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REVIEWS SYMPOSIUM

‘Choking the national demos’: research partnerships and the material constitution of global health

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By foregrounding a widened view of the rule of law in transnational legal processes, the works under discussion in this symposium can support innovative critical perspectives on global health law –a field that has gained wide attention due to the spread of COVID-19 around the world (Lander, 2020; Bhatt, 2020). Legal and socio-legal scholars in the decade and a half before the pandemic worked on locating global health law and articulating its underlying principles. Lawrence Gostin’s 2014 monograph offers a synoptic view centred on international institutions (e.g. the World Health Organization, World Trade Organization, UN Human Rights Council) and problems (e.g. infectious-disease response, tobacco control), along with an elaboration of its normative basis in universal moral principle and international human rights law (Gostin, 2014). Struggles over access to essential medicines and intellectual property in the early 2000s are, for example, represented in terms of the right to health constraining international trade law. Andreas Fischer-Lescano and Guenther Teubner’s 2004 reading is oriented more by social theory than by doctrinal or ethical frames (Fischer-Lescano and Teubner, 2004, pp. 1006, 1008). A functional health regime has ‘differentiated out’, they observe, and operates as a discrete communication system across borders, albeit one that is threatened by the preponderant economic system. On this model, the battle for access to medicines amounts to ensuring, via human rights guarantees, that the rationality of the health system is not replaced by that of its economic rival in legal and policy communications (Fischer-Lescano and Teubner, 2004, pp. 1030, 1046).

Notwithstanding their different frames of reference and theoretical origins, both approaches foreground the global over the national and local. While the state is not ignored in either account, it tends to be represented either as a potential obstacle to the reach of global health (Gostin) or as the remainder of a territorially segmented international order, now absorbed into a functionally differentiated global society (Fischer-Lescano and Teubner, 2004). As such, both call up the global as a distinct sphere of law and communication more generally. Lander and Bhatt’s interventions provide a powerful corrective to this siloed view with productive consequences in terms of method and the substantive focus of research in global health law. In short, they counsel us to study the field up-close, attending to how transnational legal processes are played out within national as much as international fora (Koh, 1996). Atina Krajewska has shown the potential of this approach, theorising transnational health law through an exemplary reading of case-law on access to reproductive technologies (Krajewska, 2018). What is needed to shed light on the operation of such messy processes, as Peer Zumbansen argues, are case-studies that take seriously concrete legal and cultural particularities (Zumbansen, 2012, p. 305). In exploring this potential, I focus here on a recent ‘telling moment’ from Kenya when the interaction of various legal forms put apparently unjustifiable aspects of a major cross-border research collaboration beyond the reach of domestic law.[1]

In its 2014 ruling in *Gwer v. KEMRI*[2] the Kenyan High Court ruled in favour of six medical doctors, former employees of the Kenya Medical Research Institute (KEMRI), who claimed that they had been

[1]For a further example of this method, see Harrington (2018).
[2]*Gwer v. KEMRI* [2014] eKLR (Industrial Court Nairobi).

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subject to racial discrimination in contravention of Article 27 of the 2010 Constitution.[3] The plaintiffs had been engaged as PhD researchers under the KEMRI-Wellcome Trust Research Partnership (KWTRP), which is run through Oxford University and aimed at capacity building for research in Kenya.[4] KWTRP extended a relationship between the two British Institutions and KEMRI that dates back to the early days of Kenya's independence in 1963. The doctors' discrimination claim had two main components: first, that expatriate staff working on the same projects were paid considerably more for the same work; and, second, that Kenyan nationals on the team were barred from applying for many major research grants, as these were limited to researchers with a connection to the European Economic Area (EEA).[5] Moreover, they claimed, most senior positions at the project site in Kilifi were held by foreign, White staff, which impeded the national objective of achieving research autonomy through the 'Kenyanization of scientific innovation'.[6] Kenyan PhD students were only intended to provide 'cheap labour' for research projects, it was alleged.[7] Nduma J. in the High Court agreed, noting that Kenya's colonial history could not be ignored in determining whether unlawful discrimination had been made out.[8] Differences between local and expatriate staff amounted to institutional racism, as defined by the McPherson report on the murder of Stephen Lawrence in the UK.[9]

That ruling was overturned in the Court of Appeal – a decision that was confirmed by the Supreme Court in January 2020.[10] The discrimination claim was held to be unfounded on the basis that expatriate researchers, employed by Oxford University, did not amount to effective comparators for Kenyan doctors working alongside them. The Court held that 'any differential with what the expatriates were paid was on the basis of their different contracts with third parties to which KEMRI was not privy'.[11] Indeed, neither the Wellcome Trust nor Oxford University had been or could be joined as parties to the litigation. This fact of separate employment contracts provided defensible grounds for the salary gap. As a result, it could not be classed as unreasonable treatment amounting to discrimination under Article 27 of the Constitution and relevant legislation.[12] The 'EEA-connection' requirement for grant applicants was similarly held to be irrelevant in this context, as it related to the operations of the Wellcome Trust in the UK, rather than to KEMRI or the KWTRP.[13] The Court and the witnesses for KEMRI urged the plaintiffs to look not to their expatriate co-workers on the same project, but to other Kenyan doctors working in the domestic public-health system as their true comparators.[14] Unlike the latter, participants in KWTRP enjoyed better pay and conditions, as well as greater, if not complete, access to funding and networking opportunities.

[3]The relevant provisions are: 'Article 27 (4) The state shall not discriminate directly or indirectly against any person on any ground including race, sex, pregnancy, marital status, health status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, dress, language or birth. (5) A person shall not discriminate directly or indirectly against another on any of the grounds specified or contemplated in clause (4).'

[4]For an overview of the current terms of this collaboration, see Kenya Medical Research Institute (2016).

[5]They also claimed infringement of their constitutionally protected intellectual-property rights. For further critical discussion of this aspect of the case, see Nzomo (2014).

[6]*Kenya Medical Research Institute v. Gwer* [2019] eKLR (Court of Appeal), per Makhandia, Kiage and Murgo J.J.A., at p. 3.

[7]*Kenya Medical Research Institute v. Gwer* [2019] eKLR (Court of Appeal), per Makhandia, Kiage and Murgo J.J.A., at p. 14.

[8]*Gwer v. KEMRI* [2014] eKLR (Industrial Court Nairobi), per Nduma J., at para. 77.

[9]*Gwer v. KEMRI* [2014] eKLR (Industrial Court Nairobi), per Nduma J., at para. 7, referring to McPherson (1999).

[10]*Kenya Medical Research Institute v. Gwer* [2019] eKLR (Court of Appeal), per Makhandia, Kiage and Murgo J.J.A.

[11]*Kenya Medical Research Institute v. Gwer* [2019] eKLR (Court of Appeal), per Makhandia, Kiage and Murgo J.J.A., at p. 13.

[12]*Kenya Medical Research Institute v. Gwer* [2019] eKLR (Court of Appeal), per Makhandia, Kiage and Murgo J.J.A., at p. 14, referring to s. 5(3)(a), (b) of the Employment Act No. 11 of 2007.

[13]*Kenya Medical Research Institute v. Gwer* [2019] eKLR (Court of Appeal), per Makhandia, Kiage and Murgo J.J.A., at p. 3.

[14]*Kenya Medical Research Institute v. Gwer* [2019] eKLR (Court of Appeal), per Makhandia, Kiage and Murgo J.J.A., at p. 10.

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Denielle Elliott, a Toronto-based medical anthropologist who has collaborated with the plaintiffs in *Gwer*, has written powerfully on the wider historical and contemporary global health contexts of the case (Elliott, 2017). She notes the pervasive dependence of researchers in African countries on unequal partnerships with institutions in the Global North to sustain individual careers and the wider scientific culture. On the side of funders, there is an interest in Africa in toto as a potential 'laboratory' – a rich source of biomedical discoveries of humanitarian import that local researchers are ill-equipped to make themselves due to weak infrastructure and more pressing clinical tasks (Tilley, 2011). As Johanna Tayloe Crane has put it, the HIV/AIDS pandemic and subsequent outbreaks, including Ebola in West and Central Africa, reinforced the fact that 'inequality is an opportunity' for Global North institutions (Crane, 2013, p. 168). The tensions inherent in this situation are managed through a discourse of 'partnership', though never with complete success, as Crane's ethnography of a US–Ugandan collaboration shows. Partnership in global health is also realised through legal forms, which are similarly beset by instabilities and contradictions. Thus, in *Gwer*, an instrument intended in principle to unite UK and Kenyan researchers operated in detail to accentuate the divide between them. While Elliott understandably laments the 'failure of international and national law to protect' African scientists (Elliott, 2017), we can give this critique further precision, drawing on the work of Lander and Bhatt. We can read the challenge to that partnership in the Kenyan courts as a moment in global health law, understood as an iterative and contested process of transnational legal ordering – one that, as they suggest, diminishes democratic accountability through a restrictive, state-centric conception of the rule of law.

Of course, it has to be acknowledged that, where Lander and Bhatt focus squarely on the global *economic* order as it territorialises in national and local jurisdictions, our concern is with *health* and particularly medical research. The KWTRP, sustained by a UK charitable trust and a Kenyan state research institution, is not centrally oriented towards commercial profit in the way that mining interests would be. Nonetheless, there are certain significant overlaps. While partnerships may themselves be philanthropic, many of their legal incidents, like securing intellectual-property rights, register in market terms. Indeed, the development of global health from the 1990s onwards has been marked by an increasingly prominent role for public–private partnerships and for philanthropies promoting market-aligned means of realising goals like increased immunisation and breastfeeding (Harmer and Buse, 2009, p. 75). The growing interpenetration of economics and global health permits us, I would argue, to extend the thematic and methodological lessons learned in the former context regarding transnational legal process and the rule of law.

Biomedical research can thus be seen under one aspect as an extractive industry, involving the acquisition of data by concerns based in the Global North, facilitated by government and state agencies in the Global South (Petryna, 2009). Indeed, the plaintiffs in *Gwer* referred to the research involved in just these terms.[15] This is so even though the data nowadays very often concern neglected diseases or health-system problems experienced in the countries in which they are gathered (Tichenor, 2016). Like mining, this extraction is done at 'intensive sites' such as research centres and dedicated hospital wards that are themselves the focus of considerable (foreign) capital investment. These sites form an archipelago of international science, often linked more to sponsoring institutions in Europe and North America than to the depleted national health and scientific systems physically located alongside them.[16] In these circumstances, northern philanthropies and universities can be expected to look for reassurance from southern partners that their capital outlay is not threatened and that the cross-border flow of data and personnel is not interrupted by on- or near-site difficulties. Detailed technical specifications, licencing and intellectual-property agreements, confidentiality and publishing restrictions, laboratory standards, ethics protocols and so on all work to secure this goal (Sack *et al.*, 2009, p. 487). The terms of such instruments have been criticised for their lopsidedness in allowing

[15]As quoted in *Kenya Medical Research Institute v. Gwer* [2019] eKLR (Court of Appeal), per Makhandia, Kiage and Murgo J.J.A., at p. 14.

[16]See Geissler (2015).

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funders to dictate the focus and timing of research and for imposing hidden costs on colleagues in resource-limited settings (Carbonnier and Kontinen, 2014). But the facts of *Gwer* show that differential employment contracts also form part of the normative corpus of cross-border research collaboration.[17] Challenges to them in court and in the media can be seen then as a kind of 'legal risk' to be avoided by the host authorities if the partnership is to endure.

What is at stake here might be called 'research-funder confidence' – a modulation of the 'investor confidence' that Lander identified as the emergent *Grundnorm* of mining law in Mongolia (Lander, 2020, p. 226). That basic rule is not to be found within the formal Kenyan Constitution, which restates principles of national sovereignty and research autonomy as pointed out by the plaintiffs in *Gwer*.[18] Evidence for it comes from the Appeal Court's observation that it is fundamental to successful partnerships, like KWTRP, that visiting scientists retain the same terms and conditions as they enjoy at home.[19] Even Nduma J. in the High Court, who ruled for the plaintiffs, felt obliged to acknowledge the benefits conferred on Kenya by exchange programmes such as KWTRP.[20] At the level of legal doctrine, the *Grundnorm* can be inferred from the privileging of the contract-law doctrine of privity over constitutional norms, with the result that expatriate salaries and other benefits were sheltered from scrutiny under Kenyan law on race discrimination. Indeed, the Court of Appeal drew on wider contract ideology, emphasising that participants in KWTRP had freely chosen to take up these positions on the subsequently impugned terms. With David Schneiderman and Gavin Anderson (Schneiderman, 2008; Anderson, 2014), we can say that what is instantiated in *Gwer* is the 'material constitution' of health research in Kenya – one that, far from being coterminous with the formal Constitution of 2010, can operate to limit the scope of its key provisions.

The sidelining of the formal Constitution in *Gwer* can be taken as a token of the retreat of the national in global health. However, this is not achieved in the case by the superimposition of higher-order norms (e.g. international human rights) as might be expected. Rather it is the outcome of what has been called a 'tangled hierarchy',[21] with lower-order private law rules setting limits to the scope of applicability of fundamental rights. Historically inflected attempts to support the claim for widened comparability were also dismissed in *Gwer*. As we have seen, the Court of Appeal refused to entertain the charge that the terms of the partnership frustrated the goal of Kenyanising scientific endeavour – a complaint that drew explicitly on language from the 1960s and 1970s, when KEMRI's founders took scientific and medical self-sufficiency as their goal (Ombongi, 2011, p. 353). The plaintiffs' insistent framing of the relationship between the British and Kenyan partners as colonial also seemed to produce a certain embarrassment on the part of witnesses from KEMRI, as well as the appellate judges, and was similarly dismissed. The 'national demos' was 'choked' then, not only through choice of law and jurisdictional moves (i.e. respecting the applicability of English contract rules), but also rhetorically. As Noémi Toussignant has found, the memory of an autonomous African science still haunts the denationalised North–South partnerships that are the hallmark of contemporary global health (Toussignant, 2013, p. 729). The litigants called up that spectre to add persuasive force to their own jurisdictional countermove (i.e. for Kenyan constitutional law). In rejecting the move and the rhetoric, the Court of Appeal saw off a political–legal threat to 'research-funder confidence' emanating from national law and history. They were thus able to affirm the *Grundnorm* of globalised health research in Kenya.

The consequences of this affirmation can be read in terms of the expanded view of the rule of law that Bhatt, Lander and Taekema offer us in the Introduction to this symposium. At its heart, the plaintiffs' claim of discrimination rested on the moral idea that the differences in pay and eligibility to apply

[17] It is worth noting that advice for southern research institutions on contract negotiations and drafting tends to neglect this issue; see e.g. Marais *et al.* (2013).

[18] *Kenya Medical Research Institute v. Gwer* [2019] eKLR (Court of Appeal), per Makhandia, Kiage and Murgo J.J.A., at p. 4. See further Lander (2020, chapter 1).

[19] *Kenya Medical Research Institute v. Gwer* [2019] eKLR (Court of Appeal), per Makhandia, Kiage and Murgo J.J.A., at p. 4.

[20] *Gwer v. KEMRI* [2014] eKLR (Industrial Court Nairobi), per Nduma J., at para. 77.

[21] See Teubner (1990).

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for grants as between expatriates and locals was the result of an 'arbitrary exercise of power' by KWTRP. They argued that the mere fact of nationality, and by extension race, was an unjustifiable ground for varying the rights and entitlements of each group. As this note has emphasised, the Court-of-Appeal decision in *Gwer* to prioritise contractual privity, in the face of these claims, put the partnership and its UK-based sponsors beyond the reach of the rule of law to that extent. In the manner of commercial investors, they were treated as private actors who were, for that reason, subject to a lower degree of scrutiny and accountability than local state agencies. The foregoing suggests that permitting inequality as between staff of different origin is a further component of the health research *Grundnorm* – one that is essential to supporting research-funder confidence. Ironically, this would be consistent with, rather than contradictory to, the capacity-building ethos that is the express goal of most North–South research collaborations.[22] Though these programmes are certainly well intentioned and participation in them is no doubt aspired to by eligible researchers (Crane, 2013, p. 142), many still draw on long-established developmentalist discourses that assume a lag between Global North and Global South to be made up with external aid.[23]

Lander and Bhatt's interventions suggest that studying global health law *in abstracto*, as a preformed and discrete body of norms set apart from national law, is likely to be inadequate in its political stakes. They prompt us instead to reconceive the field in terms of transnational legal processes: the emergent outcome of a dynamic and agonistic legal pluralism, an ongoing struggle between normative orders. This struggle is realised through material and rhetorical contests in local as well as international fora, such as courts, legislatures, ministries, research sites and health facilities. Its outcome is likely to be a ranking of normative orders – a constitutionalisation of global health in ways that can set limits to democratically established constitutions. The 'national' is indispensable in these processes: juridically, as a source of facilitating or obstructing rules; and culturally as a focus for values and idioms for the vernacularisation of global health norms, and also for resistance to them (Harrington and O'Hare, 2014, p. 16; Merry, 2006).

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[22]See e.g. Botti *et al.* (2018).

[23]See generally Escobar (1995).

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