

Philanthropic Ambition in an Age of Withdrawal

By Tanatsiwa Dambuzo

Africa's rising philanthropic class cannot, alone, fill the void left by the collapse of decades-long US health investment, but it must try harder, smarter, and together.

I. The Moment the Architecture Cracked

On 20 January 2025, as his first act on returning to the White House, President Donald Trump signed an executive order [withdrawing the United States from the World Health Organization](#) and freezing all US government transfers to the agency. The US had historically provided 18 to 22 percent of the WHO's total budget. The withdrawal projected a gap of [roughly \\$3.3 billion, 47 percent of the WHO's 2025–2028 strategy](#) before a single dollar was withheld. But the WHO exit was only the most visible act of a much larger unravelling. The effective dismantling of USAID followed. [USAID alone had spent approximately \\$12 billion in sub-Saharan Africa in 2024](#). Nigeria lost over \$600 million in health funding, more than a fifth of its entire annual health budget, almost overnight. The DREAMS programme, serving two million adolescent girls and young women across ten countries, [was halted entirely](#). What the cuts exposed was not simply a funding gap; it was an architecture built on foundations that could, and did, disappear overnight.

II. Zimbabwe: Dependence, Achievement, and Defiance

No country makes the case more starkly than Zimbabwe. By 2025, it had achieved something extraordinary: it met the [UNAIDS 95-95-95 HIV targets](#) that is, 95 percent of people living with HIV knowing their status, 95 percent on treatment, 95 percent virally suppressed. That reversal from one of the world's highest HIV prevalence rates in the 1990s was built on two pillars: a domestic 3 percent AIDS levy introduced in 1999, and an enormous injection of US funding.

According to [Zimbabwe's 2021 Health Sector Resource Mapping Report](#), PEPFAR partners namely USAID and the US Centers for Disease Control contributed \$216 million, or 48 percent of all donor health funding. Over 2016–2021, at least 86 percent of all development assistance for health came from just three sources: PEPFAR, the Global Fund, and the Health Development Fund. PEPFAR was not simply writing cheques. The [2022 PEPFAR Zimbabwe Country Operational Plan](#) confirms it was supporting 19,202 healthcare workers through salaries and stipends, and funding more than half of all community health services. A [2025 modelling study](#) estimated that sustained PEPFAR cuts through 2030 would produce an additional 85,000 infections and 25,000 deaths. [UNAIDS reported that 82.7 percent of Zimbabwe's HIV prevention funding came from US sources](#).

Into this already precarious situation came a diplomatic rupture that crystallized everything. In late 2025, President Emmerson Mnangagwa [personally directed the termination of negotiations](#) over a proposed health funding Memorandum of Understanding worth approximately US\$350–367 million over five years. The deal had been framed by Washington as the vehicle for future health support under its America First Global Health Strategy. It collapsed when Harare grasped the full terms: US agencies were demanding direct access to Zimbabwe's national health data, the national database of HIV status, vaccination records, and health data of millions of citizens with [no reciprocal guarantee that Zimbabwe would benefit](#) from vaccines or treatments developed using that data. Government sources also pointed to conditions tied to Zimbabwe's lithium and critical mineral resources.

"The President has directed that Zimbabwe must discontinue any negotiation with the USA on the clearly lopsided MoU that blatantly compromises and undermines the sovereignty and independence of Zimbabwe." — Permanent Secretary Albert Chimbindi.

Information Secretary Nick Mangwana [offered the public rationale](#): "A partnership must be built on mutual respect, transparency, and reciprocal benefit." The terms were genuinely asymmetrical, and the sovereignty

argument has real merit. But sovereignty rhetoric does not dispense antiretrovirals. A [State Department email of 12 February 2026](#) confirmed the US intends to cancel all remaining humanitarian funding to Zimbabwe entirely, on the grounds of "no strong nexus with US national interests." This was later confirmed on their [social media](#) platforms.

III. The Philanthropic Promise — and Its Hard Limits

Against this backdrop, Africa's growing philanthropic energy is often invoked as a solution. The case is genuine, up to a point. In the [2023 World Giving Index](#), Kenya ranked third globally, Liberia fourth, and Nigeria ninth. The [African Giving Report 2023](#) estimates that Africans contribute approximately \$2 billion annually to charitable causes. A new generation of African foundations has emerged with genuine scale: the [Tony Elumelu Foundation](#) has disbursed over \$100 million in seed capital to 24,000 entrepreneurs across all 54 countries; the [Mastercard Foundation committed \\$1.5 billion to Saving Lives and Livelihoods](#) with the Africa CDC; [Brookings Institution's 2024 Foresight Africa analysis](#) documents a continent increasingly investing in its own future.

In Zimbabwe, the [Higherlife Foundation](#) founded in 1996 by Strive and Tsitsi Masiyiwa at the height of the HIV epidemic, has grown into a multi-country institution spanning education, maternal health, and disaster response. In 2024, it donated \$240,000 in medical equipment to Sally Mugabe and Mpilo Central hospitals. Tsitsi Masiyiwa co-founded the [African Philanthropy Forum](#); the couple's most recent initiative, [The Beginnings Fund](#), a \$500 million global initiative targeting maternal and newborn mortality represents African philanthropic leadership operating at genuine global scale.

And yet the arithmetic is sobering. According to data from the [Africa Health Agenda International Conference, March 2025](#), African-based philanthropists contribute an estimated \$3 billion annually to health and development; non-African philanthropists add a further \$4 billion. Combined: \$7 billion. USAID alone spent \$12 billion in sub-Saharan Africa in 2024. For Zimbabwe specifically, Higherlife's \$240,000 hospital donation represents less than 0.1 percent of what PEPFAR was investing in the country annually. The [African Giving Report 2023](#) acknowledges that many African countries still rely heavily on external funding for large-scale initiatives — and that this reliance itself undermines the development of self-sustaining local philanthropy.

Beyond the money, African philanthropy remains largely fragmented, project-focused, and short-term. Foundations fund entrepreneurs, scholarships, and targeted interventions. They do not, as a rule, fund what a resilient health system actually requires: healthcare worker payroll, cold-chain logistics, laboratory infrastructure, regulatory agencies, and long-term capital expenditure. As the [Centre for Global Development noted in 2025](#), short-term funding cycles lock governments into a permanent state of transition, forever chasing the next grant cycle. A [2024 academic analysis of Africapitalist foundations](#) found they remain too weak to displace dominant actors in Africa's aid industry, and risk entrenching hegemonic patterns by not addressing systemic inequalities.

IV. From Project Philanthropy to System Philanthropy

The argument is not that African philanthropy has failed. It has not. It is that philanthropy as currently practiced has not yet evolved into the form that health sovereignty demands. Africa CDC Director General Dr. Jean Kaseya has estimated that [up to 40 percent of Africa's health spending is lost to inefficiency](#), fragmented planning, duplicative delivery and weak procurement. His modelling suggests that recovering even half that loss could, within five years, replace 50 percent of current donor financing and reduce external dependence below 20 percent of total health expenditure. But that requires structural, systems-level investment that fragmented project philanthropy cannot deliver.

Several governments are already responding at the policy level: Ghana removed the cap on its National Health Insurance Levy; Nigeria's Senate allocated 300 billion naira in additional health funding in 2025; Ethiopia proposed a new payroll tax to replace USAID-funded programmes. Zimbabwe's own [AIDS levy, now 25 years old](#), remains one of the continent's most durable models of domestically legislated health financing.

The [African Union's Lusaka Agenda](#) and the [African Leadership Meeting framework](#) both call for pooled, coordinated funding mechanisms that reduce fragmentation and twelve AU member states, including Zimbabwe, have already convened national dialogues under that framework.

What this moment demands of Africa's philanthropic community is a shift from project philanthropy to system philanthropy: multi-year, pooled, coordinated investment in the architecture of health, not annual grants to individual clinics or entrepreneurs. The Mastercard Foundation's \$1.5 billion partnership with the Africa CDC and The Beginnings Fund's \$500 million commitment offer models of what that looks like. But they remain exceptions. And [as Chatham House concluded in October 2025](#), the measure of success will not be the size of pledges at conferences in New York or Geneva, it will be whether health priorities are being decided in Abuja, Addis Ababa, Kigali, and Harare, with African governments paying a growing share of the bill.

Zimbabwe's refusal of the US MoU may, in time, be remembered as the moment a post-aid era began in earnest not as a triumph, but as a forcing function. The question it poses to African philanthropy and to African governments is stark: if not Washington, then who? The answer cannot simply be the continent's billionaires. It must be something more architecturally ambitious, coordinated, long-term, and built to outlast any single administration's foreign policy.

The philanthropic class is growing. The ambition is rising. But ambition, without coordination and without a systems perspective, remains what it has always been: generosity. And generosity, however great, has never been enough to sustain a health system.