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REPUBLIC OF KENYA

THE NATIONAL ASSEMBLY

THIRTEENTH PARLIAMENT – FIFTH SESSION – 2026

DIRECTORATE OF DEPARTMENTAL COMMITTEES

DEPARTMENTAL COMMITTEE ON HEALTH

.....

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

NATIONAL ASSEMBLY
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DATE: 08 APR 2026 DAY: Wed
TABLED BY: Hon. James Nyikal, MP Chair, Health
CLERK-AT THE-TABLE: Mode

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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

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	