

United States foreign aid freezes: A wake-up call for African countries to increase health financing

Joseph Magoola^{1,*}

¹African Field Epidemiology Network, Kampala Uganda (AFENET)

ABSTRACT

In January 2025, the United States of America (US) suspended all foreign aid, pending reviews to ensure alignment with American strategic interests. This decision significantly disrupted humanitarian assistance and healthcare services, particularly in low-and-middle-income countries that have been the biggest beneficiaries of US aid. The suspension has exacerbated funding gaps in critical sectors, including disease prevention, maternal health, and emergency response. As a result, African governments must urgently reassess their health financing strategies, reduced dependency on external donors through increased domestic resource mobilization, innovative financing mechanisms, and strengthened public-private partnerships. These strategies are essential to safeguard African healthcare systems against future financial uncertainties and external policy shifts.

KEYWORDS: Foreign aid suspension, Health Financing, Africa

*CORRESPONDING AUTHOR

Joseph Magoola, African Field Epidemiology Network, Kampala Uganda, Email: jmagoola@afenet.net / josephmagoola@gmail.com

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Opinion

When America sneezes, the rest of the world catches a cold. Never has this been truer than with the recent furor around the United States (US) government freeze on foreign aid. On 20 January 2025 which marked his first day in office, President Donald Trump signed executive orders (EO) to stop US foreign development assistance to foreign countries, non-government organisations (NGOs), international organizations and contractors [1]. The EO was followed by a work-stop order that put an immediate pause on current and new foreign aid spending and programs for 90 days, pending a review process that would ensure that external funding is aligned with American interests[2]. These decisions sent shockwaves around the world, especially among low and middle-income countries (LMICs), the majority of which are in Africa. Programs that focus on diversity, equity and inclusion have been the most affected.

In 2024, the US through programs such as the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) provided USD 4.7 billion and the President's Malaria Initiative (PMI) contributed close to USD 700 million for the Global Fund to fight HIV/AIDS, Tuberculosis and support malaria control and treatment [3]. Many countries on the African continent including the Democratic Republic of Congo (DRC), Kenya, Malawi, Mozambique, Nigeria, South Africa, Tanzania, Uganda, Zambia and Zimbabwe [4] are beneficiaries, using the funds to support their health programs. Because of PEPFAR, 25 million lives have been saved, and over 20 million people are on life-saving HIV/AIDS treatment across 54 countries[5]. These countries are now making progress towards achieving 95% diagnosis, treatment and viral suppression rates by 2030. Previous American support through the U.S. Centers for Disease Control and Prevention was crucial in the control of the biggest Ebola epidemic that occurred in 2014 in West Africa[6].

The United States Agency for International Development (USAID) funding freeze has exposed the vulnerabilities of African healthcare systems which are heavily reliant on foreign aid, and risks reversing the gains made. As I write this, many countries are now left in a state of chaos and uncertainty about what steps to take. Cutting these funds means loss of technical assistance (program

staff) and directly supported frontline personnel, loss of resources for emergency response to disease outbreaks, and shutdown of various programs ranging from water and sanitation, and security, to medicines and vaccines. Countries have been forced to withdraw or lay off critical human resources, NGOs have shut down or downsized operations, specialized clinics especially for HIV and TB have been most affected due to shortage of staff and drugs; and shut down of ongoing medical research projects. The timing of the suspension of funding assistance has come at a time when Africa is grappling with a multitude of issues, including the Ebola outbreak in Uganda, the Marburg outbreak in Tanzania, Cholera in Angola, and the ongoing war in DRC.

For decades, African countries have relied on this international aid to supplement their health budgets. Countries in sub-Saharan Africa account for more than a third of US foreign assistance spending. In addition to famine relief and medical and humanitarian support in conflict areas such as Sudan, Somalia, Nigeria, and DRC, USAID assists health ministries to run public health programs for reproductive health, immunization services, disease outbreak response, and human resource workforce development. The aid freeze leaves these countries at risk. A poorly funded health system negatively affects economic growth, while leaving the country at risk of outbreaks and with a high disease burden. While African governments face budget constraints and competing priorities such as infrastructure, education, and security, investing in health is foundational to economic growth. A sick population leads to lost productivity, lower life expectancy, and poor quality of life. African countries therefore need to wake up to the fact that donor dependency is not sustainable in the long term. Increasing domestic health financing strengthens national ownership and resilience, while also enhancing sustainability of their programs. Governments have both a moral responsibility and a strategic imperative to ensure that their citizens have access to quality healthcare.

The African Union's Abuja Declaration (2001) recommended that at least 15% of national budgets should be allocated to healthcare[7]. The declaration aimed to address the shortage of resources needed to improve health in low-income settings and harness the economic development that comes with investing in health. However, many African nations still fall far short of this target, with only two (Cabo Verde and South Africa) of the 55 African Union

member countries meeting the target as of 2021[8]. On average, African governments spent only 7.4 per cent of their national budgets on health care in 2021, far below the target of 15%. There are many perks to increasing domestic funding, such as reducing reliance on external donors, ensuring financial sustainability, strengthening sovereignty and decision-making in healthcare priorities, building public trust in government institutions, improving the overall quality of life and economic productivity; and most importantly, investing in preventive and primary healthcare to reduce long-term and expensive curative treatment costs.

The speed of the American foreign aid suspension, and how it has plunged so many around the world into chaos and uncertainty, raises questions about the wisdom of nations depending so profoundly on a foreign country for health financing. The sudden withdrawal of these funds forces African governments to either increase their own contributions or risk a collapse in essential health services. To safeguard public health and ensure the continuity of essential services, it is imperative for African governments to increase domestic health expenditure. Among the steps that can be taken to bridge this gap are: increasing allocations within the national budget for health expenditure; establishing or expanding national health insurance coverage; implementing targeted taxation for health financing; combating corruption, mismanagement and inefficiencies; and leveraging the private sector to complement public health investments.

In light of this situation, African governments must rethink their health financing strategies and reduce the risks of over-reliance on external donors. By investing in robust healthcare infrastructure, training, and sustainable financing mechanisms, African nations can build resilient health systems capable of withstanding external shocks and safeguarding the well-being of their populations. The time to act is now, and the experience with Trump's executive orders should be a lesson and wake-up call to wean off dependency on development aid. African leaders must recognize that health is not just a cost, but an investment in their nation's economic and social development. Ensuring adequate financing for equitable access to quality healthcare is not just a policy goal—it is a moral obligation. And that starts with building resilient self-sufficient health systems.

Competing Interest

The author is an epidemiologist with experience in public health research, disease control and prevention, workforce development and health system strengthening, and has collaborated with government agencies, NGOs and international public health institutions. My professional background and ongoing work in public health may align with advocacy for sustained or increased funding in this sector. The author declares no other competing interests.

Authors' contributions

JM conceptualised, drafted and finalized the opinion piece.

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