



The Hague Centre  
for Strategic Studies

# Global Health Data in a Shifting International Order

Risks and Implications for Small and Middle Powers

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# 1. Introduction

The practice of health data sharing rests on the premise that containment of an epidemic at an early stage protects all states. This premise however becomes increasingly fragile under intensifying competition between the United States (US) and People's Republic of China (PRC), strained by the increasing strategic value attached to health data.

Since the end of the Cold War, the liberal international order has fostered an era of expanding multilateral cooperation and globalisation, underpinned by shared commitments to open markets, political democracy, and human rights.<sup>1</sup> As cross-border interconnectedness intensified, so too did the conditions for communicable diseases to spread. Global health governance evolved alongside it, driven by the growing recognition that epidemics such as HIV/AIDS and Ebola required coordinated international action.<sup>2</sup> The sharing of genomic sequence and epidemiological data became a key aspect of this development, underpinned by the consensus that the practice is beneficial for all states involved. Data sharing practices in global health allow for the functioning of Early Warning Systems (EWS), inform public and international health policies and permit the advancements in medicines, vaccines and scientific research.<sup>3</sup>

The revision of the binding International Health Regulations (IHR) at the World Health Organisation (WHO) in 2005 focused the cooperation on early detection and rapid response to emerging public health threats which principally relied on member states' willingness to participate.<sup>4</sup> However, given the sensitive and strategic nature of health data sharing, binding governance of the practice is largely limited.<sup>5</sup>

In recent years, the international order has undergone a profound transformation as rising geopolitical tensions have eroded great power support for international institutions, leading to selective adherence to, and at times wilful violations of, international treaties. Multilateral participation in global health is largely affected, as observed with the US retreat of the World Health Organisation in early 2026. As a result, trust in the system declines fuelled by perceptions of double standards and unequal treatment that favour great powers and countries in the Global North. These changes impact the practice of health data sharing, which is turned into a political, economic and security instrument. If left unaddressed, these dynamics could further fragment global health governance, reducing countries' willingness to share data and capabilities to establish binding agreements when rapid collective action is most needed. This paper seeks to analyse these risks in further depth. First, it focuses on analysing the implications of the rising great power competition between the US and the PRC on the governance and practice of health data sharing. Then, the paper identifies principal risks and opportunities emerging for Small and Middle Powers (SMPs) which are likely to be disproportionately affected, using the cases of Covid-19 and Ebola.

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<sup>1</sup> Deudney and Ikenberry, "The Nature and Sources of Liberal International Order."

<sup>2</sup> De Cock, "Global Health's Evolution and Search for Identity."

<sup>3</sup> Hulsén, "Sharing Is Caring—Data Sharing Initiatives in Healthcare."

<sup>4</sup> Gostin and Katz, "The International Health Regulations."

<sup>5</sup> Meier and Sirleaf, "Global Health Landscape."

## 2. Global Health Data Sharing Governance

The governance of health data sharing between states rests on the fragmented legal architecture of global health, centred around the IHR up until Covid-19, and currently reshaped by the new Pandemic Agreement. A year later, the WHO general assembly adopted the development of a new Pandemic treaty, adopted in May 2025. The HIV/AIDS epidemic and emergence of SARS reconceived communicable diseases as matters of international security, turning health data into strategic assets and embedding global health as a security topic within political discourse. Still the governance of global health data sharing remains composed of fragmented legal frameworks with overlapping mandates and jurisdictions at international, regional and domestic levels.

At the centre of this system is the International Health Regulation (IHR). This legally binding instrument requires states to build the core surveillance capacities to prevent, detect, assess, and report potentially dangerous events (Article 5). It also contains the obligation for parties to assess all reports of urgent events within 48 hours and notify the WHO within 24 hours in case of events that may amount to international public threats.<sup>6</sup> States are then expected to communicate, where possible, data on case definitions, laboratory results, source and type of the risk, number of cases and deaths, conditions affecting the spread of the disease and the health measures employed.<sup>7</sup> Since 2024, the treaty also briefly mentions benefit sharing and the role of the WHO in facilitating and removing “barriers to timely and equitable access by State Parties to relevant health products” during public health emergencies of international concerns (Article 13).<sup>8</sup> State sovereignty however remains the guiding principle of these recommendations, as in all United Nations (UN) institutions and treaties, which explains the focus on the reporting of outbreaks rather than the fostering of collaboration in health data sharing.

The unprecedented speed of contamination and impact of the Covid-19 acted as a game changer, driven by global market integration and societal dependence on trade and cross border circulation of goods and people.<sup>9</sup> Covid-19 was not, however, the first major health emergency of the past century. In fact, the threat of global pandemics was high on the security council agenda for many years before the breakout of Covid-19. In 2016, several organisations like the WHO, Harvard and the London School of Tropical Medicine and the UN urged the implementation of new reforms following the Ebola outbreak in West Africa.<sup>10</sup> They warned that the lenient oversight and binding regulations on the sharing of data, notification and response measures were insufficient in the case of an international outbreak. A majority of these concerns were however delayed until the outbreak of Covid-19 in 2020. A year later, the WHO general assembly initiated the development of a new Pandemic treaty, adopted in May 2025.<sup>11</sup> This new treaty aims to bring stronger attention to sequence data, recognizing genetic and pathogen sequences as central rather than focusing on virus samples, as previously intended in the Pandemic Influenza Preparedness Framework entered into force in 2011.<sup>12</sup> However, negotiations are still ongoing over the Pathogen Access and Benefit Sharing Agreement (PABS) in the Annex of the

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<sup>6</sup> World Health Organisation, “International Health Regulations.”

<sup>7</sup> World Health Organisation, “International Health Regulations.”

<sup>8</sup> “World Health Assembly Agreement Reached on Wide-Ranging, Decisive Package of Amendments to Improve the International Health Regulations”; World Health Organisation, “International Health Regulations.”

<sup>9</sup> Labonté et al., “The Growing Impact of Globalization for Health and Public Health Practice.”

<sup>10</sup> “Secretary-General Appoints High-Level Panel on Global Response to Health Crises | UN Meetings Coverage and Press Releases.”

<sup>11</sup> Buder, “PABS Annex to the WHO Pandemic Agreement.”

<sup>12</sup> Abubakar et al., “Pandemic Influenza Preparedness (PIP) Framework.”

treaty. This initiative seeks to establish a binding mechanism that links the sharing of health-related data with the equitable sharing of the benefits derived from that data. Its primary objective is to reduce disparities between high-income and lower-income countries by ensuring that countries contributing data also receive a fair share of the resulting research, technologies, and medical countermeasures. However, reaching agreement has proven difficult. Persistent disagreements over how to define health data, protect national sovereignty and privacy, and determine the value of shared data have complicated the negotiations. These challenges have become even more pronounced in the context of a shifting international order, where growing geopolitical competition and diverging interests among the great powers is threatening the possibility of rules implementation.

## 3. Global Health Data in an Era of Great Power Competition

“Every day we are reminded that we live in an era of Great Power rivalry and that the rules-based order is fading, that the strong can do what they can and the weak must suffer what they must”.

Mark Carney’s intervention in Davos largely pictures the state of today’s international system. The intensification of US-PRC rivalry is slowly turning the previously multilateral domain of global health governance into an arena of strategic competition. Both countries, while engaging in different strategies, have adopted largely state-centric approaches in their foreign policy dominated by the quest for influence. As health data, disease surveillance and pandemic preparedness become increasingly complex and strategic, great power competition impacts the practice of health data sharing through the political, economic and technological spheres.

### 3.1. Political

As the primary architect of the international system, the US implemented an order relying on international law and multilateral cooperation within the UN. In the past few decades however, selective rule adherence emerged as a pattern for which great powers occasionally disregard or interpret international rules and regulations, complying with legal institutional framework only when these align with their political agenda, and circumventing or reinterpreting them when they do not.<sup>13</sup> After the onset of the Covid-19 crisis, China claimed to follow its IHR obligations to notify the WHO on a potential risk to international public health. The country is however accused to have deferred the notification of two weeks and withheld the genome sequence sharing for one week, fuelling accusations of non-transparency and non-accuracy.<sup>14</sup> The implications of these accusations are large. These alleged delays may have constrained the early assessment of the virus and slowed the adoption of appropriate public health measures, potentially contributing to its rapid spread on a global scale.<sup>15</sup>

Competition also reduces the participation of major powers in multilateral institutions, as illustrated by the US withdrawal from several international organisations and the PRC’s engagement through parallel institutional frameworks. Washington consistently favours forms of health cooperation that preserve its strategic flexibility. While supporting the cross-border exchange of health data and participating in multilateral global health efforts, it has opposed legally binding benefit-sharing arrangements, such as the PABS, which conflict with American economic and strategic interests.<sup>16</sup> The Trump administration reinforced this preference for a more transactional approach by withdrawing from the WHO and introducing its “America First Global Health Strategy”, which prioritises bilateral partnership over multilateral engagement as part of a broader objective of decreasing long-term US funding commitments.<sup>17</sup> This strategy deeply weakens the WHO’s operational capabilities, given that the US was the largest provider of the organisation’s “core voluntary contributions” budget.<sup>18</sup> Additionally, it also impacts global trust in the WHO’s mandate and role. These decreasing credibility and capability enable the PRC to expand its bilateral influence through parallel initiatives such as the

<sup>13</sup> Girardi et al., *Breakdown of the International Order?*

<sup>14</sup> team, *WHO Officials Faced “Considerable Frustration” With China’s Delays In Releasing Vital Coronavirus Information - Health Policy Watch.*

<sup>15</sup> Wright, “Covid in China.”

<sup>16</sup> Aboulenein and Aboulenein, “US Rejects WHO Pandemic Changes to Global Health Rules.”

<sup>17</sup> “America First Global Health Strategy.”

<sup>18</sup> Iwunna et al., “Flexibly Funding WHO?”

Health Silk Road and Global Development Initiative.<sup>19</sup> While it is still unclear how the PRC will position itself at the end of the PABS negotiations, the dependence of countries from these institutions offers the PRC a leverage in negotiations to lobby for limited oversight and enhanced national sovereignty in data sharing processes. Taken together, these developments demonstrate how geopolitical rivalry is reshaping the political foundations of global health governance, creating conditions in which health data is increasingly governed by strategic interests rather than multilateral norms.

### 3.2. Economic

The PRC's rise as a great power is reflected in its expanding role in the global economy, where it has become a key actor across a range of strategic sectors. The competition with the US therefore intensified to gain strategic economic advantage, including within the health domain, and is now transforming the value of data into an economic asset. Throughout the Covid-19 pandemic, the US, the PRC, and other states with the means to do so invested in Research and Development of vaccines against the virus. Besides positioning themselves as leaders in the domain, discovering working treatments offers states and companies the net strategic advantage of claiming intellectual property rights. On average, for every dollar invested in the development or delivery of a vaccine in the first year of vaccination, the estimated return on investments ranged from \$62 to \$442.<sup>20</sup> These actors therefore hold crucial leverage in commercial and political negotiations. However, the capability to develop treatment is highly reliant on the access to pathogen and genetic sequencing, turning data into an immense source of scientific and commercial value.<sup>21</sup> Exclusive or premature access to data becomes therefore a crucial strategy to guarantee an economic advantage.

The competition then alters the economic incentives surrounding health data sharing. As observed in the case of South Africa and its discovery of the Omicron variant, the cost of transparency could rise rapidly due to travel bans, trade restrictions, reduced investments, reputational costs or disruptions of supply chain.<sup>22</sup> These consequences encouraged selective reporting and reduced willingness of commitments to the IHR, leaving space for competing narratives and contested metrics to emerge. Both great powers have incentives to control the timing, interpretation and circulation of data during Covid-19 to limit economic losses and protect the competitiveness of their own pharmaceutical and biotechnology industries. This is mainly driven by the possibility that data could be manipulated from a rival power to impose economic restrictions, gain a technological advantage or damage political reputation.<sup>23</sup> Health data have therefore turned into elements of economic value and national security rather than global public goods leading to increasingly selective and controlled access to data, and further fragmentation in international health data sharing practices.

### 3.3. Technological

US-PRC competition is increasingly defined by advancements in science and technology which the two great powers heavily invest in.<sup>24</sup> With health data being increasingly digitised, the technological race is characterised by an increased role of private tech/biotech/pharmaceutical actors in the practice of data sharing which transforms it into a strategic input for innovation. These actors, generally referred to as Big Tech and Big Pharma, have acquired power which is now far beyond national state control capabilities as they possess the software and hardware needed for digitization, as well as the relevant

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<sup>19</sup> "China's Evolving Global Health Strategy And Its Implications For The US | Health Affairs Forefront."

<sup>20</sup> Benjamin et al., "The Global Return-on-Investment of COVID-19 Vaccines in the First Year of the Vaccination Programme."

<sup>21</sup> Dickens, "From Information to Valuable Asset."

<sup>22</sup> Seydi, "Southern Africa."

<sup>23</sup> D et al., "Irregularities In COVID Reporting Contract Award Process Raise New Questions."

<sup>24</sup> Kennedy and Lim, "The Innovation Imperative."

expertise to extract commercial value from the technological competitiveness of health data.<sup>25</sup> The Covid-19 strengthened Big Pharma as a national security provider and economic driver, and Big Tech's involvement in medicine, epidemiology and health research is increasing the interest of great powers in financially empowering and gaining access and authority over these entities, particularly as these ones are concentrated on their territories.<sup>26</sup> The open and early sharing of health data, as commanded by the binding IHR, may however threaten the competitive advantage and contribute to the rival's innovation capabilities. States therefore become increasingly reluctant to grant foreign entities access to databases, seeking to preserve their leadership position through an asymmetric access to information.<sup>27</sup>

These restrictions are also associated with the potential of health data to be repurposed for surveillance or as a weapon.<sup>28</sup> Certain health data such as genomic sequence data or epidemiological data are difficult to anonymize and largely relevant for surveillance and biotechnology research.<sup>29</sup> Meanwhile, private entities and pharmaceutical companies control the majority of infrastructures through which health data are collected processed and stored such as cloud infrastructures, sequencing platforms and databases, and other digital health platforms. Consequently, both the US and the PRC implemented legal restrictions in genomic data access against rival actors, which creates separate technological ecosystems with limited interoperability, reducing the effectiveness and incentives for health data sharing.<sup>30</sup>

These political, economic and technological dynamics demonstrate that health data is no longer treated solely as a global public good but increasingly as a strategic asset. As great power competition reshapes the incentives governing its collection, sharing and use, the multilateral norms that underpin global health cooperation risk being progressively replaced by fragmented, interest-driven approaches with significant consequences for pandemic preparedness and international health security. Ultimately, the transformation of health data governance thus mirrors the broader erosion of the rules-based international order. As great power rivalry increasingly shapes the political, economic and technological incentives surrounding health data, multilateral cooperation gives way to strategic competition, threatening the trust, openness and reciprocity on which effective global health security ultimately depends. Small and Middle Powers (SMPs) are particularly set to suffer the consequences of these developments.

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<sup>25</sup> Steven R Kraaijeveld and Sharon, "The Increasing Influence of Big Tech in Health and Medicine and the Need for a Public Health Ethics Perspective."

<sup>26</sup> Berger and Schneck, "National and Transnational Security Implications of Asymmetric Access to and Use of Biological Data."

<sup>27</sup> Berger and Schneck, "National and Transnational Security Implications of Asymmetric Access to and Use of Biological Data."

<sup>28</sup> McKibbin and Shabani, "Genomic Data as a National Strategic Resource."

<sup>29</sup> McKibbin and Shabani, "Genomic Data as a National Strategic Resource."

<sup>30</sup> "Office of Public Affairs | Justice Department Implements Critical National Security Program to Protect Americans' Sensitive Data from Foreign Adversaries | United States Department of Justice"; "Regulations of the People's Republic of China on the Management of Human Genetic Resources (Revised in 2024)."

## 4. Strategic Risks and Implications for Small and Middle Powers

The structural dependence of SMPs' security on the current international system and their limited agenda-setting power makes them particularly vulnerable to fluctuations in data sharing practices.<sup>31</sup> Considering their limited political, economic and strategic advantage compared to great powers, their capability to access foreign health data or to receive benefits for their contributions is largely dependent on the implementation of treaties and rules which guarantee these interests. Following the assessment of the impact of great power competition, this paper identifies three main implications for SMPs associated with an increasingly selective, controlled and conditional environment for data sharing: (1) implications related to knowledge and information; (2) implications related to security and technological dependence; and finally (3) distributional implications related to benefit sharing and crisis responses.

### 4.1. Informational implications

The US-PRC strategic competition and the conditionality of access associated to it, is increasing the risk of diverging research ecosystems associated with interoperability challenges. A central goal of global health governance is to organise the standardization and interoperability of these data to overcome barriers such as the scattering of data among databases and diverging interpretation.<sup>32</sup> Competition is also driving great powers to establish distinct data standards and requirements, imposing substantial inefficiency on SMPs and their domestic actors who must adapt and operationalise health data according to different and sometimes incompatible frameworks.<sup>33</sup> These create legal challenges to interoperability by preventing common homogenous governance for data standards. Selective data sharing also widens intelligence gaps between regions as differences in language, vocabulary and terminology create semantic challenges.<sup>34</sup> The structural dependence of SMPs on the functioning of rules therefore threaten their capabilities of effective participations within the research field. Finally, the protection of databases as economic and security objects increases requirements for technical interface, protocols and security measures enabling information sharing, imposing high costs on SMPs.

Informational risks also emerge in the context of reduced participation in multilateral institutions. The reduced funding associated, limits the capability of the WHO to provide technical assistance, laboratory support, specialised expertise and equipment for national genomic surveillance systems, over which countries with limited domestic resources largely rely on.<sup>35</sup> In that context, capacity to collect and analyse data may reduce and prevent meaningful public health response. The 2026 Ebola outbreak in the Democratic Republic of Congo illustrates the consequences of these informational gaps. The nucleotide sequence of the Bundibugyo virus is about 30% different than other virus species generally causing Ebola outbreaks, and for which no approved vaccine or treatment is available.<sup>36</sup> Limited local testing facilities and surveillance delayed diagnosis until samples reached laboratories outside the region, slowing response and increasing the risk of regional transmission.<sup>37</sup> These risks are

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<sup>31</sup> Girardi et al., *Breakdown of the International Order?*

<sup>32</sup> "Health data interoperability."

<sup>33</sup> Zuniga et al., "The Geopolitics of Technology Standards: Historical Context for US, EU and Chinese Approaches."

<sup>34</sup> "Health data interoperability."

<sup>35</sup> "WHO Health Emergency Appeal 2026."

<sup>36</sup> "Big Ebola Outbreak Puts Spotlight on Little-Known Virus."

<sup>37</sup> Caelers, "Month-Long Detection Gap Complicates Ebola Containment in DRC."

likely to deepen when great power strategies reduces involvement in institutions supporting public health monitoring efforts and early warning systems.

These interoperability and early warning system risks question capabilities of SMPs to operate in a crisis context. Nevertheless, they also create opportunities for SMPs to strengthen resilience and autonomy of global health information systems. Firstly, the fragmenting order and reduced investment in global surveillance capabilities may stimulate greater investments in regional surveillance systems and infrastructures, reducing the dependence on great power led multilateral institutions. Greater bilateral involvement also helps SMPs address limitations in domestic sequencing capabilities by focusing on coalitions pooling financial and technical resources to develop shared surveillance capabilities while retaining control over their data. These coalitions can also prevent the fragmentation produced by competing standards as they offer the opportunity to establish common requirements in data protection and access facilitating exchange such as the GDPR. These opportunities allow SMPs to counteract the informational risks posed by great power competition.

## 4.2. Technological implications

The limited economic capabilities of SMPs makes them unable to maintain the same level of technological development of great powers, making them dependent on foreign digital infrastructure. Health data are processed through AI systems, cloud platforms and digital structures, these ones mainly dominated by major powers and private firms. The Covid-19 crisis highlighted the involvement of American and Chinese big tech actors in digital biomarkers, electronic health records, contact tracing, health tracking and predictive measures for infectious disease outbreaks, upon which the majority of SMPs relied on for the management of national health data.<sup>38</sup> Great power use targeted industrial policy, providing state support through direct subsidies, low interest loans, grants and tax credits, to support development of such technologies.<sup>39</sup>

The capacity of SMPs to maintain authority over access and transfer standards may depend on the platform upon which these ones are held and under which jurisdiction they operate, causing concerns about digital sovereignty. This dependency may represent a strategic leverage to pressure SMPs to align in the competing digital ecosystem upon which it is dependent from. SMPs may also face restricted access to critical technologies allowing them to conduct surveillance and analysis, through export controls, restrictions and bans.<sup>40</sup> Finally, data may also be used as a training asset for artificial intelligence and algorithm improvement. Reliance for storage on foreign controlled digital infrastructures may enable external actors to extract, process, monetize and strategically leverage health data generated within SMPs as it subjects data to foreign regulatory sphere.<sup>41</sup>

SMPs dependencies may however create incentives to diversify sources of digital technologies and infrastructures as well as financial support. The emergence of diversified networks of partnerships may also reduce the exposure to single providers and limit the ability of great powers or private firms to obtain monopoly or exercise strategic leverage over SMPs policies. Coalitions building appears once again as a suitable alternative to stimulate development of regional initiatives and capabilities. Rather than eliminating dependence of the health ecosystem on great powers, these coalitions strategically redistribute it, aiming to enforce a system in which SMPs retain autonomy over both their infrastructures and their data.

<sup>38</sup> Steven R. Kraaijeveld and Sharon, "The Increasing Influence of Big Tech in Health and Medicine and the Need for a Public Health Ethics Perspective."

<sup>39</sup> Zhang, "Goeconomics of US-China Tech Rivalry and Industrial Policy."

<sup>40</sup> Miller and Wright, "US-China AI Competition in the Arab Gulf: Diverging Uses of Technological Statecraft on the Regional Level."

<sup>41</sup> "Resisting Digital Colonialism and Protecting Subaltern Agency in Africa | Journal of Public and International Affairs."

### 4.3. Distributional implications

Great powers' selective participation in multilateral institutions and their efforts at securing strategic advantage is reshaping the distribution of vaccines and medication increasingly channelled through bilateral alignment containing conditions or forcing compliance. SMPs become less willing to share data when their contributions are not associated with predictable and guaranteed benefits, especially since the increased commercial value of data and its weight in negotiations. The severity of the Covid-19 and unequal distribution of vaccines and medications revived the debate, this time as a general demand in global health governance leading to the PABS Annex and its ongoing negotiations. Since then, the Trump administration notified of the US withdrawal from the WHO.<sup>42</sup> Distribution of aid, vaccines and medical equipment from the US are therefore largely dependent on political alignment and agreements from SMPs.

As part of the America First Global Health Strategy, the US tie lifesaving help against HIV/AIDS, Malaria and Tuberculosis until 2030, to specific data sharing conditions.<sup>43</sup> These ones would require the supply of genetic sequence and pathogen data to US-approved laboratories up until 25 years, undermining data sovereignty. These arrangements may transform the practice of data sharing into long-term structural dependencies where SMPs lose their negotiation leverage over vaccines and treatment access developed from their own contributions, weakening the broader bargaining power of SMPs in PABS negotiations. The competition increases the incentive for great powers to play outside of regular international treaties to gain strategic advantages. Similarly, China conditions partnership to adherence to the One-China policy, excluding countries with positive relations with Taiwan entirely from its health aid and benefits distribution.<sup>44</sup>

These trends are observed in a context of decreasing credibility for international institutions like the WHO, risking that these practices become the new norms of global health interactions between SMPs and great powers. They therefore pose significant risks regarding SMP sovereignty and political independence, especially for SMPs relying on provision of foreign help. These methods also question the outcome of the PABS agreements, and the specificities of obligations the PRC and developed SMPs (excluding the US) will have towards developing states.<sup>45</sup>

The declining involvement through multilateral channels could however offer SMPs an opportunity to reduce dependence on single providers, the US or PRC, by fostering development of diversified channels and partnerships for health assistance. This would increase resilience against great power priorities shifts and prevent distribution to be used as political leverage. The creation of issue-based coalitions could also coordinate SMP position around shared interests and increase their capacity to shape the terms and conditions for health data technology distribution, including multilateral frameworks such as the PABS.

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<sup>42</sup> "Withdrawing The United States From The World Health Organization."

<sup>43</sup> Barry-Jester, "Digital Colonialism."

<sup>44</sup> Dolan et al., "Chinese Health Funding in Africa."

<sup>45</sup> Tomori, "African countries are signing bilateral health deals with the US."

## 5. Conclusion

With the shifting international order and decreasing credibility of multilateral institutions, both SMPs and great powers seek strategic assets to maintain higher levels of independence and control over their political agenda. The role of data in influencing power dynamics is increasing, and great powers have large advantages in dominating collection, storage and access, but also technologies enabling it and their interpretation. The strategic competition between the US and the PRC has the potential to make health data sharing more selective, controlled and conditional as data become economic and strategic assets of high value influencing the outcome of the technological race. Possibilities of surveillance and weaponisation of genomic sequence data also transforms the platforms storing information into national security objects to protect. As a result, SMPs access to health information ecosystems is constrained as these ones become increasingly diverging and controlled.

This threatens the accurate functioning of Early Warning Systems as informational gaps widen, and selective reporting becomes normalised. In addition, the decreasing credibility and capacities of multilateral institutions influences the rise of private actors, mostly located in great power territory, who play an increasing role in the management of data and threaten the digital sovereignty of SMPs. Finally, the political independence of SMPs is constrained by their reliance on foreign aid and technologies to contain epidemics, conduct genomic surveillance and develop treatments and vaccines. SMPs with a combination of limited financial resources, political influence and expertise are therefore likely to impose stronger informational, technological and distributional risks, which certain SMPs already mitigate thanks to their investments in collective mechanisms.

At the same time, an increasingly competitive international environment also creates opportunities for SMPs. As great powers compete for influence, SMPs may gain greater diplomatic leverage by diversifying their partnerships, engaging in issue-based coalitions, and reducing dependence on any single provider of health technologies, data infrastructures or financial support. Competition can also stimulate investment in regional surveillance networks, domestic sequencing capabilities and interoperable digital infrastructures, allowing SMPs to strengthen their own resilience while shaping emerging international norms on health data governance. Rather than remaining passive recipients of great power strategies, SMPs can use this evolving landscape to enhance their strategic autonomy through selective cooperation, institutional innovation and capacity building.

Ultimately, the extent to which SMPs experience the risks or seize the opportunities created by great power competition will depend on their ability to develop political, technological and institutional autonomy while preserving commitments to multilateral cooperation. Their challenge is not simply to navigate a more fragmented international order, but to ensure that health data continues to serve as a global public good rather than becoming another instrument of geopolitical rivalry.<sup>46</sup>

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<sup>46</sup> Girardi et al., *Breakdown of the International Order?*



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