



Kenya and the WHO Pandemic Agreement

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Abstract

The COVID-19 pandemic exposed critical weaknesses in global health governance, underscoring the urgent need for a coordinated international framework to address such crises. In response, the World Health Organisation (WHO) initiated a negotiating process that resulted in the May 2025 Pandemic Agreement, a legally binding instrument aimed at enhancing pandemic preparedness, prevention, and response capacities. This paper examines Kenya's strategic positioning in the Pandemic Agreement negotiations—a positioning grounded in its history of health diplomacy. During the Agreement negotiations, Kenya advocated for equity, pathogen data-sharing, sustainable financing, local manufacturing, and a One Health approach. The paper also examines the potential opportunities and challenges that the Agreement presents for Kenya going forward. Opportunities include strengthened health diplomacy, research and training collaborations, protection of Kenyans from global health threats, and promoting economic diversification. Challenges include global geopolitical tensions between democratic-leaning and authoritarian states, constraints on transfer of technology and know-how, limitations on pathogen access and benefit sharing, domestic health system weaknesses, and dependence on external financing. The analysis further explores how the US withdrawal from the WHO and its suspension of foreign aid disrupted global negotiations and strained Kenya's health system. Ultimately, Kenya's interactions with Pandemic Agreement processes, both before and since the Agreement's finalisation, have demonstrated the crucial interconnections, in matters of public health, between global solidarity and national resilience.

Keywords

COVID-19, World Health Organisation (WHO), Pandemic Agreement, Kenya, health diplomacy, equity, international cooperation

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I. Introduction

The COVID-19 pandemic revealed significant gaps in global public health governance, underscoring the urgent need for coordinated international responses to such health emergencies. Accordingly, the World Health Organisation (WHO) initiated development of what would eventually become the Pandemic Agreement—a comprehensive legal framework, adopted by WHO Member States in May 2025, that is aimed at enhancing global preparedness for, prevention of, and response to, future pandemics (WHO, 2025). During the negotiation process, which was led by the WHO’s Intergovernmental Negotiating Body (INB), proposed provisions sought to address the weaknesses exposed during the COVID-19 crisis and to pursue (at times conflicting) principles of global equity and state sovereignty (WHO, n.d.-b). The negotiation process was predominantly guided by the need for international cooperation, equitable access to resources, and the early sharing of pathogen data—all necessary to effectively combat global health threats (WHO, 2023d).

While the text of the Pandemic Agreement of 2025 has been praised for its comprehensive approach and its promotion of global solidarity, it has also been criticised for its lack of detailed implementation strategies and measures to ensure equal access to resources across nations (WHO, 2023d). These absences are critical given the disparities, among WHO Member States, with respect to stages of development and scale of need in times of public health crisis.

As was the case in numerous countries during the COVID-19 pandemic, Kenya grappled with shortfalls in access to vaccines and essential medical countermeasures. Accordingly, Kenya actively participated in the Pandemic Agreement negotiations (MoH, 2024b). Leveraging its longstanding prominence in the global health policy sphere, Kenya advocated, during the negotiations, for equitable access to vaccines and countermeasures, sharing of pathogen data, adoption of a One Health approach, specification of concrete financial commitments, and development of local capabilities, in the Global South, for development and manufacturing of vaccines.

Now that the Pandemic Agreement has been finalised, it offers Kenya significant opportunities—for, inter alia, international research collaboration, increased self-sufficiency, and increased economic diversification. At the same time, however, implementation of the Agreement presents Kenya with challenges linked to, inter alia, geopolitical dynamics and existing disparities in vaccine distribution.

This Open AIR Working Paper examines Kenya’s role, strategic interests, and contributions, within the context of the Pandemic Agreement negotiations. It also examines the opportunities and challenges that the Agreement, finalised in May 2025, presents for the country.

II. Kenya and Health Diplomacy

The WHO Pandemic Agreement negotiations have presented Kenya with a significant opportunity to renew its longstanding strategic role in global health diplomacy. Like many other nations, Kenya recognises the critical importance of international cooperation in addressing global health challenges.

Health diplomacy is a pivotal force in tackling global health crises. It operates as a multifaceted tool, weaving together a range of diplomatic approaches to address health challenges that transcend the confines of individual nations (WHO, 2014). These approaches comprise multilateral engagement, negotiation and cooperation; health aid and assistance; health security and emergency response; and health promotion and advocacy. The evolution of health diplomacy has been shaped by significant events and periods, including the establishment of global health organisations such as the WHO (established in 1948); responses since the 1980s to the HIV/AIDS pandemic; and notably, the challenges posed by pandemics and other public health emergencies of international concern such as Ebola, SARS, H1N1 influenza, and poliomyelitis (DiploFoundation, n.d.). Health diplomacy operates in diverse contexts, spanning multilateral organisations, international health initiatives, disaster management, academic institutions, and philanthropic efforts (DiploFoundation, n.d.).

The significance of health diplomacy is evident in the context of pressing global public health issues, notably as exemplified by the COVID-19 pandemic. This crisis served as a compelling reminder of the imperative for nations to collaborate, to share vital information, to pool resources, and to orchestrate their responses cohesively (Javed & Chattu, 2020). In today's interconnected world, phenomena such as pandemics, antimicrobial resistance, and the health impacts of climate change, all pose collective threats to the global population. Health diplomacy champions international cooperation to detect, prevent, and respond to pervasive global public health threats (DiploFoundation, n.d.).

Further underscoring health diplomacy's importance is its intersection with international security. Health threats, such as pandemics and biological attacks, carry substantial transnational political and security implications. Disease outbreaks have the capacity to disrupt economies, strain healthcare systems, and incite social and political unrest (DiploFoundation, n.d.). By fostering collaboration on surveillance, information-sharing, and joint response efforts, health diplomacy can play a pivotal role in averting conflicts and promoting stability during these crises (DiploFoundation, n.d.). Health diplomacy also plays a crucial role in advancing sustainable socioeconomic development by expanding access to quality healthcare, addressing health disparities, and strengthening health systems. It aligns with the fundamental principles of sustainable progress that are central to achievement of the UN's health-related Sustainable Development Goals (SDGs) (DiploFoundation, n.d.).

Because of its commitment to health diplomacy, Kenya could not afford to be left out of the WHO Pandemic Agreement negotiations. The negotiations offered Kenya a platform to amplify its voice on the global stage, to strengthen its diplomatic relations, and to advance its national interests in the realm of public health and pandemic preparedness. Kenya's priorities in participation in the work of the INB included equitable access to vaccines and essential medical countermeasures, dependable and fast-paced pathogen data-sharing, and heterogeneous manufacturing across the Global North and South so as to ensure the availability of needed items (MoH, 2023f).

In dealing with the West, Kenya has always had a pro-access stance to medical resources and other health crisis countermeasures. The country's defiance of the West was evident during negotiations on application of the WTO's TRIPS Agreement in 2001 (Harrington & Ngira, 2023). The resulting Doha Declaration on the TRIPS Agreement and Public Health, while recognising the value of the TRIPS Agreement, recognised the importance of supporting Member States of the WTO in their efforts to

promote access to life-saving medications. Exploiting flexibilities in the Agreement, the Kenyan Parliament stood up to pharmaceutical company lobbying and EU and US task forces and maximised access to medicine for Kenyans (Harrington & Ngira, 2023). Similarly, Kenya advocated for vaccine access during the height of the COVID-19 pandemic and called out Western states for “vaccine apartheid”—i.e., for having more vaccines than they needed while denying access to African and Latin American countries. As a result of one such reprimanding statement, the UK donated 817,000 vaccine doses to Kenya and lifted controversial travel restrictions on Kenyans (Harrington & Ngira, 2023).

Kenya’s role in the Pandemic Agreement negotiations was also grounded in its regional influence in East Africa, its economic standing, and its active participation in global partnerships. Kenya has helped shape the political, economic and environmental landscape in the East African region as a founding Member of the East African Community (EAC) and as the largest economy in the region (Dizolele et al., 2025). Kenya’s regional influence also stems from its political stability, its well-established infrastructure, and its participation in regional peace initiatives (Dizolele et al., 2025). Kenya has participated in peacekeeping partnerships with the UN, the African Union (AU) and other partners, and it embraces a foreign policy stance in line with the African Union’s Agenda 2063, seeking to contribute to a strong African presence on the global stage (Ministry of Defence, n.d.).

Kenya’s commitment to development of the Pandemic Agreement was also aligned to the African continent’s desire for more surveillance and response systems in the context of public health crises (Republic of Kenya, 2022b). This was in recognition of Africa’s vulnerability to such crises, whereby 79% of all global health emergencies affect the continent (Republic of Kenya, 2022b).

III. Kenya’s Participation in WHO Negotiations

In December 2021, establishment of the WHO INB was announced by the organisation’s decision-making body, the World Health Assembly (WHA), “to draft and negotiate a convention, agreement or other international instrument under the WHO Constitution to strengthen pandemic prevention, preparedness and response” (WHO, n.d.-b).

In January 2022, in its National Statement to the 150th Session of the WHO Executive Board, Kenya reflected the position of WHO Africa Region Member States in stating that “the lack of timely and equitable access to vaccines and other medical countermeasures” had had “the most detrimental effect” during the global response to the COVID-19 pandemic (Republic of Kenya, 2022a). As such, Kenya called for operationalisation of the principle of equity in delivering vaccines and other medical assistance during a global pandemic and emphasised its support for formulating a legally binding WHO instrument (Republic of Kenya, 2022a). Equity in this context refers to the intention to take necessary measures to protect vulnerable populations, and to ensure proper access to pandemic-related products and resources, in all phases, from preparation to countermeasures. In this regard, Kenya, as one of the WHO African Region countries, embraced the need for better knowledge-sharing, and addressing financial and technical needs to enable African countries to address pandemic situations effectively.

In the same January 2022 National Statement, Kenya stated that it looked forward to INB’s composition and operationalisation (Republic of Kenya, 2022a). Kenya’s statement also included a call to develop

mechanisms to address increased need for financial and technical resources and for sharing of technology and know-how (Republic of Kenya, 2022a). The Agreement negotiations were largely taken forward by drafting sub-groups focused on specific articles (WHO, 2024b). WHO Member States contributed to the negotiations in both formal and informal sessions. Kenya played both an active—and at times passive—role in the negotiations process.

In February 2022, during a UN General Assembly High-Level Thematic Debate titled Galvanizing Momentum for Universal Vaccination, the Kenyan Health Cabinet Secretary reiterated Kenya's support for a WHO pandemic instrument to address inequalities revealed by the COVID-19 pandemic and to enable the global community to fight pandemics with a united front (Harrington & Ngira, 2023).

In November 2022, the INB published the Conceptual Zero Draft, which served as the foundational document for discussions regarding the pandemic instrument. It was expansive in scope, stating the need to save lives and protect livelihoods by enhancing global capacities for pandemic prevention, preparedness and response, and for health system recovery (WHO, 2022). It emphasised principles of equity, good governance, and the right to health, while reaffirming the importance of state sovereignty. While Kenya's specific contributions to drafting of the Conceptual Zero Draft were not published, it publicly expressed its support to the INB negotiations. Kenya then actively took part in INB sessions 3, 4, 5, resumed 5, and 6 between December 2022 and July 2023, both as an individual WHO Member State and as part of the WHO Africa Region Member States grouping (WHO, n.d.-a). In February 2023, the INB released the Zero Draft (Rudall, 2023), with Kenya among the contributors to the negotiation of the document.

In May 2023, as a demonstration of its support to development of a WHO pandemic instrument, Kenya hosted a Geneva High Level Ministerial Meeting on Strengthening Prevention, Preparedness, Response and Recovery from Public Health Emergencies, where it noted the implications of the negotiations on national health security (MoH, 2023a). The event, which was hosted in collaboration with Amref Health Africa and the WHO, brought together health ministers from numerous Africa nations to generate joint commitments towards development of the pandemic instrument (Amref Health Africa, 2023). At the dialogue event, Kenya stated that equitable access to health products and technologies was a significant challenge for Kenya and African in general, and urged that existing inequities to be addressed (Amref Health Africa, 2023). Kenya also emphasised the need to resolve ensure sustainable financing for public health emergencies. It hoped that this challenge could be addressed through the Pandemic Fund that had been established by the World Bank in 2022 (The Pandemic Fund, n.d.). Kenya also stressed the importance of unified vision and voice from the WHO Africa Region Member States during the negotiations, as a means of strengthening the region's position and to better addressing the challenges affecting the region, particularly, on financing and equity.

Also in May 2023, Kenya delivered a statement at the 76th WHA, where the Cabinet Secretary for Health expressed Kenya's commitment to address global health issues (MoH, 2023c). Kenya called for improved collective action in responding to global health emergencies and stressed the need for equity in global public health. Kenya was dedicated to reforming the multilateral health system (MoH, 2023c).

In June 2023, at a Regional Meeting for Collaborative Arrangement for Prevention and Management of Public Health Events in Civil Aviation in Mombasa, organised by International Civil Aviation Authority and the Kenya Civil Aviation Authority, the Kenyan Ministry of Health (MoH) emphasised the need for a whole of government and society approach in pandemic prevention, preparedness and prevention (MoH, 2023e). The Principal Secretary for Public Health and Professional Standards noted that Kenya had made progress in enhancing capacities necessary for pandemic preparedness and responses—in, for instance, emergency coordination, community engagement, clinical care, risk communication and collaborative surveillance. At that time, Kenya was the Vice Chair of the WHO African Region and a Member of the Bureau of the Working Group on Amendments to the International Health Regulations (MoH, 2023e). In the same month, the Kenyan Principal Secretary for Public Health and Professional Standards met with an EU delegation in Nairobi, where they reviewed Kenya’s contributions to the pandemic-instrument negotiations (MoH, 2023f). At this meeting, Kenya noted that its priority areas in the negotiations were equitable access to essential health care commodities, the rapid and reliable sharing of health data, and diversified manufacturing to enhance security in health care commodities (MoH, 2023f).

Also in June 2023, Kenya was among 29 developing-country WHO Members States who came together to form the Group for Equity, which was announced at the INB’s 5th session and became actively involved in negotiations. The Group for Equity’s key aim was to ensure proper understanding of the unique needs faced by Global Southern countries with respect to equitable medical resource distribution and manufacturing capacity during pandemics (TWN, 2023). The Group was supported by the Third World Network (TWN), which facilitated the Group’s communications work and conducted and disseminated relevant research, helping to make the Group a vital contributor to the INB negotiations (WHO, 2024a).

In August 2023, in line with its participation in the Pandemic Agreement negotiations, Kenya took a strong stance towards better preparedness for future pandemics. A Memorandum of Understanding (MoU) was signed between the Kenya Medical Research Institute (KEMRI) and the Kenya BioVax Institute (KBI), to create new opportunities for the manufacture and supply of vaccines to Kenya and its neighbours (KEMRI, 2023). This commitment was adopted as part of the World Bank and Ministry of Health’s Kenya Health Emergency Preparedness, Response, and Resilience Project, whose aim is to increase self-reliance in manufacture and supply of medical products (KEMRI, 2023). In addition to local production of vaccines through the KBI, the project’s objectives include bolstering the capacity of the Kenyan Pharmacy and Poisons Board as a medical products regulator, and capacity-building for the National Public Health Institute, the National Quality Control Laboratory, and the Kenyan bio-manufacturing industry in general (KEMRI, 2023).

In September 2023, Kenya took part in that month’s INB drafting group meeting (WHO, n.d.-b). In the same month, a Kenyan Cabinet meeting in Kisumu approved the establishment of an Inter-Ministerial Committee to negotiate the Pandemic Agreement with the WHO (MoH, 2023b). The Kenyan Cabinet urged the Committee to advocate for equity in shaping the Agreement, and also expressed its desire to champion the establishment of a global health supplies framework, based on the principles of equity, for pandemic preparedness (MoH, 2023b). In the same month, the Kenya Cabinet Secretary for Health attended the UN High-Level Meeting on Pandemic Prevention, Preparedness and Response, which was convened by the President of the UN General Assembly during its 78th Session (MoH, 2023d). The Cabinet Secretary’s address included references to the fact that Kenya had established the Kenya BioVax Institute

in 2021 to enhance health resilience; that Kenya had been involved in strengthening both the Nairobi-based WHO Regional Emergency Logistics Hub and the Africa Centers for Disease Control and Prevention (MoH, 2023d); and that Kenya was also active in training professionals to respond to health emergencies.

In October 2023, the INB released the Proposal for Negotiating Text of the WHO Pandemic Agreement (WHO, 2023d). In a November 2023 press release, the Group for Equity Member States (of which Kenya is part) criticised the Proposal, stating that it fell short on implementation of equity standards. The press release also pointed to the fact that while all countries share the responsibility to address pandemics, they do not share equal responsibility or equal capability. As such, it was crucial to acknowledge the differing capacities and circumstances of countries, particularly between developed and developing nations, in achieving equity standards in the Agreement (TWN, 2023). Kenya continued to contribute to the negotiations and revisions of the Negotiating Text at the INB sessions 7, 8, 9 and resumed 9 that took place between November 2023 and May 2024 (WHO, n.d.-a).

In March 2024, the Kenyan MoH convened a national roundtable meeting in Nairobi to sensitise stakeholders and get views on the Pandemic Agreement—as there were now efforts being made to conclude the Agreement negotiations before the 77th WHA of May-June 2024 (MoH, n.d.-a; n.d.-b). The national roundtable inputs, not published, were expected to inform Kenya’s position for future negotiations. At the event, the Kenyan MoH emphasised its commitment to ensuring Agreement provisions on equitable access to essential medical supplies, financing, and technology transfer (MoH, 2024b).

In April 2024, the Kenya National Public Health Institute met with local and global partners, including the WHO, the UN Food and Agriculture Organisation (FAO), the International Organisation for Migration (IOM), and UN Children’s Fund (UNICEF), to develop the country’s proposal for the working with the Pandemic Fund hosted (since 2022) by the World Bank (MoH, 2024d). This involved aligning stakeholders on priorities, funding needs and implementation strategies. In addition, the meeting discussed ways for strengthening health-systems resilience through minimising the impacts and dangers of acute public health events (MoH, 2024d). In the same month, Kenya engaged with EU officials at a meeting in Nairobi on the avenues for strengthening collaboration on the Pandemic Agreement and “implementing robust counter-pandemic measures for early containment, ensuring sustainable health financing, and advancing health digitalisation” (MoH, 2024a).

In May-June 2024, at the 77th WHA, Member States decided that due to a continuing lack of consensus on several points in the Pandemic Treaty negotiations, that the INB was “to finish its work as soon as possible, and submit its outcome for consideration by the Seventy-eighth World Health Assembly in 2025, or earlier by a special session of the World Health Assembly if possible in 2024 [...]” (WHO, 2024d). In its national statement at the 77th WHA, Kenya expressed its continued support for the negotiations but, at the same time, raised concerns regarding the INB’s failure to reach consensus on the Proposal for Negotiating Text’s articles on financing and equity (Republic of Kenya, 2024). Kenya also urged WHO Members States to reconsider hardline positions on financing and equity (Republic of Kenya, 2024). Between June 2024 and April 2025, six sessions of the INB were held—sessions 10, 11, 12, resumed 12, 13, and resumed 13—and Kenya continued to contribute.

As a member of the WHO African Region grouping of Member States, Kenya pushed for foregrounding, in the Pandemic Agreement, of a One Health approach to pandemic prevention, preparedness and response. The One Health approach necessitates bridging between different scientific disciplines whereby animal, human and environmental expertise and efforts are integrated (PLOS, 2024). Through cross-sectoral partnerships, Kenya has worked on a One Health initiative to address zoonoses (Salm-Reifferscheidt, 2023). This initiative, though useful for Kenya, has been hindered by financial constraints; hence the push by Kenya in the Pandemic Agreement negotiations for concrete financial obligations. (The One Health approach found its way into the final WHO Pandemic Agreement, contained in Articles 1 and 5.)

In February 2025, the Kenya Principal Secretary for Public Health and Professional Standards met with French Embassy officials in Kenya to discuss Kenya's involvement in the Pandemic Agreement negotiations (MoH, 2025a). While the details of this meeting were not made public, it demonstrated Kenya's continued desire for a global pandemic agreement and commitment to collective actions and collaboration in global health resilience.

In May 2025, at the 78th WHA, the WHO Pandemic Agreement was adopted by WHO Member States (WHO, 2025b). The Agreement's articles include provisions in support of the following:

- pathogen access and benefit-sharing (PABS);
- equity in access to vaccines, medicines, and diagnostics;
- stronger national health systems;
- the One Health approach;
- improved global supply chains and logistics;
- research and development (R&D) cooperation;
- a financing mechanism; and
- protections for national sovereignty.

In addition, Agreement implementation is to be guided by a Conference of the Parties structure (similar to that which works in support of global climate treaties).

IV. Implications of Pandemic Agreement for Kenya

The Pandemic Agreement was adopted in May 2025 subject to two key further actions: first, drafting and negotiation of an Annex, under the Agreement's Article 12, on PABS; and, after finalisation of the Annex, opening the Agreement up for Member State signature and ratification (WHO, 2025b). The Agreement will take effect only after the PABS Annex is finalised and at least 60 WHO Member States have ratified the Agreement domestically. Additionally, WHO Member States and regional economic integration organisations were urged to take appropriate measures to further the objectives and implementation of the Agreement (WHO, 2025b). Kenya's Cabinet Secretary for Health called for a swift yet precise completion of the Annex on PABS, so as to allow developing countries to benefit from it (Shikanda, 2025).

An open-ended Intergovernmental Working Group (IGWG), open to all WHO Member States and to regional economic integration organisations, was established to draft and negotiate the Annex on PABS and submit the outcome by the 79th WHA in May 2026. The IGWG met for the first time on 9-10 July 2025 to elect its Officers, propose methods of work, agree on the timelines and deliverables, and consider modalities for engagement for relevant stakeholders (WHO, 2025d).

The Pandemic Agreement has the potential to allow Kenyans to benefit through research and training collaborations, medicine manufacture, and health service digitisation (MoH, 2023e). The country will be able to collaborate with other countries and international organisations to conduct joint research on pandemic preparedness and mitigation. Thus, Kenya will be able to improve preparedness for future health crises. In the past, Kenya collaborated with the UK, through which KEMRI conducted early vaccine trials, in October 2020, of the Oxford–AstraZeneca vaccine for COVID-19 (Harrington & Ngira, 2023). The Pandemic Agreement seeks to formalise collaborations of this sort among WHO Member States and other qualified entities through the WHO PABS system provided for in the Agreement’s Article 12.

The Agreement also has the potential to help protect Kenyans from global health threats, through minimising Kenya’s dependence on imports and aid during such crises (Maxmen, 2022). By the mid-1990s, 50% of Kenya’s health sector expenditure was reliant on international agencies and donors (Harrington & Ngira, 2023). As a result, the WHO, UNICEF and the World Bank played a key role in health policy in the country, influencing progress in matters of hygiene, nutrition and safe-sex schemes (Maxmen, 2022).

Active participation in implementing the Agreement also has the potential to increase local manufacturing of health resources such as vaccines, thus further reducing reliance on international support and increasing the supply during health emergencies such as pandemics. Agreement implementation can also increase international R&D collaborations with state and non-state actors, attracting funding and investment for healthcare initiatives in the country. Such diversification can reduce the Kenyan economy’s current heavy dependence on its tourism and agriculture sectors. However, at the same time, there are several implementation challenges that threaten to undermine the potential benefits of the Agreement for Kenya.

A. Global Geopolitical Tensions

At global level, there are at present ongoing geopolitical tensions between democratic-leaning and authoritarian states, posing barriers to matters requiring collaboration and partnerships (Fidler, 2021). The COVID-19 pandemic revealed many of these geopolitical tensions and contributed to rising populism and nationalism in local contexts in many states. As such, the question arises: how can WHO Member States ensure political commitment to a Pandemic Agreement in a world with ongoing domestic nationalism, international conflicts and ideological competition? These challenges do not make it impossible to actualise the aims of the Pandemic Agreement, but they certainly complicate the endeavour.

During the pandemic, African countries and other parts of the Global South experienced vaccine shortages while rich countries stockpiled more than a billion vaccine doses (Bajaj et al., 2022). These

access gaps resulted in what some termed “vaccine apartheid”, where high-income countries received 133 vaccine doses per 100 individuals while low-income countries received 4 doses per 100 people (Bajaj et al., 2022). At the height of the COVID-19 pandemic, there was considerable tension between statist and globalist perspectives (Wenham et al., 2022). Most high-income countries treated the COVID-19 crisis as a matter of national security rather than a chance to demonstrate global cooperation in finding solutions, with most of them departing from obligations set out in the International Health Regulations (IHR) of 2005 and not following WHO guidance and recommendations—instead focusing on protecting their populations through vaccine-hoarding, border restrictions, and prolonged shutdowns (Wenham et al. 2022).

Actualising the Pandemic Agreement will likely require painful economic and political decisions by some Member States (Wenham et al., 2022). For instance, the proponents of the equity principle envision a scenario where high-income countries agree to limitations to their power and resources in favour of low-income countries (Wenham et al., 2022). However, this dynamic was not evident during the COVID-19 pandemic, as high-income countries focused on protecting their sovereignty and on stockpiling scarce resources for the benefit of their citizens. In terms of the Pandemic Agreement, wealthy Member States face a requirement to share know-how and monetary resources, which such states may fear will pose negative implications for their citizens. Such reluctance could render the actualisation of elements of the Pandemic Agreement extremely difficult, leaving low-income countries in a disadvantaged position similar to the one faced during the COVID-19 pandemic.

(See, also, “US Withdrawal from WHO and Suspension of USAID” sub-section below.)

B. Article 11: Transfer of Technology and Know-How

Article 11 of the Pandemic Agreement addresses the transfer of technology and know-how necessary for producing health products related to pandemic. Such transfer is a matter of great significance for developing nations such as Kenya, who have faced challenges due to insufficient technology transfer and an over-reliance on market dynamics—resulting in unequal access to essential tools for managing pandemics (*Nature*, 2024). Article 11 acknowledges the vital importance, for developing countries, of technology transfer and capacity-building, which are crucial to building local manufacturing capabilities, self-sufficiency, and sustainable production of pandemic-related health products.

Among other things, Article 11 highlights the importance of making technologies developed with public funding more accessible to developing nations (WHO, 2025b). This focus on publicly funded technologies aligns with the principle that health innovations funded by public money should prioritise public health benefits over profit (WHO, 2021b). Article 11 also encourages private intellectual property rights holders to promote technology transfer, and affirms the developing-country right to use WTO TRIPS Agreement flexibilities in support of affordable access to health technologies and products (WHO, 2025b). In addition, Article 11 provides for establishment of regional or global technology-transfer hubs, coordinated by the WHO (WHO, 2025b). Such hubs could create an organised framework for the equitable distribution of technology and know-how, fostering collaboration and capacity-building among developed and developing countries.

While Article 11 presents opportunities for developing countries, it also poses several challenges. Crucially, the provisions of Article 11 are primarily suggestive and lack binding obligations or incentives. Use of terms such as “encourage”, “promote”, and “consider”, and ambiguity in defining terms such as “fair and most favourable”, “concessional”, and “preferential” (WHO, 2025b), may—with no legal mechanism or incentive to drive high-income countries or private companies to act—lead to limited actual transfer of technology and know-how, hindering developing-country access to necessary technologies (Love, 2024).

With respect to the Article’s calls for capacity-building, this assistance is conditional, qualified by phrases such as “within its capabilities” and “subject to available resources and applicable law” (WHO, 2025b). This creates additional uncertainty about the level and consistency of support that developing countries can realistically expect, potentially limiting the development of sustainable local production capacities.

An example of the weaknesses inherent in reliance on voluntary actions in the Global North to support Global Southern development is provided by US pharmaceutical manufacturer Moderna’s suspension, in April 2024, of its pledge to invest in establishing and expanding vaccine manufacturing facilities in Kenya. Moderna framed the suspension as necessary due to a lack of demand for COVID-19 vaccines (Africa CDC, 2024). This decision suggests a lack of genuine commitment from Moderna towards advancing vaccine equity and access by fostering local production capabilities in Africa (Africa CDC, 2024).

With respect to establishment of the technology-transfer hubs, their reliance on multilateral mechanisms (WHO, 2025b) means they could face significant bureaucratic hurdles and delays. Finally, the Article’s reaffirmation of the rights of developing countries to use WTO TRIPS flexibilities (WHO, 2025b) may be undermined by the challenges developing countries face in effectively utilising these flexibilities—due to a lack of legal expertise and/or political pressure linked to fear of trade retaliation (Medicines Law & Policy, 2024).

(See, also, “Domestic Challenges” sub-section below.)

C. Article 12: PABS

In the context of pandemic response, accurate and timely data-sharing is paramount. Kenya and other WHO Africa Region Member States have advocated for robust and rapid PABS mechanisms to enhance the global community's ability to detect, track, and respond to emerging health threats effectively (Republic of Kenya, 2022a). Access to real-time information is essential for early warning systems and informed decision-making during pandemics.

In its statement to the 150th Session of the WHO Executive Board in January 2022, Kenya recommended that WHO embed PABS mechanisms into the WHO BioHub System (Medicines Law & Policy, 2024) that had been established in November 2020. The BioHub System was established to promote the rapid and timely sharing of biological materials with pandemic potential; and to facilitate rapid, fair and equitable access to such pathogens and their information (WHO, n.d.-c). The first WHO BioHub Facility, based in Spiez, Switzerland, was launched in May 2021 by the WHO and the government of Switzerland. It aimed

to facilitate rapid sharing of viruses and other pathogens between laboratories and partners globally (WHO, 2021a). The Facility receives donated pathogens from countries and shares them with qualified entities so as to ensure rapid creation of vaccines and diagnostic mechanisms (WHO, 2021a).

Article 12 of the Pandemic Agreement aims to replace the bilateral sharing system with a multilateral approach, through the WHO PABS system (WHO, 2023c). The Article's primary aim is to promote the "rapid" and "timely" sharing of sequence information on pathogens that have a pandemic potential and to promote the "rapid", "timely", "fair" and "equitable" sharing of benefits arising from the PABS system (WHO, 2025b). This can, however, only be achieved through collective action and refinement of national legal and regulatory regimes, and it remains to be seen whether the aforementioned Article 12 Annex on PABS, currently under negotiation, will be able to deliver these necessary elements

Important to Kenya are the Agreement's calls, with respect to PABS, for inclusion of provisions to allow for capacity-building and technical assistance; R&D cooperation; facilitating rapid access to available vaccines, therapeutics and diagnostics with a view to responding to public health risks and events; and the granting of non-exclusive licences to manufacturers in developing countries, for the effective production and delivery of vaccines, therapeutics and diagnostics (WHO, 2025b). While these are worthy objectives, the challenge would lie with implementation. Article 12 designates the WHO as the conveyor belt for PABS implementation, and WHO capacity may pose an additional challenge, especially if there is lack of cooperation by relevant stakeholders. Nonetheless, it will be in the best interests of Kenya to actively participate in negotiations regarding the Annex to Article 12.

D. US Withdrawal from WHO and Suspension of USAID

When the WHO initiated negotiation of a pandemic instrument in December 2021, it opened the negotiations to all 194 WHO Member States to make contributions (WHO, 2025c). Subsequently, all Member States agreed to establish the INB (WHO, 2025c). Indeed, the INB's work was guided by the principles of inclusiveness, transparency, efficiency, leadership and consensus (WHO, n.d.-b). Between December 2021 and December 2024, all 194 WHO Member States collectively participated in negotiating and revising the texts of what was eventually to become Pandemic Agreement. While geopolitics and differences in the levels of development among WHO Member States were apparent, these differences also included points of convergence that provided a basis for negotiation. And developmental differences and inequities at national and international levels found their way into the Preamble of the eventual Pandemic Agreement (WHO, 2025b).

A significant shift occurred in January 2025 when US President Donald Trump was sworn in for a second term in office. Trump Executive Orders withdrew the US from the WHO and suspended aid provisioning through the US Agency for International Development (USAID). According to the Executive Order withdrawing the US from the WHO, the WHO had mishandled the COVID-19 pandemic, had failed to adopt "urgently needed reforms", had failed to demonstrate independence, and was continuously demanding onerous payments from the US that were out of proportion with payments demanded from other countries such as China. Accordingly, the US paused the transfer of funds, support and resources to the WHO and recalled its WHO personnel. The US also ceased negotiations on the Pandemic

Agreement, and noted that it would not be bound by such an agreement were it to be reached (The White House, 2025b).

The US withdrawal from the WHO has certainly been large setback for the objectives of the Pandemic Agreement. The power of the US in global public health matters is considerable. The suspension of US funds, support and resources transfer has without doubt impacted the WHO finances and operations, as the US was the WHO's largest financial supporter. The US actions also strongly undermine the spirit and practicalities of the Pandemic Agreement, an instrument founded on solidarity and collective action between entities in the developing world and those in the developed world—where US entities are in the forefront of many global public health matters, thus able to undermine or stall many of the objectives of the Pandemic Agreement.

The US withdrawal from the WHO, coupled with the freeze on USAID funds, almost certainly had an impact on the final period of Pandemic Agreement negotiations in early 2025. The entity convening the negotiations, the WHO, was in a state of turbulence caused by withdrawal of its largest funder, and developing-world WHO Member States, including Kenya, were grappling to find ways to maintain public-health programmes that had previously been reliant on USAID funds.

In Kenya, the immediate reaction to the US Executive Orders was to re-evaluate domestic programmes and forge of new relationships. The Director-General for Health indicated in January 2025 that Kenya was exploring various ways to strengthen bilateral health partnerships with other nations and institutions (*Daily Nation*, 2025). Kenya also called for strengthened support and collaboration through the AU and global platforms that support Africa's health needs (*Daily Nation*, 2025). In a March 2025 statement, the Cabinet Secretary for Health advocated for strengthened domestic-health financing, urging Parliament to prioritise budgetary allocations for the sector (MoH, 2025b). As of July 2025, Kenya was still struggling to adapt to the US funding cuts, with the consequences including lay-offs of health workers, closure of clinics, suspension of community-led initiatives, and reduced or paused HIV/AIDS prevention programmes (Physicians for Human Rights, 2025).

E. Domestic Challenges

While Kenya was an active player in the Pandemic Agreement negotiations, it was also grappling with several internal challenges that, over time, impacted the extent to which it could make specific contributions to the process. A core challenge was changes in leadership, at both Presidential and Cabinet level. The Pandemic Agreement negotiations commenced in 2022, while President Uhuru Kenyatta was still in power. Leadership changed in September 2022, when the current President, William Ruto, took office and subsequently appointed a new Cabinet Secretary for Health. Between 2022 and May 2025 when the Pandemic Agreement was adopted, President Ruto changed the Cabinet Secretary for Health a total of three times, with the latest appointment happening in March 2025 (Sayyid, 2025). These changes impacted the speed and the quality of contributions made to important health matters affecting the country, including contributions to the Pandemic Agreement negotiations. Kenya's role in the Agreement negotiations gradually became less active, especially after the 77th WHA of May-June 2024.

Kenya's prioritisation of the Pandemic Agreement negotiations was also undermined by other elements. First, the aforementioned US suspension of USAID disbursements disrupted certain important public health programmes. Second, there were additional instabilities impacting the health sector, including a doctors' strike in 2024, high levels of corruption in the sector, changes to the national health insurance fund, and a generally inadequate public health infrastructure.

Another element that presumably have diluted the Kenyan government's prioritisation of the Pandemic Agreement negotiations was the 2024 decision by US pharmaceutical company Moderna's to pause its plan to build an mRNA vaccine manufacturing facility in Kenya (Taylor, 2024). Kenya had been selected, in 2022, to be one of six African beneficiary countries of a mRNA technology-transfer programme, alongside Egypt, Senegal, South Africa, Tunisia and Nigeria (WHO, n.d.-d). The programme had been brokered by the WHO. In its statement in April 2024, Moderna stated that its plan to establish mRNA manufacturing capacity in Kenya was now on hold, as the company was assessing future demand for mRNA vaccines across Africa (Moderna, 2024). It can be assumed that the Kenyan government's faith in the WHO-brokered Pandemic Agreement process was undermined by the collapse of the WHO-brokered Moderna commitment.

V. Recommendations

A. Implementation of Article 11

For effective implementation of Article 11 of the WHO Pandemic Agreement on transfer of technology and know-how, several recommendations can be made. Strengthening binding obligations is essential, through transforming key provisions into enforceable commitments regarding technology transfer, capacity-building, and PABS (Ncube, 2024). Clarifying ambiguous terms will help ensure that developing countries receive tangible benefits under clear criteria. Enhancing support for capacity-building initiatives through guaranteed financial and technical assistance is also crucial, along with establishing dedicated funding mechanisms. Addressing practical barriers to utilising TRIPS flexibilities, by providing technical assistance and legal support, will empower developing countries to exercise their rights effectively. Also, streamlining processes for establishing technology-transfer hubs will ensure that Article 11's mechanisms are operational and effective during health emergencies.

In summary, the effectiveness of Article 11 will ultimately depend on the extent to which its provisions are enforced and practically implemented. Strengthening obligations, clarifying terms, enhancing capacity-building support, and addressing barriers to TRIPS flexibilities are essential to ensuring that the objectives of Article 11 are truly realised, leading to a more equitable global health landscape.

B. Implementation of Article 12

Ensuring that developing countries, including Kenya, receive tangible benefits under Article 12 on PABS will require clarification of the meanings of certain ambiguous terms. Among the terms requiring definition are "pathogens with pandemic potential", "PABS materials and sequence information", "fair, equitable and rapid and timely sharing", "monetary modalities" and "not-for-profit prices". Article 12 also lacks parameters what are to constitute "appropriate measures to facilitate the manufacture and

export of products” by manufacturing facilities. In addition, the Article has no formula for “annual monetary contributions”.

More importantly, the full realisation of Article 12 lies in implementation by all stakeholders. There are concerns that contrary to what is contained in the Article, fair, equitable and rapid and timely sharing of material and information may not be actualised. Special importance should therefore be placed on implementation and equity. Lastly, the role of the WHO as the overseer of the PABS system ought to be set out in clear terms. Some of these elements can be expected to come to the fore in the ongoing negotiations of the PABS Annex to Article 12.

VI. Conclusion

In conclusion, Kenya's involvement in the WHO Pandemic Agreement negotiations has demonstrated both the value and difficulty of pursuing international cooperation towards building a safer and more equitable global public health landscape. In collaboration with fellow WHO Member States in the African Group and the Group for Equity, Kenya has been able to ensure foregrounding, in the Agreement text, of the needs for equitable access, sharing of pathogen data, pursuit of a One Health approach, provision of concrete financial commitments, and the development of local manufacturing capabilities. At the same time, Kenya's engagements with the Pandemic Agreement process have in some respects been undermined by difficult international and domestic dynamics in the public health ecosystem. Notwithstanding these difficulties, Kenya's engagement in the WHO Pandemic Agreement talks, and in other linked national and international processes, has succeeded in continuing the country's longstanding commitment to international health diplomacy in support of increased public-health equity between nations of the Global North and Global South.

Kenya's commitment to international health diplomacy will continue to be tested in the short-term during the negotiation of Pandemic Agreement's Article 12 Annex on PABS, and in the longer-term as it works with fellow other WHO African Group and the Group for Equity states to ensure that implementation of the Agreement's articles corresponds to the articles' objectives.

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