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Assessment Report

Status of Implementation of the Regulatory and Policy Framework

On Access to Information in the Health Sector in Kenya

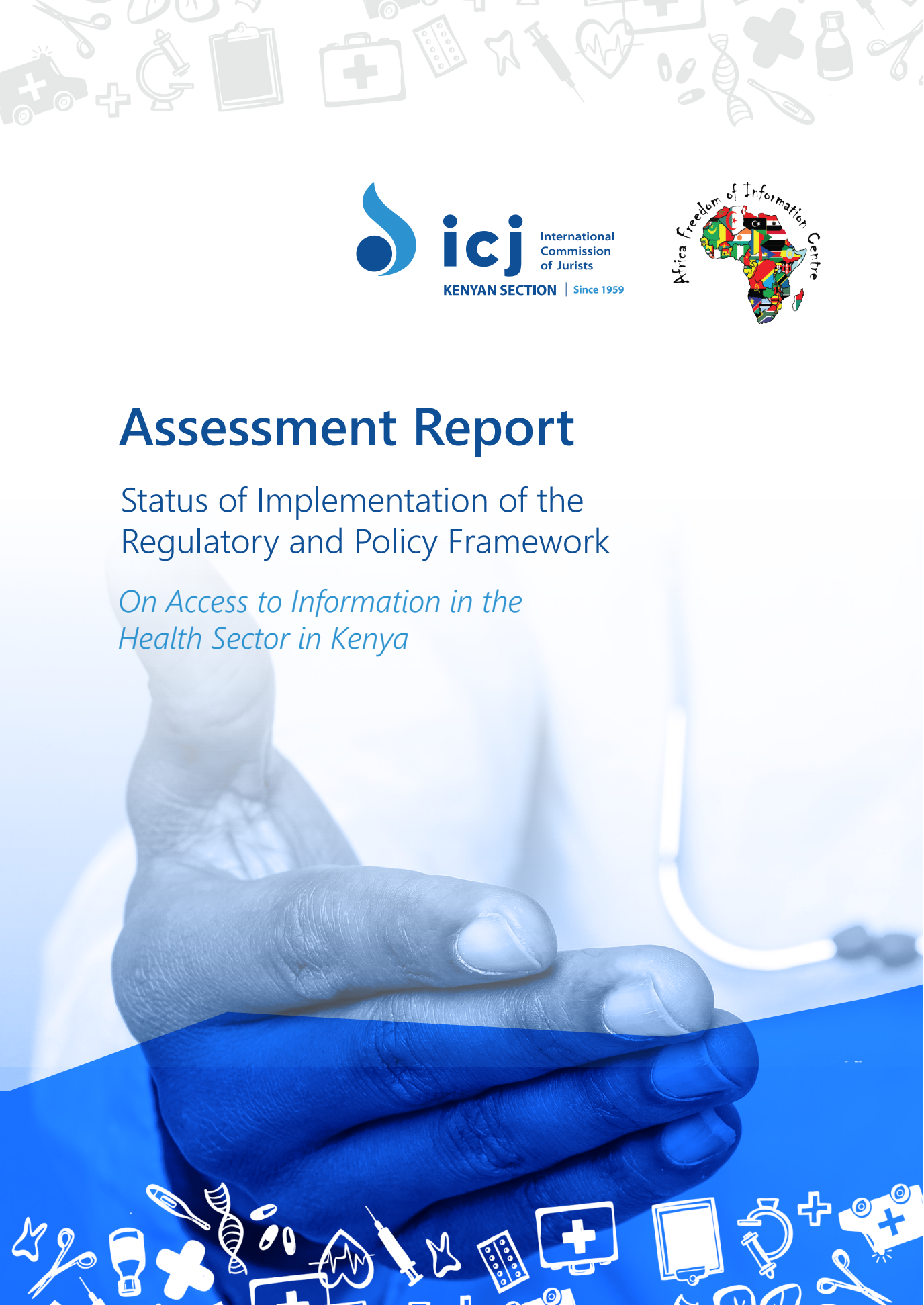

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

Access to timely and accurate information is essential in any democratic society to facilitate and enhance citizens' effective participation in governance processes. The right to access information held by the State is a fundamental right guaranteed under Article 35 of the Constitution of Kenya 2010. Additionally, the provision obligates the State to publish and publicise all vital information affecting the nation. Beyond the Constitution, Kenya has an access to Information Act (2016), which essentially gives effect to the constitutional right of access to information. For many years, ICJ Kenya advocated for the enactment of the Access to Information law in Kenya and continues to monitor its implementation in various sectors to ensure transparency and accountability in governance and public participation in decision-making. Upon this background, ICJ Kenya, with the support of the Africa Freedom of Information Centre (AFIC), commissioned this research to assess the status of implementation of the Access to Information Act, 2016 in select agencies in the health sector and make recommendations based on global best practices. The research focused on Machakos Level 5 Hospital as a pilot health institution and the National Hospital Insurance Fund (NHIF) as a critical health agency.

One of the critical pillars of a health system is how it is financed. The national and county governments' ability to ensure the realisation of the right to health for all Kenyans is heavily reliant on transparency and accountability in the flow of health funds. One of the major challenges has been access to information on these funds' flow, which has undermined accountability and transparency in the sector. Information on the policies, action plans, and budgets for the health sector, procurement procedures, and access to medical supplies is not readily available. Similarly, from a consumer perspective, health workers and health administrators are generally not forthcoming with information.

The National Hospital Insurance Fund (NHIF), a state agency tasked with financing health care, currently covers about 20% of the population. Some of the critical information in the relationship between the NHIF and other stakeholders, such as patients and public health facilities is on the allocation of funds, disbursements, and expenditures. Recently, there have been efforts to improve access to this information, but various gaps should be considered. For example, information on reimbursements by NHIF to health facilities is not publicly available. There is very little information on packages and benefits entitlements by the members. Moreover, most counties do not post financial allocations, disbursements, or expenditures on their websites.

Public health institutions have not been consistent in publishing important information relating to health financing to promote transparency and accountability. The lack of timely access to such crucial information about the health funds impairs public participation in decision making and prioritisation, which further curtails their ability to hold those charged with the management of the institutions accountable.
Some of the key findings of the study are:

1. NHIF has made great strides in improving access to information for health facilities to enhance claims processing capacity. However, NHIF has not been proactive in disseminating information to its members, and there are no mechanisms to share information with persons with auditory and visual impairment. There is still a lack of clarity on the differential pricing of services between public and private facilities.

2. Despite legal requirements for the different health sector players to enhance mechanisms to ensure timely and ease of access to information by the public, NHIF does not have core information such as funds disbursements and expenditures accessible to the public. There is little information on NHIF reimbursements for claims available to the public.

3. Public health facilities have not established mechanisms to share information on reimbursements received from NHIF and expenditures. This is further complicated by the Public Finance Management Act (2012) that requires all funds received by public health facilities to be remitted to the County Revenue Fund (CRF)

4. Both NHIF and private health insurance companies do not have a common data-sharing platform. Therefore, there are reports of double reimbursements to some facilities where a patient has both covers. Moreover, they have both registered higher reimbursements to private facilities and very low refunds to public facilities. This has increased inequity in healthcare access in Kenya, mainly due to low financial flows to public facilities, which are the primary source of care for most Kenyan poor populations.

Based on this study's findings, there is a need to revamp advocacy efforts to ensure public health agencies work towards timely access to information to all relevant consumers. Access to information plays an essential role in ensuring accountability and transparency. This will go a long way in improving efficiency and attaining the aspirations of the Kenyan Constitution under the Bill of Rights that puts a responsibility on the State to ensure equitable, affordable, and quality health care to all Kenyans.

BACKGROUND

The journey to having the progressive Bill of Rights contained in the Kenyan Constitution has been full of historical self-introspection as a country, consultation, and negotiation. It involved learning from other jurisdictions and persuasion from the international community through international instruments and discussions in various forums. The two rights that this report seeks to explore are particularly key to the socio-economic and political discourses and debates that have taken centre stage in this country. These are the Right to Health and the Right to Access to Information.

In a country where resource allocation, distribution, and utilisation have been steeped in corruption and mismanagement, the democratic values of transparency, openness and accountability are particularly resonant with the quest to meet the need for access to information. The health sector in this country is a suitable area for investigation and assessment of how these values have enhanced health service delivery in pursuance of the right to the highest attainable standard of health.

THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH IN KENYA

The inclusion of the right to the highest attainable standard of health in the Constitution of Kenya, marked a new era in the requirement for the provision of quality health services to Kenyan citizens. Article 43(1) of the Constitution provides that "everyone has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care." This right is also contained in international instruments that Kenya has ratified that form part of our domestic laws under Article 2(6) of the Constitution of Kenya, 2010. One critical international instrument is the International Covenant on Social Economic and Cultural Rights (ICESCR). Article 12 provides for the right to the highest attainable standard of health. Similar provisions are contained in various other international and regional human rights instruments, many of which Kenya has ratified. To meet its national and international obligations concerning the right to health, Kenya is under a fundamental duty under the Constitution to "conserve, respect, protect, promote and fulfill the rights and fundamental freedoms in the Bill of Rights."[1]

The State is also obligated to take legislative, policy, and other measures, including setting standards to achieve the progressive realisation of the right to health. An important step to enable the progressive realisation of the right to health is the devolution of key health services to county governments under the Constitution. County governments now have the primary duty of ensuring the right to health for all. Some of the main reasons for the devolution of the right to health are: to promote access to health services across the country; to address problems of bureaucracy in matters of health service provision; to promote efficiency in the delivery of health services; to ensure that health

1. Constitution of Kenya, 2010, Article 21(1)

services are responsive to the needs of the citizens, to ensure that citizens can participate in the key decision-making processes relating to their health and to address problems of low quality of health services. Access to information is vital to ensure the attainability of these objectives.

In interpreting the normative content of the right to health, the Committee on Economic Social and Cultural Rights, has recognised the relationship, connectivity and interdependence of the right to health with other rights such as the right to food, sanitation, water, work, education, life, non – discrimination and access to information. The Committee stated that "these and other rights and freedoms address integral components of the right to health."[2]

The right to health is also dependent on underlying and social determinants of health, such as access to health-related education and information and the participation of the population in all health-related decision-making at the community, national and international levels.[3] Similarly, within the Accessibility component of the Availability Accessibility Acceptability Quality(AAAQ) framework of the normative content of the right to health, not only should there be equal access to health facilities, physical access, and economic access, but there should also be "information accessibility."[4] Not only is access to information recognised as a core component of the right to health by the CESCR, but the World Health Organization (WHO) has also recognised it as a critical component and building block of an effective health system. [5]

The national and county governments' ability to ensure the realisation of the right to health has been hampered by numerous challenges. One of the significant challenges has been limited access to information, which has undermined accountability and transparency in the sector. Information on the policies, action plans, and budgets for the health sector, procurement procedures, and access to medical supplies is not readily available. Similarly, from a consumer perspective, health workers and health administrators are generally not forthcoming with information.

THE RIGHT TO ACCESS INFORMATION

Access to timely and accurate information is essential in any democratic society to facilitate and enhance citizens' effective participation in governance processes. The right to access to information held by the State is a fundamental right guaranteed under Article 35 of the Constitution, which provides, among other things that:
"Every citizen has the right of access to –

a. Information held by the State and
b. Information held by another person and required for the exercise or protection of any right or fundamental freedom.

2. Committee on Economic Social and Cultural Rights, General Comment No 14 on the Right to Everyone to the Highest Attainable Standard of Health, para 3
3. Ibid para 11
4. Ibid para 12(b)
5. A health system has been defined as consisting of "all the organisations, institutions, resources, and people whose primary purpose is to improve health.

Additionally, the provision obligates the State to publish and publicise all vital information affecting the nation.[6]

The Constitution also provides that "every person has the right to freedom of expression which includes – freedom to seek, receive or impart information or ideas..." [7] Good governance, integrity, transparency, and accountability are contained within the Constitution as part of the National Values and Principles of Governance.[8] Among the Constitutional values of public service is the requirement for "transparency and provision to the public of timely, accurate information." [9]

Beyond the Constitution, Kenya has enacted legislation; the Access to Information Act[10] , gives effect to the constitutional right to access information. Other relevant domestic legislation which implies the right to access information are the Health Act[11] , the County Government Act[12] , the Ethics and Anti – Corruption Act.[13] The HIV and AIDS Prevention and Control Act[14] and the East African Community HIV and AIDS Prevention and Management Act 2012[15] also have disease-specific provisions on access to information that managers in the health sector need to be aware of. It is worth noting that the law on access to information should always be read together with the legal provisions on protecting sensitive information and the provisions of the Data Protection Act 2019.

The right to access information is also internationally affirmed under the Universal Declaration of Human Rights (UDHR)[16] and further under the International Covenant on Civil and Political Rights (ICCPR)[17] . These form part of the law in Kenya under Articles 2 (5) and (6) of the Constitution and international customary law regarding treaties and conventions that have been ratified by Kenya. Other relevant international and regional instruments include:

- The United Nations Convention Against Corruption
- The United Nations Declaration on Human Rights Defenders
- The African Charter on Human and Peoples Rights
- The Africa Charter on Democracy, Elections and Governance
- The African Union Convention on Preventing and Combating Corruption
- The African Charter on the Values and Principles of Public Service and Administration
- The Declaration on Democracy, Political, Economic and Corporate Governance

Even though the right to access information is guaranteed in the Constitution, implementation challenges persist in many sectors, particularly the health sector.

Why is access to information necessary? According to the WHO, "sound and reliable information is the foundation of decision – making across all health system building blocks." Secondly, ATI is essential as it enables health services users to have "access to reliable, authoritative, usable, understandable, and comparative data." Sufficient information also allows users of health services to make autonomous and informed choices concerning their health and treatment, thus respecting their inherent human dignity. Access to information is also vital to identify problems and to formulate evidence-based solutions.

7. Article 33(1)(a), Constitution of Kenya, 2010
8. Article 10(2)(c) Constitution of Kenya, 2010; see also Chapter Six of the Constitution on Leadership and Integrity
9. Article 232(1)(f) Constitution of Kenya, 2010
10. , 2016
11. 2017, sections 10, 14, 15(r), 15 (2) (b), 20(n), and 105
12. County Government Act No 17 of 2012, Parts VIII and IX of the Act
13. Ethics and Anti-Corruption Act No 22 of 2011
14. HIV and AIDS Prevention and Control Act 2006, Part II
15. EAC HIV and AIDS Prevention and Management Act 2012, Part II
16. Article 19, Universal Declaration of Human Rights, 1948; see also Resolution 59(1) of the UN General Assembly
17. Article 19, International Covenant on Civil and Political Rights

Therefore, ATI is essential for individuals to access their health records and profiles at the health facilities and enable them to participate in the decision-making processes at the macro levels. It is also vital for health facilities and health managers to determine their resource requirements.

UNIVERSAL HEALTH COVERAGE: THE MIXING POT FOR THE RIGHT TO HEALTH AND THE RIGHT TO INFORMATION

Universal Health Coverage (UHC) is the third pillar of the Big 4 Agenda that the President unveiled in December 2017, as part of the government's development and economic growth initiatives. The WHO has defined UHC as where "all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion, prevention, treatment, rehabilitation, and palliative care."[18]

The interlinkages between Access to Information, the achievement of UHC, as well as the realisation of the right to health will be explored in this project.

The country's challenge in achieving Universal Health Coverage is to reduce out-of-pocket expenses for obtaining health care services among the citizens and provide a comprehensive essential health benefits package that meets the population's health needs. The priorities of the State are thus three-fold: (a) to expand priority services; (b) to include more people into the programme and (c) to reduce out-of-pocket expenses. Therefore, there must be proper information flow between the citizens and the policy and decision-makers, healthcare workers, and the decision-makers themselves to obtain the relevant data to ensure that these objectives are met.

The main vehicle through which UHC is proposed to be achieved is the National Hospital Insurance Fund (NHIF) as a major insurance coverage provider. The NHIF is a state corporation established in 1966, soon after independence, mandated with providing "accessible, affordable, sustainable, and quality social health insurance to the Kenyan population." However, available literature and reports have shown that the NHIF has faced various transparency and accountability challenges. The corporation has been marred with reports of corruption, mismanagement, inadequate capacity, inefficiency, and weak governance and accountability mechanisms. Recent scandals are evidence of this.[19] The lack of transparency, accountability, and reporting systems are a major contributing factor to the scandals. Further, contributors to the NHIF programme lack crucial information on the accredited facilities, their contributions, and the safety of their contributions.[20]

The uptake and utilisation of digital and technological platforms to enhance transparency and efficiency of service delivery has not been optimal. As stated by Gilbert Osoro, the Manager Benefits and Contracting at the NHIF "Fraud leads to the shrinking of the available package to members, thereby raising barriers to accessing quality health and ultimately increasing the cost of healthcare."

18. See https://www.who.int/health-topics/universal-health-coverage#tab=tab_1 accessed 9th November 2019
19. See the recent scandals where Kshs. 50 billion intended for the group life insurance policy for Kenya Prisons Service, Kenya Police Service and National Youth Service could not be accounted for; also, where Kshs. 10 billion is feared lost as a result of false medical claims where officials at NHIF collude with hospitals to generate fake medical bills for services that were never offered; other scandals involve fake DEPENDANTS or unknown individuals being loaded on the NHIF cards of existing patients; Other scandals involve the purchase of eight houses worth Kshs. 160 million by a NHIF receptionist within a period of 4 years from 2013 to 2017.
20. There was a major scandal where contributions through MPESA platform were not being reflected.

Lack of transparency and accountability as well as public participation, have led to court challenges of NHIF decision-making processes. Court cases have been filed challenging the lack of public participation in the increase of NHIF rates,[21] the introduction of penalties[22] and also in the award of tenders.[23]

Therefore, this project's overall goal is to assess the extent to which the right to access information as envisioned in the Access to Information Act, 2016 has been implemented across public agencies, including the National Health Insurance Fund (NHIF) in Kenya. A Case Study was done using Machakos County. This will go a long way in strengthening the capacity of these public health agencies to implement the existing legislative and policy framework on access to information, including the Constitutional guarantees, international obligations, and the provisions of the Access to Information Act, 2016 with greater emphasis on ensuring compliance with their proactive disclosure obligations, across the board. The assessment will be carried out in the select public health agencies to determine, within the individual agency, existing policies, resources, and practices for both statutory and proactive disclosure in terms of the Access to Information Act and make recommendations informed by global best practices.

REGULATORY FRAMEWORK ON ACCESS TO INFORMATION IN KENYA

The inclusion of the right to access information in the Constitution could not have been timelier in an environment where information, data, and decision-making processes many times are shrouded in secrecy.

In keeping with Article 35 of the Constitution, the Access to Information Act No 31 was enacted in 2016. The purpose of the Act, as stated in its preamble is to "give effect to Article 35 of the Constitution and to confer on the Commission on Administrative Justice (CAJ) the oversight and enforcement functions and powers and for connected purposes."

The Constitution and the Act provide that every citizen has the right to access information held by the State and any other person and where that information is required for the exercise of protection of any right or fundamental freedom.[24] This latter part applies to the exercise of the right to health, as has been elaborated in the previous section.

A compliance audit with the law would entail considering the parameters that are contained in the Act. A Checklist of the areas of compliance is listed below:

Section 5

1. Is there existence of facilitation of disclosure of information held by the public entity with respect to:
   a. The particulars of the organisation, functions, and duties
   b. The powers and duties of its officers

21. Public Service Commission & 4 others v Trade Union Congress of Kenya & 2 others (Petition No 62 of 2015, NBI High Court Constitutional Division)
22. St Patrick Hill School Ltd v National Hospital Insurance Fund (2019) Eklr
23. Republic v Public Procurement Administrative Review Board and 4 others ex parte BRITAM Life Assurance Company (K) Ltd & Ano (2018) eklr
24. Section 4 of the Access to Information Act

c. Any documented guide as to how to enable a person wishing to apply for information
d. A guide as to how to locate the information needed
e. The use of the local language of the area
f. A guide as to how to locate the information needed
g. The use of the local language of the area
h. Accessibility of info rmation by persons with disabilities
i. The cost of obtaining the information

Section 6
1. Is there any indication/guidance as to the particular information that is limited in access?
2. How is this communicated to the applicant?

Section 7
1. Is there an information access officer readily available to receive the requests for information within the facility?
2. Is there a template for an application for information? Is there a form that is user friendly?
3. Is there any mechanism in place for disabled or illiterate applicants to make their applications without discrimination?

Section 9
1. Is there a service charter that spells out the timelines within which the applicant should get a response?
2. Is there in place a mechanism that efficiently ensures communication of responses to the applicant?
3. Are there in place efficient and reliable mechanisms for inter-facility or inter-department consultations?

Section 11
1. Are there in place reliable, efficient mechanisms of communicating to the applicant that their applications for information access are ready

Section 12
1. What mechanisms have been put in place to ensure that applicants do not pay more fees than what is prescribed by law?
2. What mechanisms have been put in place to ensure that applicants know the economic accessibility of the information they wish to apply for?

The Commission on Administrative Justice (CAJ), otherwise known as the Office of the Ombudsman, has the oversight function and the responsibility to enforce the Act. The CAJ is established according to Article 59(4) of the Constitution and the Commission on Administrative Justice Act, No 23 of 2011. The CAJ's role in enforcing the provisions of the Access to Information Act is set out in section 21 of the ATI Act. Some of those functions include:

a. to provide oversight and enforcement of the Act;

d. to develop educational awareness and programmes on the right to access information and the right to protection of personal data;
e. to work with public entities to promote the right to access to information;
f. to hear and determine complaints and review decisions arising from the violations of the rights under the Act, amongst others.

The Commission also has the role of receiving annual transparency reports from each public entity. The powers of the Commission as it conducts its mandate is set out in section 23. These include the power to issue summons, question any person appearing before it, and require a person to disclose any information within the person's knowledge that would be relevant to any investigation being conducted by the Commission. If the Commission finds that there has been an infringement of any right under the Act, it has the power to order the release of any information that has been unlawfully withheld, to recommend for payment of compensation and to give any other lawful order or remedy.[25]

The enforcement role of the Commission received a boost from the Court of Appeal in the recent case of *Commission on Administrative Justice v Kenya Vision 2030 Delivery Board and 2 Others*[26] where the Court stated that the decisions by the CAJ are binding on the entities against whom they are made. However, that decision must be then filed in the High Court for it to be given effect.[27]

25. Access to Information Act, 2016 section 23
26. (2019) eKLR
27. See ELRC Miscellaneous Application No 140 of 2019; See also section 23(4) of the Access to Information Act 2016

METHODOLOGY

STUDY DESIGN

The study adopted a case study qualitative approach with document reviews and in-depth interviews as the primary data collection methods.

OVERALL OBJECTIVES

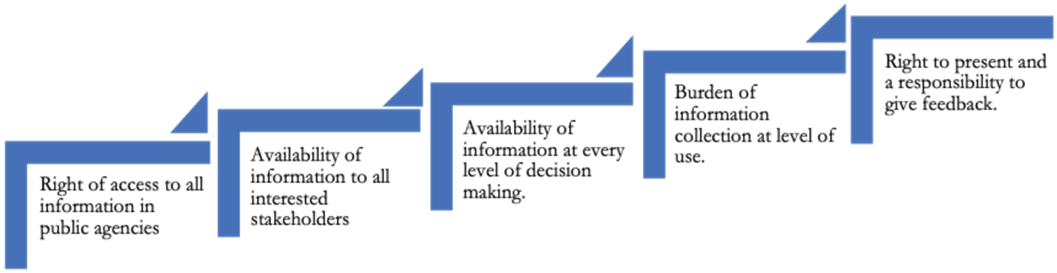
To assess the status of implementation of the legislative and policy framework on Access to Information within the health sector in Kenya, with a focus on two institutions, specifically Machakos County, and make recommendations on how to enable compliance with the existing requirements on Access to Information by targeted health agencies in Kenya.

SPECIFIC OBJECTIVES

1. To assess the status of implementation of the Access to Information Law in the Kenyan public health sector, with a focus on NHIF, and Machakos Level Five Hospital.
2. To make recommendations on how to entrench the Access to Information Law within public health agencies in Kenya, focusing on NHIF and Machakos Level Five Hospital.

CONCEPTUAL FRAMEWORK

This assessment adopted a conceptual framework based on the guiding principles to improving access to information, as[28] . According to Andrea Cornwall, accountability demands that all engaging parties are fully agreeable to and aware of their obligations, rights, and expectations and believe that each will act accordingly. Using this framework, the assessment will focus on the following guiding principles of improving access to information:



DATA COLLECTION

Initial data collection was carried out in August and November 2019. After feedback from the client, additional data was collected in September and October 2020. Semi-structured interviews were conducted with guides comprising a list of open-ended questions. Respondents were purposively sampled to include parties within the Ministry of Health, Commission on Administration of Justice, Machakos Level Five Hospital, and NHIF that were esteemed to have insights on information management or experience seeking for services at these public agencies. All interviews were conducted in English and Swahili, audio recorded and transcribed verbatim. Consent was sought prior to commencement of the interviews and Focus Group Discussions. Information gathered had no more than minimal harm to the respondents. Further, no personal identifiers were disclosed as the responses were de-identified. The interview and FGD guides are attached in Appendix 2 and 3.

Sources of data for the study included the following:

1. **Desk review of documents:** We conducted a comprehensive literature review of publicly available material on how the Access to Information Law has been operationalised in Kenya's public health agencies.

2. **In-depth interviews:** We conducted in-depth interviews with key informants as below:

- National Hospital Insurance Fund (NHIF): Two mid-level management representatives. Efforts to seek insights from senior management representatives were unfruitful.
- Machakos Level V County Hospital: One top level management representative, two

28. Andrea Cornwall, H. L. (2000) described. Accountability through participation: Developing Workable Partnership Models in the Health Sector. IDS Bulletin, 1, pp. 1-13.

mid-level managers, and three finance department representatives. The complete respondent profile is attached in Appendix 1.

- Commission on Administrative Justice: One senior legal officer at CAJ.

3. **Focus Group Discussion:** We conducted two sessions with nine patients (four and five members respectively) at Machakos Level V Hospitals. These included 3 male and 6 female patients aged between 28 years and 65 years hence an average age of 45 years. All had NHIF cover, two in the Civil Servants' Scheme and the rest were enrolled onto the Supa Cover scheme. The complete patient profile is attached in the Appendix 1.

4. **Validation:** The report was shared with selected experts working on health governance issues who provided feedback on the information gathered in activity 1, 2 and 3.

DATA ANALYSIS

The data collected was analysed using the predefined conceptual framework through the use of thematic data analysis techniques.

FINDINGS

A. ACCESS TO ALL INFORMATION IN PUBLIC AGENCIES SAVE FOR THOSE WITHIN LIMITATIONS IN SECTION 6.

The patients surveyed esteemed that access to information was essential to them as it helped them understand the services they needed and the services provided by the public agency (NHIF and hospital). Further, the information was necessary in decision making as well as planning for their medical care. The management teams sampled noted that access to information was vital for planning services, establishing and reviewing collaborations, and decision-making. The finance representatives acknowledged that access to information also strengthens their quality assurance and surveillance capacities.

> "When I visit the hospital, my biggest concern is my well-being and will only be keen on information directly relevant to my condition, not other details."
>
> Patient Representative.

Both agencies have varied extents of digital/computerised reports, which they esteemed would improve the stakeholders' accessibility of information. The hospital had installed a

Healthcare Management Information System/ Enterprise Resource Platform (ERP) that presently links service points with the pharmacy and the county's finance department. NHIF had implemented a pilot electronic claims platform for facility claims management. This pilot notwithstanding, the sampled patients noted that the information they needed was not always readily available or accessible.

Most of the respondents from the hospital administration noted the following as the key information obligations:

- Particulars of the organisation, functions, and duties.
- Information dissemination through inclusive media to reach vulnerable people groups.
- Procedures followed in decision making plus channels of supervision and accountability.

The respondents from NHIF noted the following as vital information obligations:

- Particulars of the organisation, functions, and duties.
- Information dissemination through inclusive media to reach vulnerable people groups.

Both facilities considered the following as areas of limited access information:

- Responsibilities and obligations of staff.
- Financial and procurement information of the organisation.
- Procedures followed in decision making plus channels of supervision and accountability (additional for NHIF).

> "We don't release financial information to the public. We only provide information related to claims and packages when necessary"
>
> NHIF Representative.

Most of the patients interviewed only considered information related to their immediate health as the hospital's key obligation and not other operational and administrative details. Further, even when they may consider the organisational information, there are no clear guidelines to accessing the same from the institutions

TABLE 1: QUALITATIVE ASSESSMENT OF THE LEVEL OF IMPLEMENTATION OF SECTION 5 OF THE ATI IN KENYA

OBLIGATORY INFORMATION	MCLVH	NHIF
Disclosure of particulars of the organisation, functions, and duties.	✓	✓
Information dissemination through inclusive media to reach vulnerable people groups	✓	✓
Disclosure of procedures followed in decision making plus channels of supervision and accountability.	✓	✗
Disclosure of responsibilities and obligations of staff	✗	✗
Disclosure of financial and procurement information of the organisation.	✗	✗

✓ ACCEPTABLE IMPLEMENTATION ✗ WEAK IMPLEMENTATION

IMPLICATIONS.

- All these stated aspects of public agencies are obligatory for dissemination in keeping with the provisions of Section 5 of the Access to Information Act for transparency and accountability.
- Many patients and users of NHIF services are likely not to maximise their responsibility in ensuring public agencies' accountability due to their lack of awareness of the provisions of the Access to Information Act.
- The adoption of technology for information management by both entities is commendable and can improve the stakeholders' access to information.

B. AVAILABILITY OF INFORMATION TO ALL STAKEHOLDERS & AT ALL LEVELS OF DECISION MAKING SECTION 5(2-3).

I. STAKEHOLDERS.

The hospital considered the following as its stakeholders:

- National and County Governments, hence the need to provide information on hospital statistics as well as operational reports.
- Donors and Development Partners hence the need to provide programme specific information as well as relevant operational data.
- Payers including NHIF hence the need to provide financial, administrative and some relevant medical information.
- Patients hence the need to provide relevant medical and service-related information.
- Community hence the need to provide relevant health promotion information.
- Regulatory agencies such as the Kenya Medical Practitioners' and Dentists' Council hence the need to provide requisite administrative and operational information.

NHIF considered the following as their stakeholders:

- National and County Governments hence the need to provide financial and administrative information.

- Donors and Development partners, hence the need to provide program specific information as well as relevant operational and financial data.
- Hospitals hence the need to provide relevant operational and benefit specific information.
- Payers/Contributors hence the need to provide relevant benefit specific information.
- Patients hence the need to provide relevant benefit specific information.
- Community hence the need to provide relevant benefit related information.

The NHIF and hospital representatives surveyed reported that both institutions provide annual reports as follows:

- Hospital: Service reports at the end of December while financial reports at the end of the financial year in June.
- NHIF: Financial reports and operations reports at the end of the financial year in June.

II. MODE OF COMMUNICATION.

The sampled NHIF, hospital, and patient representatives noted that NHIF mainly communicated with its members on a face-to-face basis whenever a member made inquiries. The hospital and NHIF representatives considered emails the most popular mode of communication with all stakeholders except for the community and patients for whom phone calls, text messages, radio, TV, and social media were preferred channels.
The hospital also had a service charter publicly displayed for clients, outlining services, timelines, and applicable costs where necessary. NHIF had its service charter on their website but not at the facility (a copy in Appendix 4)

> “…both hospital and patient representatives sampled reckon that NHIF is hardly proactive in disseminating information to its members.”

Both hospital and patient representatives sampled reckon that NHIF is hardly proactive in disseminating information to its members.

Facility representatives note that NHIF is very responsive in sharing relevant administrative information with the hospitals. However, they decry the delays in preauthorisations for surgical and radiological services since the function's reversion to the headquarters from the branch level.

III. INCLUSIVITY OF COMMUNICATION FOR THE VULNERABLE GROUPS.

The sampled hospital representatives noted that the hospital had partnered with the Association of Persons with Disability in Kenya (APDK), the school of the deaf, and the adolescent care center, who help support service provision to persons with disabilities and vulnerable women. The hospital management team had representation for persons with disabilities.

Further, they had four nurses trained in sign language who support the deaf. They also had patient assistants who would occasionally assist with translation and mobility as

needed. However, they neither had staff trained in support for the visually challenged nor did they have any material for communication in braille.

> "As a hospital, we only have a few trained nurses to cater for deaf patients. Often, they have to leave their respective roles to assist deaf patients, which strains them and occasions delays in service delivery."
>
> Hospital Management Representative.

> "Persons with disabilities have to bring assistants because there are no designated people to assist them access information.."
>
> Relative to a patient with disability.

The NHIF representatives noted that they had not effected any specific measures to guarantee access to information for the vulnerable persons.

The patients reported lack of special provisions to facilitate access to information for the vulnerable people groups, including the deaf and the blind, at both the hospital and the NHIF offices. Further, those with physical disabilities would often need to be accompanied by their assistants to facilitate information access.

IV. UNDERSTANDING OF NHIF AND UNIVERSAL HEALTHCARE COVERAGE

The sampled patients had a relatively good grasp of the Universal Healthcare Coverage benefits currently active in the county. However, most do not have a clear understanding of its scope of services beyond the public facility as well as referral services at other tertiary facilities like Kenyatta National Hospital and private facilities. The patients had a poor understanding of the role of NHIF and its services following the rollout of UHC.

All sampled representatives were unanimous in noting that implementing the access to information act by NHIF and the hospital had a more significant potential of enhancing patient understanding of services provided under the UHC scheme.

IMPLICATIONS.

- The hospital has made progressive steps towards disability mainstreaming to enhance access to information.
- Majority of consumers of NHIF services are potentially excluded from maximising the utility of their services as well as their right to information by the lack of apparent disability mainstreaming.
- There is significant ambiguity amongst patients on the role, scope, and benefits of NHIF and Universal Healthcare Coverage.

C. THE BURDEN OF INFORMATION COLLECTION AT THE LEVEL OF USE (SECTION 9-11).

The hospital representatives noted that the hospital collects service point statistics through paper-based and electronic systems managed by a dedicated team at the records department. NHIF representatives noted that NHIF had a reliable research and policy department that oversaw the data from branches collected through their online system and the paper records.

Notably, the hospital collected daily reports as well as monthly reports from service points. NHIF had timelines for patient information collection e.g. 24-hour window for a patient notification from the facility with exceptions for emergency cases. However, none of the institutions and representatives knew any documented guidelines governing information collection, dissemination, and transfer at the hospital or NHIF.

Both institutions had electronic systems to minimise interference with collected data. However, most of the patients did not trust the integrity of the information provided by NHIF but trusted information from the hospital.

IMPLICATIONS.

There is a mismatch in patient expectations and the reality of patient experience with NHIF services; this may account for the dissatisfaction and mistrust of NHIF by patients.

D. THE RIGHT TO PRESENT FEEDBACK AND RESPONSIBILITY TO RESPOND TO FEEDBACK (SECTION 9&22).

Both institutions collect feedback through suggestion boxes, designated phone numbers, and social media platforms, as cited by the representatives sampled. Often, clients would also seek or provide direct feedback on a face to face engagement or through social media. The hospital would occasionally conduct exit surveys at department levels. The agencies reported that they encouraged anonymity except for particular concerns of the users that necessitated their identification. However, most patients felt that the hospital and NHIF do not proactively seek feedback from service users.

> “We have suggestion boxes for client feedback.
> We also receive feedback through social media platforms,
> mostly as complaints to the county leadership.”

Hospital Management Representative.

Further, response to feedback would depend on the nature of the information sought at the hospital. Emergency and face to face feedback would be addressed almost immediately, but other forms would take longer, between 1-2 weeks. However, the patients sampled felt that most of the input sought by users would often not be addressed immediately except for emergencies at the hospital.

All sampled patients, NHIF, and hospital representatives were unaware of any institutional policies on the feedback process.

THE COMMISSION ON ADMINISTRATIVE JUSTICE (CAJ).

The mandate of the Office of the Ombudsman is two-fold and extends to both national and county governments. These include tackling improper administration in the public sector; hence it is empowered to investigate complaints of delay, abuse of power, unfair treatment, manifest injustice, or discourtesy. Secondly, the Commission has the mandate of oversight and enforcement of implementing the Access to Information Act, 2016.
In fulfilment of the latter, the respondents from the Commission noted that it had made progress in building capacity and strengthening systems to enable effective implementation of the ATI Act in the public sector. These include the following:

a. Engagement with health leadership: The Commission has engaged the health leadership at the national level (Cabinet Secretary and Permanent Secretary in the Ministry of Health) and county level (Council of Governors and County Secretaries) on ATI laws in Kenya. As a result, the MOH and 44 counties designated information access officers and 3 counties have established multi-stakeholder information access committees.

b. Sensitisation of public officers within the MOH and its respective Semi-Autonomous Government Agencies (SAGAS) KEMRI, NHIF, KEMSA, NACC, KNH, MTRH, and KMTC. This resulted in the training of more than 102 public officers on ATI laws and sensitisation of the information access officers with delegated authority and their respective committees.

c. Sensitisation of the public on the Commission's mandate across the country.

d. The Commission made it a requirement for the public institutions to publish and publicise their level of implementation of ATI Act. CAJ provided a reporting guideline for the institutions that is updated annually. Subsequently, from 2018, it received reports from the MOH and all its SAGAS. However, it had not yet received reports from the county governments.

e. The Commission developed several ATI guides for the stakeholders, including the guide on proactive disclosure, county model law on ATI, and the handbook on best practices in a bid to strengthen implementation and awareness on laws.

f. The Commission had completed developing the regulations that would support the implementation of the ATI Act and submitted them for review by the Ministry of Information Communications and Technology, whose Cabinet Secretary is responsible for developing the Regulations in consultation with the CAJ.

g. The Commission assessed the level of implementation of ATI Act in public institutions in Kenya including the ministries (National Government, County Governments and State Corporations) at the beginning of 2019 . A summary of the results is captured below (Figure 2) and in Appendix 6.

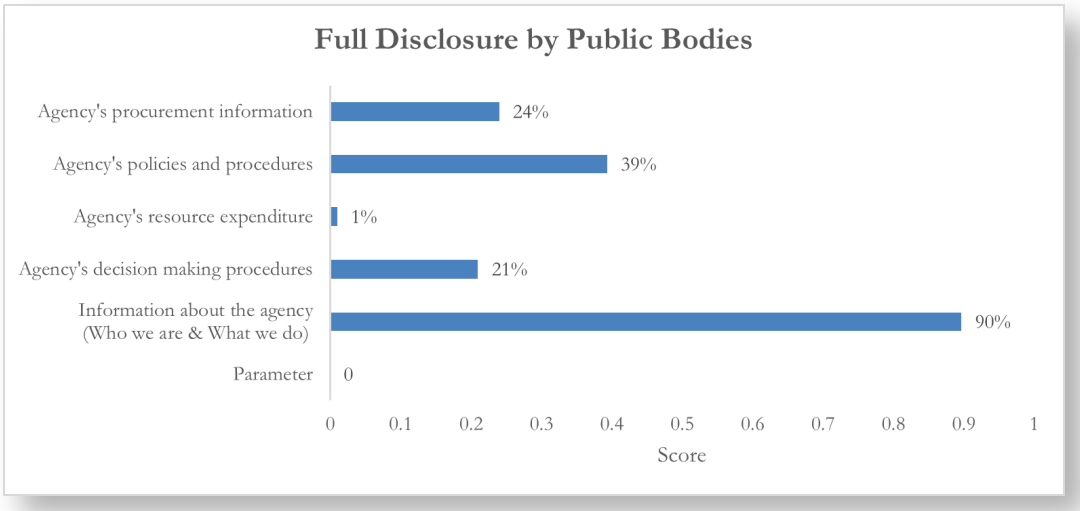
29. Commission on Administrative Justice. (2019). Survey on the Status of Proactive Disclosure of Information by Public Bodies. Nairobi.

FIGURE 2: SUMMARY OF THE EXTENT OF IMPLEMENTATION OF PROACTIVE DISCLOSURE IN PUBLIC INSTITUTIONS

KEY FINDINGS OF CAJ PROACTIVE DISCLOSURE SURVEY

- Public institutions are mainly opaque in their operations.
- The overall level of proactive disclosure was rated 52%.
- State corporations rated best at 64%, ministries in national government rated 50%, and county governments rated lowest at 43%.
- Basing on full disclosure, the least disclosure was on how resources were utilised (average 1%), followed by how decisions are made (average 21%), then how procurement was made (average 24%). Full disclosure of information on who and what the institution did was at an average of 90% whilst that of information on policies and procedures was at an average of 39%.

Source: (Commission on Administrative Justice, 2019)



Source: CAJ, 2019

ENABLERS TO AVAILABILITY AND ACCESS TO INFORMATION.

The hospital representatives noted that its adoption of digital solutions for information management i.e. Enterprise Resource Platform at the facility, E-Claims portal for the NHIF claims management and the establishment of patient experience support teams at the hospital were crucial enablers to access to information.

NHIF representatives noted that its aggressive use of social media and its website were key enablers to access to information. The patients pointed out that the well-designed spaces for the waiting lounges were a promising avenue for patient education by NHIF and hospital staff.

The CAJ representative cited the following as key enablers of ATI;

a. **Technology:** The digitisation and automation of services increases availability, access and integrity of information.

b. **Goodwill from leadership:** This helps set the stage and example for the rest of the organisation's teams. It also eases the implementation of the ATI within the organisation.

c. **Capacity Development:** This ensures the information access officers and the respective teams know the ATI requirements and can facilitate the implementation of its provisions.

d. **Institutional data management frameworks:** Existence of policies relating to data and records management (collection, storage, retrieval, and disposal) and delegation of ATI responsibilities, facilitate the implementation of ATI provisions.

e. **Adequate funding:** Implementation of the provisions of the ATI Act is costly; hence adequate resourcing of the respective agencies is vital.

CHALLENGES AND RECOMMENDATIONS

Challenge	Recommendation	Responsibility
Low political prioritisation of ATI as a function of the CAJ resulting in inadequate funding of the Commission.	Actively engage the legislature to sensitise them on the CAJ's role, advocate for budget prioritisation, and adequate funding of the Commission to facilitate discharge of the Commission's mandate.	CAJ, CSOs
Disquiet within the Ministry of ICT on the Commission, as an independent entity, being the custodian of ATI, which deters synergy that would derive from collaboration in the implementation and enforcement of the ATI Act.	Better cooperation between the Ministry of ICT and CAJ to ensure collaboration in the implementation and enforcement of the ATI Act e.g. the finalization of the Regulations	CAJ, CSOs, Ministry of ICT
Resistance of CAJ's oversight of ATI at county level on the premise of intrusion to the counties' independence.	Strengthen engagement through collaboration, e.g., capacity development	CAJ, County Govts, MOH
CAJ lacks the capacity to enforce its decisions.	Lobby stakeholders for reforms to afford the CAJ capacity to enforce its decisions.	CAJ, CSOs
Perversive culture of secrecy within government agencies and departments justified through the Official Secrets Act 2016.	Capacity development in ATI and Proactive disclosure. Champion legal reforms that would entrench ATI despite the Official Secrets Act, 2016	CAJ, MOH, CSOs
Lack of goodwill and transparency by public officers.	Capacity development in ATI and Proactive disclosure. Designate Information Access Officers.	CAJ, MOH, CSOs, NHIF, MLVH
Prohibitive fees levied on the public while seeking to access information from public institutions.	Sensitise the public on acceptable fees	CAJ, MOH, CSOs, NHIF, MLVH
Weak protection of whistle-blowers within the country.	Lobbying for better laws to protect whistle-blowers, and capacity development for public officers	CAJ, MOH, CSOs, NHIF, MLVH
Impunity within public institutions resulting in lack of proactive disclosure of information and tactful delay in the provision of requested information.	Capacity development in ATI and Proactive disclosure. Designate Information Access Officers.	CAJ, MOH, CSOs, NHIF, MLVH
Limited expertise in proactive disclosure and ATI within public institutions.	Capacity development in ATI and Proactive disclosure	CAJ, Public Institutions
Limited public awareness and understanding of the ATI laws	Targeted and aggressive sensitisation on the obligations of the service providers in public health agencies and expectations/responsibilities of the public	CAJ, Public Institutions
Inadequate levels of automation of processes and digitisation of records within public institutions.	Adopt technology design strategies that allow for stakeholder interfaces as well as fast access in their various electronic information management platforms.	NHIF, MLVH, MOH, CAJ
Limited capacity for, and levels of, disability mainstreaming to enhance access to information by PWD in public institutions.	Invest in building staff capacity in special skills for communicating with persons with disabilities such as braille and sign language and designating staff to support patients with disabilities. Raise awareness on the availability of support services for vulnerable groups.	NHIF, MLVH, MOH, CAJ
Inaccuracy of, or incomplete patient details which resulted in delayed processing of claims or weakened surveillance.	Strengthening the integrity and capacities at data entry points and analysis to guarantee accuracy, reliability, and information availability.	MLV, NHIF, Public Agencies
Inaccuracy and asynchrony of data at NHIF offices at hospital, branch and national levels resulting in delays or non-payment of claims and opened an avenue for fraud.		
Insufficient information on the UHC fund for referral services at the tertiary institutions beyond the primary point of patient care resulting in poorly coordinated referral systems at the county level.	Clarify the role of NHIF in the wake of the UHC rollout as well as referral systems and disseminate the information	NHIF, MOH, CAJ
Delays in preauthorisation of surgical and diagnostic services by NHIF as this was centrally coordinated at the national level.	Automation of processes. Adequate staffing	NHIF

Branch level surveillance teams with no medical or clinical acumen hence would make cost-relevant recommendations that may not be based on sound clinical judgement. This threatens the right to the highest attainable standards of care.	Enlist qualified assessors with background healthcare knowledge within the surveillance teams	NHIF
System delays due to poor infrastructure while using the e-claims portal for NHIF	Adopt technology design strategies that allow for stakeholder interfaces as well as fast access in their various electronic information management platforms.	NHIF
Confusion in the role of NHIF and UHC resulting in defaults in payment of premiums by NHIF clients following the inception of the UHC pilot.	Targeted and aggressive sensitisation on the role, scope, and benefits of NHIF and Universal Healthcare Coverage	NHIF, MLVH, MOH
Lack of awareness among the patients of channels for accessing requisite information from both NHIF and the facility	Avail clear guidance to stakeholders on channels for easy access to requisite information	NHIF, MLVH

CONCLUSION

Public participation and stakeholder engagement are critical for transparency and accountability in service delivery. Access to relevant information is thus essential for effective public participation and stakeholder engagement. The Constitution of Kenya and the Access to Information Act provides a solid bedrock for stakeholders in healthcare and the public to exercise their responsibility in holding public entities accountable to the rule of law and their respective obligations in service delivery.

As such, there is an immense need to raise awareness on the provisions of the Access to Information Act amongst the public and the public agencies mandated with serving the public and guarantee implementation of its provisions. Indeed, enhancing access to information would go a long way in strengthening the realisation of the right to health and promoting the UHC Agenda in Kenya.

APPENDIX 1: RESPONDENTS' PROFILE

Machakos LVH Focus Group Discussants' Profile				
Patient	**Gender**	**Age**	**Nature of Ailment**	**Insurance**
1	F	50	Chronic Illness	NHIF- Civil Servants Scheme
2	M	65	Chronic Illness	NHIF Supa Cover
3	F	45	Acute	NHIF Supa Cover
4	F	38	Chronic Illness	NHIF Supa Cover
5	F	54	Chronic Illness	NHIF Supa Cover
6	M	52	Chronic Illness	NHIF Supa Cover
7	M	38	Acute	NHIF- Civil Servants Scheme
8	F	28	Acute	NHIF Supa Cover
9	F	35	Acute	NHIF Supa Cover
Average Age		**45**		
Interview Respondents				
Respondent	**Gender**	**Age**	**Designation**	**Institution**
1	M	34	Senior Management	Hospital
2	M	32	Mid-Level Management	Hospital
3	F	42	Mid-Level Management	Hospital
4	M	36	Finance Team	Hospital
5	F	38	Finance Team	Hospital
6	F	26	Finance Team	Hospital
	M	51	Mid-Level Management	NHIF
	F	44	Mid-Level Management	NHIF
Average Age		**38**		

APPENDIX 2: INTERVIEW GUIDE

ACCESS TO INFORMATION LAW IN PUBLIC HEALTHCARE IN KENYA.

Access to Information Act No 31 of 2016

a. Access to all information in public agencies save for those in limitations in Section 6.

i. Why is access to information by stakeholders important in healthcare?
ii. Why is ATI of value to the institution?
iii. What are the obligations of your institution in providing access to information?
iv. What information is provided or available for the stakeholders?
v. To what kind of information is access limited?
vi. Do you have computerised reports? Are they readily accessible or available on electronic platforms for the stakeholders- Section 17 3 (c)?

b. Availability of information to all stakeholders including the vulnerable groups as per Section 5(2-3).

i. Who are your key stakeholders for the services you provide?
ii. What ways do you communicate the relevant information to the different stakeholders?
iii. What measures have you instituted to ensure the inclusion of vulnerable groups (Poor, PWDs, Women) in the communication? (Language, Sign/Braille etc.)
iv. What challenges have you faced in trying to achieve this function/role? (Barriers)
v. What are the gaps in legislation and in implementation that need to be addressed?
vi. What would you consider as enablers for effective access to information in your institution?
vii. How has ATI hindered/is likely to hinder the realisation of the right to health and Universal Health Coverage (UHC) programme in Kenya
viii. What are the recommendations on addressing the gaps?

c. Availability of information at level of interest including for vulnerable groups. Same as in a and b.

d. Burden of information collection at level of use as per Section 9-11.

i. How does your institution collect its information?
ii. Are there timelines that guide your institutions' information collection and dissemination periods?
iii. Incase information required is in another party outside your institution, are there processes that guide this as well as timelines for the transfer? Section 10 (1)
iv. What measures are in place in your institution to guarantee integrity of information?

e. Availability of information at all levels of decision making.

i. Are the guidelines for timely availability of information to your stakeholders? What are the guidelines?
ii. Does your institution provide annual reports? What timelines inform this process?
iii. Are these reports made public? If so, through what means?

f. Right to present feedback and responsibility to respond to feedback as per Section 9&22.

i. Does your institution collect (actively or passively) feedback from stakeholders?
ii. Is there a policy or guideline (institutional level) that guides this process?
iii. What means are available for collection of the feedback?
iv. What are the timelines for response for feedback/ complaints at your institution?
v. How does your institution protect the stakeholders or officers making disclosures (Section 16)?

APPENDIX 3: FGD GUIDE

ACCESS TO INFORMATION LAW IN PUBLIC HEALTHCARE IN KENYA.

Access to Information Act No 31 of 2016

a. Access to all information in public agencies save for those in limitations in Section 6.

i. Why is access to information by stakeholders important in healthcare?
ii. Do you feel that information is readily available and accessible when you need it?
iii. What information is provided or available for the stakeholders? (NHIF/Hospital)
iv. To what kind of information is access limited?
v. Do you have access computerised reports? Are they readily accessible or available on electronic platforms for the stakeholders?

b. Availability of information to all stakeholders including the vulnerable groups as per Section 5(2-3).

i. In what ways does the Hospital and NHIF communicate the relevant information to the Patients?
ii. What measures have the Hospital and NHIF instituted to ensure inclusion of vulnerable groups (Poor, PWDs, Women) in the communication? (Language, Sign/Braille etc.)
iii. What challenges have you faced in trying to access information from these agencies? (Barriers)
iv. What would you consider as enablers for effective access to information in these institutions?
v. What would you recommend to address the challenges?

c. Burden of information collection at level of use as per Section 9-11.

i. How do these institutions (the Hospital and NHIF) collect their information?
ii. Are there timelines that guide their information collection and dissemination periods?
iii. Incase information required is in another party outside the institution, are there processes that guide this as well as timelines for the transfer? Section 10 (1)
iv. Do you think the institutions can guarantee the integrity of the information they provide? Please explain.

d. Availability of information at all levels of decision making.
i. Are you aware of any guidelines for timely availability of information to stakeholders? If yes, which ones?
ii. Do these institutions (the Hospital and NHIF) provide annual reports? What timelines inform this process?
iii. Are these reports made public? If so, through what means?

i. Do these institutions (the Hospital and NHIF) collect (actively or passively) feedback from stakeholders?
ii. Are you aware of any policy or guideline (institutional level) that guides this process?
iii. What means are available for collection of the feedback?
iv. What are the timelines for response for feedback/ complaints at your institution?
v. Do these institutions protect the individuals giving feedback or disclosures? How do these institutions protect the stakeholders or officers making disclosures?
iv. What are the timelines for response for feedback/ complaints at your institution?
v. Do these institutions protect the individuals giving feedback or disclosures? How do these institutions protect the stakeholders or officers making disclosures?

APPENDIX 4: CAJ INTERVIEW GUIDE

Access to Information Act No 31 of 2016

1. What measures has the CAJ put in place to ensure implementation of the provisions of this Act in the public health sector?
2. What factors do you considered as enablers for public facilities to implement the Access to Information Act?
3. What barriers and gaps exist to effective implementation and oversight of the implementation of the Access to Information Act in the Public Health Sector in Kenya?
4. What can public institutions do to ensure effective implementation of the Access to Information Act in the public health sector?

APPENDIX 5: NHIF SERVICE CHARTER

Service Commitments and Stakeholder Obligations

COMMITMENT	TIMEFRAME	STAKEHOLDER	COST
REGISTRATION			
• Process and issue membership cards • Issue urgent cards • Issue company and sponsor codes • Issue membership number	• 7 working days • 1 working day • 14 working days • Immediately	• complete and submit application form • fill application forms clearly and accurately • provide all specified documents	Free of charge
PAYMENTS			
• Acknowledge receipt of contributions • Update individual account	• Immediately • Immediately	**Employer** • Deduct monthly contributions appropriately • Upload by: product • Pay at our designated pay points • Provide correct employee information • Observe payment deadlines (before the 9th of every month) **Self employed** • Remit contributions • Observe payment (before the 9th of every month. However, to access benefits, payments for the current month must be fully paid)	• As per gazetted deduction schedule
CLAIMS PROCESSING			
• Acknowledge claims submission • Process and pay claims	• Immediately • 14 working days	Employer • Prepare and document claim as per NHIF guidelines • Submit all required and valid documents • Submit claims within 90 days from the date of patient discharge • Resubmit rejected claims within 30 days • Do not falsify claims	Free of charge
DECLARING AND CONTRACTING OF HEALTHCARE PROVIDERS			
• Acknowledge applications for declaration and contracting • Issue inspection reports of health facilities for declaration and contracting	• Immediately • 14 working days	• Observe contract • Maintain high quality service standards • Pay the declaration fee as prescribed • Notify visits, admissions and discharges immediately	Free of charge
NHIF TENANTS			
• Acknowledge and document problems	• 24 hours	• Pay rent as specified in the contract • Observe contract terms	Free of charge
SUPPLIERS OF GOODS,SERVICES AND WORKS			
• Advertise tenders for goods, services and works on print media	• 14 Days prior to tender awards	• Have the right certification in field of operation • Supply goods	• Maximum Ksh 1000 Per tender document • Downloaded
• Notify bidders of tendering process results • Process invoices	• Within 14 days • 30 working days	and or services as per specifications and on time • Forward invoice(s) for services rendered or goods delivered	tender documents are free
PROVIDING PROMPT SERVICES AND RESPONSES			
• Attend to customers at the counter • Respond to enquiries	• Immediately • Within 1 working day	• Observe NHIF rules and regulations • Be courteous when dealing with our staff • Provide the required support • No smoking • No corruption	Free of charge
ACTING ON YOUR FEEDBACK			
• Acknowledge and escalate concerns • Determine and agree on a course of action and respond appropriately	• Within 1 working day • Within 5 working days	• Communicate compliments, suggestions and complaints to enable us serve you better	Free of charge

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APPENDIX 6: LEVEL OF IMPLEMENTATION OF PROACTIVE DISCLOSURE IN PUBLIC INSTITUTIONS

Parameter	Level of Disclosure		
	Full Disclosure	Partial Disclosure	Non-Disclosure
a) State Corporations			
Information about the agency *(Who we are & What we do)*	97%	3%	0%
Agency's decision making procedures	47%	23%	30%
Agency's resource expenditure	3%	50%	47%
Agency's policies and procedures	63%	20%	17%
Agency's procurement information	30%	60%	10%
b) Ministries- National Government			
Information about the agency *(Who we are & What we do)*	100%	0%	0%
Agency's decision making procedures	14%	18%	68%
Agency's resource expenditure	0%	27%	73%
Agency's policies and procedures	36%	55%	9%
Agency's procurement information	23%	54%	23%
c) County Governments			
Information about the agency *(Who we are & What we do)*	72%	23%	4%
Agency's decision making procedures	2%	23%	75%
Agency's resource expenditure	0%	77%	23%
Agency's policies and procedures	19%	47%	34%
Agency's procurement information	19%	55%	36%

Average on Full Disclosure	
Parameter	**Average Score**
Information about the agency *(Who we are & What we do)*	90%
Agency's decision making procedures	21%
Agency's resource expenditure	1%
Agency's policies and procedures	39%
Agency's procurement information	24%

APPENDIX 7: QUALITATIVE ASSESSMENT OF THE LEVEL OF IMPLEMENTATION OF AIA IN KENYA

OBLIGATORY INFORMATION	MCLVH	NHIF
Section 5 (Disclosure of information)	⊙	⊗
Section 6 (Limitation of right of access to information)	⊙	⊗
Section 7 (Designation of information access officer)	✓	⊙
Section 9 (Processing of application)	⊙	⊙
Section 11 (Providing access to information)	⊙	⊙
Section 12 (Fees))	✓	⊙
Section 16 (Protection of person making disclosure)	✓	⊙
Section 17 (Management of records)	✓	✓
Section 22 (Inquiry into complaints)	⊙	⊙

✓ ACCEPTABLE IMPLEMENTATION ⊗ WEAK IMPLEMENTATION ⊙ MODERATE IMPLEMENTATION

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