

Medical Equipment Leasing in Kenya: Neocolonial Global Finance and Misplaced Health Priorities

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DRAFT for discussion

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List of acronyms and abbreviations

AICD - Africa Infrastructure Country Diagnostic Report
ACHPR – African Charter on Human and Peoples’ Rights
AU - African Union
BIT – Bilateral Investment Treaty
CESCR – Committee on Economic and Social and Cultural Rights
CEDAW – Convention on the Elimination of all forms of Discrimination against Women
CSSD - Central Sterile Services Department (CSSD)
EPG - Eminent Persons Group
FBI - Federal Bureau of Investigations
GE - General Electric
GII – Gender Inequality Index
GOK - Government of Kenya
HDI - Human Development Index
ICA - Infrastructure Consortium of Africa
ICSECR – International Covenant on Social, Economic and Cultural Rights
ICU - Intensive Care Unit
IMF - International Monetary Fund
ISDS - Investor State Dispute Settlement
KHSSP - Kenya Health Sector Strategic and Investment Plan
Ksh Kenya Shilling
MES - Managed Equipment Service
MDB - Multilateral Development Bank
MFD - Maximising Financing for Development
MOH - Ministry of Health
NHIF - National Health Insurance Fund
OOP – Out of Pocket Payments
PPP - Public Private Partnership
PPPU - Public Private Partnership Unit
SAPs – Structural Adjustment Programmes
SDGs - Strategic Development Goals
THE - Total Health Expenditure
UHC - Universal Health Coverage
WHO - World Health Organization

Abstract

The paper brings to the fore how an undemocratic, neocolonial and neoliberal global governance system keeps African countries in an austerity and private finance chokehold, placing corporate and elite interests above the rights of citizens, exacerbating health care crises. Women bear a wildly disproportionate burden of these crises. They are the primary users of failed public health systems both for their own health and that of the people they provide care for. Their out of pocket expenditures on health care has been found to be systematically higher than men and their lower incomes puts private healthcare out of reach.

In 2015, the Government of Kenya launched a scheme that saw the outsourcing of specialised medical equipment for public hospitals across the country to private sector firms. This case study examines some of the current and potential impacts of public-private partnerships and broader macroeconomic policy decisions on women - including their health and labour. Through an extensive literature review, it begins by looking at the range of right to health-related commitments made by the Kenyan government against its history of health financing policy beginning with its earliest colonial iterations, the progressive policies of the post-colonial era, through to the debt and structural adjustment of the 1980s and 1990s, and the attempts at reform in the early 2000s. It situates the specialised medical equipment leasing scheme in wider questions around the neocolonial imposition of private financing models by international finance institutions and other players in the global financial architecture and the extent to which that impacts the social contract between State and citizen.

The paper elaborates on key problems surrounding this public private partnership, which reiterate some of the major challenges many have attributed to this model of delivering what should be publicly- delivered public goods. This scheme is characterised by an overall lack of transparency and accountability surrounding contracts, costing and allocations with many of the safeguards against these kinds of challenges blatantly ignored by several actors and in turn raising issues of accessibility for citizens. There is also a central question around priority setting, with questions around what informs the decision to spend budgets on one healthcare need versus another, what the process of making it looks like, and who are involved and consulted.

Ultimately, this paper makes the argument for greater Pan African and feminist resistance of prevailing orthodox macroeconomic policy that is increasingly centering private finance and the intensification of connected struggles against neoliberal and (neo) colonial systemic oppression across the continent.

Introduction

In writing this paper we are seeking to contribute to ongoing feminist analyses not only of public-private partnerships (PPPs), but of broader macroeconomic policy and how it impacts women and their communities. We are particularly committed to playing our part in interrogating and challenging the persistence of neoliberal policies imposed upon and embraced by African governments to the detriment of African people, while remaining cognizant of the skewed, ever evolving and complex nature of global finance and governance.

Access to quality, universal gender-responsive and affirming healthcare remains a fundamental challenge for Africa and its citizens. For women in particular, it is not only a question of our own health. Failing healthcare systems mean more hours caring for ill children and other family members, and less time available for other activities and pursuits, be they decent paid work, education, political participation or leisure. Women's unpaid labour subsidises collapsed public health systems. Seventy per cent of the health and social care work force are women and one in five women are employed in the care sector. National and local healthcare delivery are therefore not only a matter of health outcomes – but of time poverty, paid and unpaid labour, livelihoods and the full body of human rights.

This paper is written in the midst of the COVID-19 pandemic and never has the intersecting nature of multiple crises and inequalities been clearer. Now is the time to dismantle the failed global systems that fuel them and replace them with co-created systems that are sustainable, equitable and just.

1. Setting the scene

“[...] ‘world class’ in resource-limited contexts like these has tended to focus, rather dangerously, on flashiness of equipment and an array of available specialties, rather than on how the people feel about how they are being treated and guided on the path back to health. We have seen billboards with photos of futuristic diagnostic machines, but heard horrifying stories of patients suffering in the same hospitals where the sci-fi imagers sit. In many ways, we like the idea of a hospital that looks like one abroad but haven’t thought beyond that to a hospital where Kenyans are treated as though they matter.”

~Dr. Njoki Ngumi¹

Health as a global rights mandate

The right to health is recognized as an inalienable human right in a number of global and regional frameworks. Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) recognizes the right of everyone to “the enjoyment of the highest attainable standard of physical and mental health”². The African Charter on Human and People’s Rights (ACHPR) requires African Union member states to ‘take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.’³

The African Union’s Agenda 2063 is a shared strategic framework for the socio-economic transformation of the continent through seven aspirations. The first speaks to “a prosperous Africa based on inclusive growth and sustainable development”⁴. Under this aspiration, there are a number of goals that are relevant to healthcare. One is a high standard of living, quality of life and well-being for all, covering income, jobs, education, health as well as transformed economies. Another is healthy and well-nourished citizens – expanding access to quality health care services especially for women and girls. African states have committed to implementing the Sustainable Development Goals (SDGs) and Agenda 2063 and the SDG framework have points of conversion as illustrated below⁵.

African Union Agenda 2063	Priority Areas	Sustainable Development Goals (SDGs)
A high standard of living, quality of life and well-being for all	<ul style="list-style-type: none"> Incomes, jobs and decent work 	Goals: <ul style="list-style-type: none"> 1 No Poverty

¹ Ngumi, J. (2018). Health care for all: A reflection on the current state of healthcare in Kenya. Available at: <https://www.theelephant.info/features/2018/08/16/health-for-all-a-reflection-on-the-current-state-of-healthcare-in-kenya/>

² International Covenant on Economic, Social and Cultural Rights. Available at: <https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx>

³ African Charter on Human and Peoples’ Rights (Article 16.2). Available at: <https://www.achpr.org/legalinstruments/detail?id=49#:~:text=The%20African%20Charter%20on%20Human, freedoms%20in%20the%20African%20continent.>

⁴ Our aspirations for the Africa we want. Available at: <https://au.int/en/agenda2063/aspirations>

⁵ ibid.

citizens	<ul style="list-style-type: none"> ● Poverty, inequality and hunger ● Social security and protection, including persons with disabilities ● Modern, affordable and liveable habitats and quality basic services 	<ul style="list-style-type: none"> ● 2 Zero Hunger ● 8 Decent Work and Economic Growth ● 11 Sustainable Cities and communities
Healthy and well-nourished citizens	<ul style="list-style-type: none"> ● Health and Nutrition 	<p>Goal:</p> <ul style="list-style-type: none"> ● 3 Good Health and well being

Table 1: Policy framework comparison table

Crucially, health as a right is inclusive of other rights. The Committee on Economic, Social and Cultural Rights (CESCR), responsible for monitoring ICESCR refers to the wide range of factors that lead to a healthy life as the ‘underlying determinants of health’. They include safe food, safe drinking water and sanitation, adequate nutrition, adequate housing, healthy working and environmental conditions, health-related education and information and gender equality⁶. CESCR has also elaborated the entitlements⁷ contained in the right to health including equality of opportunity for everyone to enjoy the highest attainable level of health, and participation of the population in health-related decision-making at national and community levels. Article 12 of the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) requires state parties to take measures to ensure that women and men have equal access to health care services. Kenya has also ratified the Protocol to the ACPHR on the Rights of Women in Africa (or the Maputo Protocol), which commits member states to the provision of ‘adequate, affordable and accessible health services including information, education and communication programmes to women especially those in rural areas’⁸. Article 19(b) of the Protocol explicitly guarantees women’s right to sustainable development and compels states to ensure that women participate at all levels of decision making, implementation and evaluation of development programmes.

Kenya has ratified these and other global and regional human rights and development commitments. In looking at the impact of PPPs on the health sector, it is necessary to look at the entirety of these explicit commitments as they overlap in the lives of the people whose rights the state is obligated to respect, protect and fulfill.

Kenya : Interactions between governance and development visions

⁶ Office of the United Nations High Commissioner for Human Rights. (2008). The Right to health, Fact Sheet no. 31. Available at: <https://www.ohchr.org/Documents/Publications/Factsheet31.pdf>

⁷ *ibid.*

⁸ Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol Text). African Union; 2003. Available at: https://www.un.org/en/africa/osaa/pdf/au/protocol_rights_women_africa_2003.pdf

In 2010, the Republic of Kenya, promulgated a new constitution replacing the independence constitution of 1963. This new constitution significantly altered the distribution of power in the country by moving from a centralized system of national government to a devolved system characterised by forty-seven elected County units. If we examine the objectives of devolution - such as promoting democratic and accountable exercise of power, allowing communities to manage their own affairs and providing proximate and easily accessible services - alongside the realities of healthcare delivery almost exactly 10 years later, there are glaring gaps with potentially devastating ramifications on the quality of life of citizens and communities.

“[...] Growing up my parents really worked hard to ensure we had four basic needs. Over and above food, shelter and clothing there was private medical insurance. My father to date always goes on and on about how if you don't have it then you don't have access to the 'creme de la creme' of medical services and that was important. Government health services only cater to 10% of your health problems and even with drugs they give you the basic drugs. 90% of your health problems have you practically on your own. So I've grown up knowing that government services just don't cut it and that one needs to look into private insurance if they want great services”.

Kenya has an impressive framework for health decentralization and delivery - essential services are the responsibility of county governments with only health policy and the management of national referral health facilities left to the national government. In 2017, Kenya's President Uhuru Kenyatta announced a 'Big Four Agenda' aimed at bringing to life Kenya's third Medium Term Plan (MTP) towards its ambitious 'Vision 2030'⁹ development footprint for industrialisation and middle-income status. The Big Four were food security, affordable housing, manufacturing and affordable healthcare for all through universal health coverage (UHC). Two years prior to this, the government had launched the Managed Equipment Service (MES) programme, which is the subject of this paper and is described as “a flexible, long-term contractual arrangement that involves outsourcing the provision of specialized, modern medical technology and equipment to private sector service providers.”¹⁰

Kenya's population stands at just under forty-eight million¹¹ with a life expectancy at birth of 66.3 years and a poverty rate of 36.1 percent¹². In 2018, its Human Development Index (HDI) value was 0.579 putting it in the medium human development category and at rank 147 out of 189 countries (a position shared with Nepal)¹³. Kenya is ranked 134 out of 162 on the Gender

⁹ Kenya. Ministry of Planning and National Development. (2007). Available at: <http://vision2030.go.ke/>

¹⁰ Parliament of Kenya, The Senate. (2018). The Managed Equipment Service (MES) Project, Brief and Suggested Questions. Available at: http://www.parliament.go.ke/sites/default/files/2018-11/MES%20Brief_Nov%202018%20%285%29_%20With%20Suggested%20Questions%20.pdf

¹¹ Kenya National Bureau of Statistics. Available at: <https://www.knbs.or.ke/?p=5621>

¹² UNDP Kenya. Annual Report 2018. Available at: <https://www.undp.org/content/undp/en/home/librarypage/corporate/annual-report-2018.html>

¹³ UNDP Kenya. (2019). Human Development Report 2019: Inequalities in Human Development in the 21st Century, Briefing note for countries on the 2019 Human Development Report Kenya. Available at: http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/KEN.pdf

Inequality Index (GII) with a value of 0.545. GII reflects gender inequalities in reproductive health, empowerment and economic activity¹⁴.

History repeating itself: Structural Adjustment, health financing and debt

With a current GNI per capita of \$1,620, the country has been classified since 2015 as a lower middle-income country. The Brookings Institution has observed that as countries move from low to middle income status (with GNI per capita between \$1, 026 and \$3, 995), they experience a big shift in the composition of public to private spending on health.¹⁵ This is because their eligibility criteria for concessional development assistance changes and with it, foreign health aid and technical assistance declines. This combined with a global shift towards private development finance creates the perfect entry point for the private sector and for PPPs.

From the time Kenya gained independence from Britain in 1963 up to 1993 it introduced six measures in a series of healthcare reforms: (1)harmonization and (2)decentralization of medical care delivery (3) expansion of preventive health services such as family planning (4)introduction of a national medical insurance scheme (5) selective integration of traditional medicine and (6) introduction of user fees .¹⁶ (User fees are applied at each point of service and are paid directly by health seekers to access a specific service). The earliest ambitions for universal health coverage were part of an overarching development policy for post-independence Kenya articulated in *Sessional Paper Number 10 on African Socialism and its Application to Planning in Kenya*. In fact, the removal of user fees in public health facilities in 1965 - two years after independence - was a reversal of the discriminative colonial imposition of these fees for Africans. This new policy provided free basic social services for all including health services, funded primarily from tax revenue.¹⁷

The next major policy shift in this area came thirty four years later when, in its 1989-1993 Development Plan (development plans have, since independence, been the main medium of communication of reform decisions), Kenya's government reiterated a commitment it did not implement but that appeared in the preceding plan for 1983-1985. The commitment was to introduce user fees in public health facilities, and it was met with much public outcry. Nevertheless, user fees were introduced in December 1989 under 'considerable pressure from donors' (some may say excessive pressure) and the banner of 'cost sharing' which, in effect, was no different.¹⁸ Nine months after its introduction, the decision was rescinded only to be reintroduced in April 1992. Kenya's health sector has since relied on out-of-pocket payments for most levels of care.

It will not come as a surprise that these changes were primarily a result of the introduction in the 1980s of Structural Adjustment Programmes (SAPs) – a range of neoliberal

¹⁴ *ibid.*

¹⁵ The Brookings Institution. (2019). What happens to health financing during the middle-income transition? Available at: <https://www.brookings.edu/blog/future-development/2019/12/16/what-happens-to-health-financing-during-the-middle-income-transition/>

¹⁶ Mwabu, G. (1995). Healthcare Reform in Kenya: A review of the process. *Health Policy*. 32 p.245 – 255.

¹⁷ Chuma, J., Okungu, V. (2011). Viewing the Kenyan health system through an equity lens: implications for universal coverage. *Int J Equity Health* 10, 22. Available at: <https://doi.org/10.1186/1475-9276-10-22>

¹⁸ Mwabu, *op. cit.*, p. 245 - 255

macroeconomic measures promoted by the World Bank and the International Monetary Fund (IMF) in exchange for financial resources. Kenya was among the majority of countries in sub Saharan Africa in which SAPs were implemented with devastating effects on the delivery of public services stemming from cuts in government expenditure on the public sector. It is widely documented how the economic and social impacts of SAPs disproportionately affected women. The collapse of publicly delivered social services and infrastructure increased their unpaid care and domestic work burdens and low skilled public sector jobs, which employed mostly women were lost. User fees payments and cost sharing also fell heavily on women. “Health facilities were previously on average six to seven kilometres away from most households...many of them closed down while those that remained open lack(ed) basic amenities. At Nakuru District Hospital, for example, expectant mothers (were) required to buy gloves, surgical blades, disinfectants and syringes in preparation for childbirth. In addition, they (had) to bribe hospital personnel in order to be attended to. This (was) usually too expensive for many women and they opt(ed) for traditional birth attendants’¹⁹.

Over the years, some exceptions to the imposition of user fees have been introduced, such as their abolishment in 2004 in the lowest level of health facilities (dispensaries and health centres) and their replacement with a one off registration fee. There have also been a series of exemptions including for children under five years of age and malaria and tuberculosis patients. In 2007, fees for pregnant women delivering in public facilities were abolished. However, observers have noted that adherence to these progressive policy changes has been low due to cash shortages and other challenges.²⁰ If we take free maternal deliveries as an example, the introduction of what appears to be a progressive policy saw an increase in demand for services as more women went to hospital to deliver. To their disappointment, the ‘free delivery’ did not always exclude other costs such as consumables and drugs, nor did it consider other crucial issues such as human resourcing and infrastructure. Between 2008 and 2009, it is reported that in the then North Eastern Province where there was only one operational maternity facility, 68.8 percent of women were deterred because of distance, lack of transport, or because the facility was not open, versus only 4.9% who cited cost as the key barrier to skilled delivery’²¹.

The table below²² provides a useful picture of health financing policies and their equity impacts between the colonial period and 2010:

Years	Policy	Equity Impacts
Colonial Period	User Fees in all public facilities	Discriminative policy against Kenyans, imposed by colonial government
1963 - 1965	User fees initially introduced continued to exist for two years after independence	Negative impacts of affordability and utilisation of health care services

¹⁹ Parsitau, D. (2008). *The Impact of Structural Adjustment Programmes (SAPs) on Women’s Health in Kenya* Dakar: CODESRIA.

²⁰ Chuma, J., Okungu, V. op. cit.

²¹ Bourbonnais, N. (2013). *Implementing Free Maternal Health Care in Kenya*. Available at: <http://www.knchr.org/Portals/0/EcosocReports/Implementing%20Free%20Maternal%20Health%20Care%20in%20Kenya.pdf>

²² Chuma, J., Okungu, V. op. cit.

1965	User fees removed at all public health facilities. Health services provided for free and funded predominantly through tax revenue	Potential for equity provided there are mechanism to ensure that the poor benefit from tax funded system
1989	User fees introduced in all levels of care	Negative impact on demand for health care especially among the poorest population; decreased utilisation including essential services like immunisation
1990	User fees suspended in all public health facilities. Waivers and exemption put in place to protect the poor and vulnerable. Failure linked to poor policy design and implementation.	Increase in utilisation patterns, confirming previous reports that user fees are a barrier to access.
1991 – 2003	User fees were re-introduced in 1991, through a phased implementation approach starting from hospital level. Children under five, special conditions/services like immunisation and tuberculosis were exempted from payment. User fees continued to exist in Kenya at all levels of care.	User fees major barrier to access, high out-of-pocket payment, catastrophic impacts, and negative implications for equity.
2004	User fees abolished at dispensaries and health centres (the lowest level of care), and instead a registration fees of Kenya shillings 10 and 20 respectively was introduced. Children under five, the poor, special conditions/services like malaria and tuberculosis were exempted from payment.	Utilisation increased by 70%; the large increased was not sustained, although in general utilisations was 30% higher than before user fee removal. Adherence to the policy has been low, due to cash shortages
2007	All fees for deliveries at public health facilities were abolished	No data on extent to which policy was implemented and no evaluation has taken place.
2010	A health sector services fund (HSSF) that compensates facilities for lost revenue associated with user fee removal introduced. Dispensaries and health centre receive funds directly into their bank accounts from the treasury.	Possible positive impacts on adherence to fee removal policy and equity

Table 2: Kenya's health financing policy timeline

In the financial year 2015/2016 Kenya's total health expenditure (THE) including both public and private, was 3.46 billion US dollars accounting for 5.2 percent of GDP. Government health expenditure accounted for only 6.7 percent of total government expenditure with total government expenditure accounting for approximately 36% of GDP.²³ This falls quite short of the target set in the 2001 African Union 'Abuja Declaration'²⁴ of a fifteen percent minimum spend on health sector improvement. In 2011, ten years after Abuja, the World Health Organization (WHO), in taking stock of the progress made by African governments towards this target, classified Kenya as having made 'insufficient progress'.²⁵

A study²⁶ of health spending in twelve counties in the 2014/15 financial year found that, on average, the biggest source of finance was households at 37.3 percent. This was followed by county governments at 36.4 percent. Donors and corporations accounted for 16.3 and 10.1 percent, respectively. When it came to management of the funds, county governments

²³ Ministry of Health. (2019). Kenya National Health Accounts FY 2015/2016. Nairobi: Government of Kenya. Available at: http://www.healthpolicyplus.com/ns/pubs/16339-16616_KenyaNHAmainreport.pdf

²⁴ https://au.int/sites/default/files/pages/32904-file-2001_abuja_declaration.pdf

²⁵ https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1

²⁶ https://www.healthpolicyproject.com/pubs/7885_FINALSynthesisreportoftheCHA.pdf

managed thirty six percent of THE, followed by households at thirty five percent and NGOs at sixteen percent. Social health insurance - through the National Health Insurance Fund (NHIF) - and private health insurance played a minimal role, with NHIF only managing four percent of the funds (NHIF is a contributory monthly scheme that is mandatory for formally employed people - with employers remitting the monthly contribution - and voluntary for those not in formal employment). Most of the health funds went to county public hospitals, health centres and dispensaries. Save for the major cities of Nairobi and Mombasa where private health provision is prominent, the vast majority of Kenyans rely on public health facilities.

“I trust the private sector more because they are well funded and well run. I feel like government funded facilities are pretty run down. The government needs to do better and make sure these places are well run and invested in properly. I think a good amount of the tax citizens pay should be invested in the healthcare sector. And I think that the government should find more ways to tax us. Basically, finding more ways to tax the citizens who live an above average life. This way they have money to pour into the system. This way what we give helps us. So that the people who cannot afford to pay, don't have to worry.”

Malika Wangeci, 21 years old

Household health spending is primarily through out of pocket (OOP) payments defined²⁷ as ‘direct payments made by individuals to health care providers at the time of service use’. These put pressure on household budgets, which could otherwise be used for food and other basic needs, as well as increase household debt risk. It also places severe limits on whether poorer households can access or afford quality healthcare.

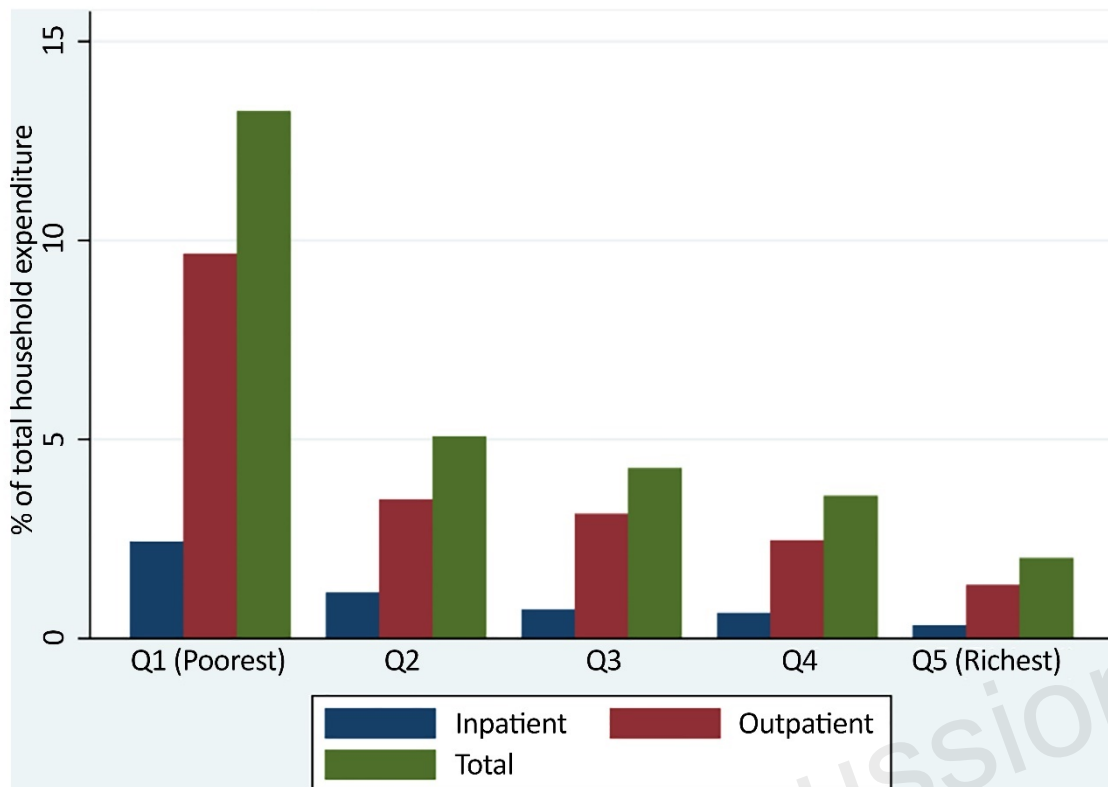
The graph below shows that the highest spend on OOP payments is in the lowest income quintile. The poorest households carry the heaviest health spending burdens. This particular data for Kenya is not disaggregated by gender, but women’s OOP expenditure has been found to be ‘systematically higher than that of men at least in part because of the high financial burden related to and paying for delivery care and other reproductive services’²⁸. In addition, high OOP expenses mean that a higher proportion of women than men have unmet health needs.²⁹ Kenya’s OOP expenditure stands at 27.7% comparing to 6.4% in Rwanda³⁰

²⁷ World Health Organization. Out of Pocket Payments, User Fees and Catastrophic expenditure Available at: https://www.who.int/health_financing/topics/financial-protection/out-of-pocket-payments/en/

²⁸ Ravindran, T.S. Universal access: making health systems work for women. *BMC Public Health* **12**, S4 (2012). Available at: <https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-12-S1-S4>

²⁹ *ibid.*

³⁰ Institute of Economic Affairs. (2020). Kenya’s comparison of Out of pocket expenditure on Health with its peers. Available at: https://www.ieakenya.or.ke/number_of_the_week/kenyaa-s-comparison-of-out-of-pocket-expenditure-on-health-with-its-peers



Graph 1: Mean OOP payments as a share of total household expenditure by income quintiles(2018)³¹

We cannot look at the question of public spending on health in Kenya, without addressing its debt crisis. Recent research from ActionAid International places Kenya’s external debt servicing for 2019 at a staggering 36% of its national budget – and its debt payments have tripled over just two years. ‘...as much money goes into paying debt as the total spending on education and health combined. If that figure was reduced to 12% through cancellation, rescheduling, or other methods, Kenya would have had an extra 4.4 billion US dollars available for spending on public services. At the same time, if a fifteen percent share of the potential four billion dollar excessive debt servicing was freed-up this could also raise another thirteen dollars per person to be spent on health, in a country which is spending around thirty dollars per person - this could boost spending.³²

PPP architecture, policy and legal frameworks

Kenya’s Health Ministry’s framing makes it clear that private sector engagement is a key priority in the delivery of its promise of quality health care to the citizens of Kenya. “Great opportunities exist for the private sector. The healthcare market in Africa was worth thirty five billion US dollars in 2016 and is set to grow to sixty five billion US dollars by 2022. Kenya, and many other African countries are open to private sector investment in

³¹ Salari, P., Di Giorgio, L., Ilinca S., and Chuma, J. (2019). "The Catastrophic and Impoverishing Effects of Out-of-pocket Healthcare Payments in Kenya, 2018." *BMJ Global Health* 4.6 (2019): E001809. Available at: <https://gh.bmj.com/content/bmjgh/4/6/e001809.full.pdf>

³² <https://actionaid.org/sites/default/files/publications/final%20who%20cares%20report.pdf>

healthcare”³³. Indeed, in his statement to the UN General Assembly, the President commits to “introduce innovative financing models that reorients private capital, create new instruments and modalities that strengthen regulatory framework to de-risk investments³⁴.”

Put together, these statements paint a picture of Kenya’s view of health care as a factor towards economic growth with the private sector being the largest contributing factor to the country achieving its targets. The country’s top officials are replicating World Bank language around de-risking investment in line with the Maximising Finance for Development narrative as described in the next chapter.

The MES programme was conceived under the 2014 - 2018 Kenya Health Sector Strategic and Investment Plan (KHSSP)³⁵ that lays a foundation for PPP coordination in the sector. This includes capacity building programmes for policy makers and private sector players and ‘deepening understanding of the role of the private sector in the health industry’. It sets out clear objectives around promoting private sector participation in financing of health through PPP and other mechanisms and increasing private sector investments in the provision of health services through infrastructure development.

More broadly, Kenya has a Public Private Partnerships Act (2013)³⁶, which establishes a PPP Committee consisting of Principal Secretaries in various State departments responsible for finance, coordination of government functions, national planning, lands, county government, the Attorney General (or a representative) and four persons who are not public officers. This Committee approves PPP projects, authorises allocations from the PPP fund, oversees monitoring and evaluation of projects as well as fiscal accountability. Its secretariat and technical arm is the Public Private Partnerships Unit (PPPU) whose mission is ‘to introduce and communicate PPP policy, to develop PPP practice and take a key role in the sustainable delivery of PPP projects in Kenya’.³⁷ Kenya’s PPP programme is supported by the Infrastructure Finance and Public Private Partnerships Project of the World Bank and has close to 40 listed bi-lateral and multilateral development partners³⁸.

Public Private Partnerships Regulations (2014)³⁹ apply to every contract for the design, financing, construction, operation, equipping or maintenance of a PPP project. They require each project proposal to include a demand assessment, an estimated cost, prevailing market rates and the socio-economic benefits of the project. For any petitions of complaints, there is a Public Private Partnerships Petition Committee, which sits as a tribunal within the Judiciary which, constitutionally, is the independent custodian of justice in Kenya.

³³ Health Cabinet Secretary for Kenya on behalf of the President at an African Union summit

³⁴ President Uhuru Kenyatta: Statement to the United Nations General Assembly (2019)

<<https://www.president.go.ke/2019/09/25/statement-by-his-excellency-hon-uhuru-kenyatta-c-g-h-president-of-the-republic-of-kenya-and-commander-in-chief-of-the-defence-forces-during-the-general-debate-of-the-74th-session-of-the-united-nat/>

³⁵ <https://www.health.go.ke/wp-content/uploads/2016/03/KHSSP-BOOK.pdf>

³⁶ Republic of Kenya, Public Private Partnerships Act 2013 <http://pppu.redhousestage.com/wp-content/uploads/2017/11/ppp-act-2013-2.pdf>

³⁷ About PPPU <http://www.pppunit.go.ke/about/>

³⁸ PPPU Development Partners <https://www.treasury.go.ke/public-private-partnership/development-partners.html>

³⁹ Republic of Kenya, Public Private Partnerships Regulations 2014 <http://pppu.redhousestage.com/wp-content/uploads/2017/11/PPP-Regulations-2014.pdf>

When it comes to PPP architecture in the country, it is difficult, at least from the outside, to see where the government starts and where the World Bank ends and, more importantly, where the space for public participation is. The PPP Unit (funded by the Bank) is strategically placed in government and has direct reporting lines to the PPP Committee and the National Treasury⁴⁰. It, or at least its Director as expressed in a blog⁴¹ in 2015, sees its role as simultaneously ensuring “effective engagement with other public sector parties and the market; exercise(ing) (its) authority with ease as the country’s guardian of the integrity of the PPP process” while being “an equal third party that is emotionally invested in the safe delivery of an impending birth (PPP project) and its eventual development into childhood, troublesome teenage years, settling into adulthood and the eventual passing on/re-birth”. Several of the top advisors to the President have had long and illustrious careers with the Bank prior to joining government.

In providing the background to its establishment, PPPU cites Kenya’s Africa Infrastructure Country Diagnostic report (AICD). The AICD forms part of the Africa Infrastructure Knowledge Programme (arising from the G8 Summit of 2005 at Gleneagles) and the Infrastructure Consortium of Africa (ICA). AICD was implemented by the World Bank and funded by the UK’s Department for International Development (DFID), *Agence Francais de Développement* (AFD), Germany’s KfW Development Bank, the European Commission and the PPP Advisory Facility of the World Bank Group. PPPU quotes AICD’s estimation that the country’s infrastructure deficit would require sustained expenditure of approximately 4 billion US dollars per year over the next decade (presumably between 2008 and 2018). Kenya has therefore ‘made infrastructure development through (PPPs) a priority as a mechanism that can help it address the major infrastructure gaps in the country’.⁴²

There is also a *Kenya SDG Partnership Platform*. Formed in 2017, the platform is rooted in achieving goal seventeen of the SDGs on partnerships. It is a high-level collaboration between the Government and the UN system in Kenya towards whose main function is to “unlock significant private-public collaborations and investments [...]”⁴³. It sets out to do this through four key strategies:⁴⁴ (1) joint advocacy and policy dialogue to create an enabling environment that helps partnerships thrive (2) identifying and brokering large scale PPPs that align with the SDG themes reflected in the Kenya UNDAF Strategic Result Areas, and drive shared value creation (3) raising required investments for the PPPs under 2 above, through optimizing blended financing instruments and redirection of capital flows towards SDG implementation, engaging a wide range of stakeholders from public and private sector, and (4) Facilitating monitoring and evaluation, learning and research to inform best and promising policy and practice for SDG partnerships. Then there is the SDG Partnership Platform Multi - Partner Trust Fund in Kenya (SDG PP MPTF), which works as the main instrument to mobilise financing through contributions from multilaterals, bilaterals, foundations and private sector⁴⁵.

⁴⁰ <https://blogs.worldbank.org/ppps/3-keys-success-public-private-partnership-ppp-unit-kenya-and-5-lessons-share>

⁴¹ *ibid.*

⁴² *ibid.*

⁴³ Kenya SDG Partnership Platform. <https://kenya.un.org/en/15284-sdg-partnership-platform>

⁴⁴ Kenya SDG Platform MPTF <http://mptf.undp.org/factsheet/fund/KEN00>

⁴⁵ *ibid.*

2. Leasing of Specialised Equipment: A Health Sector PPP through the Managed Equipment Service Programme

“We have to start by asking routinely whether private capital, rather than government funding or donor aid, can finance a project. If the conditions are not right for private investment, we need to work with our partners to de-risk projects, sectors, and entire countries⁴⁶.”

Jim Yong Kim, World Bank Group President 2012-2019

Overview of the programme

The Managed Equipment Service (MES) programme was launched in 2015 marked by the signing of contracts between the Ministry of Health, county governments and private sector providers. MES contracts, worth a total of approximately 432 million US dollars, run for seven years with the possibility of extension for an additional three years.

Now in its fourth year, the programme was to see the supply and installation of specialised medical equipment to two hospitals in each of the forty-seven counties as well as four national referral hospitals – a total of ninety-eight hospitals⁴⁷. It was designed to cover the key health care areas of dialysis, emergency, maternal-child health, basic and advanced surgery, critical care, and imaging services. This made Kenya “arguably the first country, not only in Africa but possibly globally, to enter into one of the largest sustainable healthcare projects through the MES arrangement”.⁴⁸ The rationale provided for the programme was that it would allow the government to spread its budget for healthcare over several years by deferring capital outlay⁴⁹. The MES programme was going to provide specialized, modern and state-of-the-art operating theatre equipment, sterilization equipment and operating theatre instruments, renal dialysis equipment, intensive care unit (ICU) equipment, and X-Ray and other imaging equipment.⁵⁰ Beyond providing specialised equipment, the programme was to contribute to the upgrading of hospitals including through training of staff.⁵¹ Suppliers were also to provide regular service, maintenance, repairs and replacement of equipment at no additional cost.

A closer look at the key actors

“Neo-colonialism is a system of political, cultural, and economic dominance, whereby a more powerful country, often a former colony, undermines the sovereignty of a less powerful

⁴⁶ https://www.ifc.org/wps/wcm/connect/CORP_EXT_Content/IFC_External_Corporate_Site/Annual+Report+2017/2017-Online-Report/Leadership-Perspectives/

⁴⁷ Demystifying the managed equipment scheme (MES) project in Kenya brochure <http://publications.universalhealth2030.org/uploads/MES-BROCHURE.pdf>

⁴⁸ Olotch C. (2018). Managed Equipment Services – Healthcare for Development: The Kenya MES experience. Available at: http://www.uncitral.org/pdf/english/congress/Papers_for_Congress/61-OLOTCH-Managed_Equipment_Services_for_Sustainable_Development.pdf

⁴⁹ <https://blogs.worldbank.org/ppps/transforming-kenya-s-healthcare-system-ppp-success-story>

⁵⁰ Korir, M. (2018). Managed Equipment Services: The Kenyan Story. Available at:

<https://thepathologist.com/outside-the-lab/managed-equipment-services-the-kenyan-story>

⁵¹ *ibid.*

and poorer country. This domination is reflected in the structures of exploitation whereby value is cheaply or forcefully extracted from the poorer nation and profit is realized by the colonizing nation/corporation. It is also seen in political practices that the formally colonized nation and its people continue to imbibe long after political independence is realized.”

~ Sarah Nkuchia-Kyalo

Maximizing Finance for Development (MFD) is the World Bank’s approach to “systematically leverage all sources of finance, expertise, and solutions to support developing countries’ sustainable growth”.⁵² The Bank sees MFD as a pathway to ensuring the realisation of the SDGs by bridging - through the private sector - the funding gap caused by the inability of traditional aid-heavy financing models to meet the goals set by countries.⁵³ Its “cascade approach” leverages private sector and recommends that reforms be attempted first, followed by subsidies and finally public investments⁵⁴. This approach seeks to accelerate financialisation, which has been broadly described as ‘the increasing importance of financial markets, financial motives, financial institutions, and financial elites in the operation of the economy and its governing institutions both at the national and international level’⁵⁵. A major driver of financialisation is the G20, with the G7 controlling the IMF and many multilateral development banks (MDBs), something Jason Hickel describes as a “global apartheid” in the global governance system.⁵⁶ Hickel in his writing calculates that for every vote the global North has at the World Bank, Sub Saharan Africa has 0.17 of that vote – measured in per capita. This presents the obscene imbalance of decision-making power in favour of rich global North countries.

Through its Eminent Persons Group (EPG), the G20 has pushed a set of proposals to promote financialisation, seeing the role of G20 in the global financial architecture as in need of a ‘reset’ to focus on developing political consensus on key strategic and crisis issues. The proposed approach includes devolving its agenda to the IFIs.⁵⁷ In what some critics describe as a ‘coup’,⁵⁸ this gives the G20 immense power over development finance, including the strong push for privatisation or PPPs. MFD requires MDBs to reshape the financial systems of developing countries to align to global finance⁵⁹. The G20 continues to promote a greater role for private sector in decision-making in the MDBs as “adjunct” non-voting members on their board and/or board committees, or as members of advisory panels on investments⁶⁰. None of these proposals nor the global finance architecture more broadly make room for civil society, labour unions or the voices of ordinary citizens, despite their sustained multi-level organizing against globalized neoliberalism and harmful macroeconomic policy. For years now, these groups have decried the impact of privatisation, ‘flexibilisation’ and other global finance policies on the lived realities of people and communities, particularly in the global south.

⁵² Maximizing Finance for Development <https://www.worldbank.org/en/about/partners/maximizing-finance-for-development>

⁵³ *ibid.*

⁵⁴ <http://documents1.worldbank.org/curated/en/859191517234026362/pdf/WPS8320.pdf>

⁵⁵ Epstein, Gerald A. (2006). *Financialization and the World Economy*. Edward Elgar Publishing

⁵⁶ Hickel, J. (2019). *Apartheid in the Global Governance System*. Available at:

<https://www.jasonhickel.org/blog/2019/10/16/apartheid-in-the-global-governance-system>

⁵⁷ <https://www.globalfinancialgovernance.org/assets/pdf/G20EPG-Full%20Report.pdf>

⁵⁸ <https://us.boell.org/en/2018/04/23/hijacking-global-financial-governance>

⁵⁹ <http://www.ipsnews.net/2019/04/world-bank-financialization-strategy-serves-big-finance/>

⁶⁰ <https://us.boell.org/en/2018/04/23/hijacking-global-financial-governance>

Centering private finance in development continues a neoliberal imposition of policies on global south countries in what Professor Daniela Gabor dubs “the Wall Street consensus” which takes over from the Washington consensus. It is ostensibly a “re-imagining of international development interventions as opportunities for global finance”⁶¹ Financialisation of development lending as pushed by MFD relies on the increased use of securitization markets⁶². This carries huge risks⁶², including the extensive promotion of privatisation and PPPs which have a poor track record when it comes to cost to the taxpayer and evidenced by popular action across the globe aimed at the renationalisation and remunicipalisation of public services and infrastructure.

Kenya’s MES programme has five documented international leasing companies: Shenzhen Mindray Bio-medical LTD (China), Esteem Industries (India), Bellco SRL (Italy), Philips Medical Systems (Netherlands) and General Electric (USA)

Country	Company	Value of contract (Ksh billion)
China	Shenzhen Mindray Bio-medical LTD	4.5
India	Esteem Industries	8.8
Italy	Bellco SRL	2.3
Netherlands	Philips Medical Systems	3.6
USA	General Electric East Africa Services	23.8

Table 3: Leasing companies

The above companies are the only five mentioned in official, publicly available documentation. There are provisions to subcontract local private companies to supply only consumables to support core functioning of the equipment. However, there are media reports showing that local companies such as Megascop Health (K) Ltd⁶³ have supplied, installed and commissioned core equipment subcontracted by Shenzhen Mindray Bio Medical Ltd⁶⁴. There are other reports⁶⁵ that associate a Sysmex Europe GMBH with a Ksh 2.9 billion contract.

⁶¹ Gabor, D. (2018). Why Shadow Banking is Bigger than Ever. Available at: <https://jacobinmag.com/2018/11/why-shadow-banking-is-bigger-than-ever>

⁶² <https://us.boell.org/en/2019/10/11/washington-consensus-wall-street-consensus>

⁶³ <https://megascopkenya.com/>

⁶⁴ The Star Newspaper. (2019). Chinese firm in medical gear probe says leasing expensive. Available at <https://www.the-star.co.ke/news/2019-11-07-chinese-firm-in-medical-gear-probe-says-leasing-expensive/>

⁶⁵ <https://www.standardmedia.co.ke/article/2001360362/report-billions-wasted-in-state-medical-project>

General Electric (GE) East Africa signed an MoU with the Kenyan government to develop projects in key sectors including healthcare and plays a leading role in a long list⁶⁶ of both public and private projects related to health. Lauding MES as a great example of PPP in Africa, the company reports⁶⁷ that it has deployed 585 units various types of medical equipment across all 98 hospitals. Elsewhere, a senior GE executive notes that its “mission to transform Kenya’s healthcare system is still in its infancy within the wider context of the Kenyan government’s transformation plans, but already what it has achieved serves as a powerful illustration of how an established risk sharing procurement model such as a PPP can be adapted to create a new type of partnership to successfully address the healthcare challenges faced by governments and Ministries of Health.”⁶⁸ Another GE executive, in a published opinion⁶⁹ on ‘*what to consider when pursuing a public private partnership*’ includes ‘a government that full embraces private sector collaboration’ (also described as ‘progressive thinking’) and ‘clear budget allocations and aligned stakeholders’. Conspicuously absent is any reference to public interest. In a report on its upgrading and equipping of the ICU at Nyeri County Referral Hospital, Philips reports among its results: (that this) local unit (has) been transferred into a ‘world class facility’ with increased capacity to treat patients, reduced operating costs and a staff motivated by improved workflow and regular training.⁷⁰

It is important to note that both Philips and GE are mentioned in a media report⁷¹ from August 2019 concerning a probe into suspicious sales of medical equipment to the Brazilian government. The probe concerns activity that reaches back to 2010 with allegations of payoffs to secure government contracts. Investigations by the Brazilian authorities have reportedly prompted similar investigations by the United States Federal Bureau of Investigations (FBI), Department of Justice and Securities and Exchange Commission. There is not much information available online on Shenzhen Mindray, Esteem Industries or Bellco SRL beyond their list of products and suppliers.

Lawyers and legal firms play a pivotal role in the PPP chain. As with most engagements that include private sector contracts, legal firms provide advisory commercial law services. In the case of the MES programme, Iseme, Kamau and Maema (IKM) Advocates are on record as providing legal services. The firm is part of DLA Piper Group which is an alliance of independent law firms working together across Africa and globally⁷². IKM staff have written blogs for the World Bank and one of such blogs was recognised as among the Bank's top 12 blogs for 2017⁷³. IKM cites its experience in dispute resolution, projects and infrastructure, public procurement and PPPs, and tax.

These areas have been major sites of struggle against neoliberal and neocolonial agendas on the African continent -whether in the fight for tax justice, resistance to mega infrastructure

⁶⁶ <https://www.ge.com/africa/content/kenya>

⁶⁷ <https://www.gehealthcare.com/article/opinion-what-to-consider-when-pursuing-a-public-private-partnership>

⁶⁸ <https://blogs.worldbank.org/ppps/transforming-kenya-s-healthcare-system-ppp-success-story>

⁶⁹ <https://www.gehealthcare.com/article/opinion-what-to-consider-when-pursuing-a-public-private-partnership>

⁷⁰ <https://www.philips.com/c-dam/corporate/newscenter/global/case-studies/nyeri-county-referral-hospital/nyeri-county-referral-hospital-customer-partnership.pdf>

⁷¹ <https://www.reuters.com/article/us-brazil-corruption-healthcare-exclusiv/exclusive-philips-under-investigation-in-u-s-and-brazil-fired-whistleblower-who-warned-of-graft-idUSKCN1VB0BJ>

⁷² IKM website <http://www.ikm.co.ke/>

⁷³ Year In Review: 12 top blogs of 2017, World Bank. <https://blogs.worldbank.org/ppps/year-review-12-top-blogs-2017>

projects or dispute resolutions in trade agreements that incur heavy settlement payments. There is a disturbing trend towards law firms enabling economic transactions devoid of any consideration for human rights, turning them into what Don Deya describes as “mindless mechanics of the law, rather than conscientious engineers of a just social order”⁷⁴.

A note on trade and PPPs

UNCTAD defines⁷⁵ a bilateral investment treaty (BIT) as an agreement between two countries regarding promotion and protection of investments made by investors from respective countries in each other’s territory.

BITs are expected to both attract and protect foreign investors and are subject to Investor State Dispute Settlement (ISDS) as a mechanism to settle disputes. [...] countries signing BITs commit themselves to following specific standards on the treatment of foreign investments within their jurisdiction⁷⁶. By nature, PPPs centre private finance in development and in turn expose it to global instruments traditionally reserved for commercial activity⁷⁷ like ISDS.

Between 2013 and 2019, African states had 109 recorded investment treaty arbitration claims. This six-year period accounted for 11 percent of all known investor – state disputes globally⁷⁸. These legal claims have cost Africa an estimated at 55.5 billion US dollars since 1993 and this from only 54.7% of the total number of cases⁷⁹.

With regard to health, investment treaty claims can be covered in the following three areas; (i) that government action has directly or indirectly expropriated the value of their investment; (ii) that the government by its policies or decisions has failed to accord the investor fair and equitable treatment and full protection and security; and (iii) that the government unfairly discriminates in favour of domestic investors compared to foreign investors.⁸⁰

The MES companies are from China, India, Italy, the Netherlands and the USA. Kenya had a BIT with Italy which was however terminated in 2014. It has BIT with China that has been signed but is yet to come into force. Additionally, it has one with the Netherlands that came into force in 1979. Kenya is just about to go into negotiations around a Free Trade Agreement with the USA which would also subject it to ISDS. This provides the backdrop to even greater risk for Kenya and other African countries when it comes to engaging global private finance for development outcomes. Investor claims have meant that Africa has lost large

⁷⁴ Oral interview with Don Deya (Executive Director of the Pan African Lawyers Union), May 2020

⁷⁵ https://unctad.org/en/Docs/iteiia20065_en.pdf

⁷⁶ Investment. Available at: <https://www.bilaterals.org/?-investment-35->

⁷⁷ Public-private partnerships and aid’s ‘private turn’: addressing the investment law dimensions. Available at: <https://www.bilaterals.org/?public-private-partnerships-and>

⁷⁸ Stop the unfair investor-state dispute settlement against Africa. Available at: <https://bilaterals.org/?stop-the-unfair-investor-state>

⁷⁹ Barigaba, J. (2019). Civil society seeks reforms to stem trade suits losses. Available at: <https://www.theeastafrican.co.ke/news/ea/Civil-society-seeks-reforms-to-stem-trade-suits-losses/4552908-5376918-p4x360z/index.html>

⁸⁰ Baker, B. K. and Geddes, K., ISDS, Intellectual Property Rights and Public Health (2016). Chapter in *Rethinking Bilateral Investment Treaties: Critical Issues and Policy Choices*, Kavaljit Singh and Burghard Ilge, eds., pp. 189-199 (2016); Northeastern University School of Law Research Paper No. 282-2016.

amounts of resources that could have gone directly into the healthcare provision gaps private sector players purport to be plugging.

3. Gender and Human Rights Impact of Implementation and Functioning

“Privatization of hospitals and related institutions on hearing such I outrun my shadow. Privatization has not and will not serve the interests of the majority. Women and girls are affected in compounded ways; unable to afford services they require and increased burden of care.”

~Doo Aphane⁸¹

There has been a fair amount of public outrage and attention paid to the MES programme, prompting Kenya’s Senate to form an ad-hoc committee to investigate it. The Institute for Economic Affairs (IEA) - Kenya, an economic and public policy think tank also carried out an in-depth value for money assessment⁸² aimed at determining the cost effectiveness of the scheme, and determining whether ultimately it would result in better health outcomes. These and other processes have raised several issues of concern, which we place in two categories: lack of transparency in contracts, costing and allocation and the broader question of gaps in priority setting.

Lack of transparency in contracts, costing and allocation

A Senate document lists lack of full disclosure by the health ministry on the MES contracts as one among a list of general concerns about the project. It states that ‘some facility heads are not fully aware of the exact equipment they expect to benefit from. As such some MES providers are suspected to have supplied incomplete sets of equipment to facilities.’⁸³ Indeed, in writing this paper, we have found it incredibly difficult to obtain official information on the programme as a whole.

Looking at the national government healthcare budget, MES had the third biggest allocation for the 2016/17 fiscal year after allocations to the biggest and second biggest referral hospitals. Budgets are the easiest way to tell what a government is prioritizing as they will actually put resources to those things. The table below⁸⁴ shows the distribution of Kenya’s health budget for the fiscal year 2016 / 2017. The budget allocation also shows how de-prioritized preventative public health care is which should be the underlying strategy to ensure the population is healthy.

Allotments	Billion Kenya Shillings	Million US Dollars
Kenyatta National Hospital	8.8	81.4
Moi Teaching and Referral Hospital	5.8	53.7

⁸¹ Phone interview with Doo Aphane, a women's rights campaigner from the Kingdom of Eswatini, June 2020

⁸² Mutua, J. and Wamalwa, N. (2020). Leasing of Medical Equipment Project in Kenya: Value for Money Assessment. Nairobi: Institute of Economic Affairs. Available at: <https://www.ieakenya.or.ke/publications/research-papers/leasing-of-medical-equipment-project-in-kenya-value-for-money-assessment>

⁸³ *ibid.*

⁸⁴ Kenya Health Workforce Report. (2015). Available at: https://taskforce.org/wp-content/uploads/2019/09/KHWF_2017Report_Fullreport_042317-MR-comments.pdf

<i>Lease of Medical Equipment</i>	<i>4.5</i>	<i>41.7</i>
Free Maternal Health Care	4.3	39.8
Kenya Medical training college	3.5	32.4
Doctors/Clinical Officers/Nurses Internship	3	27.7
Kenya Medical Research Institute	1.7	15.7
Roll out of Universal Health Coverage	1.4	12.9
Free Primary Health Care	0.9	8.3
Health Insurance Subsidy	0.7	6.5
National Aids control Council	0.6	5.5

Table 4: Health budget allocations

Healthcare is, across the board, the biggest budget item for county governments, accounting for approximately twenty five percent of total budgets. Approximately five per cent of county health budgets went to MES.⁸⁵ With all health functions save for health policy devolved to the county, the lack of transparency linked to health-related contracts and procurement is a major concern. Even more so because the constitution of Kenya upholds the tenets of public participation. In fact, county governments have reported that they were not given access to the actual contracts that national governments entered into on their behalf⁸⁶.

Kenya's Auditor General raised queries in his audit of county accounts for the 2015/16 and 2017/2018 financial years. Overall, for the counties audited on MES, the audit found that 'the lawfulness and accuracy of expenditure of Ksh 4.57 billion (41.7 million US Dollars) on the MES could not be verified due to lack of supporting documents'.⁸⁷ Important supporting documents such as contracts, legal opinions on contracts from the Attorney General, procurement and progress reports were not made available for the audit.⁸⁸

Payments for this programme were deducted at source by the National Treasury from allocations from the national government to county governments. From the middle of 2018, counties which previously expected to pay Ksh ninety-five million annually (approximately 950,000 US dollars) found that the deductions increased to Ksh. 200 million (1.9 million US Dollars), more than double the agreed amount.⁸⁹ No official explanation has been given for this.

The government and private sector argument for leasing of medical equipment is that it is better value for money for the government in terms of the cost of maintenance and servicing⁹⁰. Shenzhen Mindray is, however quoted as admitting at one of the Senate hearings that Kenya would have saved massive amounts of resources if it had made a direct purchases as seen in this cut out from a Kenyan daily newspaper⁹¹:

⁸⁵ Mutua, J. and Wamalwa, N. (2020). op. cit.

⁸⁶ ibid.

⁸⁷ ibid.

⁸⁸ ibid.

⁸⁹ Parliament of Kenya, The Senate. (2018). op. cit.

⁹⁰ ibid.

⁹¹ The Star Newspaper. (2019). op .cit

A Chinese firm that supplied theatre equipment under the Sh63 billion Managed Equipment Scheme has admitted that Kenyans are paying three times the market price.

Shenzhen Mindray Biomedical Company, the manufacturer, was contracted to supply theatre equipment for Sh4.5 billion under the leasing arrangement in 2015.

However, the firm told the Senate ad hoc committee probing the controversial programme that the government would have spent Sh1.5 billion if it had made a direct purchase.

Edward Ouko, Kenya's former Auditor General has called the project "a betrayal of trust of the Kenyan taxpayers," adding that "funds would have been better spent on expanding basic healthcare...more midwives and more clinics might have saved more lives in a country where 342 women die from pregnancy complications per 100,000 live births."⁹²

Gaps in priority setting

One of the most common complaints raised by county governments before the Senate committee was the fact that they were not involved in discussing the needs and service delivery priorities in health which would then inform the delivery of the equipment.⁹³ Equipment has remained unused in at least twenty nine of the forty seven counties of Kenya as a result of a lack of requisite staff to operate the equipment as well as inadequate water and electricity supply.⁹⁴ Many of these counties are in geographically remote and typically marginalised areas and it is no surprise that they have constraints when it comes to water, electricity or specialists to manage the equipment. A year after the MES programme was launched, Kenyan doctors went on the longest doctors' nationwide strike in the country's history - lasting 100 days and culminating in the jailing of the doctors' union leadership⁹⁵. The strike was to demand fairer remuneration and better working conditions – on average there is only one doctor for every 6,355 Kenyans⁹⁶ but stark inequalities in distribution mean that the capital city, Nairobi, which accounts for only eight percent of Kenya's population has thirty two percent of the share of doctors nationwide⁹⁷.

To bring the above to life, pulling from Fraym's geospatial data below⁹⁸, in 2015, only sixty five percent of women in Kenya had visited a health facility in the past year. The map below

⁹² Reuters, February 2020. <https://af.reuters.com/article/idAFKBN2080RV-OZATP>

⁹³ <https://cog.go.ke/component/k2/item/184-senate-proceedings-on-the-medical-equipment>

⁹⁴ Parliament of Kenya, The Senate. (2018). op. cit.

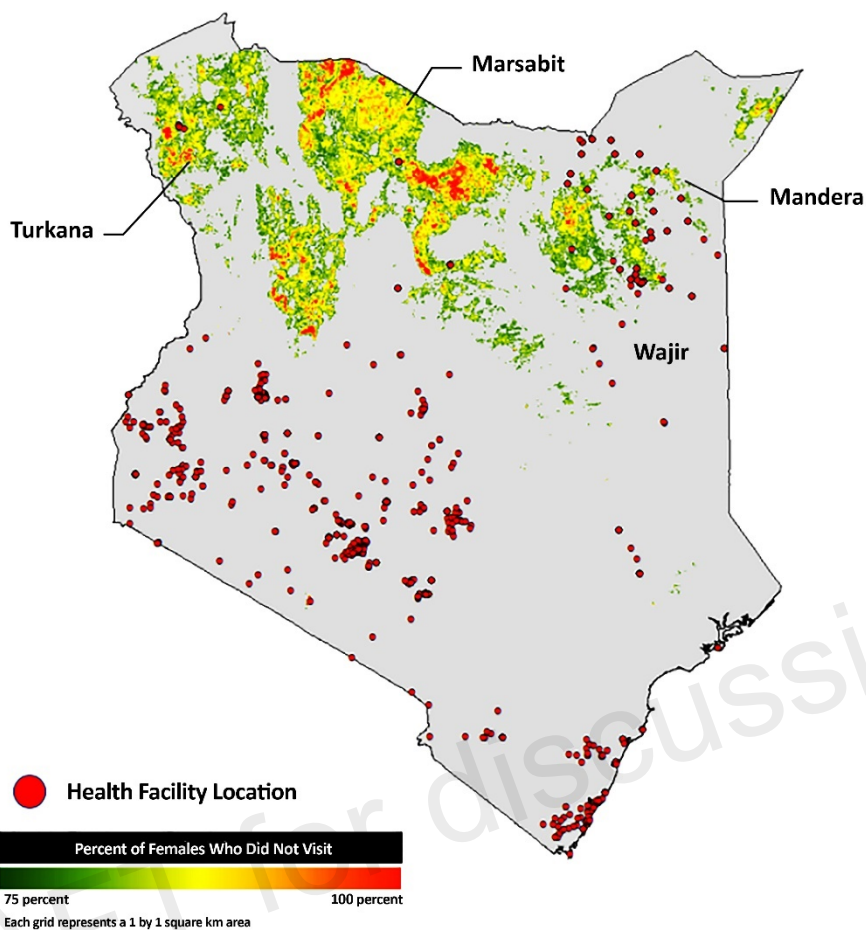
⁹⁵ The East Africa, (2017). Kenyan doctors, govt agree to end strike
<https://www.theeastafrican.co.ke/news/Kenyan-doctors-end-strike/2558-3849516-view-printVersion-rf46rez/index.html>

⁹⁶ Africa Check. <https://africacheck.org/reports/as-help-from-cuba-arrives-is-there-only-one-kenyan-doctor-for-every-16000-people/>

⁹⁷ Kenya Health Workforce Report. (2015). https://taskforce.org/wp-content/uploads/2019/09/KHWF_2017Report_Fullreport_042317-MR-comments.pdf

⁹⁸ Women's access to Health Facilities in Kenya (2019). Available at: <https://fraym.io/womens-access-to-health-facilities-in-kenya/>

shows the concentration of women who did not visit health facilities in marginalised areas that have fewer doctors and fewer facilities.



Map 1: Women's access to health facilities

This programme employs a 'one size fits all' approach to a problem that presents itself in unique and diverse ways in different counties. The lack of due diligence and consultation between national government and county governments to determine what equipment was needed in which county based on comprehensive, open and accountable needs and feasibility assessments meant that some counties received equipment they would not have been top priority for them or that they had already received from different government schemes⁹⁹.

Amplifying these obvious gaps in prioritization is the fact that prevailing philanthro-capitalist and developmental assistance to the health sector continues to weaken African health sectors due to approach. The current approach is predominantly vertical and siloed with support for single-issues or perceived needs such as specialised infrastructure taking up large percentages of working budgets. The sector needs a broader approach to reflect the interlinkages and interdependencies of different functions. Unfortunately, we have seen public and primary health strategies fall of priority lists of governments and into the hands of bilateral agencies (such as USAID) – a phenomenon described by Dr. Richard Ayah as "...our best public

⁹⁹ Parliament of Kenya, The Senate. (2018). op. cit.

health infrastructure (as) foreign owned”¹⁰⁰. This raises deeper questions around the social contract between the African state and her people. Without a robust public and community health infrastructure owned and managed by the state, it becomes next to impossible to have control over data to inform as well as effectively implement interventions to adequately keep populations healthy. The COVID-19 crisis has shown how detrimental an over-focus on vertical health interventions at the expense of horizontal interventions can be. There can be no healthy populations without access to safe water and hygiene, adequate nutrition, access to vaccines and so on. People and community interventions, and not financialisation, must be at the heart of policy making.

Making reference to a briefing by Eurodad, GADN and FEMNET¹⁰¹, there are 3 key motives as to why public services like health care are important for gender equality as per below:

1. Women’s disproportionate reliance on public services;
2. Women’s lower income, reducing their ability to pay for private services; and
3. Women’s reliance on work in the public sector.

Because women’s income is usually lower especially in countries like Kenya, they rely more on public health facilities especially for primary health care for their children and for maternal care. A redirection in resources to “non essential” specialized equipment foregoes resourcing that would otherwise ensure they have accessible and affordable primary health care. Because PPP’s come with a cost so as to be able to service the payments, it also means women are less likely to access this specialized equipment even if they were up an running with water, electricity and doctors. Lastly, the public sector has historically played a critical role in providing work opportunities for women. In fact, there is a higher quota of women working in health and education¹⁰² and this diversion of resources means there is a possibility it may affect the available allocation for the wage bill and thus reducing access to work for women.

Resistance

¹⁰⁰ Ayah, R. (Dr.) and Ndi, D. (Dr.). An Insider's Take on Kenya's Public Health System, 28th April 2020
<https://www.youtube.com/watch?v=BZK3IU0kyqs>

¹⁰¹ Eurodad, Gender and Development Network and FEMNET. (2019). Can Public Private Partnerships deliver Gender Equality: Briefing Paper. Available at:
<https://static1.squarespace.com/static/536c4ee8e4b0b60bc6ca7c74/t/5c879cd7ee6eb0145fe7e780/1552391388896/1547040-can-public-private-partnerships-deliver-gender-equality-final+12.3.pdf>

¹⁰² *ibid.*

“My feminism is about fire and there are things that I just want to set ablaze because there are some things that should be put to fire, to be put to ashes to gain retribution. Imagine living in a world where a public thing like having a disease is not worthy of attention unless it comes from a private body, unless it comes with class. If sickness and disease is public and healthcare is private, something is wrong with that equation. Spit Fire.”

~Scheaffer Okore¹⁰³

Since its signing in 2015, the Managed Equipment Scheme although shrouded in secrecy, there have been continuous and numerous calls for transparency and accountability and questioning the logic and process of the project. At the top of this resistance has been the county governors largely driven by the fact that their county budget allocations get deducted at source for the project – the equipment of which most are not using. Also linked to this is not only are the deductions made, but they have been increasing without consultation on the initial contract. The governors have increasingly raised issue with the project and together with public pressure, has culminated in a Senate probe and hearing by the Senate Health Committee which is currently ongoing. The MES project has been consistently in the news especially since the Senate probe and hearing in the last quarter of 2019. There has not been a response from the Kenya women’s rights movement yet that has been noted. This may be as a result of resistance in silos and women’s rights organisations not involved in activism around macroeconomic issues as much. This paper posits however that macroeconomic issues are indeed feminist issues and have to be central to the Pan African feminist struggle.

Our aim in writing this paper was not so much to narrow down on the intricate details of the MES programme as to shine a spotlight on the wider question of what lies at the heart of development decisions and who is part of that process. In conversations we have had with young women born in the mid to late 1990s the reality of little to no living memory or knowledge of public services has been striking. This is, of course, no surprise. Public services – publicly-funded and universally delivered - were and continue to be in a state of collapse. An unequal and undemocratic extractive global economic governance system lies at the heart of this collapse but many a time seems too far removed to be associated with a local hospital in total disrepair.

In a nation where three quarters of the population is under 35 years old, one can assume, as has been our experience, that this means the vast majority of Kenyans see few alternatives to private finance to solve public problems.

The imposition of user fees for services was a colonial project, and the neocolonial project continues to keep poorer countries in a private finance chokehold with poor people bearing the brunt. Healthcare becomes a ‘market’, citizens become ‘customers’ or ‘clients’ and their rights are trampled on as governments clamber for private investments with economic growth being the unwavering, ultimate goal.

As feminist activists invested in the co-creation of alternative futures for Africa our primary concern is understanding the impact faulty, misplaced and imposed development policy has on women and their communities. PPPs have been seen to be more costly than publicly-funded services, lacking transparency, driven by profit margins and bottom lines with virtually all risk falling on the public purse - yet our governments continue to pursue them. But the impact on the public is not just financial. There are also major flaws around priority-setting by governments when it comes to public health; who benefits from it and where the biggest investments are made. Alongside these are concerns around the absence of public participation and agency in policy making and the blatant locking out of women’s voices despite these policies having a direct impact on their everyday lives.

In researching this paper, it is increasingly clear that indeed all oppression is connected. Issues cannot be looked at in silos if we are to achieve systemic and transformative change. A government’s ability

¹⁰³ Quote by Scheaffer Okore at the African Feminist Macroeconomic Academy held in Accra, Ghana (2019).

to provide quality universal health care relies on a combination of factors. There needs to be an understanding of local community priorities, meaningful investment in co-created community health strategies and reliance on local expertise.

As much as labeling and iterations of macroeconomic interventions change through the years, the basic neoliberal and neocolonial spirit and intentions remain the same. There is the perception that the feminist struggle to reject these notions is new, when in fact this struggle goes back decades. In reimagining feminist futures, we need to revisit and build on this knowledge base, apply it to our current contexts and be more intentional in connecting struggles.

DRAFT for discussion

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