Supported by

EUROPEAN UNION

OXFAM GB URBAN POLICY BRIEFS DEVELOPMENT

Policy Briefs on NHIF Health Scheme and NSSF and MPP Pension Schemes

Dr. Anne Kamau and Dr. Paul Kamau

November 2016

Youth Alive! Kenya

Supported by

EUROPEAN UNION

OXFAM GB URBAN POLICY BRIEFS DEVELOPMENT

Wezesha Jamii Project

Policy Briefs on NHIF Health Scheme and NSSF and MPP Pension Schemes

REPORT

Submitted to

Oxfam GB, Nairobi
Atrium House 3rd Floor, Lenana Road Kilimani
P.O. Box 40680 - 00100, Nairobi
Tel: 020-2820000
Email: hecarequisition@oxfam.org.uk

By

Dr. Anne Kamau and Dr. Paul Kamau

Consultants

November 2016

OXFAM SITE ENTERPRISE PROMOTION NOPE Building Capacities, Changing Lives

Youth Alive! Kenya

Table of Contents

List of Tables

Appendices

Acknowledgements

This report is an outcome of joint effort of different individuals. We sincerely thank Oxfam GB and *Wezesha Jamii* project partners - SITE Enterprise Promotion (SITE EP), National Organisation for Peer Educators (NOPE), and Youth Alive Kenya (YAK) - for giving us the opportunity to undertake this assignment. We are grateful for the support and input that we received throughout the research process and for accompanying us on various occasions during data collection. We are very grateful to Michael Juma for the support and guidance and for timely response to our requests. We thank Lilyanne Ndinda, Immanuel Kivunga and Jacinta Kaingi of Oxfam GB for giving us technical guidance and support.

We sincerely thank our study participants. First we thank the women small scale traders and the women domestic workers who spared their time to participate in the focus group discussions. We thank the key informants who gave us valuable information and also linked us with other relevant organisations and individuals. We give special thanks to Mr. Daniel Mulinge of the National Hospital Insurance Fund for providing training to the *Wezesha Jamii* project team.

We thank the research team members who supported us during the data collection. Specifically we thank Mary Mutiso, Scholastica Kimanga and Maureen Gikaria. We are confident that the information in this report will inform the development of policy briefs that will be used to influence and inform policies on inclusion and expanding enrolment of informal sector workers in social protection and social security programmes in Kenya.

Lastly, we thank the National Commission for Science, Technology and Innovation (NACOSTI) for giving us permission to undertake the study (Appendix 1).

Abbreviations

FKE	Federation of Kenya Employers
HISP	Health Insurance Subsidy Programme
ILO	International Labour Organisation
KIIs	Key informant interviews
KNUT	Kenya National Union of Teachers
KUDHEIHA	Kenya Union of Domestic, Hotels, Educational Institutions, Hospital and Allied Workers
KUPPET	Kenya Union of Post Primary Education Teachers
MPP	*Mbao* Pension Plan
MSEA	Micro and Small Enterprises Authority
MSMEs	Medium and Small Micro Enterprises
Mtiba	Mobile health wallet
NCSP	National Council for Social Protection
NHIF	National Hospital Insurance Fund
NSPS	National Social Protection Secretariat
NSSF	National Social Security Fund
OPCT	Older persons cash transfer
OVCs	Orphans and vulnerable children
PWSD	Persons with severe disability
RBA	Retirements Benefits Authority
UNICEF	United Nations Children's Fund
WDWs	Women domestic workers
WSSTs	Women small scale trader

EXECUTIVE SUMMARY

I. Background

In July 2016, Oxfam GB and partners - SITE Enterprise Promotion (SITE EP), National Organisation for Peer Educators (NOPE), and Youth Alive Kenya (YAK) commissioned this study which led to the development of two policy briefs on (i) the National Hospital Insurance Fund (NHIF) and (ii) the National Social Security Fund (NSSF) and *Mbao* Pension Plan (MPP) pension schemes. This study came at a time when there is a global push for governments and development actors to expand social protection and universal health coverage (UHC) to their citizens; and to support inclusion of informal sector workers. The study also came at a time when the Government of Kenya, through the National Council for Social Protection (NCSP) is expanding the national social protection programmes. This research, and the work of *Wezesha Jamii* project, is therefore timely.

Results of earlier studies conducted under *Wezesha Jamii* project showed low enrolment levels of women small scale traders (WSSTs) and women domestic workers (WDWs) in social protection programmes. Hence, they depended on out-of-pocket payments in case of sickness or whenever they experienced financial and social shocks. They had to dip into their meagre earnings and savings when they encounter medical and other emergencies.

This study intended to gain deeper understanding of the reasons behind this low enrolment and retention levels of WSSTs and WDWs in social protection schemes. The study analysed the existing health care and pension schemes in Kenya. This led to development of two policy briefs (for NHIF and NSSF/MPP schemes) which formed the basis for engaging with policy makers and stakeholders on issues of the targeted social protection schemes.

II. Objectives

This study broadly identified policy recommendations and practices within the public healthcare and pension schemes that should be addressed to make social protection schemes and services appealing and responsive to the millions of domestic workers and small scale traders both in Nairobi and Kenya. The specific objectives are outlined in the main report (page 10).

III. Methodology

This study used various approaches and methods as follows:-

1. Submission of an Inception Report detailing the proposed methodology. The report was shared and discussed with Oxfam GB and partners.
2. Desk reviews of various social protection schemes in Kenya and globally.
3. Primary data collection. This was done at two levels:-
    1. Twenty (20) focus group discussions (FGDs) were held with 199 women in the five study sites (103WSSTs and 96 WDWs).
    2. Eighteen (18) key informant interviews (KIIs) were conducted with representatives of government departments, the three schemes, international organisations, private

insurance, community based health programmes, and trade unions as detailed in the methodology section (page 6).

4. Training of *Wezesha Jamii* staff on NHIF. This component was incorporated as part of data gathering process. The training focused on the NHIF scheme, registration and compliance, and claims and benefits packages.
5. Data analysis. This study generated largely qualitative data. Hence, the data were analysed thematically using content analysis. This report in an outcome of the analysed data from the various sources.

IV. Key Findings

The study covered two public social protection schemes (NHIF and NSSF) and one private pension scheme (MPP). The following are summary results.

National Hospital Insurance Fund (NHIF)

1. The NHIF if the oldest health care scheme in Africa established in 1966. At the time it was started, it covered salaried workers. Later the NHIF Act was amended in 1972 to include self-employed workers. The scheme covers both in-patient and out-patient services and has a wide range of benefits packages. NHIF is a contributory scheme and has varying premium rates for formal and informal workers. The premiums for informal economy workers are Kshs 500 per month and these can be paid through bank accounts, *M-pesa*, USSD systems and the *NHIF e-wallet*.
2. Enrolment in NHIF among the targeted women is low. Only 24% of the WSSTs and 17% of the WDWs had enrolled in NHIF. Some had previously enrolled but had dropped out (21.4% and 7.3% respectively).
3. Most WSSTs and WDWs appreciated the important of NHIF and some suggested it should be made mandatory for all. They however cited limitations and challenges that prevented them from joining.
4. Several factors contributed to the low enrolment and retention of WSSTs and WDWs in NHIF. Among the key ones are:-
   (a) Generally lack of knowledge and awareness about the NHIF scheme, enrolment procedures and benefits packages.
   (b) High and unequal premiums and fear of default. The premiums were said to be high and many women feared the penalties. Many suggest that the rates should be reduced to Kshs 200 or 300 and that the premiums should be graduated. The need to create awareness about the value of the benefits package was noted. The inability to capture the incomes of informal economy workers also makes it difficult to structure graduated premium rates.
   (c) Perceptions that NHIF registration process is complex. Whereas the *NHIF e-wallet* and *M-pesa* provides flexible payment options, most WSSTs and WDWs lacked awareness about them. There was no mention of the *NHIF e-wallet* in any of the FGDs.
   (d) Lack of registration documents. The challenges in getting children's birth certificates featured prominently during the FGDs. Consequently, most women did not see the need to enrol if their children were excluded. The challenge was associated with home deliveries and failure to get birth notifications within the required period (6 months);

single parenting and marital challenges related to naming of children, institutions challenges that led to women's exploitation, and laxity among the women.

(e) Low penetration of NHIF in informal settlements. The women expressed the need for more contact with NHIF officials and some suggested that NHIF could engage them to mobilise their communities.

(f) Restriction of outpatient services and perceptions about quality services. The choice of one out-patient health facility was considered to be restrictive. Some respondents noted that some facilities did not offer quality services and some did not give medications. According to NHIF officials health facilities receive their capitation funds prior to service provision and this include cost of medicines. Some women accessed free medical services in their areas and did not see the need to enrol in NHIF.

5. There are ongoing processes within NHIF aimed at expanding enrolment. These include the national health insurance subsidy programme (HISP) which extends coverage to vulnerable groups; free maternity cover for all pregnant women, and accreditation of more out-patient health facilities, and pilot-testing of the biometric data system to improve services provision.

National Social Security Fund (NSSF)

1. The NSSF has gone through a lot of reforms in the recent past especially with the new NSSF Act 2015. The mandate of NSSF has also expanded to cover those not in the formal employment. This gives the NSSF an opportunity to reach out to most Kenyans especially those in the informal economy.
2. The NSSF has a negative reputation among the informal settlement residents. Most people are reluctant to join for a number of reasons mainly being the past experience where it was taking long for one to get their retirement benefits. However, NSSF has an opportunity to redeem its name through appropriate marketing and awareness creation. There is need to reach out to the targeted WSSTs and WDWs under the Oxfam project.
3. The voluntary monthly contribution of Kshs 400 appears to be quite high for the informal economy workers. There is need for NSSF to develop a tailor made programme for the low income and vulnerable members of the public.

Mbao Pension Plan (MPP)

The MPP is a private pension scheme. Most women were not aware about the scheme and had not enrolled. The scheme provides flexible registration and contributions payment system mainly through mobile phones. Three organisations are involved in the managing of the scheme but the issue of the conceptualisation and ownership of the scheme is unclear.

V. Key Conclusions and Recommendations

The study drew the following conclusions and recommendations.

Conclusions

1. There was very low awareness among the target women about the various schemes. Many however expressed desire to learn more and join the schemes but cited some limitations.

2. Financial limitations and lack of necessary registration documents (in the case of NHIF) created barriers for the target women.
3. The high premium rates and possible enrolment to multiple schemes limited the women's enrolment. However, the greatest challenge was inadequate information about the benefits packages and their value.
4. The different schemes offered flexible contribution remittance options. However, many women lacked awareness and therefore had not taken advantage of them.
5. There is low presence of the various schemes in the informal settlements and low penetration rates. This was attributed to lack of physical offices in the various sites.
6. Negative perceptions and apathy about the schemes. There were negatives perceptions about the schemes that were based on experiences of the women or their relatives. These were related to denial of access to services and failure by the schemes to pay benefits and claims.
7. There are ongoing efforts to expand social protection coverage. In addition to the HISP programme, the NCSP and NSPS are developing a national data base of vulnerable individuals. This data could be complemented and harmonised with membership data from the various schemes and used for evidence based decision making.

Policy Recommendations

1. The various schemes should address information gaps about the schemes. Public awareness and education forums should be organised as well as targeted initiatives. Awareness creation should include enrolment drives for members who wish to join the schemes. The education forums should address the negative public perceptions about the schemes. The schemes should be transparent so as to build public confidence.
2. There is need for the schemes to address the issue of premiums and educate the public about the premiums and benefits package value.
3. There is need to address the challenge of accessing birth certificates and other registration documents. This requires working closely with the civil registration departments. Practical steps (and where necessary legislation) should be taken to address the gap between obtaining birth notification and birth certificates, and other identified barriers.
4. The government jointly with the various schemes and stakeholders should address the issue of multiple memberships to different schemes. Whereas each scheme operates independently, there may be need to develop a joint package for members who wish to join two or more schemes and have the contributions remitted jointly as it is done with the formally employed.
5. Information about the flexible remittance options should be shared widely. This should be supported with research to determine what options are preferred and why, and what works best for informal economy workers.
6. The schemes should increase their presence and penetration in informal settlements. The use of agency systems, local mobilisers should be explored and enhanced.
7. There is need for continuous data gathering. Socio-economic data on incomes and vulnerability levels should be routinely obtained and shared amongst the relevant schemes and stakeholders and used to inform decision making.

1. INTRODUCTION

1.1 Overview

The Oxfam Kenya's Urban Programme in partnership with SITE Enterprise Promotion (SITE EP), National Organization of Peer Educators (NOPE) and Youth Alive Kenya (YAK) are implementing a four-year *Wezesha Jamii* project with support from the European Union. The four-year project targets vulnerable women in five urban informal settlements to improve their livelihoods. The target beneficiaries are 10,000 women domestic workers (WDWs) and 20,000 women small scale traders (WSSTs) residing and/or working in Mukuru, Kibera, Korogocho, Mathare and Kawangware slums within Nairobi. The project seeks to strengthen the resilience of the targeted women by increasing their inclusion into social protection programs, particularly public health and pension schemes preferably the government National Health Insurance Fund (NHIF) and the National Social Security Fund (NSSF) and *Mbao* Pension Plan (MPP).

In July 2016 Oxfam Kenya and partners commissioned a study to critically examine the existing public social protection schemes in Kenya with a view developing two policy briefs one for NHIF scheme, and another for NSSF and MPP schemes. The policy briefs will form a basis for engaging the County Government as well national stakeholders in the reforms for social protection in Kenya. This report is based on data from the five *Wezesha Jamii project* sites. The research focused on issues of women small scale traders (WSSTs) and the women domestic workers (WDWs) enrolment in the schemes. The study also draws from experiences across Africa and other countries in the world which have rolled out social protection schemes the poor.

1.2 Objectives of the assignment

This study broadly aimed at identifying policy recommendations and practices within the public healthcare and pension schemes that should be addressed in order to make the schemes appealing and responsive to the millions of domestic workers and small scale traders in Kenya.

The specific objectives were to:-

1. Provide a detailed analysis of the contributory/membership healthcare and pension services in Kenya (public, private and CSOs) with emphasis to public healthcare and pension schemes namely NHIF and NSSF and one private scheme the MPP.
2. Present clear understanding of relevance and fit of the services offered by the respective institutions (schemes) to the urban poor and vulnerable WDWs and WSSTs and similar groups.
3. Examine challenges that deter the urban poor and vulnerable WDWs and WSSTs from enlisting and sustaining their membership with NHIF, NSSF and MPP; or make them withdraw their membership.
4. Analyse any ongoing processes e.g. policy amendments to address the identified policy and management challenges with the services and gave an up-to-date status of these developments, and
5. Give precise and specific policy recommendations and actions that should be pursued or influenced to address the challenges in order to make the schemes attractive to the target women based on the proposals from the target groups and stakeholders, best practices (in and out of Kenya) and the relevant theories.

1.2 Relevance of the study

There is currently a global push towards provision of social protection services and provision of universal health coverage (UHC) (Muiya and Kamau, 2013[1]) and inclusion of informal sector workers (Lund, 2015). Many developing countries are making efforts to provide their citizens with effective protection against financial risks of ill health with the recognition that health is a vital economic factor (Bernhard and Hoving, 2016)[2]. There are attempts by African countries to establish social protection schemes although in different forms. Rwanda, for instance, has established "*mutuellesde santé*" or community-based health-insurance schemes (CBHI) which are supervised and administered by municipal representatives (Bernhard and Hoving, 2016).

Addressing social protection issues is necessary for the rapidly urbanizing African continent. By the mid-2030s, 50% of Africans are expected to become urban dwellers (AfDB et al., 2016)[3]. Kenya has the highest annual informal settlements growth rate of 5% in the world (Oxfam GB and Care International, 2009)[4]. Urbanization is likely to continue and level off at about 56% by around 2050. Urbanization patterns are diverse across Africa, but they

generally portray unplanned and informality both of which pose a challenge to structural transformation.

It is estimated that more than half of the urban population live in 'informal' settlements (Oxfam, 2009)[5] that are characterized by high levels poverty, poor quality housing and pollution; inadequate water, sanitation and drainage; minimal or no social services and lack of basic infrastructure. All these result in increasing vulnerability and loss of livelihoods, a problem that is more pronounced among women (Kamau et al., 2015[6], Kamau, 2013[7]). Within the urban informal settlements, there is a large population of informal sector workers. In sub-Saharan Africa, about 66% of the labour force is in the informal economy particularly in micro and small enterprises, many of them being women (Charmes, 2012)[8].

The need for a strong social protection programme in Africa and Kenya, is based on the recognition that direct payments for medical treatment is not a solution for overcoming health care financing constraints. Instead this is socially inequitable and a cause of exclusion (Bernhard and Hoving, 2016). A baseline study conducted in 2015showed that less than 50% of women small scale traders belonged to formal social protection schemes with only 28% having enrolled in NHIF, 5% with NSSF and 1% with MPP (Kamau et al., 2015). However, many of them belonged to informal social networks which provided them with emergency support for school fees, during bereavement or sickness. They also depended on out-of-pocket payments in case of sickness. This means that they have to dip into their meagre earnings especially from their business when they encounter medical and other emergencies and have no retirement cushions. What is not clear are the reasons behind low enrolment levels in social protection schemes among WSSTs in spite of the current reforms that have been undertaken recently to bring on board the self-employed and those in the informal economy. This study sought to fill this gap.

2. METHODOLOGY

2.1 Design

The study utilized a descriptive qualitative research design. The target areas were Mukuru, Kibera, Korogocho, Mathare and Kawangware informal settlements in the Nairobi. These areas have been selected by Oxfam and partners as study areas for the *Wezesha Jamii* project. The following is a detailed description of the research process.

2.2 Desk Review

Relevant documents containing information about the NHIF, NSSF and the MPP pension schemes were obtained and reviewed. The information was analysed so as to understand the current forms of these schemes. Other documents on social protection schemes in Kenya and globally were also reviewed to bring out best practices. The Government of Kenya (GoK) policy documents on social protection were also reviewed.

2.3 Focus Group Discussions (FGDs)

Twenty 20 FGDs were conducted among different categories of WSSTs and WDWs in the target areas. Of the 20 FGDs, 10 were for WSST and 10 for WDWs and were distributed in the various sites as shown in Table 1. The FGDs generated in-depth information and understanding about the perspectives and experiences of the target women on how social protection schemes work in their communities and the challenges they faced in enrolling in these schemes. Each FGD had between eight (8) and 12 participants but one FGD had 13 participants. In total, 199 women (103 WSSTs and 96 WDWs) participated in the FGDs in the five sites.

Table 1: FGD participants in different sites

	Mukuru	**Mathare**	**Kibera**	**Korogocho**	**Kawangware**	**Total**
WSSTs	3	2	3	1	1	**10**
WDWs	3	3	2	1	1	**10**
Total	**6**	**5**	**5**	**2**	**2**	**20**

The participants were identified and mobilised through informal sector workers groups and WDWs contacts/networks that are working with the *Wezesha Jamii* project partners as well as through snowball. The researchers led the FGD discussions while research assistants took notes during the discussions. A bio-data form (Appendix 2) was used to get basic information about the participants as summarised below and in Table 2.

2.3.1 Women Small Scale Traders Characteristics

A total of 103WSSTs participated in the FGDs. The WSSTs were relatively young with a mean and median age of 36 and a mode of 30. The youngest WSST was aged 16 years. Most WSSTs were aged 35 years and below accounted for nearly 60%. Most WSSTs were aged between 21 and 40 years as shown in Table 2. Most were married (63%) while the singles were 28%. The widowed and divorced were less than 10%. Education achievement as measured by the highest level of education was varied. Twenty-eight percent (28%) had completed primary school education and a similar percent had completed secondary education. Another 20% had some secondary education and 18% some primary education, whereas 6% had no education and one had college training.

In terms of membership to NHIF, only 24% of the WSSTs were registered. For many of the registered, their spouses were the main contributors (14.6%) compared to 8.7% who made own contributions. One respondent made contributions through an association called *Inuka*. Some 21.4% had had been members of NHIF but had dropped out of the scheme mainly due to increase in premium, loss of income or family related reasons.

With regards to NSSF, only 10% of all the participants were registered members. The principal contributors were largely the spouses (5.8%) and traders themselves (3.9%). Among those who were not members, 11% had registered in the past but had quit the scheme. The Mbao pension scheme was the most unknown of all the schemes where only 9% had membership. The proportion of those who had joined MPP but had left was low at 4%.

2.3.2 Women Domestic Workers Characteristics

A total of 96 WDWs participated in the FGDs. Their mean age was 33 years which was low compared to 36 for WSSTs. The median was 30 and mode 28. Most WDWs were aged between 21-30 years (47.9%) whereas 31.3% were aged between 31 and 40 years (Table 2). Generally WDW were young with over 83% being aged 40 years and below.

Most of the WDWs in the FGDs were single (44%) while 37% were married. The rest were widowed (8%), divorced/separated 8%. In terms of education, 27% had completed primary education and 16% had completed secondary education. About 3% did not have any schooling while another 2% had college education.

In terms of registration to NHIF, only 17% of the WDWs were members while 7.3% had previously joined but were not active. The main contributors were the women themselves (8.3%) compared to their spouses (6.3%). This indicates that there is potential for increasing enrolment among self-paying WDWs compared to the WSSTs. For one participant, her NHIF premiums were paid through the OVC cash transfer programme.

Registration into the NSSF was even lower among the WDWs at 13% while 7.3% had earlier joined but had dropped out. The few who had registered largely contributed for themselves. For the MPP, only 3% of the WDWs were members. In fact, it emerged that most WDWs participants did not have information about the MPP. Among those who were not members only 2% had ever joined the MPP previously. Contributions to MPP were largely by the women themselves.

2.4 Key Informant Interviews

Additional information on the three social protection agencies (NHIF, NSSF and MPP) was obtained through discussions with 18 key informants (key informant interviews - KIIs). The discussions helped to clarify policy issues identified during literature review and during FGDs with the WSSTs and WDWs. Information on challenges that the schemes experienced in extending coverage to informal sector workers and the target women, as well as policy recommendations for addressing the challenges were obtained. The key informants (KIIs) were selected purposefully based on their focus on the targeted issues and also through snowballing.

The key informants were senior management personnel of the various organisations. Two interviews were conducted at the NHIF (1 headquarters and 1 at branch level) and one at NSSF. Two interviews focusing on the MPP were conducted at Eagle Africa and *Jua Kali* Secretariat. Others were held with representatives of government departments and agencies like the National Social Protection Secretariat (NSPS) and the Retirements Benefits Authority (RBA). The covered trade unions included the Federation of Kenya Employers (FKE), Kenya National Union of Teachers (KNUT), Kenya Union of Post Primary Education Teachers (KUPPET) and the Kenya Union of Domestic, Hotels, Educational Institutions, Hospital and Allied Workers (KUDHEIHA). Additional interviews were conducted with representative of International Labour Organisations (ILO) and United Nations Children's Fund (UNICEF). In addition, one private insurance company (Britam) and one community based health insurance (*Afya Yetu*[1]*),* a social health care innovation (PharmAccess Foundation/Safaricom *M-tiba*; and two health facilities (Huruma Nursing and St. Mary's Mission Hospital) were covered.

Prior to conducting the interviews, appointments were made with the relevant individuals. Two interviews were conducted through telephone. In most cases, Oxfam and partners were notified about the planned KIIs and they joined in some of the sessions. In addition, the *Wezesha Jamii* project team and the researchers participated in a half-day training offered by NHIF at the NHIF headquarters. The training, although not originally planned, was organised in response to request by the project team who are in constant contact with the targeted women. The training focused on the NHIF scheme; coverage, registration and compliance; and claims and benefits packages. The training also served as a data gaps filling session as the researchers and participants got clarification on issues that were raised by WSSTs and WDWs during the FGDs.

2.5 Ethical Considerations

A research permit was obtained from the Kenya National Commission for Science, Technology and Innovation (NACOSTI) – Appendix 2. Informed consent was obtained from the selected FGD participants prior to conducting the FGDs. They were informed about the purpose of the study, that participation was voluntary and that they could withdraw even after they had consented to participate. The participants were reimbursed travel expensed but there

[1]Information accessible at <http://afyayetu.or.ke/>

was no other monetary compensation. Verbal permission to take photographs was obtained from the participants.

2.6 Data Management and Analysis

This study obtained largely qualitative data through the desk review, FGDs and KIIs. The data collection tools are provided in Appendix 2. In both cases, the interviews were conducted face-to-face, except for two KIIs which were conducted via telephone. The researchers conducted the FGDs and the interviews. These were recorded verbatim in fieldwork notebooks and later typed into the MS Word Computer Programme. Observations were also made and recorded through photographs. The data were analysed thematically using content analysis. This report in an outcome of the analysed data from the various sources. The data is also used to generate policy briefs for NHIF and the pension schemes (NSSF and MPP).

3. FINDINGS ON THE VARIOUS SCHEMES

3.1 THE NATIONAL HOSPTIAL INSURANCE FUND (NHIF)

3.1.1 The NHIF Healthcare Scheme

The Kenya National Hospital Insurance Fund (NHIF) is a state corporation established in 1966 and mandated to provide accessible, affordable, sustainable and quality social health insurance to the Kenyan population (Mwaura et al., 2015)[9]. It is a public contributory health care scheme, established through an Act of Parliament under CAP 255 of the Laws of Kenya as a department in the Ministry of Health. NHIF is the oldest government insurance scheme in Africa (Taddese, 2014)[10] with over 40 years of experience in providing health insurance (Mwaura et al., 2015). It is also the largest national insurer providing coverage to more than 90% of the insured population in Kenya (Mwaura et al., 2015).

At the time of establishment, NHIF exclusively covered salaried employees earning Kshs 1000 and above per month, and the employees made a monthly contribution of Kshs 20. This study was framed with the understanding of these historical developments of the NHIF. In the early years, informal sector workers were excluded from NHIF. However, in 1972, an amendment was made to include voluntary members (mainly the self-employed). CAP 255 was repealed and replaced by the NHIF Act No. 9 of 1998 which transformed NHIF into a state corporation managed by a Board of Directors representing various stakeholders. From then on, informal sector workers could enrol in NHIF.

The Kenya government recognises the role of NHIF as a key health insurer in Kenya (Mwaura et al., 2015). In part xii of the Kenya Health Bill of 2016 *[86 (1):(a)]*, the government recognises the development of an integrated national health insurance system which include provisions for social health protection and health technology assessment as a key mechanisms for financing health in Kenya (ROK, 2016)[11]. The NHIF also fits within the 2010 constitutional and legal requirements of Kenya. For instance, Article 43. (1) states that every person has the right to – (a) the highest attainable standard of health; whereas Article 53. (1) states that every child has the right to – (c) basic nutrition, shelter and health care.

3.1.1.1 NHIF Coverage and Informal Sector Workers Enrolment

NHIF membership is open to all persons who (i) are Kenyan citizens, (ii) have attained 18 years of age (iii) whose total monthly income (for both formal and informal employment) is Kshs 1000 and above. There is no upper age limit in membership to NHIF.

The current coverage of NHIF is about 23 million Kenyans (both formal and informal sector members) with the principal contributors being about six (6) million (3.5 million being formal sector contributors and 2.4 informal sector) and the rest (17 million) being dependants. However, studies suggest that less than 10% of the Kenyan population is covered by NHIF (Bernhard and Hoving). Despite the amendment of the 1972 NHIF Act, enrolment of informal sector workers in NHIF remains low at 16% compared to the formal sector coverage of 98%. Yet the informal economy accounts for over 80% of Kenya's workforce (Taddese, 2014). Nevertheless, enrolment of informal sector workers into NHIF has increased by 54% from 1.1 million in 2013 to 2.4 million in 2016. However, some WSSTs and WDWs still thought that NHIF was for the formally employed. An FGD participant noted that,

> *'I thought NHIF and NSSF were for rich people... I thought that the schemes were for salaried employees, but now I know better and now I can register'.*

The NHIF '*SupaCover'* is targeted to voluntary contributors who include the target women. The *SupaCover* is open to Kenyans above 18 years of age who are eligible to register with NHIF either for single or family membership. The cover allows declaration of only one spouse and all children above 18 years.

3.1.1.2 The NHIF Benefits Packages

NHIF provides services under a benefit package modelled along the Kenya Essential Healthcare Package (EPHS) which includes both outpatient *(Mzalendo)* cover and inpatient *(Afueni)* cover. The benefits package and services include consultation, laboratory investigations, drugs administration and dispensing, dental healthcare services, nursing and midwifery services, surgical services, radiotherapy and physiotherapy services (NHIF,

2015)[12]. Other covered services include maternity package, renal dialysis package, kidney transplant package, radiology package, oncology (cancer treatment) package, rehabilitation for drugs and substance abuse package, foreign treatment package, chronic diseases package, specialised lab tests package, and surgical package. A detailed description of the benefits packages is provided in Table 4 (page 48).

3.1.1.3 Health Facilities Accreditation

The NHIF has contracted different category of health facilities to offer the various services. The hospitals are under three Categories, A (government hospitals), B (private and mission) and C (private) (Table 2). The hospitals provide in-patient medical cover and partial cover for surgical cases in some of the hospitals. NHIF members are free to attend hospitals under any category for both in-patient and out-patient services. However, there are restrictions on the bundled packages like surgery or physiotherapy where eligibility to use must be ascertained and prescribed by a medical specialist.

Table 2: NHIF Facilities Contracting and Benefits Package

Category/ Package	In-patient Services and partial cover for surgical cases
Category A - government hospitals	• Full and comprehensive cover for maternity and medical diseases including surgery. • Do not need to pay for anything on admission provided they are fully paid up members of NHIF.
Category B - private and mission	• Full and comprehensive cover but where surgery is required, the contributor may be required to co-pay.
Category C - private	• NHIF pays specified daily benefits under the current arrangements. • NHIF will continue to negotiate with other health providers not appearing in the list below to determine which category of contract they will sign. • Members will be informed of additional hospitals as and when they sign the contracts.

3.1.1.4 Health Insurance Subsidy Programme (HISP)

NHIF has a non-contributory Health Insurance Subsidy Programme (HISP) for the poor which is supported by the government. The programme was developed through partnership between NHIF, the World Bank Group and the Rockefeller Foundation. HISP is aimed at providing comprehensive coverage to the 9million people living in extreme poverty in Kenya by 2020 (Mwaura et al., 2015). The programme targets beneficiaries of the national cash transfer programmes such as those on older person's cash transfer (OPCT) programme, persons with severe disability (PWSD), and orphans and vulnerable children (OVCs). Informal sector workers who have negligible incomes can benefit from HISP if they are captured in the national social protection database. There are also sponsored programmes for OVCs where Kshs 500 is paid per three children. For these programmes, the NHIF encourages for annual payments.

3.1.1.5 NHIF Membership Contributions

Through several reforms, the NHIF has expanded its benefits package from inpatient services only to include outpatient services and informal sector workers. As a result, the premiums have also increased for both the formally employed and the voluntary contributors (Bernhard and Hoving, 2016). The premium rates vary for both the salaried and voluntary contributors. To benefit from NHIF services, one must be a fully paid-up member or a declared beneficiary. The formally employed have a graduated contributory system ranging from Kshs 150 to Kshs 1700 based on gross monthly income. Individuals earning less than Kshs 1000 per month are required to pay Kshs 150 per month (Bernhard and Hoving, 2016; Mwaura et al., 2015). However, unlike in the formal employment where membership to NHIF is mandatory, membership for informal sector workers is voluntary.

3.1.1.6 Registration as NHIF Member

To register in NHIF, the principal contributor is required to fill a registration form (NHIF 2) and attach required documents[2] for themselves, their spouses and declared dependants. In addition, the applicant should pay at least one month contribution (Kshs 500) for self-employed. Members can enrol in any of the 98 NHIF offices/branches countrywide or any of the 42 stations at *Huduma* Centres. Registration can also be done at some of the accredited

[2] National identity card of primary contributor, spouse identify document, photocopies of eligible children's birth certificates, and coloured passport size photographs of all beneficiaries.

health facilities, and through the NHIF online platform which includes registration for the self-employed[3].

3.1.1.7 NHIF Contributions Payment Methods

The voluntary contributors (self-employed) can make their payments through Mpesa, *'NHIF e-wallet'*[4], USSD payments and through bank payments at Kenya Commercial Bank, Cooperative Bank, National Bank of Kenya or Equity Bank. With the *NHIF e-wallet*, a member can save as low as Kshs 18 per day to enable them attain the required monthly premium amount of Kshs 500 and later transfer the money to their NHIF account. The *Mpesa* payments are charged Kshs ten (10) per transaction. Discussions with an MPP key informant indicated that the scheme had negotiated for lower charges with Safaricom. This option can be explored by NHIF as well.

3.1.2 NHIF Enrolment Challenges

There are several challenges that discourage WSSTs and WDWs from enrolling and retaining membership in NHIF. Among them are low awareness, high premium rate, fear of default, and lack of required documents as discussed below.

1. Lack of awareness about NHIF Scheme

Many FGD participants had low, wrong or incomplete information about NHIF and the benefits package. In this study, only 25% WSSTs and 17% of the WDWs had joined NHIF. Some had previously joined but had dropped out (25%WSSTs and 8%WDWs). Many FGD participants had vague information about what NHIF covers. These notions were based on past experiences in use of NHIF services by WSSTs and WDWs, their friends or relatives. Many participants wondered why they should contribute to NHIF, yet they may never use the services and some wondered whether the money accrued interest or whether it could be carried forward if not used. The issues raised by the women demonstrated their lack of understanding about NHIF.

[3] Can be accessed at <http://www.nhif.or.ke/healthinsurance/registeronline/>
[4]Source: 'NHIF SupaCover, Customer Information Pack'. Also accessible at <nhif.or.ke>

⇔ *Contributing to NHIF sometimes feels like losing your money each month and some of us have not even used it yet. If you are sacked before using of your NHIF you lose the money ...*

⇔ *Suppose you contribute Kshs 500 for one year and during that year you do not fall ill, what happens to those contributions?*

⇔ *If one registers for NHIF and does not get sick at all, is the money returned to the contributor?*

⇔ *'The use of NHIF for outpatient is not possible at Kenyatta National Hospital. When will I be admitted to use NHIF?'*

2. Lack of awareness about the benefits package

Most WSSTs and WDWs had incomplete or inaccurate information about the benefits packages and particularly about the out-patient services, what it coverers, how and where to seek services. Registration into NHIF is a continuous process. NHIF members are required to select one outpatient health facility. Selection of out-patient services is done bi-annually to allow NHIF generate the list of members who have selected various facilities and remit capitation funds to these facilities. Most women did not know that they were required to select an out-patient facility in order to access the services. Likewise, many of those who knew had not selected a facility. Some were not aware about the accredited facilities that they could choose from although the list is available on the NHIF website. Hence, as noted by a key informant, '*it is important to make the list available at the in the communities for instance at the chiefs offices'*. In case of emergency, NHIF allows payment of 'fee for service' where the member pays cash and is reimbursed by NHIF.

⇔ *There is no information on selection of outpatient services. Outpatient could be flexible, not restricted to one facility (WSSTs FGD, Kibera).*

⇔ *There are limitations on where one can get health care services ...outpatient services should be open and offered at any hospital all over Kenya and instead of limiting to one facility (WSSTs FGD, Kibera).*

⇔ *Hospital selection fails to appreciate the freedom of movement that has been granted in the Kenyan Constitution. Instead, it creates a barrier that one can only receive treatment in their facility of choice especially for out-patient. This inflexibility gives room for exploring other options of obtaining medical cover that are responsive to our needs for the same amount (500)*

> *such as SACCOs. (WSSTs FGD, Korogocho).*

3. Quality of services and access to medications

The NHIF accredited outpatient health facilities are expected to provide recommended services including medicine. The out-patient facilities get their funds through capitation and are allocated Kshs 300 per patient per quarter prior to service provision. However, FGD participants indicated that not all facilities provided medications and they sometimes buy medicine. However, as noted by NHIF, this is a malpractice since the money allocated to health facilities includes medicine costs. The issue of quality of services in the accredited facilities was also raised, as well as exclusion of preventive care and ambulance services and surgery. As noted, the amount of surgery costs that are covered by NHIF vary depending on the kind of facility but there is comprehensive cover for public health facilities.

> ⇔ *NHIF does not cover preventive care such as screening for cancer. Operations are also not covered by NHIF and one has to top up (WSSTs FGD, Kibera).*
>
> ⇔ *Some facilities lack drugs for common conditions like high blood pressure, diabetes arthritis among others... also accessing some of these facilities during emergencies is costly. It costs shillings 2,500 to hire an ambulance (WSSTs FGD, Korogocho).*
>
> ⇔ *...some of the hospitals listed for selection lack medication. It would be better to have private hospitals among the selection list because they offer better medical services unlike public hospitals which mistreat patients... (WSSTs FGD, Mukuru).*

4. High and unequal premium rates

Many women indicated that the premium for voluntary contributors is high. The premiums are based on assumption that informal sector workers earn at least Kshs 500 per day and can use one day's pay to make contributions. They recommended premiums of between Kshs 200 and 300 as they had other needs to take care of. The FGD participants noted:-

> ⇔ *... we enrolled in NHIF and paid only the first instalment, and then there*

was an increment. This made us to become inactive...NHIF is good but the amount to be paid is high. One off payment of Kshs 500 at end month is too much. You cannot give NHIF money and be left without food' (WDWs FGD, Korogocho).

⇔ *'It is difficult for small scale traders to contribute this amount each month..... why did NHIF set Kshs 500 for casual workers just like for those with salaries earning about Kshs 10,000 per month? (WSSTs FGD, Kibera).*

⇔ *When I had an NHIF card, we used to pay Kshs 160, but it did not cater for outpatient services. I used to be an active member...the contributions become expensive when it rose to Kshs 500.... what I earn is little, so I thought it would be a problem to keep it (WSSTs FGD, Kawangware).*

Paradoxically, despite the view that the premiums are high, many WSSTs and WDWs pay more for direct medical costs or take medical loans. Some of these costs are higher than the NHIF premiums and have less benefits value as illustrated below.

⇔ *I long to join NHIF and get the card because I am a widow and a mother of three (3) children. I have a child with disability and her monthly clinic charges at Kenyatta hospital is Kshs 750. My employer loans me this amount and cuts it from my wages. It is stressful, because I am the sole provider for my family and have to provide school fees, food among other needs. I find the Kshs 500 monthly contribution to be very expensive... when will I work to raise this amount and still provide for my children with the little wages I earn (WDWs FGD, Kawangware).*

⇔ *I spend money for medical care in private health facilities. I make at least one visit per year and pay about Kshs 1000. If 3 or 4 members of my family go to hospital in the year, we pay about Kshs 3000 – 4000 (per single visit) (WSSTs FGD, Kibera).*

The lack of graduated premiums and categorisation of informal workers as a homogenous group creates inequality. Those earning high incomes pay the same amount as those with little incomes. Whereas this is true, capturing the incomes of informal workers is challenging. They may not want to declare their incomes or to be captured in national data systems; and some are also 'hidden'. As noted by a key informant,

> *People are only able to pay two percent (2%) of their income for insurance. Hence paying Kshs 500 requires one to earn higher'. (KII, CBHI)*

The FGD participants noted,

⇔ *If government employees pay Kshs 1700 according to their salary and business people pay Kshs 500, does that mean that even with my green grocery business I have to pay Kshs 500 even if I can't afford it...Can't the government give us insurance like the payments they give to old people? (WSSTs FGD, Mathare).*

> ⇔ *The NHIF monthly contributions are high and with the casual nature of our jobs, it is hard to contribute Kshs 500 per month... our pay is low and one cannot afford to make such a commitment...I cannot afford or commit to pay this amount each month (WDWs FGD, Mathare).*

The main challenge however is not the amount paid, but the lack of information and awareness about what the Kshs 500 covers hence the need to increase public awareness about the benefits scheme and packages. A key informant termed the NHIF benefits package of in-patient and out-patient 'as a gift' but however noted that Kshs 500 is high for the target population. Another key informant while emphasizing the need for public education noted that,

> *'...the most important thing is to focus on awareness creation. What does Kshs 500 mean? There is need to educate the public about the benefits. The total per year is Kshs 6000. When this amount is divided per day, it is about Kshs 16.6. What is the value of this?' (KII, NCSP).*

From the discussions, the need to capture the different categories of informal sector workers and their incomes is evident. For the *Wezesha Jamii* project, Oxfam and partners can work together with the National Council for Social Protection (NCSP) through the National Social Protection Secretariat (NSPS) and other stakeholder to develop an appropriate mechanism for capturing the target women. As this is done, their incomes estimates should be determined as well as their poverty levels and vulnerability. Needy cases should be referred to the national social protection programmes for assistance. The data could be used to inform policy and to assess the ideal premiums that the women should pay for both NHIF and NSSF.

5. Lack of awareness about flexible payment options

Flexible payment options were recommended for informal sector workers. Whereas the amount charged appeared to be high, this is affordable if broken down into daily amounts. Many women indicted that they could pay Kshs 15 – 20 shilling per day, the total of which could be higher than Kshs 500. This is the kind of amount which could be saved through the *'NHIF e-wallet'*. Interestingly, none of the FGDs mentioned the *'NHIF e-wallet'* as an option. Hence information gap, and not simply the lack of finances, is the main reason for non-enrolment. The reasons for non-use of easier and more accessible payment options like

Mpesa mobile money and the *NHIF e-wallet* should be understood. Lessons could also be drawn from similar schemes such as *M-tiba* which promotes savings though the *mobile health wallet*[5].

> ⇔ *NHIF should reduce the costs of contributions from to Kshs 200...this is affordable if the costs are broken down to Kshs 50 per week. This way, I can sacrifice buying milk for one day so as to make the payments (WSSTs FGD, Mukuru).*

6. Fear of default, penalties and multiple contributory schemes

The fear of default and penalties deter WSSTs and WDWs from enrolling in NHIF. Section 26 of the NHIF Act requires contributors to pay their monthly premiums timely. They should also ensure that their NHIF accounts are up to date so that they are able to access services when they need to use them. Default in payment results in penalty of Kshs 250 and more depending on the number of months defaulted. Ideally, self-employed members who have defaulted for a period of one (1) to 12 months can opt to reactivate their membership through two options. One, they can opt to pay the late contributions plus penalties to access benefits immediately. Alternatively, they can opt to pay late contributions and no penalty, but they would be restricted from accessing benefits for sixty (60) days. For those who have defaulted, they are given five (5) days of paying their late contribution to complete paying of penalties. For those who have defaulted for more than 12 months, they are required to start a fresh.

The fear of default is related to irregular incomes of the target women since many do not have fixed and guaranteed incomes. Some feared that if they became sick and are not able to raise money this would lead to default whereas others did not have correct information. Some wished that the penalties could be staggered to enable them pay. The FGD participants noted,

> ⇔ 'When one skips making the monthly contributions, the penalties one has to pay discourages us from continuing to be members...'
>
> ⇔ 'Penalties make it difficult especially when you find yourself suddenly jobless and once you get another job you still have to clear the penalties. NHIF should improve the scheme by clearing the penalties, especially for those hired on casual basis...'

[5]Information on *M-Tiba* is accessible at <https://www.pharmaccess.org/update/m-tiba-is-truly-leapfrogging-healthcare-in-kenya/; https://www.safaricom.co.ke/about-us/innovation/social-innovation/m-tiba>

The issue of multiple schemes and of whether informal sector workers can afford to contribute to two schemes like both NHIF and NSSF is another concern. Unlike the salaried workers where premiums are deducted once at source, informal sectors workers have to make separate payments to each scheme. A comprehensive social protection programme should focus not on one scheme but on the affordability of enrolling in the two (or more) schemes. A key informant asked,

> *'...can informal sector workers afford to pay for NHIF and NSSF which is about Kshs 900 per month?'*

7. Lack of Supporting Eligibility documents

The issue of documents featured prominently during the discussions. Many women cited lack of birth certificates and birth notification as hindrance to enrolling in NHIF. Many recounted the challenges they faced in getting birth certificates for their children. Birth notifications are accepted for registration of children below six months but older children require birth certificates. One participant noted '*i do not bother because I do not have birth a certificate'.* Whereas the dependants are not the primary target of NHIF (as contributors), the inability of WSSTs and WDWs to enrol to NHIF due to exclusion of their children raise concerns. An FGD participant argued '*why should I enrol in NHIF if I cannot register my children?'* The gap between birth registration (notification) and obtaining birth certificates was confirmed by a key informant, who noted that,

> *A lot of people do not go to the end of the birth registration process...of getting birth certificates. Birth notifications are done up to 60% but less than 30% have birth certificates. Most people begin to look for birth certificates when they have a challenge e.g. when they have to register a child for examination' (KII, UNICEF).*

The reasons for lack of birth certificates are varied. Home deliveries, single motherhood were among the cited reasons. Ordinarily, parents of children born at home are required to obtain birth notification from their area chiefs within six (6) months. However, many do not get the notifications and this makes it difficult for them to get them later as noted below.

- ⇔ *If you gave birth at home, you have to get birth notification from the chief and your child should not be older than 6 months (WDWs FGD, Mathare).*
- ⇔ *Getting birth notification is a problem. At hospital J, they do not issue birth notification immediately after delivery. They normally tell mothers to go back after one week. Also hospital K. Some women do not go back to get them after discharge (WDWs FGD, Korogocho).*

Institutional challenges create additional barriers in getting birth certificates. Several women indicated that they paid bribes to get the certificates.

- ⇔ *Birth certificates are difficult to get if one gives birth at home. One needs a birth notification from the chief in order to get the birth certificate. However, getting the notification is difficult, especially if you gave birth in one area and relocated to another. One is usually sent back to the area chief where you gave birth in order to get the notification, but that chief sends you back to your current area of residence chief for assistance. When it comes to notifications the process is complex being sent from office to office... (WSSTs FGD, Kibera).*
- ⇔ *If the birth certificates get lost or burnt, the process of getting another copy is difficult. One has to bribe about Kshs 2,500 (bribe) for a replacement (WSSTs FGD, Kibera).*
- ⇔ *Getting a birth certificate costs between Kshs 130 – 1,700...Getting a birth certificate without a notification costs Kshs 2,500 (bribe), but this depends on where you seek the birth certificate from. This also depends on the time one has taken before getting a notification. I waited until my children were 12 years old to get the birth notification and this made it difficult for the chief to assist me (WDWs FGD, Mathare).*

Single parenthood, marriage difficulties and related children naming complications were cited as other barriers as depicted below.

- ⇔ *If one is separated from their spouse and the child's father's name does not appear in one child's birth certificate, but it appears in that of other children, does that complicate that child's registration? (WDWs FGD, Mukuru).*
- ⇔ *The issue of fathers 'baba kivuli – ako lakini hayuko' (absentee fathers) creates a problem in deciding on the name of the child...If you have a new husband, you may want to change the name of the child if he insists...he thinks he is the one taking care of the child (WDWs FGD, Korogocho).*

8. Low penetration of NHIF in informal settlements

The lack of physical offices and presence of NHIF in the informal settlements was attributed to the low enrolment rates and inadequate information. Although most FGDs participants had heard about NHIF through the media or friends, few had interacted with NHIF officials. Hence, NHIF needs to increase its presence in informal settlements. In this regard, NHIF is exploring the agency option (similar to agency banking) to increase presence in areas that are not close to NHIF offices or branches. The women also suggested that NHIF could use locals and informal networks to create awareness about NHIF and recruit in areas where NHIF officials may not reach.

> ⇔ *Registering through a group is better than joining as an individual... within a group people can make contributions consistently (WSSTs FGD, Kibera).*
>
> ⇔ *NHIF should get our own people here to recruit for them, like myself, I can become a community mobiliser and help to recruit. This is better than 'mtu wa suit' - NHIF officials. There is need for one-on-one engagement (WSSTs FGD, Kibera).*

Some women wished that registration process could be simplified.

> ⇔ *Registration process is complex. One is sent from office to office making the process difficult. This discourages community members from registering (WSSTs FGD, Kibera).*
>
> ⇔ *Will you to go look for NHIF to register or to look for work? NHIF should advertise so that we see the usefulness (WDWs FGD, Korogocho).*

To register through the groups, the officials are required to fill NHIF 33, and attach (i) a copy of Certificate of Registration/incorporation, and (ii) a copy of KRA Pin Certificate. The group is then issued with an NHIF Code as a group identifier.

9. Lack of incentives due to free medical services

Competing free medical services has created a lack of urgency in enrolling in NHIF. Donor funded free health services are available in some areas. In Kibera *Medicine San Frontiers* (MSF Belgium)[6] provides free medical services at Kibera South Clinic. In Mathare the

[6] http://www.msf.org/en/article/gallery-kibera-south-clinic-nairobi-kenya-one-year; http://www.msf-me.org/en/mission/in-the-field/msf-projects-world-wide/kenya-1.html

German Doctors[7] provide free medical services at *Baraka* Health Centre. Public health services are also perceived as being cheaper than NHIF.

> ⇔ *'In case of illness we seek treatment from Kwa Wanga (Kibera MSF). Treatment is free even for maternity. MSF will exit at the end of this year and we are worried because we do not know whether we will continue to get free services when the government takes over'.*
>
> ⇔ *'...there are hospitals which we attend that provide free medical treatment like MSF, SHOFCO and beyond Zero'*
>
> ⇔ *'I have not joined NHIF because it is cheap to get help from the council clinics.*

10. Lack of Clarity on NHIF Exemptions

There is lack of clarity on some eligibility requirements. The issue of declaring one spouse raised questions during the discussions. Some women noted that NHIF contravenes the 2010 constitution by not accepting declaration of more than one spouse as a beneficiary. Participants also wondered whether all children from the different unions can be added as beneficiaries, or whether it is only those of the declared spouse. Some also raised questions related on access to benefits after marriage dissolution. Again, a voluntary contributor may opt to stop paying. Discussions with NHIF officials indicated that the Children's Act protects children. Hence, it is an offence for parents to stop their children from accessing NHIF benefits after divorce. However, enforcing this is not within the mandate of NHIF. Nonetheless, there is provision within NHIF to change a spouse. One is required to complete the NHIF 26 amendment form and attach required documents.

The question of issuance and use of single card was raised. The women were unclear about the process of accessing services when the card is in custody of one member or spouse. Discussions with NHIF indicated that beneficiary details are stored in the NHIF system and that one is only required to provide their national ID to access services. Nonetheless, this lack of information can deter beneficiaries from seeking services.

The issue of extending coverage to illegible but dependents was raised. The women wondered whether NHIF could extend coverage to this category. This issue is not new. One

[7] http://www.germandoctorsnairobi.co.ke/

community based health insurance (*Afya Yetu*) offers an 'extended cover' health insurance for additional children. The primary contributor pays additional Kshs. 200 per child per year. This ensures inclusiveness.

11. Claims reimbursements challenges

The claims processing and reimbursements to health facilities presents challenges for NHIF. The hospitals present their claims to NHIF and once verified, NHIF submits them to the various County Governments for reimbursement. This is a deviation from the previous practice where NHIF reimbursed the hospitals directly. With the devolved system of government, health funds are managed Counties who also reimburse the health facilities. However, delays in reimbursements to health facilities have been reported. As noted, this may discourage facilities to offer services to NHIF clients. Hence, as noted by a key informant, there is to lobby County Governments and to use legislation to streamline payment of reimbursements or to revert reimbursements payment to NHIF. As noted *'it is better to ask for accountability at the facilities level, instead of subjecting them to financial strain'*.

3.1.3 Ongoing processes to address the identified policy and managerial challenges

There are efforts to extend social protection coverage within NHIF and at the national level.

1. Ongoing Efforts at the National Level

Social protection issues are covered within the '2011 Kenya National Social Protection Policy'[8] and through the '*2014 Draft National Social Protection Council Bill'*[9]. Part II, 3 (c) of the bill aims to ensure access to affordable healthcare, social security and social assistance. The Act seeks to establish a comprehensive framework for implementation of national social protection programmes[10] (5 'b'); and to provide support for individuals and households that have been socially excluded. Hence, the work of Oxfam and partners and that of NHIF, NSSF and MPP fits within the Act and the national policy framework.

[8] http://www.socialprotection.or.ke/images/downloads/kenya-national-social-protection-policy.pdf
[9] *The National Social Protection Council Bill, 2014*
[10] http://www.socialprotection.or.ke/

The government through the National Council for Social Protection (NCSP) provides access to supports social security programmes in partnership with NHIF. HISP programme beneficiaries (elderly persons, OVCs and PWSDs) can access non-contributory NHIF cover under the NSPC social protection pillar. At the time of conducting the study, enrolment of elderly persons had started. An estimated number of 2410000 OPCT beneficiaries had enrolled in NHIF scheme. The NCSP planned to have all the registered 323000 OPCTs enrolled in NHIF by end of June 2017. Thereafter, other HISP beneficiaries (OVCs and PWSDs) would be enrolled. Persons from informal settlements, and those in the *Wezesha* project, can access the non-contributory scheme if they are eligible. However, as noted by a key informant,

> '*There is need to strengthen informal sector schemes to move towards having universal schemes for the vulnerable', KII, NSPS.*

Another key informant noted,

> *'...children from informal settlements are vulnerable even when with both parents, yet they may not be included in the OVCs social assistance programme... (KII, ILO).'*

2. Rolling out Universal Free Maternity Cover

Free maternity cover has been fully taken up by NHIF. This means that WSSTs and WDWs can access free maternity cover even when they are not registered as NHIF members. The package is (at the time of data collection) being developed and funds for the programme would be provided by the Ministry of Health. However, delay in releasing the funds could affect implementation.

3. Expanding access to outpatient services

NHIF is working on expansion of accredited outpatient health facilities. Additional outpatient health facilities including level two (2) and three (3) health facilities are being reviewed for accreditation. At the time data collection, NHIF was pilot testing a biometric system which when rolled out, will allow members to access outpatient services from any service point, and hence improve access to services. NHIF received complaints that some members' names do not appear in the list of selected health facilities. To address this, NHIF requires members to fill the facility selection form, attach a copy of identification document and sign to ensure that selection is done by the member.

3.1.4 Policy Recommendations and Actions for Addressing Challenges and Enhancing Enrolment

1. Proposed Mandatory NHIF Cover

Given the direction that the government is taking towards providing social protection through HISP, there is need for inclusion of all individuals. The element of voluntary contribution should be revisited so that individuals who can afford to pay for insurance are compelled to do so. Kenya can learn from Rwanda how it has succeeded in rolling out universal health insurance coverage through community based systems. FGD participants in some of the groups suggested that the government could make NHIF mandatory for all persons. This could be implemented at birth, through schools or through other government service points. As noted,

> *'...it is important to work with teachers. Having NHIF could be passed as a law, to make contribution mandatory. The school teacher should confirm that the child has NHIF... (WSSTs FGD, Kibera)'*
>
> *'...NHIF should be integrated at birth so that everyone gets NHIF from birth...'*
>
> *...the importance of obtaining an NHIF card should be emphasized like that of a National Identity. Since the program is very helpful, there should be a law that compels people to join. For instance it could become a requirement for one to access other services e.g. driving license...'*

2. Improving Birth and Civil Registration Process

Improving access to birth registration documents is key. Hence, there is need for NHIF and stakeholders to work closely with the civil registration department. Within the informal settlements, joint birth registration and recruitment drives can be held by NHIF, *Wezesha Jamii* partners, civil registration department, local administration and children's department.

3. Providing an Extended Cover

NHIF together with partners can explore the issue of provision of an extended cover to ensure inclusion of all children in NHIF as mandated by Article 53. (1) of the 2010 Constitution which states that every child has a right to health care.

4. Increasing Enrolment through Groups

There is potential to increase enrolment of WSSTs and WDWs into NHIF through organised groups. There are advantages of registering through groups. First, the solidarity principle and desire to belong makes the members to honour their contributions. Hence, default rate may be lower. However, there are challenges related to groups' enrolment. First, group dynamics such as conflict among the members could affect contributions payment. Second, this may incur administrative costs.

5. Increasing Informal Sector Workers Representation

The issues and concerns raised by WSSTs and WDWs could be articulated and addressed if they are involved in decision making. However, most women do not belong to registered informal sector workers groups (Kamau et al., 2015). Some of the informal economy workers are represented at FKE like the *Matatu* Owners Association (MOA) but many are left out. Thus, there is therefore for the Micro and Small Enterprises Authority (MSEA) and associations of informal sector workers. The domestic workers are represented by *KUDHEIHA*. Nonetheless, the challenge with the domestic workers is that they are not organised into groups and they often have high turnover.

3.2 THE NATIONAL SOCIAL SECURITY FUND (NSSF)

3.2.1 Analysis of the NSSF

The National Social Security Fund (NSSF) was first established in 1966 under the NSSF Act Cap 258. It is reported that Kenya was the second country in African to establish NSSF as a form of social protection. According to the NSSF Act of 1965, NSSF was created to provide a secure future for Kenya in line with creating a just and equity society. At Independence in 1963, poverty, disease, and ignorance had been identified as the critical challenges facing the new nation of Kenya (Kenya, 1965). In response to these social challenges, NSSF was established to provide social security to working Kenyans. The NSSF from the time of establishment provided a platform for workers to make adequate contributions during their productive years to cater for their livelihoods in old age. The NSSF was established as a mandatory Social Security Provident Fund for working population particularly those in the formal employment. Then the NSST Act only covered workers in the formal economy and made benefits in lump sum.

From its establishment in 1966, the NSSF operated as a Department of the Ministry of Labour until 1987 when the NSSF Act was amended transforming the Fund into a State Corporation under the Management of a Board of Trustees. As per the objectives in 1966, the NSSF Act maintained NSSF as a mandatory national scheme whose main objective was to provide basic financial security benefits to Kenyan upon retirement. The Fund was set up as a Provident Fund providing benefits in the form of a lump sum.

In 2013, the NSSF Act of 1987 was repealed in order to align it to the Constitution of Kenya (Article 43(1)e and Article 21), Vision 2030, National Social Protection Policy of 2013, EAC Common Market Protocol and the 1952 Convention 102 of ILO (NSSF 2016). The NSSF Act No. 45 of 2013 received presidential assent on December 24, 2013 with an implementation date of January 10, 2014. It replaced the previous act implemented in 1965 and revised in 1987. One of the fundamental changes in the new Act was the establishment of a Pension fund and a Provident fund.[11] In addition, all Kenyans above 18 years of age and earning an income are eligible to join the scheme. The scheme provides benefits including old age

[11]The Pension Fund is mandatory and covers all workers in the formal economy. The provident fund is voluntary and covers the self-employed and those workers in the informal economy.

pension, injury and compensation, survival benefits, dependency pension for 5 years after death of a pensioner, disability pension (military only) and gratuities in the form of lump sums (Kenya, 2013). In other words, it NSSF was opened to serve all Kenyans irrespective of whether they are in the formal or informal sector employment. According to the Act of 2013, NSSF remains a government agency responsible for the collection, safekeeping, responsible investment and distribution of retirement funds of employees in both the formal and informal sectors of the Kenyan Economy. Participation for both employers and employees is compulsory. Under the NSSF Act, the pension fund would pay members monthly pensions, while the provident fund makes lump sum payments.

3.2.1.1 Enrolment/Recruitment NSSF Member

Registration or enrolment into the NSSF is mandatory for all employers and employees. Under section 19 of the NSSF Act, 'every employer who under a contract of service employs one or more employees shall register with the Fund as a contributing employer and shall, register his/her employee, as members of the Fund (Kenya, NSSF Act 2013). The Government is bound to ensure that all its employees both national and county are covered by the NSSF.

Those in self-employment may join the Fund as voluntary contributors. Therefore those in the informal economy and are self-employed are not obliged to join the Fund though they are encouraged. This somewhat creates room for the NSSF to compete with other private pension funds in attracting self-employed.

Contributory Mechanisms:

The NSSF pension monthly contribution is 12% of the pensionable wages made up of two equal portions of 6% from the employee and 6% from the employer subject to an upper limit of KES 2,160 for employees earning above KES 18,000. The employee contribution is drawn directly from his salary and wages while the employer's contribution comes directly from the employer.[12] Members can contribute above the 12% of their earnings the amount which is remitted to the Pension fund as voluntary contributions.

[12]These rates have not been implemented because of a pending court case by a group of employers and labour unions (Key Interview 24th October 2016)

The Act provides for two limits of contributors, the Lower Earnings Limit (LEL) which is KES 6,000 and the Upper Earning Limit (UEL) which is KES. 18,000. The contributions relating to the earnings below the LEL of the earnings (a maximum of KES. 720) is credited to what is known as a Tier I Account while the balance of the contribution for earnings between the LEL and the UEL (up to a maximum of KES 1,440) will be credited to what will be known as a Tier II account.

Employers with registered pension schemes are required apply to the Retirement Benefit Authority (RBA) for exemption from the contributing NSSF. This is not an automatic exemption as a thorough audit has to be conducted before the exemption is granted (Source: KII 9th October 2016).

Employers are required by law to submit accurate their returns to the NSSF including payments by the 15th day of the following month and to maintain proper and up-to-date records of employees earnings and particulars. Otherwise, they would be committing an offence which is chargeable in a court of law.

A voluntary contributor is required to make a minimum contribution of Kshs. 200 per month but ensure that they make a minimum contribution of Kshs. 4,800 per year to qualify for the benefits. Payments of less than or equal to 5,000 can be made via cash but any other amount has to be paid through NSSF M-PESA businesses number 333300. There are no penalties for late payment by voluntary contributors.

NSSF has 60 branches countrywide and also uses all the 42 Huduma Services. Therefore in total, a member can be served in about 102 branches country wide.

Mode of payment for employers include:-

a. Cheques
b. Bankers cheques
c. Real Time Gross Settlements (RTGS)
d. Electronic Funds Transfers (EFT)
e. Cash-subject to a maximum of Kshs. 5,000
f. Mobile phone application (since November 2016)

Voluntary contributions by members can be remitted through the following ways:

a. Cash-subject to a maximum of Kshs. 5,000
b. M-PESA Pay bill

Benefits Package (services):

The benefits that a member or their dependants get from NSSF include

1. Retirement Pension which is payable upon attainment of 60 years and retirement from gainful employment or when one opts for an early retirement at the age of 50 years and above.
2. Survivor's pension which is payable to the dependants upon the death of the member who had contributed for at least 36 monthly contributions immediately preceding the date of death. Those not meeting these requirements are paid a lump sum.
3. Invalidity Pension: Payable to a member who suffers physical or mental disability of a permanent, total incapacity as certified by a medical board and had contributed at least 36 monthly contributions immediately preceding the date of invalidity.
4. Funeral Grant: This is a Kshs. 10,000 payable to the dependants upon the death of the member who had contributed at least six monthly contributions immediately preceding the date of death. Applications must be submitted not later than 60 days from the date of death.
5. Emigration Benefit: This is payable to a member emigrating from Kenya to a country which is not a member state of the East African Community, without any intention of returning to reside in Kenya.

These benefits accrue from both the pension fund and the new provident fund.

3.2.2 Relevance and fit of the services offered by NSSF to the urban poor and vulnerable WDWs and WSSTs

3.2.3 Challenges that deter WSSTs and WDWs from enrolling NSSF

Challenges in Enrolling Women in Informal Settlements in the NSSF

The NSSF faces the following challenges in reaching out to members in the informal economy;

1. **Lack of awareness about NSSF**

There is a lot of information asymmetry among informal settlement residents about the NSSF. In several FGDs the participants asked us to explain what NSSF is. Most women in our FGDs indicated that the scheme was for those in the formal employment. The views obtained were for instance:-

> *'NSSF is for those who are employed in companies or in the government institutions... I thought it is for fulltime employees whose contributions are deducted directly from the payroll. For us without salaries, we are not sure whether to pay for contribution' (WDW, Mukuru).*

Most women were also not aware that there was a new NSSF Act which allowed self-employed persons to make contributions to the NSSF. It is therefore imperative that irrespective of what NSSF has been doing to increase its publicity; the impact has been very low among the women in the informal settlements. The women expressed need to be educated about NSSF so that they are able to decide on registration.

2. **Negative publicity past experience/myths**

In the past, NSSF was having very low public opinion because of poor performance. Even though NSS has reformed and become customer cantered most people especially those in the low income bracket hold on to the past negative experiences. According to one of the KII *"NSSF has gone through a huge transformation by ensuring all its systems are automated, but people still think of it in yester years when systems were manual"*. From our FGDs, many participants gave examples of people they saw sufferings after retirement as they were following their retirement benefits with NSSF. Some died before they could access their benefits and these experiences deterred many women from joining the scheme. Hence there is need for NSSF to increase educate the public about the New NSSF to change the negative perceptions. There is also need for more direct interaction with the public in order to boost their confidence in the scheme, including having onsite awareness and registration drives for the target women.

3. **High Cost of Premiums**

The monthly contribution by voluntary members amounts to Kshs. 400 per month. Most people in the informal settlements opined that the amount was quite high and therefore out of

reach for them in small businesses. Even those who may have registered while in employment, the moment they quiet employment they stopped contributing to this scheme. A WDWs FGD participant asked whether the little money they earned is what they were expected to contribute:-

> '*...hii kazi ya kufua ndio tutapeleka pesa kwa serikali? (This money that we earn by washing clothes. Is this what we are going to take to the government)? NSSF not helping us immediately'.*

4. **Retirement Age**

There was generally lack of clarity about the retirement age and when one can access their benefits. Some thought that the retirement age was 70, others 65, 60 and 50 years. Most women thought that the currently set retirement age of 60 years was too high. Some even indicated that life expectancy in Kenya is about 50 years. As such, they did not see the need to invest if the benefits would be left to their dependents only. They suggested that the retirement age for the informal sector people could be lowered to about 40-45, to encourage more informal sector workers to join the scheme. The participants noted for instance that:-

> *'...it would be better to reduce the age of receiving your contributions from 70 years to 55 years'.*

> Another participant in Korogocho noted:-
> *'...my children are my NSSF. I try to ensure that my children get good education. They will buy me land and take me home to retire there. If I am not able to pay for NHIF, can I pay for NSSF yet NHIF if more important? (WSST, Korogocho).*

5. **Tedious Process**

Most people including employers were of the opinion that registration process and paper work requirements were a deterrent to informal sector workers registration. The need to do monthly returns by employers even when they had one domestic worker was taking a lot of time. The issue of employer's enrolment of WDWs to NSSF as required by law has challenges. The requirement is that the employer should register with NSSF as an employer and get an employer's ID. Once is then required to make payments by the due date (9^{th} of every month) and late payments are penalised. Whereas this is necessary for administration

reasons, the procedures, which were described as cumbersome by one key informant, could deter employers from enrolling their employees. As noted,

> *'...there is an employer challenge in enrolling WDWs – i.e. one has to apply for an employer's number. The employer also has to make returns at NSSF (physically). This can be chaotic. There should be a way of making Mpesa remissions. Also, there is no feedback from NSSF and therefore no encouragement to make the contributions. The process is tedious and discouraging. Even when the employer has made the contributions, the worker has to go to NSSF to register...'*

6. **Fear of losing benefits and lack of knowledge on claims processing**

Most women were unaware about the claims processing procedures and several expressed fear of losing their benefits. Some cited cases of relatives who tried to get their benefits upon retirement but failed. Many questions were raised by the women who demonstrated lack of understanding about the benefits processing such as:-

> *What happens to one's pension benefits if one dies before the retirement age? Do the contributions earn interest? Is the process of getting the benefits difficult if your spouse dies? What happens if the next of kin is underage and the deceased spouse's sister or mother follow-up on the pension benefits, can they be issued to them?*

3.2.4 Ongoing processes and Possible Options to address the identified policy and managerial challenges

1. Targeted Informal Sector Workers Package

Despite the policy and legal reforms at the NSSF, the number of enrolled informal sector workers remains relatively low. Consequently, NSSF is considering a new product for the informal sector workers. The product will allow members who contribute to access some of their benefits in the short-term and the other portion in the long-term. This is because these members are always in need of money especially to meet their basic needs such as food and school fees. NSSF has no minimum contributions for the informal sector workers and each member save whatever amount they can afford to contribute each month. However, one has to make an annual contribution of Kshs. 4,800.

2. Flexible Remittances Methods

Currently, NSSF has made it easier for members to submit their contributions. However, the use of Mobile phone to remit is a new system and that cash payments would require a member to travel to the NSSF office. Some participants in the informal settlements indicated that they were not familiar with the M-pesa payment and therefore to them this was still not a good solution. Perhaps NSSF should consider having agents in the settlements where one can easily access to make payments.

3.2.5 Policy recommendations and actions for Strengthening WSSTs and WDW Enrolment and Retention in the Scheme

The scheme should consider the following in its effort to reach to the WSST and WDW in the informal settlements:

1. Education to members through media that is accessible to the informal settlement residents. The need for saving for old age seems not to get well among the residents in the informal settlements.
2. Need for awareness creation. At the moment there is a lot of information asymmetry about NSSF among the WSST and WDW in the informal settlement. This has resulted to negative publicity about the NSSF. There is need therefore to enhance public awareness to increase registration and retention.
3. NSSF should perhaps consider a special package for the informal settlement residents. This may be special by way of premiums, retirement age and access of their savings.
4. Low savings culture: In general terms the savings culture is low among Kenyans and more among the low income earners in the informal settlements.
5. There might be a need to introduce a flexible scheme for these workers whereby they can access part of their savings when calamities strike.
6. Given the huge number of informal sector workers, there is need to ensure that those in this sector are represented in the NSSF Board. At the moment, labour unions and employer federation may not be able to represent the informal MSE as well as WDW.

3.3 THE MBAO PENSION PLAN (MPP)

The *Mbao Pension Plan* also termed by some as *Mbao Mpango Poa* is a private contributory pension scheme. In most groups, the women had not heard about MPP. A few women in Mukuru, Korogocho and Kibera had joined MPP during the awareness creation forums and one had served as an agent of MPP. However, none were active members at the time of the interviews. They had joined during awareness creation. Although much is not known about MPP, those who had joined indicated that the contribution options are easy and through self-pay. One can register via mobile phone and also make their contribution and check balance. This was corroborated by the key informants as one of the benefits that MPP offers to its members.

3.3.1 Analysis of the NHIF healthcare scheme

The Mbao Pension Scheme (MPP) was launched on 28th June 2011 as a private pension scheme targeting the Medium and Small Micro Enterprises (MSMEs) sector. It was also conceptualized to help members of different *Jua Kali* Associations to save regularly to provide a long-term and reliable income when they retire from their businesses (Onyango, 2014). Before the MPP was launched, there was no pension scheme targeting the low income earners and unemployed, a gap that MPP was designed to fill. Initially, the Mbao Pension Plan's name was Blue Medium and Small Micro Enterprises Jua Kali Individual Retirement Benefit Scheme. The blue represented the colour of the Kshs 20 note. It changed to MPP when it was opened up to members of public besides the *Jua Kali* Association members.
Our interaction with stakeholders revealed that there are three institutions that were involved in the conceptualization of MPP namely the *Jua Kali* Association of Kenya, Eagle Africa Ltd and Retirement Benefit Authority (RBA). Apparently, all these three institutions claimed ownership of the idea to start MPP, but each appreciates role played by the other two institutions. There is no clarity in terms of who conceptualized and owns MPP.

In one of the discussions, we gathered that the MPP was set up by the *Jua Kali* Association, to serve its members only. To be registered as a member, one had to pay Kshs 100 as a membership to the *Jua Kali* Association. Later on, this became a deterrent as not every member of MPP member wanted to be a member of *Jua Kali* Association. It is upon this that

the Eagle Africa took over the ownership of MPP so as to open to the members of public. *Jua Kali* Association remained a sponsor of the scheme but it is owned by Eagle Africa. It was reported that Eagle African then approached RBA for buy-in and for marketing purposes. It is upon the request of Eagle Africa.

In another discussion we were informed that MPP was conceptualized at RBA to cater for the informal sector workers and self-employed persons. Because of conflict of interest as a regulator, RBA had to search for a company which would operate and manage the MPP. From the list of companies that tendered for this position, Eagle Africa qualified because it did not have a pension scheme like other insurance companies. Thus, Eagle Africa became the administrator of MPP while KCB (Kenya Commercial Bank) is the trustees and Cooperative Bank is the custodian of the scheme. During the conceptualization according to this source, the RBA contacted various stakeholders to sell the idea and this is how Jua Kali was contacted.

In another discussion, we were informed that *Jua Kali* Association is the one that conceptualized the MPP and still the legal owner of the scheme. It contracted Eagle Africa, to manage it for them given their experience in the insurance industry. In one of our visit to *Jua Kali*, we found a staff keying in data of MPP applicants into the computer, which we were informed would be then sent to Eagle Africa for management work. This again threw us off balance as to what kind of business relationship established MPP. Looking at all these, one can observe than there is a tussle in terms of who owns the scheme and how other key players are involved.

The MPP coverage is national with members scattered all over the country. However, Nairobi has the largest share of members. Data on MPP members is not assessed nor analysed but it is stored somewhere with the partners. The information from KII indicate that there could be between 170,000 - 700,000 enrolled members of MPP, but this is yet to be ascertained given that it is not very clear who keeps records of the members especially between the Eagle African and Jua Kali Association of Kenya. Of this number about 90% of members are from the informal economy. For this reason, MPP offers a good service to WSSTs and WDW. Most of the registered members are active while there are a few who have become dormant. Those who dropped out are mainly the ones who enrolled during awareness campaigns about Mbao – to test – but they did not continue to contributing. They may not have seen the need for saving for their old age. Although Eagle Africa has held a few AGMs, attendance is

normally low due to the scatteredness of its members. Even though it was initially meant for low income groups, it has opened up to cover other categories. At the time of data collection, we were informed that Eagle Africa was holding about Kshs 100 million worth of assets for MPP members.

From the KIIs, it was found that Eagle Africa is considered as the scheme administrator. It is in charge of taking information of members which includes keeping the membership records clear and up to date. It is also in charge of making sure pension scheme payments are done in time, and also ensure that contributions are rooted to the custodian. Cooperative Bank of Kenya is the custodian of the scheme. As a custodian, the bank oversees the general management of the pension scheme and also acts as the agent of the trustees (KCB). The custodian provides safe custody of the schemes assets and releases funds for investments to be made by the pension scheme on advice given by the trustees. KCB is the trustees of the scheme or what we can call the owner of the scheme. It ensures that investments are prudently done according to the investment policy of the scheme. Trustees are the owners of the MPP scheme and Eagle Africa works on instructions given by KCB. The RBA is the regulator of the MPP alongside all other pension schemes.

MPP is not regularly or aggressively marketed due to huge costs related with this venture. The most vibrant and effective advertisement for MPP was when RBA agreed to do the marketing. It is expensive to advertise. Eagle Africa identifies certain periods annually when it advertises through road shows to educate the public.

3.3.2 Enrolment/recruitment as MPP Members

Enrollment into MPP is easy as it is done from a mobile phone application. For one to register, they must be 18 years and above. The potential members give their detail through the mobile phone application. A member must pay at least Kshs 20 to become registered members. Upon registration, a member is expected to the MPP office to fill in a physical form that must cover details of the member and those of kin. It is possible to open an account for someone else but they must complete the physical form as well.

About the possibility of going online with the form, this is being explored, but some people may have difficulties in accessing the online platform. Therefore even if introduced, the

paper form would continue to be used Once a member is registered they can contribute any amount of money and on any intervals as long as it is Kshs 20 and above.

Retirement age is at 60 for MPP but one can continue to contribute even after attaining the retirement age. Pension meant to provide income after retirement. There is a grace period of 3 years when one cannot access their money in the MPP. After 3 years, partial withdrawal is allowed, but the member is expected to continue contributing. With partial withdrawal, one can withdrawal all the contribution plus interest but they remain as members. The withdrawal is NOT A LOAN as indicated by respondents during the FGDs.

3.3.3 Contribution Mechanisms

The Mbao Pension Plan utilizes mobile money transfer services to ensure wider coverage to workers in the informal sector. It is noted that Mbao Pension Plan is a voluntary contributory savings plan wherein individual workers choose the amount of their contributions subject to a minimum of Kshs. 20 per day.

The MPP targets people who can pay a minimum of Kshs 20 per day. The maximum contribution per day is as much as Mpesa can allow one to send. There is also use of Airtel Money and both work in the same way. MPP has made special arrangements with Safaricom (paybill unit), whereby Safaricom charges only Kshs 1 for any transaction to MPP. Payment is paid through 'LIPA NA MPESA' Paybill no. 710710; the Account number is the ID Number. Over and above the confirmation message from Safaricom, a member also gets a receipt acknowledgement from MPP. There is no minimum savings, and a member can save as much as they would like and in any intervals. When a member stays for a long time without transacting, he/she is sent a reminder.

3.3.4 Benefits Packages for MPP members

The main purpose for saving with MPP is to enable one save money for use in old age. As such, contributions grow with interest. MPP promises to give an interest rate of nearly 14% per annum which is computed on the amount of savings at the end of the year.

During the first three years, a member may not access his/her money but after that, one can access partial contributions (partial withdrawal). With partial withdrawal, one can access all the savings plus interest but they cannot overdraw the account.

MPP is flexible – one can access money before 50 years which is not the case with other pension schemes. There are no penalties for delayed remittances. Upon request or retirement, one can access their savings within a period of 14 days.

3.3.5 Challenges that deter WSSTs and WDWs from enrolling and remaining in MPP

There are some challenges that may hinder WSSTs and WDW to enrol in the programme. Some of these include:-

Ownership structure: The ownership structure is a bit confusing and muddled. From the analysis, we were not able to ascertain who owns the scheme and how different stakeholders participate. With the confusion around the ownership, potential members who are keen may find it challenging to join. A lot of people out there still think that MPP is a branch/department of RBA which is truly not the case.

Membership: Membership of MPP is not well known. While some stakeholders indicated that the programme had 170,000, others indicated 700,000. There is need to resolve this and have clear data that is analysed on regular basis to ascertain true members. Many people do not make an effort to fill manual registration forms after registering using mobile platform. This may mean that records that stakeholder have are not up to date.

Low Awareness: There is lack of information among informal settlement residents about the MPP. In several FGDs the participants asked us to explain what MPP is. Most women in our FGDs indicated that they had not heard about the MPP scheme. The views obtained were for instance:-

> *'I think Mbao refers to the seats we use at home made of wood. Mbao niliona kwa TV pekee' (WSST, Kibera).*

Most women were also not aware of MPP and even where their offices are and the procedure for registration. The women expressed need to be educated about MPP so that they are able to decide on registration.

Marketing: The marketing of MPP is low more so among the informal settlement workers. Given the low contributions by members and the need to keep MPP cheap, it was reported that it is tedious and cumbersome to have physical MPP offices in many places as this would require office space and personnel. At the moment, MPP depends on local media and road shows in its marketing process. According to one of the Key informant,

> *"Almost everyone has a mobile phone and the charges by Safaricom are relatively low at Kshs. 1 per transaction. This remains the most economical administrative process".*

Limitation by Use of Mobile Applications: The MPP assumes that all people have an access to a phone that is USSD enabled, and that members of public are able to use the phone to enrol and remit their contributions. This may not necessarily apply among all residents WSSTs and WDW in the informal settlements. The use of mobile platform may deter enrolment of persons from the informal economy.

3.3.6 Ongoing Reform Processes to address identified policy and managerial challenges in MPP

The programme is relatively new having been in existence for the past 5 years. It is therefore still going through the teething problems. The scheme targets to reach all the 12 million people in the informal economy as opposed to competing with the other schemes that target people in the formal economy. About the possibility of going online with the form, this is being explored, but some people may have difficulties in accessing the online platform. Therefore even if introduced, the paper forms would continue to be used. Members get SMS reminders to make contributions.

3.3.7 Policy recommendations and actions for Improving the Scheme

The MPP has been in existence for the past 5 years. It has demonstrated tremendous growth in terms of membership and asset. The Scheme targets low income earners and those in the informal economy. For this scheme to serve the clientele better there is need for:-

1. Ensure that records about membership and their status are well kept and managed. It should be noted that currently, no one seems to know how many people are registered for the scheme and where they are located.

2. There is need to clear the aspect of ownership and the roles played by different stakeholders. There is contention between RBA, Eagle Africa and Jua Kali Association in terms of ownership. If this tussle reaches members, there could be mass exodus among currently registered members who may have a different perception about ownership.
3. There is need for aggressive marketing especially among the informal settlement residents.

KEY FINDINGS AND RECOMMENDATIONS

Summary of Findings and Conclusions

The study covered two public schemes (NHIF and NSSF) and one private pension scheme (MPP). The following are summary results. The following are key findings and conclusions.

1. There was very low awareness among the target women about the various schemes. Many however expressed desire to learn more and join the schemes but cited some limitations.
2. Financial limitations and lack of necessary registration documents (in the case of NHIF) created barriers for the target women.
3. The high premium rates and possible enrolment to multiple schemes limited the women's enrolment. However, the greatest challenge was inadequate information about the benefits packages and their value.
4. The different schemes offered flexible contribution remittance options. However, many women lacked awareness and therefore had not taken advantage of them.
5. There is low presence of the various schemes in the informal settlements and low penetration rates. This was attributed to lack of physical offices in the various sites.
6. Negative perceptions and apathy about the schemes. There were negatives perceptions about the schemes that were based on experiences of the women or their relatives. These were related to denial of access to services and failure by the schemes to pay benefits and claims.
7. There are ongoing efforts to expand social protection coverage. In addition to the HISP programme, the NCSP and NSPS are developing a national data base of vulnerable individuals. This data could be complemented and harmonised with membership data from the various schemes and used for evidence based decision making.

Recommendations for Policy and Interventions

1. The various schemes should address information gaps about the schemes. Public awareness and education forums should be organised as well as targeted initiatives. Awareness creation should include enrolment drives for members who wish to join the schemes. The education forums should address the negative public perceptions about the schemes. The schemes should be transparent so as to build public confidence.
2. There is need for the schemes to address the issue of premiums and educate the public about the premiums and benefits package value.
3. There is need to address the challenge of accessing birth certificates and other registration documents. This requires working closely with the civil registration departments. Practical steps (and where necessary legislation) should be taken to address the gap between obtaining birth notification and birth certificates, and other identified barriers.
4. The government jointly with the various schemes and stakeholders should address the issue of multiple memberships to different schemes. Whereas each scheme operates independently, there may be need to develop a joint package for members who wish to join two or more schemes and have the contributions remitted jointly as it is done with the formally employed.
5. Information about the flexible remittance options should be shared widely. This should be supported with research to determine what options are preferred and why, and what works best for informal economy workers.
6. The schemes should increase their presence and penetration in informal settlements. The use of agency systems, local mobilisers should be explored and enhanced.
7. There is need for continuous data gathering. Socio-economic data on incomes and vulnerability levels should be routinely obtained and shared amongst the relevant schemes and stakeholders and used to inform decision making.

Table 3: Characteristics of FGD participants

Characteristic	**Response**	**WSSTs**		**WDWs**	
		Frequency	**Percentage (n=103)**	**Frequency**	**Percentage (n=96)**
Study Site	Kibera	29	28.2	17	17.7
	Mukuru	27	26.2	24	25.0
	Mathare	27	26.2	34	35.4
	Korogocho	8	7.8	11	11.5
	Kawangware	12	11.7	10	10.4
Age in years	16-20	3	2.9	4	4.2
	21-30	36	35.0	46	47.9
	31-40	31	30.1	30	31.3
	41-50	22	21.4	11	11.5
	51and Above	9	8.7	5	5.2
	Missing	2	0.2	-	-
Marital Status	Single	26	25.2	42	43.8
	Married	59	57.3	35	36.5
	Widowed	8	7.8	8	8.3
	Separated			1	1.0
	Divorced	1	1.0	7	7.3
	Missing	9	8.7	3	3.1
Highest Level of Education	No Schooling	6	5.8	3	3.1
	Some Primary	18	17.5	26	27.1
	Completed Primary	28	27.2	25	26.0
	Some Secondary	20	19.4	25	26.0
	Completed Secondary	28	27.2	15	15.6
	College	1	1.0	2	2.1
	Missing	2	1.9		
Are you a currently registered member of NHIF?	Yes	25	24.3	16	16.7
	No	78	75.7	80	83.3
If No, have you ever been a member of NHIF?	Yes	22	21.4	7	7.3

	No	67	65.0	81	84.4
	Missing	14	13.6	8	8.3
If Yes, who is the primary contributor	Self	9	8.7	8	8.3
	Spouse	15	14.6	6	6.3
	Cash Transfer OVC			1	1.0
	Inuka Kenya	1	1.0		
	Not Active			1	1.0
	Missing	3	2.9		
	N/A	75	72.8	80	83.3
Are you a currently registered member of NSSF?	Yes	10	9.7	12	12.5
	No	93	90.3	84	87.5
If No, have you ever been a member of NSSF	Yes	11	10.7	7	7.3
	No	84	81.6	82	85.4
	Missing	8	7.8	7	7.3
If Yes, who is the primary contributor	Self	4	3.9	8	8.3
	Spouse	6	5.8	3	3.1
	Not Active			1	1.0
	Green World Clinics	1	1.0		
	Missing	4	3.9		
	N/A	88	85.4	84	87.5
Are you a currently member of Mbao Pension Scheme?	Yes	9	8.7	3	3.1
	No	92	89.3	93	96.9
	Missing	2	1.9		
If No, have you ever been a member of Mbao Pension Scheme	Yes	4	3.9	2	2.1
	No	91	88.3	93	96.9
	Missing	8	7.8	1	1.0
If, yes who is the primary contributor	Self	5	4.9	2	2.1
	Spouse	4	3.9		
	Missing	5	4.9	1	1.0
	N/A	89	86.4	93	96.9

Table 4: Summary of NHIF Benefits Package

1.	IN-PATIENT COVER *(AFUENI COVER)*
	• Consultation • Hospital accommodation (bed charges) • Nursing care • Prescribed diagnostic laboratory or other medically necessary services • Physician's, surgeons, anaesthetists or physiotherapists fees • Operating theatre charges • Specialist consultations/visits • Prescribed drugs/medications and dressings
2.	OUT-PATIENTCOVER *(MZALENDO* COVER*)*
	• General consultation • Diagnosis and treatment of common ailments, prescribed laboratory and x-ray investigation services • Prescribed drugs administration and dispensing • Management of chroninc ailments (HIV/AIDS, diabetes, asthma, hypertension, cancer) • Health and wellness education/healthcare counseling i.e. screening for conditions e.g. cervical and prostate cancer • Treatment of sexually transmitted diseases • Minor surgical services • Family planning, midwifery, ante-and-post-natal services • Referral for specialized services • Renal dialysis
3.	ONCOLOGY
	RADIOTHERAPY • Covers up to 20 sessions at an approved rate of KES 3,600 per session (KES 18,000) per week • Additional cycles subject to review by committee and members cover balance
4.	*Radiotherapy services*
	• Radiotherapy planning • Investigations • Administration of treatment • Management of neutropenia
5.	CHEMOTHERAPY SERVICES
	• Treatment planning • Anti-cancer (cytotoxic) drugs – oral and injectables • Anti-emetics • Aprepitants • Management of neutropenia • Pre-chemotherapy investigations
6.	Dialysis
	• As per the benefits package for approved level of care. • Reimbursed up to a maximum of up to KES 9,500, twice a week.
7.	Kidney Transplant
	• Benefits package for approved level of care (V and VI) • Reimbursed up to a maximum of KES 500,000
8.	Free Maternity Package
	• Managed programme • In Phase I of the program (up to December 2016), only delivery shall be covered. Other benefits shall accrue from phase II

	• All pregnant women who are Kenyan citizens, without any form of insurance
9.	Surgical package
	• To be administered under three categories vide: • Minor (level III and above) • Major and (level III and above) • Special packages (Level V & VI) • All surgeries shall be subject to pre-authorisation
10.	Chronic disease management
	• Covers DM and Hypertension • Capitation at KES 5,000 per beneficiary per year for each case • Accessible in level IV and above • Domiciled to government hospitals and a few mission contract **B hospitals** in the beginning
11.	Other packages
	• Maternity • Rehabilitation • Specialized laboratory • Open Heart Surgery (a one off program)

APPENDICES

Appendix 1: Copy of Research Permit

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone: +254-20-2213471,
2241349, 3310571, 2219420
Fax: +254-20-318245, 318249
Email: dg@nacosti.go.ke
Website: www.nacosti.go.ke
When replying Please quote

9th Floor, Utalii House
Uhuru Highway
P. O. Box 30623-00100
NAIROBI-KENYA

Ref: No. **NACOSTI/P/16/6318/13406**

Date: **16th September, 2016**

Dr. Anne Wairimu Kamau
University of Nairobi
P.O. Box 30197-00100
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Urban policy brief development: Policy briefs on NHIF Health Scheme and NSSF and MPP Pension Schemes,"*** I am pleased to inform you that you have been authorized to undertake research in **Nairobi County** for the period ending **6th September, 2017.**

You are advised to report to **the Principal Secretaries of selected Ministries, the Chief Executive Officers of selected government agencies, the County Commissioner and the County Director of Education, Nairobi County** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

BONIFACE WANYAMA
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The Principal Secretaries
Selected Ministries.

The Chief Executive Officers
Selected government agencies.

National Commission for Science, Technology And Innovation is ISO 9001:2008 Certified

The County Commissioner
Nairobi County.

The County Director of Education
Nairobi County.

Appendix 2: Data Collections Tools

POLICY BRIEFS ON NHIF, NSSF AND MPP PENSION SCHEMES

OXFAM –GB, SITE Enterprise Promotion, NOPE and Youth Alive Kenya

---

FGD Registration Form

1. Name: …….
2. Telephone Number: ……..
3. Age: …….
4. Marital Status: …….
5. Name of the Group (if any): ……..……
6. Highest Level of Education: ……..……
7. Occupation: ……..
8. Study Site: …….. Ward …… Village……
9. Business Type ……..…….
10. Business Location: ……..
11. Are you a currently registered member of NHIF? (1) Yes (2) No
12. If NO, have you ever been a member of NHIF (1) Yes (2) N0
13. Are you a currently registered member of NSSF? (1) Yes (2) No
14. If NO, have you ever been a member of NSFF (1) Yes (2) N0
15. Are you a currently registered member of Mbao Pension Scheme? (1) Yes (2) No
16. If NO, have you ever been a member of Mbao Pension Scheme (1) Yes (2) N0

POLICY BRIEFS ON NHIF HEALTH SCHEME, NSSF AND MPP PENSION SCHEMES

Researchers: Dr. Anne Kamau and Dr. Paul Kamau,
Institute for Development Studies (IDS), University of Nairobi
Tel. 0711-966332, 0722-970366; Email: anne.kamau@uonbi.ac.ke; pkamau@uonbi.ac.ke
Oxfam: Michael Juma Tel. 0720-716021, Email: MiJuma@oxfam.org.uk

---

INTERVEIW GUIDE FOR NHIF

Name of Organisation:..... Respondent unit/department:.....
Respondent details:..... ..... Respondent designation:.....
Data of Interview:..... Start time:..... End time:.....

Preliminary information

Dr. Anne Kamau and Dr. Paul Kamau are undertaking a study of the National Hospital Insurance Fund (NHIF), National Social Security Fund (NSSF) and the Mbao Pension Plan (MPP) on behalf of Oxfam Kenya, Youth Alive Kenya (YAK), SITE Enterprises Promotion (SITE EP) and NOPE which are implementing a women empowerment project known as *Wezesha Jamii project*. We have selected you for this interview because of your key role in this scheme (state position.....). This study is part of *Wezesha Jamii* project whose target beneficiaries are women small scale traders (WSSTs) and women domestic workers (WDWs) being implemented in five informal settlements namely Kibera, Mukuru, Mathare, Korogocho and Kawangware in Nairobi County. This project seeks to engage with policy and decision makers at the national and county level and link them with implementation work of the partners mainly the Wezesha Jamii project target groups. The information which you share with us is going to be treated with confidentiality and will be used only for the purpose of this study. The results are intended to inform and address policy and administrative issues with the respective service schemes in order to encourage WSSTs and WDWs to enrol and sustain their membership with your scheme. Once the research is completed, Oxfam and partners with our support will organize a dissemination and validation meeting to communicate the findings and recommendations and receive input from other stakeholders.

SECTION A: BRIEF ON NHIF
1. What is the coverage of NHIF country-wide?
2. What proportion (estimates) of NHIF Members are informal sector workers? *Probe for audit of who is enrolled and who is not.* • *Has there been any study to document this?* • *Is there deliberate policy or action to register informal sector workers?* • *Which ones or how if yes?*
3. Linkage of this scheme with the informal economy (poor and marginalised)
SECTION B: RECRUITMENT OF INFORMAL SECTOR WORKERS TO THE SCHEME AND BENEFITS PACKAGE
Enrolment/Recruitment
4. How does your scheme create public awareness on existence of the fund and how is this done?
5. What strategies are used (are in process) to enrol informal sector workers into NHIF? *Probe for strategies to increase coverage in informal settlements.* • What efforts/approaches have worked best and how were they implemented? Cite specific examples/best practices.
Contributory Mechanisms
6. What contributory mechanisms/options are used (in existence) for informal sector workers (including WSSTs and WDWs)?
7. Are there any special considerations/exemptions for certain individuals/groups? *(Probe for subsidies, direct and indirect exemptions for the poor and marginalized groups)* ***Probe*.***

Benefits Package (services)
8. What packages does the scheme provide to informal sector workers and other poor and marginalized groups (e.g. WSSTs and WDWs)? Probe for specific services or benefits in the urban informal settlements? *(Probe for outpatient, in-patient, special groups, maternity cover)* ***Probe*.***
9. How are the different services (benefit packages) provided in the informal settlements where majority of the informal sector workers live? *(Probe for proximity, access to the services, and availability of accredited health facilities for out-patient etc).*
10. What can limit (prevent) an enrolled member (including informal sector workers) from accessing the NHIF services? ***Probe*.*** • *Under what circumstances would your institution deny them the services e.g. failure to pay monthly contribution*
11. What reimbursements models are you using to pay the service providers and how do they support provision of services in poor areas where informal sector workers are likely to be?
SECTION C: CHALLENGES IN RETAINING WSST'S AND WDW'S IN THE SCHEME
12. How successful has NHIF been in enrolling and retaining informal sector workers in the scheme. *What has contributed to this success or failure?*
13. What challenges (if any) does NHIF experience in enrolment and retention of informal sector workers? (*Probe for contributors, institutional challenges; separately for WSSTs & WDWs).* ***Probe****
14. Please tell us about some of the factors which may discourage informal sector workers in retaining their membership in your scheme? ***Probe**** • *Have there been efforts to address these challenges and with what success?*
15. Suggest specific recommendations and actions that can be taken to make NHIF attractive to WSSTs and WDWs in the informal settlements. ***Probe and cite examples****
SECTION D: POLICY RECOMMENDATIONS AND ACTIONS FOR STRENGTHENING WSST's AND WDW's ENROLMENT AND RETENTION IN THE SCHEME
16. In your assessment, what would you consider to be the Best practice and model in Africa or world with regards to Health Insurance?
17. Are there any ongoing policy reforms or processes of the NHIF aimed at the existing challenges in order to improve the services to informal sector workers (including WSSTs and WDWs) coverage and what is the status (explain)? ***Probe and cite examples* (Senate Bill, Parliamentary Bills etc)***
18. Is there anything else that you would like to share with us?
Thank you for your time

POLICY BRIEFS ON NHIF HEALTH SCHEME, NSSF AND MPP PENSION SCHEMES
PROBING GUIDE FOR NHIF INTERVIEWS

No.	Question	Probing Guides
5	Are there any special considerations/exemptions for certain individuals/groups?	a. Subsidies e.g. targeting informal sector workers (including WSSTs and WDWs) b. Direct exemptions e.g. for persons with disability, the poor, the aged and whether WSSTs and WDWs are included here. c. Indirect exemptions e.g. covering children below 18 years and whether and how WSSTs and WDWs can benefit from these. etc
6	What benefits packages does the scheme provide to informal sector workers (WSST and WDWs)? Probe for specific services in the urban informal settlements.	a. In-patient benefit package b. Out-patient benefit package c. Special/additional services e.g. theatre, caesarean sections? d. Special groups e.g. elderly persons e. Maternity cover etc
8	What can limit (denial) an enrolled member (including informal sector workers) from accessing the services? *Probe**.	a. Default in making contributions b. Lack of information about available services and where to access them c. Missing records in the NHIF systems e.g. not updated or in the selected facility Beneficiary leaving away from dependents and preference to cover the dependents d. Lack of accredited health facility close to residence/work place e. Moving to a new area away from the selected facility f. Family issues e.g. primary contributor defaulting; divorce/separation g. Work constraints /employer restrictions especially for WDWs
11	What challenges (if any) does NHIF experience in enrolment and retention of informal sector workers	Probe for challenges with contributors, institutional challenges; (separately for WSSTs and WDWs) a. Institutional challenges e.g. location of NHIF offices b. Policy-related challenges (explain) e.g. high premium rates, delay in approval and passing of bills in parliament etc. c. Resistance from external forces e.g. workers union etc. d. Negative publicity about the management of the scheme e. Reluctance by partner organisations e.g. accredited health facilities in the case of NHIF to recruit members. f. Lack of information about the scheme and the benefits package g. Competition with other schemes e.g. NHIF versus NSSF/MPP and vice versa h. Eligibility/statutory requirements e.g. National ID, birth certificate; marriage certificate; 2nd marriage; children of minors. i. Members individual challenges - fear of default; family issues e.g. women unable to make decision to join, spousal refusal etc.
12	Please tell us about some of the factors which may discourage informal sector workers in retaining their membership in the scheme?	a. Group conflicts if members are enrolled as a group (group dynamics). b. Withdrawal due to perceptions about quality of service/benefits restrictions (explain) c. Restrictions based on benefits coverage e.g. package does not permit access to certain services (explain). d. Financial challenges due to competition for enrolment with other schemes. e. Poor services. f. Lack of comprehensive cover. g. Stringent conditions that do not provide for grace period for default.
13	Suggest specific recommendations and actions that can be taken to make NHIF attractive to WSSTs and WDWs in the informal	a. Political statements to boost enrolment versus political commitment and policy b. Twin card ownership so that WSST's and WDW's can continue to use NHIF services when they give their cards to their

	settlements.	spouses/children are living away from them. c. Providing under-five services close to the business locations of the WSSTs. d. Reviewing the policy on selection of accredited health facilities to permit for selection of two or more facilities in different areas e.g. at place of residence or work place; in a rural and urban setting. e. Including informal sector workers in decision making on issues affecting them f. And any other.
14	Are there any ongoing policy reforms or processes of the NHIF aimed at improving informal sector workers (including WSSTs and WDWs) enrolment and retention and what is the status (explain)?	a. Efforts to identify and contract more private health facilities to improve provision of outpatient services. b. Inclusion of maternity services within the out-patient and in-patient cover. c. Pending bill on non-communicable disease aimed at increasing range of diseases covered by NHIF. d. Martial law in case of 2nd marriage e. Law on eligibility e.g. age of maturity versus mature minor.

POLICY BRIEFS ON NHIF HEALTH SCHEME, NSSF AND MPP PENSION SCHEMES

Researchers: Dr. Anne Kamau and Dr. Paul Kamau,
Institute for Development Studies (IDS), University of Nairobi
Tel. 0711-966332, 0722-970366; Email: anne.kamau@uonbi.ac.ke; pkamau@uonbi.ac.ke
Oxfam: Michael Juma Tel. 0720-716021, Email: MiJuma@oxfam.org.uk

---

INTERVEIW GUIDE FOR NSSF AND MPP

Name of Organisation:..... Respondent unit/department:.....
Respondent details:..... ..... Respondent designation:.....
Data of Interview:..... Start time:..... End time:.....

Preliminary information

Dr. Anne Kamau and Dr. Paul Kamau are undertaking a study of the National Hospital Insurance Fund (NHIF), National Social Security Fund (NSSF) and the Mbao Pension Plan (MPP) on behalf of Oxfam Kenya, Youth Alive Kenya (YAK), SITE Enterprises Promotion (SITE EP) and NOPE which are implementing a women empowerment project known as *Wezesha Jamii project*. We have selected you because of your key role in this scheme (state position.....). This study is part of *Wezesha Jamii* project whose target beneficiaries are women small scale traders (WSSTs) and women domestic workers (WDWs) being implemented in five informal settlements namely Kibera, Mukuru, Mathare, Korogocho and Kawangware in Nairobi County. This project seeks to engage with policy and decision makers at the national and county level and link them with implementation work of the partners mainly the Wezesha Jamii project target groups. The information which you share with us is going to be treated with confidentiality and will be used only for the purpose of this study. The results are intended to inform and address policy and administrative issues with the respective service schemes in order to encourage WSSTs and WDWs to enrol and sustain their membership with your scheme. Once the research is completed, Oxfam and partners with our support will organize a dissemination and validation meeting to communicate the findings and recommendations and receive input from other stakeholders.

SECTION A: BRIEF ON NSSF/MPP
1. What is the coverage potential of NSSF/MPP country-wide?
2. What proportion (estimates) of NSSF/MPP Members are informal sector workers? *Probe for audit of who is enrolled and who is not. Has there been any study to document this?*
3. Linkage of this scheme with the informal economy (poor and marginalised)
SECTION B: RECRUITMENT OF INFORMAL SECTOR WORKERS TO THE SCHEME AND BENEFITS PACKAGE
Enrolment/Recruitment
4. How does your scheme create public awareness on existence of the fund and how is this done?.
5. What strategies are used (are in process) to enrol informal sector workers into NSSF/MPP? *Probe for strategies to increase coverage in informal settlements.* • What efforts/approaches have worked best? Cite specific examples/best practices.
Contributory Mechanisms
6. What contributory mechanisms/options are used for informal sector workers (including WSSTs and WDWs)?
7. Are there any special considerations/exemptions for certain individuals/groups? *(Probe for subsidies, direct and indirect exemptions).*
8. Does the scheme provide regular statements to members especially the informal sector workers to update them on the status of their contributions? *Explain how this is done.*
Benefits Package (services)
9. What benefits packages does the scheme provide to informal sector workers (WSSTs and WDWs)? *Probe separately for NSSF and MPP*

10. How do you ensure access of retirement benefits after retirement/death of informal sector workers in poor settlements?
11. What can limit (prevent) a retired members (of family after death of member) from accessing pension benefits? *Probe for the reasons.*
12. Can informal sector contributors to use their pension contributions as collateral in accessing financial loans? *Probe whether this possibility can be considered?*
13. Is there an avenue or plan for members to access their contributions before they attain retirement age? 60 or 65?
SECTION C: CHALLENGES IN RETAINING WSST'S AND WDW'S IN THE SCHEME
14. How successful has NSSF/MPP been in enrolment and retaining informal sector workers in the scheme. *What has contributed to this success or failure?*
15. What challenges (if any) does NSSF/MPP experience in enrolment and retention of informal sector workers? (*Probe for contributors, institutional challenges; separately for WSSTs & WDWs)*
16. Please tell us about some of the factors which may discourage informal sector workers in retaining their membership in the scheme? • *Have there been efforts to address these challenges and with what success?*
17. In your assessment, what would you consider to be the Best practices and models in Africa and world with regards to Pension Schemes?
18. Suggest specific recommendations and actions that can be taken to make NSSF/MPP attractive to WSSTs and WDWs in the informal settlements. *Probe and cite examples**
SECTION D: POLICY RECOMMENDATIONS AND ACTIONS FOR STRENGTHING WSST'S AND WDW'S ENROLMENT AND RETENTION IN THE SCHEME
19. Are there any ongoing policy reforms or processes of the NSSF/MPP aimed at improving informal sector workers (including WSSTs and WDWs) coverage what is the status (explain)? *Probe and cite examples**
20. Is there anything else that you would like to share with us?
Thank you for your time

POLICY BRIEFS ON NHIF HEALTH SCHEME, NSSF AND MPP PENSION SCHEMES

Researchers: Dr. Anne Kamau and Dr. Paul Kamau,
Institute for Development Studies (IDS), University of Nairobi
Tel. 0711-966332, 0722-970366; Email: anne.kamau@uonbi.ac.ke; pkamau@uonbi.ac.ke
Oxfam: Michael Juma Tel. 0720-716021, Email: MiJuma@oxfam.org.uk

---

INTERVEIW GUIDE FOR NATIONAL AND COUNTY GOVERNMENT OFFICIALS; NON-STATE ACTORS AND COMMUNITY LEADERS

Name of Organisation:..... Respondent unit/department:.....
Respondent details:..... ..... Respondent designation:.....
Data of Interview:..... Start time:..... End time:.....

Preliminary information

Dr. Anne Kamau and Dr. Paul Kamau are undertaking a study of the National Hospital Insurance Fund (NHIF), National Social Security Fund (NSSF) and the Mbao Pension Plan (MPP) on behalf of Oxfam Kenya, Youth Alive Kenya (YAK), SITE Enterprises Promotion (SITE EP) and NOPE which are implementing a women empowerment project known as *Wezesha Jamii project*. We have selected you because of your key role in this organisation (state position.....). This study is part of *Wezesha Jamii* project whose target beneficiaries are women small scale traders (WSSTs) and women domestic workers (WDWs) being implemented in five informal settlements namely Kibera, Mukuru, Mathare, Korogocho and Kawangware in Nairobi County. This project seeks to engage with policy and decision makers at the national and county level and link them with implementation work of the partners mainly the Wezesha Jamii project target groups. The information which you share with us is going to be treated with confidentiality and will be used only for the purpose of this study. The results are intended to inform and address policy and administrative issues with the respective service schemes in order to encourage WSSTs and WDWs to enrol and sustain their membership with your scheme. Once the research is completed, Oxfam and partners with our support will organize a dissemination and validation meeting to communicate the findings and recommendations and receive input from other stakeholders.

	QUESTION
1.	How well are your workers/members covered by NHIF, NSSF and MPP? *Probe for coverage proportion versus potential.*
2.	Which services do you and your staff/members get from NHIF, NSSF and MPP and how well do they serve the needs of your workers/members?
3.	What are the main strengths/successes of these schemes (NHIF, NSSF and MPP) that make them attractive to your workers/members beyond the legal requirements? *Probe for enrolment and retention issues. Cite specific examples /best practices.*
4.	What challenges/problems do your workers/members face with the schemes face (NHIF, NSSF and MPP) that make them unattractive to them? *Probe for enrolment and retention of informal sector workers?*
5.	Have there been attempts in the past to address these challenges/problems and what has been success? • What else should be done to address the challenges/problems to make these schemes more attractive to your workers/members?
6.	What role(s) does your department/organisation play in supporting NHIF/NSSF/MPP? *Probe for– legislation, policy and decision making issues*
7.	Is there anything else that you would like to share with me regarding any of the issues that we have talked about?
	THANK YOU FOR YOUR TIME

POLICY BRIEFS ON NHIF HEALTH SCHEME, NSSF AND MPP PENSION SCHEMES

Researchers: Dr. Anne Kamau and Dr. Paul Kamau,
Institute for Development Studies (IDS), University of Nairobi
Tel. 0711-966332, 0722-970366; Email: anne.kamau@uonbi.ac.ke; pkamau@uonbi.ac.ke
Oxfam: Michael Juma Tel. 0720-716021, Email: MiJuma@oxfam.org.uk

---

FOCUS GROUP DISCUSSON GUIDE FOR WSST'S/WDW'S

Village:..... Location:.....
Participants & details (complete bio-data sheet):.....
Data of Interview:..... Start time:..... End time:.....

Preliminary information

Dr. Anne Kamau and Dr. Paul Kamau are undertaking a study of the National Hospital Insurance Fund (NHIF), National Social Security Fund (NSSF) and the Mbao Pension Plan (MPP) on behalf of Oxfam Kenya, Youth Alive Kenya (YAK), SITE Enterprises Promotion (SITE EP) and NOPE which are implementing a women empowerment project known as *Wezesha Jamii project.* We have selected you because you are an WSST's/WDW in this area. This study is part of *Wezesha Jamii* project whose target beneficiaries are women small scale traders (WSSTs) and women domestic workers (WDWs) being implemented in five informal settlements namely Kibera, Mukuru, Mathare, Korogocho and Kawangware in Nairobi County. This project seeks to engage with policy and decision makers at the national and county level and link them with implementation work of the partners mainly the Wezesha Jamii project target groups. The information which you share with us is going to be treated with confidentiality and will be used only for the purpose of this study. The results are intended to inform and address policy and administrative issues with the respective service schemes in order to encourage WSSTs and WDWs to enrol and sustain their membership with your scheme. Once the research is completed, Oxfam and partners with our support will organize a dissemination and validation meeting to communicate the findings and recommendations and receive input from other stakeholders.

	QUESTION
Entry questions	
1.	Please tell us more about yourself and your business/work?
2.	Are you and those you know aware about the public health insurance/pension schemes and whether there are any that target informal sector workers? *Probe about NHIF/NSSF/MPP*
Members	
3.	What motivated and other members of the schemes you to join and how did you join? • Probe for access to information about the scheme • Reasons for joining and how this was done • Method of joining (individual, group, spouse etc)
4.	How do you and other members of these schemes known to you make their contributions to the scheme NHIF and is this method suitable for informal sector workers? Probe for paying to the respective offices, mpesa, bank direct payments, contributions through groups etc. • Have you experienced any challenges in making contributions and how have you addressed them if any?
5.	How have you and members of the schemes you know benefited from the services they provide? • *Probe for provision of quality services and aspects that make the schemes attractive*
6.	What are the major success (or what works well) with you as far as these schemes are concerned?
7.	Have you or any of your family member or any person known to you experienced challenges in using the NHIF/NSSF/MPP services and why? • *Probe for challenges in enrolment, accessing services, inclusion of family members, making contributions, membership cards, identification of health facilities, etc.*
Non-members	

8.	If you have not joined, why is this so? How did you learn about the scheme? *Probe for knowledge about the schemes, eligibility requirements, distance to services, financial issues, work limitations etc.*
All	
9.	What is the one thing that must be done for you to join or retain membership in the schemes and which if not done you would not join the schemes or consider withdrawing your membership (NHIF, NSSF, MPP)
10.	What (else) should be done to make the schemes attractive to informal sector workers in this area?
11.	Is there anything else that you would like to share with us regarding any of the issues that we have talked about?
THANK YOU FOR YOUR TIME	

ENDNOTES

[1] Muiya Bernard and Kamau Anne, 2013. Universal health care in Kenya: Opportunities and challenges for the informal sector workers. *International Journal of Education and Research* 2013, Vol. 1 No. 11.

[2]Bernhard Hans and Hoving Henkel (Eds), 2016.*What makes the world healthy?* The AOK forum for health politics, practice and research. Special issue of Gesundheit und Gesellschaft (G+G), KomPart-Verlag, Berlin.

[3]African Development Bank, OECD, and UNDP. 2016. *African Economic Outlook 2016: Sustainable Cities and Structural Transformation.* Abidjan. AfDB

[4] Oxfam GB and Care International, 2009. *The Nairobi Informal Settlements: An emerging food security emergency within extreme chronic poverty.* A compilation and synthesis of key food security, livelihood, nutrition and public health data.

[5] Oxfam, 2009. Urban Poverty and Vulnerability in Kenya: Background analysis for the preparation of an Oxfam GB Urban Programme focused on Nairobi.

[6] Kamau, Anne, Kamau Paul and Daniel Muia. 2015. *Baseline Study on Women Small Scale Traders in Informal Settlements in Nairobi County. Nairobi*: Oxfam.

[7] Kamau, Paul. 2013. Developing Information Systems, Producing Accurate and Relevant Data in African Cities. Paper presented during the Cities Alliance African Strategy Conference held in Johannesburg, South Africa. 14-16 October 2013.

[8] Charmes, Jacques. 2012. The informal Economy Worldwide: Trends and Characteristics. *The Journal of Applied Economic Research*. 6:2 p. 103 -132.

[9] Mwaura Rachael et al., 2015. The Path to Universal Health Coverage in Kenya: Repositioning the Role of the National Hospital Insurance Fund. *Smart Lessons*, June 2015. International Finance Corporation (IFC), World Bank Group.

[10] Taddese Abeba, 2014. *Case Study: Kenya National Hospital Insurance Fund (NHIF) Premium Collection for the Informal Sector*. USAID, Health Finance and Governance. Accesses at <https://www.hfgproject.org/wp-content/uploads/2014/06/14-1022-HFG-Mobile-Money-Case-Study-NHIF-mpesa.pdf> on 12th June, 2016

[11]Republic of Kenya (ROK), 2016. National Assembly Bills(*Bill No. 14 of 2015*): The Health Bill, 2016. Published in the Kenya Gazette Supplement No. 44 of 2015 and passed by the National Assembly, on March 30th, 2016. N.A. /B/No. 14/2015.

[12]NHIFa, 2015. Benefit Package: Explanation of the benefit package for the National Scheme. Accessed on 8th September 2016 at <http://www.nhif.or.ke/healthinsurance/NHIF_Benefits_Package.pdf>