Date: October 27, 2022

To: The Special Rapporteur on the right to health
The Special Rapporteur on the rights of persons with disabilities
The Special Rapporteur on extreme poverty and human rights
The Independent Expert on the effects of foreign debt
The Working Group on business and human rights
The Working Group on discrimination against women and girls

Subject: Joint submission regarding human rights harms associated with the privatization and commercialization of healthcare in Kenya

Dear mandate holders,

We, the undersigned civil society organizations,[1] write to call your attention to ongoing and potential future harms associated with privatization and commercialization of healthcare in Kenya. We strongly urge you to issue, individually or jointly, allegation letters to the Kenyan government, as well as to the World Bank Group and the United States government, given the central role they have played in promoting greater private sector participation in healthcare in Kenya.

[1] This submission is transmitted on behalf of 20 civil society organizations whose work addresses human rights and health issues in Kenya and globally. The full list of signatories is below.

In recent years, the Kenyan government and development actors have encouraged the growth of the commercial private healthcare sector—notwithstanding its unaffordability, focus on wealthy urban patients, varying quality, and other associated problems—while comparatively neglecting the public one.[2] Kenya's signature policy for delivering universal health coverage (UHC), the planned adoption of mandatory social health insurance, appears set to further accelerate the growth of the private sector, despite documented issues including exclusion, impoverishment, and inadequate and unsafe care.

We believe that the way in which the government is increasing the role of the private health sector is misplaced, and that current forms of privatization and commercialization of healthcare in Kenya pose a threat to human rights—especially the right to health, and particularly for women, individuals experiencing poverty, people with disabilities, those in rural areas, and other underserved or marginalized groups. We very much hope you will engage and advise the key actors on this crucial issue at such an important moment of political transition in Kenya, and we thank you for your efforts to ensure the realization of human rights.

I. Background

General context

Healthcare in Kenya is delivered by a mix of providers, including non-governmental organizations, faith-based, and for-profit private providers, as well as public healthcare facilities. Public facilities have traditionally provided most healthcare services, and still did so as of the most recent national survey on health utilization in 2018.[3] The need for improvements is undisputed. Even before COVID-19 exposed shortcomings in the healthcare system, the Ministry of Health called healthcare quality "inadequate countrywide."[4] A 2018 survey of nearly 3,000 public and private healthcare facilities found that only a small fraction (6 percent) had all basic amenities and none had all essential medicines on the day of the survey.[5] Access to healthcare is highly unequal along socio-economic and geographic lines.[6] The cost of healthcare is a significant problem in Kenya,

[2] Unless noted otherwise, the term "private," as used in this submission, refers to for-profit private entities, and does not include not-for-profit or faith-based facilities.
[3] A 2018 national survey found that 56.7% of outpatient visits occurred at government hospitals, health centers, and dispensaries, and that 51.7% of inpatient admissions occurred at government hospitals or health centers. Ministry of Health, *2018 Household Health Expenditure and Utilization Survey*, 2018, 21, 42, https://chrgj.org/wp-content/uploads/2022/09/Ministry-of-Health_KHHEUS_2018_Clean.pdf.
[4] Ministry of Health, *Harmonized Health Facility Assessment 2018/2019 Main Report*, 2020, xxxv, https://khro.health.go.ke/files/Kenya-Harmonized-Health-Facility-Assessment-2018-2019.pdf.
[5] Ministry of Health, *Harmonized Health Facility Assessment 2018/2019 Main Report*, xxvi.
[6] Ministry of Health, *Harmonized Health Facility Assessment 2018/2019 Main Report*, xxxv, 39, 46; Stefania Ilinca et al., "Socio-Economic Inequality and Inequity in Use of Health Care Services in Kenya: Evidence from the Fourth Kenya Household Health Expenditure and Utilization Survey," *International Journal for Equity in Health* 18, no. 196 (2019): 2, https://doi.org/10.1186/s12939-019-1106-z.

where more than a third of the country live under the national poverty line;[7] in fact healthcare costs pushed an estimated 1-1.1 million people into poverty in 2018.[8]

Policy efforts to increase the role of the private health sector

In recent years, several major changes to healthcare policy and delivery have taken place in Kenya.[9] Some of these have involved the public healthcare system, but policy reforms have largely focused on increasing the role of the private health sector in a manner that inevitably gives rise to serious human rights risks that are already materializing. To be clear, the Kenyan government has not sought to sell off its public facilities.[10] Rather, it has undertaken a multi-pronged push to increase private sector participation in healthcare, while permitting the continued deterioration of public services.

Key national policies explicitly seek to expand the private sector's role. These include the overarching Kenya Health Policy 2014-2030, which aims to strengthen the role of the private sector as both a financier and a provider of healthcare services, and the Kenya Health Sector Strategic Plan 2018-2023, which calls for expanding the role of private healthcare and financing through private insurance products, specialized private hospitals, and other public-private partnerships.[11] The government has offered tax incentives,[12] effectively subsidized private providers,[13] and pursued large-scale contracts[14] including public-private partnerships.[15] Former President Uhuru Kenyatta, cabinet members, and other high-level officials have referenced the

[7] Kshs. 3,252 per person per month in rural areas and Kshs. 5,995 per person per month in urban areas. Kenya National Bureau of Statistics, *Basic Report on Well-Being in Kenya*, March 2018, 9, https://www.knbs.or.ke/?wpdmpro=basic-report-well-kenya-based-201516-kenya-integrated-household-budget-survey-kihbs.

[8] Paola Salari et al., "The Catastrophic and Impoverishing Effects of Out-of-Pocket Healthcare Payments in Kenya, 2018," *BMJ Global Health* 4 (2019): 6, http://dx.doi.org/10.1136/bmjgh-2019-001809.

[9] For example, the 2010 Constitution enshrined the right to health and granted counties significant responsibility for healthcare delivery, while the national government retained other major health-related responsibilities including health policy. Kenya Constitution, Article 43; Fourth Schedule, distribution of functions between national governments and the county governments, Parts 1 and 2.

[10] However, in at least one recent instance, a Kenyan county is reported to have leased its public facility to a private firm. Victor Raballa, "Kisumu County leases out hospital to private firm," *Business Daily Africa*, May 30, 2022, https://www.businessdailyafrica.com/bd/news/counties/kisumu-county-leases-out-hospital-to-private-firm-3831646.

[11] See Ministry of Health, *Kenya Health Policy 2014-2030*, 2014, 35, 49-50, 52-53, http://publications.universalhealth2030.org/uploads/kenya_health_policy_2014_to_2030.pdf; Ministry of Health, *Kenya Health Sector Strategic Plan*, 2018, 53, 70, 71, 77, https://www.health.go.ke/wp-content/uploads/2020/11/Kenya-Health-Sector-Strategic-Plan-2018-231.pdf.

[12] Task Force Health Care and Kenya Healthcare Federation, *Kenyan Healthcare Sector: Opportunities for the Dutch Life Sciences and Health Sector*, 2016, 56, https://www.tfhc.nl/publication/kenyan-healthcare-sector-report-2016.

[13] Stacey Orangi et al., "Examining the Implementation of the Linda Mama Free Maternity Program in Kenya," *International Journal of Health Planning and Management* (2021): 5, https://doi.org/10.1002/hpm.3298.

[14] GlobeNewswire, "Gruppo San Donato, Italy's Leading Private Hospital Group, and Kenya Sign an Agreement to Strengthen the East African's Local Health Care," news release, July 19, 2021, https://www.globenewswire.com/en/news-release/2021/07/19/2264986/0/en/Gruppo-San-Donato-Italy-s-leading-private-hospital-group-and-Kenya-sign-an-agreement-to-strengthen-the-East-African-s-local-health-care.html.

[15] Monish Patolawala, "Transforming Kenya's Healthcare System: A PPP Success Story," *World Bank Blogs*, May 24, 2017, https://blogs.worldbank.org/ppps/transforming-kenya-s-healthcare-system-ppp-success-story; "300-Bed Private Hospital," Public-Private Partnerships Unit, portal.pppunit.go.ke/project/9/300-bed-private-hospital.

role of private investment in achieving universal health coverage and presented the health sector as an opportunity for private firms, with President Kenyatta declaring the country "open to private sector investment in healthcare."[16]

Even the government's flagship policy for achieving universal health coverage—under which insurance from an already existing social health insurance entity, the National Hospital Insurance Fund (NHIF), will be made mandatory nationwide—will deeply embed the private sector's role and has the potential to transform the government from a provider to a purchaser of healthcare.[17] The NHIF Amendment Act, which codifies this approach and which received presidential assent January 10, 2022,[18] appears set to accelerate privatization and commercialization of healthcare. The Act cements the NHIF as *the* primary route for pursuing universal health coverage. The NHIF has many private facilities enrolled in its network and has historically favored the private sector; absent much-needed reforms, selecting the NHIF as the vehicle for universal health coverage, rather than the public healthcare system, risks exacerbating the problems associated with privatization and commercialization of healthcare.[19]

The rapid growth of the private health sector and decline of public healthcare

As a result of government policy, the role of for-profit private healthcare providers is rapidly growing. Between 2013 and 2022, the proportion of private for-profit facilities grew from 33 to 44 percent of the total,[20] while private clinics experienced a more than sixfold increase in the share of health spending between 2009/10 and 2015/16.[21] The proportion of outpatient visits conducted at private hospitals and clinics increased from 17 to 25 percent between 2013 and 2018, while visits at public primary health care facilities (dispensaries and clinics) fell from 40.1 percent to

[16] John Muchangi, "Private Hospitals to Get UHC Cash," *The Star*, September 6, 2019, https://www.the-star.co.ke/news/2019-09-06-private-hospitals-to-get-uhc-cash/; "Kenya Encourages Private Sector Investment in the Health Sector," Ministry of Health, October 31, 2019, https://www.health.go.ke/kenya-encourages-private-sector-investment-in-the-health-sector/; State Department for Planning, *A Summary of Key Investment Opportunities in Kenya*, undated, 24-25, newdemo.planning.go.ke/wp-content/uploads/2021/02/A-SUMMARY-OF-KEY-INVESTMENT-OPPORTUNITIES-PRESENTATION-revised-2-22-01-2021.pdf.

[17] Bassam Khawaja and Rebecca Riddell, "Stealth privatization: Kenya's approach to universal health coverage is a private sector giveaway," *OpenGlobalRights*, May 20, 2022, https://www.openglobalrights.org/stealth-privatization-kenyas-approach-to-universal-health-coverage-is-a-private-sector-giveaway/?lang=English.

[18] See Kenya, The National Hospital Insurance Fund (Amendment) Act, 2022, http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/2022/TheNationalHospitalInsuranceFund__Amendment_Act_No1of2022.pdf; see also "President Kenyatta Launches UHC National Roll Out," Presidential Strategic Communication Unit, February 7, 2022, https://www.president.go.ke/2022/02/07/president-kenyatta-launches-uhc-national-roll-out/.

[19] Khawaja and Riddell, "Stealth privatization."

[20] According to the Kenya Master Health Facility List, as of July 2022, there were 6,401 public facilities, 6,102 private facilities (44 percent of the total), and 1,424 faith/non-profit facilities. According to a 2013 Ministry of Health document, 49 percent of facilities in the country were government-owned, 33 percent were private for-profit, and 16 percent private non-profit. "Kenya Master Health Facility List," Ministry of Health, accessed July 28, 2022, http://kmhfl.health.go.ke/#/facility_filter/results; Ministry of Health, *Kenya Service Availability and Readiness Assessment Mapping (SARAM),* 2013, 12, http://guidelines.health.go.ke:8000/media/Kenya_Saram_Report.pdf.

[21] Health Policy Plus, *Kenya Health Financing System Assessment: Time to Pick the Best Path*, 2018, 84, http://www.healthpolicyplus.com/pubs.cfm?get=11323.

27.5 percent.[22] Between 2010 and 2021, payouts to for-profit private healthcare facilities from the NHIF rose more than 30-fold, vastly outstripping increases for public facilities. In 2011, 32 percent of total spending on benefits went to public facilities and 30 percent to private for-profits. Just 10 years later, payouts to for-profits had soared to 64 percent, while just 20 percent went to public facilities.[23]

This push has coincided with chronic underinvestment in the public health system, which has hurt the quality and availability of care and driven many towards private providers. Although public health spending has increased in recent years, the allocation of about 7-9 percent in recent budgets is still well under the Abuja Declaration goal of 15 percent, and a significant portion of that is in fact directed towards the private sector.[24] The public healthcare system has been starved of resources for years and is woefully underequipped, meaning individuals often have to travel great distances, sometimes at considerable cost, to reach government facilities. Once there, they frequently encounter facilities with long waits, short working hours, and routine shortages of staff, basic equipment, and drugs.[25] These manufactured shortcomings effectively push people towards the private sector, even if they have reservations about the high prices or quality. [26]

Promotion of private health sector by the World Bank Group and the United States

Development actors have played a central role in promoting private healthcare in Kenya, with international financial institutions and wealthy countries directing significant energy and resources towards private sector-friendly reforms and to private actors directly. World Bank Group institutions have long advanced private sector participation in health. As early as 2010, the Bank called for several pro-private sector measures[27] and it has provided $90 million in loans to—in its own words—"kick-start Kenya's public-private partnership (PPP) programs."[28] This includes a loan whose disbursement is tied to steps moving the public-private partnership agenda forward, such as gazetting new public-private partnership financing regulations and closing PPP agreements.[29] The World Bank Group's private sector arm, the International Finance Corporation

[22] Ministry of Health, *2018 Household Health Expenditure and Utilization Survey*, 21. The category of private facilities does not include chemists/pharmacies or faith-based facilities.
[23] "Annex: Questions for the National Hospital Insurance Fund," NHIF, March 12, 2022, https://chrgj.org/wp-content/uploads/2022/03/NHIF-response-to-CHRGJ-query.pdf.
[24] Darmi Jattani and Oscar Ochieng, "Can People Afford to Pay Out of Pocket for Health Care in Kenya," *Institute for Economic Affairs* (blog), July 15, 2021, https://ieakenya.or.ke/blog/can-people-afford-to-pay-out-of-pocket-for-health-care-in-kenya/.
[25] GI-ESCR, *Patients or customers? The impact of commercialised healthcare on the right to health in Kenya during the COVID-19 pandemic* (2022), 19-24, available at https://doi.org/10.53110/RPCN4627.
[26] Hakijamii and CHRGJ, *Wrong Prescription: The Impact of Privatizing Healthcare in Kenya* (2021), 24, https://chrgj.org/all-projects/wrong-prescription/.
[27] World Bank, *Private Health Sector Assessment in Kenya*, April 2010, xvii-xix, https://openknowledge.worldbank.org/handle/10986/5932.
[28] World Bank, *Kenya: Enabling Private-Sector Participation in Infrastructure and Social Services*, April 2018, https://www.worldbank.org/en/about/partners/brief/kenya-enabling-private-sector-participation-in-infrastructure-and-social-services. See also "Kenya Infrastructure Finance/PPP project," World Bank, accessed February 24, 2020, https://projects.worldbank.org/en/projects-operations/project-detail/P121019.
[29] World Bank, *Financing Agreement Between Republic of Kenya and the International Development Association*, August 2017, 14-15, documents1.worldbank.org/curated/en/153191504040149253/pdf/Financing-Agreement-for-Credit-6121-KE-Closing-Package.pdf. The Bank's work in Kenya is consistent with its broader global commitment to Maximizing Finance for Development (MFD), adopted in 2017, which explicitly prioritizes private sector

(IFC), has committed over USD $50 million to private healthcare companies in Kenya since 2010.[30] It has also encouraged private sector-friendly reforms and mobilized financing from other development actors.[31] For example, in 2019 the IFC launched a holding company to acquire healthcare businesses in East and Southern Africa, with backing from other European development finance institutions like Swedfund and Finnfund.[32]

Wealthy foreign countries have also promoted private healthcare, at times with an explicit aim of creating opportunities for their domestic companies. The United States has long advocated for the role of private actors in healthcare around the world and in Kenya specifically, where it has carried out a number of pro-private sector healthcare projects since at least 2004.[33] Its aid agency, the United States Agency for International Development (USAID), adopted a Private Sector Engagement Policy in 2018 that is a "call to action" to "embrace market-based approaches," and which explicitly aims to benefit US companies and promote US economic growth.[34] In 2020, referencing the private-sector engagement policy, USAID requested bids for a multimillion-dollar project to "reshape the healthcare supply in Kenya using market-based approaches."[35] The project sought to "shift significant patient volumes to private-sector care." In 2021, USAID announced a $10 million private health initiative that would focus on Kenyans "who can pay for the full cost of their care in the private sector" and would leave "members of poor and vulnerable populations" to

---

solutions in achieving development goals. World Bank, *Maximizing Finance for Development: Leveraging the Private Sector for Growth and Sustainable Development*, September 2017, 1-2, https://www.devcommittee.org/sites/dc/files/download/Documentation/DC2017-0009_Maximizing_8-19.pdf.

[30] "Response from the International Finance Corporation," International Finance Corporation, October 5, 2021, https://chrgj.org/wp-content/uploads/2021/11/IFC-response-to-CHRGJ_October-2021.pdf.

[31] See International Finance Corporation, *Creating Markets in Kenya: Unleashing Private Sector Dynamism to Achieve Full Potential*, 2019, 8, 54-55, https://www.ifc.org/wps/wcm/connect/9cdd17da-fccb-4ca8-a71c-ea631593463a/201907-CPSD-Kenya.pdf?MOD=AJPERES&CVID=mMGBDRv.

[32] International Finance Corporation, "IFC and Development Partners Make Landmark Health Care Investment in East and Southern Africa," news release, November 23, 2019, https://pressroom.ifc.org/all/pages/PressDetail.aspx?ID=24868. See also, "Project Hippo," IFC Project Information & Data Portal, International Financial Corporation, accessed February 25, 2021, https://disclosures.ifc.org/project-detail/ESRS/38280/project-hippo.

[33] From 2004 to 2009, USAID ran PSP-One, a "flagship project" to increase private sector's provision of health services. One of the activities was an assessment of the private health sector in Kenya that would go on to be published as a World Bank working paper. Between 2009 and 2016, USAID ran its Strengthening Health Outcomes through the Private Sector (SHOPS) project, a "flagship initiative in private sector health," with an objective of increasing the role of the private sector in providing health products and services. Through this project, USAID implemented an initiative in Kenya to "help increase the role of the private sector in health," which promoted PPPs and offered guidance to the Kenyan Ministry of Health on its universal health coverage and private sector strategies. See USAID, *PSP-One and Health Financing*, May 2008, https://www.shopsplusproject.org/sites/default/files/resources/5111_file_Health_Financing_Final_1_pager.pdf; World Bank, *Private Health Sector Assessment in Kenya*, April 2010, xiv, https://openknowledge.worldbank.org/handle/10986/5932; USAID, *Strengthening Health Outcomes through the Private Sector Project - Final Report 2009-2016*, 2016, 2, 64-65, https://www.shopsplusproject.org/sites/default/files/resources/SHOPS_Project_Final_Report.pdf; USAID, "Sustainable Strategies For Accessible, Quality Health Care: Public-Private Sector Engagement in Kenya," undated, 1-2, https://www.shopsplusproject.org/sites/default/files/resources/Kenya Program Brochures_0.pdf.

[34] USAID, *Private-Sector Engagement Policy*, 2018, 3-4, https://www.usaid.gov/sites/default/files/documents/1865/usaid_psepolicy_final.pdf.

[35] "RFI Attachment 1: Private Sector Opportunities to a Fully Private Care and Treatment," USAID, 1, available at: https://www.grants.gov/view-opportunity.html?oppId=328744

the "overburdened" public health sector, and also conducted a "Willingness to Pay Study" to assess HIV patients' interest and ability pay for treatment at private pharmacies.[36]

II. Factual allegations

We, as a collection of civil society organizations, include groups who have directly supported people adversely affected by the private health sector in Kenya, as well as organizations that have conducted research into the impact of privatization and commercialization of healthcare in Kenya.[37] Except where noted, the information below is based on the experience and research of signatories.

Lack of affordability drives hardship, poverty, and exclusion

Kenyan individuals have been pushed into poverty and debt to pay for private care, which generally costs more than public care. They have also been turned away from private facilities they could not afford and been forced to stop treatment altogether because of unaffordable private care, and in some instances the denial of care due to inability to pay has led to loss of life.[38]

Various studies confirm that private facilities often charge significantly more than public facilities for the same service.[39] For example, one comprehensive study found that private sector breast cancer screening was more than four times as expensive as public sector screening (USD $18 private vs. $3.90 public), diagnostic procedures were more than three times as expensive (USD $1,205 vs. $401), and treatment was eight to 12 times as expensive depending on the stage of the cancer.[40]

Individuals in informal settlements and rural areas report facing hardships trying to afford private care. Some said they went into debt, quit school, or sold important assets like cars, livestock, and land. Others reported being refused care by private providers unless they paid a significant deposit, as well as ending or pausing treatment due to high costs in the private sector. Many community members report avoiding care altogether due to the anticipated cost.[41]

[36] "Program Description for Activity 3: USAID Private Sector Engagement in Health Services and Systems Strengthening Activity," USAID, 5, available at: https://www.grants.gov/web/grants/view-opportunity.html?oppId=336359

[37] See, e.g GI-ESCR, *Patients or customers?*; Hakijamii and CHRGJ, *Wrong Prescription.*

[38] GI-ESCR, *Patients or customers?*, 28.

[39] Sujha Subramanian et al., "Cost and Affordability of Non-Communicable Disease Screening, Diagnosis and Treatment in Kenya: Patient Payments in the Private and Public Sectors," *PLOS ONE* 13, no. 1 (January 2018): https://doi.org/10.1371/journal.pone.0190113; Benjamin Daniels et al., "Use of Standardised Patients to Assess Quality of Healthcare in Nairobi, Kenya: A Pilot, Cross-Sectional Study with International Comparisons," *BMJ Global Health* 2, no. 2 (2017): 8, http://dx.doi.org/10.1136/bmjgh-2017-000333; World Bank and Government of Kenya, *Kenya Health Service Delivery Indicator Survey 2018 Report*, May 2019, 72, https://www.sdindicators.org/sites/sdi/files/countryreports/Final%20KESDI%20Health%20Technical%20Report%20-%20May%202019.pdf.

[40] Subramanian et al., "Cost and Affordability," 7-8.

[41] See, e.g. Hakijamii and CHRGJ, *Wrong Prescription*, 34.

Despite multiple court rulings finding the detention of patients unlawful, private healthcare providers in Kenya continue the practice.[42] Individuals said they, or their family members, were detained by private facilities until bills were paid, and private healthcare workers confirm that the practice is ongoing.[43] Private hospitals have also refused to release the bodies of family members and loved ones who had passed away until bills were settled.[44]

Insurance coverage through Kenya's social insurer, the NHIF, does not sufficiently remedy these problems, in part because private facilities are able to charge patients more than what the NHIF covers, and often do so. We have spoken with numerous individuals who said they faced high and unaffordable costs at private providers and incurred debt to pay for care, despite having NHIF coverage.[45]

Bias towards certain areas, patients, and services

Taken as a whole, the private health sector is selective about the services it offers, the people it serves, and the areas in which it operates. Private facilities are more likely to operate in urban areas[46] and are much more likely to care for wealthy Kenyans.[47]

Private facilities are also less likely than the public ones to offer certain key health services. For example, a 2018 survey of thousands of facilities nationwide found that private providers were less likely to offer routine child immunizations, care for tuberculosis and HIV/AIDS, and other important services.[48] Another large survey found that private facilities were less likely to offer vaccination services, with public facilities offering on average 81.4 percent of key vaccinations and private facilities on average offering far fewer, just 40.7 percent.[49] Private facilities in Kenya are, however, considerably more likely to offer curative services like comprehensive surgical services—which have higher returns.[50]

[42] See MAO v. Attorney General, Petition 562 of 2012, eKLR (High Court of Kenya at Nairobi, 2015), http://kenyalaw.org/caselaw/cases/view/131104/; Veronicah Nyangai v. Nairobi West Hospital Ltd, Petition 63 of 2017, eKLR (High Court of Kenya at Nairobi, 2017), http://kenyalaw.org/caselaw/cases/view/133560; Mary Nyang'anyi Nyaigero v. Karen Hospital Limited, Civil Suit 448 of 2015, eKLR (High Court of Kenya at Nairobi, 2016), http://kenyalaw.org/caselaw/cases/view/118675/; Gideon Kilundo v. Nairobi Women's Hospital, Petition 242 of 2018, eKLR (High Court of Kenya at Nairobi, 2018), http://kenyalaw.org/caselaw/cases/view/158915/.
[43] See, e.g. Hakijamii and CHRGJ, *Wrong Prescription*, 35.
[44] *Id*.
[45] *Id*., 40.
[46] World Bank and Government of Kenya, *Health Service Delivery Indicator Survey 2018 Report*, 83-84.
[47] Ilinca et al., "Socio-Economic Inequality and Inequity in Use of Health Care Services," 9.
[48] They were less likely to deliver family planning services, antenatal and postnatal care, post-abortion care, routine child immunizations, care for child malnutrition, adolescent health services, tuberculosis diagnosis and treatment, care and support for HIV/AIDS, and services for survivors of violence and sexual abuse. Ministry of Health, *Harmonized Health Facility Assessment 2018/2019 Main Report*, 58, 61, 82, 78, 90; Ministry of Health, *Harmonized Health Facility Assessment 2018/2019 Annex Tables, Questionnaires, and Footnotes*, 2020, 71, 78, 97, 103, 161, https://www.health.go.ke/wp-content/uploads/2020/01/KHFA-2018-19-ANNEX-TABLES-FINAL.pdf.
[49] World Bank and Government of Kenya, *Health Service Delivery Indicator Survey 2018 Report*, 50-51.
[50] Ministry of Health, *Harmonized Health Facility Assessment 2018/2019 Main Report*, 199.

Substandard quality leading to inadequate care

The private health sector in Kenya consists of a highly heterogenous, uncoordinated collection of providers, offering widely varying levels of care. There are significant issues with the quality and safety of many private providers, especially those that operate in lower-income areas such as informal settlements.[51] While expensive and higher quality private facilities cater to the wealthy, quality issues are particularly acute at the lower-cost private providers that operate in informal settlements. Residents in these areas are more likely to encounter a private sector that is characterized by low quality—at times illegal—clinics and pharmacies, with less qualified staff and little specialized equipment.[52] Surveys and studies have found that private healthcare professionals often have inadequate training,[53] that private facilities are less likely to have a system for regular, continuous medical education than public facilities,[54] and that people are more likely to avoid private facilities due to unqualified staff.[55]

Numerous people have reported receiving misdiagnoses and unsafe or inadequate care at private healthcare providers. They described being treated for conditions they did not have and providers failing to diagnose common illnesses. One woman said her mother died after visiting a private hospital that failed to correctly diagnose her because her endoscopy results were swapped with those of another patient, and another woman said that a botched surgery at a private hospital left her with a disability.[56] Many feel the public sector offers better quality care, though there are often barriers to accessing it like long wait times and lack of medications.[57]

Disproportionate impact on underserved groups

The privatization and commercialization of healthcare have disproportionate impacts on different groups, including those who have been historically underserved and marginalized, and who therefore should be the focus of efforts to expand access to healthcare.

Rural residents are, in many respects, ignored by the private sector, and therefore may be particularly harmed by policies that increase reliance on private healthcare. People in rural areas are far more reliant on public health facilities.[58] They also experience higher rates of poverty, and

[51] One 2018 World Bank survey of over 3,000 health facilities in Kenya found that private facilities had worse diagnostic accuracy, adherence to clinical guidelines, and management of maternal and neonatal complications than public facilities. Another 2018 survey of thousands of Kenyan facilities found that private ones were less likely to have a system for monitoring adverse events, undertaking mortality and morbidity reviews, and providing supportive supervision. World Bank and Government of Kenya, *Health Service Delivery Indicator Survey 2018 Report*, xiii; Ministry of Health, *Harmonized Health Facility Assessment 2018/2019 Main Report*, 259, 268, 264.
[52] See, e.g., Kennedy Abuga et al., "Sub-Standard Pharmaceutical Services in Private Healthcare Facilities Serving Low-Income Settlements in Nairobi County, Kenya," *Pharmacy* 7, no. 167 (December 2019): 4, https://doi.org/10.3390/pharmacy7040167.
[53] Aisha Walcott-Bryant et al., "Addressing Care Continuity and Quality Challenges in the Management of Hypertension: Case Study of the Private Health Care Sector in Kenya," *Journal of Medical Internet Research* 23, no. 2 (2021): 5, https://doi.org/10.2196/18899.
[54] Ministry of Health, *Harmonized Health Facility Assessment 2018/2019 Main Report*, 258.
[55] Ministry of Health, *2018 Household Health Expenditure and Utilization Survey*, 33.
[56] See, e.g. Hakijamii and CHRGJ, *Wrong Prescription*, 34.
[57] See, e.g. *id*., 42.
[58] Ministry of Health, *2018 Household Health Expenditure and Utilization Survey*, 41.

are therefore less able to afford expensive private care.[59] Relying on the private sector to deliver healthcare risks rural residents' financial and physical access to care.

People with disabilities, who in many cases have been woefully failed by the existing healthcare system, have voiced concerns about the lack of accessible and appropriate services at private facilities. Some community members feel that public facilities are generally more physically accessible than private facilities.[60]

Women are also disproportionately affected by the privatization and commercialization of healthcare, both because of their relative economic disadvantage and because the private sector comparatively neglects their specific health needs. Kenyan women earn less,[61] are more likely to be in poverty,[62] and are more dependent than men on public healthcare[63]—and therefore more negatively affected by greater systemic reliance on private providers. Private facilities are less likely to offer family planning services, post-abortion care, antenatal care, and maternal postnatal care,[64] while public facilities are about twice as likely to offer services for survivors of violence and sexual abuse.[65] Research shows that women who delivered in private facilities in Kenya had a higher chance of cesarean delivery,[66] a phenomenon that has been linked to financial incentives.[67] Women said they routinely face high fees at private facilities for labor and delivery, as well as pre-natal care.

The privatization and commercialization of care also risks the rights of poor and low-income Kenyans. They are the least able to afford expensive private care and more likely to access lower quality—often unregulated, at times substandard and unsafe—private facilities that are concentrated in low-income areas. Poor Kenyans start off at a huge disadvantage in accessing care,[68] face significant socio-economic inequalities and obstacles in accessing healthcare,[69] and are far more likely to forgo care altogether.[70] National survey results show that the richest households used preventative and inpatient care nearly twice as often as their poorer counterparts.[71] Instead of addressing these imbalances, prioritizing the private sector may exacerbate inequalities in access. Community members from informal settlements told us that private providers are unaffordable, and described fees for routine care that would pose a burden to anyone under the national poverty line.

---

[59] Kenya National Bureau of Statistics, *Basic Report on Well-Being in Kenya*, 44.
[60] See, e.g. Hakijamii and CHRGJ, *Wrong Prescription*, 36.
[61] Kenya National Bureau of Statistics, *Inequality Trends and Diagnostics in Kenya 2020*, 67, 103-105.
[62] Kenya National Bureau of Statistics, *Basic Report on Well-Being in Kenya*, 62.
[63] Ministry of Health, *2018 Household Health Expenditure and Utilization Survey*, 27.
[64] Ministry of Health, *Harmonized Health Facility Assessment 2018/2019 Main Report*, 58, 78, 61, 82.
[65] Ministry of Health, *Harmonized Health Facility Assessment 2018/2019 Annex Tables, Questionnaires, and Footnotes*, 161.
[66] Malachi Ochieng Arunda, Anette Agardh, and Benedict Oppong Asamoah, "Cesarean Delivery and Associated Socioeconomic Factors and Neonatal Survival Outcome in Kenya and Tanzania: Analysis of National Survey Data," *Global Health Action* 13, no. 1 (2020), https://doi.org/10.1080/16549716.2020.1748403.
[67] Ana Pilar Betrán, et al., "Interventions to Reduce Unnecessary Caesarean Sections in Healthy Women and Babies," *The Lancet* 392, no. 10155 (October 2018), https://doi.org/10.1016/S0140-6736(18)31927-5.
[68] Ministry of Health, *2018 Household Health Expenditure and Utilization Survey*, 26, 41.
[69] Ilinca et al., "Socio-Economic Inequality and Inequity in Use of Health Care Services," 2.
[70] Ministry of Health, *2018 Household Health Expenditure and Utilization Survey*, 18.
[71] Ilinca et al., "Socio-Economic Inequality and Inequity in Use of Health Care Services," 4-6.

Significant use of public resources

Despite being presented as a solution for scarce public resources, the growing role of the private sector has placed a significant burden on the state. The Kenyan government does not make public the total amount of government expenditure on private healthcare, and has not responded to civil society queries on the issue.[72]

However, based on publicly available information, it is clear that large sums of public money are being transferred to the private sector. For example, Kenya's social health insurer sent more than Kshs. 34 billion (about USD $289 million) to private facilities in 2020/21—64 percent of its total benefit expenditure that year.[73] In the 2021/22 national budget, the government allocated 6 percent of its total health spending to a single public-private partnership (or PPP), about half of what it allocated to the entire rollout of universal health coverage[74]—and counties also reported spending up to 14 percent of their annual health budgets on the deal.[75] That partnership, known as the Managed Equipment Services project, was intended to equip Kenyan public hospitals with leased medical equipment for seven years at an estimated cost of more than Kshs. 60 billion (or USD $500 million), much of which went to global firms including General Electric and Philips.[76] Public-private partnerships in health can create what is effectively hidden debt, draining public coffers.

It is not clear whether the government is getting good value for money by relying on the private sector. For example, although the NHIF's contracts with private facilities are—problematically—not publicly available, the NHIF has confirmed that it reimburses private facilities at higher rates than public facilities for the same services.[77] The public-private partnership discussed above has drawn significant scrutiny from civil society organizations,[78] Kenyan officials, and others amidst widespread reports that some of the equipment was never delivered, substantially delayed, or was unusable due to lack of infrastructure and staff.[79] It appears that some was overpriced, with

[72] See, e.g., "Correspondence," CHRGJ, last accessed August 25, 2022, https://chrgj.org/kenya-health-correspondence/.
[73] "Annex: Questions for the National Hospital Insurance Fund," NHIF, March 12, 2022, https://chrgj.org/wp-content/uploads/2022/03/NHIF-response-to-CHRGJ-query.pdf.
[74] Parliamentary Budget Office, *Unpacking the Estimates of Revenue and Expenditure for 2021/2022*, 11-12.
[75] Mutua and Wamalwa, *Leasing of Medical Equipment Project in Kenya*, 18.
[76] John Mutua and Noah Wamalwa, *Leasing of Medical Equipment Project in Kenya: Value for Money Assessment*, (Nairobi: Institute of Economic Affairs, 2020), 6, 13-15, https://ieakenya.or.ke/download/leasing-of-medical-equipment-project-in-kenya-value-for-money-assessment/.
[77] "Annex: Questions for the National Hospital Insurance Fund," NHIF, March 12, 2022, 4, https://chrgj.org/wp-content/uploads/2022/03/NHIF-response-to-CHRGJ-query.pdf. Limited information available in scholarship and reports confirms that the NHIF reimburses private facilities at higher rates than public facilities for certain services. See, e.g., Gabriella Appleford and Edward Owino, *National Hospital Insurance Fund Tariffs: What are the Effects on Amua Franchisee Businesses?* (London: Marie Stopes International, 2018), 5, https://hanshep.org/our-programmes/AHMEresources/case-study-national-hospital-insurance-fund-tariffs.
[78] See, e.g., Crystal Simeoni and Wangari Kinoti, *Medical Equipment Leasing in Kenya: Neocolonial Global Finance and Misplaced Health Priorities* (Suva: DAWN, 2020), https://dawnnet.org/wp-content/uploads/2021/01/Medical-Equipment-Leasing-in-Kenya_Neocolonial-Global-Finance-and-Misplaced-Health-Priorities_DAWN-discussion-paper-25.pdf.
[79] See John Mutua, "Taxpayers Paid 6 Times More for GE Hospital Machine," *Business Daily*, November 25, 2019, https://www.businessdailyafrica.com/economy/Taxpayers-paid-6-times-more-for-GE-hospital-machine/3946234-

Ministry of Health records suggesting pieces of equipment were leased at many times their normal market price, and counties reporting they had procured similar equipment at a fraction of the lease cost.[80] One official said that the government provides private facilities with certain drugs for free in order to increase access to these drugs, but that some private facilities nonetheless charge high prices for them, casting doubt on whether this is an efficient use of public resources.

Simultaneously, the public health sector is woefully underfunded and under-supported. Public healthcare workers have long been neglected, with significant delays in compensation and a lack of much-needed psychosocial support and personal protective equipment during the COVID-19 pandemic.[81] Significant public health spending is directed to the private sector, starving public facilities of much-needed resources. The demand for public healthcare is strong—for example, 13 new public health facilities recently constructed by Nairobi Metropolitan Services treated more than 131,000 patients within months of opening.[82] But until there is sufficient commitment to improving the public system, patients will continue to face problems like long wait times, medicine shortages, and difficulty reaching distant public facilities.

Lack of information and participation

Civil society organizations have also documented serious problems with access to information about the private sector's role in healthcare, and a lack of opportunities to participate in health- and economic-related policy decisions relating to the private sector.

Accessing information about private sector involvement in health is difficult even for civil society organizations, and many community members have described being able to access exceedingly little information about such arrangements. As noted above, the Kenyan government does not make public the total amount of government expenditure on private sector healthcare and financing, and has not responded to civil society queries on the issue. Civil society organizations often encounter claims that contracts or related documents are confidential. Organizations seeking information from the NHIF about its dealings with the private sector were first told that they could access information in media reports, and then were informed in writing that they should seek such information from individual hospitals directly because reimbursement terms were "based on

5362374-4j8ch0z/index.html; Ibrahim Oruko, "Medical Kits 'Lying Idle' in 27 Counties," *The Nation*, October 22, 2019, https://allafrica.com/stories/201910230354.html; "Tana River's Sh800m Idle Medical Machines," *The Standard*, November 11, 2019, https://www.standardmedia.co.ke/coast/article/2001348873/tana-river-s-sh800m-idle-medical-machines; Roselyn Obala and Jacob Ng'etich, "How Sh63 Billion Health Project Bleeds Taxpayers," *The Standard*, December 1, 2018, standardmedia.co.ke/health-science/article/2001304678/how-sh63-billion-health-project-bleeds-taxpayers; Angela Oketch and Samwel Owino, "How Uhuru's MES health care scheme went to the dogs," *The Nation*, October 4, 2020, https://nation.africa/kenya/news/how-uhuru-s-mes-health-care-scheme-went-to-the-dogs-2456164.

[80] Senate Ad-Hoc Committee to Investigate the Managed Equipment Services, *Report of the Investigation of the Managed Equipment Services*, September 2020, 101-02., https://www.kelinkenya.org/wp-content/uploads/2020/09/Final-Version-of-MES-Committee-Report-for-Tabling_08092020.pdf.

[81] Human Rights Watch, *Kenya: Pandemic Health Workers Lack Protection*, October 2021, https://www.hrw.org/news/2021/10/21/kenya-pandemic-health-workers-lack-protection.

[82] Maureen Kinyanjui, "28 new hospitals in Nairobi relieve residents in slums," *The Star*, July 14, 2022, https://www.the-star.co.ke/counties/nairobi/2022-07-14-28-new-hospitals-in-nairobi-relieve-residents-in-slums/; see also Kinyanjui, "Newly Launched Hospitals Record High Patient Turnout," *The Star*, August 26, 2021, https://www.the-star.co.ke/counties/nairobi/2021-08-26-newly-launched-hospitals-record-high-patient-turnout/.

individual contractual agreements between NHIF & the hospitals."[83] Even the former Attorney General said his office was denied access to the contracts for the medical equipment public-private partnership, despite his responsibility for scrutinizing and approving the contracts to ensure their compliance with the Constitution and other relevant laws.[84]

We are aware of few meaningful opportunities for Kenyan individuals to influence policies relating to the private health sector, and of numerous private health sector initiatives that appear to be moving forward with no or inadequate opportunities for participation. For example, in 2019, the Kenya Medical Practitioners Pharmacists and Dentists Union (KMPDU) sued the Ministry of Health and the Board of Kenya's premier public referral hospital, Kenyatta National Hospital (KNH) over a proposed public-private partnership that would establish a for-profit, user-fee funded private hospital on the KNH campus. KMPDU alleged that public participation was inadequate, given that they, as major stakeholders in the medical field, were not consulted.[85]

Development actors' failures to account for risks

In light of the issues set out above, development actors' continued promotion of the private health sector is highly concerning. Signatories to this submission who have engaged directly with several of these entities are concerned that an ideological commitment to the private sector may be contributing to their unwillingness to recognize evidence of harm or to reconsider the overall approach. We have encountered recurring assertions—often without evidence—that greater private sector participation will help the country achieve its development goals and, paradoxically, that it will support the public health sector. Despite their long track record of promoting private care, some development actors have sought to shift blame for problems to the Kenyan government rather than accept responsibility for the shortcomings of a privatized and commercialized approach.

Some representatives have appeared insufficiently concerned about, or unaware of, inequalities in access to private sector healthcare in Kenya and about the issues that plague lower quality private facilities. This is consistent with the findings of a 2018 assessment of the World Bank Group's support for health services, which found that "World Bank project financing and IFC investments supporting health services seldom monitor and evaluate all dimensions of quality," and that "distributional impacts are rarely monitored and evaluated when specific disadvantaged population groups are identified as beneficiaries."[86] In direct engagement with the IFC, representatives have implied that concerns like affordability or the socio-economic background of patients were "management" issues not within the IFC's purview. On the other hand, USAID has explicitly

[83] "Annex: Questions for the National Hospital Insurance Fund," NHIF, March 12, 2022, https://chrgj.org/wp-content/uploads/2022/03/NHIF-response-to-CHRGJ-query.pdf
[84] Rawlings Otieno, "Former AG Faults CS Macharia on Multi-Billion Medical Leasing Deal," *The Standard*, July 23, 2020, https://www.standardmedia.co.ke/business/article/2001379751/former-ag-faults-cs-macharia-on-multi-billion-medical-leasing-deal.
[85] Kenya Medical Practitioners Pharmacists and Dentists Union v. Kenyatta National Hospital Board & Others, petition 452 (High Court of Kenya, Constitution and Human Rights Division 2019), para. 25. KMPDU also alleged also that the new private hospital would lead to discrimination in healthcare provision.
[86] World Bank. *World Bank Group Support to Health Services: Achievements and Challenges* (2018) viii, https://ieg.worldbankgroup.org/evaluations/world-bank-group-health-services

acknowledged the pro-rich bias of the private sector but pushed ahead with private sector projects, seemingly accepting that they will prioritize wealthier Kenyans.[87]

Failure to effectively regulate and monitor private health care facilities

To the extent that the government intentionally relies in part—and increasingly—on the private sector as a way of achieving universal health coverage and of fulfilling the right to health, the existing regulatory framework is weak and lacking in meaningful enforcement. Unlicensed private clinics and laboratories operate widely, especially in informal settlements.[88] Monitoring and enforcement activities are seen as underfunded and not sufficiently transparent, and there are widespread reports of private clinics closing on the day of inspection, suggesting advance knowledge of regulatory visits.[89] Serious concerns have also been raised about the NHIF's ability to adequately monitor quality at the providers it empanels.[90]

III. Threat to human rights

Given the concerns set out above, we believe that the privatization and commercialization of healthcare in Kenya is already compromising the enjoyment of the right to health, and that risks to human rights will be amplified by an approach to universal health coverage that embeds the private sector more deeply.

The right to health guarantees that goods and facilities be available in sufficient quantity, accessible to everyone without discrimination, culturally acceptable, and of good quality.[91] Analyzing the developments in Kenya using the so-called "AAAQ" framework, one can observe how the physical accessibility, economic accessibility, availability of services, and quality of care are threatened by the growth of an unaffordable, powerful private sector that focuses on wealthy, urban patients, and varies widely in quality. The many real problems we and others have documented with private sector care in Kenya—including inequitable access, exclusion, and quality and safety issues—underscore the seriousness of the threat.

There are additional ways in which the privatization and commercialization of healthcare could violate guarantees under international human rights law. The concerns set out above indicate that the State is not fulfilling its obligation to regulate private actors in order to ensure that health goods and services are adequate and accessible to all.[92] The government is failing to ensure—or as far as we are aware, to even consider—meaningful regulations that could, in theory, guarantee respect for the various components parts of the right to health by private sector actors who are assuming previously public functions.

[87] "Program Description for Activity 3: USAID Private Sector Engagement in Health Services and Systems Strengthening Activity," USAID, 5, available at: https://www.grants.gov/web/grants/view-opportunity.html?oppId=336359
[88] GI-ESCR, *Patients or Customers?*, 32; see 31-34 for an in-depth discussion.
[89] Hakijamii and CHRGJ, *Wrong Prescription*, 25.
[90] Edwine Barasa et al., "Kenya National Hospital Insurance Fund Reforms: Implications and Lessons for Universal Health Coverage," Health Systems & Reform 4, no. 4 (2018): 356, https://doi.org/10.1080/23288604.2018.1513267.
[91] UN Committee on Economic, Social and Cultural Rights, General Comment No. 14, paras.12.
[92] UN Committee on Economic, Social and Cultural Rights, General Comment No. 24, para. 22.

The disproportionate impact on certain groups—which have traditionally been underserved and/or which are more likely to rely on the public sector—suggests that prioritizing the private sector may violate the prohibition on non-discrimination. The diversion of public resources to ineffective private actors also casts doubt on whether maximum available resources are being dedicated to the realization of the right to health. States' obligations with regards to public services are also implicated.[93] Additionally, the right to health-related information as well as the right to participate in health-related political decisions are imperiled.[94]

International actors and foreign countries supporting greater private sector participation in health may be running afoul of their obligations,[95] especially if their international assistance promotes health privatization and commercialization to the detriment of Kenyans' right to health.[96]

IV. Request for intervention

We wish to impress upon you the seriousness of these issues, and our sincere belief that your engagement can play a valuable role in protecting the rights of Kenyans, especially at a critical moment of transition following the recent general elections. We feel the issuance of joint or individual allegation letters could do a great deal to bring these human rights risks to the attention of relevant stakeholders and to promote the right to health in Kenya. We ask you to urge the Kenyan government to guarantee the right to health for all, including by strengthening the public healthcare system and adopting laws and policies that will ensure that privatization and commercialization are not undermining human rights. Given their longstanding efforts to promote greater private sector participation in health in Kenya, the World Bank Group and the United States government should be cautioned about the ongoing and potential future rights violations associated with the current forms of privatization and commercialization of healthcare in the country, advised

[93] For a more extensive discussion of these obligations, see GI-ESCR, *States' Human Rights Obligations Regarding Public Services: The United Nations Normative Framework*, October 2020, https://www.gi-escr.org/publications/states-human-rights-obligations-regarding-public-services-the-united-nations-normative-framework; see also, *The Future is Public: Global Manifesto for Public Services*, 2021, https://futureispublic.org/wp-content/uploads/2021/10/Future-is-Public-Global-Manifesto-for-public-services.pdf.

[94] UN Committee on Economic, Social and Cultural Rights, General Comment No. 14, paras. 12, 17.

[95] For a more extensive discussion of these obligations, see Human Rights Centre Clinic at the University of Essex, GI-ESCR, and the Initiative on Social and Economic Rights (ISER), *Private Actors in Health Services: Towards a Human Rights Impact Assessment Framework*, 2019, 27-30, https://static1.squarespace.com/static/5a6e0958f6576ebde0e78c18/t/5dfb832f7894511787b02d52/1576764300874/Private+Actors+and+the+Right+to+Health+Report+-+December+2019.pdf; International Covenant on Economic, Social and Cultural Rights, art. 2; Juan Pablo Bohoslavsky (Independent Expert on the effects of foreign debt and other related international financial obligations of States on the full enjoyment of all human rights, particularly economic, social and cultural rights), Effects of Foreign Debt and Other Related International Financial Obligations of States on the Full Enjoyment of all Human Rights, Particularly Economic, Social and Cultural Rights, A/74/178, paras. 61-64 (July 16, 2019), https://undocs.org/en/A/74/178.

[96] In several contexts, CESCR has made clear that a State's support for privatization through development assistance could run afoul of its obligations, clarifying that international assistance related to sexual and reproductive care should not push recipient countries to adopt models of privatization, and expressing concerns about the United Kingdom's support for privatized education in developing countries. UN Committee on Economic, Social and Cultural Rights, General Comment No. 22, The Right to Sexual and Reproductive Health, E/C.12/GC/22, para. 52 (May 2, 2016), https://undocs.org/E/C.12/GC/22; UN Committee on Economic, Social and Cultural Rights, Concluding Observations on the Sixth Periodic Report of the United Kingdom of Great Britain and Northern Ireland, E/C.12/GBR/CO/6, paras. 14-15 (July 14, 2016), https://undocs.org/E/C.12/GBR/CO/6.

of their obligations, and asked to clarify whether and how their activities comport with these obligations.

Given the gravity of our concerns, we also urge you to consider the issuance of a press statement in the near future to ensure the wider public is alerted to the allegations. Please contact us should you need additional information.

Sincerely,

1. Alliance of Women Advocating for Change (Uganda)
2. Amnesty International Kenya (Kenya)
3. Center for Human Rights and Development (Rwanda)
4. Economic and Social Rights Centre – Hakijamii (Kenya)
5. ESCR-Net (Global)
6. FIDA Uganda (Uganda)
7. Global Initiative for Economic, Social and Cultural Rights (GI-ESCR) (Global)
8. Global Justice Now (United Kingdom)
9. Human Rights Research Documentation Centre (HURIC) (Uganda)
10. Kenya Legal & Ethical Issues Network on HIV & AIDS (Kenya)
11. Muungano wa wanavijiji social movement (Kenya)
12. Nairobi Peoples Settlement Network (NPSN) (Kenya)
13. Pamoja Trust (Kenya)
14. People's Health Movement Kenya (Kenya)
15. Phenix Center for Economic Studies (Jordan)
16. Public Services International (France)
17. Southern and Eastern Africa Trade Information and Negotiations Institute (SEATINI) (Uganda)
18. The Center for Human Rights and Global Justice at New York University School of Law (United States)
19. The East African Centre for Human Rights (EACHRights) (Kenya)
20. Wemos (The Netherlands)