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REPUBLIC OF KENYA

THE NATIONAL ASSEMBLY

THIRTEENTH PARLIAMENT – FIFTH SESSION – 2026

DIRECTORATE OF DEPARTMENTAL COMMITTEES

DEPARTMENTAL COMMITTEE ON HEALTH

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REPORT ON PUBLIC PETITION NO. 021 OF 2025 REGARDING ACCESS TO HEALTHCARE BY CANCER PATIENTS IN THE COUNTRY

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CHAIRPERSON'S FOREWORD

It is my honour, on behalf of the Departmental Committee on Health and pursuant to Standing Order 227, to present to the House this Report on Public Petition No. 021 of 2025 on access to healthcare by cancer patients in Kenya. The Petition was submitted by the Kenya Network of Cancer Organizations (KENCO) and tabled by Hon. Gladys J. Boss, MGH, MP, Deputy Speaker of the National Assembly, on Tuesday,7th October 2025, on behalf of the Petitioners pursuant to Standing Order 225(2)(a).

The Petitioners prayed that the National Assembly, through the Health Committee:

(i) Ensures enhancement of oncology benefits, which were reduced from Kshs. 600,000 per individual under the NHIF to Kshs. 400,000 per household under SHA;
(ii) Commissions an independent audit of SHA funds, reviews benefit structures, creates reforms for fairness and sustainability in cancer care financing, and ensures adequate allocation of funds to both the Primary Healthcare Fund and the Emergency, Chronic and Critical Illness Fund; and
(iii) Makes any other order or direction it deems fit in addressing the plight of cancer patients.

Cancer remains one of Kenya's most significant public health challenges. The country records approximately 44,000 new diagnoses and over 29,000 cancer-related deaths annually. Breast and cervical cancers disproportionately affect women, while prostate cancer is the leading diagnosis among men. Against this burden, equitable access to affordable and comprehensive cancer care is a matter of public importance.

The transition from the National Health Insurance Fund (NHIF) to the Social Health Authority (SHA) was undertaken to advance Universal Health Coverage. However, evidence presented before the Committee identified unintended consequences for cancer patients arising from the restructuring of oncology benefits. Under the NHIF, patients received an individual oncology benefit of Kshs. 600,000 per year while under SHA, this has been reorganised into a household-based benefit of Kshs. 550,000; comprising Kshs. 400,000 under the Social Health Insurance Fund (SHIF) and Kshs. 150,000 under the Emergency, Chronic and Critical Illness Fund (ECCIF). For households in which more than one member requires treatment, this shift from individual to household coverage significantly reduces the financial protection previously available.

A survey of 118 cancer patients conducted by the Petitioners underscored the scale of the challenge: Sixty (60%) had exhausted their SHA benefits before the end of the policy year, with over a third depleting their cover within just three months. Some thirteen point five percent (13.5%) reported discontinuing care entirely once benefits were exhausted. The Petitioners also reported serious operational concerns including SHA system errors, delays in approvals and limited customer support, with sixty (60%) of patients reporting at least one denial of treatment attributable to system failures.

In considering the Petition, the Committee engaged the Petitioners on 11th November 2025 and also received a written submission from the Cabinet Secretary for Health dated 4th November 2025. Following consideration of all information submitted, the Committee makes recommendations directed at the Ministry of Health, the Social Health Authority, and the National Treasury. These include raising the individual oncology benefit to a minimum of Eight hundred thousand (Kshs. 800,000) per beneficiary per year; strengthening digital and administrative systems for claims approvals; increasing budgetary allocations to both the

Primary Health Care Fund and the Emergency Chronic and Critical Illness Fund (ECCIF); improving patient and provider awareness of available benefits; and commissioning an independent forensic audit of all SHA disbursements since inception.

The Committee expresses its appreciation to KENCO, the cancer patients and caregivers who courageously shared their experiences, the Ministry of Health for its engagement, and the Offices of the Speaker and Clerk of the National Assembly for their guidance and support. I also extend my sincere gratitude to all Committee Members for their dedication and diligence throughout the consideration of this Petition.

Pursuant to National Assembly Standing Order 199, the Committee now lays this Report before the House for consideration.

Sign.....**Date**.....7/4/2026.....

HON. DR. NYIKAL JAMES WAMBURA, CBS, MP
CHAIRPERSON, DEPARTMENTAL COMMITTEE ON HEALTH

CHAPTER ONE

1.0 PREFACE

1.1 Establishment and Mandate of the Committee

1. The Departmental Committee on Health is one of the Departmental Committees of the National Assembly established under Standing Order 216 whose mandates pursuant to the Standing Order 216 (5) are as follows:
    a) To investigate, inquire into, and report on all matters relating to the mandate, management, activities, administration, operations and estimates of the assigned ministries and departments;
    b) To study the programme and policy objectives of ministries and departments and the effectiveness of the implementation;
    c) on a quarterly basis, monitor and report on the implementation of the national budget in respect of its mandate;
    d) To study and review all legislation referred to it;
    e) To study, assess and analyse the relative success of the ministries and departments as measured by the results obtained as compared with their stated objectives;
    f) To investigate and inquire into all matters relating to the assigned ministries and departments as they may deem necessary, and as may be referred to them by the House;
    g) To vet and report on all appointments where the Constitution or any law requires the National Assembly to approve, except those under Standing Order 204 (Committee on Appointments);
    h) To examine treaties, agreements and conventions;
    i) To make reports and recommendations to the House as often as possible, including recommendations of proposed legislation;
    j) To consider reports of Commissions and Independent Offices submitted to the House pursuant to the provisions of Article 254 of the Constitution; and
    k) To examine any questions raised by Members on a matter within its mandate.

1.2 Subjects under the Committee

2. In accordance with the Second Schedule of the Standing Orders, the Committee is mandated to consider matters related to health, medical care and health insurance, including universal health coverage.

1.3 Oversight

3. In executing its mandate, the Committee on Health oversees the:
    i. State Department for Medical Services; and
    ii. State Department for Public Health and Professional Standards.

1.4 Committee Membership

4. The Departmental Committee on Health was constituted by the House on 27th October 2022 and comprises the following Members:

Chairperson
Hon. Dr. Nyikal James Wambura, MP
Seme Constituency
ODM Party

Vice-Chairperson
Hon. Ntwiga, Patrick Munene MP
Chuka/Igambang'ombe Constituency
UDA Party

Hon. Owino Martin Peters, MP
Ndhiwa Constituency
ODM Party

Hon. Muge Cynthia Jepkosgei, MP
Nandi (CWR)
UDA Party

Hon. Wanyonyi Martin Pepela, MP
Webuye East Constituency
Ford Kenya Party

Hon. Kipng'ok Reuben Kiborek , MP
Mogotio Constituency
UDA Party

Hon. (Dr) Robert Pukose, MP
Endebess Constituency
UDA Party

Hon. Kibagendi Antoney, MP
Kitutu Chache South Constituency
ODM Party

Hon. Julius Ole Sunkuli Lekakeny, MP
Kilgoris Constituency
KANU

Hon. Maingi Mary, MP
Mwea Constituency
UDA Party

Hon. Mathenge Duncan Maina, MP
Nyeri Town Constituency
UDA Party

Hon. Lenguris Pauline, MP
Samburu (CWR)
UDA Party

Hon. Oron Joshua Odongo, MP
Kisumu Central Constituency
ODM Party

Hon. (Prof.) Jaldesa Guyo Waqo, MP
Moyale Constituency
UPIA Party

Hon. Mukhwana Titus Khamala, MP
Lurambi Constituency
ODM Party

1.5 Committee Secretariat

5. The Committee is facilitated by the following staff secretariat:

Mr. Adan Gindicha
Principal Clerk Assistant II-HOD

Mr. Ellam Omuhinda
Clerk Assistant III

Ms. Gladys Jepkoech Kiprotich
Clerk Assistant III

Ms. Marlene Ayiro
Principal Legal Counsel I

Ms. Faith Chepkemoi
Legal Counsel II

Mr. Hiram Kimuhu
Fiscal Analyst II

Mr Eric Lungai
Hansard Reporter II

Ms. Sheila Chebotibin
Principal Serjeant-At-Arms

Ms. Abigael Muinde
Research Officer III

Ms. Mercylyn Kerubo
Audio Recording Officer

Mr. Hillary Mageka
Media Relations Officer III

CHAPTER TWO

2.0 BACKGROUND OF THE PETITION

2.1 Introduction

6. The Public Petition No.021 of 2025 regarding access to healthcare by cancer patients in the country by Kenya Network of Cancer Organizations (KENCO), was presented to the House on Tuesday, 7th October 2025, by the Hon. Gladys J. Boss, MGH, MP, Deputy Speaker of the National Assembly, on behalf of Kenya Network of Cancer Organizations (KENCO).

7. This was pursuant to Article 119 of the Constitution, which accords any person the right to petition Parliament to consider any matters within its authority. Further, Standing Order 225(2)(b) requires the Speaker to report to the House any petition other than those presented by a member. The Petition was therefore committed to the Departmental Committee on Health for consideration and reporting to the House.

8. The Petition highlights systemic failures experienced under the Social Health Authority (SHA) and seeks urgent reforms in cancer care financing. Specifically, it raises various challenges that have been encountered by cancer patients under SHA in the following ways: reduction and inadequacy of cancer benefit packages, bureaucratic delays and system failures, poor communication and lack of transparency, service suspensions due to pending bills, underfunding of SHA, and emotional and mental strain.

9. In consideration of the Petition, the Committee engaged the Petitioners and the Cabinet Secretary, Ministry of Health.

2.2 Petitioner's Prayers

10. The Petitioners prayed that the National Assembly, through the Departmental Committee on Health, —
    (i) Ensure enhancement of oncology benefits, which were cut from six hundred thousand shillings (Kshs. 600,000) per individual under the NHIF to four hundred thousand shillings (Kshs. 400,000) per household under SHA;
    (ii) Commissions an independent audit of SHA funds, reviews benefit structures, creating reforms for fairness and sustainability in cancer care financing and ensuring adequate allocation of funds to the Primary Healthcare Fund and the Emergency, Chronic and Critical Illness Fund; and
    (iii) Make any other order or direction that it deems fit in addressing the plight of cancer petitioners.

CHAPTER THREE

3.0 STAKEHOLDER SUBMISSIONS ON THE PETITION

11. The Committee convened a sitting on **Tuesday, 11th November 2025**, at which it received oral and written submissions from KENCO and engaged in substantive deliberations. The Ministry of Health, through the Cabinet Secretary, Hon. Aden Duale submitted a formal response dated **4th November 2025** providing a comparative analysis of oncology benefits under the former National Health Insurance Fund (NHIF) arrangement and the current SHA framework.

3.1 THE PETITIONERS

12. The Kenya Network of Cancer Organizations (KENCO) submitted as follows during a meeting with the Committee held on **Tuesday, 11th November 2025.**

a) Introduction

13. The Kenya Network of Cancer Organizations (KENCO) represents over 70 civil society groups and thousands of cancer patients in Kenya. As SHA commemorates one year, KENCO takes the opportunity to highlight the issues that cancer patients have been facing since the scheme's rollout.

14. KENCO recognizes the creation of SHA as a hopeful step towards Universal Health Coverage. SHA is a landmark reform in healthcare financing, which on paper presents a bold and transformative vision, one where every Kenyan, regardless of income or geography, can access the health services they need without financial hardship. The Primary Healthcare Fund (PHCF) and the Emergency, Chronic and Critical Illness Fund (ECCIF) present revolutionary ideas in cancer care financing, provided that adequate resources are allocated to them.

15. However, one year after the SHA rollout, cancer patients have been facing obstacles that hinder access to life-saving care. It has become increasingly clear that the reality for cancer patients has not matched the promise. Across Kenya, people living with cancer continue to face financial ruin, delayed treatment, treatment abandonment, inconsistent coverage, bureaucratic obstacles, and emotional trauma — all of which undermine their right to health and dignity. The Petition therefore, documents key challenges observed over the past year and calls for urgent corrective action. The Petition is presented in the spirit of constructive engagement, accountability, and reform, with the shared goal of ensuring that SHA delivers on its noble vision.

b) Reduced Cancer Package Support: A Retreat from Progress

16. Under the previous scheme the (NHIF), oncology patients were entitled to an annual cover of Kshs 600,000 per individual, with the added flexibility of utilizing their spouse's cover once their own benefits were exhausted. This model, while not perfect, offered a lifeline to many families navigating the high cost of cancer care. Under

SHA, this has changed drastically. The oncology benefit has been reduced to Kshs 400,000 per household or Kshs 550,000 if the ECCIF allocation is factored in. Coverage is now household-based rather than individual, eliminating the possibility of sharing cover between spouses. For most patients, the benefit ceiling is often exhausted in less than six months, depending on the type of treatment.

17. A recent KENCO survey of one hundred and eighteen (118) cancer patients and caregivers found that sixty (60%) had exhausted their SHA cover before the end of the year, with thirty-five-point eight percent (35.8%) exhausting their benefits in less than three months and another thirty-four point three percent (34.3%) within three to six months. Among those whose cover ran out, (38.5%) were able to pay out of pocket,twenty seven point nine percent (27.9%) could only pay partially, 20.2% could not pay for treatment at all, and thirteen-point five percent (13.5%) were forced to abandon treatment completely. These findings confirm that the current oncology cover is grossly inadequate and that SHA has not protected households from catastrophic health expenditure.KENCO reported that One jane a care giver at KNH who was a caregiver to her sister who is battling stage 4 breast cancer that has metastasized to the liver, lungs, and brain and had completed 6 sessions of chemotherapy and ten (10) sessions of radiotherapy, and was due for another 12 cycles of chemotherapy.Jane averred that they were told that the sister had exhausted her SHA cover. A single session costs ninty thousand shillings (KSh 90,000). she intimated that they didn't have that kind of money, the patient skipped her sessions. she was at a loss and since cancer won't wait until SHA's financial year which they were told is October.

18. The inadequacy of the current cover becomes stark when one examines the real-world cost of treatment. A documented case of a woman diagnosed with triple-positive breast cancer at a public hospital in Kenya illustrates this vividly. Standard chemotherapy costs KSh 21,000 per session for eight sessions (KSh 168,000), blood works add approximately KSh 36,000, and imaging and diagnostics,including CT scans, echocardiograms, and a PET scan,raise costs by a further KSh 76,400. Targeted therapy with Herceptin alone costs approximately KSh 33,800 per cycle for 18 cycles, totalling KSh 608,400. Kadcyla, often prescribed for maintenance or resistance cases, costs KSh 180,000 per cycle for 14 cycles, a staggering KSh 2.52 million. Hormonal therapy exceeds KSh 100,000 in the first year, radiotherapy totals KSh 108,000 over 30 sessions, and surgery costs around KSh 120,000. The direct cost of comprehensive treatment for this patient easily exceeds KSh 3.8 million. This demonstrates beyond any doubt that the current SHA cancer cover of KSh 550,000 is grossly insufficient to provide equitable access to care. Reducing the oncology package is not just a technical policy change,it is a life-and-death decision for thousands of Kenyans.

19. KENCO then recommended the following:
    (i) Increase of the oncology benefit to at least one point two million shillings (Kshs 1.2 million) per individual per year.
    (ii) SHA to ensure that benefits under ECCIF are clearly accessible and not merely theoretical, and that they are increased gradually.

c) **Bureaucratic Delays, System Failures and Unresponsiveness**

20. Cancer treatment is time-sensitive. Delays of even a few days can mean disease progression, a worsening prognosis, or treatment failure. Unfortunately, SHA's current administrative systems have created bureaucratic bottlenecks that prevent timely access to care. Findings from KENCO's 2025 survey show that 65.3% of patients experienced delays in SHA approvals, with nearly one in five (19%) facing delays exceeding one week. Over half (55.9%) reported being denied treatment due to system indications of 'depleted' or 'expired' accounts, even when premiums were valid. While 69.5% of respondents had contacted SHA customer care, nearly 48% said they did not receive the support they needed, and another 36% received only partial assistance. Furthermore, 60.2% had been denied treatment at least once due to SHA system failures, with many reporting such incidents multiple times.

21. Patients have reported long approval times for treatment requests, including emergencies; system errors where accounts appear expired or depleted despite valid premium payments; unresponsive SHA helplines; and facility staff refusing to initiate treatment until SHA confirms payment, even for already-approved patients. The ongoing rollout of the biometric system is also adding harm, critically ill patients have been reported to be moved from their wards to have biometrics captured, causing additional distress and compromising their dignity.

22. KANCO informed the committee that Mary Nafula, a breast cancer warrior, registered with SHA in May 2024 and paid my full annual premium of Kshs 12,360. In July, she paid another KSh 12,360 to cover her until 2027. So, she was fully paid up for 3 years. She had only used KSh 108,000. Recently, when she went for her second chemotherapy session, the hospital told her that her SHA account had expired and she was required to pay cash. She called SHA, and there was no response. eventually, she found someone internally who confirmed that her account was valid until 2027. The hospital still insisted that its system showed otherwise.

23. Kenya Network of Cancer Organizations (KANCO) further informed the Committee that a breast cancer warrior at Jaramogi Oginga Odinga Teaching and Referral Hospital raised concerns regarding the Social Health Authority (SHA) system, stating that it is worse and more frustrating. The patient reported that in Kisumu (JOOTRH), treatment cannot be accessed without prior approvals, which may take up to three days. Consequently, patients traveling from distant areas are forced to spend nights at the hospital gate while awaiting authorization. The patient further noted that the system experiences frequent downtimes, and urged that chemotherapy approvals be fast-tracked to ensure timely access to care.

24. KENCO then recommended that there is need to:
    (i) Invest in efficient, real-time claims and approval systems that are responsive to clinical urgency.
    (ii) Create a dedicated oncology information desk and hotline with a guaranteed response time for both facilities and patients.
    (iii) Hold accredited facilities accountable for delays and denials resulting from internal misalignment with SHA systems.
    (iv) Ensure patients' benefits and balances reflect automatically on the *Afya Yangu* App and the SHA portal.
    (v) Reform biometric capturing processes to be flexible and mobile biometrics should be taken to patients, not the reverse.

d) Inflexible Premium Payment Model

25. Under SHA, premium payments are required annually and in full. For many cancer patients especially those from low-income households this upfront cost is prohibitive. Patients already struggling with job loss or reduced income due to their illness find the absence of payment flexibility deeply punitive. The SHA premium financing model through the Hustler Fund (*Lipa Pole Pole*) has also created unintended harm. There is a documented case where patients' M-Pesa balances were deducted without their consent to repay SHA premium financing loans they had not subscribed to, representing a system failure, a breach of patient data, and an erosion of trust.

26. According to the KENCO survey, 55.9% of respondents currently pay their SHA premiums annually, 10.2% use the *Lipa Pole Pole* initiative, and 9.3% are unable to pay at all. A vast majority (79.7%) expressed a preference for monthly payments, indicating strong demand for a more flexible contribution model. Alarmingly, 7.6% reported unauthorized deductions from their M-Pesa accounts for SHA-related loans. Universal Health Coverage must be inclusive by design. A rigid financing model that excludes the poor or disadvantages them through interest-bearing loans for premiums is incompatible with the principle of equity.

27. KENCO subsequently recommended the need to:
    (i) Reintroduce monthly premium payment options for vulnerable households, away from the loan model through the Hustler Fund.
    (ii) Allow grace periods or staggered contributions for patients with verified income shocks.
    (iii) Explore subsidies for indigent cancer patients, including integration with social protection programs.

e) Lack of Clear and Accessible Information

28. There is widespread confusion arising from poor communication by SHA. The benefit package is not clearly explained to patients or providers. Facilities are often unaware of the range of services covered under SHIF, or of the existence of ECCIF and how it is accessed. Patients receive contradictory information about SHA's financial year, their benefit entitlements, and whether they can use a spouse's cover. Many facilities' systems cannot show patients what benefits are still available to them.

29. The KENCO survey found that only 16.1% of respondents understood the SHA oncology benefit package very well, while nearly half (46.6%) admitted they understood it poorly or not at all. Awareness of ECCIF was especially low, only 6% had information about it, and a mere 2.6% reported ever accessing it. This widespread information gap fuels confusion and deepens inequities in care access.

30. KENCO subsequently recommended the need to:
    (i) Immediately publish and share a clear, user-friendly guide on the SHA benefit package, including ECCIF,
    (ii) disease-specific, and especially tailored to major disease areas like cancer.
    (iii) Clarify and widely communicate SHA's financial year to avoid contradictions and misinformation.

(iv) Update facility systems to align with SHA systems, showing patients their covered benefits and balances in real time through the SHA portal and the *Afya Yangu* App.

f) Issues with SHA-Accredited Facilities

31. Even after accreditation, many facilities are failing patients. Patients reported instances where they were being asked to pay for SHA forms at hospitals such as Kenyatta National Hospital, an unnecessary and exploitative practice. In some cases, facilities refuse to process pre-authorizations for patients, shifting the bureaucratic burden onto patients and caregivers who are already suffering. Essential cancer medicines are frequently unavailable in SHA-accredited facilities, forcing patients to seek them from private facilities at prohibitive costs.

32. The KENCO survey found that while only 11.9% of patients reported being charged for SHA forms, nearly half (49.2%) said they had been asked to purchase cancer medicines privately even though those medicines should have been covered by SHA. Only 42.4% said cancer medicines were always available in their facilities, while 37.3% said they were only sometimes available, confirming persistent gaps in medicine availability across the SHA-accredited network.

33. KENCO subsequently recommended the need to:
    (i) Eliminate exploitative practices such as charging patients for SHA forms.
    (ii) Enforce the SHA policy that requires accredited facilities to process pre-authorizations on behalf of patients.
    (iii) Strengthen and closely monitor supply chains to ensure cancer medicines are universally available in all SHA-accredited facilities.
    (iv) Invest in health systems strengthening and streamline the supply chain system for cancer medicines.

g) Disruptions in Care due to Suspension of SHA by Facilities

34. Access to care is being severely disrupted as health facilities suspend SHA services over unpaid bills and delayed reimbursements. The Rural Private Hospitals Association of Kenya (RUPHA) recently announced the suspension of SHA because of unpaid claims, calling the scheme unreliable and unsustainable. Thirty percent of surveyed patients reported being personally affected by such disruptions, illustrating how even short-term facility withdrawals have immediate and harmful effects on patient access.

35. When facilities withdraw from SHA, patients bear the greatest cost. They are forced to pay out of pocket, postpone critical treatment, or abandon care altogether. These disruptions not only damage SHA's credibility but directly put lives at risk, particularly for patients requiring ongoing treatments such as chemotherapy and radiotherapy. A sustainable health financing system cannot function without trust between the payer and providers, and timely payment of claims is a non-negotiable foundation for that trust.

36. KENCO subsequently recommended the need to:
    (i) Immediately pay all pending bills owed to health facilities, or agree on a credible payment plan to restore patient access to services.

(ii) Create a transparent, efficient, and predictable claims payment system that ensures facilities are reimbursed on time.
(iii) Engage health providers proactively to rebuild trust and prevent further service suspensions.

h) **Uniform Oncology Package: A Flawed Model**

37. SHA currently treats cancer as a single disease, applying a uniform benefit cap across all cancer types. This approach ignores the vast differences in treatment costs across different cancers, subtypes, and stages. A patient with early-stage cervical cancer may need only a few cycles of chemotherapy and surgery, while a patient with HER2-positive metastatic breast cancer may require 18 cycles of Herceptin at a cost of over KSh 70,000 per dose — before any other treatment modality is considered. Applying a flat KSh 400,000 cap to both cases is not only inequitable but unscientific. A fair health financing system must recognize clinical realities and tailor benefits to meet diverse patient needs.

38. KENCO subsequently recommended the need to:
(i) Establish a technical working group of oncologists, patient advocates, and health economists to review and revise the current oncology package structure.
(ii) Design tiered oncology packages that align benefit levels with disease complexity and treatment cost.

i) **Overseas Treatment Policy**

39. SHA recently abruptly halted overseas treatment support including for patients who were already abroad and mid-treatment. This sudden change left many patients stranded in foreign countries without care or financial support, despite having received prior approvals to access treatment abroad. These abrupt policy shifts are inhumane and violate the principles of clinical ethics, human rights, and patient dignity. While KENCO acknowledges that the Ministry of Health has since issued new guidelines on overseas treatment support, changes in policy without proper planning or communication create unnecessary stress, disrupt care, and weaken public trust in the health system.

40. KENCO subsequently recommended the need to:
(i) Ensure that policy transitions protect human dignity and do not disrupt patients' access to ongoing care.
(ii) Guarantee continuity of care, no patient should be left without support due to abrupt policy changes.
(iii) Allow patients with prior approvals to continue accessing overseas treatment under the previous policy terms without interruption.
(iv) Communicate future policy changes in advance, implement them gradually, and back them with clear transition plans that prioritize patients' health and lives.

j) **Emotional and Mental Strain on Patients**

41. Cancer is already a devastating diagnosis. For many patients, navigating SHA has become an additional and often overwhelming emotional burden. The uncertainty of

whether treatment will be approved, whether the system will function correctly, whether cover will be exhausted midway through treatment, whether recommended diagnostics are covered, or whether they will be told to 'wait until October' for the new financial year all of this adds immense psychological strain to an already fragile situation.

42. The KENCO survey found that 63.6% of patients reported that dealing with SHA caused them significant emotional distress, while only 15.3% said they were not emotionally affected. An overwhelming 93.2% of respondents said that psychosocial support should be part of SHA's oncology package. Mr.Waigwa, a prostate cancer patient from Nyeri. Wondered how he was expected to sit back and wait for the next financial year while cancer continued to ravage his body.

    Universal health coverage is not just about physical access, it is about dignity, security, and peace of mind. These dimensions must be embedded into how SHA is designed and how it communicates with patients.

43. KENCO subsequently recommended the need to:
    (i) Embed psychosocial support into cancer care packages as a standard component.
    (ii) Ensure that communication with patients is timely, respectful, and empathetic.
    (iii) Provide clear, transparent updates on coverage, approvals, and any delays

k) Mismanagement and Misallocation of Funds

44. Reports from investigative media and whistleblowers have flagged serious allegations of fraud, mismanagement, and irregular payments to facilities with no proven capacity or to institutions that do not exist at all. Meanwhile, real patients in real facilities are being denied services for lack of funds. The contrast between fraudulent claims being processed and legitimate patients being turned away is not only unjust it is inhumane. Health financing must be built on integrity, transparency, and accountability. Any perception of corruption in a fund designed to save lives undermines public trust and defeats the very purpose of SHA.

45. KENCO subsequently recommended the need to:
    (i) Conduct an independent forensic audit of SHA disbursements and make the findings public.
    (ii) Take immediate action against individuals or institutions involved in fraudulent claims, including recovery of funds already paid and legal prosecution.
    (iii) Fire and pursue legal action against SHA officials who took part in accrediting non-existent facilities or processing fraudulent claims.
    (iv) Implement stringent vetting and continuous monitoring of accredited facilities to ensure value for money and patient safety.

l) Chronic Underfunding of the Primary Health Care Fund and ECCIF

46. While SHA has created new financing mechanisms on paper, these remain grossly underfunded in practice. The Primary Health Care Fund, which is critical for cancer screening and prevention, was allocated KSh 4.1 billion against a resource requirement of KSh 61 billion in the current year. The ECCIF, which is meant to

support patients after their SHA benefits are exhausted, was allocated only KSh 2 billion against a resource requirement of KSh 107 billion. The funding gap is massive, persistent, and projected to continue under the current Medium-Term Expenditure Framework through 2028. Without adequate financing, even the best-designed health systems fail. Cancer care cannot be scaled without genuine investment.

47. KENCO subsequently recommended the need to:
    (i) Substantially increase budgetary allocations to both the Primary Health Care Fund and the ECCIF.
    (ii) Ringfence cancer funding to protect it from reallocation or diversion.
    (iii) Ensure timely disbursement of allocated funds to enable program continuity.
    (iv) Increase the health budget to at least 7% of the National budget, in line with progress toward the Abuja Declaration target of 15%.

m) Conclusion: From Policy to People -Promise to Practice

48. One year into SHA's implementation, KENCO noted that was evident that the intentions were noble, but the execution has fallen short especially for people living with cancer. SHA was envisioned as a vehicle to help Kenya achieve Universal Health Coverage, yet the reduction in oncology benefits, systemic inefficiencies, chronic underfunding, and a lack of patient-centered design are creating new barriers instead of removing old ones. This is a setback to the UHC journey that Kenya cannot afford.

49. Cancer patients are not statistics. They are mothers, fathers, daughters, and sons' real people who deserve dignity, equity, and timely care. As a country, we must ensure that SHA becomes a platform of hope, not despair.

50. KENCO therefore concluded by making the following collective appeal:
    (a) to the Ministry of Health, to reform oncology benefits, improve SHA responsiveness, and strengthen facility accountability;
    (b) to the Social Health Authority, to center patient dignity and clinical realities in all policy and practice decisions; and
    (c) to the National Treasury and Parliament, to invest meaningfully in cancer care financing and protect it from austerity.

51. They indicated that the appeals are not optional reforms, they are moral imperatives as cancer does not wait. Neither should the systems meant to treat it.

52. KENCO reiterated that it remains committed to working collaboratively with all stakeholders to ensure that SHA fulfills its promise, not just on paper, but in the lives of the people it was created to serve.

3.2 THE MINISTRY OF HEALTH

53. The Cabinet Secretary for the Ministry of Health formally submitted the Ministry's response to the Petition vide a letter dated 4th **November 2025.**

54. In the response, the Cabinet Secretary provided a comparative analysis of the oncology package under the previous NHIF arrangement and the current SHA implementation, as highlighted in the table below:

NHIF Benefits	SHA Benefits
Covered cancer management through chemotherapy, radiotherapy, hormonal therapy and immunotherapy.	Chemotherapy, immunotherapy, hormonal therapy, radiation therapy, and targeted therapy are accessed with the Oncology package. Palliative care is covered separately under the Palliative care package and not within the Oncology limit.
Members were limited to six (6) chemotherapy cycles per year reimbursed at a rate of KES 25,000 per cycle for basic chemotherapy, and up to KES 100,000 per cycle for complex chemotherapy.	Beneficiaries have an annual limit of KES 400,000 under SHIF and an additional KES 150,000 under ECCIF (Emergency Chronic and Critical Illness Fund) per beneficiary. This limit is accessed on reducing balances and is not capped per cycle. There are no limitations on the number of treatment cycles (*The ECCIF limit is being revised to KES 400,000*).
Patients were also entitled to additional NHIF benefits, including inpatient up to two (2) imaging procedures per year under the Family cover. Tests were covered within the Medical Imaging package only.	Upon suspicion of cancer, a SHA beneficiary is covered for tests to confirm the diagnosis and determine the type and stage of cancer. - One (1) MRI and one (1) CT-scan during the diagnosis stage are covered within the oncology limit. More tests can be accessed through the Medical Imaging package, which is within the Household cover. - The limit for the Household cover is two sessions per image per year. A wide range of specialized laboratory investigations has been introduced in the package, including specialized diagnostic tests. The cost of the tests varies across healthcare providers, and SHA covers them up to the stated liability limit (the tariff). These are accessed once per policy period through prior authorizations and approvals, which are made based on the sub-limits. If a patient exhausts the allocated MRI/CT-scans within the Oncology package, they can access two more MRIs and CT-scans under the Household cover.
Surgical interventions were accessed under the corresponding surgical packages where necessary.	Once a treatment plan is determined, SHA beneficiaries are covered under the different treatment options, which include: Surgery, financed under the Surgical Benefit package with a limit of KES 550,000.

55. Under the NHIF, beneficiaries who exhausted their allocated number of cycles could not continue treatment within the same benefit period, even when their prescribed

treatment protocols required additional cycles. Most patients whose cycles cost less than the maximum limit per cycle were unable to utilize the full limit.

56. Under SHA, surgical procedures and other patient needs are catered for under the gazetted tariffs. Some of the procedures covered are:

    a) Biopsies at KES 16,800 to KES 50,000, depending on size and complexity;
    b) TURP for prostate cancer patients at KES 16,800; and
    c) Mastectomy for breast cancer patients at KES 134,000.

57. Patients can get up to three minor surgeries, two major surgeries, and one specialized surgery within the policy period, independent of their Oncology package limit. Other benefits for cancer patients under SHA include:
    a) Daily admission rebates for inpatient services;
    b) Palliative care package; and
    c) Critical care services, where SHA pays KES 28,000 per day of admission for a maximum of 12 days for every admission episode.

58. The Cabinet Secretary noted that the Ministry of Health had established the Benefits Package and Tariffs Advisory Panel in line with the Social Health Insurance Act, 2023 and the attendant regulations. The Panel will be reviewing the benefits and tariffs every two years.

59. The Ministry had requested the Panel to revise the existing packages and provide recommendations to the Cabinet Secretary for proposed additional allocations for patients. The Social Health Authority was also considering taking care of patients who are in remission and require annual tests to monitor their cancer status.

60. SHA is further implementing the National Cancer Control Program differentiated care model for priority cancer management and will integrate it within the digital health system to ensure tailor-made treatment approaches/protocols, cost efficiency, better monitoring and follow-up, informed policy development, equity in access, collaborative care and sustainability of health systems.

CHAPTER FOUR

4.0 COMMITTEE OBSERVATION

61. Upon engaging the Petitioners and the Ministry of Health, the Committee made the following observations on the concerns raised by the Petitioners:

(a) The combined household benefit of Kshs. 550,000, comprising Kshs. 400,000 under the Social Health Insurance Fund (SHIF) and Kshs. 150,000 under the Emergency, Chronic and Critical Illness Fund (ECCIF), falls below the Kshs. 600,000 individual annual cover previously available under the NHIF. The shift from individual to household-based coverage eliminates the flexibility that previously allowed spouses to supplement each other's benefits.

(b) The structural foundations of SHA's cancer care financing are underfunded. The Primary Health Care Fund, essential for cancer screening, prevention, and early detection, received an allocation of Kshs. 4.1 billion against an identified requirement of Kshs. 61 billion, representing a funding gap of 93%. The ECCIF, the safety net for patients who exhaust their SHIF benefit, was allocated only Kshs. 2 billion against a requirement of Kshs. 107 billion, translating to a shortfall of 98%.

(c) The Emergency, Chronic and Critical Illness Fund (ECCIF), designed as the financial safety net for patients who exhaust their SHIF benefits, remains effectively inaccessible and almost entirely unknown to both patients and healthcare providers.

(d) Annual payment of SHIF in full is prohibitive and punitive for cancer patients especially those from low-income households.

(e) The manner of revising the benefits package and the tariffs under the social health insurance framework is cumbersome, lengthy, and is not responsive when urgent policy change is required.

(f) A waiting period before access to benefits provided by SHA is necessary to cushion SHIF contributions from depletion as happens for other insurers.

(g) There is a severe and systemic information deficit affecting both cancer patients and health facilities in relation to the benefit entitlements, the SHA financial year, and access procedures.

(h) The administrative procedures and digital systems of the Social Health Authority have created serious bottlenecks in the approval and delivery of cancer treatment, posing significant risks to patient health and survival due to cancer progression.

(i) SHA's delayed and unpredictable reimbursements to health facilities have occasioned service suspensions, which is burdensome, especially for cancer patients.

(j) SHA's abrupt and unilateral cessation of services adversely impacts on the right to health guaranteed under Article 43 of the Constitution. Policy changes must be properly communicated with adequate advance notice and sufficient transitional safeguards for all patients, and in particular for cancer patients

CHAPTER FIVE

5.0 COMMITTEE RECOMMENDATIONS

62. Pursuant to the Provisions of Standing Order 227, the Committee recommends as follows in response to the prayers:

(a) That the Cabinet Secretary for Health and the Social Health Authority (SHA) to urgently review the Tariffs for Healthcare Services, 2025 (Legal Notice No. 56 of 2025) to enhance the oncology benefits to a minimum of eight hundred thousand shillings (Kshs. 800,000).

(b) That the Ministry of Health and the Social Health Authority to undertake civic education on the benefits package and tariffs with a focus on cancer care services; and reports to the Committee within four months upon tabling of this report on the details of civic education undertaken.

(c) That the Ministry of Health and the Social Health Authority collaborate to ensure that the Social Health Insurance Fund (SHIF) contributions are increased and sustained and reports to the House within four months upon tabling of this report on—

(i) The mechanisms for enhancing the contributions of the informal sector; and
(ii) The measures adopted to ensure that SHIF contributions are paid on time.

(d) That the Social Health Authority reimburses health facilities within ninety (90) days in accordance with Regulation 59(1)(a) of the Social Health Insurance Regulations, 2024 (Legal Notice No. 49 of 2024) and the SHA Contracts for Provision of Health Care Services and reports to the House within four months upon tabling of this report on-

(i) The mechanisms for timely verification and settlement of claims; and
(ii) The capacity building programs to create awareness for health facilities on the submission of valid claims with no clerical errors.

(e) That the Social Health Authority and the Digital Health Agency make provision for a fast-track platform for the processing of pre-authorizations and clearances for the treatment of cancer patients.

(f) That the Social Health Authority implements section 27(5) of the Social Health Insurance Act, No. 16 of 2023 by providing premium financing products for the informal sector for the payment of contributions to the Social Health Insurance Fund.

(g) That section 27(4) of the Social Health Insurance Act, No. 16 of 2023 be amended to introduce a waiting period of three months for access to healthcare services under the Social Health Insurance Fund. The proposed amendment to be introduced by the Committee pursuant to Standing Order 114 is annexed to this report.

(h) That pursuant to the provisions of Standing Order 208A(2)(c), the findings arising from the consideration of this Petition be debated by the House.

SIGNED..... DATE..... 7/4/2026

HON. DR. JAMES NYIKAL WAMBURA, CBS, M.P.
CHAIRPERSON, DEPARTMENTAL COMMITTEE ON HEALTH

REPORT ADOPTION SCHEDULE

THE NATIONAL ASSEMBLY

13TH PARLIAMENT – FIFTH SESSION (2026)

DIRECTORATE OF DEPARTMENTAL COMMITTEES

DEPARTMENTAL COMMITTEE ON HEALTH

REPORT ON...Public Petition No. 21 of 2025 Regarding Access To Healthcare By cancer Patients In the country.....

We, the undersigned Members of the Departmental Committee on Health do hereby append our signatures to adopt this Report **Date:** 31/3/2026

NO	NAME	SIGNATURE
1.	The Hon. Dr. Nyikal James Wambura,CBS,MP- **Chairperson**	
2.	The Hon. Ntwiga Patrick Munene, MP -**Vice-Chairperson**.	
3.	The Hon. Dr. Pukose Robert, **CBS**, MP	
4.	The Hon. Titus Khamala, MP	
5.	The Hon. Sunkuli Julius Lekakeny Ole, **EGH, EBS**, MP	
6.	The Hon. Prof. Jaldesa Guyo Waqo, MP	
7.	The Hon. Owino Martin Peters, MP	
8.	The Hon. Wanyonyi Martin Pepela, MP	
9.	The Hon. Lenguris Pauline, MP	
10.	The Hon. Mary Maingi, MP	
11.	The Hon. Muge Cynthia Jepkosgei, MP	
12.	The Hon. Oron Joshua Odongo, MP	
13.	The Hon. Kibagendi Antony, MP	
14.	The Hon. Mathenge Duncan Maina, MP	
15.	The Hon. Kipngor Reuben Kiborek, MP	

PUBLIC PETITION UNDER CONSIDERATION BY THE COMMITTEE

REPUBLIC OF KENYA

THIRTEENTH PARLIAMENT– (FOURTH SESSION)

THE NATIONAL ASSEMBLY

PUBLIC PETITION

(No. 021 of 2025)

REGARDING ACCESS TO HEALTHCARE BY CANCER PATIENTS IN THE COUNTRY

1. **Honourable Members,** Article 119 of the Constitution accords any person the right to petition Parliament to consider any matters within its authority. Further, Standing Order 225(2) (b) requires the Speaker to report to the House any Petition other than those presented by a Member.

2. In this regard, **Honourable Members**, I wish to report to the House that my office has received a Petition from the **Kenya Network of Cancer Organisation (KENCO),** which represents over 70 civil society groups and thousands of cancer patients in Kenya.

3. **Honourable Members,** the Organisation is seeking to highlight systemic failures experienced through the Social Health Authority (SHA), and to call for urgent reforms in cancer care financing. Various challenges have been encountered by cancer patients through SHA in the following ways: reduced and inadequate cancer benefit packageS, bureaucratic delays and system failures, poor communication and lack of transparency, service suspensions due to pending bills, overseas treatment policy changes, underfunding of SHA funds and emotional and mental strain.

4. The **Kenya Network of Cancer Organisation (KENCO)** further contends that universal and fair health coverage remains far from reality for cancer patients. It requires urgent reforms, otherwise cancer patients will continue to experience needless delays, overwhelming costs, and avoidable deaths.

5. **Honourable Members**, the **Kenya Network of Cancer Organisation (KENCO) concludes** by praying that the National Assembly—

(1) Ensuring an enhancement of oncology benefits which were cut from Kshs. 600, 000 per individual under NHIF to Kshs. 400,000 per household under SHA;

(2) Commissions an independent audit of SHA funds, reviewing benefit structures, creating reforms for fairness and sustainability in cancer care financing, and ensuring adequate allocation of funds to the Primary Healthcare Fund and the Emergency, Chronic and Critical Illness Fund; and

(3) Makes any other order or direction that it deems fit in addressing the plight of the petitioners.

6. Given the nature of the prayers sought by the Kenya Network of Cancer Organisation (KENCO), I hereby commit this matter to the **Departmental Committee on Health** for consideration, especially as the Committee is seized of similar matters. The Committee is required to consider the matters contained in the prayers of the Organisation, conduct an inquiry, and report its findings to the House and to the Petitioners. Further, the Committee will also be expected to provide policy and legislative interventions to be actualized by this House, to bring this matter which keeps recurring to closure.

7. As I conclude, I wish to recognise the presence of ten (10) officials of KENCO seated in the Speaker's Gallery. May I ask them to rise for the House to recognize them.

I thank you.

THE HON. GLADYS J. BOSS, MGH, MP
DEPUTY SPEAKER OF THE NATIONAL ASSEMBLY

Tuesday, 7th October 2025

contacts: 0721968215
PHOEBE ONGADI
EXECUTIVE DIRECTUR
KENCO

KENCO
Kenyan Network of Cancer Organizations
United Against Cancer

PETITION ON ONE YEAR OF SHA: FROM PROMISE TO PRACTICE

Submitted by: Kenya Network of Cancer Organizations (KENCO)

TO: Hon. Aden Duale, CS, Ministry of Health

Dr. Mercy Mwangangi, CEO, Social Health Authority

Dr. Mohammed Abdi, Chairperson, Social Health Authority

Mr. Samuel Njoroge, Clerk of the National Assembly

Hon. John Mbadi, CS, The National Treasury

CC: Hon. Dr. James Nyikal, Chairman, Parliamentary Health Committee

Date: October 07, 2025

Introduction

The Kenya Network of Cancer Organizations (KENCO), represents over 70 civil society groups and thousands of cancer patients in Kenya. As we commemorate one year of SHA, KENCO takes this opportunity to highlight issues that cancer patients have been facing.

What is working:

KENCO recognizes the creation of the Social Health Authority (SHA) as a hopeful step toward Universal Health Coverage. On paper, SHA promised to tackle inequities in health service access by providing structured financing, expanding benefits, and protecting against overwhelming health costs. If fully implemented and funded, it could transform cancer care in Kenya by addressing the gaps between intention and access, diagnosis and treatment, and geographical disparities and survival rates. The Primary Healthcare Fund (PHCF) and the Emergency, Chronic and Critical Illness Fund (ECCIF) present revolutionary ideas in cancer care financing if adequate resources are allocated to the two funds.

Challenges:

One year after the SHA rollout, cancer patients have been facing obstacles that hinder access to life-saving care. We, the cancer patients, caregivers, and advocates under the KENCO umbrella, present this petition to highlight systemic failures and to call for urgent reforms in cancer care financing through SHA:

Reduced and Inadequate Cancer Benefit Package - Under SHA, oncology benefits were cut from Kes 600,000 per individual under NHIF to Kes 400,000 per household (or Kes 550,000 if supported by the Emergency, Chronic and Critical Illness Fund). This reduction is devastating in a context where cancer treatment can cost millions of shillings. A HER2-positive breast cancer patient, for example, requires at least 18 cycles of targeted therapy (Herceptin), which costs on average Kes 33,000 per cycle in public health facilities and twice that amount in private facilities. This is in addition to several diagnostic tests and other treatment modalities like surgery, chemotherapy, and radiotherapy. A documented real-life case of a woman diagnosed with triple-positive breast cancer and accessing services at a public hospital in Kenya shows that the patient faces an overwhelming financial burden from the breakdown shown below:

- Standard chemotherapy costs Kes 21,000 per session for eight sessions, amounting to Kes 168,000,
- blood works at approximately Kes 4,500 per cycle for 8 cycles adds to Kes 36,000,
- Imaging and diagnostic monitoring further raise the costs, including a CT scan (Kes 20,000, echocardiograms every three months (Kes 3,000), and a PET scan at Kes 53,400.
- Targeted therapy, Herceptin alone costs about Kes 33,800 per cycle for 18 cycles (or more for some patients), totaling Kes 608,400,
- Kadcyla, often prescribed for maintenance or resistance cases, costs Kes 180,000 per cycle for 14 cycles - a staggering Kes 2.52 million.
- Hormonal therapy, including Zoladex (Kes 19,615 every three months indefinitely) and Letrozole (Kes 5,000 for a three-month dose over 10 years), summing to over Kes 100,000 in the first year alone.
- Radiotherapy averages Kes 3,600 per session for 30 sessions (Kes 108,000),
- surgery, which costs around Kes 120,000,
- follow-up CT scans of the chest and pelvis cost Kes 8,000 and Kes 12,000, respectively.

The direct cost of comprehensive treatment for this patient easily exceeds Kes 3.8 million. This demonstrates that the current Social Health Authority (SHA) cancer cover of Kes 550,000 is grossly insufficient to provide equitable access to care. This is not an isolated case. Many other patients have exhausted their cover mid-treatment. Patients are forced to abandon treatment, raise money through collections, or wait for the next financial year, but cancer will not wait. The change from individual to household coverage has also unfairly excluded spouses who previously could access services through each other's cover.

Bureaucratic Delays and System Failures - Cancer treatment is time-sensitive, but SHA's administrative and approval systems are filled with delays. Patients report long approval times, unexplained account "expiry" despite full premium payment, and unresponsiveness from SHA helplines. At Jaramogi Oginga Odinga Hospital (JOOTRH), for example, patients sleep outside for days while waiting for approvals. Critically ill patients at JOOTRH have been reported to be taken out of wards to capture biometrics. These failures are not minor inconveniences—they lead to harmful treatment delays, emotional pain, and loss of trust.

Punitive Premium Financing Model - The need for annual lump-sum premium payments has shut out the most vulnerable patients. Many are not able to raise their annual premiums in one go. Furthermore, the premium-financing model linked to Hustler Fund loans adds an interest burden for patients already struggling. There are reports of unauthorized deductions from patients' M-Pesa accounts, violating data protection and ethical standards.

Poor Communication and Lack of Transparency - Patients and facilities receive insufficient and inconsistent information about SHA. The oncology benefit package is unclear, ECCIF coverage is poorly communicated, and even the financial year used for allocating benefits is contradictory. There is mixed treatment of patients—for example, some being allowed to use their spouse's coverage while others are denied—has created confusion and mistrust.

Facility-Level Failures - SHA-accredited facilities have themselves become barriers to care. Patients are asked to buy SHA forms at public hospitals, while facilities delay or refuse to submit pre-authorizations, forcing patients to pay out of pocket. Many accredited facilities lack essential cancer medicines, forcing patients to refer to private pharmacies to buy them at steep prices. Frequent breakdown of diagnostic and treatment machines also affects access to services in public hospitals.

Service Suspensions Due to Pending Bills - Recently, health facilities under the Rural Private Hospitals Association of Kenya (RUPHA) stopped SHA services, citing billions in unpaid claims. Such sudden suspensions leave patients stranded mid-treatment and erode confidence in SHA's sustainability.

Inflexible Benefit Design - SHA treats cancer as a single, uniform condition, yet treatment costs vary significantly by type and stage. For example, HER2+ breast cancer requires costly targeted therapy, unlike early-stage cervical cancer. Offering flat, uniform coverage for all cancers does not promote fairness or equity.

Overseas Treatment Policy Changes - SHA suddenly stopped overseas treatment support, even for patients who were already abroad and mid-treatment. Although new policy guidelines have been issued, such rapid policy changes violate the principle of continuity of care and have left

families stranded. Policy transitions must protect patients' dignity and ensure no one is abandoned mid-treatment.

Underfunding of SHA Funds - SHA's ongoing underfunding undermines its capacity to support patients. For instance, the Primary Health Care Fund received Kes 4.1 billion against a Kes 61 billion need, while the Emergency, Chronic, and Critical Illness Fund got Kes 2 billion against a Kes 107 billion requirement. These gaps lead directly to delays in cancer early detection and lack of a safety net for cancer patients once there SHIF cover depletes, leading to treatment abandonment.

Emotional and Mental Strain - Beyond the physical toll of cancer, patients face extreme psychological stress from system failures, treatment delays, and financial hardship. Missed treatments, rejected approvals, and uncertainty have left many cancer patients feeling abandoned by the system that should protect them.

To address these issues, we collectively make the following immediate call to action:

Social Health Authority (SHA): Improve benefit design to reflect actual cancer costs, implement responsive approval systems, reform biometric procedures, and ensure benefit packages and balances are clearly communicated to both facilities and patients.

Ministry of Health: Provide leadership to ensure transparency, humane policy transitions, and accountability in SHA operations. Ensure essential medicines are consistently available at accredited public health facilities.

Parliament (Health Committees): Exercise oversight by commissioning an independent audit of SHA funds, reviewing benefit structures, creating reforms for fairness and sustainability in cancer care financing, and ensuring adequate allocation of funds to the PHCF and ECCIF.

National Treasury: Address ongoing underfunding by significantly increasing allocations to SHA funds, protecting cancer financing, and prioritizing disbursements to prevent service stoppages. Increase health budgetary allocation as a percentage of the national budget to at least 7% of the national budget. Explore other health financing mechanisms like enhanced tobacco, alcohol and sugar-sweetened beverages taxation.

Conclusion

One year later, SHA's promise of universal and fair health coverage remains far from reality for cancer patients. Without urgent reforms, patients will continue to experience needless delays, overwhelming costs, and avoidable deaths. Cancer cannot wait, and neither should the systems meant to protect those most in need. We therefore urge immediate action to restore trust, protect patients, and fulfill the constitutional right to health for all Kenyans.

THE PROPOSED COMMITTEE SPONSORED SOCIAL HEALTH INSURANCE (AMENDMENT) BILL, 2026

THE SOCIAL HEALTH INSURANCE (AMENDMENT) BILL, 2026

A Bill for

AN ACT of Parliament to amend the Social Health Insurance Act, 2023

ENACTED by the Parliament of Kenya as follows—

Short title.

1. This Act may be cited as the Social Health Insurance (Amendment) Act, 2026.

Amendment of section 27 of No. 16 of 2023.

2. Section 27 of the Social Health Insurance Act, 2023 (in this Act referred to as "the principal Act") is amended by inserting the following new subsection immediately after subsection (4)—

"(4A) A person shall access healthcare services under the Social Health Insurance Fund ninety days from the date of payment of contributions under this section."

Insertion of a new section 27A in No. 16 of 2023.

3. The principal Act is amended by inserting the following new section immediately after section 27—

Exemptions on emergency treatment.

27A. Despite section 26(5), 27(4) and 27(4A), nothing in this Act shall limit the right to emergency medical treatment.

MEMORANDUM OF OBJECTS AND REASONS

The principal object of the Social Health Insurance (Amendment) Bill, 2026 is to introduce a three month waiting period for access to healthcare services under the contributory Social Health Insurance Fund. The waiting period is intended to prevent "adverse selection" where people purchase insurance only after falling ill or discovering that they need expensive treatment. This flows from the basic principle in health insurance where health insurance is designed to cover the unexpected and not the already-planned or already-known issues. The waiting period therefore shall protect the Social Health Authority from fraud and will enable it to better manage risks by allowing premiums to remain stable for all SHA beneficiaries.

The Bill further seeks to ensure that the provisions of Article 43(2) of the Constitution are adhered to in relation to the right to emergency medical services by expressly exempting this right from the provisions of section 26(5), 27(4) and the proposed new section 27(4A). This accords with the judgement of the High Court in the case of Aura v Cabinet Secretary, Ministry of Health & 11 others; Kenya Medical Practitioners & Dentist Council & another (Interested Parties) (Constitutional Petition E473 of 2023) [2024] KEHC 8255 (KLR).

Statement on the delegation of legislative powers and limitation of fundamental rights and freedoms

The Bill does not delegate legislative powers or limit fundamental rights and freedoms.

Statement on whether the Bill concerns County Governments

The Bill concerns the county governments in terms of Article 110(1)(a) of the Constitution.

Statement that the Bill is not a money Bill within the meaning of Article 114 of the Constitution

This Bill is a not money Bill within the meaning of Article 114 of the Constitution.

Dated the ....., 2026.

.....

Dr. James Nikal, MP

Chairperson of the Departmental Committee on Health.

Section 27 of No. 16 of 2023 which it is proposed to amend –

27. Contributions

(1) The following persons shall be liable to contribute to the Fund under this Act—

(a) every Kenyan household;

(b) a non-Kenyan resident, ordinarily residing in Kenya for a period exceeding twelve months;

(c) the national government;

(d) a county government; and

(e) any other employer.

(2) Contributions under this Act shall be paid as follows—

(a) in the case of a household whose income is derived from salaried employment, by a monthly statutory deduction from the wages or salary by the employer at a rate prescribed under this Act;

(b) in the case of a household whose income is not derived from salaried employment, by an annual contribution of a proportion of household income as determined by the means testing instrument in the manner prescribed under this Act;

(c) in the case of households in need of financial assistance as determined by the means testing instrument, by the government at a rate apportioned from funds appropriated by Parliament and County Assemblies for that purpose as prescribed under this Act;

(d) in the case of persons under lawful custody, by the Government from funds appropriated by Parliament for that purpose at a rate prescribed under this Act;

(e) in case of a person who is a permanent resident in Kenya, by such person at a rate as may be prescribed under this Act; and

(f) in the case of any other person, by the person himself out of his own funds in the manner prescribed under this Act.

Provided that the contributions under this section shall be paid at the time of registration.

(3) A person referred to in subsection (2)(b) shall pay their contributions on an annual basis.

(4) A person shall only access healthcare services under this Act where their contributions to the Social Health Insurance Fund are up to date and active.

(5) The government shall ensure that premium financing products are provided for non-salaried persons for the payment of social health insurance.

(6) Any person who fails to pay any contribution in respect of any period on or before the day on which payment is due shall be liable to a penalty equal to two percent of the amount due for contribution for the period which the contribution remains unpaid and the total annual contributions.

(7) A person shall pay all outstanding contributions and penalties accrued before resuming access to the healthcare services provided under this Act.

MINUTES OF COMMITTEE SITTINGS

MINUTES OF THE 21ST SITTING OF THE DEPARTMENTAL COMMITTEE ON HEALTH HELD IN COMMITTEE ROOM 23, 5TH FLOOR, BUNGE TOWER ON TUESDAY, 31ST MARCH 2026, AT 11.00 AM

PRESENT

1.	The. Hon. Dr. Nyikal James Wambura,CBS, MP	**-Chairperson**
2.	The Hon. Dr. Pukose Robert,CBS,MP	**-Member**
3.	The Hon. Prof. Jaldesa Guyo Waqo, MP	-Member
4.	The Hon. Oron Joshua Odongo, MP	-Member
5.	The Hon. Mary Maingi, MP	-Member
6.	The Hon. Cynthia Muge, MP	-Member
7.	The Hon Kibagendi Antoney, MP	-Member
8.	The Hon. Sunkuli Julius Lekakeny Ole, EGH, EBS, MP	-Member
9.	The Hon. Owino Martin Peters, MP	-Member

ABSENT WITH APOLOGY

1.	The Hon. Ntwiga Patrick Munene, MP	-Vice Chairperson
2.	The Hon Wanyonyi Martin Pepela, MP	-Member
3.	The Hon. Kipngor Reuben Kiborek, MP	-Member
4.	The Hon. Lenguris Pauline, MP	-Member
5.	The Hon. Ntwiga Patrick Munene, MP	-Vice Chairperson
6.	The Hon. Mathenge Duncan Maina, MP	- Member
7.	The Hon. Titus Khamala, MP	-Member

COMMITTEE SECRETARIAT

1.	Mr. Adan Gindicha II-HOD	-Principal Clerk Assistant
2.	Ms. Gladys Kiprotich	-Clerk Assistant III
3.	Ms. Mercylyn Kerubo	- Audio Officer
4.	Mr.Eric Lungai	-Hansard Officer
5.	Mr.Daniel Psirmoi	-Media Relations Officer
6.	Ms.Maryan Gabow Officer	-Public Communication
7.	Ms. Belac Otieno	-intern

IN AGENDA

1. Prayers
2. Preliminaries
3. Adoption of the Agenda
4. Confirmation of previous minutes
5. Matters Arising

6. **Briefing on the following:**
    i. **Briefing and adoption of the Committee's Schedule of activities for April 2026.**
    ii. **Public Petition No. 001 of 2026 Regarding Management of Haemophilia and Other Bleeding Disorders Among Patients and Children in the Country.**
    iii. **Public Petition Regarding Comprehensive National Measures to Address the Escalating Cancer Burden in Kenya.**
    iv. **Memorandum from the Kenya Union of Clinical Officers regarding the transition and unpaid salaries of employees under the Global Fund TB Programme.**
7. **Adoption of the Report on the Harm Reduction Bill (National Assembly Bill No. 37 Of 2025) Sponsored by Hon.Esther Passaris, Mp and Report on Public Petition No. 021 Of 2025 Regarding Access to Healthcare By Cancer Patients in the Country**
8. Pending Business (enclosed)
9. Any Other Business; and
10. Adjournment.

MIN. NO. NA/DC-H/2026/101: PRELIMINARIES/INTRODUCTION

The Chairperson called the meeting to order at eleven o'clock, followed by the Prayer and self-introductions.

MIN. NO. NA/DC-H/2026/102: ADOPTION OF AGENDA

The agenda of the meeting was adopted, having been proposed by the Hon. Mary Maingi, MP, and seconded by the Hon. Dr. Pukose Robert, CBS, MP.

MIN. NO. NA/DC-H/2026/103:BRIEFING AND ADOPTION OF THE COMMITTEE'S SCHEDULE OF ACTIVITIES FOR APRIL 2026, PUBLIC PETITION NO. 001 OF 2026 REGARDING MANAGEMENT OF HAEMOPHILIA AND OTHER BLEEDING DISORDERS AMONG PATIENTS AND CHILDREN IN THE COUNTRY,PUBLIC PETITION REGARDING COMPREHENSIVE NATIONAL MEASURES TO ADDRESS THE ESCALATING CANCER BURDEN IN KENYA AND MEMORANDUM FROM THE KENYA UNION OF CLINICAL OFFICERS REGARDING THE TRANSITION AND UNPAID SALARIES OF EMPLOYEES UNDER THE GLOBAL FUND TB PROGRAMME.

A. Briefing and adoption of the Committee's Schedule of activities for April 2026.

The Committee considered the proposed Schedule of Activities for the fourth Quarter (April) of the Financial Year 2025/2026. The Chairperson informed Members that the Schedule had been prepared to guide the Committee's engagements in the execution of its mandate pursuant to Standing Order 216(5)(b) of the National Assembly. The Committee Clerk subsequently took Members through the proposed Schedule of Activities.

The committee therefore adopted the Schedule of Activities for the fourth Quarter (April) of FY 2025/2026 as follows;

DRAFT SCHEDULE OF ACTIVITIES FOR FOURTH QUARTER 2025/2026

FINANCIAL YEAR (UP TO 30TH APRIL 2026)

Date	Activity	Venue
Tuesday, 31st March 2026 10.00am	Meeting to be briefed on the following: i. Adoption of Committee Schedule of activities for April, 2026 ii. Public Petition No. 001 of 2026 Regarding Management of Haemophilia and Other Bleeding Disorders Among Patients and Children in the Country. iii. Public Petition Regarding Comprehensive National Measures to Address the Escalating Cancer Burden in Kenya. **iv.** Memorandum from the Kenya Union of Clinical Officers regarding the transition and unpaid salaries of employees under the Global Fund TB Programme.	Committee Room 23,5th Floor, Bunge Tower
Thursday 2nd April, 2026 10.00 am	Meeting with the Kenya Union of Clinical Officers on the Memorandum regarding the transition and unpaid salaries of employees under the Global Fund TB Programme.	Committee Room 23,5th Floor, Bunge Tower

Tuesday 7th April, 2026 10:00 am	Meeting to adopt the report on the Quality Healthcare and Patient Safety Bill (National Assembly Bill No. 41 of 2025)	Bunge Towers
Thursday 9th April, 2026 7.00 am 11:00 am	• Follow-up breakfast meeting with the Kenya Private Sector Alliance (KEPSA) to align on key partnership priorities for the first half of the year and to discuss strategies for strengthening public-private collaboration in the health sector. • Meeting with the Kenya Renal Association regarding the inquiry into the alleged malpractice and Ethical breaches of kidney transplant Services • Meeting to consider and adopt the report on the Inquiry into the alleged malpractice and Ethical Breaches of Kidney Transplant Services at Mediheal Group of Hospitals	Serena Hotel, Nairobi Bunge Towers Bunge Towers
Tuesday 14th April, 2026 10:00 am	Meeting with the Digital Health Authority to deliberate on aspects of the implementation of the Social Health Authority in respect of its mandate	Bunge Towers
Thursday 16th April, 2026 10:00 am	Meeting with the Cabinet Secretary, Ministry of Health, to deliberate on the US funding agreement and Kenya–US Health data sharing framework and the status of the transition from	Bunge Towers

	the Managed Equipment Services (MES) Project to the National Equipment Service Programme (NESP) Project implementation.	
Tuesday 21st April, 2026 10:00 am	i. Meeting with Haemophilia Association of Kenya (Petitioners) regarding the petition on the management of haemophilia and other bleeding disorders among patients and children in the country ii. Meeting with Mr. Kipruto Patrick, the Petitioner regarding the Petition on measures to address escalating cancer burden in Kenya iii. Meeting with the State Department of Medical Services regarding the petitions above	Bunge Towers
Thursday 23rd April, 2026 10:00 am	Meeting with the Tobacco Control Board to be apprised of the operations of the Tobacco Control Fund	Bunge Towers
Friday 24th and Saturday 25th April	Proposed Retreat to meet with the PS State Department for Public Health and Professional Standards regarding the following programme/project i. National Malaria Programme ii. Building Resilient and Responsive Health Systems Project	To be communicated

Tuesday 28th April, 2026 10:00 am	Meeting with Kenyatta National Hospital (KNH) regarding the Status of the Kenyatta National Hospital Oxygen Processing Plant	Bunge Towers
Thursday,30th April, 2026 10:00 am	Consideration and adoption of the Report of the Site Visit to Kenyatta National Hospital (KNH)	Bunge Towers
LONG RECESS. SCHEDULE FOR PROCESSING OF 2026/2027 ESTIMATES TO BE SHARED		

NB: Kindly note that the schedule of activities may be amended as necessary where urgent business with timelines is committed to the Committee.

Following deliberations, the Committee resolved as follows:

1) The Committee amended its schedule of activities and resolved that on 14th April 2026, it will meet with Digital Health Authority to deliberate on aspects of the implementation of the Social Health Authority in respect of its mandate instead of holding the session to be briefed by Legal Counsel on the pre-publication scrutiny of the proposed Family Reproductive Health Care Bill, 2025, sponsored by Hon. Millie Odhiambo, MP. The briefing will instead be considered in May.
2) The researcher was tasked with analyzing the Kenya–US Health Data Sharing Agreement, comparing it with similar arrangements in other countries, reviewing relevant Kenyan laws, and assessing whether the agreement is beneficial to the country.
3) Regarding the meeting with the Tobacco Control Board to be apprised of the operations of the Tobacco Control Fund, the Committee tasked the Legal Counsel to develop draft proposed amendments to the Tobacco Control Act, particularly addressing the composition of the Board and identifying the weaknesses in the Act.

B. Public Petition No. 001 of 2026 Regarding Management of Haemophilia and Other Bleeding Disorders among Patients and Children in the Country.

The Committee was briefed on a petition presented by the Hemophilia Association of Kenya. The petition highlights the significant and growing burden of hemophilia in Kenya, a life-threatening bleeding disorder affecting approximately one in every 10,000 individuals. It is estimated that around 4,500 Kenyans are living with the condition, a large proportion of whom are children. However, only 1,265 patients, representing approximately 23 per cent of the estimated total, have been formally identified, indicating a critical gap in diagnosis and registration.

The Committee was further informed that treatment coverage remains severely inadequate. Current donation programmes supply only 30 per cent of the required clotting factor levels, leaving a deficit of 70 per cent. This situation is expected to

deteriorate further, as the donation programme is projected to end within two years, presenting an imminent public health crisis.
The petitioner raised four core concerns: the life-threatening nature of the condition, which results in frequent bleeding episodes, disabling joint disease, chronic pain, and reduced life expectancy; the high cost and complexity of treatment, which places considerable physical, financial, and psychological strain on patients and their families; significant data gaps arising from fragmented information systems, particularly affecting children; and inadequate infrastructure, including a limited number of operational haemophilia treatment centres and persistent shortages of clotting factor concentrates.

In light of the foregoing, the petitioner made the following prayers:

1. That clotting factor concentrates be formally recognised as essential medicines for both adult and paediatric haemophilia treatment, to ensure their consistent and sustainable availability.
2. That the Government strengthen infrastructure and capacity by establishing additional haemophilia treatment centres, enhancing diagnostic capacity, improving healthcare worker training , including specialised paediatric care, reviewing medical curricula to incorporate bleeding disorder management, and increasing funding for public awareness and early childhood screening.
3. That haemophilia be formally recognised as a disabling condition to enable registration with the National Council for Persons with Disabilities (NCPWD), and that haemophilia treatment be included under the Social Health Insurance Fund (SHIF).
4. That the Committee considers any other measures it deems appropriate to address the plight of persons living with haemophilia in Kenya.

C. Public Petition Regarding Comprehensive National Measures to Address the Escalating Cancer Burden in Kenya.

The Committee received a briefing on a public petition presented to the National Assembly of Kenya by Kipruto Patrick, a citizen and cancer advocate based in Nairobi. The petition was brought pursuant to Article 119 of the Constitution of Kenya, 2010, and the Petitions to Parliament (Procedure) Act, 2012, in the petitioner's individual capacity as a Kenyan citizen.
The petition draws urgent attention to Kenya's escalating cancer crisis and calls for immediate legislative and policy reforms across prevention, access to treatment, financing, and survivor support on a nationwide scale.

The petition highlights Kenya's escalating cancer crisis, stating that approximately 44,726 new cases and 29,317 deaths occur annually, with 70–80% of diagnoses occurring at late stages. It calls for urgent legislative and policy reforms to address prevention, access to treatment, financing and survivor support nationwide.

Petitioners' prayer

The petitioner requests the National Assembly to take the following legislative and policy actions:

1. Re-Introduction and Expansion of Emergency SHA Cover for Overseas Treatment (Up to KSh 3 Million)
2. Establishment of a Dedicated Food and Drug Administration (FDA) for Oversight of Chemical Substances
3. Monthly Grants for Cancer-Vulnerable Families Nationwide (KSh 10,000–15,000)
4. Enhanced Nationwide Pediatric Cancer Support and Treatment, Including Recovery Centers
5. Targeted Support Initiatives for Men's and Transgender Cancer Care Nationwide
6. Framework for Cancer Treatment Follow-Up After Screening and Diagnosis
7. Channels for Registration, Support, Advocacy, and Reducing Stigmatization
8. Targeted Support Initiatives for Men's and Transgender/gender-diverse Cancer Care Nationwide
9. Support for Cancer Patients with Drugs and Medications
10. Introduction of Cancer Counselling Centers per County
11. Nationwide Cancer Biometrics Tracking System with National Tally
12. Formation of an Independent National Cancer Board
13. Support for Nationwide Cancer Awareness, Communication, and Information Channels
14. Survivors' Reintegration, Employment Protections, Reasonable Accommodations, Reservation Incentives, and Vocational Training

Having been briefed on the petition, the Committee noted the following:

1. The cancer burden in Kenya constitutes a public health emergency requiring immediate multi-sectoral intervention at both national and county levels.
2. The high proportion of late-stage diagnoses (70–80%) reflects systemic gaps in early detection, screening infrastructure, and health-seeking behaviour that must be urgently addressed.
3. The Kenya Women Parliamentary Association (KEWOPA) and the departmental Committee on Health should champion and advocate for the nationwide scaling up of cancer screening programmes and Human Papillomavirus (HPV) vaccination, particularly targeting women and girls, as a critical preventive public health measure.
4. The National Cancer Institute shall coordinate with all relevant institutions, including the Kenya Medical Research Institute (KEMRI) and other stakeholders, to consolidate data and produce a comprehensive National Cancer Status Report. The report shall encompass cancer causation factors, prevention strategies, treatment modalities, ongoing research, and a geographical mapping of specific cancer prevalence across the country, and shall be submitted to the Committee within thirty (30) days from the date of adoption of these minutes.
5. The Committee resolved to allocate budgetary resources towards cancer research, with a view to strengthening the national evidence base for policy formulation, improving treatment outcomes, and supporting the development of Kenya-specific cancer control interventions.

D. Memorandum from the Kenya Union of Clinical Officers regarding the transition and unpaid salaries of employees under the Global Fund TB Programme.

The Committee was briefed on a Memorandum from the Kenya Union of Clinical Officers regarding the transition and unpaid salaries of employees under the Global Fund TB Programme.
The Committee was informed that the Global Fund TB Programme employees constitute a special cadre of workers originally employed under the Global Fund and seconded to the Ministry of Health between 2009 and 2015. They were tasked with implementing tuberculosis (TB) control interventions across Kenya at a time when TB, caused by Mycobacterium tuberculosis, was the leading opportunistic infection and cause of death among People Living with HIV (PLHIV).

The Committee was further informed that through their dedication and technical contribution, these employees played a critical role in reducing TB incidence and improving treatment outcomes, achievements that are verifiable through Ministry of Health data.
The Committee was additionally advised that the majority of these employees were engaged prior to the advent of devolution and were therefore never transitioned to the County Governments during the 2013/2014 transition period. Consequently, they have remained employees of the Ministry of Health, continuing to operate under national programmes and supervision.

1. Parliament to convene an urgent multi-agency consultative meeting (MoH, PSC, and Treasury, Council of Governors, and worker representatives) to fast track resolution of this impasse.
2. Immediate payment of all outstanding salaries and statutory benefits covering the 16-month non-payment period (effective 1st July 2024) in compliance with Section 18 of the Employment Act.
3. The Ministry of Health to be directed to absorb all officers under defunct Global Fund project now that County Governments are unwilling, and upon absorption, job-grouping to be commensurate with years of service, qualifications and experience for all affected officers.
4. Any other remedial measures necessary to restore dignity, livelihood, and career continuity for these officers.

Way Forward

The Committee Clerk informed the Committee of the applicable timelines for the consideration of petitions, as provided under the Standing Orders. The Committee has a maximum of ninety (90) days within which to consider a petition and report back to the House and to the petitioner. It was accordingly noted that both petitions ought to be tabled before the House on or before 3rd May 2025.

MIN. NO. NA/DC-H/2026/105: ADOPTION OF THE REPORT ON THE HARM REDUCTION BILL (NATIONAL ASSEMBLY BILL NO. 37 OF 2025) SPONSORED BY HON.ESTHER PASSARIS, MP AND REPORT ON PUBLIC PETITION NO. 021 OF 2025 REGARDING ACCESS TO HEALTHCARE BY CANCER PATIENTS IN THE COUNTRY

1. The Committee adopted the report on the Harm Reduction Bill (National Assembly Bill No. 37 of 2025) Sponsored by Hon.Esther Passaris, MP, having been proposed by Hon. Prof. Jaldesa Guyo Waqo, MP, and seconded by Hon. Mary Maingi, MP.

2. The Committee adopted the report on the Report on Public Petition No. 021 of 2025 Regarding Access to Healthcare by Cancer Patients in the Country, having been proposed by Hon. Cynthia Muge, MP, and seconded by the Hon. Mary Maingi, MP

MIN. NO. NA/DC-H/2026/105: ANY OTHER BUSINESS

There was no other business arising

MIN. NO. NA/DC-H/2026/106: ADJOURNMENT

There being no other business, the meeting was adjourned at 12 noon.

Sign..... Date.....7/4/2026.....

THE. HON. DR. NYIKAL JAMES WAMBURA, CBS, MP
CHAIRPERSON, DEPARTMENTAL COMMITTEE ON HEALTH

LETTER INVITING STAKEHOLDERS TO SUBMIT VIEWS ON THE PETITION

THE NATIONAL ASSEMBLY
OFFICE OF THE CLERK

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Nairobi, Kenya
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When replying, please quote

REF: NA/DDC/DC-H/2025/94

22nd October, 2025

Hon. Aden Barre Duale, E.G.H
Cabinet Secretary
Ministry of Health
Afya House.
NAIROBI

Dr. Oluga Fredrick Ouma, OGW
Principal Secretary
State Department for Medical Services
Ministry of Health
Afya House
NAIROBI

Ms. Mary Muthoni Muriuki, CBS
Principal Secretary
State Department for Public Health and Professional Standards
Ministry of Health
Afya House
NAIROBI

Dr. Mercy Mwangangi
Chief Executive Officer
Social Health Authority
SHA Building, Ragati Road
Community Area
NAIROBI

Mr. Anthony Lenaiyara
Ag. Chief Executive Officer
Digital Health Agency
9th Floor, Social Health Authority (SHA) Building
Cmmunity Area
NAIROBI

Dear Hon Duale

RE: REQUEST FOR SUBMISSION OF VIEWS ON PUBLIC PETITION NO. 021 OF 2025 REGARDING ACCESS TO HEALTHCARE FOR CANCER PATIENTS IN THE COUNTRY

The Departmental Committee on Health is mandated by the National Assembly Standing Order 216(5) (b) to ***"study the programme and policy objectives of ministries and departments and the effectiveness of the implementation"*** .

The National Assembly, has received a Petition from the **Kenya Network of Cancer Organizations (KENCO)** concerning access to healthcare for cancer patients in Kenya.

The petition highlights systemic failures experienced through the Social Health Authority (SHA) and seeks urgent reforms in cancer care financing. Specifically, the petitioners prays that the National Assembly:

1. Ensures enhancement of oncology benefits, which were cut from ksh.600,000 per individual under NHIF to ksh.400,000 per household under SHA;
2. Commissions an independent audit of SHA funds and reviews benefit structures, creating reforms to ensure fairness and sustainability in cancer care financing and;
3. Takes any other measures deemed necessary to address the plight of cancer patients.

The Petition has since been committed to the **Departmental Committee on Health** for consideration and reporting to the House. In this regard, the Committee wishes to seek your written views and comments on the issues raised in the petition.

Accordingly, the Committee hereby invites you to submit your views and comments on the petition **by 29th October 2025**. Kindly provide a physical copy of your submission and send an electronic copy to the Office of the Clerk via email: cna@parliament.go.ke

The Liaison Officer for this meeting is **Mr. Hassan A. Arale**, Committee Clerk, who may be contacted on Tel No. **0721480578** or email: **ddc@parliament.go.ke**

Yours

JEREMIAH W. NDOMBI, MBS
For: CLERK OF THE NATIONAL ASSEMBLY

Copy to: **Dr. Mohammed Abdi**
Chairperson
Social Health Authority
SHA Building, Ragati Road
Community Area
NAIROBI

Mr. Silas Simatwo
Chairman, Board of Directors
Digital Health Agency
9th Floor, Social Health Authority (SHA) Building
Community Area
NAIROBI

CPA. Dr. Aurelia C. Rono, CBS
Principal Secretary
State Department for Parliamentary Affairs
Railway Building
Haile Selassie Avenue
NAIROBI

LETTER INVITING STAKEHOLDERS FOR A MEETING WITH THE COMMITTEE ON THE

PETITION

THE NATIONAL ASSEMBLY
OFFICE OF THE CLERK

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When replying, please quote
REF: NA/DDC/DC-H/2025/95

21st October, 2025

Ms. Phoebe Ongadi
Executive Director
Kenya Network of Cancer Organizations (KENCO)
Tetu Apartments, D7, Ralph Bunche Road
off State House Road
P.O. Box 106383 – 00100
NAIROBI
ed@kenconetwork.org

Dear Ongadi

RE: PUBLIC PETITION REGARDING ACCESS TO HEALTH CARE FOR CANCER PATIENTS IN THE COUNTRY

Reference is made to your petition regarding achievements made by the Social Health Authority one year since its inception.

The National Assembly is in receipt of your petition and the same has been committed to the **Departmental Committee on Health** for consideration and subsequent reporting to the House. In this regard, the Committee invites you for a meeting on **Tuesday, 11th November 2025** at **10:00 am** at a venue to be communicated within Parliament Buildings.

The Liaison Officer for this meeting is **Mr. Hassan A. Arale**, Committee Clerk, who may be contacted on Tel No. **0721480578** or email: **ddc@parliament.go.ke**

Yours

JEREMIAH W. NDOMBI, MBS
For: CLERK OF THE NATIONAL ASSEMBLY

THE NATIONAL ASSEMBLY
OFFICE OF THE CLERK

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Nairobi, Kenya
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When replying, please quote
REF: NA/DDC/DC-H/2026/001

10th February, 2026

Ms. Mary Muthoni Muriuki, CBS
Principal Secretary
State Department for Public Health and Professional Standards
Ministry of Health, Afya House
NAIROBI

Dr. Oluga Fredrick Ouma, OGW
Principal Secretary
State Department for Medical Services
Ministry of Health
Afya House
NAIROBI

Dr. Mercy Mwangangi
Chief Executive Officer
Social Health Authority
SHA Building, Ragati Road
NAIROBI

Mr. Anthony Lenaiyara
Ag. Chief Executive Officer
Digital Health Agency
9th Floor, Social Health Authority (SHA) Building
NAIROBI

Dr. Elias Melly
Ag. Chief Executive Officer
National Cancer Institute of Kenya
P.O Box 30016-00100
Landmark Plaza Along Arwings Kodhek Road
NAIROBI

Dr. Waqo Ejersa, OGW
Chief Executive Officer
Kenya Medical Supplies Authority
P.O. Box 47715-00100
NAIROBI

Dr. David G. Kariuki
Chief Executive Officer,
Kenya Medical Practitioners and Dentists Council,
KMP & DC House,
Woodlands Rd, off Lenana Road
P.O. Box 44839-00100
NAIROBI

Dear

RE: INVITATION TO DELIBERATE ON THE PUBLIC PETITION NO. 021 OF 2025 REGARDING ACCESS TO HEALTHCARE FOR CANCER PATIENTS IN THE COUNTRY

Reference is made to your letter Ref. No: **MOH /CS/004/2025** dated **20th November, 2025** on the above subject matter requesting that the Committee meeting scheduled on 27th November, 2025 be rescheduled to a letter date.

In this regard, this is to convey the decision of the Committee to schedule the meeting on Tuesday, **17th February 2026, at 10:00 a.m** at Committee Room 23 on 5th Floor Bunge Towers. All other aspects of the meeting including the agenda remain as earlier communicated vide the aforementioned correspondence.

The Liaison Officers for this meeting are **Mr. Adan Gindicha**, Head of Department (Social Sector) who may be contacted on Tel No. **0720450112** or email: adan.gindicha@parliament.go.ke **and Ms. Gladys Kiprotich, Clerk Assistant, who may be contacted on Tel. No. 0718721253 and** gladys.kiprotich@parliament.go.ke

Yours

JEREMIAH NDOMBI, MBS
For: CLERK OF THE NATIONAL ASSEMBLY

Copy to: **Hon. Aden Barre Duale, E.G.H**
Cabinet Secretary
Ministry of Health
Afya House.
NAIROB

Dr. Mohammed Abdi
Chairperson
Social Health Authority
SHA Building, Ragati Road
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NAIROBI

Mr. Silas Simatwo
Chairman, Board of Directors
Digital Health Agency
9th Floor, Social Health Authority (SHA) Building
Community Area
NAIROBI

Dr. Timothy Olweny
Chairperson
National Cancer Institute of Kenya
P.O Box 30016-00100
Landmark Plaza Along Arwings Kodhek Road
NAIROBI.

Dr. Hon. Samuel Tunai, EGH
Chairperson
Kenya Medical Supplies Authority
P.O. Box 47715-00100
NAIROBI

Prof. Stanley Khainga
Chairman
Kenya Medical Practitioners and Dentists Council
KMP & DC House,
NAIROBI

STAKEHOLDER SUBMISSIONS

(1) DDC
&
5/11/25

MINISTRY OF HEALTH
OFFICE OF THE CABINET SECRETARY

Telegraphic Address "Health"
Telephone Nairobi 254-020-2717077
Email cs@health.go.ke
When replying please quote:

AFYA HOUSE
CATHEDRAL ROAD
P. O. Box 30016-00100
NAIROBI

Ref: MOH/SDMS/ADM/NA/VOL.V

4th November 2025

Mr. Samuel Njoroge, CBS
Clerk of the National Assembly,
Parliament Buildings,
NAIROBI

(2) Aden Gindicha, HoD
Hassan Arale
Pls bring to the attention of the Dept. Comm. on Health.
6/11/25

Dear Clerk,

RESPONSE TO PUBLIC PETTITION NO. 012 OF 2025 REGARDING ACCESS TO HEALTHCARE FOR CANCER PATIENTS IN THE COUNTRY

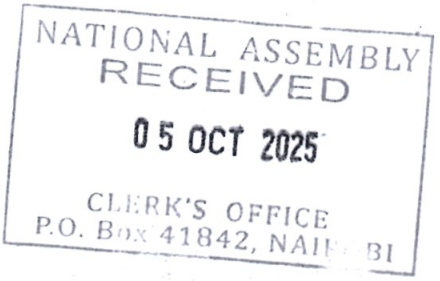
Reference is made to a letter by the Clerk of the National Assembly Ref. NA/DDC/DC-H/2025/94 dated 22 October 2025, requesting for a statement on the above subject matter.

Attached herewith find the Ministry's response to the issues raised.

Yours Sincerely

HON. ADEN DUALE, EGH
CABINET SECRETARY

Encls.



MINISTRY OF HEALTH
OFFICE OF THE CABINET SECRETARY

RESPONSE TO PUBLIC PETTITION NO. 012 OF 2025 REGARDING ACCESS TO HEALTHCARE FOR CANCER PATIENTS IN THE COUNTRY

Honourable Chair, pursuant to the letter from the Clerk of the National Assembly **Ref. NA/DDC/DC-H/2025/94** dated **22 October 2025**, addressed to the Cabinet Secretary, I hereby submit the Ministry's response for the consideration of the House, as follows:

Honourable Chair and members,

The Oncology Package under the previous NHIF arrangement primarily covered cancer management through chemotherapy, radiotherapy, hormonal therapy, and immunotherapy, where clinically indicated. However, members were limited to six (6) chemotherapy cycles per year, reimbursed at a rate of up to KES 25,000 per cycle for basic chemotherapy and up to KES 100,000 per cycle for complex chemotherapy. This structure often restricted access, as beneficiaries who exhausted their allocated number of cycles could not continue treatment within the same benefit period, even when their prescribed treatment protocols required additional sessions. Additionally, most patients whose cycles cost less than the maximum limit per cycle were unable to utilize the full limit.

Patients were also entitled to additional NHIF benefits, including inpatient services and up to two imaging procedures (MRI or CT scans) per year under the family cover. Where surgical intervention was necessary, the corresponding surgical package was applied to cover the related medical expenses.

Honourable Chair and members,

Under the Social Health Authority (SHA), significant improvements have been made to enhance equity, flexibility, and comprehensive coverage. The cover is individual-based, to protect households that have two or more cancer patients. The cover is designed to provide comprehensive support for cancer treatments, ensuring patients are well cared for throughout their treatment journey. It includes:

1. Diagnostic and staging: Involves confirming the presence of cancer and determining how far the cancer has spread from its initial site.
2. Treatment Options: Covers various treatments like chemotherapy (medicine to kill cancer cells), radiotherapy (using radiation), hormonal therapy (using hormones), and immunotherapy (boosting the immune system to fight cancer).
3. Medical Supplies and Equipment: Includes consumables (medical supplies used during treatment), stoma appliances (for patients with certain surgeries), medications before and after treatment, and special pumps for chemotherapy.
4. Lab Tests: Routine and specialized blood tests are covered, such as Total Blood Count (TBC) to check blood cell levels, Urea, Electrolytes, and Creatinine (UECs) for kidney function, and Liver Function Tests (LFTs) to check how well the liver is working.
5. Blood Products and Transfusions: Covers blood screening, matching, and transfusions, including administration of blood products like plasma, artificial blood products, and special biological serums.
6. Radiological Services: Necessary MRIs, CT scans, PET Scans or other imaging used to help plan and stage cancer treatments.

7. Surgical Management: Surgeries related to cancer or blood disorders are covered if needed.
8. Pre-cancerous Lesions: Coverage also includes managing lesions or growth that could develop into cancer if not treated.

Overview of the Benefit Package

Benefit Package 1: Haematology & Oncology Package

Honourable chair and members,

Beneficiaries now enjoy an annual limit of KES 400,000 under the Social Health Insurance Fund (SHIF) and an additional KES 150,000 under the Emergency, Chronic, and Critical Illness Fund (ECCIF) per beneficiary. This limit is accessed on a reducing balance basis and not capped per cycle; hence beneficiaries have access to the full amount. SHA has removed the limitation on the number of treatment cycles, enabling patients to receive all medically necessary sessions within their annual limit.

Upon suspicion of cancer, a SHA beneficiary will be covered for tests to confirm the diagnosis and determine the type and stage of cancer. A comprehensive list of specialized laboratory investigations have been introduced and these are;

1. Histology Small Specimen
2. Histology Medium Specimen
3. Histology Large Specimen
4. Immunoperoxidase studies (Immunohistochemistry)
5. Cytology (Gynae Cytology Vaginal or cervical smears)
6. Cytology Sputum, all body fluids and tumour aspirates
7. Cytology (performance of FNA procedure)
8. Flow cytometry (for diagnosis of leukaemia patients)

9. Bone marrow aspiration cytological examination
10. Bone marrow trephine biopsy
11. Bone marrow aspiration procedure
12. Bone marrow trephine procedure
13. PCR analysis (for gene detection for cancer)
14. Tumour markers (immunoassay / individual antibody test e.g. CA125, CA19-9, CA15-3, PSA, etc)

Additionally, specialized diagnostic tests covered include;

1. CT scan for treatment planning
2. MRI
3. PET SCAN
4. PSMA PET SCAN
5. Radionuclide scan
6. Bone scan

The cost of these tests varies across healthcare providers, and SHA will cover them up to the stated liability limit (tariff). Overall, the beneficiary has access to the limits for diagnosis, staging and treatment planning that shall be accessed once per policy period through prior authorization and approvals will be made based on the above sub-limits.

Under NHIF, the above tests were covered within the medical imaging package only. Under SHA, if you exhaust the allocated MRI, CT Scans within the oncology package, you can dig in to your medical imaging limits and access 2 more MRIs and CT Scans under the household cover.

Once a treatment plan is determined, the SHA beneficiary will be covered for the different treatment options that include;

- **Surgery:** Removal of the tumour and sometimes surrounding tissues. This will be financed through the surgical benefit package. This is financed separately under the surgical benefit package and not within the oncology individual limits of KES 550,000.
- **Chemotherapy:** Use of drugs to kill cancer cells or stop them from growing.
- **Immunotherapy:** Boosts the immune system to help it fight cancer.
- **Hormone Therapy:** Used for hormone-sensitive cancers (like breast or prostate cancer).
- **Radiation Therapy:** High-energy radiation is used to destroy cancer cells or shrink tumours.
- **Targeted Therapy:** Drugs that target specific molecules involved in the growth and survival of cancer cells.
- **Palliative Care:** Focuses on improving quality of life by managing symptoms, especially in advanced stages of cancer. This will be reimbursed only when the patient is admitted. This is covered separately under the palliative care package and not within the oncology individual limits of KES 550,000.

Benefit Package 2: Surgical Benefit Package

Honourable chair and members,

The surgical benefit package kicks in to cater for any surgical procedure that the patient needs; the tariffs are as outlined in the Benefits & Tariffs regulation. This caters for biopsies and surgical procedures that are part of the patient's journey.

Some procedures covered are;

- ✓ Biopsies from KES 16,800 to KES 50,000, depending on site and complexity.
- ✓ TURP for prostate cancer patients at KES 168,000
- ✓ Mastectomy for breast cancer patients at KES 134,000.

Patients can get up to 3 minor surgeries, 2 major surgeries, and 1 specialized surgery in a policy period independent of their oncology package limit of KES 550,000.

Benefit Package 3: Medical Imaging Package

Honourable chair and members,

While the cancer patient can access one MRI and 1 CT scan during the diagnosis stage and within the oncology limit of KES 550,000. Those who require more can access through the medical imaging package, which is a household cover, and comprises MRIs, CT scans, specialized ultrasounds, Echo, EEG, and Mammogram. The household limit for this is two sessions per image per year.

Other benefits for cancer patients to support their patient journey

1. **Inpatient Services:** In the event that the patient is admitted, SHA pays for the daily admission, and any cancer treatment that they receive during their admission.
2. **Palliative Care Services:** Patients who undergo palliative care admission are also covered under the palliative care package.
3. **Critical Care Services:** If a patient complicates and is admitted in a critical care unit, SHA pays KES 28,000 per day of admission up to a maximum of 12 days for every admission episode.

Honourable Chair and members,

The Ministry of Health has redefined treatment guidelines as per the National Cancer Control Program (NCCP) Adult & Child Cancers Differentiated Model for Adult and Child Cancers. This protocol has clearly defined the various treatment regimens, drugs, dosage, and cycles a patient should receive. Additionally, it has

indicated the tariffs that SHA will use to purchase the different medicines and tests. These guidelines are currently being automated in the SHA system.

SHA is implementing the NCCP Differentiated Care models for priority cancer management and will integrate this including the rates within the digital health system. This offers several advantages, particularly in terms of cost-effectiveness, resource allocation, and improved patient outcomes as outlined below.

1. **Tailored Treatment Approaches/Protocols:** Differentiated models allow for tailored treatment plans based on cancer type, stage, and patient demographics, leading to more effective interventions. Each cancer type will have specific guidelines that optimize treatment protocols, reduce unnecessary procedures, and focus on evidence-based practices.
2. **Cost Efficiency:** By differentiating care based on cancer types, resources will be allocated more efficiently, ensuring that funds are directed where they are most needed.
3. **Better Monitoring and Follow-up:** Differentiated models facilitate closer monitoring of patients, enhancing early detection of complications and improving overall survival rates.
4. **Informed Policy Development:** Collecting and analysing data specific to various cancers allows for more informed decisions regarding resource allocation and treatment guidelines.
5. **Equity in Access:** Differentiated models will address the specific needs of underserved populations, ensuring equitable access to appropriate care regardless of socio-economic status.
6. **Collaborative Care:** Differentiated models promote collaboration among oncologists, radiologists, pathologists, and other specialists, leading to comprehensive care strategies.

7. **Sustainability of Health Systems:** By reducing unnecessary treatments and focusing on effective care pathways, differentiated models can contribute to the sustainability of health systems in the long run.

Honourable Chair and members,

The Ministry of Health has established a Benefits Package and Tariffs Advisory Panel (BPTAP) in line with the Social Health Insurance (SHI) Act, 2023 and Regulations, whose role is to design and undertake periodic review of the Benefits Package and Tariffs every two years. The Panel will be reviewing the Benefits and Tariffs, ensuring it remains evidence-based, cost-effective, and financially sustainable.

Meanwhile, SHA has requested BPTAP to review the existing package limits under the recently allocated ECCIF Fund and provide recommendations to the Cabinet Secretary for Health on the proposed additional allocations for patients going forward. The objective is to progressively enhance the Oncology package limit, while simultaneously implementing cost control measures through strict adherence to the tariffs outlined in the NCCP guidelines.

SHA is considering taking into account patients who are in remission but still require annual follow-up tests to monitor their cancer status, ensuring that continuity of care and regular medical reviews are supported.

Honourable chair and members, I hereby submit,

HON. ADEN DUALE, EGH
CABINET SECRETARY

KENCO
Kenyan Network of
Cancer Organizations
United Against Cancer

MEMORANDA ON ONE YEAR OF THE SOCIAL HEALTH AUTHORITY (SHA):

From Promise to Practice – Making Universal Health Coverage Work for Cancer Patients

Submitted by: Kenya Network of Cancer Organizations (KENCO)

To: Hon. Aden Duale, CS, Ministry of Health

Dr. Mercy Mwangangi, CEO, Social Health Authority

Dr. Mohammed Abdi, Chairperson, Social Health Authority

Mr. Samuel Njoroge, Clerk of the National Assembly

Hon. John Mbadi, CS, The National Treasury

CC: Hon. Dr. James Nyikal, Chairman, Parliamentary Health Committee

First Submitted: October 7, 2025

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INTRODUCTION

The Kenya Network of Cancer Organizations (KENCO), represents over 70 civil society groups and thousands of cancer patients in Kenya. As we commemorate one year of SHA, KENCO takes this opportunity to highlight issues that cancer patients have been facing.

WHAT IS WORKING

KENCO recognizes the creation of the Social Health Authority (SHA) as a hopeful step toward Universal Health Coverage. SHA is a landmark reform in the healthcare financing, which on paper presents a bold and transformative vision to deliver on the promise of Universal Health Coverage (UHC) — where every Kenyan, regardless of income or geography, can access the health services they need without financial hardship.

On paper, SHA promised to tackle inequities in health service access by providing structured financing, expanding benefits, and protecting against overwhelming health costs. If fully implemented and funded, it could transform cancer care in Kenya by addressing the gaps between intention and access, diagnosis and treatment, and geographical disparities and survival rates. The Primary Healthcare Fund (PHCF) and the Emergency, Chronic and Critical Illness Fund (ECCIF) present revolutionary ideas in cancer care financing if adequate resources are allocated to the two funds.

CHALLENGES

One year after the SHA rollout, cancer patients have been facing obstacles that hinder access to life-saving care. It has been increasingly clear that the reality for cancer patients has not matched the promise. Across Kenya, people living with cancer continue to face financial ruin, delayed treatment, treatment abandonment, inconsistent coverage, bureaucratic obstacles, and emotional trauma, all of which undermine their right to health and dignity.

This memorandum documents key challenges observed over the past year and calls for urgent corrective action. It is presented in the spirit of constructive engagement, accountability, and reform — with the shared goal of ensuring that SHA delivers on its noble vision.

1. REDUCED CANCER PACKAGE SUPPORT: A RETREAT FROM PROGRESS

Under the previous scheme (NHIF), oncology patients were entitled to an annual cover of KSh 600,000 per individual, with the added flexibility of utilizing their spouse's cover once their own benefits were exhausted. This model, while not perfect, offered a lifeline to many families navigating the high cost of cancer care.

Under SHA, this has changed drastically. The oncology benefit has been reduced to KSh 400,000 per household, or KSh 550,000 if the ECCIF allocation is factored in. Coverage is now household-

based rather than individual, eliminating the possibility of sharing cover between spouses. For most patients, the benefit ceiling is often exhausted in less than 6 months depending on the type of treatment.

A recent KENCO survey of 118 cancer patients and caregivers found that 60% had exhausted their SHA cover before the end of the year, with 35.8% exhausting their benefits in less than three months and another 34.3% within three to six months. Among those whose cover ran out, 38.5% were able to pay out of pocket, 27.9% could only pay partially, while 20.2% could not pay for treatment at all, and 13.5% were forced to abandon treatment completely.

These findings confirm that the current oncology cover is grossly inadequate for the financial realities of cancer treatment and that SHA has not protected households from catastrophic health expenditure. This policy shift has left many cancer patients with no option but to pay out of pocket, seek communal contributions through harambees, or abandon treatment altogether — with catastrophic health and financial consequences.

"I am a caregiver to my sister who is battling stage 4 breast cancer that has metastasized to the liver, lungs, and brain. She had completed 6 sessions of chemo and 10 sessions of radiotherapy, and was due for another 12 cycles of chemo. We were told she has exhausted her SHA cover. A single session costs KSh 90,000. We simply don't have that kind of money. She skipped her sessions. What do we do? Cancer won't wait until SHA financial year which we were told is October." Says Jane (not her real name) who has been getting services at KNH.

A HER2-positive breast cancer patient, for example, requires at least 18 cycles of targeted therapy (Herceptin), which costs on average Kes 33,000 per cycle in public health facilities and twice that amount in private facilities. This is in addition to several diagnostic tests and other treatment modalities like surgery, chemotherapy, and radiotherapy. A documented real-life case of a woman diagnosed with triple-positive breast cancer and accessing services at a public hospital in Kenya shows that the patient faces an overwhelming financial burden from the breakdown shown below:

- *Standard chemotherapy costs Kes 21,000 per session for eight sessions, amounting to Kes 168,000,*
- *blood works at approximately Kes 4,500 per cycle for 8 cycles adds to Kes 36,000,*
- *Imaging and diagnostic monitoring further raise the costs, including a CT scan (Kes 20,000, echocardiograms every three months (Kes 3,000), and a PET scan at Kes 53,400.*
- *Targeted therapy, Herceptin alone costs about Kes 33,800 per cycle for 18 cycles (or more for some patients), totaling Kes 608,400,*
- *Kadcyla, often prescribed for maintenance or resistance cases, costs Kes 180,000 per cycle for 14 cycles - a staggering Kes 2.52 million.*

- *Hormonal therapy, including Zoladex (Kes 19,615 every three months indefinitely) and Letrozole (Kes 5,000 for a three-month dose over 10 years), summing to over Kes 100,000 in the first year alone.*
- *Radiotherapy averages Kes 3,600 per session for 30 sessions (Kes 108,000),*
- *surgery, which costs around Kes 120,000,*
- *follow-up CT scans of the chest and pelvis cost Kes 8,000 and Kes 12,000, respectively.*

The direct cost of comprehensive treatment for this patient easily exceeds Kes 3.8 million. This demonstrates that the current Social Health Authority (SHA) cancer cover of Kes 550,000 is grossly insufficient to provide equitable access to care.

Reducing the oncology package is not just a technical policy change — it is a life-and-death decision for thousands of Kenyans. While SHA was envisioned to expand access, this reduction has effectively reversed gains made under NHIF.

We urge the Ministry of Health and SHA to:

- Increase the oncology benefit to at least KSh 1.2 Million per individual per year.
- Ensure that benefits under ECCIF are clearly accessible and not theoretical and that they are increased gradually.

2. BUREAUCRATIC DELAYS, SYSTEM FAILURES & UNRESPONSIVENESS

Cancer treatment is time-sensitive. Delays of even a few days can mean disease progression, worsening prognosis, or treatment failure. Unfortunately, SHA's current administrative systems have created bureaucratic bottlenecks that prevent timely access to care.

Findings from KENCO's 2025 survey show that 65.3% of patients experienced delays in SHA approvals, with nearly one in five (19%) facing delays exceeding one week. Over half (55.9%) reported being denied treatment due to system indications of "depleted" or "expired" accounts, even when premiums were valid.

While 69.5% of respondents had contacted SHA customer care, nearly 48% said they did not receive the support they needed, and another 36% only received partial assistance. Furthermore, 60.2% of respondents had been denied treatment at least once due to SHA system failures, with many reporting such incidents multiple times. These findings underscore how administrative breakdowns are creating dangerous treatment delays for cancer patients.

Patients have encountered the following as the survey data indicate:

- Long approval times for treatment requests, including emergencies.
- System errors where accounts appear "expired" or "depleted" despite valid premium payments.
- Unresponsive SHA help lines, leaving patients stuck

- Tensions between facilities and SHA, where facilities refuse to initiate treatment until SHA confirms payment, even for approved patients.

Mary Nafula, a breast cancer warrior, shared her story as follows:

"I registered with SHA in May 2024 and paid my full annual premium of KSh 12,360. In July, I paid another KSh 12,360 to cover me until 2027. So I'm fully paid up for 3 years. I've only used KSh 108,000 — KSh 53,000 for a PET CT and another KSh 53,000 for chemo. Recently, when I went for my second chemo session, the hospital told me my SHA account had expired. I was told to pay cash. I called SHA — no one answered. Eventually, I found someone internally who confirmed that my account was valid until 2027. The hospital still insisted their system showed otherwise and told me to follow up myself. I stood my ground and told them it's their duty as an accredited facility to call SHA. Only after that did they call and I got approval. I was in tears."

This experience is not isolated. Many patients at major public hospitals like KNH and Jaramogi Oginga Odinga Teaching and Referral Hospital (JOOTRH) report similar frustrations. *"The SHA system is worse and frustrating. In Kisumu (JOOTRH), you can't be treated without approvals which take up to 3 days. Patients from afar are forced to sleep at the hospital gate. The system has frequent downtimes. We urge chemo approvals to be fast-tracked. We should have people working throughout on the approvals,"* Says Judy (not her real name), a breast cancer warrior accessing services from JOOTRH.

The ongoing rollout of the biometric system is also problematic. Critically ill patients have been reported to be moved from their wards to have their biometrics captured. This causes additional distress and compromises their dignity.

These administrative failures are not mere inconveniences — they are delays that can cost lives. They undermine trust in SHA and force patients into emotional distress.

We call upon SHA to:

- Invest in efficient, real-time claims and approval systems that are responsive to clinical urgency.
- Create a dedicated oncology information desk and hotline with guaranteed response time for facilities and patients.
- Hold accredited facilities accountable for delays and denials resulting from internal misalignment with SHA systems.
- Ensure patients' benefits and balances reflect automatically on the Afya Yangu App and on the SHA portal.
- Reform biometric capturing processes to be flexible, mobile, and focused on patients. Biometrics should be taken to patients instead of moving critically ill patients to where their biometrics can be taken.

3. INFLEXIBLE PREMIUM PAYMENT MODEL

Under SHA, premium payments are required annually and in full. For many cancer patients — especially those from low-income households — this upfront cost is prohibitive.

One patient expressed the following:*"I have cancer and cannot access treatment because I was not able to raise the full annual premium. Why can't I pay monthly like before under NHIF? There are many others like me who would be comfortable with monthly contributions but are now locked out."*

This requirement excludes the very people that SHA should be safeguarding. For patients already struggling with job loss or reduced income due to their illness, the lack of flexibility in contributions is punitive.

The SHA premium financing model (Lipa pole pole through the Hustler Fund) has created unintended harm.

There is a documented case where patients' M-Pesa balances were deducted without their consent to repay SHA premium financing loans, even though they did not subscribe to such loans. There could be other cases that we are not aware of. This represents a system failure, a breach of patient data, and a loss of trust.

According to KENCO's survey, 55.9% of respondents currently pay their SHA premiums annually, 10.2% use the "Lipa Pole Pole" initiative, and 9.3% are unable to pay at all. A vast majority (79.7%) expressed a preference for monthly payments, indicating strong demand for a more flexible contribution model. Alarmingly, 7.6% of respondents reported unauthorized deductions from their M-Pesa accounts allegedly for SHA-related "Lipa Pole Pole" loans — further evidence of system flaws and eroding trust in SHA's premium collection process.

Universal Health Coverage must be inclusive by design. A rigid financing model that excludes the poor or disadvantages them through interest on loans for their premiums is incompatible with equity.

We recommend:

- Reintroducing monthly premium payment options for vulnerable households, away from the loan model through the Hustler Fund.
- Allowing grace periods or staggered contributions for patients with verified income shocks.
- Exploring subsidies for indigent cancer patients, including integration with social protection programs.

4. LACK OF CLEAR AND ACCESSIBLE INFORMATION

There is widespread confusion due to poor communication from SHA. The benefit package is not clearly explained to patients or providers. Facilities are unaware of the range of services covered by SHIF and of the existence of ECCIF or when or how ECCIF is accessed. Patients receive contradictory information about SHA's financial year, their benefit entitlements, and whether they can use their spouse's cover. Many facilities' systems cannot show patients what benefits are still available to them.

The KENCO survey revealed that only 16.1% of respondents understand the SHA oncology benefit package very well, while nearly half (46.6%) admitted they understand it poorly or not at all. Awareness of the Emergency, Chronic, and Critical Illness Fund (ECCIF) was especially low — only 6% had information about it, and a mere 2.6% reported ever accessing it. This widespread information gap fuels confusion and inequities in care access.

We urge SHA to:

- Immediately publish and share a clear, user-friendly guide on the SHA benefit package, including ECCIF. This should be disease-specific, especially for major disease areas like cancer.
- Clarify and communicate SHA's financial year to avoid contradictions and misinformation.
- Update facility systems and align with SHA systems to show patients their covered benefits and balances in real time. This information should be available to the patients through their SHA portal and through the Afya Yangu App.

5. ISSUES WITH SHA-ACCREDITED FACILITIES

Even after accreditation, facilities are failing patients. Patients report being asked to buy SHA forms at facilities like Kenyatta National Hospital. This is an unnecessary and exploitative practice. In some cases, as highlighted in 2 above, facilities refuse to process pre-authorizations for patients, shifting bureaucratic burdens to patients and caregivers who are already suffering. Essential cancer medicines are often unavailable in SHA-accredited facilities. Patients are referred to private facilities at prohibitive costs.

KENCO's survey findings highlight the continued dysfunction at facility level. While only 11.9% of patients reported being asked to buy SHA forms, almost half (49.2%) said they had been asked to purchase cancer medicines privately, even though they should have been covered by SHA. Only 42.4% said cancer medicines were always available in their facilities, while 37.3% said they were only sometimes available — confirming persistent gaps in medicine availability across accredited facilities.

We urge SHA, the Ministry of Health and health facilities to:

- Eliminate exploitative practices such as charging for SHA forms.
- Enforce SHA policy that requires accredited facilities to process pre-authorizations for patients.
- Strengthen and monitor supply chains to ensure cancer medicines are universally available in SHA-accredited facilities.
- Invest in health systems strengthening and service availability.
- Streamline the supply chain system for cancer medicines.

6. DISRUPTIONS IN CARE DUE TO SUSPENSION OF SHA BY FACILITIES

Access to care is being severely disrupted as health facilities suspend SHA services over unpaid bills and delayed reimbursements. Recently, the Rural Private Hospitals Association of Kenya (RUPHA) announced the suspension of SHA because of unpaid claims, calling the scheme unreliable and unsustainable. 30.5% of surveyed patients in the KENCO survey reported being personally affected — illustrating how even short-term disruptions in facility participation have immediate and harmful effects on patient access to care.

This is deeply concerning. When facilities withdraw, patients suffer the most. They are forced to pay out of pocket, postpone important treatment, or abandon care altogether. These disruptions not only damage SHA's credibility but also put lives at risk, especially for patients needing ongoing treatment like chemotherapy and radiotherapy. A sustainable health financing system cannot work without trust between the payer and providers. Timely payment of claims is a basic requirement to ensure continuity of services. Patients must never again be caught in the middle between facilities and SHA because of delayed payments. Reliable claims management is essential to protecting the right to health

We urge SHA and the Ministry of Health to:

- Immediately pay all pending bills owed to health facilities or agree with the facilities on a payment plan to restore patient access to services.
- Create a transparent, efficient, and predictable claims payment system that ensures facilities are reimbursed on time.
- Engage health providers proactively to rebuild trust and prevent further service suspensions.

7. UNIFORM ONCOLOGY PACKAGE: A FLAWED MODEL

SHA currently treats cancer as a single disease, with a uniform benefit cap across all cancers. This approach ignores the vast differences in treatment costs across cancer types, subtypes, and stages. For example, a patient with early-stage cervical cancer may need a few cycles of chemotherapy and surgery, while a patient with HER2+ metastatic breast cancer may require 18

cycles of Herceptin, which alone costs over KSh 70,000 per dose. Applying a flat KSh 400,000 cap in both cases is inequitable and unscientific.

A fair health financing system must recognize clinical realities and tailor benefits to meet diverse needs.

In the medium to long term, we recommend the following:

- Establishing a technical working group of oncologists, patient advocates, and health economists to review and revise the current package structure.
- Designing tiered oncology packages that align with disease complexity and cost.

8. OVERSEAS TREATMENT POLICY

SHA recently abruptly halted overseas treatment support - even for patients already abroad and mid-treatment. This sudden change left many patients stranded in foreign countries without care or support, even though they had prior approvals to access treatment abroad. These abrupt shifts are inhumane and violate principles of clinical ethics, human rights, and patient dignity.

We acknowledge that the Ministry of Health has issued new guidelines on overseas treatment support through SHA. However, changes in policy without proper planning or communication create unnecessary stress, disrupt care, and weaken trust in the health system.

We urge SHA and the Ministry of Health to make sure that:

- Policy transitions protect human dignity and are not disruptive to patients' access to care.
- Continuity of care is ensured; no patient should be left without support due to policy changes.
- Patients with prior approvals can continue to access overseas treatment under the previous policy terms without interruption.
- Future policy changes are communicated in advance, implemented gradually, and backed by clear transition plans that prioritize patients' health and lives.

9. EMOTIONAL AND MENTAL STRAIN ON PATIENTS

Cancer is already a devastating diagnosis. For many patients, navigating SHA has become an additional emotional burden. Quantitative data reinforce this lived experience: 63.6% of patients in the KENCO survey reported that dealing with SHA has caused them significant emotional distress, while only 15.3% said they were not emotionally affected.

The uncertainty of whether treatment will be approved, whether the system will work, whether the cover exhausts mid-way through, whether the doctor recommends a test that is not covered, whether they will be told to "wait until October", etc., all adds immense psychological strain.

Mr. Waigwa, a prostate cancer patient from Nyeri as quoted in a Daily Nation Story asks: *"How can I sit and wait for the next financial year while cancer is ravaging my body? The mental torture is worse than the disease itself."*

In line with this, an overwhelming 93.2% of respondents said that psychosocial support should be part of SHA's oncology package, underscoring the urgent need to integrate mental health and counseling services into routine cancer care.

Universal health coverage is not just about physical access — it's about dignity, security, and peace of mind.

We urge SHA and the Ministry of Health to:

- Embed psychosocial support into cancer care packages.
- Ensure that communication with patients is timely, respectful, and empathetic.
- Provide clear, transparent updates on coverage, approvals, and any delays.
- Ensure the system is working for the patients

10. MISMANAGEMENT AND MISALLOCATION OF FUNDS

Reports from investigative media and whistleblowers have flagged serious allegations of fraud, mismanagement, and irregular payments to facilities with no proven capacity or even non-existent health institutions.

Meanwhile, real patients in real facilities are being denied services for the lack of funds. The contrast between fraudulent claims being paid and legitimate patients being turned away is not only unjust — it is inhumane.

Health financing must be built on integrity, transparency, and accountability. Any perception of corruption in a fund meant to save lives undermines public trust and defeats the purpose of SHA.

We demand, with Parliament's oversight that:

- An independent forensic audit of SHA disbursements be conducted and the findings made public.
- Immediate action be taken against individuals or institutions involved in fraudulent claims, including recovery of funds already paid and legal action.
- Strict action should be taken against SHA officials who took part in accrediting non-existent facilities and processing fraudulent claims. The action should include firing and legal action.
- SHA put in place stringent vetting and monitoring of accredited facilities to ensure value for money and patient safety.

11. CHRONIC UNDERFUNDING OF PRIMARY HEALTHCARE & ECCIF FUNDS

While SHA has created new financing mechanisms on paper, these remain grossly underfunded. The Primary Care Fund (critical for cancer screening and prevention) was allocated KSh 4.1B against a resource requirement of KSh 61B in the current year. Similarly, the ECCIF, meant to support patients after SHA benefits are exhausted, was allocated KSh 2B against a resource requirement of KSh 107B.

The funding gap is massive, persistent, and projected to continue under the current Medium-Term Expenditure Framework (MTEF) to 2028. Without adequate financing, even the best-designed health systems fail. Cancer care cannot be scaled without investment.

We urge the Treasury and Parliament to:

- Substantially increase budgetary allocations to the Primary Care and ECCIF funds.
- Ringfence cancer funding to protect it from reallocation or diversion.
- Ensure timely disbursement to enable program continuity.

CONCLUSION: FROM POLICY TO PEOPLE, PROMISE TO PRACTICE

One year into SHA's implementation, it is evident that the intentions were noble, but the execution has fallen short — especially for people living with cancer. SHA was intended to serve as a vehicle to help Kenya achieve Universal Health Coverage (UHC). However, the reduction in oncology benefits, systemic inefficiencies, underfunding, and lack of patient-centered design are creating new barriers instead of removing old ones. This is a setback to the UHC journey.

Cancer patients are not statistics. They are mothers, fathers, daughters, and sons — real people who deserve dignity, equity, and timely care. As a country, we must ensure that SHA becomes a platform of hope, not despair.

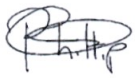
We therefore make the following collective appeal:

- To the Ministry of Health: Reform oncology benefits, improve SHA responsiveness, and strengthen facility accountability.
- To the Social Health Authority: Center patient dignity and clinical realities in policy and practice.
- To the National Treasury and Parliament: Invest meaningfully in cancer care financing and protect it from austerity. Increase budgetary allocation to health to at least 7% of the National budget in line with achieving the Abuja declaration of 15% of national budget.

Cancer does not wait. Neither should the systems meant to treat it.

KENCO remains committed to working collaboratively with all stakeholders to ensure that SHA fulfills its promise — not just on paper, but in the lives of the people it was created to serve.

On Behalf of KENCO, KENCO Member Organizations and Cancer Patients,



Phillip Odiyo,

Chairperson, Kenyan Network of Cancer Organizations.