



Embracing
Intersectionality
for Health Equity
& Justice

THE AFRICA MEDICAL EQUIPMENT FACILITY (AMEF) IN KENYA

**Does this new blended finance facility contribute
to equitable access to healthcare services?**



EXECUTIVE SUMMARY

This report critically analyses the design and rollout of the Africa Medical Equipment Facility (AMEF) in Kenya. We describe how the AMEF, like many development projects involving private healthcare provision and blended finance, ultimately does not manage to reach poor populations and thus fails to promote universal and equitable access to healthcare.

The AMEF is a blended finance facility that supports private healthcare providers in seven African countries (potentially more in the future) to buy medical equipment from manufacturers by de-risking loans provided by local banks. Kenya, along with Ivory Coast, is one of the first two countries where the AMEF was implemented. It is financially supported by the Global Financing Facility for Women, Children and Adolescents (GFF) and the International Finance Corporation (IFC), the private sector arm of the World Bank. The facility aims to increase healthcare provision, foster innovation, and increase investment in the private health sector by demonstrating its bankability.

While medical equipment is really needed in Kenya and many African countries, the promotion of private healthcare services in a context of high inequality in access to care, like Kenya, should not increase the existing inequality. The main question of our study was whether the AMEF in Kenya truly contributes to equitable access to healthcare services, with a focus on vulnerable populations and reproductive and maternal health services, since it is co-financed by the GFF. To assess this, we used a qualitative methodology, which included desk research and semi-structured key informant interviews.

We found that the AMEF is mainly attractive for higher-end, medium-to-large private facilities, allowing them to access more financing to purchase medical equipment. However, its loans are unlikely to benefit small, low-end healthcare providers. It is doubtful that the AMEF will contribute to universal and equitable access to healthcare services, reaching “people who are left behind”, making the AMEF hardly suitable for the mission of the GFF. Since essential services for Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH-N) are delivered through the public system, investment in the AMEF could divert scarce GFF resources.

From the interviews, we learned that civil society representatives were often unaware of the initiative. Most interviewees raised criticism on the lack of support to local manufacturers. Civil society representatives and some healthcare officials expressed concerns that the AMEF, like other financing facilities focused on private healthcare, could hamper progress towards health equity in Kenya. Based on the findings, some of the proposed recommendations for the policymakers involved in the project include:

» **For the GFF**

Since this initiative does not reach people living in poverty, we recommend reassessing their blended finance approach and their support to the AMEF in particular.

» **For the World Bank and its arms - the International Finance Corporation (IFC) and International Development Association (IDA) who is co-financier of the AMEF in Ivory Coast**

We recommend assessing investments in the health sector with a health equity lens. And, to expand access to medical equipment, the World Bank should consider directly supporting local (Kenyan or African in general) manufacturers, or work with the African Union and its existing initiatives, like the Africa Medical Supplies Platform - rather than financing private healthcare providers.

» **For the Kenyan government**

We recommend investing and strengthening public healthcare provision. This should be financed through progressive taxation, and by increasing the amount of National Health Insurance Fund resources allocated to the public sector.

About us

This study has been carried out by two organisations, Akina Mama wa Afrika and Wemos, and is part of the Make Way Programme.

Akina Mama wa Afrika (AMwA) is a regional feminist Pan-African development organization with headquarters in Kampala, Uganda. AMwA's work is rooted in feminist principles and beliefs guided by the Charter of Feminist Principles for African Feminists which define our work building women's individual and collective power to influence policy and social change. AMwA envisions a dignified and equitable feminist society for African women, girls and gender-expansive persons. At AMwA, how we conduct our work is as important as the work itself and we are intentional about community, inter-generational solidarity, and intersectional feminism in pursuit of a gender just society.

Wemos is an international civil society organisation, based in the Netherlands. We advocate structural change to realise global health justice. A group of Dutch medical students founded Wemos in 1979 because they believed that medical interventions in low- and middle- income countries can only be effective if the underlying causes of health inequity and injustice are addressed. Together with our partners around the world, we develop, propose and support evidence-based solutions to ensure that everyone, everywhere has optimal access to quality healthcare and is protected against threats to health. We strive for global advocacy that reflects 'local realities', and jointly advocate global policies that address countries' needs.

Make Way is a five-year programme that promotes innovative practices in intersectional SRHR advocacy. The Intersectionality Consortium, which leads our Make Way programme, consists of Akina Mama wa Afrika, The Circle of Concerned African Women Theologians, Kenya, Forum for African Women Educationalists, Liliane Foundation, and Wemos as lead. The Make Way programme is implemented in Ethiopia, Kenya, Rwanda, Uganda, and Zambia, and at the global and regional level.

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1. INTRODUCTION

This report describes our critical analysis of the design and rollout of the Africa Medical Equipment Facility (AMEF) in Kenya. The AMEF is a blended finance facility that supports private healthcare providers in seven African countries (potentially more in the future) to buy medical equipment from manufacturers by de-risking loans provided by local banks. Kenya, along with Ivory Coast, is one of the first two countries where the AMEF was implemented. It is financially supported by the Global Financing Facility for Women, Children and Adolescents (GFF) and the International Finance Corporation (IFC), the private sector arm of the World Bank. The facility aims to increase healthcare provision, foster innovation, and increase investment in the private health sector by demonstrating its bankability.

While medical equipment is really needed in Kenya and many African countries, the promotion of private healthcare services in a context of high inequality in access to care, like Kenya, should be wary not to increase the existing inequality. In our study we assessed whether the AMEF in Kenya truly contributes to equitable access to healthcare services, with a focus on vulnerable populations and reproductive and maternal health services, since it is co-financed by the GFF.

1.1 UNDERFUNDED HEALTHCARE SYSTEMS AND THE USE OF BLENDED FINANCE

Developmental Financial Institutions like the World Bank and the International Monetary Fund have since the 1980s-90s promoted deregulations and privatization as key development policies. These ideas have continued to be promoted through austerity measures coupled with the promotion of private actors in the health sector. Based on this, we see that the policies of these developmental financial institutions – despite their continued failure – keep being promoted as the best alternative.

Also due to these austerity measures, health systems in many low- and middle-income countries, such as Kenya, are overwhelmed and chronically underfunded. On the other hand, developmental financial institutions propose “innovative solutions” to the lack of funding, which rely on the private-for-profit sector to fill the public funding and external financing gaps. This leads to financing and incentivising private healthcare companies and private financial institutions.¹ This private capture of the healthcare sector, in many cases, is also driven by the economic interest of rich countries and their private sector, which see low-and middle-income countries as an opportunity to expand their market.² One way development institutions work with the private sector is called **blended finance**. This means “the strategic use of development finance for the mobilisation of additional finance towards sustainable development”, mainly by attracting private investment by removing part of the investment risk.³ The intention to systematically use blended finance to achieve the Sustainable Development Goals was first mentioned in a World Bank document from 2015,⁴ which set the ambitious goal of transforming “billions into trillions” by leveraging private investment.

¹ Wemos (2022). Improving healthcare, but for whom? [\[LINK\]](#)

² Wemos (2020). In the interest of health for all? The Dutch ‘Aid and Trade’ agenda as pursued in the African healthcare context [\[LINK\]](#)

³ Blended Finance - OECD. From: www.oecd.org [\[LINK\]](#)

⁴ WB & IMF (2015). From billions to trillions: transforming development finance [\[LINK\]](#)

Many World Bank institutions still try to use blended finance in selected cases for development purposes. Three of these institutions are:

1. the **International Finance Corporation (IFC)**, the private sector arm of the World Bank Group;
2. the **International Development Association (IDA)**, also part of the World Bank Group, which helps the world's poorest countries by providing zero to low-interest loans; and
3. the **Global Financing Facility for Women, Children and Adolescents (GFF)**, a multi-stakeholder global partnership housed at the World Bank that aims to improve Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH-N).

1.2 THE USE OF BLENDED FINANCE IN THE GFF, IDA AND IFC

The GFF's goal when it comes to funding is to be catalytic. From the beginning it recognised that it could not close the financing gap for RMNCAH-N alone. But it could leverage additional resources from various partners; domestic resources, external financing, and "innovative" engagement of the private sector. From its 2014 concept note, the GFF approach seems to have "*smart, scaled, and sustainable financing*" at its heart, together with a rigorous focus on achieving and measuring results. The GFF identified that the private sector could particularly contribute to addressing challenges of supply chains, medical technology, and access to capital for private healthcare providers. Interestingly, the GFF highlights the flexibility of its financing, with an example that resembles the AMEF project:⁵

"If an Investment Case⁶ highlights that access to capital is a major constraint to purchasing the equipment that will improve the quality of care in the private sector, trust fund resources could be used to establish a revolving loan fund to address this."

However, it is important to note here that in the same strategic document it is highlighted that resources should be directed to high impact RMNCAH-N activities and results. The two key criteria for mobilising resources, according to the GFF, are efficiency and equity, with the latter referring to access for poor women, adolescents, and children who are often particularly disadvantaged in terms of access to healthcare and rely heavily on out-of-pocket expenditures.

In its latest 2021-2025 Strategy, under its strategic direction to build more resilient, equitable and sustainable health financing systems, the GFF suggests "*scalable global innovative financing opportunities, such as Sustainable Development Bonds and blended finance, that can increase the pool of available investment capital to expand access to quality health services for women, children and adolescents.*"⁷ So, again, blended finance appears as a tool, but with the aim of expanding access to quality RMNCAH-N services.

The Investment Case for Kenya is the 2016 Kenya RMNCAH Investment Framework.⁸ The document pointed out the main causes of child and maternal mortality and the needs of the healthcare system to improve RMNCAH-N services. Among these, the document highlights the need for basic medical equipment, such as sterilisers, neonatal ambu bags, suction machines, solar lights, and the creation of sick child nurseries.

⁵ GFF (2015). Business Plan [\[LINK\]](#)

⁶ The Investment Case is "a description of the changes that a country wants to see with regard to RMNCAH and a prioritised set of investments required to achieve these results." [\[LINK\]](#)

⁷ GFF (2020). GFF 2021–2025 Strategy [\[LINK\]](#)

⁸ Kenya Ministry of Health (2016). Kenya RMNCAH Investment Framework [\[LINK\]](#)

To use blended finance, the GFF relies on the expertise of the IFC in the private sector, by allocating part of its own resources into IFC projects which are deemed relevant for the mission of the GFF.

Similar to the GFF, the IDA also uses blended finance, through its Private Sector Window (IDA PSW). Since 2018, this mechanism assigns a pool of IDA funds to the IFC, in order to catalyse private investment in the poorest countries towards strategic areas for achieving the Sustainable Development Goals.⁹ Also in the case of IDA, private sector growth is seen as a way to achieve development goals, not as an end in itself.

In the case of the IFC, blended finance can be used to mobilise additional private investment other than IFC's own resources. Blended finance solutions at IFC can be structured as debt, equity, risk-sharing, or to guarantee investment products.

1.3 THE AFRICA MEDICAL EQUIPMENT FACILITY

Since the Covid-19 pandemic, lack of access to medical equipment (such as ventilators and oxygen concentrators) has been identified as a key issue for healthcare systems in low- and middle-income countries. To address this barrier, development institutions looked at blended finance strategies. In 2021, the IFC launched the **Africa Medical Equipment Facility (AMEF)**, in collaboration with the GFF and the IDA PSW.¹⁰ The AMEF aims to support private healthcare providers to access financing for the purchase of medical equipment from manufacturers at reduced interest rates. This is done in collaboration with local banks using blended finance. By doing so, the AMEF aims to make medical technology more accessible and affordable, improve the effectiveness of healthcare provision, and increase investment in the private health sector by demonstrating its bankability.¹¹ This is intended to create a market for medical equipment in the recipient country, not only by increasing sales, but also financial investments by local banks.

It is important to note that, with the AMEF, it is the first time that the IDA PSW and the GFF work with a healthcare blended finance project.

Thus far the AMEF has only started to be functional in two countries: Côte d'Ivoire and Kenya. In Côte d'Ivoire, the IDA PSW is the co-funder, and in Kenya the GFF is the co-funder for the first phase (with a USD 6 million contribution).¹² In this case study we look at the design and rollout of AMEF in Kenya only. A more in-depth description on the AMEF can be found in the section: "How the AMEF is designed and operationalised in Kenya" (page 13 of the paper).

1.4 CONTEXTUAL BACKDROP FOR IMPLEMENTATION OF AMEF IN KENYA

Financing facilities for medical equipment are very relevant for the Kenyan healthcare context. The AMEF is rolled out against the backdrop of policies rolled out by the government and developmental institutions to incentivise the procurement of medical equipment and the private sector. The following paragraphs will touch on these.

⁹ What is the IDA Private Sector Window? From: www.ida.worldbank.org [LINK]

¹⁰ IFC's Africa Medical Equipment Facility. From: www.ifc.org [LINK]

¹¹ Africa Medical Equipment Facility | Summary of Investment Information. From: www.disclosures.ifc.org [LINK]

¹² DFI Working Group Joint Report on Blended Concessional Finance for Private Sector Projects [LINK]

Medical equipment

In its Universal Health Coverage (UHC) policy 2020-2030 the Kenyan Ministry of Health¹³ stated that access to basic medical equipment is inadequate in Kenya and most of the health facility infrastructure is not up to the standards set by the government. Improving access to priority health products and technologies (HPT) is part of the UHC strategy and should go hand in hand with further investments in human resources for health (HRH) for instance. The strategic goal is formulated as follows: “Improve the efficiency of use and equity in the availability of health system resources e.g., human resources for health, health products and technologies, health infrastructure and information systems.” According to the MOH this requires investments by national and county governments in HRH, HPT and basic equipment.

The most well-known government action in upgrading medical equipment in public hospitals across the country is the Managed Equipment Service (MES) scheme (2015), in which six private firms were contracted to lease equipment to the highest tier hospitals in every county.¹⁴ However, the project was designed without involving civil society and labour unions, and the equipment was delivered without a proper assessment of the needs at the county and healthcare facility level, which resulted in underutilization of the equipment.¹⁵ The MES was criticised for its top-down approach, the resulting mismatch of delivered equipment with the local priority needs in the health system, and the extremely inflated costs that went with the comprehensive service contract.¹⁶ Moreover, there was a lack of transparency in how the contracting process happened and how resources were allocated.¹⁷ In practice, the flaws in the scheme outweighed its alluded benefits.

Kenya has been considered an attractive market for medical equipment and technology; it is seen as a tech hub, which attracts medical tourism as well as investment from equipment manufacturers.¹⁸ One example of this is the presence in Kenya of Philips Capital,¹⁹ a subsidiary company that facilitates the purchase of Philips’ equipment by providing financial solutions (such as leasing, extended payment terms and trade finance) to healthcare providers.

Also, several donor-supported initiatives have been rolled out in the Kenyan context. For instance, the IFC²⁰ and the Medical Credit Fund,²¹ which has also been co-financed by the IFC, have been offering guarantees and loans to small and medium-sized healthcare enterprises for various needs, including medical equipment. The purchase of medical equipment with the financial and advisory support from The Netherlands, through Official Development Assistance (ODA) and other development finance channels, has been part of the Dutch Aid and Trade agenda.²²

While these policies have made Kenya an attractive market for medical equipment manufacturers, the Kenyan healthcare system still heavily relies on imported products, as domestic manufacturing is scarce due to limited infrastructure, technical capacity, and access to raw materials.²³

¹³ Kenyan Ministry of Health (2020). Kenya Universal Health Coverage Policy 2020 – 2030 [\[LINK\]](#)

¹⁴ Mutua, J. and Wamalwa, N. (2020). Leasing of Medical Equipment Project in Kenya: Value for Money Assessment. Nairobi: Institute of Economic Affairs. [\[LINK\]](#) Accessed on 12th August 2022.

¹⁵ Council of Governors of Kenya (2019), Senate. Proceedings on the medical equipment [\[LINK\]](#)

¹⁶ Korir, M. (2018). Managed Equipment Services: The Kenyan Story. [\[LINK\]](#) Accessed on 12th August 2022.

¹⁷ Mutua, J. and Wamalwa, N. (2020). Leasing of Medical Equipment Project in Kenya: Value for Money Assessment. Nairobi: Institute of Economic Affairs [\[LINK\]](#)

¹⁸ Intellectap (2019). Innovative Health Financing Models for Universal Health Coverage in Kenya [\[LINK\]](#)

¹⁹ Healthcare financing services | Extended Payment Term| Philips Capital. From: [philips.co.ke](#) [\[LINK\]](#)

²⁰ DFI Working Group Joint Report on Blended Concessional Finance for Private Sector Projects [\[LINK\]](#)

²¹ Medical Credit Fund. From: [www.medicalcreditfund.org](#) [\[LINK\]](#)

²² Wemos (2020). In the interest of health for all? The Dutch ‘Aid and Trade’ agenda as pursued in the African healthcare context [\[LINK\]](#)

²³ International Trade Administration (2022) Kenya Country Commercial guide - Healthcare-Medical Devices [\[LINK\]](#)

Parallel goals of expansion of the private-for-profit sector and achieving UHC

Since nearly a decade the Kenyan government has been striving for more private sector involvement in health services provision and finance,²⁴ and intensified collaboration with the private sector through public-private partnerships (PPPs) in health²⁵ in line with the general aspiration to transform the country into a globally competitive and prosperous industrialised, middle-income country.²⁶ An important legal instrument in this quest is the PPP Act, enacted in 2013.²⁷ Through the PPP Act the government can involve the private sector in the financing, development, and operationalisation of public services, through government concessions and other types of contracts.

In parallel, achieving UHC became one of the goals of Kenya's former President's Big Four Agenda.²⁸ The health system reform programme for UHC was launched in 2018. Important vehicle in the UHC programme is the National Health Insurance Fund (NHIF), which was formerly only focused on private healthcare and only covered a small proportion of the Kenyan population. The goals of the programme include full coverage of the population, and a complete package of essential services without user fees at the primary and secondary levels of the health system. The Kenyan UHC programme began as a pilot in four of Kenya's 47 sub-national governments.²⁹

In practice, there are many problems. First of all, there is a lack of public finance for health. A policy brief on healthcare financing³⁰ described that despite Kenya's strong economic growth led to tripling of government expenditures across all sectors, government expenditures on health as a percentage of total government expenditures had nonetheless stagnated around 8-9%,³¹ putting Kenya farther from the government's goal of increasing health expenditures towards 12% of total expenditure. Secondly, the enrolment in the NHIF remains low at the disadvantage of lower income groups. The scheme's coverage among informal workers who form 83% of the Kenyan workforce is only 17.7% of the total population is estimated to be covered by the NHIF.³² Moreover, the payments from the NHIF towards the public sector services are hampered by the fact that public facilities are not set up to submit insurance claims.³³

However, the main concern regarding the NHIF is about equitable access. While the majority of the Kenyan population seeks care in the public sector, the public sector receives only 20% of the NHIF funds.³⁴ This situation is seen as unequal, since national statistics showed how the poorer quintiles are by far the most likely to seek care in the public sector.³⁵ Whilst the NHIF was supposed to eliminate economic barriers to private healthcare access for everyone, in practice this is not the case. This is because many private providers require high co-payments when the bill exceeds what is reimbursed by the NHIF; also, many vital services are not included in the basic insurance plan and must be paid out-of-pocket.

²⁴ Kenyan Ministry of Health (2014). Kenya Health Policy 2014–2030 [\[LINK\]](#)

²⁵ Kenyan Ministry of Health (2014) Kenya Health Sector Strategic Plan (KHSSPI) 2014-2018 [\[LINK\]](#)

²⁶ Government of Kenya, Kenya Vision 2030 [\[LINK\]](#)

²⁷ Republic of Kenya, Public Private Partnerships Act 2013 [\[LINK\]](#) and PPP Regulations 2014 [\[LINK\]](#)

²⁸ Government of Kenya, Kenya Vision 2030 [\[LINK\]](#)

²⁹ Kenya Ministry of Health (2018) President Uhuru launches Universal Health Coverage Pilot Program [\[LINK\]](#)

³⁰ Kenya Ministry of Health (2019). A Case for Increasing Public Investments in Health [\[LINK\]](#)

³¹ World Bank database [\[LINK\]](#)

³² Institute for Global Health Sciences (2019). Gender Disparities in NHIF Access and Use: A Barrier to Achieving UHC in Kenya. [\[LINK\]](#)

³³ P4H Network (2022). It takes two to tango: enabling public facilities to participate in purchasing arrangements in Kenya [\[LINK\]](#)

³⁴ CHRGI and Hakijamii (2021). Wrong Prescription - The Impact of Privatizing Healthcare in Kenya [\[LINK\]](#)

³⁵ Kenya National Bureau of Statistics et. al (2020). Inequality Trends and Diagnostics in Kenya 2020 [\[LINK\]](#)

1.5 AIM OF THE STUDY

Since the AMEF is the first important blended finance project in the health sector for the GFF and the IDA PSW, aimed to reach poor populations, it represents a relevant case study. We are interested in assessing how the AMEF can contribute to increased healthcare access for poor populations and UHC. The involvement of the GFF makes the research particularly relevant for the Make Way programme, which highly overlaps with the GFF's mission to protect the health of vulnerable groups through targeted strengthening of primary health care systems. After the conclusions, we will provide recommendations to all the actors involved: GFF, IDA-PSW and IFC, also considering the different roles and missions of each institution. This study builds on an earlier desk review by Wemos, which described the investments of the IFC in health in recent years,³⁶ and on previous studies on the relation between private sector promotion and the right to health in Kenya.³⁷

³⁶ Wemos (2022). Improving healthcare, but for whom? [\[LINK\]](#)

³⁷ CHRGI and Hakijamii (2021). Wrong Prescription - The Impact of Privatizing Healthcare in Kenya [\[LINK\]](#)

2. RESEARCH QUESTIONS

1. How is the AMEF designed and operationalised in Kenya?
2. Which healthcare providers benefit (or are supposed to benefit) from the AMEF?
3. What is AMEF's likely impact on people's access - women of reproductive age, the most vulnerable, people living with disabilities, and the poorest in particular - to health services?
4. How does AMEF contribute to Kenyan health system strengthening?
5. To what extent does the AMEF fit in national strategies to reach UHC?

3. METHODOLOGICAL NOTES

The authors of this report adopted a qualitative methodology consisting of a desk review and key informant semi-structured interviews. The authors used Make Way's adapted Intersectionality Based Policy Analysis³⁸ tool to create the research questions and the question guides.

The desk review entailed the analysis of relevant documentation on the project, such as: disclosed documentation from the IFC website and online database and the GFF website, news items from the local and international press, press releases from the manufacturers' websites, any relevant documentation obtained from the participating companies (manufacturers, financial institutions and healthcare providers).

A consultant (Kenyan Medical Doctor Stellah Bosire) conducted the interviews, together with one or two staff members of AMwA and/or Wemos, between July-August 2022. The key informant interviews included representatives from the following stakeholder groups: government and public health care actors, health care entrepreneurs, development actors (IFC, GFF, IDA), and civil society organisations in Kenya. A validation meeting was conducted in October 2022 to present and discuss the findings with all the interviewees.

AMwA and Wemos staff jointly wrote the final recommendations for the GFF, IDA and IFC, while AMwA and the consultant formulated the recommendations for the Kenyan government.

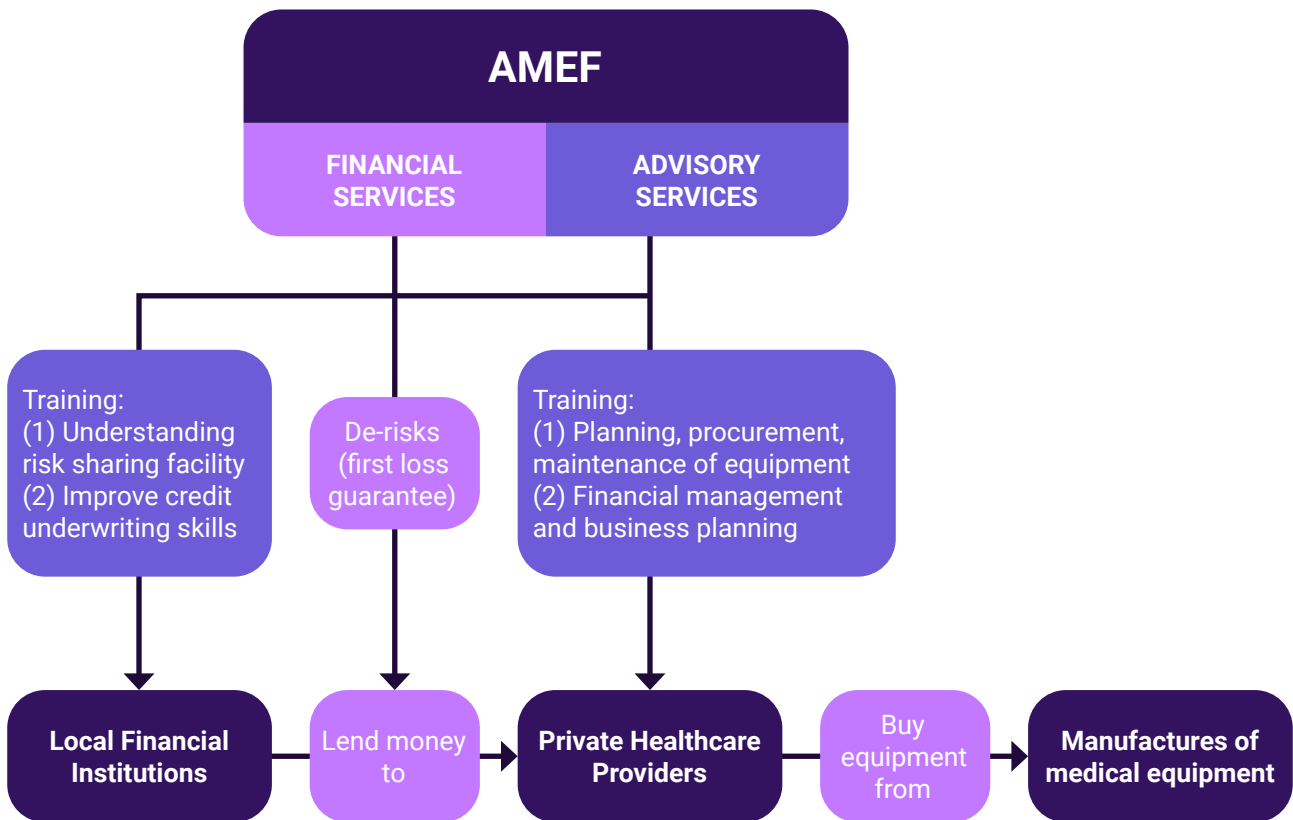
³⁸ Hankivsky et al. (2012). Intersectionality-based policy analysis. An intersectionality-based policy analysis framework, 33-45.

4. RESULTS

4.1 HOW IS THE AMEF DESIGNED AND OPERATIONALISED IN KENYA

According to the Summary Investment Information³⁹ provided by IFC, the Africa Medical Equipment Facility (AMEF) is a financing facility aimed at supporting small and medium-sized healthcare providers to access up to USD 300 million in loans and leases from local banks. The aim of these loans is to finance the acquisition of medical equipment and thus support the private healthcare sector in Cameroon, Côte d'Ivoire, Kenya, Rwanda, Senegal, Tanzania and Uganda.

This is done by de-risking the loans that will be disbursed to the healthcare providers by local banks. While the total project cost is USD 150 million, by incentivising loan disbursement the AMEF aims to mobilise up to USD 300 million in loans from local banks to small and medium healthcare providers. The project also includes advisory services to banks and healthcare providers participating in the project. The flowchart below summarises the functioning of the AMEF.



³⁹ IFC disclosures website, "Africa Medical Equipment Facility | Summary of Investment Information" [\[LINK\]](#)

Financial services

The AMEF collaborates with:

» **Local Financial Institutions (e.g., local banks)**

They provide loans to the healthcare providers. Loans are covered by “First-Loss guarantee”. This is a de-risking mechanism whereby a third party (in this case, the AMEF) compensates lenders if the borrower defaults. This gives investors more confidence to give out loans and lowers the interest rates they charge, making credit more accessible. At the moment, the only participating bank in Kenya is the Cooperative bank of Kenya

» **Healthcare Small and Medium Enterprises**

These are the private healthcare providers that receive loans to purchase medical equipment. The loans have a tenor of three to seven years and a grace period of 6 months to two years, allowing the healthcare providers to repay the loans gradually after they have started to gain returns from the investment. The names and number of healthcare providers that have thus far benefited from the project are currently not publicly disclosed.

» **Original Equipment Manufacturers**

Equipment manufacturers sell their products, and possibly provide maintenance services. The project, according to the IFC webpage, is intended for both local equipment manufacturers as well as international equipment manufacturers who have a presence in the country through authorised distributors. Equipment manufacturers that are interested in participating in the project can do so by responding to the open call⁴⁰ on the IFC website. All the participating equipment manufacturers are currently international ones, namely General Electric⁴¹ (USA), Philips⁴² (The Netherlands), Getinge⁴³ (Sweden) and Karl Storz⁴⁴ (Germany).

Advisory services

The project includes advisory services⁴⁵ to banks (project onboarding and general training) and healthcare providers (medical equipment planning, procurement, maintenance, as well as financial management and business planning toolkit). The advisory service consists of:

- » Training modules
- » Workshops, training events, seminars, conferences, etc.
- » Reports, like assessments, surveys, manuals, research, analytical, and evaluations.

⁴⁰ IFC's Africa Medical Equipment Facility. From: www.ifc.org [LINK]

⁴¹ “GE Healthcare, NSIA and IFC Partner to Strengthen Medical Equipment Financing Support Across Africa” [LINK]

⁴² “IFC Partners with Philips and Co-operative Bank of Kenya to Help African Healthcare Providers Access Essential Medical Equipment” [LINK]

⁴³ “Getinge partners with IFC to help increase access to medical equipment across Africa” [LINK]

⁴⁴ “KARL STORZ Joins IFC Medical Equipment Facility to Improve Healthcare Services in Africa” [LINK]

⁴⁵ From: IFC disclosures website, “Africa Medical Equipment Facility | Advisory Services” [LINK]

Impact

According to press releases and project's disclosures, the expected impact is described in terms of market creation and support to the healthcare sector in Africa:

» Support to the healthcare sector in Africa

The project aims to increase access to medical equipment from private healthcare providers, which will benefit the patients. IFC anticipates that the project will enable local banks to sustainably increase their healthcare loan portfolio and, hence, contribute to increasing access to longer-term finance, which is scarce in these markets. The financing will be used to acquire medical equipment which is expected to improve the effectiveness of the healthcare provided and strengthen the human capital.⁴⁶ The development impact is expected to be further strengthened with the IFC Advisory Services provided to selected Healthcare Small and Medium Enterprises and PFIs and the inclusion of maintenance and servicing of medical equipment by the equipment manufacturers.

» Market creation and competitiveness

This includes: (1) increased competition among equipment manufacturers, which could result in equipment prices falling for the benefit of the private healthcare providers; (2) the expansion of local bank's portfolio in loans to private healthcare providers, which will demonstrate to the wider market that they are bankable, thus increasing lending to private healthcare providers from the wider market; and (3) a general increase in access to technologies in healthcare in Africa.

Budget, size of the loans and conditions

The budget of the project is USD 150 million, which provides the financial guarantee for the loans. The bank's product is in the form of asset financing or a leasing option between KSH 500,000 to KSH 200,000,000⁴⁷ (USD equivalent) to cover up to 90% financing for 5 years which may be extended to 7 years in unique instances. The loans are given at an interest rate of 10.5% and with an appraisal fee.⁴⁸

Access to the loans is conditional to (1) the acquisition of the medical equipment from the participating equipment manufacturers and (2) meet at least 2 of the IFC criteria⁴⁹ used to define a Small and Medium Enterprises, namely:

- » Having less than 300 employees
- » Total assets between 100,000 and 15 million USD
- » Total annual revenues between 100,000 and 15 million USD

IFC MSME Definition				MSME Loan Size Proxy
Indicator	Employees	Total assets US\$	Annual sales US\$	Loan size at origination
Micro enterprise	< 10	< \$100,000	< \$100,000	< \$10,000
Small enterprise	10 - 49	\$100,000 - < \$3 million	\$100,000 - < \$3 million	< \$100,000
Medium enterprise	50 - 300	\$3 million - \$15 million	\$3 million - \$15 million	< \$1 or \$2 million [1]

Table 1 - IFC definitions of Micro, Small and Medium Enterprises. From: www.ifc.org [LINK]

⁴⁶ The term human capital refers to the economic value of a worker's experience and skills. Human capital includes assets like education, training, intelligence, skills, health.

⁴⁷ USD 4200- 1,680,672, KSH-USD rates as on 12th August 2022 [LINK]

⁴⁸ Kenya Healthcare Federation, Africa Medical Equipment Facility Launch: Post-Event Report [LINK]

⁴⁹ IFC's Definitions of Targeted Sectors [LINK]

Who finances the AMEF?

The AMEF is co-funded by two international channels for public funds: the IDA PSW and the GFF (also hosted by the World Bank). In particular, IDA PSW finances the AMEF in Côte d'Ivoire, whereas in Kenya, the AMEF is co-financed by the GFF, which committed a modest sum of 6 million USD. The financing of the AMEF consists of a USD 200 million envelope divided as follows: 50% of the investment risk is carried by local financial institutions; 30% of the risk is carried by the AMEF; 20% of the risk is carried by equipment manufacturers.

Since the AMEF is funded by the IDA PSW, it is expected to have a good development impact. The IDA PSW aims to finance only projects which, despite being riskier for private investors, are considered particularly impactful - hence the use of zero-interest loans to mobilise and de-risk additional private finance (blended finance). The development impact of IFC projects is measured through the Anticipated Impact Measurement and Monitoring (AIMM) Framework.⁵⁰ The AIMM Framework rates each IFC project with a score from 10 to 100; to be eligible for financing from the IDA-PSW, IFC projects must have a rating of at least 47 (i.e., "good" development impact). In particular, the IDA PSW is financing the AMEF because this platform is expected to increase access to healthcare services, by financing low-end, small healthcare providers.

It is important to note that, with the AMEF, it is the first time that the IDA PSW finances a healthcare financing platform. Therefore, the AMEF represents a first important step in the use of IDA finances to support the private healthcare sector, with potentially more blended finance projects in this sector to be funded in the future.

With regards to the GFF, its contribution to the AMEF means that the platform is expected to also deliver health goals, particularly related to RMNCAH-N services for poor populations, as this represents the GFF's mandate. Since its inception, the GFF has committed to focus on prioritising evidence-driven and high-impact investments to improve RMNCAH-N through targeted strengthening of primary health care systems. The collaboration with the IFC was highlighted in the GFF's 2021-2025 Strategy for the first time, with the aim to "promote investments in private healthcare providers that commit to reach underserved women, children and adolescents."⁵¹ In its 2015 Business Plan, the GFF only referred to tapping on IFC's expertise with the private sector.⁵²

⁵⁰ IFC (2020). How IFC Measures the Development Impact of Its Interventions [\[LINK\]](#)

⁵¹ GFF (2020). GFF 2021–2025 Strategy [\[LINK\]](#)

⁵² GFF (2015). Business Plan [\[LINK\]](#)

4.2 WHICH HEALTHCARE PROVIDERS BENEFIT FROM THE AMEF?

According to the press releases, IFC disclosures, and IFC health experts, the AMEF project aims to finance affordable, small and medium healthcare enterprises, especially at a primary healthcare level. However, the latter is unlikely going to be the case. The interviewed stakeholders stated that the healthcare providers who have been most interested in the services provided by the AMEF are high end, large providers - especially compared to local standards.

Three main factors are at play here. In the first place, according to the stakeholders, the selection criteria for the Small and Medium Enterprises outlined by the IFC do not reflect the local reality. What are considered as Small and Medium Enterprises by IFC standards are, in fact, medium-to-large healthcare providers when compared to Kenyan standards. This was confirmed by both the staff involved in the preparation of the training sessions as well as the healthcare providers who attended the training, who noted how the equipment that the AMEF made available was too expensive for their activity.

Secondly, the equipment manufacturers involved are very expensive, making the equipment completely unaffordable for small providers. One interviewee (who was involved in the implementation of the AMEF) noted how the equipment is “high-end, extremely high-end”. According to another interviewee (also involved in the implementation of the project), the equipment manufacturers involved in the AMEF are “the ones who raised their hands”: they are manufacturers that have been involved for several years in development projects and have tried to expand their market in Sub-Saharan Africa – they were the first ones to get to know the initiative and to respond to the open call. However, what the involved equipment manufacturers have to offer might not respond to the needs of local stakeholders, especially small, primary healthcare providers.

Finally, the type of equipment offered by the equipment manufacturer is generally for highly specialised, secondary and tertiary care – which is not only too expensive, but also not necessary for small, primary healthcare providers. One interviewee noted how small healthcare providers “wouldn’t even have the space to place this equipment in their clinics, let alone the money to buy it.” The type of equipment that small, primary healthcare providers need, and which would potentially serve many more people, is much more basic than what the AMEF currently has to offer: hemograms, blood pressure machines, simple biochemistry tests, urinalysis machines, liver function machines, infusion pumps, fetoscopes, sterilisers.

As it is, the AMEF seems to be better suited for large, secondary and tertiary healthcare providers. As one interviewee noted: “the providers which will be interested in the AMEF are going to be high end. It is surely not going to be the low-cost primary healthcare provider that anyone can afford.” At the moment of writing, only one loan has been disbursed in Kenya. The loan, amounting to KHS 350 million, was given to a high-end tertiary healthcare provider in Nairobi, which is considered a large healthcare provider when compared to Kenyan standards.

4.3 IMPACT ON PEOPLE'S ACCESS - WOMEN OF REPRODUCTIVE AGE, THE MOST VULNERABLE, PEOPLE LIVING WITH DISABILITIES, AND THE POOREST IN PARTICULAR - TO HEALTH SERVICES

Most interviewed stakeholders were not aware of the GFF's support of the AMEF, and were surprised to hear from the interviewees that the GFF was co-financing the project. Most stakeholders (including representatives of the private sector) agreed that a facility such as the AMEF is not likely to fulfil the GFF mandate to promote RMNCAH-N. They stressed how, when it comes to sexual and reproductive health services, as well as maternal and childcare, the grand majority of the population relies on the public sector. This is especially true for vulnerable populations, such as people living in poverty, adolescents and women of reproductive age.

Interviewees also noted that the healthcare providers that are likely to be financed are not going to be low end healthcare providers of RMNCAH-N services, as the equipment offered is far too high end (see previous paragraph). Furthermore, the equipment offered by the AMEF at the moment does not correspond to the basic medical equipment needed for RMNCAH-N facilities (sterilisers, neonatal ambu bags, suction machines, solar lights and the creation of sick child nurseries) highlighted in the Kenya RMNCAH Investment Framework.⁵³

4.4 HOW DOES AMEF CONTRIBUTE TO KENYAN HEALTH SYSTEM STRENGTHENING?

The interviewees had different views on the AMEF when it came to support for health system strengthening. In general, private healthcare providers responded that, while the AMEF might need some adjustment in its design, it can support health system strengthening. On the other hand, civil society representatives, government officials and public healthcare practitioners had a negative view on AMEF's likely impact on the health system.

Opportunities for health system strengthening

1. Increased quality and availability of services

The interviewed private healthcare providers generally had a positive view of initiatives aimed at financing the acquisition of medical equipment for private healthcare providers, noting how these initiatives can increase the availability and quality of the service provided. One interviewee, a gynaecologist, said: *"I do not have an echo-machine, for example. Whenever I need an echo then, I need to refer my patients somewhere else. These services would allow me to improve my activity."* When asked about affordability and accessibility of the services, interviewed private providers agree that *"It is not the task of private providers to guarantee accessibility of the services. Our task is to provide a service; affordability and access are the government's tasks."*

2. Increased affordability of medical equipment due to lower interest rates and better loan conditions

Many healthcare providers welcomed the AMEF intention to lower the cost of financing for the acquisition of medical equipment. However, some interviewees expressed concern regarding the grace period on payment of the loans. It was suggested that the rates of the AMEF should be lowered and the grace period on repayment should be extended. Some healthcare providers added that local banks and Savings And Credit Cooperative Organisations (which go by the acronym of "SACCO" in Kenya) might offer better rates and conditions - mentioning also a "monopolistic behaviour" of the Cooperative Bank of Kenya, which is already the largest bank in the country.

⁵³ Kenya Ministry of Health (2016). RMNCAH investment framework [\[LINK\]](#)

3. Direct purchasing of the equipment by the healthcare provider

One of the main problems of purchasing medical equipment within the public health-care sector is the top-down approach: since the decisions regarding the purchase of the equipment are made at a central level (as in the case of the Managed Equipment Service), they do not necessarily reflect the needs and the capacity of the facilities. The AMEF, however, will not present such issues: health care providers can decide if and what equipment to buy, depending on their needs at the facility level. This choice is however limited by the narrow range of equipment manufacturers involved.

4. Increased investment in the tertiary sector, where the government does not invest

One of the interviewees, a government official, noted how the AMEF could be beneficial only if invested in areas where the government will not invest, namely tertiary care. They noted how private provision often competes with the public sector at a primary and secondary healthcare level, diverting NHIF resources away from public services and fragmenting the healthcare system. They noted however, that the government does not have enough funds to invest in tertiary care; thus, the AMEF can support the healthcare system through increased investment in this area.

Risks for health system strengthening

1. Increased disparity in access to secondary and tertiary healthcare services

Civil society representatives noted how the disparity in access to healthcare services is most evident at the secondary and tertiary care level. The interviewee noted that while there is a large availability of low-cost, small private healthcare providers for primary care, which most patients can afford, the inequality in healthcare access is much wider at the higher levels of healthcare provision. Secondary and tertiary private care is very expensive; even when accessing it through the NHIF, it requires large co-payments that most people cannot afford. By financing private provision at a secondary and tertiary level, civil society representatives believed that the AMEF could widen the gap in access to healthcare services. From one interview: *“The private healthcare sector is a major driver of inequality at the secondary and tertiary care level. Private healthcare providers are less of a problem at a primary healthcare (PHC) level: many people can get PHC in the private health sector at a very affordable rate. The problem is that care is unaffordable at secondary and tertiary care, which is very expensive for the average Kenyan. [...] Also, at the PHC level there is less asymmetry of information. People get the same diseases many times, they have an idea about what treatment is needed and what the cost is. Once you get malaria several times, you know how it is, you know the costs, so you can go to several healthcare providers and decide what is best for you. At the secondary and tertiary care you don’t have that; patients have no idea what is needed and so it is easy to inflate the bills, prescribe unnecessary examinations and things like that.”* Civil society representatives also noted how the existence of the NHIF in Kenya did not allow for access to private healthcare services, since this often requires very high co-payments, which are usually covered only in part (or not at all) by the NHIF.

2. Double practice of health professionals and misuse of healthcare equipment in public hospitals

Many interviewees noted how, while public hospitals have medical equipment, this is often left unused due to the phenomenon of the “double practice”. As many healthcare workers (mostly medical doctors) work both in public and private hospitals, they will often not perform diagnostic procedures in the public hospital, even when the public hospital has the necessary equipment to perform them. The doctors will instead refer patients to their private practice, where they will be able to charge the patients for the procedure. Civil society representatives noted how the AMEF could amplify this issue, if more and more private providers will access financing for medical equipment.

3. Uneven and inequitable distribution of medical equipment

Interviewed civil society representatives noted how using a market approach for the supply of medical equipment might lead to uneven concentration of medical equipment in richer areas. This is because the private sector will invest only in the areas where it can recover the cost, for example in areas where the population can afford private services. As one interviewee noted: *“Doing a project on medical equipment in a market-driven way would result in a very uneven concentration of equipment, with some richer areas with a lot of equipment and other areas with a scarcity.”*

4. Indebtedness and escalation of costs

Many interviewees expressed concerns that spurring the acquisition of medical equipment from private healthcare providers would increase the cost for the end user, by providing an incentive for the private sector to increase the patient turnover or their prices to repay the equipment. There is concern that this might incentivise the over-prescription of medical procedures by private healthcare providers in order to recover the costs; moreover, there is also a concern that this could provide an incentive for the private sector to lobby the government to include private services in the NHIF.

5. Lack of involvement of civil society and unawareness regarding the AMEF

Something that clearly emerged is the lack of involvement and awareness of many civil society representatives as well as healthcare providers regarding the AMEF. Interviewees suggested bringing on board various organisations, including clinical officers, and regulatory bodies to have consultative discussions. *“There is a need to make it a capacity-building discussion with no pre-fabricated opinions in mind and have a multi-sectoral discussion on the reality on the ground.”* There was also unawareness with regards to the GFF involvement in the AMEF, not only among civil society and healthcare practitioners, but also by interviewees who were involved in the rollout of the AMEF.

6. Lack of involvement of local manufacturers

Many interviewees were concerned about the lack of involvement of local manufacturers, that could increase dependency on import and disincentivise local manufacturing. While there is a limited number of equipment manufacturers in Kenya, interviewees believed that it would be better to involve them, or at least involve regional (African) manufacturers.

7. Lack of involvement of lower cost manufacturers

Other interviewees noted how the AMEF could involve more low-cost manufacturers (from China, India or Japan) who offer generic medical supplies. In their view, this could make the AMEF more affordable and broaden the number of healthcare providers that would access the loans. However, among civil society representatives, there was disagreement regarding the involvement of foreign manufacturers (whether low or high cost), because the involvement of African companies is considered the better choice.

8. The limited range of equipment offered does not respond to the local needs

Another point of concern was the fact that the limited availability of equipment offered by the AMEF mostly does not respond to the local needs. All the interviewees agreed that the AMEF rollout in Kenya needed to deal with the disconnect between the services offered and needs on the ground.

4.5 TO WHAT EXTENT DOES THE AMEF FIT IN NATIONAL STRATEGIES TO REACH UHC?

Interviewees agree that the AMEF is in line with the Kenyan strategy for healthcare development, which has been heavily focused on private sector engagement and financing. The private sector receives major financing from the government. For example, between financial years 2016/17 and 2019/20, private facilities received 82% of NHIF outpatient benefits and 64% of inpatient benefits, as shown by a recent report on Kenyan healthcare.⁵⁴ Most civil society representatives and government officials interviewed argued that this occurs because private healthcare providers lobby the government to provide incentives to the private sector. Moreover, the AMEF is in line with the aim of Kenya to become a tech hub in East Africa, particularly with regards to medical equipment.

Despite the government's intention to promote local manufacturing, the fact that the AMEF only includes large international manufacturers, causes concern that it will actually disincentive local manufacturing. One of the interviewees noted that *"A declaration was made by the government to encourage local manufacturing of medication and equipment. Tax for certain medical equipment was also to be zero rated to reduce the cost of accessing healthcare services and to ensure proper coverage."*

While the AMEF is in line with the government approach to support medical equipment manufacturers and private healthcare providers, the AMEF is not a government policy. As the financing is based on a voluntary approach from the healthcare providers, the destination of the financing is only based on the market and does not necessarily reflect healthcare system needs, such as even distribution of medical equipment across the country, affiliation of the facilities to the NHIF, affordability of the services, etc.

⁵⁴ CHRGGJ and Hakijamii (2021). Wrong Prescription - The Impact of Privatizing Healthcare in Kenya [\[LINK\]](#)

5. DISCUSSION

An overall observation emerging from our interviews is that the view on the AMEF correlates with the category of the interviewees: while private healthcare providers were interested and moderately positive about the AMEF, most of the interviewees from the public sector and from civil society has a less positive view.

It is important to note that the study has many limitations. First of all, this study does not address the actual impact of the AMEF, since its rollout is still at a very early stage. Secondly, it was impossible to interview representatives of equipment manufacturers and local banks, as they did not respond to the interview invitation. Thirdly, the study only examines the rollout of the AMEF in Kenya, and not in Côte d'Ivoire. And finally, detailed budget breakdowns, contracts and any documentation beyond what is available online were not provided to us.

The findings of this study highlight strengths and weaknesses in the design and operationalisation of AMEF. The design of the project allows private facilities to access more financing and directly choose what equipment to purchase, thus avoiding top-down decisions that do not respond to the needs at the healthcare facility level. However, this choice is limited by the small selection of equipment manufacturers that participate in the AMEF. Such equipment manufacturers are considered very high end and expensive, thus being unaffordable for the majority of the healthcare providers. Moreover, the equipment seems to target specialised healthcare needs of the population offered at secondary and tertiary facilities. The willingness of the AMEF to work with more affordable manufacturers is considered a positive aspect, even though so far only large international manufacturers have expressed interest; interviewees also stressed the need to involve local (Kenyan or African) manufacturers.

Access for populations to healthcare services

We find that the AMEF is unlikely to contribute to the access of poor populations to healthcare services. The only private providers that are accessible for poor populations are primary-level, low-end healthcare providers. However, according to all our interviewees, it is unlikely that these providers can ever be the target for the AMEF, since the type of equipment offered and the interest rates of the loans are inaccessible for small providers. Also, even when these bottlenecks are addressed, low-end primary providers will still not be an ideal target for the AMEF, as their needs in terms of equipment are much more basic than what is likely to be financed through blended finance.

Communication products regarding the AMEF focus on willingness to support small and medium providers, implying that they cater for lower income or underserved populations in hard-to-reach areas. Despite the fact that the AMEF finances providers that fall under the formal definition of Small and Medium Enterprises, this is not the case.

Contribution to RMNCAH-N and to the GFF mission

In particular, the AMEF is unlikely to contribute to GFF's mission and to RMNCAH-N. Since its inception, the GFF has committed to focus on prioritising country-led, evidence-driven, and high-impact investments to improve RMNCAH-N through targeted strengthening of primary health care. In fact, one of GFF's key areas of interest is to support the most disadvantaged populations and close health inequalities. In its Operational Plan for Implementing its approach to PHC, discussed during the 15th Investors Group meeting in November 2022, the GFF highlighted that PHC is the backbone of its activities and the most cost-effective and equity-supporting way to improve RMNCAH-N. For instance, one of its investment areas is to extend essential PHC services from secondary/tertiary care and down to primary and community care levels.⁵⁵ However, the AMEF does not seem to contribute to this mission. This is because RMNCAH-N services are mainly provided by the public

⁵⁵ GFF (2022). Operational Plan for Implementing the Global Financing Facility's Approach to Primary Health Care [\[LINK\]](#)

sector in general, and in the lower quintiles of the population in particular. Even assuming that a part of the population accesses RMNCAH-N services through lower-end providers, it is highly unlikely that these would be reached by AMEF's financial services, for the reasons described in the previous paragraph. The equipment offered by the AMEF is also different from the basic medical equipment needed for RMNCAH-N facilities (sterilisers, neonatal ambu bags, suction machines, solar lights and the creation of sick child nurseries) according to the Kenya RMNCAH Investment Framework.⁵⁶ This raises questions regarding the relevance of AMEF to the mission of the GFF, and whether the GFF should allocate its limited resources to a financing mechanism that cannot promise high impact RMNCAH-N services for the most underserved women, children and adolescents.

Interviewees pointed out a lack of communication, public consultation and/or transparency with regards to the AMEF. Many stakeholders, including GFF staff, did not know about the AMEF and found it difficult to understand how the AMEF works and how it is financed. There has also been no disclosure or public consultation around the decision-making process of the Trust Fund Committee. The names of the facilities who access the loans are not publicly disclosed, which would make it difficult to assess whether the AMEF loans are reaching those that need them the most. Issues of transparency and confidentiality when working with private finance are acknowledged in the global health literature,⁵⁷ and have been recorded in previous private-sector initiatives in Kenya.⁵⁸

This is potentially problematic for GFF involvement, since transparency and accountability have been a priority in GFF's 2021-2025 Strategy.⁵⁹ In June 2022, the Trust Fund Committee of the GFF expressed strong support for a new Implementation Research and Evaluation Strategy, to strengthen transparency and mutual accountability for achievement of measurable results within the GFF partnership. This strategy was published in October 2022. One of its objectives is to explicitly examine the GFF Logic Model against country experience to better understand what is working, where, and how, and how to adapt to improve outcomes; within and across countries. It also aims to enhance the use of evidence in decision-making and inform the development and implementation of the countries' priorities in terms of RMNCAH.⁶⁰ In this case for example, the AMEF could be a good learning opportunity, providing local evidence on the impact of blended finance on health systems and UHC.

Alternative: direct support for African manufacturers

Considering the difficulty to reach underserved populations through the AMEF, it might be more effective to use a different approach to expand the availability of medical equipment, instead of incentivising its purchase by private providers. This can be done, for example, by directly investing in local manufacturers, hence making equipment more accessible for both private and public sector.

While a counterargument to this is the scarcity of healthcare manufacturers in Kenya (and in Africa in general), increasing the dependence of the healthcare system on imported products will only reinforce the existing situation. Kenya has a limited number of domestic manufacturers, and heavily relies on imported equipment. However, it represents a promising market for medical equipment and there are opportunities to invest in local manufacturing.⁶¹ Moreover, supporting existing African manufacturers was also considered a better way to improve the supply chain by the interviewees.

⁵⁶ Kenya Ministry of Health (2016). RMNCAH investment framework [\[LINK\]](#)

⁵⁷ Stein and Sridhar (2018). The financialisation of global health. *Wellcome Open Research*

⁵⁸ Mutua, J. and Wamalwa, N. (2020). *Leasing of Medical Equipment Project in Kenya: Value for Money Assessment*. Nairobi: Institute of Economic Affairs. [\[LINK\]](#)

⁵⁹ GFF (2020). *GFF 2021–2025 Strategy* [\[LINK\]](#)

⁶⁰ GFF (2022). *Implementation Research and Evaluation Strategy*. [\[LINK\]](#)

⁶¹ International Trade Administration (2022) *Kenya Country Commercial guide - Healthcare-Medical Devices* [\[LINK\]](#)

Other development institutions have started to support local manufacturing also in the field of medical equipment. For example, in 2021, the African Union, with the support of the World Health Organization, the African Centre for Disease Control and other United Nation bodies, created the Africa Medical Supplies Platform,⁶² a virtual market of medical equipment for national healthcare systems, which focuses particularly on “Made in Africa” equipment.

Concern regarding private healthcare promotion

Finally, we must note that the interviewed civil society representatives are concerned with private healthcare financing and its effect on health equity. One major concern of civil society regarding the AMEF remains the appropriateness of financing private healthcare providers, especially high-end ones. Given that poor populations access healthcare services primarily through the public system, many Civil society representatives did not see the AMEF as a positive use of development finance. Financing private healthcare providers can be a source of inequality and lead to uneven distribution of health system resources. Even with the Kenyan NHIF, which was supposed to guarantee access to both private and public healthcare providers, access to private healthcare services is still widely unaffordable for people living in poverty. These findings confirm previous studies that pointed out how the NHIF is insufficient to address economic barriers in access to care.⁶³ These findings, however, cannot be considered specific to the AMEF, but touch on the broader discussion regarding the appropriateness of financing private healthcare provision (especially through development finance) in a context of high inequality of access to healthcare. This broader discussion is relevant to the AMEF too.

⁶² Africa Medical Supplies Platform [\[LINK\]](#)

⁶³ CHRGI and Hakijamii (2021). Wrong Prescription - The Impact of Privatizing Healthcare in Kenya [\[LINK\]](#)

6. CONCLUSIONS

From this study of the design and first rollout of the AMEF in Kenya from a health system strengthening point of view, we draw the following conclusions:

- » The strength of the AMEF is that, if rolled out effectively, it will allow private facilities to access more financing to purchase medical equipment, which potentially raises the quality of the services they provide. Private providers and manufacturers are interested in this project.
- » The AMEF is unlikely to contribute to the access of poor populations to (primary or higher level) healthcare services, because it is not designed to do so, and its loans are unlikely to benefit small, low-end healthcare providers. Furthermore, according to the results of the interviews and the literature,⁶⁴ low-income populations access healthcare mainly through the public sector.
- » As essential RMNCAH-N services are delivered through the public system, especially for “people who are left behind”, investment in the AMEF could divert scarce GFF resources.
- » There seems to be a lack of communication and public consultation regarding the AMEF; civil society representatives were often unaware of the initiative.
- » The lack of support to local manufacturers is one of the main points of critique on the AMEF, which was raised by almost all interviewees.
- » All civil society representatives, as well as some healthcare officials, are concerned that in Kenya (where equitable healthcare access is not ensured yet) AMEF, and any other financing facility focused on private healthcare, could hamper progress towards health equity.

⁶⁴ CHRGI and Hakijamii (2021). Wrong Prescription - The Impact of Privatizing Healthcare in Kenya [\[LINK\]](#)

7. RECOMMENDATIONS

We propose the following recommendations:

For the GFF:

- » Given that the AMEF is unlikely to contribute to the GFF mission, we recommend the GFF not to allocate further resources to the AMEF and to avoid rolling it out to more countries, at least until proven otherwise.
- » The GFF Trust Fund Committee and Investors Group should reassess its blended finance approach. It seems that blended finance initiatives can hardly manage to combine economic viability and a positive impact for poor populations. This makes blended finance unlikely suitable for the GFF mission.
- » The GFF Trust Fund committee should be more transparent in its funding-related decision-making processes.
- » The AMEF case fits the criteria of the GFF's Implementation, Research and Evaluation Strategy activities. The GFF can use AMEF as a learning opportunity to better understand the impact of blended finance in Kenya, but also as a cross-country learning opportunity that can inform future decisions with regards to blended finance and their collaboration with the IFC.

For the IDA:

- » As health goals should not be a trade-off against economic and trade goals, we recommend the IDA team, its board and its member countries to assess investments in the health sector with a health equity lens.⁶⁵ In particular, the effects that the financing of (higher end) private healthcare providers can have on equitable access to healthcare should be given critical consideration.
- » Taking our assessment of AMEF in Kenya into consideration, and before co-funding the rollout of AMEF in other countries, the IDA PSW team should assess whether the current rollout of AMEF in Côte d'Ivoire is likely to contribute to the goal of health equity, and whether it does not risk widening of inequality gaps in access to essential health services.
- » To expand access to medical equipment, IDA-PSW should consider directly supporting local (Kenyan or African in general) manufacturers, or work together with the African Union and its existing initiatives, like the Africa Medical Supplies Platform.

For the IFC:

- » To expand access to medical equipment, the IFC should consider directly supporting local (Kenyan or African in general) manufacturers or work together with the African Union and its existing initiatives, like the Africa Medical Supplies Platform.

⁶⁵ Health equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, or by other dimensions of inequality; according to the UN, health equity is a requirement for UHC (UN 2019, Political declaration of the high-level meeting on UHC - [\[LINK\]](#)).

For the Kenyan Government:

The right to health is guaranteed by the Constitution of Kenya, granting that the State shall ensure the highest standards of healthcare. Further, as the government of Kenya implements Universal Healthcare, it has committed to ensuring that Kenyans do not suffer any catastrophic out of pocket expenditure. Private for-profit initiatives like the AMEF, despite making the promise of improving access, are driven by profits of which the costs are inevitably passed to the patients.

1. The Kenyan government should ensure that part of the proposed reforms made for NHIF include safeguarding resources that are meant to improve access to healthcare in the public sector. The failures of NHIF indiscriminately reimbursing the private sector have costs for public health developments; equitable access for vulnerable populations ought to be addressed.
2. To achieve Universal Health Coverage, broader tax-based financing is the most suitable and progressive source to improve quality and ensure equitable access to healthcare for all indiscriminately. The investments to achieve UHC should focus on the public health sector.
3. The government should come up with a clear sustainability plan. While blended finance is expected to play only a transitory role, past transactions show that the period of transition may be longer than expected. Therefore, blended finance transactions should be initiated with a clear sustainability plan – a robust pool of partners that includes government to eventually take the program forward, a strong technical assistance program to support the partners in this journey, and a clear ongoing assessment and redress of gaps.