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A CIVIL SOCIETY ADVISORY ON THE IMPLEMENTATION OF THE KENYA–UNITED STATES COOPERATION FRAMEWORK ON HEALTH AND THE DATA SHARING AGREEMENT

Public Health, Public Assets, Public Accountability
Health Cooperation Rooted in Rights, Sovereignty, and Public Trust

I. Introduction: The Right to Health and the Importance of State Responsibility

The Constitution of Kenya guarantees every person the right to the highest attainable standard of health, including the right to health care services and reproductive health care, under Article 43(1)(a)[1]. Article 43(2)[2] further provides that a person shall not be denied emergency medical care. This right imposes binding, justiciable, and non-delegable obligations on both the national and county governments to observe respect, protect, promote, and fulfil access to health care services for all persons in Kenya.

Health is a shared function under the Fourth Schedule of the Constitution of Kenya, 2010. Regardless of institutional arrangements, donor partnerships, or bilateral agreements, cooperation frameworks, the ultimate responsibility for health outcomes rests with the State. International cooperation should not dilute constitutional obligations; the Government of Kenya remains accountable.

For more than two decades, Kenya's health system has depended significantly on external donor financing, especially for HIV, tuberculosis, malaria, surveillance systems, laboratories, commodities, and support for the health workforce. While this assistance has been lifesaving, the over-reliance on donor funding must be addressed. The current global context, characterized by declining aid, geopolitical shifts, polycrises and changing donor priorities, highlights the urgent need for prioritizing domestic funding, sustainability, and accountability in the health sector.

True health system strengthening now requires:

- Clear prioritisation and allocation of domestic resources.
- Deliberate efforts to reduce leakage, wastage, and corruption.
- Strong governance of data, specimens, and public assets; and
- Robust oversight mechanisms that protect the public interest.

This advisory addresses the implementation of the Kenya – United States Cooperation Framework on Health and the related Data Sharing Agreement, signed on December 4, 2025, within the context of constitutional, fiscal and governance considerations.

[1] Constitution of Kenya, 2010 Article 43 (1) (a) Every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive healthcare.

[2] Constitution of Kenya, 2010 Article 43 (2) A person shall not be denied emergency medical treatment

II. Purpose and Constitutional Basis of this Advisory

We, the undersigned organisations and associations, being representative of health and human rights, civil society and non-governmental organisations, community-based organisations, professional bodies, and experts in economic, digital health and governance, acknowledge the recently signed Kenya-United States Cooperation Framework on Health and related Data Sharing Agreement, as well as the public concern it has generated.

We write pursuant to our constitutional mandate under Articles 3,10,31,35 and 43 (1) (a) and (2) of the Constitution on the responsibility to defend and protect the Constitution, the right to participate in matters concerning us and to access public information respectively.

As individual stakeholders, we have engaged with the government to advocate for a rights-based approach to implementing the agreement. Considering this, we are issuing a comprehensive advisory that includes multi-stakeholder perspectives to guide a transparent implementation process that protects the health and rights of all, particularly the most vulnerable and underserved populations in Kenya. We acknowledge that Kenya still faces challenges in realising the right to health as outlined in the Constitution of Kenya, 2010, which adversely affect the health, economic and social well-being of the communities we represent.

While we recognise the potential value of international cooperation in strengthening Kenya's health system, however, such large scale cooperation, which encompasses surveillance, digital health systems, specimen collection, modernised laboratories, commodities, financing and emergency preparedness, must be implemented in a lawful, transparent and inclusive manner that prioritises people, rights and public benefit over technical efficiency alone.

III. Transparency, Disclosure, and Democratic Governance

We appreciate the Government of Kenya's efforts in establishing the cooperation framework with the United States and acknowledge the publication of both the Cooperation Framework and the Data Sharing Agreement, which affirms that health data is a national strategic asset under the Digital Health Act, 2023 and that Kenya retains ownership of such data.

It is noted that disclosure of these agreements governing sensitive health data, surveillance infrastructure, biological materials, and long-term fiscal commitments only happened after sustained public pressure. To align with Articles 10 and 35(3) of the Constitution and Section 5(1) of the Access to Information Act, government agencies must proactively disclose this information, ensure meaningful public participation, and allow for parliamentary oversight. Additionally, the information provided to date has been insufficient and lacks clarity on how implementation of the framework will support public health, protect health data, safeguard public assets, and ensure public accountability.

Further, the Framework envisages multiple assessments, audits, transition plans, and subsidiary instruments, including surveillance assessments, institutional readiness assessments, data system transition plans, and joint data audits.

Yet there is no clear commitment to public disclosure of these processes or their outcomes.

We therefore call for:

1. Proactive disclosure of all implementation frameworks, assessments, audits, transition plans, benefit-sharing instruments, and subsidiary agreements developed under the Framework and the Data Sharing Agreement.
2. Publication of draft terms of reference and methodologies before finalisation, with opportunity for public and stakeholder input.
3. Publication of system technology, including interoperability, and mechanisms to address different protocols that may hinder aggregate data exchange.
4. Public access to assessment findings, decisions taken, and implementation timelines.

IV. Participation, Inclusion, and Article 10 Values

Article 10 binds all state organs, state officers, public officers, and agencies to the national values and principles of governance, including participation of the people, inclusiveness, equity, equality, human rights, non-discrimination, integrity, transparency, accountability, and protection of the marginalised.

While the Framework is structured as a government-to-government (G2G) cooperation arrangement, this must not be interpreted to exclude civil society, communities, professional associations, and non-governmental actors and citizens from meaningful participation. Experience from HIV, TB, malaria, and health systems programming in Kenya demonstrates that community-led and civil society engagement is essential to effective planning, accountability, and service delivery.

We are concerned that the implementation of the Framework may be overly focused on technical aspects and exclude important aspects of community/people involvement.

We therefore call for:

- Inclusive stakeholder participation in all assessments, planning, and implementation processes, including communities, youth, older persons, patients' groups, key and marginalised populations, informal sector actors, and county stakeholders.
- Explicit safeguards to ensure that no population is excluded, directly or indirectly.
- Clear articulation of how Article 10 values are operationalised across surveillance, digital health, procurement, and emergency response.
- Formal inclusion of civil society, community representatives, and professional bodies in workplan development, annual reviews, and mid-course corrections under the Framework;
- Publicly documented mechanisms for stakeholder input into priority-setting, implementation sequencing, and evaluation of outcomes under the G2G cooperation model.

In relation to disease-specific national programmes, including HIV and STI programmes under NASCOP and tuberculosis programmes under the National TB Programme, we

emphasise the heightened risks of stigma, discrimination, and exclusion associated with granular surveillance, contact tracing, and digital reporting systems.

We further emphasise that implementation of the Framework must not result in the exclusion, de-prioritisation, or indirect restriction of sexual and reproductive health (SRH) services, nor services for key and marginalised populations, based on external policy positions, funding restrictions, or bilateral priorities. Kenya's constitutional obligations under Articles 27, 28, 31, and 43(1) and 2 of the Constitution of Kenya, 2010 apply equally to all persons, regardless of donor policies or geopolitical considerations.

These risks are particularly acute for key and marginalised populations, informal workers, migrants, people in congregate settings, and persons with limited access to legal or social protection, where public health measures can easily intersect with coercive or punitive practices.

We therefore call for:

- **Explicit safeguards** to prevent surveillance, notification, or contact-tracing practices that enable targeting, profiling, or discrimination of affected individuals or communities;
- **Structured and ongoing consultation** with affected communities, including TB survivors, people living with HIV, and key populations, on the design, use, and evolution of data and reporting systems.
- **Clear firewalls** between health data systems and law-enforcement, immigration, employment, or other punitive uses, except where strictly required by law and subject to due process and oversight.
- Explicit safeguards to ensure that SRH services, including family planning, adolescent health, safe abortion care as provided for in Kenyan law, and services for key and marginalised populations are not excluded, restricted, or conditioned by donor policies, funding rules, or external political considerations.

V. Preventing Corruption, Leakage, and Wastage

Kenya's experience with large-scale health financing under the Global Fund[3], Gavi[4], and other mechanisms demonstrates that weak governance and corruption undermine health outcomes and cost lives.

We note with concern that the Framework places greater emphasis on audits after harm occurs, rather than on preventive governance.

[3] See Global Fund OIG reports
The Global Fund, Office of the Inspector General, 2018 "Investigation Report: Global Fund Grants to the Republic of Kenya"https://www.theglobalfund.org/media/7169/oig_gf-oig-18-004_report_en.pdf
The Global Fund, Office of the Inspector General, 2025 "Investigation Report: Global Fund Grants to the Republic of Kenya" https://www.theglobalfund.org/media/b1uineuy/oig_gf-oig-25-002_report_en.pdf
[4] See Constitutional Petition No. E063 of 2021 Kenya Legal and Ethical Issues Network on HIV & AIDS (KELIN) vs Cabinet Secretary, Ministry of Health, The Attorney General and The Commission on Administrative Justice (Interested Party)

We urge the Government to prioritise:

- Preventive anti-corruption safeguards embedded upfront;
- Open contracting and conflict-of-interest management;
- Real-time transparency and accountability mechanisms; and
- Integrity and risk-mitigation plans informed by past failures.

Corruption in health is not merely a financial issue—it is a right to life and dignity issue.

VI. Digital Health and Data Governance

Implementation should not commence in any form unless minimum governance, transparency, and oversight conditions are met and publicly disclosed.

The Framework emphasises digital health transformation, including electronic medical records, data warehouses, surveillance platforms, and analytics. While digital systems can improve coordination and service delivery, their expansion must be anchored in rights-based safeguards.

Key concerns include:

- Undefined thresholds for identifiability and re-identification;
- Weak consent and purpose-limitation safeguards;
- Unclear cross-border data enforcement; and
- Limited visibility of independent oversight and redress.
- Third-party data sharing with private bodies

In addition, there is insufficient clarity on the points at which health data collected under the Framework is aggregated, the entities with access to de-aggregated or person-level data, and the safeguards governing any subsequent re-identification. It remains unclear which Kenyan institutions, agencies, or third parties may access de-aggregated data under the cooperation arrangements, and what legal and technical firewalls exist to prevent secondary use for non-health purposes, including insurance profiling, law enforcement, immigration control, or employment decisions.

There are also unresolved questions regarding interoperability between Kenyan and United States data systems, including whether aggregation occurs prior to cross-border transfer or only after receipt by U.S. systems. Aggregation that occurs solely on the recipient side would undermine the stated purpose of aggregate data sharing and increase risks of inappropriate access or use.

We further note that while the Cooperation Framework focuses on infectious diseases, Kenya's health system increasingly manages co-morbidities, including non-communicable diseases (NCDs) among people living with HIV and TB. Integrated surveillance and health information systems that aggregate infectious and non-communicable disease data without appropriate logical separation create a heightened risk of indirect disclosure of sensitive

infectious status through less-protected NCD records. Implementation of the Framework must therefore ensure logical and architectural segregation of data, access controls, and differentiated protection standards to prevent stigma, discrimination, and secondary misuse.

Digital transformation must strengthen—not weaken—protections under Article 31 of the Constitution and the Data Protection Act, 2019[5]. We note that aspects of the Kenya–United States Cooperation Framework on Health are currently the subject of judicial consideration. Nothing in this Advisory is intended to anticipate, pre-empt, or comment on issues before the Court. This Advisory is offered solely to support rights-respecting, transparent, and accountable implementation, should implementation proceed.

As the statutory custodian of national digital health systems under the Digital Health Act, 2023[6], the Digital Health Agency bears responsibility to ensure that donor-supported systems migrated into national infrastructure do not compromise constitutional rights, public accountability, or long-term sustainability.

We therefore call for:

- Clear safeguards against vendor lock-in and inherited proprietary systems that undermine national digital sovereignty;
- Public disclosure of all donor-built or externally supported systems proposed for migration into the National or County Health Data Banks;
- Public disclosure of all data protection impact assessments related to the data sharing agreement;
- Public disclosure of all US or Kenyan third-party data sharing agreements relating to data collected from Kenyans under the agreement, including with pharmaceutical companies and other private entities.
- Transparent governance of access, reuse, and value-generation from data housed in the National and County Data Banks, including benefit-sharing principles aligned with public interest.
- Clear, publicly documented data-flow maps specifying points of aggregation and de-aggregation, categories of authorised users on the Kenyan side, interoperability safeguards, and enforceable firewalls preventing secondary or punitive uses of health data.

[1] See the Regulatory Framework on Data Protection in Kenya, https://www.odpc.go.ke/data-protection-laws-kenya/ including:
Data Protection Act, 2019; Data Protection (General) Regulations, 2021; Data Protection (Registration of Data Controllers and Data Processors) Regulations, 2021; Data Protection (Complaints handling and Enforcement) Regulations, 2021; Data Protection (Civil Registration) Regulations, 2020
[2] See Digital Health Act, No. 15 of 2023 https://new.kenyalaw.org/akn/ke/act/2023/15/eng@2023-11-24
The Digital Health (Health Information Management Procedures) Regulation, 2025 https://new.kenyalaw.org/akn/ke/act/ln/2025/76/eng@2025-04-11

VII. Specimen Collection, Biological Materials, and Sovereign Control

Beyond digital data, the Framework envisages extensive specimen collection, testing, storage, referral, and analysis, particularly in surveillance and emergency preparedness contexts.

However, the Framework and Data Sharing Agreement are silent on the governance of biological specimens as sovereign public resources, despite their scientific and potential commercial value.

This creates a risk that specimen collection may be treated as a purely technical activity, rather than one requiring explicit and informed consent, strict purpose limitation, benefit-sharing, and enforceable oversight, consistent with Articles 10, 28, 31, and 43(1)a of the Constitution and applicable laws.

Without clear safeguards, specimens collected from the population in Kenya may be subjected to secondary use, cross-border transfer, or downstream research and innovation without adequate transparency or benefit to the public health system. Specimen collection must therefore be governed by principles of sovereignty, consent, accountability, and equity, and must not become an extractive input into global research or health security pipelines.

Where biological specimens and laboratory data are used for research, quality assurance, or secondary analysis, particularly through institutions such as the Kenya Medical Research Institute (KEMRI), Kenya External Quality Assessment Scheme (KNEQAS), and the National Blood Services. We emphasise the need for:

- Clear individual consent and ethical approval for secondary use;
- Transparent disclosure of international research collaborations arising from the Framework;
- Explicit benefit-sharing arrangements linked to public health system strengthening; and
- Absolute protection against commercialisation of blood, blood products, or associated personal data.

VII A. Public Health Surveillance, Intelligence Systems, and Emergency Coordination

The Cooperation Framework places significant operational responsibility on public health and surveillance institutions, including the Kenya National Public Health Institute (KNPHI), the National Public Health Intelligence Information System (NPHIIS), and national and county Emergency Operations Centres (EOCs). These institutions play a central role in outbreak detection, specimen collection, data aggregation, analytics, and emergency response coordination.

While these functions are essential to public health protection, their expanded digitisation and integration under the Framework raise important constitutional, governance, and accountability considerations.

Kenya is currently among the 51 African States participating in negotiations under the World Health Organization on the Pathogen Access and Benefit-Sharing (PABS) system, through which African States have adopted a common position on equitable access to pathogens, data, technologies, and the fair sharing of benefits arising from their use. Implementation of the Kenya–United States Cooperation Framework must therefore be consistent with, and not undermine or pre-empt, Kenya's obligations and collective commitments under the emerging PABS framework and other multilateral health governance processes.[7]

We therefore call for:

- Clear, publicly available surveillance thresholds, escalation criteria, and de-escalation protocols, to prevent prolonged or excessive monitoring without justification;
- Explicit governance rules for specimen collection, retention, secondary use, and destruction within surveillance systems, consistent with Articles 10, 31, and 43 of the Constitution of Kenya, 2010;
- Transparent access controls and audit trails within NPHIIS, including disclosure of categories of authorised users and purposes of access.
- Clear safeguards to ensure that surveillance data and specimens are used strictly for public health purposes and are not repurposed for non-health objectives without lawful authority and oversight; and
- Mandatory post-emergency reviews and public reporting by EOCs, including data and specimen roll-back measures once emergencies end.

VIII. Enforcement, Accountability, and the Risk of Hollow Safeguards

While the Data Sharing Agreement contains important declaratory safeguards, such as data ownership and primacy of Kenyan law, it lacks clear, binding enforcement mechanisms.

Of concern is the absence of:

- Defined consequences for non-compliance.
- Clear dispute-resolution pathways accessible to the State and affected communities; and
- Transparent monitoring mechanisms for external actors and contractors.

There is a real risk that obligations bind Kenyan institutions while remaining effectively optional for external actors, particularly in cross-border contexts. Effective cooperation requires clear enforcement architecture, not reliance on goodwill.

Effective enforcement of safeguards cannot rely solely on internal audits, executive reporting, or post-hoc compliance reviews. Independent, non-state oversight is essential to prevent implementation drift, regulatory capture, and erosion of public trust. Civil society organisations and community structures play a critical accountability role by monitoring service delivery, identifying access barriers, providing early warning of service disruption, and surfacing rights violations that may not be visible through national-level reporting systems.

[7] Health Policy Watch, Africa stuck between global pathogen-sharing talks and conflicting US bilateral agreements, available at:Beyond digital data, the Framework envisages extensive specimen collection, testing, storage, referral, and analysis, particularly in surveillance and emergency preparedness contexts.

Implementation arrangements under the Framework should therefore incorporate structured, resourced, and independent civil society accountability mechanisms that complement statutory oversight institutions.

We further note that continuity of essential health services during transition periods must be understood in relation to the communities and patients who rely on them, regardless of the ownership or governance model of the facilities through which services are delivered. Many HIV, TB, and other essential services are currently provided through faith-based and other non-state facilities supported by external partners. Implementation of the Framework must therefore include clear, enforceable transition arrangements to ensure uninterrupted access to services at facility and community level, accompanied by independent monitoring and early-warning mechanisms to detect and address service disruption.

IX. Co-Financing, Taxation, and Benefit-Sharing

The Framework envisages progressive co-financing and eventual assumption of costs by Kenya. While localisation is necessary, poorly planned co-financing risks service disruption and inequity.

Any indicators, benchmarks, or performance metrics set out in the Framework or its subsidiary instruments should be understood as a minimum baseline rather than a ceiling for ambition. Kenya's constitutional obligation to progressively realise the right to health requires continuous scale-up of prevention, testing, treatment, and retention in care — particularly for HIV, TB, malaria, and emerging public health threats.

Sustainability must also account for who captures value arising from Kenyan public investments, data, and biological materials.

The Agreement does not define "benefit," nor does it address taxation, royalties, or revenue implications where Kenyan data or specimens contribute to commercial products or technologies.

We therefore call for:

- Clear benefit-sharing frameworks.
- Transparent tax treatment and revenue capture; and
- Reinvestment of value into Kenya's public health system.
- Recognition that agreed metrics represent a minimum floor, and that national programmes must retain flexibility to adopt additional indicators aligned with Kenya's epidemiological needs, key population realities, and treatment scale-up goals.

IX(A). Health Financing Transitions and Protection of Continuity of Care

The transition from donor-financed health services to domestically financed systems places the Social Health Authority (SHA) at the centre of sustainability, equity, and continuity of

care. However, the current SHA design and benefit structures, as publicly understood, do not adequately provide for comprehensive HIV, TB, malaria, and other vertically supported services. This gap presents a material risk of service disruption, exclusion, and regression in hard-won public health gains.

Given the scale and fiscal implications of the transition from U.S. Government support to domestic financing, there is a need for a formal parliamentary process to quantify, scrutinise, and approve the associated obligations. This includes costs related to absorption of frontline health workers, laboratories, and the progressive assumption of financing for essential health products and technologies. We therefore call for the National Treasury, in collaboration with the Ministry of Health, to table a Sessional Paper or equivalent instrument before Parliament, outlining the full fiscal implications, timelines, and sustainability measures associated with implementation of the Cooperation Framework, in alignment with the national budgetary process.

We further note that many essential public health functions — including surveillance, laboratories, emergency preparedness, health promotion, outbreak response, and regulatory oversight — cannot be financed through insurance mechanisms and must continue to be funded through annual parliamentary appropriations. Implementation of the Framework must not assume that SHA can substitute for sustained public investment in these core public health functions.

We therefore call for:

- Explicit safeguards to ensure that integration of HIV, TB, malaria, and other donor-supported services into benefit packages does not result in service disruption, exclusion, or delays in access.
- Public disclosure of actuarial assumptions and transition risks associated with absorbing donor-funded services;
- Clear communication to patients and providers on continuity of coverage during transition periods; and
- Assurance that access to essential health services is not conditioned on expanded data extraction or surveillance beyond what is strictly necessary for care and financing.
- Explicit confirmation that HIV, TB, malaria, and other donor-supported services are fully and sustainably integrated into SHA benefit packages, with ring-fenced financing where necessary;
- Public disclosure of how gaps in current SHA design will be addressed before donor transition milestones are reached.

X. Implementing Partners, Private Sector Engagement, and Procurement

The Framework anticipates implementing partners and private sector involvement. We seek clarity on:

- Selection and accountability of implementing partners;

- Compliance with Articles 10 and 227 of the Constitution of Kenya, 2010 on procurement; and
- Safeguards against vendor lock-in and loss of public control.

All actors must be subject to Kenyan law and oversight.

Given the significant role of Kenya Medical Supplies Authority (KEMSA), the National Quality Control Laboratory, and the Pharmacy and Poisons Board in procurement, quality assurance, and regulation, the Framework's emphasis on transitioning donor-supported commodity systems raises important governance concerns.

Where the Framework contemplates absorption or transition of frontline health workers, such measures must comply with the constitutional division of functions between national and county governments. Health workforce absorption is primarily a county government function and cannot be implemented through national-level agreements without clear county consent, fiscal alignment, and legal compliance.

We therefore call for:

- Transparent transition plans for donor-funded procurement functions, including risk mitigation for supply disruptions.
- Clear separation between procurement decision-making and quality assurance functions to prevent conflicts of interest.
- Public reporting on detection of substandard and falsified products; and
- Assurance that regulatory reliance mechanisms do not displace or weaken Kenyan regulatory authority and accountability.

XI. Agency-Specific Recommendations

To the Ministry of Health

- Lead proactive disclosure of all assessments, protocols, and subsidiary instruments.
- Publish national specimen governance and benefit-sharing guidelines.
- Establish enforcement protocols for breaches of data and specimen obligations.

To the National Treasury (in collaboration with the Ministry of Health)

Table before Parliament a Sessional Paper or equivalent fiscal instrument outlining the full financial implications of implementing the Kenya–United States Health Cooperation Framework, including the costs of absorbing frontline health workers, laboratories, and essential health products and technologies currently supported by external partners, together with proposed timelines, sustainability measures, and alignment with the national budgetary process.

To the Digital Health Agency

- Publish rights-centred data governance frameworks.
- Implement independent compliance monitoring with public reporting.
- Clarify rules on third-party and cross-border data access.

To the Office of the Data Protection Commissioner

- Assert oversight over high-risk health and genomic data processing.
- Require Data Protection Impact Assessments for surveillance and specimen-linked systems.
- Take action in response to any non-disclosure of Data Protection Impact Assessments for data sharing systems under the MOU, especially surveillance and specimen-linked systems.
- Strengthen accessible remedies for rights violations.

To the Kenya Revenue Authority

- Clarify tax treatment and revenue capture for commercial products derived from Kenyan health data or specimens.
- Ensure no preferential exemptions undermine public benefit.

To the Attorney-General

- Clarify legal enforceability of cooperation instruments and available remedies.
- Review subsidiary agreements for constitutional and public finance compliance.

To County Governments

- Participate actively in assessment and implementation processes.
- Protect community interests in data, specimens, and service delivery.
- Ensure local health priorities remain central.
- Require formal consultation and agreement before any absorption, redeployment, or transition of frontline health workers linked to the Framework;
- Ensure no unfunded mandates are imposed on counties through implementation of the cooperation agreement.

XII. Parliamentary Oversight: Role of the National Assembly and the Senate

Parliament has a constitutional duty to oversee public policy, public finance, and executive action. Agreements of this nature cannot be treated as purely executive or technical instruments.

A. National Assembly – Departmental Committee on Health and Related Committees

We call upon the National Assembly to:

- Summon the Ministry of Health to table all assessments and agreements;
- Scrutinise data and specimen governance frameworks;
- Examine fiscal, tax, and co-financing implications; and
- Ensure procurement transparency and value for money.

B. Senate – Standing Committee on Health

We call upon the Senate to:

- Examine impacts of the Cooperation Framework on county health systems;
- Safeguard against unfunded mandates;
- Ensure county participation in governance decisions; and
- Promote accountability to communities at county level.

C. Joint Parliamentary Responsibilities

Both Houses should:

- Require regular implementation reports;
- Conduct public hearings where appropriate; and
- Treat health cooperation agreements as matters of public interest requiring ongoing scrutiny.
- Scrutiny of whether sufficient budgetary allocations are maintained for non-SHA public health functions critical to disease control and emergency preparedness.

XIII. Conclusion

International cooperation can support Kenya's health system, but it cannot replace constitutional responsibility, democratic accountability, and domestic leadership. The Kenya–United States Cooperation Framework on Health must be implemented as a people-centred, rights-respecting, transparent, and corruption-resistant public undertaking, firmly grounded in the Constitution and responsive to Kenya's lived realities.

We remain ready to engage constructively with all stakeholders to ensure that this cooperation strengthens—rather than compromises—the right to health for all in Kenya.

Signed by the following organisations:

- AYARHEP
- Community Initiative Action Group Kenya (CIAG-K)
- Confraternity of Patients Kenya (COFPAK),
- Health NGOs' Network (HENNET)
- ICJ Kenya
- ICW - Kenya
- Inclusivity, Diversity & Equity Advocacy Organization (IDEAo)
- International Institute for Legislative Affairs
- Jenga Afrihub
- Katiba Institute
- Kenya Community Advisory Team (K-CAT)
- KELIN
- Key Population Consortium of Kenya
- Lean on Me Foundation
- NEC Regional Budget Hub
- Nelson Mandela TB & HIV Information CBO
- Network of TB Champions Kenya
- Raise Your Voice CBO
- Tech For Nonprofits
- The Institute for Social Accountability (TISA)
- Transform Health Kenya (THK)
- Transparency International Kenya
- YOSWA
- Youth Empowerment Movement Kenya
- Zamara Foundation