

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

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MEDICAL EQUIPMENT LEASING IN KENYA:  
NEO-COLONIAL GLOBAL FINANCE AND MISPLACED HEALTH  
PRIORITIES

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**ABSTRACT**

*The chapter brings to the fore how an undemocratic, neo-colonial and neo-liberal global governance system keeps African countries in an austerity and private-finance chokehold, placing corporate and élite interests above the rights of citizens, exacerbating health-care crises. Women bear an enormously 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 for whom they provide care. Their out-of-pocket expenditure on health care has been found to be systematically higher than that of men, and their lower incomes put private health care out of reach.*

*In 2015, the government of Kenya launched a scheme that provided for 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 impact of public-private partnerships (PPPs) 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 the history of its health financing policy, beginning with its earliest colonial iterations, the progressive policies of the post-colonial era, through to the debt and structural adjustments 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 about the neo-colonial imposition of private financing models by international finance institutions and other players in the global financial architecture, and the extent to which this impacts upon the social contract between the state and its citizens.*

*The chapter elaborates on the key problems surrounding this public private partnership, which reiterate some of the major challenges that 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 the contracts, the costs and the allocations, with many of the safeguards against these kinds of challenges being blatantly ignored by several actors, and, in turn, it raises issues of accessibility for citizens. There is also a central question regarding priority setting, with questions concerning what informs the decision to spend budgets on one health-care need versus another, what the process of making it looks like, and who are involved and consulted.*

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

## **INTRODUCTION**

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

Access to quality, universal gender-responsive and affirming health care remains a fundamental challenge for Africa and its citizens. For women in particular, it is not just a question of our own health. Failing health-care systems mean more hours caring for sick children and other members of the family, 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 workforce is performed by women, and one in five women are employed in the care sector. National and local health-care delivery are, therefore, not only a matter of health outcomes, but also one of time poverty, paid and unpaid labour, livelihoods, and the full body of human rights.

This chapter 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 to 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 Ngumi*<sup>1</sup>

### 1.1. Health as a Global Rights Mandate

The right to health is recognised 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) recognises the right of everyone to “the enjoyment of the highest attainable standard of physical and mental health”.<sup>2</sup> 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”.<sup>3</sup>

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”.<sup>4</sup> Under this aspiration, there are a number of goals that are relevant to health care. One is a high standard of living, quality of life, and well-being for all, covering income, jobs, education, and 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 themselves to implementing the United Nation’s Sustainable Development Goals (SDGs), and Agenda 2063 and the SDG framework have points of conversion as illustrated below.<sup>5</sup>

**Table 1: Policy Framework Comparison Table**

African Union Agenda 2063	Priority Areas	Sustainable Development Goals (SDGs)
A high standard of living, quality of life, and well-being for all citizens.	<ul style="list-style-type: none"> <li>● Incomes, jobs and decent work;</li> <li>● Poverty, inequality and hunger;</li> <li>● Social security and protection, including for persons with disabilities;</li> <li>● Modern, affordable and liveable habitats and quality basic services.</li> </ul>	Goals: <ul style="list-style-type: none"> <li>● 1 No Poverty;</li> <li>● 2 Zero Hunger;</li> <li>● 8 Decent Work and Economic Growth;</li> <li>● 11 Sustainable Cities and Communities.</li> </ul>
Healthy and well-nourished citizens.	<ul style="list-style-type: none"> <li>● Health and Nutrition.</li> </ul>	Goal: <ul style="list-style-type: none"> <li>● 3 Good Health and Well-being.</li> </ul>

Crucially, health as a right is inclusive of other rights. The Committee on Economic, Social and Cultural Rights (CESCR), responsible for monitoring the ICESR, 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 equality.<sup>6</sup> The CESCR has also elaborated the entitlements<sup>7</sup> contained in the right to health, including equality of opportunity for everyone to enjoy the highest attainable level of health, and the participation of the population in health-related decision-making at both 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 for women, especially those in rural areas”.<sup>8</sup> 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 Public Private Partnership (PPPs) on the health sector, it is necessary to look at these explicit commitments in their entirety, as they overlap in the lives of the people whose rights the state is obligated to respect, protect, and fulfil.

## **1.2. Kenya: Interactions between Governance and Development Visions**

In 2010, the Republic of Kenya, promulgated a new constitution, thereby replacing the independence constitution of 1963. This new constitution significantly altered the distribution of power in the country by moving from a centralised 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 health-care 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 ‘crème de la crème’ of medical services, and that was important. Government health services only cater to 10 per cent of your health problems and, even with drugs, they give you the basic drugs. Ninety per cent 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

Kenya has an impressive framework for health de-centralisation 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 fulfilling Kenya’s third Medium Term Plan (MTP) and moving towards its ambitious “Vision 2030”<sup>9</sup>

development blueprint for industrialisation and the attainment of middle-income status. The Big Four were food security, affordable housing, manufacturing, and affordable health care 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 chapter 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”.<sup>10</sup>

Kenya’s population stands at just under forty-eight million,<sup>11</sup> with a life expectancy at birth of 66.3 years and a poverty rate of 36.1 per cent.<sup>12</sup> In 2018, its Human Development Index (HDI) value was 0.579, putting it in the medium human development category and at rank of 147 out of 189 countries (a position shared with Nepal).<sup>13</sup> Kenya is ranked 134 out of 162 countries on the Gender Inequality Index (GII) with a value of 0.545. The GII reflects gender inequalities in reproductive health, empowerment, and economic activity.<sup>14</sup>

### **1.3. History Repeating Itself: Structural Adjustment, Health Financing, and Debt**

With a current Gross National Income (GNI) *per capita* of 1,620 USD, 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 USD and 3,995 USD), they experience a big shift in the composition of public to private spending on health (Brookings Institute, 2019). 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 in which Kenya gained independence from Britain in 1963 up to 1993, it introduced six measures in a series of health-care reforms: (1) harmonisation and (2) decentralisation of medical-care delivery; (3) expansion of preventive health services, such as family planning; (4) the introduction of a national medical insurance scheme; (5) the selective integration of traditional medicine; and (6) the introduction of user fees (user fees are applied at each point of service and are paid directly by health seekers in order to access a specific service) (Mwabu, 1995). 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*.<sup>15</sup> 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 (Chuma and Okungu, 2011).

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 which it did not implement but which had nonetheless 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 might say excessive pressure) and the banner of "cost sharing", which, in effect, was no different (Mwabu, 1995: pp. 245-255). Nine months after its introduction, the decision was rescinded only to be re-introduced in April 1992. Kenya's health sector has since relied on out-of-pocket payments for most levels of care.

It will come as no surprise that these changes were primarily a result of the introduction, in the 1980s, of Structural Adjustment Programs (SAPs) – a range of neo-liberal 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 the SAPs were implemented with devastating effects on the delivery of public services, stemming from cuts in government expenditure imposed on the public sector. It is widely documented how the economic and social impact of the 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 mainly employed women, were lost. User-fee 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." (Parsitau, 2008)

Over the years, some exceptions to the imposition of user-fees have been introduced, such as their abolition 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, which have included children under five years of age, and malaria and tuberculosis patients. In 2007, fees for pregnant women giving birth 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 (Chuma and Okungu, 2011). If we take free maternity services 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 give birth. To their disappointment, the “free delivery” did not always exclude other costs, such as medicines and other consumables 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 per cent of women were deterred from presenting themselves because of distance, lack of transport, or because the facility was not open, versus only 4.9 per cent who cited cost as the key barrier to skilled delivery.<sup>16</sup>

The table below (Chuma and Okungu, 2011) provides a useful picture of health financing policies and their equity impact between the colonial period and 2010:

**Table 2: Kenya’s Health Financing Policy Timeline**

Years	Policy	Equity Impact
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
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 mechanisms 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 such as 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 such as 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 impact, and negative implications for equity
2004	User fees abolished at dispensaries and health centres (the lowest level of care), and instead registration fees of 10 and 20 Kenya shillings, respectively, were introduced. Children under five, the poor, special conditions/services such as malaria and tuberculosis were exempted from payment	Utilisation increased by 70%; the large increase was not sustained, although, in general, utilisation was 30% higher than before user-fee removal. Adherence to the policy has been low, due to cash shortages
2007	All fees for deliveries/childbirth at public health facilities were abolished	No data exist 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 was introduced. Dispensaries and health centres receive funds directly into their bank accounts from the treasury	Possible positive impacts on adherence to fee-removal policy and equity

**Source:** Jane Chuma and Vincent Okungu. “Viewing the Kenyan Health System through an Equity Lens: Implications for Universal Coverage”, (2011) *International Journal of Equity in Health*, 10 (22), available at: <https://doi.org/10.1186/1475-9276-10-22>.

In the financial year 2015/2016, Kenya’s total health expenditure (THE) including both public and private, was 3.46 billion USD, accounting for 5.2 per cent of GDP. Government health expenditure accounted for only 6.7 per cent of total government expenditure, with total government expenditure accounting for approximately 36 per cent of GDP (Ministry of Health - Kenya, 2019). This falls quite short of the target set in the 2001

African Union “Abuja Declaration”<sup>17</sup> of a fifteen per cent minimum spending increase 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” (WHO, 2011).

A study<sup>18</sup> 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 per cent. This was

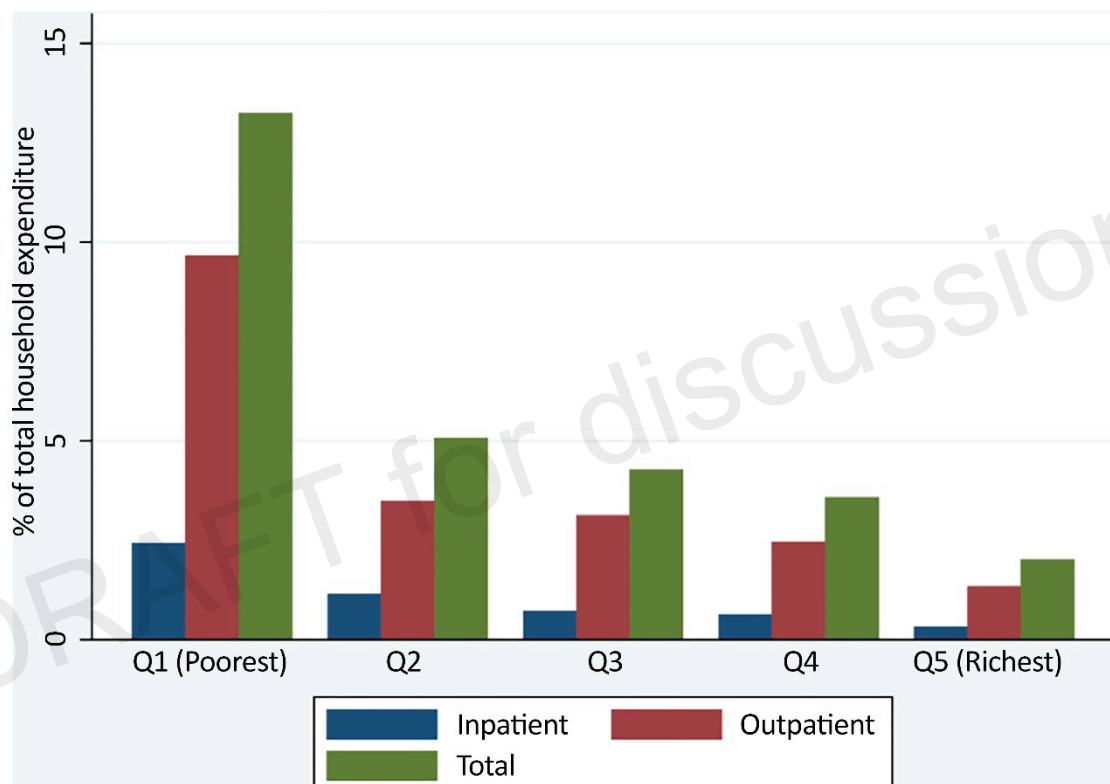
“I trust the private sector more because they are well funded and well run. I feel that government funded facilities are pretty run down. The government needs to do better and make sure these places are well run and invested in properly. I think a good amount of the tax citizens pay should be invested in the health-care 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 Wangeji, 21 years old*

followed by county governments at 36.4 per cent. Donors and corporations accounted for 16.3 and 10.1 per cent, respectively. When it came to the management of the funds, county governments managed 36 per cent of the THE, followed by households at 35 per cent and NGOs at 16 per cent. Social health insurance - through the National Health Insurance Fund (NHIF) and private health insurance - played a minimal role, with NHIF only managing four per cent of the funds (the NHIF is a contributory monthly scheme that is mandatory for formally employed people - with employers remitting their 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.

Household health spending is primarily through out-of-pocket (OOP) payments defined<sup>19</sup> 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 health care.

The graph below shows that the highest spending on OOP payments is in the lowest income quintile. The poorest households carry the heaviest health-spending burdens. This particular datum 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” (Ravindran, 2012). In addition, high OOP expenses mean that a higher proportion of women than men have unmet health needs (Ravindran, 2012). Kenya’s OOP expenditure stands at 27.7 per cent, compared to 6.4 per cent in Rwanda (Institute of Economic Affairs, 2020a).



**Figure 1: Mean OOP Payments as a Share of Total Household Expenditure by Income Quintiles (2018)**

**Source:** Salari, *et al.*, “The Catastrophic and Impoverishing Effects of Out-of-pocket Healthcare Payments in Kenya, 2018”, *BMJ Global Health*, 4 (6): E001809, available at: <https://gh.bmj.com/content/bmjgh/4/6/e001809.full.pdf>.

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 per cent 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 per cent 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 per cent 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.” (ActionAid, 2020)

#### **1.4. 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 healthcare.”<sup>20</sup>

Indeed, in his statement to the UN General Assembly, the President has committed himself to “introduce innovative financing models that reorient private capital, create new instruments and modalities that strengthen regulatory framework to de-risk investments”.<sup>21</sup>

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 of de-risking investment in line with the Maximising Finance for Development narrative as described in the next section.

The MES programme was conceived under the 2014-2018 Kenya Health Sector Strategic and Investment Plan (KHSSP)<sup>22</sup> that lays the foundation for PPP co-ordination in the sector. This includes capacity-building programmes for policy-makers and private-sector players, and a “deepening understanding of the role of the private sector in the health industry”. It sets out clear objectives about promoting private-sector participation in the financing of health through PPPs 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),<sup>23</sup> which has established a PPP Committee, which consists of Principal Secretaries in various state

departments responsible for finance, the co-ordination 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 the 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”.<sup>24</sup> 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 multi-lateral development partners.<sup>25</sup>

Public Private Partnerships Regulations (2014)<sup>26</sup> apply to every contract for the design, financing, construction, operation, equipping, and/or maintenance of a PPP project. They require each project proposal to include a demand assessment, an estimated cost, the prevailing market rates, and an evaluation of the socio-economic benefits of the project. For any petitions or 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.

When it comes to the 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 actually lies. The PPP Unit (funded by the World Bank) is strategically placed in government and has direct reporting lines to the PPP Committee and the National Treasury (World Bank Blogs, 2015). It, or at least its director, as expressed in a blog in 2015 (World Bank Blogs, 2015), sees its role as simultaneously ensuring “effective engagement with other public sector parties and the market; exercis(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 World Bank prior to joining the government.

In providing the background to its establishment, the 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). The AICD was implemented by the World Bank and funded by the UK's Department for International Development (DFID), the *Agence Française de Développement* (AFD), Germany's KfW Development Bank, the European Commission, and the PPP Advisory Facility of the World Bank Group. The PPPU cited the AICD's estimation that the country's infrastructure deficit would require sustained expenditure of approximately 4 billion USD 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".<sup>27</sup>

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 an example of high-level collaboration between the government and the UN system in Kenya, whose main function is to "unlock significant private-public collaborations and investments [...]".<sup>28</sup> It sets out to do this through four key strategies:<sup>29</sup> (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 optimising blended financing instruments and the re-direction of capital flows towards SDG implementation, engaging a wide range of stakeholders from both the public and the private sector; and (4) facilitating the monitoring and evaluation, learning and research, in order to inform on the best and most 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 multilateral, bi-lateral, foundations, and the private sector.<sup>30</sup>

## **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 countries." (International Finance Corporation, 2020)



*Jim Yong Kim, World Bank Group President 2012-2019*

## **2.1. 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 (MoH), county governments, and private sector providers. MES contracts, worth a total of approximately 432 million USD, 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 47 counties as well as four national referral hospitals – a total of 98 hospitals.<sup>31</sup> 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” (Olotch, 2018). The rationale provided for the programme was that it would allow the government to spread its budget for health care over several years by deferring capital outlay.<sup>32</sup> The MES programme was to provide specialised, modern and state-of-the-art operating theatre equipment, sterilisation equipment and operating theatre instruments, renal dialysis equipment, intensive care unit (ICU) equipment, and X-Ray and other imaging equipment (Korir, 2018). Beyond providing specialised equipment, the programme was to contribute to the upgrading of hospitals.

## **2.2. A Closer Look at the 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 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*

Maximising 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”.<sup>33</sup> The World 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.<sup>34</sup> Its

“cascade approach” leverages the private sector and recommends that reforms be attempted first, followed by subsidies, and finally by public investments (World Bank Group, 2018). This approach seeks to accelerate financialisation, which has been broadly described as “the increasing importance of financial markets, financial motives, financial institutions, and financial élites in the operation of the economy and its governing institutions both at the national and international level” (Epstein, 2006). 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 (Hickel, 2019). In his writing, Hickel calculates that, for every vote that the Global North has at the World Bank, sub-Saharan Africa has 0.17 of that vote – measured in income *per capita*. This presents the obscene imbalance of decision-making power in favour of the 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 the G20 in the global financial architecture as in need of a “reset” in order to focus on developing political consensus on key strategic and crisis issues. The proposed approach includes devolving its agenda to the IFIs.<sup>35</sup> In what some critics describe as a “*coup*”,<sup>36</sup> this gives the G20 immense power over development finance, including the strong push for privatisation or PPPs. MFD requires the MDBs to reshape the financial systems of developing countries forcing them to align to global finance.<sup>37</sup> The G20 continues to promote a greater role for the 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 investments.<sup>38</sup> 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 organising against globalised neo-liberalism 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.

Centring private finance in development continues a neo-liberal 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” (Gabor, 2018). The financialisation of development lending, as pushed by MFD, relies on the increased use

of securitisation markets. This carries huge risks,<sup>39</sup> including the extensive promotion of privatisation and PPPs, both of which have a poor track record when it comes to the actual cost to the taxpayer, and is evidenced by popular action across the globe aimed at the re-nationalisation and re-municipalisation 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 (The Netherlands) and General Electric (USA).

**Table 3: Leasing Companies**

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

**Source:** 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](http://www.parliament.go.ke/sites/default/files/2018-11/MES%20Brief_Nov%202018%20%285%29_%20With%20Suggested%20Questions%20.pdf).

The above companies are the only five mentioned in official, publicly available, documentation. There are provisions to subcontract local private companies solely to supply consumables to support core functioning of the equipment. However, there are media reports that show that local companies, such as Megascop Health (K) Ltd,<sup>40</sup> have supplied, installed and commissioned core equipment subcontracted by Shenzhen Mindray Bio Medical Ltd.<sup>41</sup> There are other reports<sup>42</sup> that associate Sysmex Europe GMBH with a 2.9 billion Kenyan shillings (KES) contract.

General Electric (GE) East Africa signed a MoU with the Kenyan government to develop projects in key sectors, including health care, and plays a leading role in a long list<sup>43</sup> of both public and private projects related to health. Lauding the MES as a great example of a PPP in Africa, the company reports<sup>44</sup> that it has deployed 585 units of 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” (World Bank Blogs, 2017). Another GE executive, in a published opinion (GE Healthcare, 2019) on “*what to consider when pursuing a public private partnership*”, includes the phrases “a government that fully 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 (Philips, 2017).

It is important to note that both Philips and GE are mentioned in a media report (Reuters, 2019) 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 pay-offs to secure government contracts. Investigations by the Brazilian authorities have reportedly prompted similar investigations by the United States Federal Bureau of Investigations (FBI), the Department of Justice, and the Securities and Exchange Commission. There is not much information available online regarding Shenzhen Mindray, Esteem Industries, or Bellco SRL, beyond their lists 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 both across Africa and globally.<sup>45</sup> IKM staff have written blogs for the World Bank, and one of such blogs was

recognised as being among the World Bank's top 12 blogs for 2017.<sup>46</sup> IKM cites its experience in dispute resolution, projects and infrastructure, public procurement and PPPs, and tax issues.

These areas have been major sites of struggle against neo-liberal and neo-colonial agendas on the African continent – be they in the fight for tax justice, resistance to mega infrastructure projects, or dispute resolution 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”.<sup>47</sup>

### **2.3. A Note on Trade and PPPs**

UNCTAD defines<sup>48</sup> a bilateral investment treaty (BIT) as an agreement between two countries regarding the promotion and protection of investments made by investors from the respective countries in each other's territory.

BITs are expected both to attract and to protect foreign investors, and are subject to the Investor State Dispute Settlement (ISDS) as a mechanism to settle disputes. “Countries signing BITs commit themselves to following specific standards on the treatment of the foreign investments within their jurisdiction.”<sup>49</sup> By nature, PPPs focus on private finance in development, and, in turn, expose it to the global instruments traditionally reserved for commercial activity,<sup>50</sup> such as the ISDS.

Between 2013 and 2019, African states had 109 recorded investment treaty arbitration claims. This six-year period accounted for 11 per cent of all known investor-state disputes globally.<sup>51</sup> These legal claims have cost Africa an estimated at 55.5 billion US dollars since 1993, and this is from only 54.7 per cent of the total number of cases.<sup>52</sup>

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 (Baker and Geddes, 2016).

The MES companies are from China, India, Italy, The Netherlands, and the USA. Kenya had a BIT with Italy, but it was terminated in 2014. It has a BIT with China that has

been signed but is yet to come into force. In addition, it has one with The Netherlands that came into force in 1979. Kenya is just about to go into negotiations about a Free Trade Agreement with the USA, which would also subject it to the ISDS. This provides the backdrop to the even greater risk for Kenya and other African countries when it comes to engaging with global private finance for development outcomes. Investor claims have meant that Africa has lost large amounts of its resources, which could have gone directly into the health-care provision gaps that private-sector players purport to be plugging.

### **3. GENDER AND HUMAN RIGHTS IMPACT OF IMPLEMENTATION AND FUNCTIONING**

“Privatisation of hospitals and related institutions? On hearing such, I outrun my shadow.<sup>53</sup> Privatisation has not and will not serve the interests of the majority. Women and girls are affected in compounded ways; unable to afford the services they require and increased burden of care.”

*Doo Aphane*<sup>54</sup>

There has been a fair amount of public outrage and attention paid to the MES programme, which has prompted Kenya’s Senate to form an *ad-hoc* committee to investigate it. The Institute for Economic Affairs (IEA) - an economic and public policy think tank also - carried out an in-depth “value-for-money” assessment,<sup>55</sup> aimed at determining the cost effectiveness of the scheme, and determining whether it would ultimately result in better health outcomes. These and other processes have raised several issues of concern, which we place in two categories: (1) lack of transparency in contracts, costing and allocation, and (2) the broader question of gaps in priority setting.

#### **3.1. Lack of Transparency in Contracts, Costing and Allocation**

A Senate document lists a lack of full disclosure by the health ministry on the MES contracts as one among a list of several 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.”<sup>56</sup> 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 health-care budget, the MES had the third biggest allocation for the 2016/17 fiscal year after the allocations to the biggest and second biggest referral hospitals. Budgets are the easiest way to tell what a government is prioritising, as

they will actually put resources into these items. The table below<sup>57</sup> shows the distribution of Kenya's health budget for the fiscal year 2016/2017. The budget allocation also shows how de-prioritised preventative public health care is, which should be the underlying strategy to ensure that the population is healthy.

**Table 4: Budget Allocations**

Allotments	Billion KES	Million USD
Kenyatta National Hospital	8.8	81.4
Moi Teaching and Referral Hospital	5.8	53.7
<b>Lease of Medical Equipment [MES]</b>	<b>4.5</b>	<b>41.7</b>
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

Health care is, across the board, the biggest budget item for county governments, accounting for approximately 25 per cent of total budgets. Approximately five per cent of county health budgets went to the MES (Institute of Economic Affairs, 2020b). With all health functions except health policy devolved to county level, 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 the national governments entered into on their behalf (Institute of Economic Affairs, 2020b).

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 the MES, the audit found that "the lawfulness and accuracy of expenditure of 4.57 billion KES (41.7

million USD) on the MES could not be verified due to lack of supporting documents” (Institute of Economic Affairs, 2020b). Important supporting documents such as contracts, legal opinions on contracts from the Attorney General, and procurement and progress reports were not made available for the audit (Institute of Economic Affairs, 2020b).

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 95 million KES annually (approximately 950,000 USD) found that the deductions increased to KES. 200 million (1.9 million USD), more than double the agreed amount.<sup>58</sup> No official explanation has been given for this.

The government and private sector argument for the leasing of medical equipment is that it is better value for money for the government in terms of the cost of maintenance and servicing.<sup>59</sup> However, a representative of Shenzhen Mindray is quoted as admitting at one of the Senate hearings that Kenya would have saved massive amounts of resources if it had made direct purchases, as seen in this extract from a Kenyan daily newspaper (*The Star*, 2019):

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.

**Source:** *The Star*, “Chinese Firm in Medical Gear Probe says Leasing Expensive”, by Julius Otieno, 7 November 2019, available at: <https://www.the-star.co.ke/news/2019-11-07-chinese-firm-in-medical-gear-probe-says-leasing-expensive>.

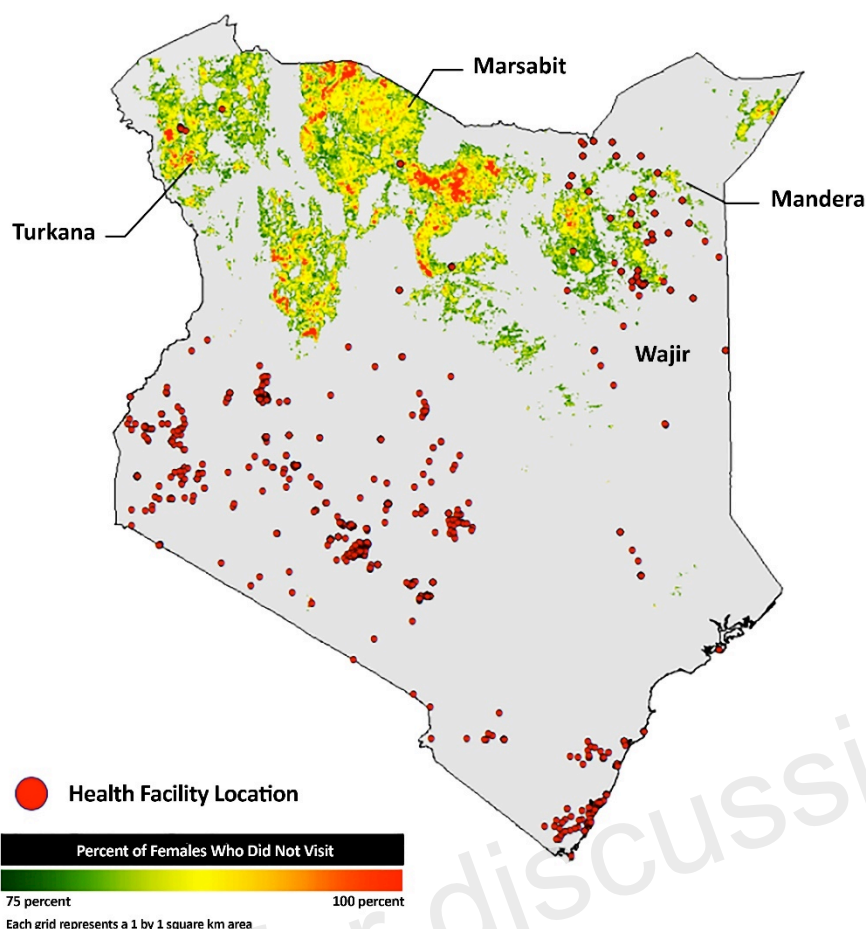
Edward Ouko, Kenya’s former Auditor General, has called the project “a betrayal of trust of the Kenyan taxpayers,” adding that the “funds would have been better spent on expanding basic healthcare ... more midwives and more clinics might have saved more lives in a country where 342 women die from pregnancy complications per 100,000 live births” (Reuters, 2020).



### 3.2. 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 them on the delivery of the equipment.<sup>60</sup> Equipment has remained unused in at least 29 of the 47 counties of Kenya, as a result of a lack of the requisite staff to operate the equipment, as well as inadequate water and electricity supply.<sup>61</sup> Many of these counties are in geographically remote and typically marginalised areas, and it comes as 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 leadership (*The East African*, 2017). The strike was to demand fairer remuneration and better working conditions – on average, there is only one doctor for every 6,355 Kenyans (Africa Check, 2018), but stark inequalities in distribution mean that the capital city, Nairobi, which accounts for only eight per cent of Kenya's population, has 32 per cent of the share of doctors nationwide.<sup>62</sup>

To bring the above to life, pulling from Fraym's geospatial data below,<sup>63</sup> in 2015, only 65 per cent of women in Kenya had visited a health facility in the past year. The map below 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 the national government and the county governments to determine what equipment was needed in which county based upon comprehensive, open and accountable needs and feasibility assessments meant that some counties received equipment that they would not have been top priority for, or that they had already received the said equipment from different government schemes.<sup>64</sup>

Amplifying these obvious gaps in prioritisation is the fact that the prevailing philanthro-capitalist and developmental assistance to the health sector continues to weaken African health sectors due to its approach. The current approach is predominantly vertical and skewed towards 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 the various functions. Unfortunately, we have seen public and primary health strategies fall off the 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 health infrastructure (as) foreign owned”.<sup>65</sup> Without a robust public and community health infrastructure owned and managed by the state, it becomes next to impossible to implement interventions effectively to keep the population adequately healthy. The Covid-19 crisis has shown how detrimental an over-focus on vertical health interventions can be, at the expense of horizontal interventions. There can be no healthy populations without access to safe water and hygiene, adequate nutrition, access to vaccines and so on. It is people and community interventions, not financialisation, that must be at the heart of policy-making.

Making reference to a briefing by Eurodad, GADN and FEMNET,<sup>66</sup> there are three key motives as to why public services, such as health care, are important for gender equality:

The disproportionate reliance of women on public services;

The lower income of women, which reduces their ability to pay for private services; and

The reliance of women on work in the public sector.

Because the income of women is usually lower, they rely more on public health-facilities, especially for primary health care for their children and for maternal care. A re-direction in resources to “non essential” specialised equipment directly impacts the availability of finance for accessible and affordable primary health care. Given that treatment using the equipment purchased with the PPP comes at a cost to the end-users, that is to say, the patients, even if the equipment is in working order with qualified personnel to run it, women are less likely to be able to pay to access it. 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 education,<sup>67</sup> and any re-direction of resources brought about by privatisation is likely to lead to cuts in public sector wage bills and the loss of jobs.

#### **4. RESISTANCE**

“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.”

Since the signing of the Managed Equipment Scheme in 2015, and despite the secrecy that has surrounded it, there have been both numerous and continuous calls not only for transparency and accountability, but also questioning the underlying logic and process of the project. This resistance has principally been led by the county governors, largely driven by the fact that their county budget allocations were deducted at source to finance the project – and to pay for equipment that most counties are not even using. This is not only linked to how the deductions are made, but also to the fact that the sum deducted has been increasing without consultation on the original contract. The governors have increasingly taken issue with the project, and this, together with public pressure, has culminated in a Senate probe and hearing by the Senate Health Committee, which was ongoing at the time of writing this chapter. The MES project has been consistently in the news, especially since the announcement of 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, as far as is known, possibly due to its limited co-ordinated engagement with macro level economic policy. However, macroeconomic issues are, indeed, feminist issues and have to be central to the Pan African feminist struggle.

Our aim in writing this chapter 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 that 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, of course, comes as 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 in which three quarters of the population are under 35 years old, one can assume - as has been our experience - that this means that the vast majority of Kenyans see few alternatives to private finance in order to solve public problems.

- The imposition of user fees for services was a colonial project, and the neo-colonial project continues to keep poorer countries in a private-finance chokehold with poor people bearing the brunt. Health care 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 to understand the impact that faulty, misplaced, and imposed development policy has on women and on their communities. PPPs have been seen to be more costly than publicly-funded services, they lack transparency, are 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 concerning 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 about the absence of public participation and agency in policy-making, and the absence of women’s voices, despite the fact that these policies have a direct impact on their everyday lives.

A government’s ability 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.

Although the labelling and iterations of macroeconomic interventions change through the years, the basic neo-liberal and neo-colonial 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 re-imagining feminist futures, we need to re-visit and build upon this knowledge base, apply it to our current contexts, and be more intentional in connecting struggles.

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