AFYA NAFUU FOR REDUCED INEQUALITIES IN KENYA

RAPID SITUATIONAL ANALYSIS OF THE EXISTING NATIONAL HEALTH INSURANCE PLAN IN KENYA

AMNESTY INTERNATIONAL

Amnesty International Kenya and
The People's Health Movement

Contents

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Executive Summary

National Health Insurance Fund (NHIF) has come a long way since its inception in 1966. Over the years, it has grown to become the main provider of health insurance in Kenya. In 2023, NHIF is at the center of an important policy debate as the Kenya Kwanza administration seeks to strengthen the financial revenue to expand the range and quality of public health services to more Kenyans.

In 2023, NHIF has over 15.4 million registered members. However, as reported by Business Daily, 48per cent of the registered members were dormant by January 2023, a result attributed to the tough economic times. One of the main challenges facing NHIF is inadequate funding. This has led to delays in payments to providers and a shortage of funds for critical operations. Additionally, NHIF has faced challenges in the management of fraud and abuse, which have led to a loss of resources.

NHIF is primarily financed by employees in the formal sector and are the main beneficiaries of the scheme. While the government provides subsidies to the Hospital Insurance Fund, the details of the contributions, regularity and appropriation of the said subsidies is not clear. The nature of the citizens contributory scheme is key to the government's intention to realise universal health coverage.

On the other hand, NHIF has several opportunities to improve its operations. The organisation can improve its digitisation efforts to streamline its processes and reduce costs. NHIF can also invest in partnerships with public and private sector organisations to enhance its services and ensure better access to healthcare for its members.

In conclusion, NHIF faces both challenges and opportunities in providing health insurance to Kenyans. By addressing these challenges and embracing its opportunities, the state agency can improve its services and continue to be a critical enabler of public healthcare.

Summary Findings

1. Despite being paid-up, 94 percent of NHIF clients still encounter difficulties accessing public and private healthcare facilities using NHIF insurance.
2. The mandatory monthly contribution of KES 500 is deemed excessively high by 48 percent of the individuals interviewed across the five counties examined in this study.
3. Delayed remittance by employers remains a prevalent concern across all five counties.
4. Key target communities across the five counties exhibit low awareness of NHIF services and their legal requirements.
5. Marginalized counties excluded from the Universal Health Coverage Programme, such as Kisumu, continue to face challenges in fulfilling their obligations to deliver the right to health.

Key Recommendations

1. Urgent policy and operational reforms

are necessary to strengthen corporate governance, reduce corruption and wastage, and promote greater public transparency, thus fostering trust and legitimacy.

2. The monthly statutory NHIF subscription fee for all contributors should be reduced from KES 500 to KES 300. Furthermore, the government must engage and listen to the public when proposing or implementing subscription fee adjustments.
3. Investment in public health education and information regarding the benefits of NHIF membership is urgently needed to accelerate the uptake of this essential program.
4. Expanding the number of accredited facilities will increase NHIF coverage for underserved populations.
5. Exploring alternative payment plans that focus on community-based health insurance programs may expand NHIF's reach and coverage.
6. Encouraging the Council of Governors to adopt the National Government Universal Health Coverage model, with a focus on providing health insurance to vulnerable individuals in their respective counties.
7. Safeguarding income generated in hospitals and ancillary health functions for health-related investments.

[1] Linet Owoko, Business Daily, April 05, 2023.Available at https://www.businessdailyafrica.com/bd/economy/kenya-banking-on-sh300-a-month-nhif-contribution--4185120 (accessed 30/05/2023).
[2] International Budget Partnership, 'Healthy Ambitions? Kenya's National Hospital Insurance Fund (NHIF) Must Become More Transparent if it is to Anchor Universal Health Coverage's Budget Brief. No. 14 (2012).
[3] n 1 above.

Introduction

The right to health is the entitlement to access health services necessary for complete mental and physical wellness, not just the absence of disease. This right is integral to all other human rights. The Constitution of Kenya guarantees this right, affirming the Universal Declaration of Human Rights and Sustainable Development Goals (SDGs). SDG 3 focuses on several targets related to improving health outcomes and addressing various health issues globally.

Achieving Universal Health Coverage is one of the targets which member states set when adopting the SDGs in 2015. Countries reaffirmed this commitment at the United Nations General Assembly High-Level Meeting on UHC in 2019. This commitment means that all people and communities receive the health services (e.g., the full spectrum of health services from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course) they need and of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship.

Health became a devolved function in Kenya following the adoption of the 2010 Constitution. The devolution of health services in Kenya aimed to bring healthcare closer to the people, improve access to healthcare, and address each county's specific health needs of each county. Despite the efforts by the state to improve the right to health, access to health care has been burdened by inequalities, poor infrastructure between counties, varying resource allocation, and coordination issues between the national and county governments. Despite increases in health sector expenditure over the last five years, the current expenditure trend still falls below the Abuja Declaration wherein the Government pledged to invest at least 15 per cent of total expenditure in the health sector. Two decades later, Kenya has not attained this standard, further delaying the promise of affordable and accessible healthcare for all Kenyans. As noted by Amnesty International Kenya, the government has failed to realise Universal Health Coverage. As part of this study, we shall do a comparative study of Rwanda, the only Country which has achieved a 15 per cent budgetary allocation to healthcare.

To realise this right, Kenya has put in place laws, policies, practices, procedures, and schemes to recognise this right. They include the Vision 2030 policy document, which houses the Big Four Agenda, where the government allocates resources to ensure comprehensive coverage of affordable healthcare in Kenya and the National Hospital Insurance Fund (NHIF)

[4] United Nations General Comment No.14.
[5] Article 43. Constitution of Kenya 2010
[6] United Nations Department of Economic and Social Affairs Sustainable Development https://sdgs.un.org/goals/goal3
[7] World Health Organization The Global Health Observatory https://www.who.int/data/gho/data/themes/theme-details/GHO/universal-health-coverage
[8] Human-Rights-Based Analysis of Kenya's Budget 2021/22 by the United Nations Human Rights Office of the High Commissioner https://www.ohchr.org/sites/default/files/2022-09/Human-Rights-Based-Analysis-of-Kenya-Budget-2022-23.pdf
[9] Amnesty International, Missed Opportunities: A Scorecard on the Jubilee Administration and Lessons for the Next Government (2022) at 8.
[10] National Health Insurance Fund Act, 1998.

came in as one of the drivers towards realization of universal healthcare. This is a national scheme designed to ensure that all Kenyans, despite their financial ability, have access to Universal Healthcare. NHIF has, over the years, taken different shapes, including UHC, County Insurance Scheme plans such as Marwa in Kisumu County and Oparanya Care in Kakamega County. The fundamental question is, has the scheme facilitated the realisation of affordable and accessible, quality health care and progressive realization towards UHC?

The COVID-19 pandemic had a profound impact on the healthcare system of the country, leading to an increased strain on healthcare infrastructure and overburdening healthcare workers. It also resulted in disruptions to the supply chain of essential medical equipment, personal protective equipment, and pharmaceuticals, further exacerbating the situation. Moreover, the pandemic exposed and exacerbated existing health disparities within the population. In light of these challenges, the importance of achieving Universal Health Coverage (UHC), which ensures that everyone has access to quality healthcare services without experiencing financial hardship, has become even more evident. A well-funded healthcare system that offers affordable and equitable healthcare to all can effectively respond to and manage public health emergencies.

Objective of the study

The purpose of this research is to analyze the aftermath of healthcare insurance structures and their capacity to provide affordable and easily accessible healthcare to all Kenyans. The study aims to evaluate the accomplishments, challenges, and missed opportunities of the National Hospital Insurance Fund (NHIF) as the state corporation responsible for realizing affordable healthcare for the entire population. By establishing a baseline, this study can contribute to improving healthcare in Kenya, making it more affordable and accessible for all individuals. Additionally, the research will propose alternative measures to strengthen NHIF as a reliable health safety net for millions of people living in poverty and facing marginalization.

Background

The Kenyan UHC program was launched in 2018 as a pilot project in Nyeri, Isiolo, Machakos and Kisumu counties. The four counties were selected due to the high incidences of communicable diseases, non-communicable diseases, maternal and child deaths as well as road accident-related injuries. The Program is coordinated through the Ministry of Health of Kenya (MOH) which established a department to oversight, plan, monitor, and report on progress made on the UHC pilot. The department was also tasked with engaging stakeholders at the national level to identify key services and strategies for the improvement of the national UHC package.

The UHC model adopted a two-phase medium-term approach. The first phase was expected to abolish all user fees at the primary level (local health centres) and the secondary level (county referral) hospitals. The second phase was the rollout of a social health insurance scheme through the NHIF. In this second phase, contributions were to be mandatory for all Kenyans above the age of 18 years while the government would complement the scheme by paying for the poor.

[11] Shano, Guyo, and Ileana Vîlcu (2020). A review of Afya Care – the Universal Health Coverage pilot program – in Isiolo county. Kenya Brief 5. Washington, DC: ThinkWell. Retrieved from: https://thinkwell.global/wp-content/uploads/2020/09/Isiolo-UHC-pilot-brief_11-September-2020.pdf
[12] UHC Pilot expands health services to 3.2 Kenyans. Retrieved from: https://www.health.go.ke/uhc-pilot-expands-health-services-to-3-2-kenyans/

According to the Ministry of Health, by 2020, the program had enlisted more than 200 community health units, with 7,700 community health volunteers and over 700 health workers. Between 2018 and 2019, the project is said to have supported 3.2 million Kenyans to access critical healthcare services. Financing the UHC project through NHIF has been the greatest challenge for the government.

In 2023, President William Ruto, during Labor Day, announced a revision of NHIF contributions to a standard rate of 2.75 per cent for salaried employment. The revisions are pegged on the proposed National Health Insurance Fund Regulation (2023). Not only does the fund propose an increase in the standard contribution for the employed, but contributors who are not employed or listed as persons marginalized by poverty and vulnerability will be expected to pay a monthly contribution of Kes 1,000/=.

This proposal elicited a myriad of reactions from the public, raising concern over the state's commitment to achieving affordable health for all. It remains to be seen whether this model will reduce glaring inequalities towards access to quality health care in Kenya.

Reducing inequality and ending discrimination is a strategic 2021-2023 strategic goal of Amnesty International Kenya. As part of this initiative, AIK conducted this research as a means of addressing concerns raised by our constituents on the affordability of healthcare in Kenya. The constituents who are NHIF members cited worries about the high contribution costs, non-remittance by employers and non-availability of NHIF services in some hospitals. The difference in the accessibility of services was brought about by the civil servants' comprehensive cover, which attracted higher rates from the employer. Kenya has domestic and International Laws as provided for in Article 2 of the Constitution, which provides that general rules under international law and other treaties and conventions ratified by Kenya shall form part of International Law. The Universal Declaration of Human Rights guarantees the right of all persons to access quality standards of living, including access to health. This provision has been reinforced by the International Convention on Economic, Social and Cultural Rights, which mandates states to ensure physical and mental health realization. The Convention on Elimination of All Forms of Discrimination Against Women introduces a unique aspect which requires states to provide the highest standard of health for women, including access to reproductive health for women across all regions.

Article 16 of the African Charter on Human and Peoples' Rights (Banjul Charter) (1981) underscores Article 12 of the ICESCR by providing that "every individual has the right to the best attainable state of physical and mental health." The state parties should take the necessary measures to protect their people's health and ensure they receive medical attention when sick.

The Constitution of Kenya under Article 43 provides that: *'Every person has the right to the highest attainable health standard, including the right to healthcare services, including reproductive healthcare.'* This right is echoed in the Health Act, Mental Health Act, and the National Health Policy, designed to ensure that all Kenyans have access to the highest standard of healthcare. It is against this background that the National Hospital Insurance Fund is anchored. NHIF was first created in 1966 by an Act of Parliament, with its core mandate being to ensure that Kenyans have access to healthcare. Its order has

changed over the years to accommodate the changing health needs of Kenyans. Currently, NHIF is governed by the amendment act of 1998, which converted NHIF into a state corporation. NHIF has the mandate to contribute towards realising the right to health by ensuring affordability and accessibility of medical care, including reproductive rights for women. In 2020 NHIF was designed to align with the broader Universal Health Coverage scheme.

UHC is supposed to ensure that all Kenyans have comprehensive healthcare coverage.

According to NHIF, it has approximately 14 million registered members and about 12.4 million dependents.

Findings

In this study, 46 percent of the participants were aged between 25 and 35 years, with a majority of 59 percent being women. Regarding income, a quarter of the respondents earned between KES 20,001 and 40,000.

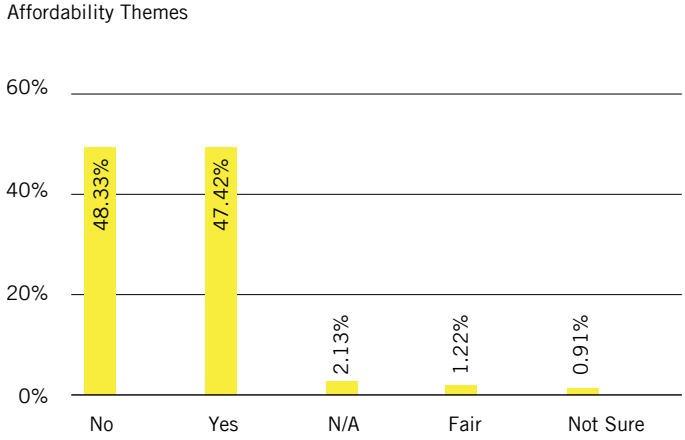

Chart A: Number of people who can afford monthly NHIF remittance.

Regarding the accessibility of NHIF facilities, nearly half (46 percent) of the respondents nationwide expressed the belief that the facilities were not easily accessible. This finding underscores the need for increased efforts to enhance the accessibility of NHIF services. Additionally, it was found that almost half (48 percent) of the respondents considered the NHIF remittance of KES 500/= per month to be too expensive.

This information is of utmost importance for stakeholders in the healthcare industry as it offers valuable insights into the perception of NHIF services throughout the country. It presents an opportunity to identify and address the challenges that hinder accessibility to Kenyans.
Notably, over half of individuals with disabilities earn less than KES 10,000, and nearly half of them find NHIF unaffordable. Additionally, approximately

[13] The National Health Insurance Fund Regulations, 2023
[14] Article 25. [15] Article 12.
[16] Article 12 &14.
[17] NHIF, https://www.nhif.or.ke/profile/

1 in 5 respondents with special needs reported that NHIF accredited facilities pose structural and administrative barriers. These statistics serve as a stark reminder of the obstacles faced by individuals with disabilities in accessing healthcare in Kenya.

My wife has health problems; in most cases, we pay as the NHIF card doesn't help –Man, Nakuru.

A significant finding from the study is that over one-third of the respondents agreed that NHIF is more acceptable in public hospitals compared to private ones. In order to enhance the accessibility of outpatient services, one potential solution is to increase the insurance limit.

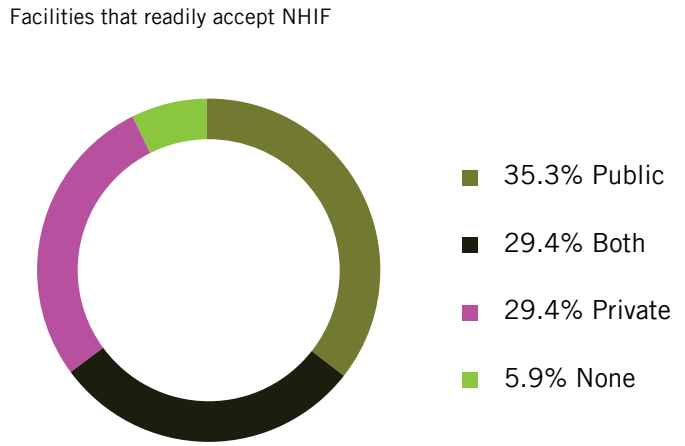

Chart B: Facilities that accept NHIF

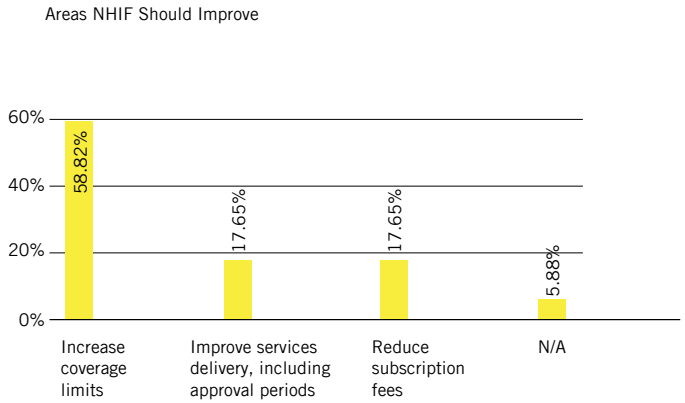

Chart C: Areas of Improvement

Wajir County

Wajir County is a county in the former Northeastern Province of Kenya. The county has a roughly estimated population of 781,263 as of the 2019 census, with 413,374 males, 365,840 females and 49 intersex. According to the 2019 census, 77.3 per cent of the community lives in rural areas, while 22.7 per cent live in urban areas. The county has eight sub-counties: Buna, Eldas, Habaswein, Tarbaj, Wajir East, Wajir North, Wajir South, and Wajir West. Wajir has 115 public health facilities, and 29 private and 2 NGO/ mission-run facilities. There are 10 level IV hospitals, 26 level III healthcare centers, 79 level II dispensaries, three private hospitals, one nursing home and 27 clinics.

Only 0.2 per cent of the population has medical insurance coverage.

In Wajir East, the NHIF registration rate stands at an impressive 93 percent. However, only 26 percent of the registered members are up to date with their payments. It is worth noting that all up-to-date payments are from government employees belonging to job group L and above. Limited information about the NHIF scheme accounts for 7 percent of unregistered members.

The County Government covers the subscription fees for its employees, but those below job group L can only access limited services in hospitals, despite remitting their contributions every month. Delays in remittance by the County Government further hinder accessibility to NHIF services. Additionally, hospitals provide unequal treatments to patients with the same NHIF subscription. Moreover, registration under the Universal Health Coverage restricts healthcare access to Wajir referral hospital. Challenges in accessing outpatient services arise due to the requirements of additional documentation beyond the NHIF card. Government insurance has limited outpatient coverage, making it difficult to obtain prescribed medications for those fortunate enough to access outpatient services. The referral hospital in Wajir has limited essential medicines and equipment, leading residents to purchase them from private-owned chemists at their own expense. Respondents reported that private hospitals do not accept NHIF payments for outpatient services, often leading to unnecessary hospital admissions for conditions that do not require inpatient care.

To disseminate information about NHIF benefits, entitlements, and membership, residents heavily rely on social workers, registration exercises, radio stations, voluntary counseling and testing (VCT) centers, and social media platforms. These findings shed light on the challenges faced by NHIF beneficiaries in Wajir East, emphasizing the need for improved information dissemination, equitable access to healthcare services, timely remittance of payments, and addressing the limitations in outpatient coverage under the Universal Health Coverage scheme.

In Wajir, Persons with Disabilities (PWDs) have NHIF coverage under the Universal Health Coverage (UHC) program but are limited to receiving treatment exclusively at the County Referral Hospital.

In Lafaley, only 70 individuals currently benefit from the UHC program, with

[18] 2019 Kenya Population and Housing Census: Volume 1: Distribution of Population by County Page 7 [19] Ibid
[20] Wajir County Integrated Development Plan 2018-2022 "A Secure, Resilient and Globally Competitive First Class County in Service Delivery for All. Feb 2018 [21] 2015/2016 KIHBS

the government supporting their NHIF subscription fees. An additional 30 people have been submitted to NHIF and are awaiting enrollment. The village elders identify the most vulnerable individuals who require UHC services, and the area chief compiles a list of beneficiaries. However, despite having UHC coverage, some residents of Lafaley have to travel a considerable distance of at least six miles to access the only certified UHC hospital in Wajir town. Moreover, their UHC cover is accepted only in public facilities.

Polygamy is a common practice in the region, resulting in only one spouse being covered under NHIF. As a result, the other spouses and their children must subscribe separately. In Wajir town, certain sexual and reproductive health services, such as maternity care, are provided free of charge, making NHIF services unnecessary.
The members of the community proposed alternative payment methods for subscriptions, such as using livestock like goats in exchange for health services. They also emphasized the need for sensitization on NHIF and its advantages. Those who have NHIF coverage suggested expanding the coverage to accommodate more dependents. For individuals without universal health coverage, they recommended the option to add more than one spouse. However, the high monthly subscription fee was deemed unaffordable, and they proposed that the government subsidize it. The group advocated for NHIF services to be available beyond major towns and emphasized the establishment of health facilities that accept the NHIF card. These suggestions reflect the community's desire for accessible and affordable healthcare services, including expanded coverage, alternative payment options, government subsidies, and improved healthcare facilities across the region.

"Last year I delivered through CS, and I had to buy medicine"
Thiress, Wajir East Town Resident

"Sometimes the County delays remittance to NHIF. If you are lucky, if you take your payslip to NHIF, they will write you a letter to receive the services. However, this is tedious for people and should not be the case."
Abdullahi, Wajir East Town Resident

"When my sister was delivering, we had to buy gloves, medicine, and everything the hospital uses, and NHIF does not cover those items."
Amina, Wajir East Town Resident

"My sister lost her baby because they did not have scissors, they used a knife that pricked the baby's head, and he bled to death- in 2021. NHIF forces us only to use the Referral hospital, which is not well equipped."
Leila, Wajir East Town Resident

"Yesterday I went to the hospital but was told that my money was too little for outpatient, so I opted to use inpatient; whenever someone is admitted at Wajir Hospital under NHIF, they immediately send someone to verify whether there is a patient. I had to leave because my illness did not warrant admission. Now I must pay in cash for the services I received."
Salima, Wajir East Town Resident

Garissa County

Garissa County is situated in the former Northeastern Province. The county has an estimated population of 841,353 as of 2019, with 458,975 males, 382,344 females and 34 intersex. According to a 2019 census, 74.9 per cent of the community lives in rural areas, while 25.1 per cent live in urban areas. Garissa County has a total of 205 health facilities, seven of which are level IV, 85 are privately owned clinics, 13 are level III private, 4 are private nursing homes, one is a private hospital, 21 are level 3 facilities, and 1 is a level 5 facility based in Garissa Town.

In Garissa County, over half of the respondents are enrolled in NHIF, but only a quarter of them are up to date on their payments. Around 20 percent of the population prefers private insurance due to perceived reliability issues with NHIF and the desire for acceptance in private medical facilities. Some individuals are covered under family plans.

NHIF offers a range of medical services to its cardholders, but there are limitations in terms of the facilities and treatments covered. While you can use your NHIF card for diagnosis at a private hospital, separate private insurance coverage is required for medications. It is important to note that NHIF's priorities may be more focused on profit-making than helping people. The level of contribution determines the services available, with higher contributions providing better quality care, including unlimited inpatient and outpatient services. Super Cover subscribers paying a monthly fee of Kes 500 enjoy access to limited outpatient services and bed charges.

Residents enrolled in NHIF face challenges in accessing healthcare services due to limited accredited facilities nearby and a lack of understanding of NHIF benefits. NHIF coverage does not always guarantee access to medication, and patients are sometimes required to pay for medical equipment, including gloves and syringes.

The current NHIF system seems to discourage residents from contributing as they do not see the value in it. Many individuals choose to use their money for medical bills when needed instead of paying for a service they may not even benefit from. Discrimination against super-cover subscribers is also a concern, as they are sometimes referred to as "student card" holders and easily dismissed from hospitals. Residents have expressed dissatisfaction with hospitals overcharging NHIF cardholders. Even though the regular amount is charged for medications when paid in cash, NHIF cardholders are often charged excessively high prices. Moreover, the biometric NHIF machines in clinics are frequently non-functional, causing inconvenience for residents.

At times, private hospitals may request cash from NHIF cardholders for costly treatments due to the extended time taken to receive reimbursement from NHIF. The bureaucratic process involved in reimbursement can cause hospitals to worry about operating at a loss. It is essential to note that being an NHIF member does not always guarantee access to medical care in underprivileged regions, where proper equipment, testing facilities, and medications may be lacking. Out of 15 people, only two confirmed utilizing their NHIF cards in 2022, despite approximately one out of every six citizens being registered under NHIF.

Different NHIF premiums offer varying services with accompanying limitations. For example, subscribers paying Ksh. 500 monthly have limited access to dental

services, male circumcision, optical services, and outpatient services. However, they can still enjoy outpatient services if the bill remains below Ksh. 2,500 per visit. Sometimes, NHIF only covers beds for inpatients, and there is no uniform policy that covers the different experiences of patients. One respondent mentioned that access to surgery is possible with a monthly contribution of Ksh. 500.

Another respondent claimed that paying NHIF premiums worth Ksh. 2,200 and above supposedly guarantees access to a wider range of health facility services (both private and public). Another individual shared how their mother was fully covered for surgery at a private hospital. It is essential to maintain and regularly update the biometric NHIF reading machines, and any questions regarding NHIF should be directed to its offices. Local radio and FM stations, in general, run campaigns to increase NHIF awareness, and people can ask relevant questions. Community health workers can provide information on NHIF to those in remote areas.

Tana River County

Tana River County is a county in the former Coast Province of Kenya. According to the 2019 Kenya Population and Housing Census, Tana River has a total population of 315,943 people, with 158,550 males, 157,391 females and two intersex. A 2019 census shows that 76 per cent of the community lives in rural areas, while 24 per cent live in urban areas. The county has three sub-counties: Tana North, Tana Delta, and Tana River. Tana River County has 71 health facilities, with two-level IV public hospitals in Hola and Ngao. Bura has one subcounty hospital, five public health centers, 40 dispensaries, 20 private clinics, two mission dispensaries and one private health center. The county needs more healthcare providers due to difficulties attracting and retaining them.

Approximately one-quarter of the surveyed individuals were enrolled in the NHIF program, and out of that group, only one-fifth were up-to-date subscribers. The participants cited various reasons for the poor adoption and usage of NHIF, including the low economic status of Tana residents, the unavailability of NHIF offices in Bura and Delta areas, the unreliability of biometric machines, limitations on accessing hospitals, and inadequate information about NHIF usage and operation. Additionally, certain services like dental care, surgeries, and x-rays are not covered by NHIF in private hospitals, although maternity services are covered under the Linda Mama program.

Patients with NHIF cards in private hospitals are often encouraged to undergo unnecessary tests, which can result in overcharging. NHIF users have reported being denied access to healthcare services in private hospitals despite making regular monthly contributions. Furthermore, NHIF members can only access in-patient beds in underfunded public hospitals, so there is no guarantee of adequate healthcare availability even with an NHIF card.

According to information from Community Health Volunteers (CHVs), NHIF utilizes a criterion to determine beneficiaries of the health insurance subsidy for the poor (HISP) of UHC. For example, in Tana Delta, each CHV was instructed to identify 50 vulnerable individuals from a community of 5,000 people, including orphans, widows, people living with disabilities, and the elderly over 60. Some CHVs were asked to select six families each to determine eligibility for the HIS program.

The biometric reader of the NHIF system frequently malfunctions, preventing cardholders from accessing services and forcing them to pay for medicine, syringes, and gloves out-of-pocket.

Kisumu County

Kisumu is a county in Nyanza Province, Western Kenya. The estimated total population is 1,155,574 as of the 2019 census, with 594,606 female, 560,942 male and 23 intersex. According to the 2019 census, 61.8 per cent of the community lives in rural areas, while 38.2 per cent live in urban areas. The county has a total of 7 sub-counties, namely Kisumu East, Kisumu West, Kisumu Central, Muhoroni, Nyakach, Nyando and Seme. The highest hospital level is the level 5 Kisumu County Referral Hospital in Kisumu. The hospital provides a wide range of inpatient and outpatient services, including maternal care. Approximately 93 per cent of the participants had registered for NHIF. The unregistered member did not know much about NHIF. 35 per cent of the attendees were from Seme, 30 per cent from Nyando, 30 per cent from Kisumu West,19 per cent from Ubonga and 15 per cent from Kisumu East.

Only half of the respondents were up to date with their monthly NHIF payments. The rest had stopped using NHIF because they could not afford the monthly subscription fee, and the services and facilities covered were limited. For instance, public hospitals only offered consultations, and patients had to buy medicine from private pharmacies.

Respondents noted that private hospitals were better with NHIF compared to public hospitals. Kisumu residents avoid using NHIF because the monthly subscription fee is too high, there are delays in service delivery, and there are unresolved fraud cases leading to the closure of accounts. The group raised concerns about NHIF, including why couples cannot use one cover and the extent to which NHIF covers polygamous families.

The privacy of data submitted to NHIF was also unclear. Kisumu County developed a county insurance plan known as Marwa to complement NHIF and universal health coverage (UHC). Marwa is sponsored by the county government and hosted by NHIF. The county government identifies persons marginalized by poverty and vulnerability and is registered with NHIF, with the county government contributing to their monthly payments. Respondents were confident in Marwa, and hospitals in Kisumu were receptive to the Marwa scheme.

However, most hospitals shifted their focus and stopped offering services to people with UHC cover. The identification criteria for UHC and Marwa beneficiaries were unreliable, leaving out needy people. Respondents were confident that Marwa would be successful if the identification process were improved.

Kilifi County

Kilifi County is a county coast of Kenya, north of Mombasa. The county has a roughly estimated population of 1,453,787 as of the 2019 census. Kilifi County has a male population of 704,089, a female population of 749,673 and 25 intersex persons the female population leading at 51.6 per cent compared According to a 2019 census, 72.9 per cent of the community lives in rural areas, while 27.1 per cent live in urban areas. The county has a total of 9 sub-counties, namely Chonyi, Kauma, Kilifi North, Kilifi South,

Kaloleni, Rabai, Ganze, Malindi, and Magharini. The highest hospital level is level 4, Kilifi District Hospital, which is in Kilifi. The hospital provides a wide range of inpatient and outpatient services, including maternal care. The biggest health issue facing Kilifi County is malnutrition.

We held 5 Focus Group Discussions in Kilifi. The discussions were held in Malindi, Kaloleni, Ganze, Kilifi South and Rabai sub-counties. See Table 3 below for the distribution of registered members.

Table 3: Kilifi FGD distribution table

Sub-County		No. of PeopleRegistered under NHIF	Registered and up-to-date with monthly subscriptions	Registered and halted the subscriptions
Malindi	4	4	2	2
Kaloleni	5	5	1	4
Kilifi				
South	3	2	2	1
Rabai	4	4	1	3
Ganze	5	5	3	2
Magharini	5	5	0	3
Kilifi North	7	5	3	2

In Malindi sub-county, 75 percent of the respondents were registered with NHIF. However, out of those registered members, only 25 percent were up to date with their insurance remittances, which was attributed to unemployment and the high cost of insurance. NHIF information was accessible through various channels, including NHIF offices, mobile SMS, Google searches, and informal conversations.

The participants had access to outpatient services in both public and private health institutions. However, some clinics and dispensaries such as Mtangani, Ganda, Msoloni, and Gahaleni did not accept NHIF cards. On the other hand, inpatient services, CT scanning, ultrasound, laboratory tests, and x-ray services were not readily available to NHIF cardholders. As a result, some participants had to pay out of pocket for these services, especially in marginalized areas. The non-coverage of chronic illnesses, high monthly contributions, and limited access had a significant impact on the community.

To address these issues, participants suggested employing NHIF field agents to provide more localized support and assistance. They also recommended reducing the monthly fees to make NHIF more affordable. Additionally, utilizing user-friendly technology was proposed to improve accessibility to NHIF services and reduce system delays or failures.

Overall, improving NHIF accessibility and

addressing the concerns raised by the participants would be crucial in increasing the uptake and utilization of NHIF services in Malindi sub-county.

In Kaloleni sub-county, all respondents were registered members of NHIF. However, only 20 percent of them were up to date with their monthly contributions due to financial constraints and unemployment. NHIF information was accessible through various channels such as social media, community gatherings (barazas), schools, and the media. Access to chronic disease services was limited in both public and private health facilities. Private hospitals were more inclined to accept NHIF cards due to faster reimbursement, while late remittance from employers was a common issue. NHIF was appreciated for its timeliness during emergencies but was criticized for not fully covering payments for chronic and pandemic diseases. Participants suggested the regularizing of NHIF services to ensure equitable access to medical services.

In Kilifi South sub-county, 40 percent of the respondents were enrolled in NHIF. However, out of those enrolled, 75 percent were defaulters and not actively contributing on a monthly basis. NHIF information was not readily available to participants unless specifically asked for or during hospital visits. Public hospitals were more receptive to NHIF cards compared to government and private hospitals. Participants acknowledged NHIF as a convenient option for emergencies, especially for low-income earners, providing a more affordable means of accessing hospital services. The payment deadlines were seen as unfavorable, limiting access for those who receive their salaries at the end of the month. Changing the payment deadline to the 15th of the month was recommended to better accommodate other household needs. Women also reported difficulties in accessing NHIF-covered gynecology and family planning consultations in hospitals, suggesting the need for access to multiple health facilities. In Rabai sub-county, around 30 percent of the respondents were enrolled with NHIF. NHIF information was accessible through SMS, visits to the branch in Mariakani, social media pages, and regular updates. The high default rate was attributed to limited access to services and challenging economic conditions.

In Ganze sub-county, only 40 percent of the respondents were registered with NHIF, while 60 percent cited a lack of jobs and limited access to information as the main reasons for not enrolling. NHIF information was easily accessible through social media. Despite NHIF offering outpatient services, financial limitations hindered easy access to these services in hospitals. Some public health facilities, such as Kilifi General, did not accept NHIF, leading patients to pay in cash. However, NHIF was praised for providing affordable counseling and treatment for chronic diseases during emergencies. To improve access, participants recommended accrediting more health facilities with NHIF.

"I went to the hospital but couldn't use NHIF because the system was down."
Umazi, Kilifi South Resident

"Aga Khan Hospital does not allow even civil servants to use their NHF cover, while at Khairat Hospital, X-RAY services are not covered by NHIF."
Salim, Kilifi Resident

"Mephi Hospital limits the amount to be catered for by NHIF, that is, 300 shillings only, which is unreasonable."
Mohammed Kilifi Resident

"At Tawfiq Hospital, most services, including consultation services, are not covered."
Zainab Kilifi Resident

"Despite being a dependent under my cover, my daughter couldn't use the NHIF card because she was far from the "NHIF acceptable hospitals.""
Ali, Man, Kilifi South Resident

According to a clinical director and family physician at Garissa Referral Hospital, achieving Universal Health Coverage in Kenya through NHIF requires fast-tracking the implementation plans of sustainable universal health coverage, similar to the system used in Cuba. The Cuban National healthcare system focuses on Primary Healthcare (PHC) and integrates all the necessary factors at the community level to improve the population's health status. This approach has helped Cuba achieve universal healthcare coverage.

When asked about the leadership structure in healthcare systems, including NHIF, the doctor highlighted the need to address issues such as corruption, improper management of human resources, and inconsistent product supply. These factors contribute to demotivation among staff and hinder effective service provision.
The feedback on NHIF suggests that comprehensive coverage should be provided to all Kenyans, and services should be decentralized. Increasing literacy levels about the importance of education is also seen as crucial. The current system implemented by the Kenyan government is viewed as disrupting the achievement of Universal healthcare and effective NHIF service provision.

The doctor's final opinions include the decentralization of NHIF, allowing sub-counties to function autonomously, and the placement of individual specialists in every referral and sub-county hospital. These measures aim to improve the efficiency and effectiveness of the healthcare system and enhance access to quality healthcare services.

A health practitioner at the Tana River Referral was kind enough to help us with our research questions. When asked about her opinions on what she thought could be improved regarding NHIF at the community level, along with the impact policymakers can make concerning the same. She responded that Tana River County should have thorough sensitization programs towards NHIF and the provision of its services. She also highlighted the need to sensitize the elderly in the community and educate them on the necessity for them to be insured.

The health practitioner emphasized the shortage of medicine in the hospital and proposed the establishment of NHIF-owned pharmacies in each county. These pharmacies would be fully stocked with medicine for NHIF-registered patients to access in case the hospitals are understocked. The practitioner suggested introducing a parliamentary bill to give NHIF the mandate to enforce the establishment of these pharmacies nationwide, aiming to reduce corruption scandals related to procurement and medicine shortages.

In Tana River County, where 80% of the community benefits from public hospitals, the health practitioner highlighted the need for a digital registration system for NHIF users. However, the lack of computer electronics and stable internet connection has hindered the proper facilitation of NHIF services in public hospitals. System downtimes also disrupt service provision. The practitioner mentioned the challenges faced by unregistered patients with diabetes and hypertension who struggle to access medicine, which is not only understocked but also expensive to purchase.

To improve NHIF and achieve universal healthcare coverage, the health practitioner suggested increasing the outpatient limit and raising awareness among widows and

the elderly about NHIF and its services in the area.

Regarding the low NHIF registration in Tana River County, the health practitioner emphasized the need for sensitization and education to increase awareness among community members. The high poverty level in the area makes it difficult for many to afford the monthly remittance fee.
In Kisumu, St. Jairus Hospital and St. Consolata Hospital reported limited equipment, forcing patients to seek specific tests in other hospitals. The lack of well-stocked medicine also leads patients to obtain treatment from other pharmacies.
In Wajir County, HRDs reported that mothers delivering at the Wajir Referral Hospital have to provide their own gloves, medicine, and other necessities. The power rationing policy in the county forces mothers to bring their own torches for medical personnel to use during delivery. The hospital administrator mentioned that the UHC cover includes dialysis treatment, but focus group discussions revealed that residents often have to purchase medication outside the hospital due to its unavailability.

These accounts highlight the challenges and gaps in healthcare provision, including medicine shortages, inadequate equipment, and infrastructure limitations, that need to be addressed to improve the accessibility and quality of healthcare services in Kenya.
NHIF Wajir Branch Visit
We Interviewed an officer from NHIF, Wajir branch. The officer preferred to remain anonymous.

He gave us the overview of NHIF services as follows:

Table 2: NHIF Services

Cadre	Amount paid either by self or employer	Services	Facilities
National Scheme	500 by individuals	Unlimited access to outpatient services	General hospitals
National Scheme	1700 statutory (for employees below job group L)	Unlimited in and outpatient	General hospitals
Comprehensive	Statutory (job group L and above)	Limited outpatient Limits to 1.5 million inpatients and covers optical and dental	All hospitals

We requested his response regarding fraud in the NHIF. He acknowledged the existence of fraudulent activities but mentioned that resolving them at the branch level is beyond their control. To illustrate this, he shared a personal experience where he was charged three times for the same facility visit. Being an NHIF employee, he was able to identify the discrepancy, and he expressed concern that ordinary citizens (Wananchi) do not have the same access and are therefore vulnerable to fraud. He also explained that NHIF cannot change the payment amount as it is determined by statutory regulations, which can only be modified by parliament. NHIF received appreciation for covering the costs of hospital beds, surgeries, and general primary care. Additionally, hospitals associated with NHIF are incentivized to provide better services in order to attract

more patients. Maternity services are readily available and free in all counties through the Linda Mama program. However, in Wajir County, maternity patients are compelled to purchase drugs, gloves, and other delivery materials because they are often unavailable in most public hospitals where maternal care is supposed to be free. Sometimes, these patients are forced to seek care at private facilities that do not accept NHIF.

Nevertheless, several complaints have arisen. These include limited access to only specific hospitals, frequent failures of the biometric identification system causing delays in service provision, and instances of discrimination against patients without comprehensive coverage. Furthermore, there is limited awareness about the services offered, coverage packages, limits on dependents, and benefits provided, resulting in underutilization by contributing members. The complaints process also lacks clarity, leaving many grievances unresolved and patients unsatisfied. A transparent and direct feedback mechanism is sorely needed.

The minimum contribution fee of KES 500 is affordable only to some individuals, particularly those without economic stability. The insurance scheme fails to address the needs of disabled groups due to the lengthy and cumbersome registration process, as well as the absence of inclusive packages such as eye care.

Lastly, the NHIF cover lacks a more efficient backdating system. Individuals who experience delays in payment must wait three months before accessing healthcare services. This delay disproportionately affects the poor, who make up a significant portion of NHIF beneficiaries, and are more prone to delayed payments.

Corruption and fraud also manifest in cases where doctors unnecessarily refer patients to their private clinics and subsequently charge higher fees to their NHIF cover for services available in public hospitals. Some patients are compelled to pay out of pocket despite having NHIF coverage. Additionally, complaints against employers who fail to remit monthly contributions are not adequately addressed. NHIF, being a key driver towards achieving Universal Health Coverage, needs to prioritize the establishment of efficient and trustworthy systems that encourage people to utilize their services.

Intersectional Discrimination and Inequality within NHIF

NHIF, like other health insurance providers, has certain limitations on coverage. Unfortunately, this means that their Super Cover plan does not include coverage for certain diseases, including sickle cell anemia. Patients with sickle cell anemia are not covered for screening, diagnosis, and general care, which poses a financial burden on their families. Parents of sickle cell disease patients may have to pay approximately KES 10,000 for a diagnosis, in addition to the costs of medication and ongoing management.

Moreover, NHIF's coverage for hearing aids and eye treatments is also limited. This creates barriers for individuals with disabilities to access necessary healthcare services. This situation becomes even more challenging for people with disabilities or life-changing illnesses who struggle to afford the monthly subscription fees. In fact, the high cost of subscription fees was identified by 56 percent of respondents as the primary reason for not paying into NHIF, with 57 percent of them being women earning less than KES 10,000 per month. These challenges contribute to intersecting

inequalities among different social classes and health conditions. When NHIF limits its coverage of sexual and reproductive services to maternity services only, it adversely affects other individuals who require reproductive healthcare services. NHIF should strive to make reasonable accommodations for persons with disabilities, women, and individuals with underlying conditions that require additional resources for their treatment.

Lessons from Rwanda

This research analyzed the health insurance system in Rwanda. Rwanda has, over the years, rebuilt its healthcare system to accommodate the needs of its people. It is designed so that people with financial challenges can still access healthcare services. This research shall borrow lessons from Rwanda because it is part of the East Africa Community. Its economic development is close to that of Kenya. Importantly, their healthcare insurance scheme has led to an 85 per cent subscription rate. Analyzing the Rwandan system will give ideas on improving the Kenyan NHIF. According to the National Institute of Statistics of Rwanda, life expectancy increased from 49 years in 2000 to 69.06 years in 2020. The primary healthcare utilization rate increased from 0.81 visits per inhabitant in 2009 to 1.6 per inhabitant in 2019. This is significantly attributed to healthcare delivery improvements and several policy initiatives, including a nationwide Community-Based Health Insurance Scheme (CBHI). The Introduction of CBHI also saw an increase in the utilization of health services from 31 per cent in 2003 to 107 per cent in 2012.

In Rwanda, Rwandaise d'Assurance Maladie covers civil servants and employees of state-owned enterprises, while Military Medical Insurance provides basic insurance coverage to military personnel. The Community-based Health Insurance scheme CBHI, or Mutuelles de Santé, covers persons from both the formal and informal. CBHI covers people who are not covered under any other health insurance schemes. This law policy was informed by Law No. 62/2007. CBHI started in 1999 as a pilot project in 3 districts in response to the reintroduction of user fees and to extend coverage to all Rwandans. The success of these pilot schemes led progressively to the initiation of several schemes in the country, the development of a CBHI policy, and the national roll-out of CBHI in 2004. Coverage increased significantly from 7 per cent in 2003 to 91 per cent in 2011 and has helped promote the participation of communities in their socio-economic development. The CBHI is currently the country's most significant health insurance scheme, with an estimated coverage rate of 85.6 per cent of the target population as of April 2021. In October 2015, the management of CBHI was transferred from the Ministry of Health to Rwanda Social Security Board to improve the financial management and efficiency of the system.

Remittance within NHIF is conducted through a three-tier premium scaling system known as Ubudehe. Ubudehe classifies households into six categories based on their income and assets. The government provides full subsidy for the premium of the two poorest and most vulnerable categories, which amounts to 2,000 Rwandan francs (RWF). The two middle categories pay a slightly higher premium of RWF3,000, while the two highest categories are required to pay the highest premium of RWF7,000.

This tiered system helps ensure that the burden of payment is distributed based on an individual's financial capacity.

Implementation Framework

The healthcare system in Rwanda follows a decentralized approach, with central government agencies responsible for policy formulation and regulation, while the districts handle local planning and coordination of public services. This decentralization ensures targeted programming that meets the specific needs of each community. Funding for healthcare delivery and health systems is also decentralized at the district level.
At the grassroots level, health centers and health posts provide primary and preventive healthcare services, as well as essential pharmaceutical and laboratory support. District hospitals focus on both preventive and curative services, as well as health promotion. Provincial referral hospitals offer more extensive services and have broader geographical coverage. National referral hospitals provide specialized services, training, and expanded medical facilities. Members of the Community-Based Health Insurance (CBHI) can access services at any of these facilities, including the cost of ambulance services.

The healthcare system in Rwanda is supported by a network of 45,000 community health workers (CHWs). These CHWs play a crucial role in linking communities with health centers and conducting routine surveillance and monitoring of health events using mobile applications like Rapid SMS and Ubuzima. They facilitate case management and monitor health indicators, contributing to the overall effectiveness of the healthcare system. Additionally, the Rwanda Health Management Information System, launched in February 2012, collects data from health facilities through a web-based application. Rwanda has achieved a high coverage rate of 85.6 percent in healthcare, thanks to various factors such as political commitment, strong leadership, community participation, a decentralized healthcare structure utilizing CHWs, and effective coordination of donor assistance.

The country has implemented evidence-based policies and practices, scaling up successful pilot initiatives. However, Rwanda faces challenges in sustaining health coverage, including declining registered members and decreasing incomes. The wage bill has led to significant government debts owed to doctors, community health volunteers, and pharmacies. To address these financial challenges, the government has explored alternative means of income collection, such as increasing budget allocation. The healthcare coverage receives an annual state allocation of FRW 6,000,000, which is derived from fines collected by the ethics committee, registration fees from government agencies, levies, and income from government agencies.

The government of Rwanda classifies individuals based on their contributions, income, and financial abilities. It also ensures financial assistance from the government and citizens through co-payment arrangements, with support from donors to sustain the health insurance scheme.

Conclusion

Kenya has the potential to benefit from adopting certain elements from the Rwanda health insurance scheme for its NHIF. One key aspect is the introduction of a community-based health insurance scheme where individuals contribute according to their economic status. This approach would ensure that the system is designed to cater to the needs of those who lack sufficient financial resources to meet their health insurance requirements. By implementing a

system that accounts for varying economic capacities, Kenya can work towards achieving more equitable healthcare coverage.

Furthermore, decentralizing the administration of the health insurance scheme is crucial for enhancing accessibility and improving service delivery. Involving community-based health organizations, private sector players, and local government structures can help develop a comprehensive health plan that addresses the needs of different communities. By engaging various stakeholders, Kenya can create a system that is responsive to local contexts and ensures that healthcare services reach all segments of the population effectively.
In conclusion, Kenya can draw valuable lessons from the Rwanda health insurance scheme and apply them to enhance its NHIF. Implementing a community-based health insurance scheme and decentralizing the administration would contribute to a more inclusive and accessible healthcare system, ultimately improving health outcomes for the population.

Insurance Coverage Amongst counties

Health coverage in the counties of interest varies in terms of design and availability. For example, Tana River County does not have a dedicated insurance scheme at the County level, whereas Kisumu County boasts a comprehensive County insurance scheme, making it better equipped to achieve universal health coverage. Within Kisumu County, there are three insurance regimes that operate under the National Hospital Insurance Fund (NHIF), which can be outlined as follows:

- National Hospital Insurance Fund.
  In addition to the aforementioned insurance schemes, Kisumu County also offers the Super Cover, which is designed specifically for individuals engaged in business and informal employment, and the Civil Servants cover, which caters to the majority of government employees. Employers are required to deduct monthly contributions from their employees' salaries and top them up as per statutory requirements, remitting the total amount to NHIF.
  For individuals in the informal sector, the standard contribution is a monthly fee of KES 500. However, Civil Servants' coverage varies based on their job groups. Those in job group "L" and above are entitled to more extensive benefits compared to their counterparts in job group "K" and below.

- UHC Coverage
  This initiative is a National Government project aimed at achieving universal health coverage for all individuals, particularly those in need who may be unable to make regular monthly contributions. The National Government directly makes payments to NHIF, enabling individuals registered under this scheme to access healthcare services. The objective is to ensure that essential health services are available to everyone, regardless of their ability to make financial contributions on a monthly basis.

- Marwa Scheme.
  The county government of Kisumu funds this scheme. Under this scheme, registered members are identified by Community Health Volunteers, and the county government takes the responsibility of remitting payments on their behalf, enabling them to access healthcare services.

However, it is worth noting that this model is not currently replicated in other counties. Many counties have yet to undertake the duty and responsibility of identifying or developing their own County Insurance schemes to cater to the needs of the less fortunate. Nonetheless, Wajir County stands out as they have relatively broader NHIF coverage due to the presence of Universal Health Care sponsored by the National Government and implemented through NHIF.

On the other hand, Garissa, Tana River, and Kilifi are not included in the Universal Health Care Program and have no planned County Government insurance programs. Consequently, individuals in these counties are required to pay for the National Health Insurance scheme since there are no county-specific schemes available.

Delayed remittances

Delayed remittance of contributions to NHIF was a prevalent issue in all five counties. Employers, including County governments, exhibited a slowdown in remitting the deducted funds to NHIF. Consequently, subscribers faced challenges in accessing healthcare services, despite having made the required salary deductions.

Non-Comprehensive Coverage

NHIF subscribers have raised valid concerns regarding the extent of coverage, particularly when it comes to additional costs for medicine, gloves, and other medical equipment.

By implementing these measures, NHIF can address the concerns raised by subscribers regarding coverage limitations and ensure that a wider range of medical expenses are covered. This will enhance the effectiveness and reliability of NHIF as a provider of comprehensive healthcare coverage for all its subscribers.

Accessibility of hospitals

The survey conducted during this research revealed that 35.3% of respondents expressed a higher level of acceptance of NHIF in public hospitals compared to private facilities, despite private hospitals often offering more extensive facilities. Respondents suggested that the NHIF card should be more widely accepted in private hospitals, and there should be a resolution to pending bills to prevent NHIF patients from being turned away. Furthermore, the requirement for subscribers to visit a specific hospital to access outpatient services emerged as a significant concern.

Lack of information on services offered by NHIF

The limited access to information on NHIF benefits, processes, and administrative recourses, as identified in this study, highlights the need for improved communication and transparency to address this issue and enhance the understanding and experience of NHIF subscribers.

Recommendations

Based on our findings, we propose the following recommendations to NHIF:

Transparent Governance and Accountability
To enhance governance and accountability within NHIF and promote transparency while combating corruption, several measures can be implemented. These include:

1. Strengthening internal control systems: Implement robust internal control mechanisms within NHIF to prevent fraudulent activities, ensure proper

financial management, and enhance accountability.

2. Regular audits and inspections: Conduct frequent audits and inspections of NHIF accredited facilities to ensure compliance with standards and regulations, as well as to detect any potential irregularities or misuse of funds.

3. Financial management and procurement processes: Establish a robust framework for financial management and procurement processes, ensuring transparency, fairness, and adherence to best practices. This will help prevent corruption and promote efficient resource allocation.

4. Development of a public accountability policy: Create a public accountability policy that advocates for making NHIF's collections, budgetary allocations, and expenditures accessible to the public. This information should be easily accessible on the NHIF official website, as NHIF is primarily funded by the public. Regular and consistent sharing of financial information will build transparency and public confidence.

5. Reduction of NHIF monthly subscription fee: Consider reducing the NHIF subscription fee for all voluntary contributors from the current statutory KES 500 to KES 300. This adjustment can help increase the number of subscribers and improve retention rates, especially considering the economic challenges post-COVID-19.

6. Strengthening data collection and identification: Enhance NHIF's capacity for data collection, including biometric identification, analysis, and utilization. Establish robust health information systems such as electronic medical records and data-sharing platforms, facilitating efficient data exchange between NHIF, healthcare providers, and other stakeholders. Collaboration with the Department of Social Services can be explored to obtain data on vulnerable populations.

Implementing these measures will contribute to improving governance, accountability, and transparency within NHIF, ensuring that Universal Health Coverage is inclusive and reaches all individuals.

Revisiting the Social Contract

In paraphrasing Locke and Rousseau the society is always willing to contribute to governance and realization of their rights if there is the promise of greater protection and realization of these rights. Kenyans are more likely to accept the NHIF and religiously make monthly remittances if they can see tangible results. If the monthly subscriptions will enable them fully and comprehensively realise their right to health.

The success stories of Rwanda and Kisumu County in the health insurance sphere can be attributed, in part, to the clear explanation and proper design of their health insurance schemes. Education and information play a crucial role in ensuring the effective implementation and understanding of health insurance systems.

To enhance the success of NHIF and promote the right to health, the following recommendations are made:

1. Public awareness and education campaigns: NHIF should prioritize public awareness and education

campaigns to ensure that citizens have a clear understanding of NHIF's benefits, contribution mechanisms, and how to access healthcare services. This can be achieved through various channels such as mass media, community outreach programs, and educational materials that are accessible and easily understandable.

2. Community engagement mechanisms: NHIF should develop community engagement mechanisms to encourage community participation and foster a sense of ownership and accountability. This can include town hall meetings, community forums, and stakeholder consultations where citizens can provide input, voice their concerns, and contribute to the decision-making processes of NHIF.

3. Partnership with stakeholders: NHIF should collaborate with relevant stakeholders, including community leaders, healthcare providers, and civil society organizations, to strengthen public awareness and education efforts. These partnerships can help disseminate information effectively and reach diverse segments of the population.

4. User-friendly communication channels: NHIF should establish user-friendly communication channels to facilitate easy access to information and address subscriber inquiries. This can involve a well-designed website with clear and concise information, a dedicated customer service helpline, and interactive digital platforms for engagement and information sharing.

5. Continuous evaluation and improvement: NHIF should regularly evaluate the effectiveness of their public awareness and education campaigns and make necessary improvements based on feedback and emerging needs. This ensures that the information provided remains relevant, accurate, and accessible to the public.

By implementing these recommendations, NHIF can enhance public awareness, education, and community engagement, promoting a better understanding of NHIF's services and fostering a sense of ownership among citizens. This will contribute to the successful implementation of the health insurance scheme and the realization of the right to health for all Kenyans.

Efficient Claims Processing

Streamlining and expediting the claim's processing system is crucial to minimize delays in reimbursement to healthcare providers and ensure timely access to healthcare services. We propose using digital solutions and automation to improve claims processing efficiency, accuracy, and speed, reducing administrative burdens for NHIF and healthcare facilities.

By implementing these recommendations, NHIF can streamline the claims processing system, minimize delays in reimbursement, and ensure timely access to healthcare services for both healthcare providers and NHIF subscribers. The use of digital solutions, proactive resolution of non-remittance cases, and continuous improvement efforts will contribute to a more efficient and effective claims processing system.

Provider Payment Mechanisms

By implementing appropriate provider payment mechanisms such as capitation, bundled payments, and pay-for-performance

approaches, NHIF can incentivize healthcare providers to deliver high-quality, cost-effective, and patient-centered care. These innovative payment models promote value-based care delivery and encourage healthcare providers to focus on preventive measures, care coordination, and efficient resource utilization, ultimately improving the overall healthcare experience for NHIF subscribers.

Expand Coverage

Implementing targeted programs for the informal sector, affordable contribution options, expansion of NHIF accredited facilities and periodic reviews of benefit packages, NHIF can expand its coverage to reach more individuals in the informal sector and marginalized communities, while also addressing the specific needs and challenges they face. This will contribute to greater inclusivity and ensure that all segments of the population have access to affordable and quality healthcare services through NHIF.

Robust Stakeholder Engagement

Collaborating with healthcare stakeholders is crucial for understanding their needs, challenges, and suggestions for improving NHIF. By engaging hospitals, clinics, community health volunteers/workers, healthcare professionals, and employees from different sectors, NHIF can gain valuable insights and ensure that the system is responsive to the requirements of all stakeholders. Suggestions for NHIF improvement include statutory deduction rates, conducting regular consultations, forums, or working groups to gather feedback on the current system and identify areas for enhancement.

Community-Based Health Insurance

Support community-based health insurance programs in Kenya, like Rwanda's. These programs should accommodate alternative payment plans to address community-specific needs depending on context.

Prioritize Preventive Care

Place a strong emphasis on preventive care within the NHIF system. Rwanda's health insurance system focuses on preventive measures, including health education, immunizations, and regular check-ups. Encouraging preventive care can lead to early detection and management of diseases, reducing the burden on the healthcare system in the long run we propose the following recommendations to County and National Governments:

Legal and Policy Reform

The adoption of a comprehensive County Insurance Scheme by Kisumu County, known as the Marwa scheme, is a positive step towards improving access to quality healthcare for vulnerable individuals in the county. This scheme, which pays monthly insurance subscriptions to NHIF on behalf of marginalized individuals, demonstrates the commitment of Kisumu County to addressing the health needs of its residents. The passage of the Health Act by Kisumu County, which incorporates aspects of the Marwa health scheme, provides a legal framework for the implementation of such initiatives. This not only ensures the sustainability and continuity of the scheme but also encourages the involvement of partners and generates interest among Kisumu residents.

To replicate the success of the Marwa scheme in other counties, it is recommended that county governments

consider passing health laws mandating them to take charge of health insurance financing for their residents. These laws can provide the necessary framework and accountability mechanisms to support the implementation of county-specific insurance schemes and ensure transparency in the use of funds.

It is crucial for these projects to have proper checks and balances, including transparency and accountability measures, to avoid any misuse of resources. This can be achieved through regular audits, financial reporting, and engagement with stakeholders, including civil society organizations and community representatives. By adopting similar comprehensive County Insurance Schemes and implementing strong governance structures, other counties can improve access to quality healthcare and address the health needs of their vulnerable populations effectively.

Increase Budgetary Allocation and Make Expenditure More Efficient
This study recommends taking various steps to increase funding to NHIF and improve its financial sustainability. The following measures are suggested:

1. Increased funding through donor sourcing: NHIF should actively seek donor support to supplement its funding. Efforts should be made to secure additional resources from international donors to strengthen NHIF's capacity and expand its coverage.

2. Increased government budget allocation: The Parliament should prioritize and advocate for an increased budgetary allocation to the health sector. Specifically, the budget allocation for the health sector should be raised from the current 2% to 10.5% in the first two years (2023/2024 and 2024/2025), and subsequently to 15% from the third year onwards. This increased funding will help realize the right to health for all Kenyans.

3. Immediate allocation of funds to key donor-dependent programs: NHIF should allocate its funds to critical donor-dependent programs, such as those addressing HIV, tuberculosis, malaria, family planning, and reproductive, maternal, newborn, and adolescent health. This will reduce reliance on external resources and ensure continuity of essential services even as donor support declines. It will also enhance self-reliance within the health sector.

4. Reallocating health sector revenues: Revenues generated from hospitals and other ancillary health functions should be channeled back to support health functions in both the National and County Governments. This reallocation of funds will provide additional resources for the health sector and contribute to its financial sustainability.

5. Performance-based budgetary allocations: The finance systems in the country should be reviewed, and performance-based budgetary allocations should be introduced across ministries. Ministries dealing with fundamental human rights, such as health, should receive increased financing based on their functions and responsibilities.

6. Reducing administrative costs: NHIF should develop strategies

to reduce the amount of money spent on administration. Embracing technology and implementing advanced technological systems for handling claims and inquiries can streamline administrative processes, improve efficiency, and minimize administrative costs.

By implementing these measures, NHIF can increase its funding, improve financial sustainability, and enhance the allocation of resources within the health sector. This will contribute to the realization of the right to health for all Kenyans and ensure the provision of quality healthcare services. Timely disbursement of the equalization fund to the counties

Non-remittance or delayed remittance of NHIF contributions by counties is indeed a significant problem reported by county employees. To address this issue and ensure timely remittance, the following actions can be taken:

1. Timely disbursement of funds to counties: The National Government should prioritize and ensure timely disbursement of funds to the counties. This will provide the necessary resources for counties to fulfill their financial obligations, including the remittance of NHIF contributions on behalf of county employees.

2. Direct remittance of contributions to NHIF: The National Government should consider developing a policy or mechanism that allows for the direct remittance of NHIF contributions on behalf of county employees. This would eliminate the reliance on counties to make the remittances, reducing the chances of non-remittance or delays.

3. Compliance monitoring and enforcement: The NHIF and relevant government agencies should strengthen their monitoring and enforcement mechanisms to ensure that counties comply with their obligations of remitting NHIF contributions. Regular audits and inspections can help identify any non-compliance issues and take appropriate actions to rectify the situation.

4. Enhanced communication and coordination: Improved communication and coordination between the National Government, NHIF, and county governments are crucial. Clear guidelines and procedures should be established to ensure a smooth and efficient process for remittance, and channels for reporting and addressing any issues should be readily available.

By implementing these measures, the problem of non-remittance or delayed remittance of NHIF contributions by counties can be addressed. Timely disbursement of funds and the development of policies for direct remittance will contribute to the smooth operation of NHIF coverage for county employees, ensuring uninterrupted access to healthcare services.

Annex 1: Detailed Methodology

Background

Amnesty International Kenya is running an #Afya Nafuu campaign this year 2023 - Swahili for Affordable Health. The campaign is designed to bring awareness and reduce inequality and discrimination when it comes to an affordable, accessible, available acceptable quality of health. We seek to advocate for the continuous progress by the government to achieve Universal Health Care by improving its main driver NHIF.

Methodology

The research conducted to assess health inequity and progress towards Universal Health Coverage in Tana River, Garissa, Wajir, Kilifi, and Kisumu counties provides valuable insights into the challenges faced by individuals in accessing healthcare services and utilizing NHIF in these areas. The inclusion of diverse groups such as community health volunteers, nurses, community leaders, human rights defenders, and NHIF clients in focus group discussions ensured a comprehensive understanding of the issues and concerns.

By conducting the research in historically marginalized counties like Tana River, Wajir, Garissa, and Kilifi, the study aimed to shed light on the specific challenges faced by these communities in terms of service delivery and healthcare access. Kisumu was included as a county that had undergone the Universal Health Coverage pilot project, providing an opportunity to assess the progress and outcomes of such initiatives. The research methodology, including focus group discussions, a public perception survey, and interviews, enabled the collection of qualitative and quantitative data from various perspectives. This comprehensive approach allowed for a deeper understanding of the sensitive areas and collectives that require particular attention to address health inequity and improve healthcare services.

The findings from this research will serve as a foundation for identifying key areas for improvement and informing policy recommendations to enhance the accessibility, affordability, and quality of healthcare services. By understanding the challenges faced by individuals in utilizing NHIF and healthcare facilities, policymakers and stakeholders can develop targeted interventions and strategies to address the specific needs of these communities and work towards achieving Universal Health Coverage for all.

Table 1: Participants

Categories of the FGD participant	Male	Female	GNC	Below 35 years	Above 35 years	Special Needs (PWD)	Total
Kisumu	6	8	1	3	12	1	31
Garissa	7	7	0	11	3	0	14
Tana River	6	8	0	8	7	0	15
Kilifi	16	17	0	18	15	2	33
Wajir	11	7	0	8	10	2	18

At the validation meetings, members of the community reviewed and validated the draft report. These meetings were held in various counties. Those who had attended the initial meetings were given the opportunity to attend the validation meetings. The attendance at validation meetings is as follows:

Categories of the FGD participant	Male	Female	GNC	Below 35 years	Above 35 years	Special Needs	Total
Kisumu	10	9	0	14	5	2	19
Garissa	8	7	-	4	12	0	16
Tana River	9	11	-	9	11	0	20
Kilifi	6	13	2	6	15	1	21
Wajir	10	10	-	14	6	0	20

The research conducted six Focus Group Discussions (FGDs) to gain insights into the first-hand experiences of the public with the NHIF system in their respective counties. The objective of the FGDs was to analyze the accessibility and affordability of healthcare in each county. Each FGD aimed to have a minimum of 15 participants, who were encouraged to share their experiences and perspectives on the NHIF system. The data collected from these discussions was transcribed and analyzed to generate a comprehensive report.

In the specific case of Wajir, the FGD took place in the Lafaley area, which is situated approximately 16 miles away from Wajir town. Lafaley comprises three villages that are approximately 35 kilometers apart from each other. The area is served by a dispensary located near the chief's camp. This dispensary primarily provides assistance with childbirths and treats minor ailments. However, it does not have NHIF coverage as all services are provided free of charge.

During the FGD, it was highlighted that out of nearly 200 households in Lafaley, only five had the financial capacity to pay for NHIF subscriptions. This indicates that the majority of households in the area do not have access to NHIF coverage due to financial constraints. The area chief provided this information, shedding light on the limited ability of the local community to afford NHIF subscriptions.

This information gathered from the Lafaley FGD contributes to the broader understanding of the challenges faced by communities in accessing and affording healthcare in Wajir County. It highlights the need for targeted interventions and strategies to improve healthcare accessibility and affordability, particularly in areas with limited financial capacity to pay for NHIF subscriptions.

FGD QUESTIONS

1. How many of us are enrolled under NHIF and are up to date with our monthly contributions?

Follow-up Question:
- How many are not enrolled and why?
- In your community, how many people would you estimate are enrolled under NHIF?
- How many would you estimate are not enrolled?
- How many of you have stopped or are irregular contributors and why?
- Where do you go to receive information about NHIF?

2. When was the last time you used NHIF?

Follow-up Questions
- What kinds of health facilities do you generally use?
- Which kinds of services did you find easily accessible and which ones are not?
- Which health facilities did you find are more accepting of NHIF and which ones are the least accepting?
- Are there health services which you must pay out of pocket? From which health facility in particular?

3. Have there been incidences where you were unable to use your NHIF despite being a paid-up member?

Follow-up question:
- Please describe your experience.
- How would you describe the strengths and weaknesses of NHIF?

4. For those whose employers remit their contributions, has anyone had any issues with on-time payment?

Follow-up questions
- Please describe your experience.
- Have you solved or attempted to solve the situation?
- What channels did you use and what was the outcome?

5. Has anyone sought out Sexual and Reproductive health services using their NHIF in any of the hospitals?

Follow-up questions
- Please describe your experience

6. If you could change one thing about NHIF, what would it be?

Follow-up questions
- Is there anything else you would like to say about NHIF?

Survey

The study was conducted to gather secondary data and understand the accessibility and affordability of NHIF across Kenya. The survey collected responses from 329 Kenyans above the age of 18, representing all 47 counties. The data was analyzed using KOBO Collect. The language used in the survey was English.

Interviews

We gathered valuable insights by conducting one-on-one interviews with hospital personnel, medical practitioners, and NHIF officials. Through their

administrative perspective, we were able to get initial responses on the issues raised in the focus group discussions and surveys regarding NHIF.
The interviews provided us with a crucial understanding of the viewpoints of these key stakeholders. Our findings will help us develop a comprehensive strategy that addresses the challenges faced by NHIF and results in better healthcare for all. We carried out interviews in the following areas:

i) Garissa Referral Hospital Field Visit, 14 February 2023
It is a level five referral hospital in Garissa County. The purpose was to shed light on the corruption and insufficient service provision of NHIF services in public hospitals for the #AfyaNafuu research. Garissa County Referral Hospital, formerly known as the Garissa Provincial General Hospital (PGH), is the highest-level hospital in Garissa County, with a bed capacity of 224. Neonatal disorders of types Communicable, maternal, neonatal, and nutritional diseases are the hospital's most significant health concern and have increased by 49.0 per cent since 2009.

ii) Tana River Referral Hospital, 16 February 2023
During the visit to Tana River County as part of the #AfyaNafuu research, the focus was on uncovering corruption and addressing the inadequate provision of NHIF services in public hospitals. The campaign aims to raise awareness and promote equality in marginalized communities, challenging the perception that health services are limited to those with NHIF cards.

Tana River County is located in the former Coast Province of Kenya and had a population of 315,943 according to the 2019 census. The gender distribution in the county is approximately 50.2 percent male and 49.8 percent female. The majority of the population, around 76 percent, resides in rural areas, while the remaining 24 percent lives in urban areas. The county is divided into three sub-counties: Tana North, Tana Delta, and Tana River.

The highest-level hospital in the county is the Hola County Referral Hospital, which operates at a level 4 designation. This hospital provides a range of inpatient and outpatient services, including maternal care. However, Tana River County faces various health challenges, including issues related to mental health stability and the prevalence of cholera.
The visit to Tana River County aimed to shed light on the specific health issues faced by the community and the shortcomings in NHIF service provision. By understanding the unique challenges and needs of the county, the #AfyaNafuu campaign seeks to advocate for improvements in healthcare accessibility and quality, particularly for marginalized communities.

iii) Kisumu Hospital Visits, 14 February 2023
The interviews were conducted at St. Jairus and St. Consolata Hospitals.

iv) Wajir Referral Hospital, 14 February 2023
Wajir Referral hospital is in Wajir, Wajir-East ward. The hospital is the main hospital in Wajir travel as far as 60 Kilometers to access the services at the hospital.

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RAPID SITUATIONAL ANALYSIS OF THE EXISTING NATIONAL HEALTH INSURANCE PLAN IN KENYA

AMNESTY INTERNATIONAL

Amnesty International Kenya and
The People's Health Movement