



# IN THE INTEREST OF *HEALTH FOR ALL?*

## THE DUTCH 'AID AND TRADE' AGENDA AS PURSUED IN THE AFRICAN HEALTHCARE CONTEXT

*Discussion paper*

### EXECUTIVE SUMMARY

For the last 10 years, the Netherlands has been pursuing a combined Aid and Trade agenda (A&T). This is in line with the international policy shift in finance for development towards the promotion of private sector engagement and the general trend among donor countries to strive for win-win, meaning development in the recipient and donor countries' interests would go hand in hand.

The financial instruments to support A&T – in the form of grants, loans, guarantees or equity investments – are used increasingly in various sectors, including healthcare. Prompted by critical questions from African civil society (CSOs) and health professionals' organisations in our networks, we took a closer look at the use of these instruments. This discussion paper reflects our study about the depth and breadth of Dutch A&T policy implementation in healthcare in sub-Saharan Africa.

We first analysed characteristics of these instruments and how they are used in the healthcare sector in sub-Saharan Africa. Subsequently, together with representatives of Kenyan CSOs, we carried out a case study on projects supported with Dutch A&T funds with an explicit win-win approach: projects aimed at market development for the Dutch Life Sciences and Health top sector in Kenya. Finally, we discussed our findings with CSOs and project stakeholders. While Dutch A&T instruments are aimed at strengthening business and the business climate, we applied a health lens to look at the possible impact of A&T instruments.

Our study shows how Dutch A&T instruments in healthcare prioritise private sector development and push for public-private partnerships in primary healthcare without using a theory of change that is sufficiently based on evidence. CSOs and scientific literature point at the risks of this approach. A&T in health may unintentionally hinder instead of support countries' progress towards universal and equitable access to health services.

We conclude with a number of recommendations for future policy and implementation in the best interest of health for all.

This discussion paper is designed to contribute to the public debate on finance for health and the quality of aid, in both recipient and donor countries, and also in multilateral institutions. It forms part of Wemos' *Public Return on Public Investment: Aid for Trade in Healthcare* project (2018-2019), performed with the support of Open Society Foundations.

Wemos is a Dutch civil society organisation that advocates the right to health for all. Together with civil society organisations in the South and as a member of global networks, we analyse policies that affect health and propose policy changes to governments and multilateral organisations. We also seek to raise public awareness of urgent health and health system issues, and to strengthen cross-border civil society learning and collaboration.

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## LIST OF ABBREVIATIONS

ADSB	Atradius Dutch State Business
A&T	Aid and Trade
CSO	Civil Society Organisation
DAC	The OECD Development Assistance Committee
DDE	Sustainable Economic Development department of the Dutch Ministry of Foreign Affairs
DGGF	Dutch Good Growth Fund
ECIs	Export credit insurances
FMO	The Dutch Entrepreneurial Development Bank
FTDC	Minister for Foreign Trade and Development Cooperation
GDP	Gross Domestic Product
GNI	Gross National Income
HIF	Health Insurance Fund
IEG	The World Bank's Independent Evaluation Group
IFC	International Finance Corporation (part of the World Bank Group)
IFHA	Investment Fund for Health in Africa
KMPDU	Kenya Medical Practitioners, Pharmacists and Dentists Union
L&MICs	Low- and middle-income countries
LSH	Life Sciences and Health
LS&H4D	Life Sciences & Health for Development fund
MFA	Ministry of Foreign Affairs
MOH	Ministry of Health
NHIF	National Hospital Insurance Fund
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
ORIO	Facility for Infrastructure Development
IMF	International Monetary Fund
P4PC	Partners for Primary Care
PDP III	Product Development Partnerships fund III
PHC	Primary Health Care
PHC-NL	Public Health Consultants Netherlands
PPPs	public-private partnerships
PSD	Private Sector Development
PwC	PricewaterhouseCoopers Netherlands
SDGs	Sustainable Development Goals
SDGPP	Kenya SDG Partnership Platform
SMEs	Small and medium-sized enterprises
SPV	Special Purpose Vehicle
TJ	Triple Jump Ltd
TFHC	Taskforce Healthcare
UHC	Universal Health Coverage
UN	United Nations
UNDP	United Nations Development Programme
UNECE	The United Nations Economic Commission for Europe
MES	Managed Equipment Services
VHI	Voluntary health insurance
WHO	World Health Organization

# 1. INTRODUCTION

Since 2010, the Dutch government is shifting from aid to trade relations with its developmental partners. This resulted in the Aid and Trade agenda (A&T) in 2012. A&T policy instruments aim to better engage Dutch business and expertise in development efforts, especially in the area of private sector development. This is not unique in view of the worldwide finance for development policy shifts. What stands out in A&T policy is how straightforwardly it links the donor country's economic goals to development goals, also known as the 'win-win' approach. This approach, however, may be at odds with international agreements on the right to health, commitments to the Sustainable Development Goals (SDGs) and development effectiveness.

In 2017, during our Finance for Health work in Kenya, we took notice of critical questions posed by a number of Kenyan civil society organisations (CSOs), including organisations of health professionals. For instance, questions about 'the Dutch' seeking market expansion in healthcare - referring to a recent market study commissioned by the Dutch Embassy<sup>4</sup> -, their involvement in a large leasing contract<sup>5</sup>, and business meetings with high-level Kenyan officials<sup>6</sup>. 'The Dutch' referring to (representatives of) Dutch government, (multinational) companies, banks and other organisations, backed by the Dutch Embassy as a donor.

The CSOs' biggest concern was the perceived Dutch influence on Kenyan health politics in favour of greater (foreign) business involvement in health and a possible push for privatisation, commercialisation and financialisation in health (see box 1). They saw the development support for business in health as a rather opaque area - or 'black box' - raising questions about terminology, actors, money, financial modalities and exact aims involved. In the following year, we heard similar critical questions and concerns from other CSOs, based in Mozambique, Sierra Leone, South Africa, Tanzania and Uganda, during regional and international health governance and financing meetings.

## BOX 1 - Definitions

**Privatisation in health:** the growth of the share of private sector involvement in public health systems.<sup>1</sup>

**Commercialisation in health:** increased provision of healthcare services through market relationships, where accessibility depends on willingness and ability to pay.<sup>2</sup>

**Financialisation in health:** a situation where financial motives, markets, actors and institutions play an increasingly important role in the provision of health services.<sup>3</sup>

There is a paucity of information about the Dutch A&T agenda from a health perspective. Therefore, we decided to look into the A&T agenda and analyse its health-related content, through an interactive study called 'Public Return on Public Investment: Aid for Trade in Healthcare' (2018-2019). To open the 'black box' and understand the depth and breadth of Dutch A&T policy instruments in healthcare, we searched for answers to the following questions:

- To what end and to what extent are Dutch A&T instruments used in the healthcare sector?
- What does an explicit win-win approach in A&T projects in healthcare look like?
- What is the impact of the use of Dutch A&T instruments in health on countries' progress towards universal and equitable access to health services?

<sup>1</sup> ISER, GI-ESCR, Human Rights Centre Clinic (2019). Private actors in health services. [\[LINK\]](#)

<sup>2</sup> Mackintosh & Koivusalo (2005). Commercialization of Health Care. Global and Local Dynamics and Policy Responses.

<sup>3</sup> Epstein (ed), 2006, Financialization and the World Economy; Hunter & Murray (2019), Deconstructing the Financialization of Healthcare. Development and Change [\[LINK\]](#)

<sup>4</sup> TFHK and KHF (2016). *Kenyan Healthcare sector. Opportunities for Dutch Life Sciences & Health Sector.* [\[LINK\]](#)

<sup>5</sup> It concerned the 7-year Managed Equipment Services contract, published in the GE Business Wire 2015 [\[LINK\]](#) for instance.

<sup>6</sup> TFHC website (2017) articles 'Philips Partners with the Government of Kenya and the UN to Advance the African Healthcare Agenda' [\[LINK\]](#) and 'Kenya: a 3-Day visit in search of partnerships & investments'; summary report LSH trade mission [\[LINK\]](#)

Governments should ensure policy coherence for sustainable development: what you do in one policy area (or SDG) should reinforce positive and avoid any negative effects in other policy areas, in the future and elsewhere. The Dutch government uses an ex ante impact analysis tool for policy coherence. This tool was amended in 2019, to include the SDGs and direct special attention to 'effects on developing countries'.

The Dutch A&T instruments are generally aimed at strengthening the private (business) sector and the infrastructure for trade and investment (business climate), which is part of the SDG-agenda. However, when they are used in health - which is also part of the SDG-agenda and grounded in the universal human rights framework - we would expect health system strengthening goals to be guiding too. That is why we included a question on the impact of these instruments on the central health SDG: Universal Health Coverage (UHC), or universal and equitable access to health services.

Donor governments should also respect the principles for Effective Development Cooperation, which include democratic ownership, the untying of aid, transparency and accountability. In the discussion of the use of Dutch A&T instruments in health, we keep these general principles in mind, next to health and UHC.

Looking at the A&T agenda through a health lens, this paper aims to contribute to an informed political debate in the Netherlands about the effectiveness of the Dutch A&T agenda and instruments. The Dutch Foreign Ministry's Policy and Operations Evaluation Department is expected to deliver a formal evaluation of the implementation of Dutch A&T agenda (2012-2019) by the end of 2020.<sup>7</sup> This paper also contributes to finance for development policy or guidance in other countries – whether at the giving or receiving end - and in multilateral institutions at international level. Furthermore, it is relevant to anyone engaged in access to health services and/or effective international cooperation, and those who are interested in the implications of development policy approaches that prioritise private sector involvement.

Chapter 2 (Background) explains the national and international background of the A&T agenda and its instruments. Chapter 3 explains the nature and methodology of study. Chapter 4 (Findings) examines how the A&T agenda is rolled out in the healthcare sector in sub-Saharan Africa. This chapter also zooms in on Dutch A&T projects in healthcare with an explicit win-win objective, in Kenya. In chapter 5 (Discussion) we discuss our findings and the potential implication of the A&T agenda, based on the available evidence from the literature and the views expressed by local stakeholders, such as health workers, CSOs and government representatives. Chapter 6 draws conclusions and gives recommendations for future policy.

## 2. BACKGROUND

### 2.1 THE DUTCH 'AID & TRADE' AGENDA AND ITS POLICY INSTRUMENTS

For years the Netherlands was among the few donor countries providing Official Development Assistance (ODA) above the threshold of 0.7% of Gross National Income (GNI). Since 2010 this percentage has been decreasing, dropping below 0.7% in 2012 and reaching 0.59% of GNI in 2019.<sup>8</sup> At the same time, the Dutch government increased the part of their ODA expenditure that is meant to engage (i.e. involve as development partner) the private for-profit sector; from 4% of total ODA in 2010 to 6% in 2014 and 11% in

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<sup>7</sup> Letter Minister for Foreign Trade and Development Cooperation to the Dutch Parliament (20 August 2019) about the forthcoming release of the official policy evaluation of the Aid and Trade agenda [*Beleidsdoorlichting artikel 1 BHOS* in Dutch]. Publication in Dutch only [[LINK](#)]

<sup>8</sup> OECD database query on Net ODA as percentage of GNI 1960-2017 [[LINK](#)] - visited March 2020

2018.<sup>9,10</sup>

The Netherlands has always been engaging the private sector<sup>11</sup> in development programmes, particularly in Private Sector Development (PSD). These programmes are aimed at strengthening the private sector and entrepreneurial climate in recipient countries to increase employment and reduce poverty. Since 2010, Dutch private sector development *and* engagement, premised on mutual benefits for both partner countries and the Netherlands, became a core element of Dutch development cooperation policy.<sup>12</sup> Moving away from aid relations towards trade relations became the new agenda.

From 2013, a single Minister for Foreign Trade and Development Cooperation (FTDC) was installed at the Ministry of Foreign Affairs (MFA), and an official Aid and Trade policy was adopted. The government's FTDC policy aims for the reduction of poverty and inequality worldwide, as well as for '*success for Dutch business abroad*'<sup>13</sup> or '*enhancing Dutch international earning capacity*'.<sup>14</sup> The rationale for combining these very different policy aims were:

- better policy coherence (between the policy areas of foreign trade and development cooperation),
- more efficiency through more narrowly focused expertise ('doing what you are good at'),
- and mutual benefits ('what is good for the world is good for the Netherlands')<sup>14</sup>, in Dutch circles also commonly explained as a two-way win or win-win situation or as 'development in the national interest' by the Organisation for Economic Co-operation and Development (OECD).<sup>15</sup>

### Combined A&T policy instruments and their financing channels

FTDC policy instruments – financial instruments such as grants, loans, equity and guarantees – are either meant for foreign trade only, for development cooperation only or for the *combined area* of Aid and Trade (A&T) (see figure 1). For the purpose of our study we looked at the third category, the combined A&T instruments<sup>16</sup>. Most of the A&T expenditure is grouped under FTDC policy theme 1 'Sustainable economic development, trade and investments'. Other A&T expenditure relates to other policy themes, like food, climate, and water. The A&T instruments are managed by five governmental and private actors (see box 2), which we refer to as the *A&T financing channels*.

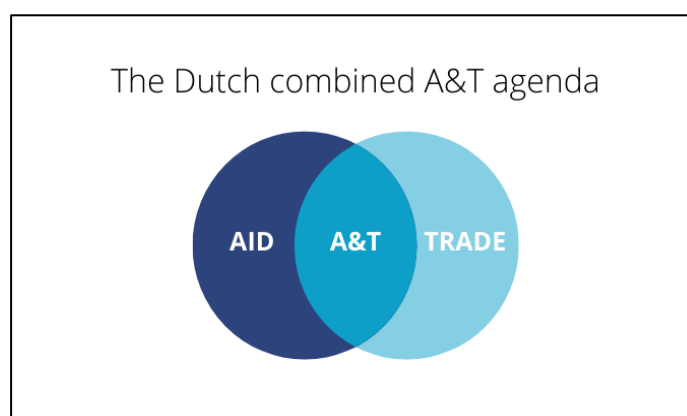


Figure 1: The Dutch combined Aid & Trade agenda is represented by the A&T overlap area in this diagram. The relative volume in the figure does not represent real policy expenditure volume.

<sup>9</sup> Algemene Rekenkamer/Dutch Court of Audit (2016). Monitoring beleid voor ontwikkelingssamenwerking: het financieringskanaal bedrijfsleven. Publication in Dutch [\[LINK\]](#)

<sup>10</sup> Oxfam Novib (2017). Zaken eerst: BV Nederland in ontwikkelingssamenwerking. Publication in Dutch [\[LINK\]](#)

<sup>11</sup> In the context of this discussion paper by 'private sector' we mean the *for-profit* private sector (companies, businesses, investors). When referring to the *not-for-profit* private sector we will use terms such as non-profit organisations, foundations and faith-based organisations.

<sup>12</sup> OECD DAC (2016). Private Sector Peer Learning. Country report: Netherlands. [\[LINK\]](#)

<sup>13</sup> Foreign Trade and Development Cooperation policy document (2014), *A World to Gain: a new agenda for Aid, Trade and Investment* [\[LINK\]](#)

<sup>14</sup> Foreign Trade and Development Cooperation policy document (2018), *Investing in Global Prospects: for the world, for the Netherlands* [\[LINK\]](#)

<sup>15</sup> OECD (2020), Development Co-operation Report 2019 [\[LINK\]](#).

<sup>16</sup> The English term 'A&T instruments' is used in this paper. Please note that we used another translation of the Dutch term *bedrijfsleveninstrumentarium*, namely 'Business Strengthening Instruments' (BSIs), in our previous [discussion paper](#). We apologise for any confusion.



## BOX 2 – Main Dutch A&T financing channels

1. The **Netherlands Enterprise Agency RVO** is a government agency that supports Dutch enterprises worldwide. It manages A&T (ODA) funding through over 35 instruments. These include: 1) grant facilities for governments in low and middle-income countries (L&MICs), especially for public infrastructure development and trade facilitation, 2) PSD funds for companies and other non-state actors, and 3) partnership funds for product development. RVO also provides services such as the organisation of trade missions and coaching for Dutch Embassies.
2. The **Entrepreneurial Development Bank FMO** is the Dutch development financing institution. It is 51% state-owned and 49% owned by Dutch commercial banks. It has a development mandate and works through private actors, making it A&T by definition.<sup>17</sup> FMO manages its own risks and investments from its own funds (FMO-A), and also manages specific government funds (also called revolving funds). A diversity of development finance products, like (concessional) loans, fund investments, direct equity, mezzanine and guarantees, are invested in key sectors that correspond with FMO's areas of expertise: 1) Agribusiness, 2) Energy, and 3) Financial Institutions. Dutch Business was added as key sector in 2017 when the government entrusted FMO with a fund called NL Business/Development Accelerator.
3. **Atradius Dutch State Business (ADSB)** is the Dutch State facility for export credit insurances (ECIs) for Dutch exporting companies. It implements the ECI window of the Dutch Good Growth Fund (DGGF)<sup>18</sup>. DGGF ECIs and ECIs to a country in the DGGF country list, are accounted as ODA.
4. **PricewaterhouseCoopers Netherlands (PwC)** is a private consultancy firm and **Triple Jump Ltd (TJ)** is a company providing micro credits to small and medium-sized enterprises (SMEs). PwC had been commissioned to manage A&T grant facilities<sup>19</sup> which were phased out in recent years. Currently, a consortium of TJ and PwC manages the Financing local SMEs window of the DGGF: SMEs in DGGF countries get financing through loans and equity, mostly via intermediary funds. The DGGF Investment Fund is a fund of funds, but also provides concessional loans and equity directly.
5. And last but not least, a significant proportion of A&T expenditure (ODA grants) is managed by **ministerial departments** themselves, such as the MFA Sustainable Economic Development department (DDE). The magnitude of ODA support through this channel varies greatly. It may concern one-off support (often involving small grants) for interventions to improve one concrete aspect of the business climate in a specific country. It may also entail long-term commitment (involving large grants) to develop a new commercial market in a specific region.

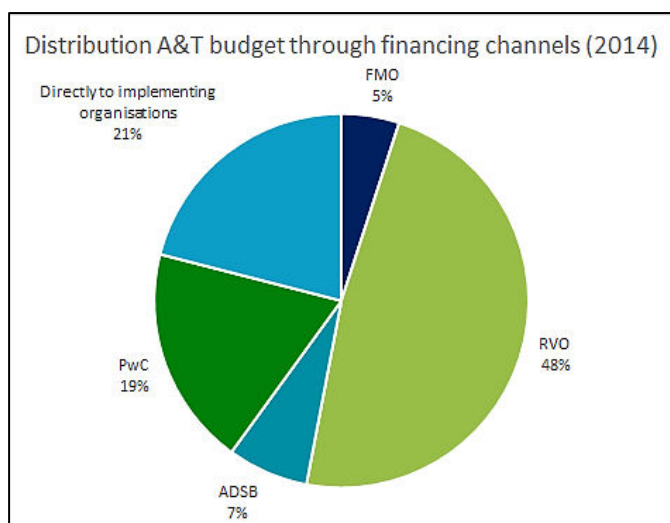


Figure 2: The distribution pie is an adaption of figure 5 of Oxfam Novib's publication in 2017, and based on 2014 statistics (source: Dutch Court of Audit 2016). The relative volumes of the different slices of the pie may not represent present reality.

<sup>17</sup> We call the money that FMO that FMO puts to work in developing countries 'development finance'. Nor the funds that the government entrusts to FMO for special purposes, nor the money that FMO puts to work for development purposes are reported as ODA by the Dutch government.

<sup>18</sup> The DGGF, established by the Ministry of Foreign Affairs in 2014, has three windows. It provides 1) financing and 2) credit insurances for Dutch enterprises for development-related export transactions and investments, and 3) investment funds in the Netherlands and in low- and middle-income countries to support small and medium enterprises in developing countries. See website: <https://english.dggf.nl/>

<sup>19</sup> One of the recently phased out grant facilities is ORET (Development related Export Transactions), which PwC managed between 2007 and 2019.



## Implicit versus explicit win-win expectation in A&T

The win-win approach is attached to the whole combined A&T policy, although in many of the A&T policy instruments it is not stated in explicit terms; win-win is often an *implicit* goal (see figure 3). Grants for the development of products or infrastructure and (co-)funded projects, often involving relatively large budgets, do not explicitly point at the benefits for Dutch investors or companies. Only the more general descriptions of the Dutch PSD programme clarify that such projects are expected to improve the business climate for Dutch enterprises as well.

In some A&T instruments, win-win is made more *explicit*.

We will give three examples; two from current A&T instruments and one from an instrument that is in the pipeline:

- The so-called PSD toolkit, which is managed by the RVO and used for grant making by Dutch Embassies, explicitly describes how win-1 (development gains) will also contribute to win-2 (gains for Dutch companies). It is there to ‘(...) create a business-enabling environment, remove trade barriers and match local and Dutch business partners, in order to shape the local implementation of the Dutch agenda for Aid, Trade and Investment’<sup>20</sup>.
- As for the NL Business Funds, managed by the FMO, win-win is described explicitly and win-2 is mentioned first: “We create partnerships leading to shared value for Dutch businesses and for the development in emerging markets.”<sup>21</sup>
- A new financing facility - *Invest International* – is to be launched by the Dutch MFA by the end of 2020. It will bring together various ODA grant facilities (now managed by RVO) and development finance facilities (FMO) and add extra state capital (for loans and equity), thus partly taking over the role of RVO and FMO. Fully in line with the A&T agenda, and with an explicit win-win approach, it aims to “facilitate trade and investment in bankable projects in developing countries” and be of “optimal service to Dutch businesses.”<sup>22</sup>

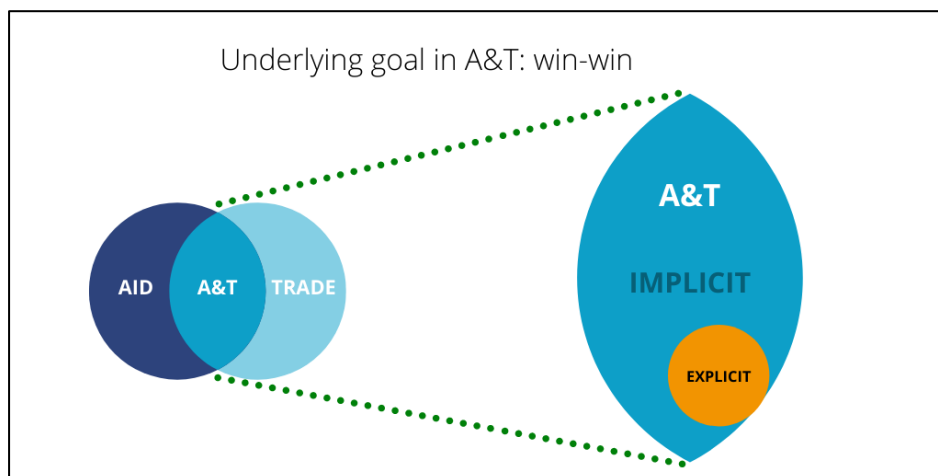


Figure 3: A&T expenditure with an explicit versus an implicit win-win goal. The relative volumes in the figure do not represent real volumes.

## 2.2 AN INTERNATIONAL POLICY SHIFT FROM PUBLIC TO PRIVATE

Since the third International Conference on Financing for Development in 2015 and the Addis Ababa Action Agenda (AAAA), the international community started to call more explicitly on the private sector - and the for-profit private sector in particular - to step into the development arena and supplement public finance

<sup>20</sup> RVO IATI database, programme descriptions, PSD toolkit [\[LINK\]](#) – visited March 2020

<sup>21</sup> FMO website, NL Business Funds [\[LINK\]](#) – visited March 2020

<sup>22</sup> See the communications of the Minister for FTDC to Parliament (available in Dutch only) on 20 December 2019 [\[LINK\]](#) and 28 January 2020 [\[LINK\]](#)

gaps with private finance. There is an estimated USD 2.5 trillion investment gap per annum in order to achieve the Sustainable Development Goals (SDGs) by 2030.

### Tight public budgets

Governments around the world are faced with tighter public budgets,<sup>23</sup> as tax revenues (especially trade and corporate taxes) are shrinking under the influence of global competition to attract foreign investment. Moreover, government revenue in developing countries is projected to further decrease due to the COVID-19 crisis.<sup>24</sup> SDG 17 ('Partnership for sustainable development') reiterates the importance of international support to expand public resources by improving taxation, other sources of revenue collection, and long-term debt sustainability. It also reminds high-income countries to fully implement their ODA commitments of at least 0.7% of GNI.

However, many donor countries, multilateral institutions and the World Bank put more emphasis on the part of SDG17 that is about direct involvement of the private sector through foreign direct investments and public-private partnerships (PPPs).

### Private first approach

The World Bank had sown the seed of a 'private first' approach in the healthcare context through its special Investing in Health World Development Report back in 1993. Private first is central to the World Bank's Maximizing Finance for Development approach, also known as the 'Cascade approach' (figure 4).

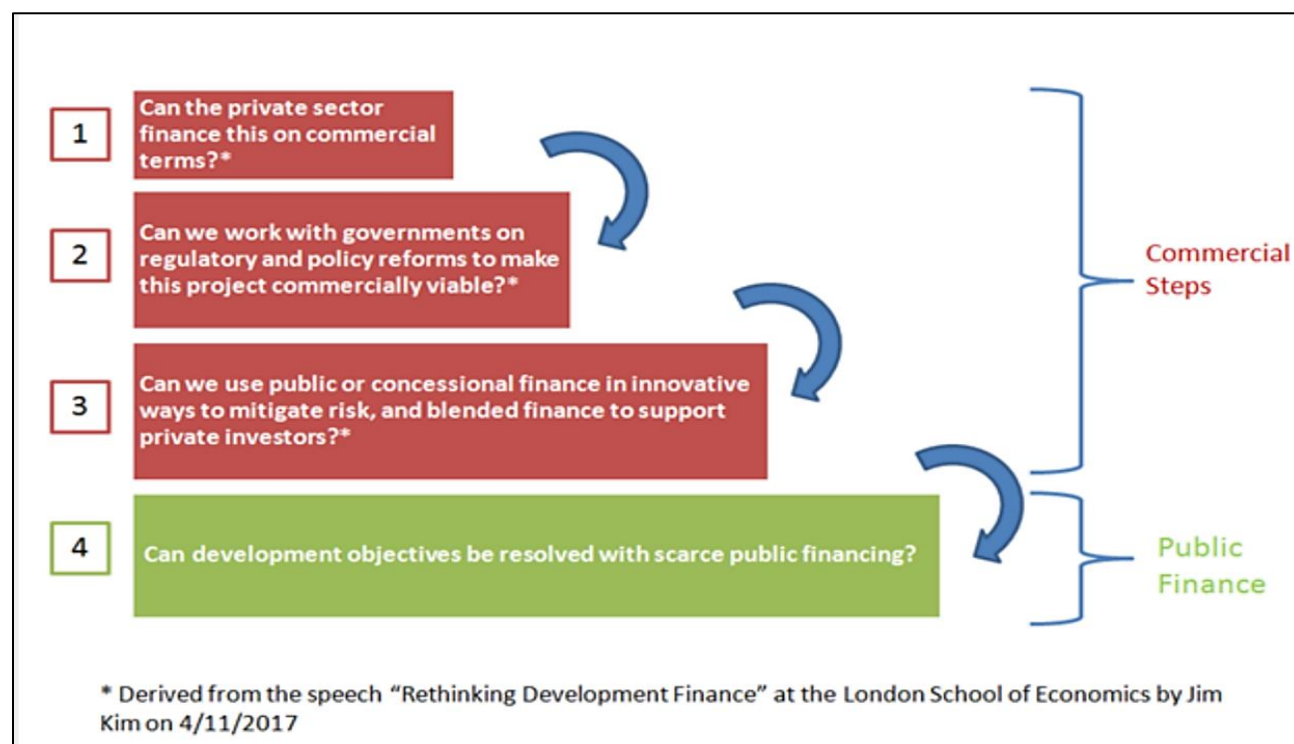


Figure 4: The Cascade approach as presented by former World Bank President Jim Kim (2017). Source: [Blog](#) (2017) on website Just Governance

<sup>23</sup> According to the OECD database, visualised in *Our World in Data*, the total tax revenue of governments worldwide is going down in recent years from 19.82% in 2013 to 18.77% in 2017 [[LINK](#)].

<sup>24</sup> Dodd, Tew and Hope (2020) for Development Initiatives. Covid-19 and financing projections for developing countries [[LINK](#)]

This approach gives preference to private investment over public investment in diverse sectors of development, including health. It does so by creating new markets and more conducive environments for private investment and business.

## ODA modernisation to leverage private finance

Donor countries have followed suit. ODA supplied through what are known as private sector instruments, is increasingly being used to leverage private sector finance.<sup>15</sup> This can take the form of blended finance and initiatives to de-risk private sector investments. Finance through Development Finance Institutions, in the form of loans, equity and guarantees to support private sector operations, has grown three-fold in the past decade.

Simultaneously, more and more donors are combining their aims in development assistance with their domestic economic, diplomatic, security and commercial interests. Donors nowadays openly state that the Maximizing Finance for Development approach can also be regarded as a mutual prosperity approach - which we call a win-win approach in this paper - arguing that the benefits of development programmes should be felt not just overseas, but also at home. Developing countries have growing young populations, with a potential for high productivity and rising health expenditure. This can be turned into investment opportunities for generating high returns, which are harder to find in advanced economies. The figures tell the story: according to the International Finance Corporation (IFC) of the World Bank Group, the African healthcare sector was worth USD 35 billion in 2016 and is forecasted to grow by 6% by 2024, while the African pharmaceutical market was worth USD 19 billion in 2016 and is actually expected to more than triple in value by 2024. Africa is an attractive market for the healthcare industry.<sup>25</sup>

These changes altered the focus of ODA and widened the criteria of what can be accounted as ODA, referred to as ODA modernisation by the OECD. Without going into detail, it needs to be remarked that these changes have not just been promoted, but criticised too, both within<sup>26</sup> and from outside<sup>27</sup> multilateral institutions such as the OECD.

## Private sector involvement in health

The involvement of the private for-profit sector in healthcare is not new. The promotion of private health service delivery and finance, by the World Bank and other development actors, has been fuelled by gaps in the adequate resourcing of public systems. What is striking in recent years, though, is the keen political interest in the rapid build-up of this involvement, by encouraging public-private partnerships (PPPs) in health (see box 3) and by creating new asset classes for private investments and bonds. These changes have also been characterised as pathways to privatisation in health.

<sup>25</sup> Goldstein Research (2019). Africa Healthcare Market Outlook: Opportunity And Demand Analysis, Market Forecast, 2016-2024. [\[LINK\]](#)

<sup>26</sup> Atwood, Manning and Riegler (2018) letter of warning from three former OECD-DAC top-level experts, Don't undermine the basic architecture of OECD/DAC statistics [\[LINK\]](#); Scott (2019), A note on current problems with ODA as a statistical measure [\[LINK\]](#)

<sup>27</sup> TUDCN-RSCD and CSO Partnership for Development Effectiveness (2018) Aligning blended finance to development effectiveness [\[LINK\]](#); Attridge and Engen (2019) for ODI, Blended finance in the poorest countries [\[LINK\]](#). Caio and Craviotto (2020) in DEVEX, What the new data on private sector instruments doesn't tell us [\[LINK\]](#). Axelsson Nycander (2020) for ACT, Blending finance: finding its right place [\[LINK\]](#)

### BOX 3 - Defining public-private partnerships in the health context

There is no universal definition of a public-private partnership (PPP). For the purpose of this paper, we follow the World Bank's definition: *'a long-term contract between a private party and a government entity, for providing a public asset or service, in which the private party bears significant risk and management responsibility, and remuneration is linked to performance.'*<sup>28</sup>

According to the World Bank's independent evaluation group (IEG), PPPs in healthcare typically focus on healthcare service delivery and health facility finance (through concessions, leasing, build/operate contracts or private finance initiatives) or a combination of the two (through joint ventures). The IEG observes a spectrum from less to more complex health PPPs, and varying degrees of risk sharing between the private and public partners depending, among others, on how payment mechanisms are structured.<sup>29</sup>

## 2.3 THE IMPORTANCE AND DIMENSIONS OF UNIVERSAL HEALTH COVERAGE

Health is a human right, and the importance of health and Universal Health Coverage (see box 4) are captured in the SDGs, particularly in SGD3. Health is also recognised as key to the attainment of other SDGs, for example inclusive economic growth (SDG8). States must take progressive steps to realise health for all, meaning equitable access to health services and protection against threats to health, and have core obligations in the provision of Primary Health Care (PHC). Moreover, the COVID-19 crisis clearly highlights that strong, resilient and responsive health systems are crucial for a functioning society and are a matter of national and international security.

UHC is often misinterpreted as solely referring to coverage through health insurance. WHO Africa stresses that UHC depends on the performance of the health system: 'A country is only able to provide the essential health and related services its people deserve if it has a functioning health system that can provide the services as and when needed.'<sup>30</sup> Evidence shows that countries that have made significant progress towards UHC in all its dimensions, have moved towards a health system that relies predominantly on public funding from compulsory funding sources, effective pooling of resources for redistribution and cross-subsidisation.<sup>31,32</sup> UHC can only be sustainably achieved with a stronger emphasis on PHC, and human resources for health are at the heart of delivering effective PHC.<sup>33</sup>

UHC requires allocation of sufficient public resources and a well-designed domestic health financing policy. Any external funding (ODA and/or development finance) should align with the country's health system priorities and health financing policy.

<sup>28</sup> World Bank Group, PPP Legal Resource Centre website. [\[LINK\]](#) last accessed March 2020

<sup>29</sup> World Bank Group, Independent Evaluation Group (2019) Public-Private Partnerships in Health. [\[LINK\]](#)

<sup>30</sup> World Health Organization Regional Office for Africa (2017): Leave no one behind: strengthening health systems for UHC and the SDGs in Africa. Framework of actions. [\[LINK\]](#)

<sup>31</sup> WHO (2019). Financing for Universal Health Coverage: Dos and Don'ts. Health financing guidance note no 9. Conference copy. [\[LINK\]](#)

<sup>32</sup> See reviews of evidence in the WHO Commission for the Social Determinants of Health (2007) Challenging Inequality through Health Systems [\[LINK\]](#). WHO (2018) Aligning public financial management and health financing [\[LINK\]](#); World Bank (2019) High-Performance health financing Universal Health Coverage. Executive Summary [\[LINK\]](#), full report [\[LINK\]](#)

<sup>33</sup> WHO and UNICEF (2018). A vision for primary health care in the 21st century: towards universal health coverage. [\[LINK\]](#)

#### BOX 4 – Universal health coverage (UHC)

UHC means that **all people** can use the promotive, preventive, curative, rehabilitative and palliative **health services they need**, of **sufficient quality** to be effective, while it is ensured that the use of these services does not expose the user to **financial hardship**.<sup>34</sup>

The term coverage in UHC refers to **three dimensions of access**, often represented as the 'UHC cube' (figure 5), that can be increased within the limits of available resources: 1) services, 2) population, and 3) financial protection.<sup>35</sup>

The pursuit of **equity** is central to UHC. Policies aimed at UHC require that their design and management specifically enable equal access across the whole population, particularly improving access of poor or otherwise disadvantaged groups (those left furthest behind).

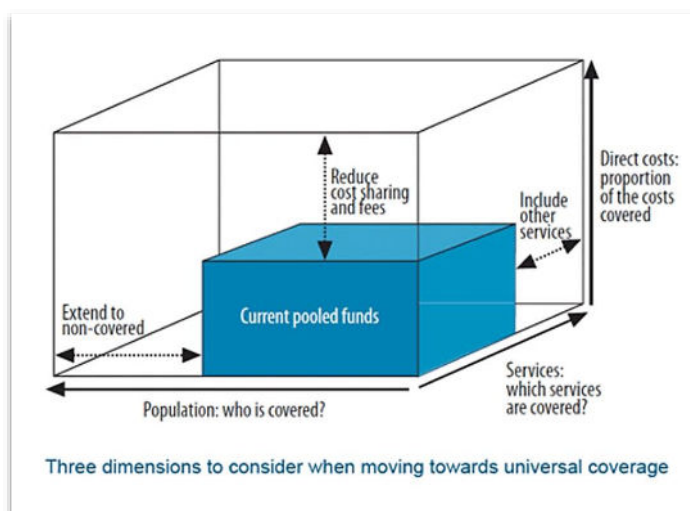


Figure 5: The [UHC cube](#), World Health Report 2010

## 2.4 PRIVATE SECTOR ENGAGEMENT POLICY IN AN EMERGING ECONOMY: KENYA

Kenya transitioned from low-income to lower-middle-income status in the last decade. Its Gross Domestic Product (GDP) rose from USD 40 billion (USD 1 million per capita) in 2010 to USD 87 billion (USD 1.7 million per capita) in 2018. Even though Kenya is often referred to as an emerging economy, poverty still affects millions of Kenyan citizens' lives. Nearly 37% of the population lives below the USD 1.90/day poverty line and there are wide inequality gaps.<sup>36</sup>

### Ambitions to improve life

Kenya's ambitions speak through [Kenya Vision 2030](#) to create 'a globally competitive and prosperous country with a high quality of life', and through the President's '[Big Four Agenda](#)' which incorporates four priority areas for development: industry, food security, universal health coverage (UHC) and affordable housing. Kenya stimulates private sector engagement in development, for instance through PPPs. Kenya has adopted the PPP Act as a legal tool to enable PPPs (see box 5).

<sup>34</sup> WHO website page on universal health coverage and health financing [\[LINK\]](#) – last visited March 2020

<sup>35</sup> WHO (2010). World Health Report 2010: Health Systems financing: The path to universal health coverage [\[LINK\]](#).

<sup>36</sup> World Bank country profile Kenya [\[LINK\]](#) - accessed December 2019; Oxfam (2017), Taxing for a more equal Kenya [\[LINK\]](#)

### BOX 5 – Kenya’s Public Private Partnership (PPP) Act

After adopting a PPP policy in 2011, the PPP Act was enacted in 2013. The PPP Act is a legal instrument for the government to involve the private sector in the financing, development, and operationalisation of public services, through government concessions and other types of contracts.

The PPP Act also defines PPPs and the institutional framework. A PPP Committee is mandated with assessing and approving PPP projects in the country. The PPP Unit, under the Cabinet Secretary for the National Treasury, functions as a centre of expertise, advising the PPP Committee and providing technical support to competent authorities (government agencies) in preparation of PPP projects.

The PPP Act was conceived to regulate PPP agreements. In 2014, the PPP Unit developed the PPP Regulations to guide the implementation of PPP projects. Because of unclarity about county governments’ possibilities to use the PPP Act, the PPP Unit also developed a PPP Amendment Bill, so as to facilitate its use by government authorities at county level.

Contracts with private companies that could be considered PPPs in the wider PPP-spectrum, such as leasing contracts for medical equipment, have thus far not been established under Kenya’s PPP Act but under public procurement law.

### What about health?

Prior to the ‘Big Four’ agenda, which includes UHC<sup>37</sup>, Kenya had shown great commitment to health for all by incorporating the legal Right to Health in its constitution.<sup>38</sup> UHC is also a priority in Kenya’s Health Policy 2014–2030.<sup>39</sup>

Although the government of Kenya made certain strides towards UHC, many challenges remain (see box 6). For instance, the budget is too tight to finance UHC and prevent impoverishing health expenditure.<sup>40</sup> According to Kenya’s Ministry of Health (MOH), this calls for an increase in public investments in health.<sup>41</sup> As a way to fill public finance gaps in health, the Kenyan government aims to mobilise resources from the private sector through innovative financing models and PPPs.<sup>42</sup>

<sup>37</sup> Kenya MOH (2018) Press release President Uhuru launches Universal Health Coverage Pilot Program [\[LINK\]](#) Note: UHC pilots were launched in four counties: Kisumu, Isiolo, Nyeri and Machakos. The government envisages to achieve UHC by adopting an insurance-based system, through the National Hospital Insurance Fund (NHIF), with subsidies for the poorest. It also stresses the importance of PHC as the most efficient and cost-effective way to organise a health system

<sup>38</sup> Kenya’s Constitution Bill of Rights (2010). [\[LINK\]](#)

<sup>39</sup> Kenya Ministry of Health (MOH) (2014) *Kenya Health Policy 2014–2030*. [\[LINK\]](#)

<sup>40</sup> KELIN and EQUINET (2018). Mapping the constitutional provisions on the right to health and the mechanisms for implementation in Kenya, [\[LINK\]](#); Chibanzi, Gitahi, and Kibani quoted in Daily Nation (2018) Road to UHC: What it will take to achieve health for all [\[LINK\]](#);

<sup>41</sup> MOH Kenya Policy Brief (2019). A Case for Increasing Public Investments in Health. [\[LINK\]](#)

<sup>42</sup> Kenya MOH (2019). Harnessing strategic partnerships and innovations for attainment of SDGs [\[LINK\]](#); Kenya MOH (2014), Ministerial Strategic & Investment Plan, July 2014 - June 2018. [\[LINK\]](#); Kenya SDG Partnership and Intellectap (2019) white paper ‘Innovative Health Financing Models for Universal Health Coverage in Kenya’ [\[LINK\]](#)

## BOX 6 - Kenya on the road to UHC

In 2013, the Kenyan government acknowledged that poverty was an important obstacle to health access. It removed user fees in PHC facilities and made maternal healthcare free at public health facilities in 2013.<sup>43</sup> Though not perfectly implemented everywhere, statistics suggest that this was an important measure in removing financial barriers to essential health services:

- Government spending for health, as a percentage of GDP, increased from 1.3% in 2000 to 2.1% in 2017.
- People's out-of-pocket spending, as a percentage of GDP, fell from 2.2% in 2000 to 1.2% in 2017; out-of-pocket spending formed nearly half (47%) of all health expenditure in 2000, while by 2017 it fell to 24%.<sup>44</sup>

While such gains are important to be noted, they are also fragile as Kenya's health system is still afflicted by inequality and underinvestment:

Access to healthcare varies greatly across regions and income groups. It is estimated that nearly 2.6 million Kenyans - over 6% of households - fell into poverty or remained poor due to out-of-pocket spending for healthcare costs in 2013.<sup>41</sup> The health delivery infrastructure (or service readiness) also shows gaps and in-country inequality<sup>45</sup>, with greater needs in Kenya's rural areas where working conditions are usually poor and health facilities struggle with stockouts and a relatively bigger shortage of healthcare professionals.

Kenya has a medical density of 1.74 doctors, nurses and midwives per 1,000 inhabitants,<sup>44</sup> which is not yet halfway to reaching the WHO recommended minimum threshold of 4.45 per 1,000 inhabitants in order to reach SDG 3 and UHC.

The government's health expenditure accounts for about 8% of the government budget, around 2% of GDP, and USD 33 per capita, according to 2017 data.<sup>46</sup> This is just over half of the government's commitment to the Abuja Agreement (stating 15% of the national budget should be allocated to health) and less than half of the internationally recommended threshold of public health spending of at least 5% of GDP and USD 86 per capita.<sup>47</sup>

## 3. METHODOLOGY OF THE STUDY

### 3.1 NATURE AND FOCUS

There is a paucity of research looking at the Dutch A&T agenda from a health perspective. Therefore, we did an explorative study ourselves, aided by consultants, aimed at understanding the depth and breadth of the use of Dutch A&T policy instruments in the healthcare context, and its implications for UHC. In looking at A&T expenditure in health, we focused on sub-Saharan Africa to narrow it down to the region where we have most interactions with CSOs in our Finance for Health work.

For a better understanding of the win-win approach Dutch A&T support, we focussed on official support for activities in the health sector where win-win is an *explicit* goal, including support for the so-called Dutch Life Sciences and Health (LSH) sector (see box 7).

<sup>43</sup> Chuma, J. and Maina, T. (2014) Free Maternal Care and Removal of User Fees at Primary-Level Facilities [\[LINK\]](#).

<sup>44</sup> WHO Global Health Observatory. [\[LINK\]](#) – last accessed in December 2019.

<sup>45</sup> Leslie et al (2017). Service Readiness of Health Facilities in Bangladesh, Haiti, Kenya, Malawi, Namibia, Nepal, Rwanda, Senegal, Uganda and the United Republic of Tanzania. Bulletin of the World Health Organization 95 (11): 738–48 [\[LINK\]](#)

<sup>46</sup> Global Health Expenditure Database, Health Expenditure Profile Kenya accessed December 2019. [\[LINK\]](#)

<sup>47</sup> Chatham House (2014). Shared Responsibilities for Health: A Coherent Global Framework for Health Financing Final Report of the Centre on Global Health Security Working Group on Health Financing [\[LINK\]](#) Also see: Wemos Fact sheet (2018): Public finance targets for UHC - [\[LINK\]](#)



### BOX 7 - The Dutch Life Sciences & Health sector and perspectives for A&T in Kenya

The Life Sciences and Health (LSH) sector refers to one of the nine top sectors for government-backed international trade promotion since 2015. Top sector policy is driven by the Ministry of Economic Affairs and implemented in part by the Minister for FTDC. The LSH sector, branded Health-Holland, represents a broad range of companies, including pharmaceuticals, medical technology, and healthcare infrastructure (see the Health-Holland guide 2017-2018 or 2020-2021).



There is official government support for the LSH top sector, including high-level diplomatic action and financial support in the form of grants, loans and export credit insurance. Support for activities in L&MICs (referred to as 'emerging markets') is part of the combined A&T agenda.

In 2015, the year that Kenya transitioned from low-income to lower-middle-income status, the Dutch LSH top sector's strategy marked out East Africa - with Kenya as its hub - as one of its focal regions. Kenya's special place from a Dutch trade relations perspective was reiterated in the mission booklets of two recent LSH trade missions to Kenya (in 2017 and 2019).

The Dutch government recently reiterated its A&T relation with Kenya while acknowledging the challenges of inequality and poverty: 'Kenya is an important partner to the Netherlands in the focus region of the Horn of Africa. Our co-operation is shifting from aid to trade. Kenya's economic prospects are reasonably good, but inequality and lack of job opportunities are problematic.'<sup>48</sup>

In the case study we zoomed in on Kenya for the following reasons:

1. Kenyan CSOs' critical questions had first prompted us to look at Dutch A&T in health.
2. Dutch A&T has a special focus on Kenya's healthcare sector (see box 7).
3. Kenya is committed to the goal of universal and equitable access to health, yet faces major challenges to achieving it (see chapter 2.4). This calls for a critical look at the development additionality<sup>49</sup> of the Dutch A&T approach.

## 3.2 MAIN QUESTIONS

We specified our study's main questions as follows:

1. To what end and to what extent are Dutch A&T instruments used in the health sector in sub-Saharan Africa, through the major financing channels of RVO, FMO, Atradius DSB, TJ/PwC and MFA?
  - a) Which A&T instruments have been used between 2015 and 2019?
  - b) For what type of activities or products?
  - c) With what primary aims and/or success indicators?
  - d) What is the relative importance of the health sector in the Dutch A&T agenda in quantitative terms (e.g. money volumes involved over time) and in qualitative terms (narratives)?

<sup>48</sup> Government of the Netherlands Development Results website, Results 2018 (published May 2019), Kenya [[LINK](#)] - website visited March 2020

<sup>49</sup> This term refers to the development impacts that arise as a result of investment that otherwise would not have occurred. In this case, one of the main rationales for partnership is that it facilitates faster, larger or better development impacts than the public or private sector would be able to achieve working alone. Source: OECD DAC (2016) Private sector engagement terminology [[LINK](#)].

2. What does an explicit win-win approach in A&T projects in healthcare look like?
  - a) What do market development activities for the Dutch LSH top sector, or any other A&T projects with an explicit win-win approach, in Kenya in recent years (2015-2019) entail?
  - b) What are the theories of change<sup>50</sup> towards health specific development gains - if described - in these A&T investments?
3. What is the impact of the use of Dutch A&T instruments in health on countries' health systems and progress towards universal and equitable access to health services (UHC, see box 4)?

### 3.3 METHODS USED

To answer these questions, we used a mix of methods: database and literature review combined with interviews in consecutive stages. The methods used differed per question (see below).

#### Question 1: A&T in health mapping exercise

For the first question we did a mapping exercise based on study of the databases of the main A&T financing channels of the Dutch government. In the databases, the level of detail and possibilities to use filters to limit down results to a certain category of expenditure varied greatly.

- For the grants managed by the RVO Development Cooperation, we consulted an [IATI database](#)
- For expenditure of government funds via FMO, we used FMO's [client database](#) and [website](#)
- For Atradius DSB we looked at the [yearly reports of realised export credit insurances \(ECIs\)](#) and the [DGGF website](#)
- For TripleJump/PwC DGGF we used their [5-year report](#) (2019)
- The Dutch government's ODA expenditure is reported in the [openaidNL IATI website](#)

In the mentioned RVO IATI database a more systematic search and an analysis over time were possible, as opposed to the other databases and online sources. In the RVO database all projects are supported with A&T funds, and by using filters we could narrow down results to A&T projects in the health sector and countries in sub-Saharan Africa.<sup>51,52</sup> This data set allowed us to do some quantitative analysis to complement qualitative analysis. We did two mapping exercises on all A&T projects registered in the RVO database to assess changes over time: 1) in March 2018<sup>53</sup> and 2) in March 2020.

We did specific searches in the other sources of information listed above. However, it proved to be impossible to systematically narrow down expenditure to 'A&T' or 'health sector' or the combination of both, as we did in the RVO database. Instead, we scanned for relevant projects by using search terms (such as health, health sector and medical services) or scrolling through the online sources manually. While we

<sup>50</sup> Dutch development cooperation policy prescribes working with a theory of change [\[LINK\]](#)

<sup>51</sup> In the RVO database each project carries a so-called sector tag. 14 out of 150 sector tags relate to the health sector. These are: Basic health care, Basic health infrastructure, Health education, Health personnel, Health policy and administrative management, Infectious disease control, Malaria control, Medical education/training, Medical research, Medical services, Pharmaceutical production, Reproductive health care, STD control including HIV/aids, and Tuberculosis control.

<sup>52</sup> When looking for a specific project in healthcare in Kenya, we found that yet another tag was used: Research/scientific institutions. Thus there might be a under-estimation in our A&T in health mapping exercise.

<sup>53</sup> We did this first part of the mapping exercise with SOMO (Centre for Research on Multinational Corporations), SOMO Services (2018). Mapping Nederlandse 'Aid for Trade' in de gezondheidszorg in Sub Sahara Afrika (2018). (Not published, available upon request)

were able to get a fair picture of the breadth and depth of A&T in health through these financing channels, it is not as detailed as the picture about the first financing channel (RVO).

## Question 2: Case study on explicit win-win approach in health in Kenya

In the first round of the mapping exercise in the RVO IATI database we found a category of projects aimed explicitly at market opportunities and an increased role for the Dutch LSH top sector in a country's health sector. We labelled this category as market development for Dutch LSH enterprises, 'LSH market development' for short. Taking this set of RVO-managed projects as a point of departure we conducted a case study to get a better understanding of these activities and their theories of change; all in the Kenyan healthcare context. The largest part of this case study was conducted in collaboration with a consultant from Public Health Consultants Netherlands (PHC-NL)<sup>54</sup> and the Kenya Medical Practitioners, Pharmacists and Dentists Union (KMPDU). We studied project documentation, did field visits and spoke to the projects' stakeholders (Dutch government agencies, companies and non-profit organisations), Kenyan government representatives, health CSOs and professionals' organisations. See annex 1 for more details.

## Question 3: Impact on health systems and UHC

For the question on impact, we reviewed available impact assessments or evaluations of A&T expenditure in the healthcare context.

## Discussion: Literature review and stakeholder consultations

To further analyse and discuss the findings in answer to our study questions, we sought insights from the following sources:

- Interviews and consultations with Kenyan CSOs, organisations of health professionals, academic organisations, government representatives and companies (the mentioned case study on explicit win-win approach in healthcare in Kenya; see annex 1).
- Consultations with African CSOs during meetings, for instance in Kenya in May 2018 (35 organisations), and in Morocco in June 2019 (20 organisations), where we discussed results of our study.
- A literature review.

In light of the assessed or potential impact of the found A&T projects on UHC, we were especially interested in the impact on countries' capacity to progress towards UHC in all its dimensions, including financial protection and improving health access for the furthest left behind. Enhancing countries' own capacity to progress towards sustainable development results is part of the principles for effectiveness in development cooperation. Other principles are country ownership, untying of aid, and accountability according to democratic structures.

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<sup>54</sup> Horstman (2019), *Dutch ODA support for Dutch business in Kenyan healthcare*. A qualitative assessment of its impact on the health system. Not published. Any requests for the report should be addressed to: [info@wemos.nl](mailto:info@wemos.nl)

## 4. FINDINGS REGARDING THE DEPTH AND BREADTH OF DUTCH AID & TRADE IN HEALTH

### 4.1 CHARACTERISTICS OF RECENT A&T EXPENDITURE IN HEALTHCARE IN SUB-SAHARAN AFRICA

In this section we report what we found in our search through the online databases of the five A&T financing channels introduced in chapter 2.1: RVO, FMO, Atradius DSB, TJ/PwC and MFA. These findings answer our first question:

To what end and to what extent have Dutch A&T instruments been used in the health sector in sub-Saharan Africa in recent years (2015-2019)? by addressing the five sub questions:

- a) Which A&T instruments have been used between 2015 and 2019?
- b) For what type of activities or products?
- c) With what primary aims and/or success indicators?
- d) What is the relative importance of the health sector in the Dutch A&T agenda in quantitative terms (e.g. money volumes involved over time) and in qualitative terms (narratives)?

They also address the first part of our second case study question (2a):

What do market development activities for the Dutch LSH top sector in Kenya, or any other A&T projects with an explicit win-win approach entail?

These findings are placed in orange highlight boxes near the respective financing channels.

#### 1. Netherlands Enterprise Agency (RVO)

##### a) *A&T instruments used in health*

Since 2015, a wide variety of RVO-managed A&T grant instruments has been used in health: 12 out of 33 grant instruments.<sup>55</sup> Two of these are specifically designed for health. The others are designed for other sectors (agriculture and infrastructure) or for general business strengthening.

- 2 PPP funds are dedicated to health: the Life Sciences & Health for Development (LS&H4D) fund and the Product Development Partnerships fund III (PDP-III).
- 4 funds dedicated to other sectors: agriculture (FDOV), and public infrastructure (ORIO, DRIVE, and D2B).
- 6 instruments for generic business strengthening instruments: for general private sector or market development (e.g. PSI, PSD toolkit, LED, DGGF-TA), and start-up funds for Dutch companies (DHI, DHK).

##### b) *Type of activities or products*

Based on an analysis of the project descriptions, the project activities could be categorised as follows:

1. **Health product development**, i.e. vaccines, drugs and technology (PDPIII, LS&H4D). The PDPIII projects concerned large, multi-country partnerships, and thus represent many more sub-projects when looking at country level. Projects in this category had medium sized budgets (above EUR 100,000) and large budgets (above EUR 1 million).
2. **Health insurance development**, creation of community insurance schemes for health and agriculture (via FDOV), few but large budget projects.

<sup>55</sup> Some of the RVO-managed grant instruments are not open for new applications anymore

3. **eHealth solutions** (LS&H4D, DGGF-TA), including digitalisation projects for better health data systems for providers, users and financier, and telemedicine (patient services and health education), involving medium budgets. In this category we also see a multi-country technical assistance project 'Preparing for Data driven healthcare in Sub-Saharan Africa' which does not carry a budget.
4. **Infrastructure development for health facilities** (via ORIO, DRIVE, D2B, PSI), most often including construction works and/or transactions/services in medical equipment (instalment, upgrades, services, IT-connectivity, training, and maintenance. Projects have large, multi-million budgets of ODA funds. See our [discussion paper \(2019\)](#) 'Best value for public money?' for an example of an ORIO project in healthcare, in Tanzania.
5. **Development of health SMEs**, start-up grants or professionalisation support for local clinics, pharmacies or other entrepreneurs (via LS&H4D and FDOV). A few projects with small to medium budgets.
6. **Market development for LSH enterprises**, where LSH refers to the Dutch 'life sciences and health' top sector. Activities are performed for individual companies (DHI, DHK) or the LSH sector as a whole (PSD toolkit, LED). It concerns a large number of projects with small budgets (below EUR 50,000). See box 8 for more information on this particular category of project activities in the Kenyan context.

### c) *Primary aims and/or success indicators*

As to the progress or success indicators of the RVO-managed projects, there is no information in the database other than a general indication of the SDG or SDGs the project contributes to.<sup>56</sup>

- There is a marked lack of information in the RVO IATI database regarding output and outcome indicators.
- The SDG labels were recently attached to already running projects.

The health funds (PDPIII and LS&H4D) aim to contribute to SDG3 (Health). The other RVO-managed A&T instruments, although applied in health, were generally aimed at SDG8 (Economic growth/decent work), sometimes in combination with SDG9 (Infrastructure/industry innovation) and SDG17 (Partnerships).

### d) *Relative importance of the healthcare sector*

A relatively small number of RVO-managed A&T projects in sub-Saharan Africa takes place in health (3%). However, the volume of ODA money involved in these projects is quite significant (21% of total RVO A&T portfolio) and increased in relative terms in the past two years:

- In March 2018, 35 out of 1800 projects (2%) of RVO-managed A&T projects carried a health-related sector tag, while in March 2020 this was 108 out of 3105 projects (3%).<sup>51</sup>
- In March 2018, 17% of the total volume of grants spent in sub-Saharan Africa was spent in the healthcare context (EUR 160 million out of EUR 940 million). This figure had risen to 21% (EUR 200 million out of 962 million), when we repeated the mapping exercise two years later.

<sup>56</sup> We have noted a significant design change in RVO's IATI database since our second A&T/H mapping study 2020. In our earlier studies –first A&T/H mapping exercise (2018) and A&T case study on ORIO in Tanzania (2019) – this database did not show SDG-labels but 'output' indicators for the projects, and if possible also 'outcome' indicators (such as number of jobs realised). The database reported on these indicators as the projects progressed. Output indicators were of generic nature (number of contracts realised for Dutch or for local companies, amount of co-funding leveraged (from recipient governments or private parties)) and sector specific nature (e.g. number of hospitals provided with medical equipment).

#### BOX 8: RVO-managed grants for market development in Kenya for Dutch LSH enterprises

A closer look at the activities for market development of Dutch LSH enterprises (category 6) in Kenyan healthcare shows that RVO-managed ODA grant instruments are used for individual financial start-up support, general promotional support, and business climate support with a special focus on the fast realisation of health PPPs:

Via the fund for 'Demonstration projects, feasibility studies and investment preparation studies' (DHI) two Dutch companies got **individual financial start-up support**.

- Symax got funding to prove the efficiency of a new technology for mobile malaria labs (2017)
- Elevate for a feasibility study on the best financial model for online courses for health professionals (2019)

Via the PSD toolkit the Dutch LSH sector as a whole got **general promotional support** in two ways:

- The Taskforce Healthcare (TFHC) performed a market study, which is published in an online report '*Kenyan Healthcare sector: Opportunities for Dutch Life Sciences & Health Sector*' (2016)<sup>4</sup>
- The TFHC, in conjunction with the Dutch Ministry of Health, organised and guided a trade mission to Kenya to facilitate learning and match-making, described in online articles (2017)<sup>6</sup>

Via the PSD toolkit the Dutch LSH sector as a whole also got '**business climate**' support with a special focus on the **fast realisation of health PPPs** in Kenyan counties:

- Mannion Daniels, in conjunction with Advise & Action, did a scoping study for a technical assistance (TA) project called 'PPP in LS&H sector Kenya' (report published in 2017)<sup>57</sup>
- Following the scoping study, Rebel Group performed a capacity building project in Kenya's Isiolo County to facilitate a proof-of-concept for health PPPs or public-private collaborations (2019)

A quote that illustrates the explicit win-win approach:

*'The goal of the project is to conduct a market study to identify Dutch business opportunities in the medical sector in Kenya and contribute through Dutch expertise in the longer run to the development of this sector in Kenya.'*<sup>58</sup>

Please note:

- In all these activities, the involved amounts of ODA money are small (below EUR 50,000).
- Only the funds for individual Dutch companies, via DHI, are registered as tied aid.
- The acting agencies listed above are beneficiaries of the DHI funds or implementing agencies of work commissioned by the Dutch Embassy in Nairobi (PSD toolkit); all - except the TFHC - are private firms.
- The TFHC is a membership organisation funded in 1996. It provides a collaborative platform for activities in health for Dutch companies, research centres, NGOs, healthcare providers and Dutch government institutions. The TFHC plays an important role in the promotion of the Dutch LSH top sector by providing services, including match-making events (such as seminars, workshops and the annual World of Health Care conference), information, market research and outgoing trade missions, incoming trade visits, and representation and lobby towards the Dutch government.

<sup>57</sup> Advise & Action and Mannion Daniels (2017). *Scoping Study: Technical Assistance Project for Public Private Partnerships in the Health Sector*. Received upon request by email from Dutch Foreign Ministry, 12 December 2019.

<sup>58</sup> RVO IATI database, project Business opportunities in the Medical/Health Care Services and Infrastructure sector in Kenya [[LINK](#)] – visited March 2020

## 2. Entrepreneurial Development Bank (FMO)

### a) *A&T instruments used in health*

Since 2015, FMO has financed development undertakings in the healthcare sector through:

- Equity investments in financial intermediary funds with a development mission, which in turn serve local SMEs with a diversity of equity and loan products.
- Loans or repayable grants via the government's NL Business Development Accelerator fund.

### b) *Type of activities or products*

Investments in intermediary funds are reinvested in: 1) private health insurances, ranging from small scale community health plans to larger commercial health insurances, and 2) private health facilities, ranging from small community clinics and pharmacies to larger private hospitals.

- In 2015 FMO invested EUR 200,000 (from government fund MASSIF) in the Global Partnerships Fund. This fund is a social impact investor in enterprises around the world. Health is one of the three opportunity areas. In Kenya it invests for instance in Penda Health clinics.
- In 2015 FMO reinvested EUR 24 million (from its own funds) in the second replenishment of the Investment Fund for Health in Africa (IFHA-II), in which it had already invested in 2008, as an anchor investor.<sup>59</sup> The IFHA portfolio includes insurance schemes such as CarePay, Hygeia Lagoon and AAR Insurance, private clinics and hospitals such as Hygeia Lagoon, CLM Clinics, and AAR clinics, and medical commodities and digitalisation via Trivitron Healthcare Africa.

The *NL Business Development Accelerator* fund, specifically aimed to support Dutch business in early phase projects in emerging markets, has served health facility infrastructure development projects in Africa, in particular via PPPs:

- EUR 200,000 for a pilot and EUR 1 million for a scale up project of the Partnership for Primary Care (P4PC) in Kenya in 2018. See box 9 for more information on FMO support for this particular project in the Kenyan context. See section 4.2.3 for more information on the theory of change of P4PC.
- EUR 1 million in 2019, to a trust fund for facilitation of PPP projects with Dutch companies in healthcare and water in Africa, managed by the World Bank's International Finance Corporation (IFC).
- EUR 0.6 million FMO co-financed construction of a referral hospital in Rwanda (Dutch Health, 2019).
- EUR 0.8 million for infrastructural upgrades for multiple health facilities at PHC level in the Republic of Congo (Royal Philips and UNFPA, 2020).

### c) *Primary aims and/or success indicators*

Traditionally, FMO only assesses the *financial* sustainability and additionality of investments, plus compliance with international Environmental, Social and Governance standards. In 2017, FMO developed a strategy to evaluate development impact, taking into account the SDGs and particularly SDG 8 (Economic growth/jobs), SDG10 (Climate) and 13 (Inequalities).

As of yet FMO does not have a health-specific (SDG3/UHC) impact evaluation framework for investments in health. The relatively new partnership projects in health state aims for better health, quality health services and UHC, but information about the indicators measured or to be measured is not publicly available.

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<sup>59</sup> As an anchor investor FMO gave the start of the IFHA a boost, raising confidence among other investors (in the world). Other Dutch investors in IFHA are: the DGGF, Social Investor Foundation for Africa (SIFA contributors include: ACHMEA, AEGON, Heineken, Shell, SNS-REAAAL and Unilever), Pensioenfond ABP, and Achmea Pensioen- en Levensverzekeringen, according to the IFHA website – visited March 2020



The intermediary funds for investments in health use indicators for financial outcomes, such as return on investment, and numerical outputs related to healthcare infrastructure such as the number of hospital beds.

#### **d) Relative importance of the healthcare sector**

While health has not among FMO's key focus sectors thus far, the recent investments in health indicate that it may become one soon, and so do the following recent partnership agreements of FMO:

- In December 2018 the *NL Business* director explained that FMO's Dutch Business department is developing a 'health strategy for deploying development capital'.
- When announcing the investment in the IFC PPP Trust Fund in April 2019, FMO stated healthcare to be one of two sectors of advanced expertise of The Netherlands.
- In November 2019, FMO and the TFHC signed a partnership agreement to speed up funding for healthcare projects in emerging economies. They published an overview of official financing instruments, provided through the RVO, the FMO and Atradius, that are currently available to Dutch companies for their projects in healthcare (differentiated by project cycle).<sup>60</sup>

#### **BOX 9: FMO's *NL Business Development Accelerator* for Dutch enterprises in healthcare Kenya**

The first financing agreements of the NL Business Development Accelerator Fund, which is dedicated to Dutch business in L&MICs, were for the health sector. In the Kenyan healthcare context it concerned the Partnership for Primary Care (P4PC) between a private consortium and Makueni county government.

P4PC is a health business and financing model. It is a public private collaboration in health in which the county government outsources specific responsibilities for its public primary care system to a private consortium of Royal Philips, a multinational company headquartered in the Netherlands, and Amref Health Africa through its subsidiary Amref Enterprises Ltd. For a description of the distinct roles of these partners, see section 4.2.3.

According to its Development Accelerator case study report (2019), FMO as co-developer focuses on the bankability of the P4PC project, reiterating that P4PC should 'demonstrate that the outsourcing of the management of public primary healthcare system to the private sector leads to better health results'.

FMO provides **co-finance**, next to Philips foundation, and plays an **advisory role** in the project development:

- In 2018, FMO supplied two tranches of funding (EUR 1.2 million in total) for the business planning, feasibility study and preparation for scale-up of the P4PC-project.
- The ambition of P4PC for its financial model: start with grant funding, then move to blended funding during scale up, to ultimately transition to commercial funding.<sup>61</sup>
- FMO played an advisory role drawing from its legal and business expertise. Other external advisors included consultancy firms by Accenture, Rebel Group and Intellectap.

A quote that illustrates the explicit win-win approach:

*'The arrangement aims to bring business opportunities to the market that are relevant for the Dutch private sector and at the same time create development impact in emerging markets.'*<sup>62</sup>

Please note:

- FMO funding was provided in the form of a repayable grant, where the repayment is dependent on whether the project can successfully go to scale.

<sup>60</sup> TFHC (2020). Overzicht financieringsinstrumenten ['Overview of financing instruments']. In: Presentation of online slides 'Ondersteuning bij internationaal zakendoen' ['Support for business abroad']. In Dutch only [LINK]

<sup>61</sup> Amref, Government of Makueni, Philips Partnership for Primary Care website [LINK] – visited January 2020; Amref, Philips, Accenture (Brochure May 2018) Partnership for Primary Care Business Plan.

<sup>62</sup> FMO website (2019), IFC and FMO's NL Business partner up to promote water and health PPPs [LINK] – visited March 2020

- Many organisations, including FMO, refer to P4PC as a PPP, even though it is not a long-term contract with Makueni county as yet. Philips emphasised that the P4PC model is not an official PPP until it becomes one under Kenya's PPP law (described in box 5), and views P4PC as a model with the 'potential to be the first public-private partnership for primary care'. According to the World Bank's definition (see box 2), P4PC would be regarded a PPP if the outsourcing concerned a longer term contract, among others.

### 3. Atradius Dutch State Business (ADSB)

#### **a) A&T instruments used in health**

In recent years ADSB has been issuing export credit insurances (ECIs) with a guarantee from the Dutch government, for exports to DGGF countries relevant to healthcare.

#### **b) Type of activities or products**

Through ECIs the government invests in market development for Dutch LSH companies. Examples are:

- The DGGF ECI facility has provided insurances for the export of ambulances to Mali in 2016 (maximum liability nearly EUR 3 million) through ADSB.
- ADSB provided a credit insurance for the export of medical equipment to Tanzania, the premium of which (EUR 0.5 million) was paid from the ODA grant facility ORIO (managed by the RVO) and the maximum liability of the insurance was EUR 15 million.

#### **c) Primary aims and/or success indicators**

The government guarantees through ECIs in the context of the health sector may be evaluated on impact, but not specifically on health impact.

- The insurance policy issued via the DGGF facility states an intended impact on 'job creation' (with a specification of how jobs are expected to be created) and lists 'better healthcare for the population' among the secondary effects.
- The other insurance policy only stated a 'no harm' check: 'the project has minimal or no potentially adverse environmental and/or social effects.'

#### **d) Relative importance of the healthcare sector**

We cannot assess the magnitude of government guaranteed ECIs in the health sector, because we have not systematically reviewed the ADSB's database of policy covers of exports to Africa.

### 4. Triple Jump/PricewaterhouseCoopers consortium (TJ/PwC) for DGGF

#### **a) A&T instruments used in health**

The TJ/PwC consortium, managing the government's DGGF Investment Fund for local SMEs, has been investing indirectly in the health sector in sub-Saharan Africa through equity and seed capital for intermediary funds. For instance:

- In 2015 the DGGF participated in the second replenishment of the Investment Fund for Health in Africa (IFHA-II) with an amount of EUR 10.5 million. See the earlier description under FMO.
- In 2016 the DGGF provided seed capital and technical assistance to Vakayi Capital Zimbabwe, that invests in a number of sectors, including healthcare.

### **b) Type of activities or products**

These intermediary funds, through diverse products, invest in small, medium and large private enterprises in 1) health insurances, 2) healthcare facilities, 3) medical commodities, and 4) digitalisation products.

- IFHA: see earlier description under FMO.
- Vikaya Capital Zimbabwe invests in health insurance schemes and healthcare facilities in smaller towns, particularly in the area of diagnostics and eye care.

### **c) Primary aims and/or success indicators**

The DGGF's aim to invest in local SMEs and create jobs is translated in outcome indicators, but does not include health-related indicators. Note, however, that the reinvested EUR 10.5 million, through the IFHA, also includes larger enterprises in private health insurance and health service delivery.

### **d) Relative importance of the healthcare sector**

Investments via the DGGF in health represent a relatively small proportion of the overall investment portfolio. There is no indication that the DGGF investment fund is going to expand in the health sector.

## **5. Dutch Ministry of Foreign Affairs (MFA)**

### **a) A&T instruments used in health**

The MFA department of Sustainable Economic Development itself manages a number of A&T grants, among which two are important for the health sector<sup>63</sup>:

- the Health Insurance Fund
- the Kenya SDG Partnership Platform

### **b) Type of activities or products**

The Health Insurance Fund invests in 1) private health insurances, 2) private health SMEs, and 3) digital health solutions.

- The Health Insurance Fund (HIF) was created in 2006 as a vehicle for development cooperation activities of PharmAccess Foundation. PharmAccess activities have been concentrated in four African countries, providing insurance schemes, technology to facilitate health payments (mHealth) and data exchange, finance to health SMEs (Medical Credit Fund), and quality improvement with the SafeCare programme. PharmAccess has a spin-off technology company CarePay Ltd (headquartered in the Netherlands), with its first health insurance subsidiary, m-Tiba, registered in Kenya. Via the HIF, the MFA donated an extra grant of EUR 25 million to CarePay in 2017. CarePay/m-Tiba is a private 'health wallet', an application that operates on a mobile phone through which participants can save, receive and spend money for healthcare only. The total of ODA grants to the HIF, including the special grant for CarePay, since 2015 is EUR 100 million, amounting to over EUR 200 million since 2006.

Funds for the Kenya SDG Partnership Platform (SDGPP) are used for the facilitation of health PPPs.

- The SDGPP is a collaborative platform for representatives from business and Kenyan central and county governments, with an explicit win-win approach: accelerating attainment of SDG3/UHC in Kenya while

<sup>63</sup> We learned that these funds are considered part of A&T through communications with Dutch government staff (at the MFA DDE department and the Embassy in Nairobi Kenya) during our case study (end of 2018). We saw this fact confirmed in the Ministry's official communications through its development results website (regarding the SDGPP) and in the FTDC Minister's 2019 letter to Parliament (regarding the official A&T evaluation).

growing Kenya's health market for private investment. See box 10 for more information on this particular project in the Kenyan context.

**c) Primary aims and/or success indicators**

The HIF has a number of objectives that include UHC (healthcare access, quality, and insurance coverage), primarily focussed on private healthcare and health insurance. These are regularly studied by researchers in an institute liaised to PharmAccess (AIGHD). The MFA commissioned a formal evaluation of the HIF to the Boston Consultancy Group in 2015.

The SDGPP will be evaluated on its primary policy markers which partly relate to health. They are 'Reproductive, Maternal, Neonatal and Child Health', 'Gender equality' and 'Trade development'.

**d) Relative importance of the healthcare sector**

The fact that the Health Insurance Fund is described as the Ministry's 'flagship fund for UHC in Africa' and has received relatively large amounts of government support indicates that health and UHC are considered important, and healthcare an important sector. It is especially the private healthcare sector and private, voluntary insurance that is strengthened with this fund.



Photo by Vitaly Taranov via Unsplash

#### BOX 10: The Dutch MFA's funds for the Kenya SDG Partnership Platform

##### *Founders and funders*

The Kenya SDG Partnership Platform (SDGPP) was set up by the Kenyan government, in collaboration with the United Nations (UN) in Kenya and the private sector, and launched in September 2017 during the UN General Assembly.

The SDGPP is funded via the United Nations Development Programme's (UNDP) multi-partner trust fund – a fund that blends contributions from different donors. The Dutch MFA was the first (and thus far only) governmental donor contributing to the SDGPP (EUR 300,000 in 2017 and EUR 200,000 in 2019, equalling USD 590,658 in total), next to the first private donor Royal Philips (USD 750,000 in total). These first contributions were followed by AstraZeneca, Merck&Co, and Rockefeller Foundation (USD 800,000 in total).

Philips was in fact also the first to communicate a vision and ambition with regard to the SDGPP well before its launch (Philips news center, 2017; TFHC website, 2017). Building on the experience with its Community Life Centre model in Kiambu and Mandera counties (2014 and 2017), Philips strives to engage in PPPs aimed at improving primary care.

##### *Aims and focus*

According to the UNDP factsheet, the SDGPP aims to **identify and broker large scale PPPs** for Kenya's 'big four' SDG themes. The first focus of the SDGPP is on SDG3.8 (UHC), and specifically on **primary healthcare**. It is called the PHC Accelerator window. Joint activities focus on:

- Enhancing legislation, policy and governance for optimisation of public-private collaboration.
- Innovative financing and business models to increase private sector engagement in PHC.
- Promising technical solutions to enhance PHC.

A quote that illustrates the explicit win-win approach:

*'[the SDGPP] was officially launched with the purpose of facilitating the involvement of the private sector in realising the SDGs through public-private partnerships (PPP) and innovative financing models.'*<sup>64</sup>

Please note:

- According to Dutch Embassy staff interviewed in the case study, the Dutch government's ambition in the SDGPP is for Dutch companies to get involved in health PPPs.
- It was the SDGPP that had requested the Dutch Embassy to commission and fund the scoping study 'PPP in LS&H sector Kenya'<sup>57</sup> listed in box 8.

## 4.2 ZOOMING IN ON THE THEORIES OF CHANGE OF AN EXPLICIT WIN-WIN APPROACH IN HEALTH IN KENYA

The previous section showed a wide array of recent Dutch A&T support in the healthcare context of sub-Saharan Africa. It also answered case study question 2a as to what market development activities for the Dutch LSH top sector in Kenya entail.

In summary, we found three subsets of activities that are supported with A&T funds and finance:

1) **financial start-up support** for individual Dutch companies' feasibility studies with a view on selling a specific product or service

<sup>64</sup> Dutch government, MFA (2019), Development results in 2018 [[LINK](#)]

2) **promotional support for the Dutch LSH top sector as a whole** through the publication of a market study report and two dedicated trade missions, and

3) a mix of **financial, advisory and brokering support for the fast realisation of primary healthcare PPPs** in which Dutch companies are to play a significant role.

Now this section will zoom in on our findings with regard to the second case study question (2b): [What are the theories of change<sup>50</sup> towards health specific development gains – if described - in these A&T investments?](#)

We answer this question for each of the subsets of activities, based on our study of available project documentation, supplemented by clarifying notes from the stakeholder interviews (see table 1 in the annex).

### 1. Financial start-up support for individual Dutch companies

For the two cases of DHI grants to individual Dutch LSH companies for demonstration projects in Kenya (see box 8), we investigated the DHI fund's 16 eligibility criteria. Nearly all criteria focus on characteristics of the Dutch SME itself and on the need for a subsidy (financial additionality). Only one of the 16 criteria asks the company to self-motivate how its product or service will contribute to development.

Criteria for the assessment of the development gains - health related or other - as well as the theory of change about how they will be reached, are missing.

### 2. Promotional support for the Dutch LSH top sector as a whole

Before going into our findings regarding the theory of change towards health or UHC related outcomes, first a note on the promotional support itself.

As listed in box 8, via the PSD toolkit the Dutch government promoted the Dutch LSH sector through dedicated trade missions to Kenya in 2017 and 2019. Moreover, the glossy report of the market study (2016)<sup>4</sup>, next to describing the market opportunities for Dutch companies in Kenya's healthcare market, provides ample information about Dutch expertise, products and services in 1) medical devices and supply chain solutions, 2) eHealth, 3) training, 4) hospital build, and 5) health financing solutions (including insurances and digital services). Therefore, it can easily be seen as a promotional product.

As to the gains for development, the report sometimes describes market opportunities or commercial demand as a 'need'. For instance: *'as the middle class is becoming larger, the need for investments in healthcare facilities is present'*. The win-win mechanism is also described as a match between that which the Dutch LSH top sector offers and what Kenya needs or should 'harness' to accelerate health system development, especially in terms of (mobile) technology. The booklets for the LSH trade missions to Kenya in 2017 and 2019 phrase this match as follows:

- The Netherlands 'has a unique position in offering integrated healthcare solutions. The growth and investment in the healthcare sector creates opportunities for interesting and innovative partnerships. Governments will remain key players. Yet, in order to keep healthcare accessible, affordable and innovative it is crucial to cooperate with knowledge institutes and private businesses.'
- Kenya: '...has at its disposal multiple innovations that were not evident or possible for developed economies. Leapfrogging, or taking innovative shortcuts that are cost-effective, scalable and easily accelerated, is the way to achieve an 'ideal' health system. Kenya now has an excellent opportunity



under its Big 4 Health pillar to work towards realizing its ambition of achieving 100% universal access to health by 2022. Such a bold goal requires strong partnerships and innovative approaches. (...)'.<sup>65</sup>

Both the mission booklets and the market study report fail to provide an evidence-based theory of change. They do not define which commercial activities can (or *cannot*) be expected to contribute to the country's progress towards an accessible and affordable health system, and how development impact is going to be monitored. A theory of change vis-a-vis health and UHC is, in effect, missing.

### 3. Support for the fast realisation of PPPs in primary healthcare

When it comes to primary care level health PPPs in Kenya with an envisaged partner-role for Dutch companies (box 8, 9 and 10), there is direct reference to health and UHC. And also to the importance of strengthening primary healthcare (PHC) or 'primary care level services' in Kenya's counties. The report of the scoping study for technical assistance for health PPPs (2017)<sup>57</sup> explains this as follows: '*(...) enhancing for profit providers and investors in joining the government's efforts to deploy quality, sustainable and integrated care services close to the populations who need those most, to reach the SDGs and make universal health care a reality*'.

In the same report, however, we could not find an evidence-based explanation of the assumption that primary care services in Kenya would best be strengthened through PPPs or other collaborations with the private sector. The report mainly describes *how* (not *why*) to speed up the process of realising PPPs at county level. It considers hurdles of 'complex and time-consuming steps and measures prescribed by Kenya's PPP Act' that are apparently experienced by interested parties. We also could not find an evidence-based explanation in online FMO sources of why Dutch business opportunity and development impact in healthcare PPPs would go hand in hand.

The Kenya SDG Partnership Platform clarified the benefits for the public and for the private (for-profit) sector in its brochure (2019)<sup>66</sup> in a more elaborate way. Next to accelerating access to PHC, it includes increased investments by private companies and reduced reliance on government and donor funding as public benefits. For the private sector it highlights growing the market for healthcare in Kenya for private investment and creating a replicable model for other countries across the African continent. However, it does not describe *how* such models would reduce reliance on government funds and *how* that promotes universal access to primary healthcare. An evidence-based theory of change misses. See screenshot of the public and private sector benefits below.

<sup>65</sup> Mission booklet *Netherlands Economic Mission to Kenya and Ethiopia*, 1-5 July 2019 [\[LINK\]](#); Mission booklet *Netherlands Economic Mission to Kenya*, 18-21 April 2017 [\[LINK\]](#)

<sup>66</sup> SDG Partnership Platform brochure, UN Kenya (2019) [\[LINK\]](#)



Through the public-private partnerships and the work of the SDG3 Primary Healthcare Accelerator Window:

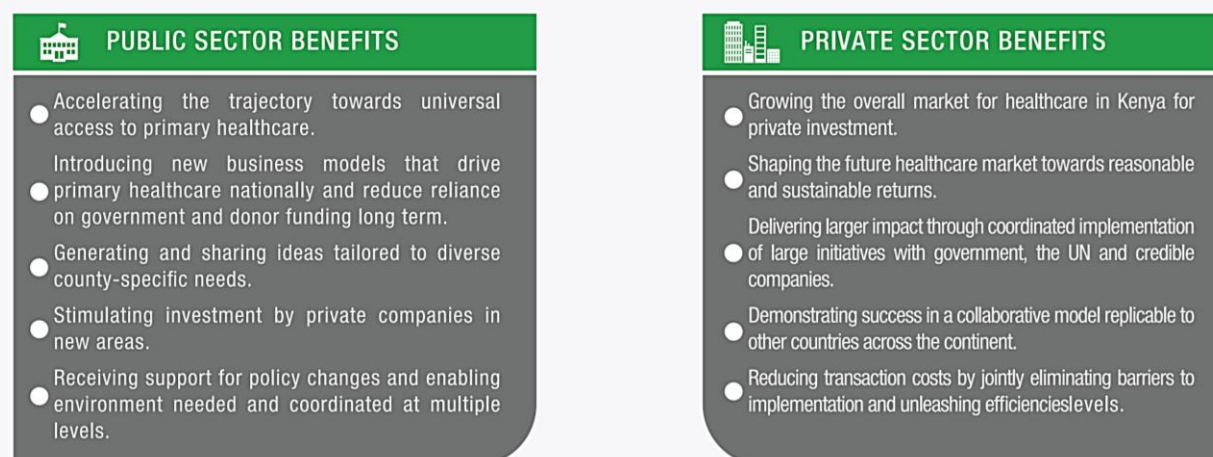


Figure 6: Benefits of PPPs for the public and private sector as described in the [brochure](#) of the Kenya SDG Partnership Platform (2019)

The list of mutual benefits quoted from the Kenya SDGPP is not only lacking an evidence-based argumentation regarding the development gains, it is also not clear from the brochure how the private companies would create a market, generate a return (a profit) and improve access to PHC at the same time. The Partners for Primary Care (P4PC) project in Makueni county, however gives more insight into this question.

The Makueni P4PC model, the feasibility study of which was co-financed by FMO (see box 9 on page 23), gives an idea of both the (financial) business model and expectations on how it will contribute to health and the public health system, should it become a PPP.<sup>67</sup>

The (financial) business model would roughly be as follows according to Philips<sup>68</sup>:

- The private consortium of Philips and Amref would form a new company – a Special Purpose Vehicle (SPV) - to get into a PPP contract with Makueni county, agreed under Kenya's PPP law. The SPV would provide four services under the PPP-contract:
  - Making the community health units fully functional through recruitment, training, tooling and oversight management.
  - Upgrading selected primary care facilities with improved infrastructure, equipment and furniture, including the responsibility for maintenance and replacement of all equipment.
  - Cluster management aimed at making a primary care cluster (facilities and community health units) perform optimally through a process of ongoing performance management and improvement, working with the facility staff, county government, social health insurance (NHIF Supa Cover) and other relevant stakeholders.
  - Rollout of social health insurance,<sup>69</sup> and improvement of the claims process.

<sup>67</sup> Philips, in verbal clarifications on 5 October 2020, explained that the P4PC feasibility study (also known as the P4PC pilot) ended in January 2020. And that a proposal for an official, longer term (12 year) PPP has been submitted to the Makueni county government.

<sup>68</sup> Correspondence and verbal clarifications (October 2020)

<sup>69</sup> For rollout of the social health insurance Amref involves the community health volunteers with whom it currently has an informal working relationship. This has been tried out in the P4PC feasibility study. The volunteers, normally playing their roles in health education and demand

- In return, the private consortium would generate income for itself through a county PPP fee only, while previously (in the feasibility study) also other types of fees had been considered.

The envisaged PPP fee consists of:

- A fixed base payment: a fixed fee for services of the private consortium company in the PPP contract.
- Variable components:
  - A volume-based payment, based on the number and type of PHC clinics managed and/or upgraded (infrastructural works including equipment)
  - A performance-based component: a bonus or penalty depending on performance respectively above or below certain targets. Such targets can for instance include household enrolment in the NHIF, and percentages in pregnant women receiving antenatal care and assisted delivery.
- Makueni County government retains the overall public responsibility for its primary care system and will continue to be responsible for:
  - Maintenance of the PHC clinic infrastructure;
  - Employment of personnel for PHC-facilities;
  - Supply of drugs and consumables to PHC-facilities.

The costs of these will be carried by Makueni County.

In addition, Makueni County will pay the PPP-fee to the SPV.

- In order to cover the total cost of the primary care system under the PPP-arrangement, the Makueni county government receives public revenue from the central government of Kenya, of which it allocates a share to health, it receives reimbursements from the social health insurance (NHIF) and it will receive a grant for viability gap funding in the first years of the PPP-project.

Based on available written information, we summarise the theory of change in the envisaged P4PC PPP as follows. The interventions of the private consortium would lead to:

- increased quality of and better access to care at primary level, and
- this in turn would lead to improved population health on the one hand, and financial sustainability (better cost-effectiveness) of healthcare on the other hand.

In the words of Makueni County Minister of Health (2018): *‘to significantly improve access to health care for 20,000 residents (...) this new and innovative approach of outsourcing operations of primary health clinics to non-government actors is a first of its kind model in Kenya and can revolutionise health care in Makueni, leading to positive health impact and more financially-sustainable care’*.<sup>70</sup>

In response to our question about financial sustainability and expected efficiencies, Philips clarified that an affordability calculation for the Makueni government was included in the PPP proposal<sup>67</sup>. This calculation assumes that increased use of better quality care in both the PHC clinics and in the community health units leads to a decrease in unnecessary use of care at higher levels of the public health referral system, which compensates for the calculated higher costs for primary level care as pictured in the PPP (financial) business model.<sup>71</sup>

How exactly improvements in health, access to services for all residents (leaving no one behind) without

creation (e.g. guiding pregnant women to clinic for the essential package of care), would add the role of enrolling households in the clinics’ catchment areas into the NHIF upon payment of the premium. (Source: interviews in our case study, see annex 1)

<sup>70</sup> FMO website, News item 28 June 2018 [\[LINK\]](#) – visited December 2018

<sup>71</sup> Verbal clarifications Philips (5 October 2020)

financial hazard, and how financial sustainability for the duty bearers (Makueni government and government of Kenya) and the private consortium are exactly being measured and evaluated is not clear to us, as the P4PC pilot's key evaluation questions were formulated in quite general and cost/revenue-related terms in the available documentation<sup>61</sup>.

Philips explained<sup>72</sup> that the evaluation of the pilot was based on a theory of change geared towards comprehensive health system improvements and UHC, developed ahead of the feasibility study. A copy-paste from the evaluation report says the theory of change is 'following five impact pathways:

1. Improved quality of care through enhanced facilities
2. Increased Financial Sustainability
3. Optimized Human resource for Health
4. Reduced Out of Pocket Expenditure for Patients: (Due to the COVID crisis we were not able to interview communities and evaluate this pathway) Financial risk protection is a crucial element of UHC. This item will be evaluated in a later stage
5. Improved Health Systems Governance.'<sup>72</sup>

All in all we conclude that there are UHC related theories of change underlying the (fast) realisation of PPPs in PHC in all reviewed activities with A&T support, i.e. the scoping study, the SDGPP and the P4PC pilot. However, they lack an evidence-based explanation as to how exactly PPPs would perform better and in a more cost-effective way in the interest of all, than options that would improve the public health system without the use of PPPs.

### 4.3 IMPACT ON UNIVERSAL AND EQUITABLE ACCESS TO HEALTH

To assess the impact of A&T instruments in healthcare (question 3 of our study), we looked at available impact assessments and evaluations of A&T instruments.

A systematic review of 16 evaluations of PSD programmes, including the infrastructure development grants that have been used in the health sector (ORET and ORIO), was done in 2017 by the Royal Tropical Institute in The Netherlands.<sup>73</sup> On the positive side, it concluded there was 'increased coherence within and between Aid and Trade programmes', but drew a host of more critical conclusions, including the fact that they found 'little empirical evidence about their development effects in low and middle-income countries'.

A mid-term evaluation of the PSD toolkit, including a review of 30 projects supported by Dutch Embassies through the PSD toolkit, was done in 2018 by Technopolis.<sup>74</sup> It concluded that the toolkit was highly relevant to Dutch policy priorities and Dutch business. However, it also warned that the effects in local private sector development are not evident and that 'optimal use of *one* instrument for *two* objectives proves to be challenging in practice.'

Neither of the aforementioned evaluations covered health projects, and the evaluations did not make use of a health or UHC lens.

<sup>72</sup> According to Philips (5 October 2020), the P4PC pilot was evaluated by consultancy firm [Intellectap](#) and the evaluation report was delivered in May 2020 titled 'Partnerships for Primary Care (P4PC), Project Makueni Feasibility Study, Summary of findings and recommendations'. The report is not publicly available and we did not receive the report upon request (except for the copy-pasted paragraph).

<sup>73</sup> Royal Tropical Institute (2017). Aid & Trade in Dutch Development Cooperation. [\[LINK\]](#)

<sup>74</sup> Technopolis (2018). Mid-term Review of PSD Apps programme. [\[LINK\]](#). Note: the PSD toolkit was called the PSD Apps programme from 2014-2017.

Examples of projects in healthcare infrastructure development in Zanzibar Tanzania, Ethiopia, Ghana and Nicaragua, were included in a more recent evaluation of the ORIO programme, done at the request of the Dutch MFA by Erasmus University and published in March 2020.<sup>75</sup> The evaluation concluded that financial additionality and relevance were satisfactory; the health projects related to priority issues of the (co-funding) governments in the countries, and would not have been done without the Dutch ORIO grants. Effectiveness of the projects, however, could not be assessed as results were not yet available. As described in the case study of the Zanzibar project – which involved turnkey upgrades of a referral hospital and 15 PHC units – effectiveness is also dependant on other factors. Reported bottlenecks in Zanzibar were lack of health staff, especially in the PHC units, and medical-technical staff for the operation and maintenance of the installed medical equipment in the period beyond the project period. Neither the case study project nor the other projects were evaluated on the potential impact on the government's fiscal space for health and UHC. See our [discussion paper](#) (2019) on ORIO in Tanzania Mainland for a discussion on such longer term impacts.

To our knowledge, the only A&T impact evaluation available with content related to health and UHC was performed by the Boston Consultancy Group assessing the impact of the Health Insurance Fund in 2015. This evaluation found the fund to be successful, because the number of prepayment schemes and enrolled households increased, local banks entered the health care sector, and local insurance companies entered the low-income insurance market. The latter two successes refer to economic development. Whether enrolment in voluntary prepayment schemes is a good parameter of progress towards better health and UHC, will be discussed in chapter 5.

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<sup>75</sup> Erasmus University Rotterdam (2020) Evaluation ORIO 'Ontwikkelingsrelevante Infrastructuurontwikkeling' Final report [\[LINK\]](#)

## 4.4 SUMMARY OF THE MAIN FINDINGS

*To what end and what extent are Dutch A&T instruments used in the healthcare sector in sub-Saharan Africa?*

**The Dutch Aid&Trade agenda is being effectuated in healthcare in sub Saharan Africa in significant ways.** In recent years (2015-2019), the Dutch government has been using A&T instruments including grants, loans, equity funds and guarantees, via every A&T financing channel, in the healthcare sector of sub-Saharan Africa. The relative amount of A&T ODA grants has increased over the past 5 years, and it is clear that the health sector is gaining importance in A&T financing via loans and equity funds.

**The primary A&T objectives of private sector development and business climate improvement, including through the realisation of PPPs, are also the dominant objectives in A&T expenditure in the healthcare context.** While the range of activities supported with A&T financing in healthcare is quite diverse, our analysis shows that the most important objectives are to strengthen private healthcare and health insurance and/or to strengthen commercial actors' role in healthcare.

*What does an explicit win-win approach in A&T projects in healthcare look like?*

**Dutch business interests in the healthcare sector are explicitly being furthered,** in diverse ways and with diverse A&T financing modalities, **most recently through a push for PPPs in primary healthcare.** In the Kenyan healthcare context, A&T funds have been used to support individual companies to start up a business and to promote the Dutch LSH top sector as a whole. More recently, A&T funds have facilitated the fast realisation of PPPs in PHC, and this trend is set to continue.

**Theories of change for health specific development in this category of A&T projects in health are either absent or lack an evidence-based ground** for effectiveness with regard to access to health services of those furthest left behind.

*What is the impact of the Dutch A&T agenda on countries' progress towards UHC?*

**The impact of the combined A&T policy on countries' progress towards universal and equitable access to health services (UHC) has not been assessed, but a positive impact is not plausible.** Although many A&T programmes are conducted in the healthcare sector, thorough ex-ante and ex-post assessments on progress towards UHC in all its dimensions (including financial protection and equity) are largely lacking.

## 5. DISCUSSION OF THE MAIN FINDINGS

This section discusses the main findings from our study into recent Dutch A&T expenditure in health, drawing from insights in literature and insights from our consultations with CSOs and other organisations in Africa.

### 5.1 LACK OF HEALTH-RELATED THEORIES OF CHANGE AND IMPACT ASSESSMENTS

The lack of impact assessments and evidence-based theories of change indicate that A&T programmes are often developed without considering that private sector promotion in healthcare bears significant risks. For example, it is widely acknowledged, also by the WHO, that markets cannot compensate for inequalities in access to health resources. On the contrary, they may exacerbate them.<sup>76</sup>

Therefore, healthcare interventions that promote market solutions in healthcare should at least assess the impact on access to health services for those left furthest behind. For example, the WHO and the World Bank advise that, in order to monitor progress towards UHC, data on access to services should be disaggregated by demographic and socio-economic strata.<sup>77</sup>

Proper management of private sector engagement in health care would require grounding programmes in an evidence-based theory of change, and monitoring results in terms of UHC indicators.<sup>78</sup> Moreover, a theory of change should be used to conduct more appropriate impact evaluations, that clearly connect the programmes' implementation to the progress made towards UHC.<sup>79</sup> This is currently not the case in the A&T programmes in the healthcare sector in sub-Saharan Africa.

### 5.2 A&T SUPPORT FOR THE FAST REALISATION OF PPPS IN PHC: A RISKY PUSH

The Netherlands is not the only donor country that pushes for the realisation of health PPPs in L&MICs. There is a trend among a number of donors, multilateral institutions such as the World Bank, and developing countries to favour privatisation, particularly in the provision of health insurance (see next discussion point) and through PPPs, in order to achieve UHC.<sup>80</sup> The UK is an important one, for instance.<sup>81</sup>

There is a lack of research on the effectiveness of health PPPs (see definition in box 3) in L&MICs.<sup>82,83</sup> While acknowledging the paucity of systematic research in L&MICs, it needs to be acknowledged that there is a growing body of empirical literature on highly problematic health PPPs in high and higher-middle-income countries and – to a lesser extent – in low and lower-middle-income countries.<sup>84</sup> In Africa, there are detailed

<sup>76</sup> WHO (2018). The private sector, universal health coverage and primary health care [\[LINK\]](#)

<sup>77</sup> WHO and WB (2015). Tracking Universal Health Coverage - First Global Monitoring Report

<sup>78</sup> De Wolf and Toebes, 2016, *Assessing Private Sector Involvement in Health Care and Universal Health Coverage in Light of the Right to Health*, *Health Hum Rights*, 18(2): 79–92. [\[LINK\]](#)

<sup>79</sup> Breuer et al (2015). Using theory of change to design and evaluate public health interventions: a systematic review. *Implementation Science*, 11(1).

<sup>80</sup> Chapman (2016), *Global health, human rights and the challenge of neoliberal policies*, Cambridge University Press, United Kingdom

<sup>81</sup> Jubilee Debt Campaign UK (2017). *Double Standards*. [\[LINK\]](#)

<sup>82</sup> Parker et al (2019) Promoting population health with public-private partnerships: Where's the evidence? [\[LINK\]](#)

<sup>83</sup> Languille (2017). Public private partnerships in education and health in the global South: a literature review. *Journal of International and Comparative Social Policy*, 33(2), 142-165. [\[LINK\]](#)

<sup>84</sup> ODG (2019) PPPs as tools for privatisation in the health sector [\[LINK\]](#); Acerete et al (2011). Spanish Healthcare Public Private Partnerships. In: *Critical Perspectives on Accounting* 22(6); Chung (2009). 'Developing an Analytical Framework for Analysing and Assessing Public-Private Partnerships: A Hospital Case Study,' *Economic and Labour Relations Review* 19(2); Eurodad (2018) *History Repeated - How public-private partnerships are failing* [\[LINK\]](#); Latindadd (2019) *Public Private Partnerships and universal healthcare in Latin America – at what cost?* [\[LINK\]](#); Jubilee Debt Campaign UK (2017), *Double Standards*, [\[LINK\]](#)

case studies of the currently running 18-year PPP hospital contract in Lesotho<sup>85</sup>, a PPP hospital<sup>86, 87</sup> and the Reproductive Health Voucher Project<sup>88</sup> in Uganda. These, and other available empirical literature, warn against PPPs in health and in other sectors. They articulate the following concerns:

- **High cost and worse cost-effectiveness:** the evidence for a greater cost-efficiency of PPPs appears weak, and even false in a number of described cases. PPPs carry high cost for governments, and thus for citizens, due to liabilities in their financing mechanisms. Figure 7, published by Jubilee Debt Campaign UK<sup>81</sup>, visualises how this works. PPPs share characteristics that make them potentially more expensive than public procurement.<sup>89</sup> The cost of financing PPP projects, like a hospital, is usually higher than the public counterpart, as governments can borrow at a lower interest rate than private companies.<sup>90,91</sup> Private companies are expected to make a profit on their investment, which has to be added to the overall cost of the project.<sup>85</sup> And there might be additional transaction costs associated with the negotiation of complex PPP contracts that benefit consultancy firms.<sup>92</sup> The International Monetary Fund (IMF) and the OECD warned against the implementation of PPPs, as they are used by governments to stall public expenditure for infrastructure while future expenditure likely rises.<sup>93</sup> This makes PPPs a riskier financing mechanism than the public option.
- **Lack of transparency and complex contracts:** academic literature emphasises how lack of transparency in the agreement and renegotiations often lead to significant escalation of the initially agreed cost of the PPP project, with disruptive consequences for government health budgets.<sup>94</sup>
- **Public interest is a concern in health PPPs,** as the private partner generally does not have public interest but financial interest as a primary goal.<sup>95</sup> Evidence from European PPPs in health shows that public interest is at stake as a consequence of cost-saving and profit-maximising behaviour of a commercial business.<sup>96</sup>

<sup>85</sup> Oxfam (2014), A dangerous diversion, [\[LINK\]](#); Bhekisisa (6 February 2020) Why one hospital takes up almost 30%, [\[LINK\]](#)

<sup>86</sup> ISER Uganda (2019) Achieving equity in health: Are Public Private Partnerships the solution? [\[LINK\]](#)

<sup>87</sup> Civil Society Statement on the Lubowa International Specialized Hospital of Uganda [\[LINK\]](#)

<sup>88</sup> ISER Uganda (2020) Failing to reach the poorest? [\[LINK\]](#)

<sup>89</sup> Romero and Ellmers (2018), The financial and social costs of public-private partnerships. In: Sovereign Debt and Human Rights (2019) [\[LINK\]](#)

<sup>90</sup> Hellowell and Pollock (2009) The Private Financing of NHS Hospitals: Politics, Policy and Practice. *Journal of the Institute of Economic Affairs*, 29:1.

<sup>91</sup> National Audit Office. (2013). Review of the VFM assessment process for PFI (Briefing for the House of Commons Treasury Select Committee).

<sup>92</sup> Engel et al (2010). The economics of infrastructure finance: Public-private partnerships versus private provision (Documentos de Trabajo No 276). Centro de Economía Aplicada, Universidad de Chile.

<sup>93</sup> IMF (2004). Public-Private Partnerships [\[LINK\]](#); OECD (2012) Public Governance of Public-Private Partnerships [\[LINK\]](#); Independent Evaluation Group of the IMF (2016). The Portuguese Crisis and the IMF [\[LINK\]](#); Irwin et al (2018). How to Control the Fiscal Costs of Public-Private Partnerships. International Monetary Fund (IMF) How To Notes. [\[LINK\]](#)

<sup>94</sup> Guasch et al (2014). Renegotiation of PPP contracts: An overview of its recent evolution in Latin America (Discussion Paper No. 2014-18, International Transport Forum). Paris: OECD.

<sup>95</sup> Bayliss & Van Waeyenberge (2018). Unpacking the public private partnership revival. *The Journal of Development Studies*, 54(4), 577-593.

<sup>96</sup> Dentico, SID (2019), Making health a global bankable project, In: Spotlight on justice [\[LINK\]](#); Barlow, Roehrich & Wright (2013), Europe sees mixed results from public-private partnerships for building and managing health care facilities and services. *Health Affairs*, 32(1).



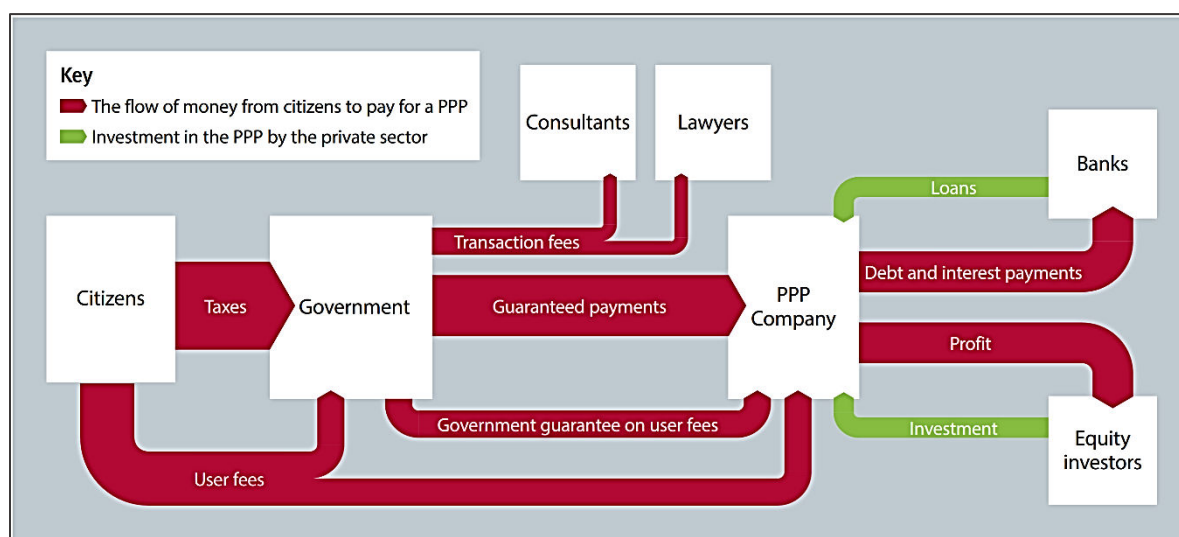


Figure 7: Visualisation of money flows in a typical PPP (Jubilee Debt Campaign UK, 2017)

These issues in PPPs are leading many high-income countries to abandon the PPP model.<sup>97</sup> The IMF, the World Bank and the United Nations Economic Commission for Europe (UNECE) are developing guidelines to strengthen regulation of PPPs and prevent their negative effects.<sup>98</sup>

According to the World Bank's definition, PPPs are in practice a step towards privatisation of public services. In 2012, the Special Rapporteur on the Right to Health concluded that privatisation often leads to disproportionate investment in secondary and tertiary care sectors, where greater profits can be made, at the expense of primary health care and that it increased disparity in the availability of health facilities, goods and services among rural, remote and urban areas.<sup>99</sup> In the case of Dutch A&T support for health PPPs, however, it is development of primary care and community level services that are being upgraded. This is positive. Still, the available evidence calls for a cautious stance vis-à-vis PPPs in health, also in PHC, because of the inherent risks listed above.

The A&T funded advice for technical assistance towards selected county governments (report 2017)<sup>57</sup> - see box 8 - recommends avoiding general capacity building regarding PPPs and calls for helping counties to realise PPPs. It also recommends that the interested parties discuss with Kenya's PPP Unit the possibility of a 'light version' of the PPP Act for modest health PPPs, like the ones envisaged in PHC. However, in light of the increasing body of evidence described above this is the exact opposite of what is needed. A cautious stance would mean only considering PPPs if there is convincing evidence that a PPP will contribute to realising UHC, better than public financing would, and that regulation and due diligence procedures be secured and fully transparent.

Many CSOs, at the different meetings we participated in in Africa with our study findings (in 2018 and 2019), emphatically voiced concerns regarding the plans for PPPs in health because of the available empirical

<sup>97</sup> The UK's National Audit Office and Parliament, the German, French, Albanian and European court of auditors, and the French Senate have underscored the negative experiences with PPPs, calling into question the validity of the assumptions on which their use is based. European Court of Auditors (2018), Public Private Partnerships in the EU: Widespread shortcomings and limited benefits; Comendeiro-Maaløe et al, 2019, Public-private partnerships in the Spanish National Health System: The reversion of the Alzira model. Health policy, 123(4), 408-411. [\[LINK\]](#)

<sup>98</sup> IMF (2017). Enforcing Public-Private Partnership Contract: How do Fiscal Institutions Matter?; IMF & WB (2019). PPP Fiscal Risk Assessment Model [\[LINK\]](#); UNECE (2015). UNECE PPP Standard for Healthcare Policy (Draft) [\[LINK\]](#)

<sup>99</sup> Grover (2012), Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN A/67/302 [\[LINK\]](#)

evidence. The director of the Ugandan CSO Initiative for Social and Economic Rights says, in the foreword of their report on health PPPs in Uganda:

*'If anything, evidence has shown that private for-profit is unlikely to deliver better health outcomes for the poor people and exacerbates inequalities, resulting in the rich being able to access better healthcare and the poor being excluded. This report cautions against employing PPPs [PPPs in health] as a vague panacea for Uganda's more intractable healthcare problems. To achieve universal health coverage, investing in a quality and equitable public health system should be prioritised - by both the government and donors. The public health system is often the first point of call for the poor and vulnerable.'*<sup>86</sup>

Most organisations we consulted in Kenya observed a clear push for health PPPs by development partners such as the Netherlands (whether the Dutch government or the FMO) and called this outright risky. Notably, in virtually every interview and meeting, the Managed Equipment Services (MES) contract was discussed as a case in point for the problem of a lack of transparency. MES is a seven-year lease contract for medical devices and equipment between the Kenyan government and five multinational companies. With the MES project, several referral hospitals were upgraded in a relatively short time frame. However, as some CSOs explained, it has been hard to assess independently and according to clear parameters, what was achieved at what cost, because the MES contract was not disclosed. County governments filed a complaint in 2015 stating that the cost of the contract weighed too heavily on the counties' health budgets and rose significantly over time, while they had no control over the centralised procurement process nor insight in the details of the MES contract.<sup>100,101</sup>

Notes:

- Philips is among the five multinational companies in the MES contract, but MES has not received any Dutch donor support. Although MES is not an A&T project, we included the comments on MES because nearly every CSO in Kenya made reference to it as an example of a PPP in healthcare in Kenya.
- MES is often referred to as a PPP because a leasing contract in a public hospital is in the spectrum of PPPs (see box 3). However, the MES contract was signed under Kenya's public procurement act and not the relatively new PPP Act that is described in box 5.

The CSOs also brought other reasons to the table as to why a PPP approach is *not* helping the country to reach UHC. These points are introduced by quotes from the consulted CSOs and health professionals and further clarified below.

- ***Conditions and regulatory safeguards underestimated***

*'The right conditions are not in place. Regulatory safeguards are largely lacking in Kenya, because of a lack of county governments' knowledge of and experience with negotiating contracts in the public interest.'* (Health professional)

Health professional organisations stressed that it is dangerous to assume that the PPP Act in Kenya and the additional regulations and procedures that were developed by the PPP Unit provide sufficient guidance. When co-conducting the interviews in the case study they found that some government representatives

<sup>100</sup> Counties argued that the obligation to pay for MES is unconstitutional because they had not signed for the contract, and adversely affects their budget ceilings and expenditure to county level priorities in health(care), according to the Council of Governors petition against Kenyan central government in 2015 [\[LINK\]](#)

<sup>101</sup> Institute of Economic Affairs (2020) Leasing of Medical Equipment Project in Kenya: Value for Money Assessment [\[LINK\]](#)

were unable to name or state the specific mechanisms that are in place to safeguard the right to health in the (PPP) engagements between the private health sector and the government of Kenya. This was the case for public officers at the Council of Governors, both at county level and at the Ministry of Health. Also many CSOs expressed doubts about the actual capacity of county governments to regulate the negotiate arrangements with commercial parties in the best interest of public health.

CSOs further posed a number of critical questions: Would a PPP financing model be built on public guarantees to the private investor, whereby public investments would be delayed? Or would it be built on a business model where private companies make money from private services, in addition to the publicly covered services? In that case, is the county government aware of the health and equity risks, especially in a resource-constrained environment? And how do they cope with these?

A company representative commented that companies certainly want a strong government. They need one, in order to develop workable solutions and contracts. This representative reiterated that through the Kenya SDG Partnership Platform (SDGPP) companies are co-financing government capacity-building and technical assistance to county governments. The question is then again: technical assistance to what end? Since the SDGPP is co-financed by multiple companies, there is a risk that technical assistance will first and foremost serve the companies' interests.

- ***Health staff needs not addressed***

*'PPPs may not take account of staffing needs at county level, even though this is a risk factor for the health system that requires full attention.'* (Health professional)

From the interviews with health officials in Kiambu we learned that in the pilot of Philips' Community Life Centre, service delivery improved. Due to new diagnostic and other equipment, and physical improvements in the clinic, health workers felt more motivated. There was a notable increase in patients and pregnant women.

However, this sudden increase in patient load also presented problems to the already overburdened health staff, to which the Community Life Centre could not offer a solution. CSOs also flagged the concern that PPP arrangements, when they mainly focus on infrastructural and technological upgrades and efficiency gains, without being embedded in a comprehensive strategy to improve health services, do not address the structural bottle-neck of shortages of professional health workers at PHC level in Kenya.

- ***Special attention to access of those furthest left behind? The issue of user fees***

*'Privatisation in public health is a problem for equity and those furthest left behind.'* (CSO representative)

Expectations differed widely with regard to access of relatively poor populations to services in the new models for PPPs in PHC as piloted in P4PC. Some CSOs highlighted the fact that health service improvements at the PHC level are more likely to benefit the poorer segment of the population than improvements at secondary or tertiary levels of the health system, because PHC is the first point of entry for many users. However, most CSOs warned that PPPs in PHC, because of their profit-making motive and potential measures such as the introduction of user fees for certain services, risk worsening access of the poor to

health services. They referred to experience with user fees in Kenya<sup>102</sup> and in other African countries<sup>103</sup>. Some organisations referred to the progress Kenya had made in pushing back out-of-pocket spending while increasing government spending for health (see figures in box 6). That trend should be sustained and consolidated, not disturbed. It was stressed that current pilots in PPPs at PHC level, including any pilots supported with Dutch development finance, should be accompanied by adequate and independent monitoring on this type of impact.

PPPs in public healthcare were often regarded a step towards privatisation, as is illustrated in the quote above. The voice of the CSOs we consulted also resounds in the African Commission on Human and Peoples' Rights' latest resolution (2019). It expresses concerns about the trend of bilateral donors and international institutions putting 'pressure on States Parties to privatize or facilitate access to private actors in their health and education sectors' in disregard of states' human rights obligations.<sup>104</sup>

- **Fragmenting versus strengthening the public health system**

*'The PPP model may contribute to more fragmentation in the health system, rather than unifying it.'* (CSO representative)

In response to our question whether PPPs are the best way to help county governments strengthen PHC, company and government representatives stressed they see few other options as the public purse for health is limited and external aid in support of the health basket is rapidly phasing out. However, the argument that 'the private sector needs to step in, preferably through PPPs', is odd. PPP experiences in high- and middle-income countries have shown that PPPs often raise the costs of the government. In addition, such an argument ignores options to enlarge the public purse. This could be done, for example, by ODA and development finance. But, more importantly, by expanding the tax-base, reducing corporate tax exemptions and reversing illicit financial flows. The performance of public healthcare provision has been substandard in many ways, in Kenya and many other African countries. Yet, evidence warns that fragmentation and commercialisation in the health sector often exacerbates access to healthcare of large sections of the population, while concerted efforts to improve the public health system - in which cross-subsidisation and risk-sharing are the main guiding principles - is the best option for access to health services for all.<sup>105</sup>

### 5.3 IMPLICATIONS OF THE PUSH FOR PRIVATE, VOLUNTARY HEALTH INSURANCE

The A&T programme that focuses on health system specific objectives, the Health Insurance Fund, strengthens private healthcare and expands private, voluntary health insurance (VHI) in Africa. It succeeded in increasing the number of households enrolled in VHI schemes. However, this should not necessarily be considered an achievement from a UHC perspective. Academic literature and WHO guidance are clear and rather outspoken about the fact that VHI schemes can undermine equitable access to health services.<sup>31</sup>

<sup>102</sup> Obare et al (2018), Assessing the community-level impact of a decade of user fee policy shifts on health facility deliveries in Kenya 2003-2014 [LINK]; Mwoka (2019) Health for All Kenyans by 2022: Are we going to be trailblazers like our long-distance runners? [LINK]; Ravishankar (2020) Now and forever: removing financial barriers to health services in Kenya [LINK]; Yates, Brookes and Whitaker (2017). Hospital Detentions for Non-payment of Fees [LINK]; MOH Kenya Policy Brief (2019). A Case for Increasing Public Investments in Health. [LINK]

<sup>103</sup> Pot et al (2018), When things fall apart: local responses to the reintroduction of user-fees for maternal health services in rural Malawi [LINK]

<sup>104</sup> Global Initiative of Economic Social and Cultural Rights et al (2019) press release, African Commission on Human and Peoples' Rights adopts landmark resolution on privatisation of education and health and recognises the Abidjan Principles [LINK]

<sup>105</sup> See for instance reviews of evidence in the WHO Commission for the Social Determinants of Health (2007) Challenging Inequality through Health Systems [LINK]. Oxfam (2009) Blind Optimism [LINK].

There is a strong evidence base indicating that, to reach UHC, countries should seek to move toward predominant reliance on compulsory funding sources, because no country has achieved UHC based on a system organised around voluntary prepayment. In countries where the health budget derives largely from VHI – such as South Africa and the US - VHI does not contribute to the attainment of UHC. Instead, it has driven large inequities, and often inefficiencies, making it a barrier rather than an enabler for UHC.

According to the WHO guidance note on health financing,<sup>31</sup> VHI does not need to be encouraged, but rather managed in order to prevent its potential adverse effects. Active promotion of VHIs might compromise health equity, when the insurance scheme is not affordable for the whole population.<sup>106</sup> It might reduce efficiency, leading to repetition of services and adverse selection.<sup>107</sup> And it might skew the availability of human resources for health, as VHI schemes might drain resources from the public sector.<sup>108</sup>

To avoid these problems, the WHO guidelines discourage the promotion of VHIs, especially in countries that have not yet reached UHC. They state that the lack of resources for the implementation of an effective public health system should not be a reason to attempt methods that have already failed in the past. It should be noted that not all the A&T funding is in support of VHI, but also in support of the national insurance scheme (NHIF). A shift from the support of VHI to the support of the NHIF is more aligned with official WHO guidelines and should be regarded as an improvement. Moreover, regarding civil society views, some CSO's commented positively the Dutch digital products to professionalise the NHIF and curb wastage or fraud.

There were widely differing opinions about the role of the NHIF or other voluntary health insurances in UHC. However, as documented in the Reflection Essay ahead of the 1st East African Governance for Health Convening in Nairobi (2018), CSOs agree that private for-profit insurance providers should be subordinated to state control.

## 5.4 PURSUING A WIN-WIN SITUATION IN A&T: WHAT ABOUT THE UNTYING OF AID?

We found that only a tiny proportion of the Dutch A&T ODA funds in health - the small start-up grants to individual Dutch companies - was registered as 'tied aid'. Tied aid describes official grants or loans that limit procurement to companies in the donor country.<sup>109</sup> It proves to impair aid (cost-)effectiveness because it fails to aim for optimal use and development of local resources and significantly increases transaction costs in development efforts. While there is no reason to doubt that the registered tying status follows the formal criteria<sup>110</sup>, our study shows that significantly more ODA and development finance ends up being used by Dutch companies (for delivery of goods, technical assistance, construction or services) and for the promotion

<sup>106</sup> Pettigrew and Mathauer (2016). Voluntary Health Insurance expenditure in low-and middle-income countries: exploring trends during 1995–2012 and policy implications for progress towards universal health coverage. *International journal for equity in health*, 15(1), 67; Kazungu and Barasa (2017). Examining levels, distribution and correlates of health insurance coverage in Kenya. *Tropical Medicine & International Health*, 22(9).

<sup>107</sup> Kutzin et al (2016). Alternative financing strategies for universal health coverage. In *World Scientific Handbook of Global Health Economics and Public Policy: Volume 1: The Economics of Health and Health Systems* (pp. 267-309); Jensen et al (2018). How basis risk and spatiotemporal adverse selection influence demand for index insurance: Evidence from northern Kenya. *Food Policy*, 74, 172-198.

<sup>108</sup> Pfeiffer et al (2008). Strengthening health systems in poor countries: a code of conduct for nongovernmental organizations. *American journal of public health*, 98(12), 2134-2140. Rubagumya et al (2016). Physician brain drain in Sub-Saharan Africa. *RMJ*, 73(1), 5.

<sup>109</sup> OECD, DAC web page 'Untying aid: The right to choose'. [\[LINK\]](#) – last visited May 2020

<sup>110</sup> OECD, DAC Recommendation on Untying Official Development Assistance, OECD/LEGAL/5015 [\[LINK\]](#). Criteria include a threshold for the ODA amount granted directly to companies domiciled in the donor country or any limited group of countries, and open procurement according to international standards.

of Dutch business interests in general. This concurs with findings in research on the procurement practices of the OECD Development Assistance Committee (DAC) donors that, even when ODA is formally untied, there is a tendency for donors to ‘informally tie’ their ODA.<sup>111</sup> The win-win objective in development assistance, especially when pursued in such an explicit way as we found in the promotional activities around the Dutch LSH top sector in Kenya, runs contrary to the objectives of the international untying of aid agenda and the principles for effective development cooperation.<sup>112</sup>

The earlier mentioned PSD toolkit mid-term evaluation (2018)<sup>113</sup> distinguishes between the primary and secondary goals in the win-win objective. It noted that the secondary goal (success for Dutch trade and investment) often proved to be the dominant goal in activities funded by the PSD toolkit, as we also found in the context of Kenya’s healthcare sector. We consider this to be a *reversed* win-win approach: win-2 (gain for the company) is expected to lead to win-1 (development), instead of the other way around. The evaluation recommends that the secondary goal should be a means to achieve the primary development goal, and not the other way around.<sup>113</sup>

There is both praise and critique on the Dutch A&T agenda and instruments in the OECD DAC’s latest peer review of the Netherlands as a donor country (2017)<sup>114</sup> with regard to private sector engagement. The Netherlands is called a pioneer in innovative development financing: ‘*the Netherlands is a relatively small but influential member of the international community*’, as it ‘*is willing to be creative and to take risks in order to attract development finance from a variety of sources*’. However, the same peer review exhorts important warnings about Dutch bilateral ODA. It talks of ‘erosion of the untying of aid agenda’, meaning the weakening of this important agenda. It also mentions fragmentation, a lack of alignment with country strategies, and - most importantly - lower development effectiveness. It urges the Dutch government to review and rationalise its instruments and tenders, particularly in its A&T approach.

As to medical devices and commodities sold by Dutch companies, CSOs commented being convinced that these are of good quality and therefore may help raise the quality standard of health services in Kenya. It was pointed out that companies often seem to target the market of private health facilities, which makes products more easily accessible to middle- and high-income population groups than to low-income groups, because of required payments. With a large proportion of the population living in poverty, such products may thus be out of reach for many. Therefore, it may contribute to the UHC dimension of service expansion but is unlikely to contribute to the dimension of expanding coverage for those most left behind.

CSOs generally responded with disbelief to the fact that Dutch development funds are used to promote Dutch business interests in the LSH sector, while being considered a form of development assistance. A number of the interviewed Dutch companies added that they did not see much validity and use in the promotion of the LSH sector as a whole with development money.

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<sup>111</sup> Meeks, Eurodad 2018. *Development, Untied*. [\[LINK\]](#); Reality of Aid (2018) *The Changing Faces of Aid: Encouraging Global Justice or Buttreasing Inequalities?* [\[LINK\]](#)

<sup>112</sup> Website of the Global Partnership for Effective Development Co-operation [\[LINK\]](#) – visited April 2019; The Busan Partnership document (2011) [\[LINK\]](#), and Nairobi Outcome document (2016) [\[LINK\]](#)

<sup>113</sup> Technopolis (2018). *Mid-term Review of PSD Apps programme*. [\[LINK\]](#). Note: the PSD toolkit was called the PSD Apps programme from 2014-2017. This evaluation included a review of 30 specific projects, but unfortunately did not cover any of the health sector related projects.

<sup>114</sup> OECD (2017). *The DAC’s main findings and recommendations*. Extract from: OECD DAC Peer Reviews The Netherlands 2017. [\[LINK\]](#)



## 5.5 DEMOCRATIC OWNERSHIP AND ACCOUNTABILITY AT STAKE

The question of good country ownership in projects (co-)funded from outside is a complicated issue, CSOs in Kenya explain. Also in health. While Kenya promotes a bigger role for the private sector in its 'Big Four' agenda (see chapter 3.4), in the context of healthcare there are organisations that want to voice specific concerns and expectations about this role to their government. However, their voices are hardly heard. On the other hand, companies - with or without Dutch government support - get a seat at the table more easily, for instance, in the SDGPP, but also in other high-level meetings, according to interviewed respondents. With respect to this influence of publicly backed, foreign companies a Kenyan government representative commented that 'the Dutch [government] could pay more attention to the fact that the Government of Kenya tends to move towards agendas that are developed elsewhere'.

When discussing the needs for the health system to be strengthened, Kenyan CSOs and health professionals stressed the importance for Kenya to spend the health budget more effectively and increase fiscal space for health, for instance by broadening the tax base in general. Yet, Kenya introduced tax exemptions for foreign companies to create a conducive and favourable environment for trade and investment which is applauded in the market study and trade mission for Dutch LSH companies. CSOs criticised this approach, as the reduction in tax revenues leaves governments with less resources to invest in healthcare and then induces direct reliance on the private sector. At the same time CSOs pointed a critical finger at internal problems; of public resources in Kenya going to waste because of inefficiency and corruption in the health system, lack of transparency, and lack of capacity to regulate the private sector and defend public interests in innovative contracts.

Many things need to improve to make health services accessible to all in an equitable way in Kenya but leaving healthcare to commercial enterprises is not a credible solution many emphasised. Achieving UHC is the responsibility of the Kenyan government, and part of the 'social contract' between the Kenyan government and Kenyan citizens. The promotion of PPPs and other forms of privatisation in health sector development, with the support of development money and other types of support from the Dutch government, was seen as an interference with that social contract and CSOs' role in advocacy and accountability.

One CSO representative put it this way: *'Foreign trade propositions are fine. But we don't need foreigners to teach our government that what our country's health system most needs is commercial fixes or schemes. We shouldn't let our government off the hook. They have a social contract with us. The right to health for everyone is a public responsibility.'*



## 6. CONCLUSIONS AND RECOMMENDATIONS

### 6.1 CONCLUSIONS

In our study we unpacked information on the Dutch government's Aid & Trade agenda, with its underlying win-win approach, as being effectuated in the context of healthcare in sub-Saharan Africa. In this context, various A&T policy instruments - including grants, loans, equity funds and guarantees – have been and are being used via all main A&T financing channels. The relative amount of A&T ODA grants increased over the past five years and the health sector is gaining importance in A&T financing.

Our study's findings confirm the original concern of African CSOs that this type of donor support promotes privatisation in their healthcare systems. The general goals of private sector development and business climate improvement, sometimes specifically focussed on the private healthcare sector including health insurances, are also the dominant objectives of A&T expenditure in the healthcare context.

The impact of the combined A&T policy on countries' progress towards universal and equitable access to health services (UHC in all its dimensions) has not been assessed in evaluation studies. However, a positive impact is not plausible considering that the success indicators attached to the studied A&T expenditure in health either lack a focus on UHC in all its dimensions or lack a solid evidence base.

Zooming in on Kenya, we see that A&T instruments have been used in projects to support Dutch Life Sciences and Health companies to expand their business in healthcare, pursuing a win-win in an explicit way. Dutch business interests are prioritised in these projects and generally lack a grounded theory of change towards UHC. This is at odds with the global agendas on the untying of aid and development effectiveness.

More recently, win-win is pursued by actively supporting rapid realisation of public-private partnerships in Kenya, with an underlying aim of commercialisation (introducing profit making) in primary healthcare alongside improvements in the quality and accessibility of care. Even though evaluation has yet to confirm that these two outcomes can be reached in parallel and help ensure universal and equitable access to healthcare, this trend is set to continue. The Dutch government announced further support to the development of PPPs in PHC in emerging economies.

Joining efforts to strengthen PHC is laudable at first sight as it is a priority in health system policy in Kenya and many other countries. However, the existing body of evidence on health PPPs - even if relatively limited in the African context - shows that PPPs in health run real risks in terms of high cost and increased liability for the government and ultimately the taxpayer. Other risks are the loss of transparency and flexibility, exacerbating inequalities in access to health services, through (re)introduction of user fees, and further fragmentation of countries' health systems.

Coupled with the serious concerns of African civil society and health professional organisations, we conclude that the realisation of PPPs should *not* be speeded up, but approached with great caution instead. Health PPPs should not be promoted unless there is convincing evidence for its effectiveness, and sufficient capacity in central and decentral government to regulate the private sector and secure contracts that are in the public interest and leave no one behind. In the meantime, concerted efforts in improving the public health system – in which universality, quality, equity, responsiveness, resilience and cost-effectiveness are guiding principles - are needed for UHC and health for all.

Our study shows that better policy coherence for sustainable development, which was among the original rationales for the merge of foreign trade and development cooperation in the Netherlands, is not a given in A&T in the healthcare context. When A&T policy, and the wider 'private first' in financing for development

policy it is embedded in, is rolled out in health, it may unintendedly hinder instead of support countries' progress towards universal and equitable access to health services.

## 6.2 RECOMMENDATIONS

The Dutch government has made a commitment to policy coherence for sustainable development. Considering this, and in order to protect the right to health, in our view the Dutch government should not provide ODA or other forms of official development support to projects that are primarily aimed at strengthening business or at engaging the private for-profit sector in development in the context of the healthcare sector, unless the following conditions are met:

1. Make sure the support enhances universal and equitable access to quality health services based on need and regardless of the ability to pay (UHC). It should not be guided by business interest.
2. Adopt a cautious stance towards PPPs in health. Only support PPPs in healthcare delivery or financing when they prove to contribute to UHC in all its dimensions. Avoid support to ventures in which the business model is at odds with access to quality healthcare for all without financial hazard, such as ventures that introduce or reinforce user fees for essential health services.
3. Interventions should benefit equity and ensure access of those farthest behind, including marginalised groups and individuals. To this end, develop key indicators for *ex ante* and *ex post* assessment and due diligence procedures.
4. Include checks on positive and negative effects on equitable distribution of the (human and financial) resources of the healthcare system in evaluations of PPPs. Don't limit it to economic and financial sustainability.
5. Do not implement programmes that support private or voluntary health insurance schemes, as they hinder progress towards Universal Health Coverage.
6. Prioritise essential services by insisting on safeguards and regulations that protect the right to health for all; put in place mechanisms to ensure that the business model employed does not lead to drawing away scarce resources from essential services.
7. Stimulate national and local authority capacity building, through independent expertise that is fully free from vested interests, to interact with private sector actors in the health system effectively in the public interest and to avoid any short or long term risks in contracts with private actors.
8. Make sure ODA support and development finance is aligned with the recipient country's democratic ownership, including a broad CSO voice; build the capacity of CSOs to be fully engaged and accessible in partner dialogues such as the SDG Partnership Platform.

We realise that above mentioned recommendations may not always lie fully within the Dutch government's sphere of influence. In those cases we call on active collaboration with governments of recipient countries and/or with multilateral (donor) organisations the Netherlands is part of - including the World Bank Group, the OECD-DAC and the European Commission – to achieve that valuable ODA and other official development resources in the healthcare context protect the right to health for all.

***In this discussion paper Wemos takes full responsibility for the conclusions and recommendations addressed to the Dutch government.***

***Wemos is grateful for the generous collaboration of all organisations and individuals in the case study and CSO consultations.***

## ANNEXES

### METHODOLOGY NOTES OF THE CASE STUDY ON MARKET DEVELOPMENT FOR DUTCH LSH COMPANIES IN KENYA

A large part of this case study was conducted by a consultant from Public Health Consultants Netherlands (PHC-NL), working closely with the Kenya Medical Practitioners, Pharmacists and Dentists Union (KMPDU). They conducted a total of 18 interviews, 2 field visits (with interviews involving multiple government officials and health professionals), and 1 round table discussion with NGOs, health professionals and companies in Kenya and 18 interviews in the Netherlands (end of 2018). The case study was complemented by Wemos in 2019-2020, involving desk review, additional interviews in the Netherlands (8), reviews with direct stakeholders of projects described in the case study in the Netherlands (2), and discussion of preliminary case study results in round table meetings in Kenya (3).

In total, 90 people, representing 32 organisations in Kenya and 16 in the Netherlands, were spoken to at least once. The key organisation categories included Kenyan and Dutch governments, LSH companies, CSOs, organisations of health professionals, and research institutes. See the table for the list of organisations that were included in either the consultant's or our own conversations. All interviews and (group) consultations were documented.

Table 1: Organisations interviewed or consulted for the case study				
Key organisation categories	In Kenya		In the Netherlands (or vicinity)	
	Organisations	No. of persons	Organisations	No. of persons
<b>Government, government related or multilateral institution</b>	<ul style="list-style-type: none"> <li>Dutch Embassy</li> <li>Kenya Vision 2030</li> <li>Council of Governors</li> <li>Kenya Ministry of Health</li> <li>Makueni Ministry of Health</li> <li>Kenya SDG Partnership Platform</li> <li>World Bank Kenya</li> </ul> 7 organisations	9	<ul style="list-style-type: none"> <li>Ministry of Foreign Affairs</li> <li>Netherlands Enterprise Agency (RVO)</li> <li>Entrepreneurial Development Bank (FMO)</li> </ul> 3 organisations	5
<b>LSH companies and affiliated non-profit organisations</b>	<ul style="list-style-type: none"> <li>Philips East Africa</li> <li>Amref Enterprises Ltd</li> <li>Aga Khan Foundation</li> <li>Africa Health Business/Kenyan Healthcare Federation (KHF)</li> </ul> 4 organisations	12	<ul style="list-style-type: none"> <li>Delft Medical Imaging</li> <li>Achmea (foundation)</li> <li>Philips</li> <li>Cardimed</li> <li>GenKey</li> <li>AMPC International Health Consultants</li> </ul> 6 organisations	7
<b>Health professionals</b>	<ul style="list-style-type: none"> <li>Kenya Medical Practitioners Pharmacists and Dentists Union</li> <li>Kiambu county health staff</li> <li>Kenya Association of Radiology</li> <li>Kenyan Union of Clinical Officers</li> <li>Kenya Medical Association</li> <li>Union of Medical Laboratory Officers</li> <li>Kenya Health Professionals Society</li> </ul>	26		

	<ul style="list-style-type: none"> <li>National Nurses Association of Kenya</li> <li>Kenyan Union of Pharmaceutical Technicians</li> <li>Kenya Progressive Nurses Association</li> </ul> 9 organisations			
<b>Civil Society Organisations</b> (in health, human rights and/or development)	<ul style="list-style-type: none"> <li>African Medical &amp; Research Foundation (Amref Health Africa)</li> <li>Health NGOs Network (Hennet),</li> <li>Kenya Legal and Ethical Issues Network (KELIN)</li> <li>Reality of Aid Africa</li> <li>Global Initiative of Economic Social and Cultural Rights (GI-ECSR)</li> <li>Open Society Initiative East Africa</li> <li>Family Health Options</li> <li>Malteser International</li> <li>Provide international Hakijami</li> <li>Transparency International Kenya</li> <li>International Council of Jurists Kenya</li> </ul> 11 organisations	20	<ul style="list-style-type: none"> <li>Taskforce Healthcare (TFHC)</li> <li>PharmAccess Group</li> <li>Amref Flying Doctors</li> <li>Cordaid</li> <li>Oxfam</li> </ul> 5 organisations	10
<b>Academic organisations</b>	<ul style="list-style-type: none"> <li>Institute of Economic Affairs Kenya</li> </ul> 1 organisations	2	<ul style="list-style-type: none"> <li>Centre for International Development Issues (CIDIN)</li> <li>Centre for research on multinational corporations (SOMO)</li> </ul> 2 organisations	3
<b>Total</b>	<b>32 organisations</b>	<b>69</b>	<b>16 organisations</b>	<b>25</b>