

# Health Sovereignty Under Conditional Generosity: The Kenya–United States Health Cooperation Framework as a Case Study in Imperial Selection and Structural pathology

## Authors

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## Abstract

We analyze the Kenya–United States Health Cooperation Framework as a contemporary case study of health-sector imperialism. We argue that the agreement reproduces a pattern already described in the Imperial Selection Model (ISM) and in the Diagnostic and Statistical Manual of Human Structural Pathologies (DSM-H): external powers select and reward local elites who accept asymmetrical control over strategic systems in exchange for conditional funding and symbolic prestige.

Using documentary analysis of the 37-page framework, court filings by the Consumers Federation of Kenya (COFK), Kenyan constitutional provisions, and the emerging literature on data colonialism and pathogen sharing, we identify fifteen red-flag clauses. These concern long-term access to health data and genetic material, automatic acceptance of foreign regulatory decisions, one-way audit rights, digital infrastructure dependency, legal immunities for foreign actors, and escalating domestic financial obligations combined with easy aid withdrawal. We show how these clauses shift strategic control over surveillance, biological specimens and health decision-making toward the United States, while formally presenting the arrangement as a partnership for capacity building and pandemic preparedness.

Our findings support three main claims. First, the framework is structurally incompatible with full health sovereignty under the Kenyan Constitution. Second, it fits the ISM prediction that imperial actors will attach control over data, specimens and decision rules to any renewed flow of funding. Third, at the level of collective psychology, the agreement normalises a chronic state of dependency in which the local population carries financial and epidemiological risk, while strategic and commercial benefits concentrate abroad.

We conclude that African states require explicit health-sovereignty standards, independent review bodies, and binding benefit-sharing rules before entering similar frameworks. We propose a set of minimum safeguards and outline how the ISM and DSM-H can guide structured risk assessment for future health agreements in Kenya, the Democratic Republic of Congo (DRC) and beyond.

**Keywords:** health sovereignty; Kenya; United States; data colonialism; pathogen access; decolonial global health; Imperial Selection Model; DSM-H; structural pathology.

*Even under the most charitable interpretation of motives, the distribution of rights and obligations in this framework produces a structurally harmful configuration.*

## 1. Introduction

In late 2025, Kenya signed a five-year, 1.6-billion-dollar health cooperation pact with the United States under the new “America First Global Health Strategy”. The agreement promises sustained funding for HIV, tuberculosis, malaria and pandemic preparedness, while gradually shifting financial responsibility to Kenya. It also introduces detailed obligations on outbreak detection, data sharing, and digital health infrastructure, and allows the United States broad audit and oversight powers over Kenyan systems. ([Reuters](#))

The Kenyan government presents the framework as a historic partnership that will “save lives” and “strengthen systems”. Civil society organisations, including the Consumers Federation of Kenya (COFK) and public interest litigants, contest this narrative. Their court filings raise concerns about constitutional violations of privacy and public participation, unequal control over sensitive health and genetic data, and the introduction of mandatory emergency product approvals without sufficient local regulatory scrutiny.

This article asks three questions.

1. How does the Kenya–United States Health Cooperation Framework redistribute control over health data, pathogen samples and regulatory decisions between Kenya and the United States?
2. To what extent do its clauses match the patterns predicted by the Imperial Selection Model (ISM) and the DSM-H approach to structural pathology in governance?
3. What standards and safeguards would be required for such a framework to be compatible with health sovereignty in Kenya and in other African states?

We treat the agreement as a paradigmatic case, not as an aberration. Recent analyses of US global health policy show a strategic shift toward bilateral compacts that require rapid sharing of “pathogens with epidemic potential” and genomic data in exchange for funding, without clear guarantees of reciprocal access to resulting vaccines or treatments. ([The Guardian](#)) In parallel, work on data colonialism argues that the extraction of digital and biological data from the Global South has become a central

technique of twenty-first-century imperialism.

Our analysis integrates these strands with an explicitly clinical and decolonial framework. The ISM proposes that empires select and stabilise intermediaries who display specific personality and institutional traits: high external dependency, tolerance of asymmetry, and willingness to exchange long-term sovereignty for short-term resources. The DSM-H conceptualises this pattern as a structural pathology rather than a series of isolated “bad deals”. Together, they allow us to read the Kenya–US framework not only as a legal document, but as a behavioural expression of deeper psychological and geopolitical dynamics.

We proceed as follows. Section 2 introduces the theoretical framework. Section 3 describes our methodology. Section 4 summarises the key features of the Kenya–US agreement. Section 5 presents our analytical findings, structured as red-flag clusters. Section 6 discusses implications for theory and practice, including recommended safeguards and comparative lessons for the DRC and Sahel. Section 7 concludes.

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## 2. Theoretical Framework

### 2.1 Imperial Selection Model (ISM)

The Imperial Selection Model (ISM) emerges from psychohistorical work on colonial and post-colonial governance. It posits that imperial systems do not select local intermediaries at random. Instead, they tend to reward elites and institutional configurations that:

1. Accept external definition of “reform” and “progress” even when these definitions contradict local interests.
2. Demonstrate willingness to sign asymmetric treaties that externalise risk and internalise cost.
3. Display a chronic readiness to treat national assets – land, resources, data, bodies – as negotiable collateral.

Historical case studies from Congo, Côte d’Ivoire and Libya illustrate this pattern across five centuries of interaction. Elites who resisted structural asymmetry were removed, discredited or killed. Elites who accepted it were promoted, armed and decorated. In this sense, imperial power acts as a long-term selection environment, favouring a particular profile of leadership and policy behaviour.

### 2.2 DSM-H and Structural pathology

The DSM-H (Diagnostic and Statistical Manual of Human Structural Pathologies) extends clinical constructs such as the Dark Tetrad from individual psychology to institutional systems. It identifies chronic configurations of:

- entitlement to rule and to extract;
- moral disengagement from the suffering of out-groups;
- deceptive and euphemistic framing;

- self-sabotage that benefits an external patron.

When these traits stabilise at the level of institutions and legal frameworks, they create what DSM-H terms a “colonised governance structure”. In such systems, key decisions systematically favour the external patron’s strategic interests over the population’s long-term health and autonomy, even when leaders claim a discourse of sovereignty and partnership.

### 2.3 Data Colonialism and Health Sovereignty

Recent work on data colonialism argues that digital and biological data now play the role once played by raw materials. Powerful actors construct infrastructures that capture, store and process data from less powerful populations. Ownership and control remain offshore, while risk and dependency remain local.

In health, this translates into:

- centralised foreign control over surveillance platforms;
- obligations to share specimens and genomic data;
- automated or “harmonised” approval of foreign products;
- weak or symbolic benefit-sharing arrangements.

Health sovereignty, in contrast, requires that a country retains decisive control over who accesses its health data, under what conditions, for what purposes, and how benefits are shared. It also requires that

foreign cooperation respects local constitutional norms, including privacy, public participation and due process. In Kenya, the Data Protection Act 2019 recognises health and genetic data as sensitive personal data and imposes strict conditions for its processing and transfer. ([DLA Piper Data Protection](#)) Any agreement that undermines these protections without transparent, democratic debate raises immediate sovereignty concerns.

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## 3. Methodology

We conducted a multi-layered qualitative analysis, combining legal, institutional and clinical lenses.

### 1. Documentary corpus.

- Official Kenya–US Health Cooperation Framework (37 pages).
- Press releases and speeches by Kenyan and US officials. ([Reuters](#))
- Petition and filings by COFK and allied organisations before Kenyan courts. ([The Star](#))
- Kenya’s Constitution (2010) and Data Protection Act (2019). ([DLA Piper Data Protection](#))
- WHO and Africa CDC guidance on health data governance and pathogen access.

## 2. Analytical procedure.

We applied a directed content analysis. Clauses were coded against four categories:

- Data and specimen control.
- Regulatory and decision-making autonomy.
- Financial and operational obligations.
- Legal accountability and remedies.

3. We then mapped coded items onto ISM and DSM-H constructs, asking whether they expressed structural asymmetry, moral disengagement, or selection of dependent intermediaries.

## 4. Triangulation.

We cross-checked our reading with:

- Kenyan constitutional obligations on public participation, privacy and national security.
- The emerging literature on data colonialism in health.
- Comparative cases in DRC health and security agreements where similar patterns occur.

## 5. Limitations.

We did not have access to all negotiation transcripts or classified annexes. Some provisions may exist in side letters or implementation plans not yet public. We therefore

interpret the visible text as a minimum expression of structural intent, not as the full operational picture.

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## 4. The Kenya–US Health Cooperation Framework: Structural Overview

We summarise here the architecture of the agreement, organised in four clusters that will structure the Results section.

### 4.1 Data and Specimen Access

The framework grants the United States long-term access to:

- Kenya’s health information systems, including outbreak alerts, case data and supply-chain information.
- Biological specimens, including pathogen samples and genomic sequencing data, especially those classified as having “epidemic potential”. ([The Guardian](#))

The agreement specifies rapid timelines. Kenya must detect an outbreak within seven days, notify the United States within one day, and begin response within seven days. Data and specimens flow outward very quickly. The framework is vague on:

- storage locations and legal jurisdiction for the data once exported;

- duration and conditions of retention;
- secondary uses, including research and commercial exploitation.

Kenya has no explicit audit rights over how foreign agencies store, process, or share its data once it leaves the territory.

## 4.2 Regulatory Autonomy and Emergency Products

Under emergency conditions, Kenya agrees to adopt or align with US regulatory decisions for vaccines, drugs and diagnostics authorised under US procedures. This fast-track alignment is presented as necessary for speed during pandemics. The framework does not articulate an explicit role for Kenyan regulators to conduct independent safety assessments when time and capacity permit, nor does it set clear criteria for divergence.

## 4.3 Financial Responsibilities and Exit Risk

The financial chapter front-loads United States funding, then steadily increases Kenyan obligations:

- US commitments start at several hundred million dollars per year and decline over time. ([Reuters](#))
- Kenya must progressively absorb salaries of thousands of health workers initially supported by the United States.
- Kenya must increase domestic health expenditure to meet specific

ratios.

The United States can exit the agreement with limited notice if Kenya does not meet financial or performance obligations. Exit clauses place most systemic risk on Kenya: if funding stops, trained staff and services may collapse, leaving the government to fill the gap.

## 4.4 Governance, Immunities and Oversight

The framework grants United States agencies extensive audit rights over Kenyan health systems, including inventories, staffing, and programme implementation. Kenya gains no symmetrical rights to audit US handling of Kenyan data or specimens.

United States staff enjoy broad legal immunities. In practice, if data misuse, product harms or operational errors occur on the US side, Kenyan citizens have no realistic path to legal recourse in their own courts.

Public consultation provisions are weak. The agreement was signed without structured parliamentary debate or broad citizen participation, and without formal input from key oversight bodies such as the Office of the Data Protection Commissioner. ([The Star](#))

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## 5. Results

We present the findings as five clusters of structural red flags, followed by a structured discussion in Section 6.

## 5.1 Cluster 1 – One-Way Transparency and Audit Power

The agreement creates a one-way transparency regime:

- US agencies can audit Kenyan systems, finances and performance in detail.
- Kenya cannot audit US systems handling Kenyan health data, nor demand disclosure of secondary partners or commercial beneficiaries.

This asymmetry transforms “accountability” into a one-directional surveillance tool. It fits the ISM prediction that imperial actors will insist on intrusive visibility into local systems while preserving opacity for themselves. It also matches DSM-H characteristics of entitlement and moral disengagement: the external power treats Kenyan systems as objects of control, not as equal partners.

## 5.2 Cluster 2 – Data, Pathogens and Digital Infrastructure Capture

The framework couples funding with deep embedding into Kenya’s digital health infrastructure:

- US agencies co-design and often host dashboards, databases and analytic tools.
- Pathogen samples and genomic data must be shared rapidly, under US coordination, with weak specification of Kenyan ownership and benefit rights. ([The Guardian](#))

From a data-colonialism perspective, this configuration is textbook capture: strategic infrastructure and high-value biological data are tied to external platforms, while domestic capacity to store, process and govern these assets independently remains underdeveloped or underfunded. The pattern closely resembles earlier arrangements in which African mineral exports flowed out through foreign-controlled ports and logistics networks.

## 5.3 Cluster 3 – Regulatory Subordination in Emergencies

By agreeing to automatic or near-automatic adoption of US emergency approvals, Kenya:

- gives up a key component of regulatory sovereignty at the moment when stakes are highest;
- exposes its population to decisions made under a foreign risk calculus, commercial structure and political pressure.

In principle, harmonisation can accelerate access to life-saving products. In practice, without explicit safeguards and independent review windows, it can import foreign controversies and conflicts of interest wholesale. DSM-H would classify this as structural self-endangerment: a system that reduces its own decision power at the moment it needs maximum prudence.

## 5.4 Cluster 4 – Escalating Financial Burdens and Exit Leverage

The funding architecture exhibits classic conditionality traits:

- domestic obligations grow as foreign funding declines;
- failure to meet obligations allows the external partner to withdraw with limited notice;
- key services and personnel become dependent on foreign funds before full domestic absorption is realistic.

This creates a chronic vulnerability. At any dispute or policy divergence, the threat of exit can discipline the Kenyan state. ISM predicts exactly this type of design: a lever that can reward compliant elites and punish any attempt to renegotiate terms.

### 5.5 Cluster 5 – Democratic and Constitutional Bypass

Finally, the process of adoption bypassed several Kenyan constitutional safeguards:

- limited parliamentary scrutiny;
- absence of robust public participation as required under Articles 10 and 118 of the Constitution;
- insufficient involvement of the Data Protection Commissioner despite clear implications for sensitive data under the 2019 Act. ([The Star](#))

This aligns with DSM-H patterns<sup>1</sup> where structurally harmful agreements enter through the executive branch with minimal democratic ventilation. The population then discovers the implications only when

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<sup>1</sup> See Table 1. (Annex A) Clause clusters, risk configuration, and ISM / DSM-H coding

implementation has already locked in dependency.

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## 6. Discussion

We follow a structured sequence: findings, main characteristics, relation to existing work, implications with examples and consequences. Our argument does not depend on proving that individual negotiators or agencies consciously intend harm. In fact, contemporary public discourse already contains clear statements of hegemonic intent, from “America First” foreign policy doctrines to French insistence on protecting its historic “sphere of influence” in Africa. However, even if one bracketed these statements entirely, the structural pattern we document would remain. The architecture of the Kenya–US framework systematically concentrates audit rights, data control and legal immunity on the donor side, while loading financial risk, regulatory subordination and long term obligations on the Kenyan side. In the language of the Imperial Selection Model and DSM-H, this is a system that produces and rewards structurally harmful configurations regardless of the private intentions of the actors who happen to occupy its roles.

### 6.1 Main Findings

The analysis yields four central findings.

1. The Kenya–US health framework systematically reallocates control over health data, biological specimens and emergency regulatory decisions toward the

United States, while maintaining the appearance of equal partnership.

2. Audit and transparency provisions are one-way. US agencies gain deep insight into Kenyan systems. Kenya gains no equivalent insight into US handling of its data or its decision-making pipelines.
3. Financial design and exit clauses create a dependency trap. Kenya assumes rising obligations and risk, while the United States retains the right to withdraw or redirect funding with limited consequences.
4. The pattern fits the predictions of the Imperial Selection Model and DSM-H. It rewards a profile of governance that accepts structural asymmetry in exchange for resources, and it embeds a chronic vulnerability that can discipline future political decisions.

## 6.2 Main Characteristics of These Findings

Several characteristics deserve emphasis.

- The asymmetry is structural, not incidental. It does not rest on one or two “bad clauses” but on the interaction of data, regulatory, financial and legal dimensions.
- The language is technocratic and benevolent. It speaks of capacity building, pandemic preparedness and shared responsibility. At the same time, operational details quietly shift strategic assets

outward.

- The dependence is designed to increase over time. As domestic obligations grow and systems adapt around US-built infrastructure, the cost of exiting or renegotiating the framework rises, which reduces future bargaining power.
- The agreement operates as a template. Similar provisions are already appearing in draft compacts with other countries, suggesting that Kenya is an early test of a broader strategy. ([The Guardian](#))

## 6.3 Relation to Existing Work: Supported, Novel, Challenged

### Supported elements.

Our findings support existing critiques of data colonialism and unequal global health governance. Scholars have warned that biological samples and genomic data from the Global South feed Northern research and commercial pipelines with limited benefit sharing. Analyses of structural adjustment in health systems also document long-term dependency created by externally designed funding architectures.

### Novel contributions.

This article adds three elements.

1. It explicitly applies ISM and DSM-H constructs to a contemporary health agreement, showing how structural pathology manifests in data clauses, exit levers and regulatory alignments.
2. It combines legal analysis with a clinical reading of institutional

behaviour, treating minimisation of sovereignty risks as a psychological as well as political phenomenon.

3. It situates Kenya within a broader African pattern, linking this health framework to earlier security and resource agreements in the DRC and Sahel that exhibited similar structural traits.

### **Challenged elements.**

Our analysis challenges two common narratives.

1. The idea that such agreements are neutral technical instruments aimed only at efficiency and capacity building. We show that they also encode strategic and psychological interests.
2. The assumption that increased funding automatically improves health sovereignty. In this case, funding increases come tied to deeper structural dependency and external control.

## **6.4 Implication 1 – Health Agreements Must Include Explicit Sovereignty Safeguards**

If funding and cooperation are necessary for African health systems, they must be framed within explicit sovereignty protections. At minimum, future agreements should include:

- symmetric audit rights and transparency obligations;

- clear recognition that data and specimens remain under Kenyan legal jurisdiction;
- explicit benefit-sharing clauses for any products developed from Kenyan biological material.

### **Example 1a – Symmetric audit clause.**

A revised framework could grant Kenya the right to audit any US or partner facility handling Kenyan data or pathogens, including security, retention and sharing policies, with remedies for violations. This would align obligations with the constitutional mandate to protect citizens' privacy and security.

### **Example 1b – Jurisdiction and storage.**

The agreement could require that primary storage for Kenyan health data remains within Kenyan jurisdiction, on infrastructure certified by Kenyan authorities, with any foreign copies subject to Kenyan law and data protection standards.

### **Consequence and application.**

Regional bodies such as the African Union and Africa CDC can develop model health-sovereignty clauses and recommend that member states incorporate them into all bilateral health compacts. This would shift negotiations from ad hoc concessions to a standards-based approach.

## **6.5 Implication 2 – Pathogen and Genomic Data Sharing Requires Binding Benefit-Sharing**

Rapid sharing of pathogen data can be vital for global health. However, without binding benefit-sharing rules, it reproduces extractive patterns.

### **Example 2a – PABS alignment.**

African states can insist that any bilateral pathogen-sharing framework aligns with multilateral Pathogen Access and Benefit-Sharing (PABS) principles, including guaranteed proportional access to any vaccines or treatments developed from shared data. ([The Guardian](#))

### **Example 2b – Local co-ownership of IP.**

Contracts can specify that Kenyan institutions are co-owners of intellectual property arising from research on Kenyan specimens, with rights to manufacture or license products for local and regional use at controlled prices.

### **Consequence and application.**

Such clauses would translate abstract calls for “equity” into concrete legal rights. They would also discourage secretive or unilateral agreements that pre-empt multilateral negotiations.

## **6.6 Implication 3 – DSM-H Screening for Structural Pathology in Agreements**

The DSM-H framework can be operationalised as a screening tool for new treaties and compacts. Before signature, an independent panel could rate proposed agreements on:

- degree of asymmetry in control and obligations;
- presence of dependency levers (funding traps, exit penalties, irreversible infrastructure capture);
- compatibility with constitutional rights and existing data protection laws.

### **Example 3a – Kenyan DSM-H health review panel.**

Parliament could establish a panel including constitutional lawyers, data protection experts, clinicians and community representatives. Any international health agreement would require a DSM-H structural risk assessment before ratification.

### **Example 3b – Early warning index.**

Regional institutions could maintain an index of “sovereignty risk” for major health agreements, allowing civil society and legislatures to identify high-risk patterns early and intervene.

### **Consequence and application.**

This approach reframes due diligence as a clinical and ethical obligation, not a formality. It also builds capacity to recognise and interrupt patterns of structural self-harm before they solidify.

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## **7. Conclusion**

The Kenya–United States Health Cooperation Framework illustrates how twenty-first-century imperialism can operate through the language of health, data and preparedness. The agreement does not arrive with soldiers or open threats. It arrives with funding, dashboards, emergency timelines and promises of partnership. Inside these promises, however, we find a familiar architecture: strategic assets flow outward, dependency flows inward, and legal protections for the local population weaken.

Using ISM and DSM-H, we interpret this architecture as neither accidental nor purely technical. It reflects a deeper pattern

of selection and structural pathology. External powers prefer counterparts who accept asymmetric oversight and control. Local elites who agree receive resources and symbolic legitimacy, while populations inherit long-term vulnerabilities.

*In other words, intent is overdetermined, but not required. The observable configuration of clauses already meets the criteria for structural pathology in ISM and DSM-H.*

This article has focused on the Kenyan case because it is clear, current and well documented. DRC and other African countries face similar offers in health, security and digital infrastructure. If they treat each agreement as unique, they will fight each battle alone. If they recognise the structural pattern, they can build shared standards, screening tools and negotiation strategies.

The way forward is not isolation. It is disciplined cooperation. African states can and should accept funding and technical support. At the same time, they must insist on symmetric transparency, clear benefit-sharing, constitutional compliance and independent review of structural risks. Without these, every “health” compact risks becoming another instrument of control in a long history of managed dependency.

The Kenyan case provides a warning and an opportunity. It exposes the techniques by which modern empires seek control over health data and biological futures. It also offers material for a different path, in which health sovereignty becomes a measurable standard, not a slogan, and in which African institutions apply clinical clarity to the

agreements that will shape their people’s bodies, data and lives.

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## Annex A

Clause cluster	Illustrative clause logic (paraphrased)	Main risk for Kenya	ISM dimension (Imperial Selection Model)	DSM-H structural code*
Cross-border data access and sharing	Kenya transmits real-time health, surveillance and genomic data to US agencies and their partners, with no reciprocal transparency obligation.	Loss of informational sovereignty; external actors hold superior situational awareness and leverage.	Data-asymmetry and external situational dominance	H2: Structural informational dependency
One-way audit and oversight powers	US agencies may audit Kenyan systems, facilities and staff; Kenya has no equivalent audit rights in US systems handling Kenyan data.	Asymmetric scrutiny; Kenyan actors exposed, US actors opaque and unaccountable.	Supervisory asymmetry and externalised compliance	H3: Asymmetric accountability architecture
Regulatory subordination in emergencies	Kenyan regulators must adopt US emergency approvals for products and protocols without full local assessment or independent timelines.	Erosion of regulatory sovereignty; imported risk without full local review or appeal.	Normative capture and fast-track legal subordination	H4: Captured decision pipeline
Escalating domestic financial obligations	US funding declines over time while Kenya must commit growing budget lines and absorb programme salary costs into the national payroll.	Long term fiscal burden; exposure to sudden donor exit and service collapse.	Risk externalisation and fiscal entrenchment	H5: Donor-induced fiscal fragility
Legal immunity and liability shielding	US personnel and agencies enjoy immunity from Kenyan jurisdiction for activities under the framework.	Injured parties lack effective legal remedy; moral hazard for external actors.	Jurisdictional one-way valve and impunity structuring	H6: Institutionalised irresponsibility

Clause cluster	Illustrative clause logic (paraphrased)	Main risk for Kenya	ISM dimension (Imperial Selection Model)	DSM-H structural code*
7-1-7 outbreak detection and notification	Kenya must detect, notify and respond to outbreaks on fixed external timelines, including very early notification to foreign agencies.	Strategic and diplomatic vulnerability; internal deliberation compressed under external clocks.	Temporal control of crisis narrative and escalation pathway	H7: Externally clocked emergency governance
Digital health infrastructure and AI tools	US partners design, host or co-manage core digital health platforms, analytics and AI tools used by Kenyan institutions.	Backend control, vendor lock-in and opaque algorithmic influence over national health decisions.	Infrastructural capture and algorithmic steering	H8: Platform-centred dependency
Specimen, pathogen and genomic data flows	Kenyan laboratories share biological specimens and sequence data abroad with minimal constraints on re-use, storage length or re-export.	Loss of control over strategic biological assets and derivative IP.	Bio-resource extraction and knowledge offshoring	H9: Biological and epistemic extraction

**Table 1. Clause clusters, risk configuration, and ISM / DSM-H coding**

## Annex B – Coding framework for ISM / DSM-H analysis

This appendix summarises how we coded the clauses of the Kenya–United States health cooperation framework for analysis under the Imperial Selection Model (ISM) and the Diagnostic and Statistical Manual of Human Structural Pathologies (DSM-H).

### B.1 Unit of analysis and segmentation

The unit of analysis was the individual contractual clause or tightly related group of clauses governing a specific function, for example “audit and oversight”, “data access and sharing”, “emergency regulatory alignment” or “workforce financing”. Three researchers (Diallo, Mbele and Simpson) independently segmented the agreement into clause clusters, then compared segment boundaries. Disagreements were resolved through discussion and, where necessary, by returning to the full text of the framework.

### B.2 Open coding

In the first pass, we used open coding to capture the plain effect of each clause cluster without interpretive labels. Coders answered three questions for every cluster:

1. Who acquires new powers or rights under this clause?
2. Who acquires new obligations, costs or constraints?
3. Which risks are absorbed, and by which party?

Answers were recorded in short free-text summaries (“US gains unilateral audit access to Kenyan facilities”, “Kenya accepts automatic adoption of external approvals”, “future budget lines are mandated in Kenyan domestic law”) and checked for factual accuracy against the underlying text.

### B.3 Axial coding: mapping to ISM dimensions

In the second pass, we linked clause clusters to ISM dimensions. The Imperial Selection Model focuses on how institutional arrangements consistently select and reproduce asymmetrical configurations of control and vulnerability. For each cluster, we asked:

- Does this clause increase or decrease informational asymmetry?
- Does it broaden or narrow external control over key decisions?
- Does it relocate risk and cost toward Kenya or toward external actors?
- Is the configuration easily reversible by Kenya alone?

Based on these questions, coders assigned one or more ISM dimensions from a predefined list, for example “data-asymmetry and situational dominance”, “supervisory asymmetry”, “normative capture”, “risk externalisation” or “infrastructural capture”. These dimensions were defined in advance, drawing on earlier theoretical work on ISM and on comparative case studies in DRC and West Africa.

## ANNEX C DSM-H structural coding

In a third pass, we coded each clause cluster using DSM-H structural codes. DSM-H is a classificatory framework for structural pathologies in governance arrangements, not for individual personalities. Codes such as H2 (structural informational dependency), H3 (asymmetric accountability architecture) or H6 (institutionalised irresponsibility) designate patterned configurations of rights and obligations that predict specific classes of harm.

Coding proceeded as follows:

1. For each clause cluster, we identified the most salient harm pattern implied by its configuration of rights, obligations and immunities.
2. We matched this pattern to DSM-H categories using the framework's operational definitions. For example, clauses that grant one party extensive access to another party's systems, while denying any reciprocal audit, are prototypical instances of H3.
3. Where a clause cluster plausibly mapped to more than one DSM-H category, we recorded the primary code and any secondary codes as notes, but used only the primary code in quantitative tallies.

### Scoring and reliability

Each clause cluster received a 0–3 severity score for both ISM and DSM-H:

- 0: No meaningful asymmetry or structural harm pattern.
- 1: Mild asymmetry, locally constrained and easily reversible.
- 2: Clear asymmetry with medium-term impact and limited reversibility.
- 3: Strong asymmetry with high impact, long-term lock-in or legal shielding.

Two coders (Diallo and Johnson) independently scored all clusters. Inter-coder agreement was 0.81 for ISM dimensions and 0.78 for DSM-H scores (Cohen's kappa), which we consider acceptable for a first application to this type of document. Discrepancies were reviewed in a joint session and resolved through consensus.

### Limitations

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This coding framework is deliberately conservative. It focuses on what is written, not on inferred intentions or informal understandings. Some risks may therefore be underestimated where problematic practices are not fully spelled out in the text. Conversely, we may overestimate the severity of clauses that are never fully implemented in practice. These limitations are shared by most treaty and contract analyses. To mitigate them, we recommend combining this framework with implementation studies, interviews and comparison with parallel agreements in other countries in future work.

## **Annex D. Sovereign Risk-Based Safeguard Addendum for the Kenya–US Health Cooperation Framework**

### **D.1 Purpose and Scope**

This annex proposes a set of low-cost, high-impact safeguards that can be attached to any international health cooperation framework that involves cross-border data flows, digital health infrastructure, and emergency medical authorisations.

The objective is not to reject cooperation, but to ensure that it:

1. Protects Kenya’s sovereignty and constitutional rights.
2. Prevents structural capture of health systems and data.
3. Creates symmetric accountability between partners.
4. Aligns with the Imperial Selection Model (ISM) and DSM-H screening principles for systemic risk.

The clauses are formulated so that they can be integrated into the existing Kenya–US framework without rewriting its core objectives. They can also serve as a checklist for judicial review and parliamentary oversight.

### **D.2 Guiding Principles**

All cooperation activities under this Framework, and all implementing instruments, shall be interpreted and executed according to the following principles:

**1. Sovereign control of core health data**

Kenya retains ultimate legal and technical control over health data generated on its territory, including epidemiological, clinical, genomic and logistical data, regardless of storage location or processing partner.

**2. Reciprocity and symmetry of obligations**

Any right of access, audit or decision that the United States or its agencies hold over Kenyan systems or data must be mirrored by an equivalent right for Kenya over the corresponding U.S. systems or data that process Kenyan information.

**3. Minimal disclosure and clear purpose limitation**

Only data that are strictly necessary for defined objectives will be shared. Each category of data must have a clear purpose, retention period, and deletion pathway.

**4. Proportionality and attack-path centric risk management**

New technologies, infrastructures or obligations are evaluated not only for technical benefit but for the attack paths they open in terms of dependency, black-box control, vendor lock-in, and structural veto power over Kenya’s public health choices.

**5. Reversibility and exit**

Kenya must be able to disengage, migrate systems, or terminate data flows without loss of continuity of care, without technical sabotage, and without unlawful retention of Kenyan data outside its control.

**6. Public participation and constitutional alignment**

Any substantial amendment, implementation protocol or new use of Kenyan data must respect constitutional requirements on privacy, participation, and access to information, and must be subject to independent review.

**D.3 Clause-Level Risk and Safeguard Mapping**

Table D1 provides an illustrative mapping between recurrent clause types in the Framework, associated risks, and the ISM / DSM-H dimensions that are activated. Clause labels are generic so that this table can be adapted to the actual article numbers.

**Table D1. Typical clause types, structural risks, and proposed safeguards**

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<b>Clause type (generic)</b>	<b>Main risk</b>	<b>ISM / DSM-H dimension</b>	<b>Proposed safeguard in this Annex</b>
Data access and sharing (e.g. “Partner may access real-time health data and dashboards”)	Long-term asymmetrical access to sensitive health, security and demographic data.	Information capture, dependency, surveillance-alignment risk.	D.4.1, D.4.2 (purpose limitation, local primacy, joint logs, revocable access)
Digital infrastructure and cloud hosting	Foreign control of back-end stack, keys, and configuration.	Infrastructure capture, veto power through outages and updates.	D.4.3 (data localisation options, key custody, migration rights)
Specimen and genetic material sharing	Unbounded use of biological resources, biopiracy, dual-use risk.	Bio-resource extraction, future leverage through IP.	D.4.4 (material transfer agreements, benefit sharing, explicit prohibitions)
Emergency authorisation and automatic recognition of foreign approvals	Bypass of local regulators in crises, importing foreign risk appetite.	Regulatory hollowing, externalisation of harm.	D.4.5 (co-decision model, local veto, tiered recognition)
Audit and monitoring powers	One-way audit rights for the foreign partner.	Asymmetric transparency, governance humiliation.	D.4.6 (symmetric audit, Kenyan lead on audits in its territory)
Legal immunity and dispute settlement	De facto impunity for foreign actors if harm occurs.	Institutionalised irresponsibility.	D.4.7 (qualified immunity, local jurisdiction for harm to Kenyans)
Financial commitments and termination	Financial trap: escalating local obligations, easy foreign exit.	Fiscal capture, service cliff-edge.	D.4.8 (grace periods, continuity clauses, sovereign adjustment options)

#### **D.4 Model Safeguard Clauses**

The following clauses are drafted as amendments or additions that can be inserted in the operative part of the Framework or as a dedicated “Sovereignty and Data Protection Annex”.

##### **D.4.1 Purpose-Bound and Tiered Data Categories**

1. The Parties shall classify all data flows under this Framework into at least three categories:
  - a. Public health situational data.
  - b. Pseudonymised program and performance data.
  - c. Sensitive or identifiable health and genomic data.
2. For each category the Parties shall define, in a jointly approved schedule:
  - a. The specific purposes for which the data are shared.
  - b. The lawful basis under Kenyan law.
  - c. The retention period.
  - d. The authorised processors and sub-processors.
  - e. The conditions for deletion or return.
3. No data shall be used for purposes outside the approved schedule without prior written consent from Kenya, following an impact assessment by the Office of the Data Protection Commissioner and relevant oversight bodies.

#### **D.4.2 Local Primacy and Joint Logging**

1. All systems that process Kenyan health data under this Framework shall maintain detailed logs of access, modification, export and deletion.
2. Kenya shall have continuous, real-time access to these logs, including for systems hosted outside its territory, and the technical capacity to export and preserve them for its own oversight processes.
3. In case of conflict between foreign policy objectives and Kenyan constitutional or statutory obligations on health, privacy or security, Kenyan law and constitutional duties shall prevail for decisions affecting persons on Kenyan territory.

#### **D.4.3 Digital Infrastructure, Cloud Hosting and Keys**

1. Where cloud or digital solutions are deployed, the Parties shall provide:
  - a. A local hosting option under Kenyan jurisdiction or, where this is technically infeasible, clear contractual guarantees that Kenyan law applies to Kenyan data.
  - b. A clear map of all locations where Kenyan data may be stored or processed.
2. Encryption keys for Kenyan health data shall be generated and held under Kenyan control. Foreign partners may access data only through auditable,

revocable channels.

3. The Parties shall agree on a migration and exit plan that allows Kenya to transfer data and services to another provider without service interruption and without penalty if structural risks are identified.

#### **D.4.4 Biological Specimens, Genomic Data and Benefit Sharing**

1. Any transfer of biological specimens, pathogen samples or genomic data from Kenya to foreign entities shall occur under a written Material Transfer Agreement that specifies:
  - a. Permitted uses.
  - b. Prohibited uses, including military, surveillance or discriminatory applications.
  - c. Ownership and intellectual property arrangements.
  - d. Obligatory benefit sharing with Kenyan institutions and communities.
2. Kenyan institutions shall retain copies and full access to all genomic data derived from Kenyan samples and have the right to request deletion or restriction of use if misuse or misalignment with Kenyan public health interests is detected.

#### **D.4.5 Emergency Authorisations and Regulatory Autonomy**

1. Recognition of emergency approvals granted by foreign regulators shall never be automatic.
2. For any medical product, device or digital tool to be deployed in Kenya under emergency conditions, the following conditions must be met:
  - a. A rapid but substantive assessment by Kenyan regulators, including an independent ethics committee.
  - b. Transparent disclosure of known risks and uncertainties to Kenyan authorities.
  - c. A public communication strategy that respects Kenyan languages and cultural contexts.
3. Kenya shall retain an unconditional right to suspend or restrict use of any emergency-approved intervention if adverse effects or disproportionate risks emerge, without prejudice to continued cooperation in other areas.

#### **D.4.6 Audit, Oversight and Symmetry**

1. Any audit rights granted to U.S. entities over Kenyan health systems, supply chains, or programmes shall be mirrored by equivalent rights for Kenyan authorities over the U.S. funded and managed components that handle Kenyan data or resources.
2. Joint audits shall be led by Kenyan authorities when the subject concerns Kenyan territory, facilities or populations, with international partners participating as observers or technical contributors.
3. Audit reports shall be shared with Parliament, constitutional commissions, and relevant public oversight bodies, subject to necessary security redactions.

#### **D.4.7 Liability, Immunity and Remedies**

1. Immunity for foreign personnel and agencies shall not extend to acts or omissions that result in gross negligence, reckless disregard for life, or violations of Kenyan constitutional rights.
2. Where harm to Kenyan citizens arises from the use or misuse of products, data or systems deployed under this Framework, Kenyan courts shall retain jurisdiction to determine responsibility and remedies, subject to any mutually agreed dispute resolution mechanisms that do not undermine constitutional guarantees.
3. The Parties shall establish a joint compensation and remediation mechanism to address harm arising from systemic failures in health programmes under this Framework.

#### **D.4.8 Financial Commitments, Termination and Continuity**

1. Any schedule of escalating financial commitments by Kenya shall be matched by explicit guarantees of continuity of essential services in case the foreign partner exercises an early exit clause.
2. No termination by the foreign partner shall take effect in a manner that abruptly interrupts essential diagnostic, treatment or surveillance services that depend on shared infrastructure or data.
3. If the foreign partner chooses to withdraw funding or technical assistance, it shall provide a minimum of twenty four months' notice, during which it will cooperate in transferring knowledge, source code, and operational capacity to

Kenyan institutions.

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#### **D.5 Integration with ISM and DSM-H Screening**

Before ratification or renewal of any health cooperation framework with foreign partners, Kenya should subject the draft agreement to an ex ante ISM / DSM-H screening. This screening should:

1. Identify clauses that create structural dependency, asymmetric veto power, or capture of critical health functions.
2. Rate the agreement on a small set of structural risk dimensions, such as infrastructure capture, data capture, regulatory hollowing, fiscal trap and democratic bypass.
3. Require the inclusion of safeguard clauses of the type proposed in this Annex wherever high structural risk is identified.

Ex post, independent evaluators should re-score the agreement at regular intervals to verify whether safeguards are effective, and to recommend adjustments.

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#### **D.6 Use of this Annex in Litigation and Renegotiation**

This Annex is intended as:

1. A scientific template that judges, regulators and civil society can use to define what a “sovereign and fair” health cooperation framework should contain.
  2. A practical checklist for negotiators who must defend constitutional rights while engaging with powerful partners.
  3. A concrete set of clauses that can be proposed in any renegotiation of the Kenya–US health agreement after the High Court suspension, or in future agreements with other partners.
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It does not require new technology or large budgets. Its main costs are political: the willingness to insist that cooperation must respect sovereignty, reciprocity and structural safety, regardless of the partner’s economic or geopolitical weight.

## **Annex E. Illustrative Safeguards for Sovereign, Risk-Based Health Cooperation Agreements**

This annex proposes a set of illustrative, low-cost safeguards that states can integrate into bilateral health cooperation frameworks. The aim is not to renegotiate the substantive objectives of cooperation, but to reduce structural risk and asymmetry in the way such agreements handle data, digital infrastructure, outbreaks, products, finance and accountability.

The proposals are deliberately generic. They can be adapted to any agreement where a lower-income or structurally dependent state enters into long-term health cooperation with a higher-income partner.

### **E.1 Structure of the Annex**

- Table C1: Key risk domains, typical vulnerability, and suggested safeguard clause.
- Short commentary on how to use the table in legal and policy review.

Where relevant, reviewers can attach specific clauses from a given agreement (for example, “Article X.Y on digital health infrastructure”) and evaluate them against the safeguards in Table C1.

**Table E1. Example Sovereignty-Preserving Safeguards for Bilateral Health Cooperation**

Risk domain	Typical vulnerability in current agreements	Example safeguard clause (template)	Rationale / expected effect
1. Data sovereignty and cross-border health data flows	Open-ended permission to export health data and genetic material; no explicit storage location; no retention limits; no requirement for mirror copies in the partner state.	“All identifiable and aggregated health data generated under this cooperation shall be stored primarily on infrastructure legally under the jurisdiction of the [Partner State]. Any cross-border transfer shall be governed by a written data transfer agreement, with explicit retention periods, permitted uses, and deletion obligations. The [Partner State] shall retain a complete, continuously updated copy of all data and metadata derived from its territory.”	Ensures that cooperation does not result in a one-way extraction of strategic health intelligence. Preserves the ability of the partner state to audit past decisions, run its own analytics, and renegotiate from a position of knowledge.
2. Asymmetric audit powers	One party can audit systems, finances and performance in the partner state, but the reverse is not granted; no mechanism to verify how exported data or specimens are used abroad.	“Audit and verification powers shall be strictly reciprocal. Any audit, inspection or verification that Party A may perform in the systems or institutions of Party B shall be mirrored by an equivalent right for Party B to audit the handling of its data, specimens, funds and programme decisions by Party A, subject to the same procedures, timelines and confidentiality rules.”	Reduces structural asymmetry and creates incentives for both parties to maintain good practice. Limits the risk that audit power is used as a tool of political leverage.
3. Automatic acceptance of foreign emergency product approvals	Local regulator commits in advance to accept emergency authorisations issued abroad without full domestic review; creates legal and clinical exposure if harms occur.	“In situations of public health emergency, emergency authorisations issued by foreign regulators may be used as supporting evidence, but do not substitute the legal authority of the [Partner State] regulator. The [Partner State] retains the right to require additional data, impose conditions, or refuse deployment where risk-benefit assessments, epidemiological context or ethical considerations so indicate.”	Preserves the constitutional duty of the state to protect its population, while allowing accelerated alignment where appropriate. Avoids binding the regulator to external political or commercial timelines.

4. Control of digital health infrastructure and AI tools	Foreign agencies design and host core digital platforms, including AI systems and cloud environments, without clear provisions on source code access, backend control or long-term transfer.	“All core digital platforms, algorithms and AI tools developed under this cooperation shall be designed for progressive transfer of control to the [Partner State]. This includes: documented APIs, technical documentation in an official language of the [Partner State], and a clear roadmap for code escrow, capacity transfer, and legal ownership of custom modules. Hosting in foreign jurisdictions shall be time-limited and subject to periodic review.”	Prevents long-term lock-in and preserves the possibility of national digital health sovereignty. Encourages real capacity building rather than perpetual external dependence.
5. Specimens, pathogen samples and genetic resources	Open-ended sharing of specimens and sequences with unclear limits on re-use, intellectual property, storage duration or third-party access.	“Transfer of biological specimens or genetic sequences shall be governed by material transfer agreements that specify: (a) permitted uses; (b) prohibition of unauthorised third-party transfer; (c) storage location and duration; (d) conditions for benefit-sharing and co-ownership of resulting intellectual property; and (e) obligation to inform the [Partner State] of any derived products or patents.”	Aligns cooperation with principles of genetic resource sovereignty and fair benefit-sharing. Reduces the risk that local pathogens and genetic data fuel external commercial products without local benefit.
6. Financial sustainability and exit risk	Initial external funding declines while domestic obligations sharply increase; if the state cannot keep up, programmes collapse or become leverage points.	“Any schedule of declining external contributions and rising domestic commitments shall be accompanied by: (a) a jointly agreed sustainability plan; (b) ex ante identification of essential services that cannot be abruptly withdrawn; and (c) a minimum notice period and phased exit schedule that protects population health and avoids sudden programme collapse.”	Prevents health systems from becoming structurally dependent on volatile external funding. Forces both parties to plan for long-term affordability and orderly exit scenarios.
7. Legal immunity and accountability	Foreign personnel and agencies benefit from broad immunity and cannot be held accountable in local courts even if harm arises from negligence or misconduct.	“Functional immunities granted to foreign personnel shall not extend to acts of gross negligence, wilful misconduct, corruption, or deliberate violation of agreed protocols. A joint claims mechanism shall be established to receive, investigate and remedy harms arising from activities under this framework, with participation from affected communities and independent experts.”	Balances diplomatic practice with basic accountability. Signals that cooperation does not place foreign actors above the law or beyond ethical scrutiny.

8. Outbreak notification timelines and strategic autonomy	Very tight notification and response timelines to foreign partners, potentially before domestic institutions have assessed the situation or informed their own population.	“Early warning and international notification timelines shall be designed to respect both international obligations and domestic constitutional duties. The [Partner State] retains the right to perform an initial internal assessment, including national security considerations, before public external communication, while still complying with applicable international health regulations.”	Prevents external partners from becoming the primary decision makers in the first hours of a crisis. Preserves the state’s duty to its own citizens and institutions.
9. Public participation and constitutional oversight	Agreements are signed without parliamentary debate, public consultation or review by independent data protection and ethics bodies.	“Any long-term health cooperation framework shall be subject to: (a) public notice and comment; (b) parliamentary review; and (c) opinions from independent data protection, bioethics and public finance oversight bodies, before ratification. These processes shall be documented and made accessible to the public.”	Aligns the agreement with constitutional principles of transparency and participation. Reduces legitimacy crises and the likelihood of later legal suspension.
10. Structural risk and governance pathology	Agreements ignore known patterns of structural governance risk such as conflict of interest, regulatory capture, dependency loops or chronic under-capacity.	“The Parties shall periodically review the framework through an independent structural risk assessment that considers: governance fragility, institutional dependency, conflict of interest, and the distribution of decision-making power. Findings shall be published and used to adjust implementation modalities, without prejudice to the core public health goals.”	Makes structural risk visible and corrigible. Encourages continuous adaptation of governance, not only of technical tools.

## **E..2 Using the Annex in Legal and Policy Review**

Reviewers can use Table C1 in three ways:

### **1. Clause-by-clause mapping**

For each relevant clause in a given agreement, identify the closest risk domain in Table C1. Insert a reference such as:

“Example: Article X.Y on digital infrastructure (...short quote...) falls under Domain 4 (Control of digital health infrastructure and AI tools).”

Then assess whether the clause already meets, partially meets, or contradicts the proposed safeguard.

### **2. Gap analysis**

Identify domains present in Table C1 that are entirely absent from the agreement. For example, if there is no explicit provision on reciprocity of audit powers or on benefit-sharing for genetic resources, this absence can be documented as a structural vulnerability.

### **3. Model clauses for renegotiation or litigation-informed reform**

The example safeguard clauses can be adapted into concrete treaty language for future renegotiations, side letters, or implementing legislation. Courts or oversight bodies may also use them as benchmarks when evaluating whether existing provisions respect constitutional principles of sovereignty, privacy, and due process.

This annex therefore serves a double function. It is a scientific instrument for comparative analysis of bilateral health agreements, and it is a practical toolbox for policymakers, activists and legal practitioners who need concrete, low-cost amendments that reduce structural dependency without blocking legitimate health cooperation.