUJA/3. *Abuja* - <https://au.int/sites/default/files/pages/32894-file-2001-abuja-declaration.pdf>

²⁹ *Abuja Declaration on health – 20 years later*, Gil Analytics - <https://gilanalytics.com/abuja-declaration-on-health-20-years-later/>

3. Engaging with the AFGHS in ESA countries to protect health equity

It is against this background that SEATINI, EQUINET and Ahaki as regional organisations/consortia in ESA are jointly urging, facilitating, inviting partnership in and providing a space for a programme of information dissemination, and engagement on protecting key principles and constitutional/ legal rights, population health and equity, and ESA public sector interests in the AFGHS, covering ESA countries.

Applying public health and constitutional principles: Any engagement or health diplomacy in ESA should apply core principles that are enshrined in our policy and legal frameworks, in public health norms and standards and in multilateral declarations of social, economic and political rights and health conventions that that region's countries are signatory to. This includes a priority for protection of public health rights, a duty to control harms to health, and a policy commitment to health equity. It is based on principles of collective responsibility, transparency, reciprocity, equity and benefit sharing in national, regional and global interactions and in health diplomacy. Where there is a likelihood of harm to population health the precautionary principle asserts that measures must be taken to monitor and prevent public health harms.

The engagement around the AFGHS in various forms intends to inform, exchange and bring the publics, public sectors, populations and key health institutions in the ESA region into an accessible, informed regional conversation and dialogue to interrogate what has been signed in our names, to honour and learn from the East and Southern African states that have signed, suspended, refused or been excluded, and to inform and engage those negotiating or in process of applying the MoUs. It aims to connect national experiences in the ESA region to the national laws and regional, continental and multilateral instruments through which countries in the region obtain bargaining leverage. It aims to build a coordinated voice and options for challenging and addressing public health challenges across the EAC, SADC and the wider ESA region that no country or organisation can carry alone and to engage with multilateral and other alliances from an ESA lens.

As an overall aim and theory of change informed regional dialogue and engagement in the communities, public sectors, policy actors and technical personnel in ESA on the implications of and options for response to the AFGHS in key areas affecting public health³⁰ is foundational, for the various constituencies and with wider alliances to take specific informed actions to protect Africa's population health equity, health sovereignty, governance systems, and development policy space.

The broad actions to realise the aim include

- Accessing the MoUs for them to be in public domain for information, analysis, legal, institutional, policy and public health assessment of their implications in the key areas affecting public health.
- Sharing information and providing a space for regional dialogue and awareness from community to national, regional and international levels on key principles, and implications of and the actions pertinent social, technical and policy constituencies can take to protect public health.
- Engaging regional bodies (SADC, EAC, ESCA HC), global health diplomacy institutions (such as the Africa Group of Diplomats) and pertinent national legislative and state institutions to set strategic and diplomacy norms/principles and standards for engaging with the AFGHS.
- From an African lens, alerting and generating solidarity and co-operation from progressive states, other regional and global networks and institutions.
- Monitoring, reviewing, and assessing the impact of the AFGHS and acting on the learning from the engagement.

³⁰ Including population health, health equity, health rights, standards, sovereignty and governance, data systems and protection, industrialisation agenda, development priorities, policy alignment and space, and health diplomacy