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Communication Factors Influencing Awareness of Government Medical Schemes among Informal Sector Workers: A Study of Kibera Sub-County, Nairobi County, Kenya

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Abstract

Purpose: This study examined communication factors influencing awareness of government medical schemes in Kenya among informal sector workers in Kibera Sub-County, Nairobi County.

Methodology: The study utilized an explanatory sequential mixed-methods design. The target population comprised urban informal sector workers, from which a sample of 130 respondents was drawn for a quantitative survey, complemented by 12 purposively selected Key Informant Interviews (KIIs) and content analysis of 50 communication artifacts. Quantitative data were processed using SPSS Version 28 to generate descriptive statistics and inferential tests.

Findings: The findings highlighted that while 95.4% of respondents superficially recognized the scheme's existence, there was a functional awareness deficit: 31.5% were unable to identify basic benefits, and 46.9% associated mandatory contributions with taxation. There was a significant association between technical English-language materials and lower comprehension (chi-square = 34.28, $p < .001$, Cramer's V = .586), while Sheng-based materials generated superior comprehension. Interpersonal channels generated a five-fold comprehension leverage ratio compared to mass media broadcasting. Inferential analysis revealed a positive correlation ($r = .363$, $p < .001$) between message comprehension and institutional trust. Demographic variables showed no protective effect against confusion. The study concluded that awareness and trust deficits within the informal sector are not demographic challenges, but structural institutional communication design failures rooted in bureaucratic messaging, language exclusion, and opaque financial terminology.

Unique Contribution to Theory, Practice and Policy: The study validated the Health Belief Model's construct that awareness without comprehension is a weak cue to action and Social Marketing Theory's Promotion principle that the effectiveness of the channel and not just the channel reach is key in determining the uptake of government medical schemes in the informal sector. SHA must be flexible in its language policy to include comprehensible Swahili and Sheng to dismantle the cognitive barriers erected by bureaucracy. SHA should scale up Community Health Volunteers (CHV) access to increase understanding of the medical scheme. The SHA Communication department must ensure technical terminology and registration instructions are replaced with plain language so as to transparently address the existing trust deficit. Additionally, campaigns must transition from top-down institutional directives to peer-led advocacy.

Keywords: *Health Communication, Social Health Authority, Informal Sector, Message Clarity, Institutional Trust*

JEL Codes: *I12, I13, I18, D83, J46*

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INTRODUCTION

The universal health coverage (UHC) target is one of the targets in the global policy framework, which is stated in Sustainable Development Goal 3.8 and emphasized by the WHO's importance of equitable and prepaid health financing to close health gaps that are avoidable and unacceptable, both between and within countries (United Nations, 2015; World Health Organization, 2010, 2020). This goal has taken a profound step forward in Kenya with the shift from the National Hospital Insurance Fund (NHIF) to the Social Health Authority (SHA) as per the Social Health Insurance Act, 2023, one of the most significant health-financing reforms in the country's recent history (Republic of Kenya, 2023). It's been rocky so far, with early battles before the Kenyan High Court (Cliffe Dekker Hofmeyr, 2024), inconsistencies in enrollment and compliance within its first 18 months, and implementation gaps identified by policy analysts continuing to be a challenge (Kamau et al., 2025). The announcement of the transition from NHIF to SHA contributions has generated more confusion among the public than the new scheme itself, as workers in the informal sector report that the government has not made any clear announcements about the next step for those who contributed to NHIF before the new scheme came into effect (Kinyanjui, 2024).

Statement of the Problem

Effective uptake of any contributory health financing scheme relies not only on the legal framework but also on the awareness, trust, and willingness of the population targeted to join it, particularly in the informal sector in Kenya. This population made up a large proportion of the country's labor force, but has historically been under-represented in formal social protection systems (International Labor Organization, 2002; World Bank, 2021), and previous studies on NHIF's era showed that voluntary membership rates in the system were far lower than those of formally employed, paid workers (Mathauer, Schmidt, & Wenyaa, 2008; Barasa, Mwaura, Rogo, & Andrawes, 2017).

This structural exclusion is not just a logistical error, but also a structural mismatch, as it is the regularity of payroll deductions within formal employment that allowed them to be planned for and accommodated in health-financing arrangements, whereas the irregular income flows from informal employment like day labor, market trading, and artisanal services are difficult to incorporate (World Bank, 2021). For informal sector workers, information on the scheme is often presented in foreign languages, with complex procedures that demand a lot of independent understanding, whereas for formal sector workers, it is a simple payroll deduction, and they do not require much independent interpretation. This creates a communicative burden on informal sector enrolment which is not seen for formal sector enrolment, and the transparency and accessibility of SHA's public-facing communication becomes not an ancillary but a primary determinant of whether Kenya's UHC efforts will work for the population most in need of them.

As detailed in the literature review below, previous research has mostly treated low awareness as a demographic deficit and not a communications design issue, leading to the need to research on whether a similar recognition-comprehension paradox exists in the recently launched SHA.

This study tried to fill this gap by investigating the general objective of the communication factors that affect awareness of the government medical schemes among informal sector workers of Kibera Sub-County in Nairobi County. The objectives that guided the inquiry were fourfold: to explore the extent of awareness of government medical scheme amongst informal sector workers, to explore the clarity of information related to government medical scheme, to explore the communication channels effectiveness in disseminating government medical

scheme information, and to explore what influence communication factors have on perceptions of government medical schemes. These objectives were investigated through four corresponding research questions addressing the same dimensions of awareness, clarity, channel effectiveness, and trust.

LITERATURE REVIEW

Theoretical Framework

Two complementary theoretical frameworks guided this study. Social Marketing Theory (Andreasen, 1995, 2016; Kotler & Lee, 2017) suggests that the communication of behavior change should be assessed within four levels: Product, Price, Place, Promotion, and that the success of the behavior change campaign should be judged by the understanding and uptake of behavior, not by the number of people reached. This makes social marketing different from traditional marketing, where the goal is exposure, whereas the goal is to promote behavior change (Hastings & Angus, 2011; French, Russell-Bennett, & Lefebvre, 2020). The Health Belief Model (HBM; Rosenstock, 1966; Rosenstock, Strecher, & Becker, 1988; Champion & Skinner, 2008) has been used to predict individual health-related behavior, and postulates that awareness of a scheme's existence is only a weak cue to action, and does not encompass the perceived benefits and self-efficacy that are needed for enrollment. These frameworks predict in isolation that reaching people with awareness campaigns will result in an overestimation of the impact by the campaign.

Conceptual Framework

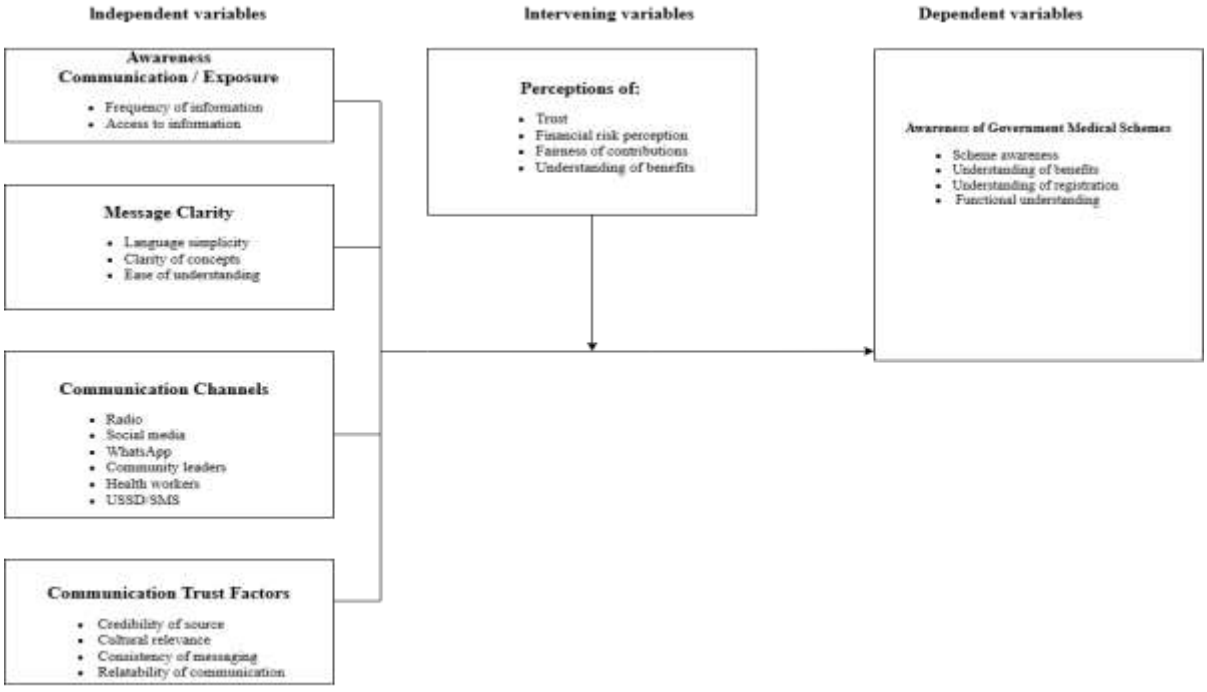

Figure 1: Conceptual Framework for Government Medical Scheme Awareness among Informal Sector Workers

Empirical Review

The literature on uptake of health insurance in sub-Saharan Africa has mostly seen low awareness as a demographic or information deficit that should be addressed by increased information dissemination efforts across more channels (Okumu, Wanyonyi, & Wabuya, 2024). There has been little empirical exploration of the specific communication elements and design strategies, such as language, medium choice, and message framing, that can lead to information becoming functional knowledge. Similarly, in its study on Ghana's National Health Insurance Scheme, Jehu-Appiah, Aryeetey, Agyepong, Spaan, and Baltussen (2011) found that although there was high statistical awareness, a lack of understanding of how to use the information was identified as the cause of the limited understanding by members. It has not been empirically investigated whether a similar pattern exists in the recently launched SHA in Kenya or what types of communication are responsible for this.

These two theoretical frameworks interface directly in that the Social Marketing Theory's *Product* dimension govern the supply side of communication in terms of the framing choices selected by organizations, what language to use, which channels to select, while the Health Belief Model explains those aforementioned design choices are cognitively received and processed on the demand side thereby shaping perceived barriers, perceived benefits and ultimately driving self-efficacy. This interface is applied to highlight that a message that scores highly under the Social Marketing Theory Promotion dimension but fails to address and reduce the Health Belief Model's perceived barriers will still produce nominal awareness but with low functional comprehension. This recognition-comprehension paradox is study examines. These theoretical frameworks forecast that campaigns optimized for reach only will ultimately overestimate their actual behavioral impact.

Research Gaps

Most significantly, Jehu-Appiah et al. (2011) documented the precise recognition-comprehension paradox this study set out to test: high nominal awareness of Ghana's NHIS coexisting with severely limited functional knowledge among low-income populations. Despite this literature, three gaps remained. First, most existing Kenyan studies frame uptake as a function of demographic predictors, leaving communication design itself under-theorized as an independent causal factor. Second, few studies triangulate survey data on audience comprehension with supply-side content analysis of the actual communication artifacts audiences receive. Third, no empirical study had yet examined these dynamics specifically within Kenya's SHA transition. This study addressed all three gaps through its mixed-methods design.

METHODOLOGY

The study used a mixed-methods explanatory sequential design, in which the quantitative phase was followed by the qualitative phase, with the quantitative phase informing the qualitative phase (Creswell & Clark, 2018; Leavy, 2017). This design was needed to examine complex social issues like health insurance awareness, because numbers alone don't tell the whole story of what makes some people distrustful of the government or of communication (Bukve, 2019; Saunders, Lewis, & Thornhill, 2019). The quantitative phase identified statistical patterns; the qualitative phase provided contextual explanations; and content analysis of official communication artifacts examined supply-side characteristics. This design enabled triangulation of audience-side statistical patterns, practitioner-level explanations, and supply-side message characteristics.

The study was conducted in Kibera Sub-County located in Nairobi with an estimated population of 185,777 (Kenya National Bureau of Statistics, 2019; UN-Habitat, 2020). The community was chosen because it is one of the most concentrated informal settlements in Nairobi and is typically denied access to formal social protection systems. The quantitative component targeted 130 adult informal sector workers, determined using Cochran's (1977) formula at a 90% confidence level, and consistent with established guidance on adequate sample sizes for exploratory social-science survey research (Mugenda & Mugenda, 1999). Multi-stage stratified sampling recruited respondents across five zones (Soweto, Gatwekera, Laini Saba, Makina, and Kianda), stratified by occupational category.

Thematic studies use a small number of key informants to achieve data saturation in qualitative research (Braun & Clarke, 2006; Saunders et al., 2019); 12 key informants, SHA communication officers, partner-organization specialists, and community health promoters were purposively selected. Two raters independently evaluated the content analysis of the 50 official communications for message clarity and language and cultural relevance, which was above the threshold for strong agreement of 0.80 (Landis & Koch, 1977), with a Cohen's Kappa of 0.84.

Descriptive statistics, chi-square test of association (Cramer's V for effect size measure), Pearson correlation, Spearman correlation, and Kruskal-Wallis H tests for group comparison were used for the quantitative data analysis using SPSS Version 28 software. Cronbach's Alpha for the seven items on the Trust and Perception Scale and the six items on the Channel Effectiveness scale were 0.825 and 0.568, respectively, which were acceptable as these are exploratory scales with conceptually different items but not likely to correlate strongly under one latent construct. Thematic analysis as outlined by Braun and Clarke (2006), which consisted of six phases of familiarization, initial coding, developing themes, reviewing the themes, naming the themes and lastly elaborating the themes, was used for qualitative analysis, with the analyses of Braun and Clarke proceeding iteratively, with two researchers independently coding a subsample of transcripts to ensure interpretive consistency before the full sample was analyzed. Content validity for the survey instrument was established by aligning all questionnaire items with the study's specific objectives and conceptual framework, followed by expert review from the supervisory team. Construct validity was addressed by grounding scale items in the established constructs of the Health Belief Model and Social Marketing Theory rather than generating items ad hoc, and a pilot study with a comparable informal sector population confirmed that respondents interpreted key items as intended, leading to the revision of two questions on contribution mechanisms and the addition of Kiswahili translations for technical terms that pilot respondents found confusing. Ethical clearance was obtained from the university's Institutional Review Board and NACOSTI, and all participants provided informed consent consistent with standard biomedical research ethics principles, including voluntary participation, confidentiality, and the right to withdraw without penalty (Beauchamp & Childress, 2013).

RESULTS

Sample Profile and Response Rate

A total of 138 informal sector workers covering the 5 sampled zones were approached, of whom 130 returned completed questionnaires, yielding a response rate of 94.2%, a higher rate than is generally acceptable for conducting social-science research in an exploratory manner (Mugenda & Mugenda, 1999). Of the sample collected, 69 (53.1%) were women, 61 (46.9%) men, which broadly aligns with the female-dominated nature of Kibera's informal service

sector, with some sectors such as domestic work and salon services having higher female participation rates compared to men (Kenya National Bureau of Statistics, 2019). The overall sample was youthful, with 76.2% being 35 years or younger, reflective of the age profile of Kibera, as estimated by UN-Habitat (2020). In the informal sector, 39.2% of the individuals had a university-level education and a further 37.7% had a technical or college education; a situation for which the Standard Media (2026) reported that, increasingly, it is not a lack of educational opportunity, but rather of structural unemployment that pushes highly literate workers into Nairobi's informal economy. The largest employment category was casual labor (32.3%), and the informal sector had a median stay time of one to three years (37.7%), showing the ephemeral and changeable nature of the informal economy, which impacts the implementation of continuous and long-term health insurance messages.

The Recognition-Comprehension Paradox

The study's central finding was a marked divergence between nominal recognition and functional comprehension of government medical schemes. 95.4% knew the scheme existed, but only 68.5% could name at least two of the rewards, with 23.8% unable to explain how the contributions were calculated. The mean comprehension was 2.77 (SD = 1.19), and 37.7% of the respondents reported finding the scheme hard/very hard to understand. As a composite awareness score (recognition + benefit identification/comprehension scores), the population's mean score of 6.05 (SD = 1.77), out of a maximum score of 9, indicates fairly low awareness (even though it is rather widespread).

Language and Message Clarity

Content analysis of the 50 official communication artifacts found that 100% of English-language digital materials were coded as unclear. In contrast, Sheng-based materials, though comprising only 10% of the sample, were uniformly rated as clear. The survey confirmed this with 86.2% of responders saying they mostly hear scheme information in English, and 61.5% saying they would like to have scheme information presented in their native or preferred language. The chi-square test indicated a large, significant relationship between the language of the information received and comprehension level (chi-square = 34.28, $p < .001$, Cramer's V = .586).

Channel Reach versus Channel Effectiveness

A gap was detected in how messages were received between the two systems. The two systems were misaligned as to which channels were reaching the most people and which were used; those that gave true understanding were not the same. Overall, the channel people used most (34.6%), trusted most (46.2%), and had the highest comprehension contribution (43.8%) was television. Community Health Volunteers (CHVs), however, even though the primary channel was -only- used by 4.6% of respondents, who attributed 24.6% of improving their understanding using CHVs, got a "royal credit" with a leverage ratio (comprehension to reach) of about 5:1. The exact opposite trend was evident for WhatsApp: it was very used (33.1%) with low trust (5.4%) and contribution of understanding (7.7%). This information has been summarized in Table 1.

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Table 1: Communication Channel Reach, Trust, and Comprehension Contribution (N = 130)

Channel	Most Frequently Used n (%)	Most Trusted n (%)	Most Improved Understanding n (%)
Television	45 (34.6)	60 (46.2)	57 (43.8)
WhatsApp	43 (33.1)	7 (5.4)	10 (7.7)
Radio	11 (8.5)	13 (10.0)	10 (7.7)
TikTok	11 (8.5)	7 (5.4)	–
Facebook	7 (5.4)	4 (3.1)	4 (3.1)
Community Health Volunteers	6 (4.6)	27 (20.8)	32 (24.6)
SMS/USSD	4 (3.1)	6 (4.6)	1 (0.8)
Friends/Family	3 (2.3)	5 (3.8)	15 (11.5)
Community Leaders	–	1 (0.8)	1 (0.8)

Trust and Institutional Perceptions

The lowest of all the dimensions measured was institutional trust. The composite mean for the seven items of the Trust and Perception Scale (alpha = 0.825) was 2.80 (SD = 0.84). The least positive item was trust in government's management of contributions (M = 2.35, SD = 1.27), and 46.9% of respondents strongly disagreed with the notion that the scheme was different from taxation. In contrast, the item with the highest mean score was perceived personal relevance (M = 3.14), which implies initial receptivity to the scheme that has not yet been converted into trust by the current communication.

Inferential Findings

Beyond the language-comprehension association reported above, correlation analysis found a significant positive relationship between message comprehension and institutional trust ($r = .363$, $p < .001$), the study's most practically consequential statistical finding, discussed further below. Channel effectiveness also had significant – yet modest – correlations with composite awareness ($r = .219$, $p = .013$) and trust ($r = .242$, $p = .006$). Interestingly, none of the four chi-square tests and two Kruskal-Wallis H-tests for four demographic variables (age, education) by the two variables (comprehension or trust) were statistically significant, suggesting that no single demographic could be used as a reason for the observed awareness deficit. The key results are summarized in Table 2.

Table 2: Summary of Key Inferential Statistical Results

Test / Relationship	Statistic	p	Effect Size / Interpretation
Language of information x comprehension	chi-sq = 34.28	< .001	Cramer's V = .586 (large)
Message clarity x registration intent	chi-sq (reported)	< .001	Very large effect
Comprehension x institutional trust	r = .363	< .001	Moderate positive correlation
Channel effectiveness x composite awareness	r = .219	.013	Small positive correlation
Channel effectiveness x trust score	r = .242	.006	Small positive correlation
Education level x comprehension score	H (Kruskal-Wallis)	n.s.	No significant group difference
Age group x institutional trust	H (Kruskal-Wallis)	n.s.	No significant group difference

Qualitative Themes

Thematic analysis of the key informant interviews converged strongly with the quantitative findings. Informants consistently distinguished the function of mass media from that of interpersonal communication: as one communication officer put it, “Mass media creates awareness; interpersonal communication creates comprehension.” Some informants said the use of technical language was the result of an institutional design process that was managed by policy teams, which drafted materials geared to what policy teams consider accessible but not tailored to the abilities of community engagement teams. However, pointing to the history of NHIF mismanagement, informants stated that as a result of ongoing trust issues, “public mistrust transferred directly from NHIF scandals to SHA” and that the new authority had yet to be set up to afford it its own learning curve. Informants also reported a lack of good beneficiary storytelling that could have been leveraged as an opportunity to restore relationship trust.

SUMMARY, CONCLUSION AND RECOMMENDATIONS

Summary

The study findings indicated that while 95.4% of respondents superficially recognized the scheme's existence, there was a functional awareness deficit: 31.5% were unable to identify basic benefits, and 46.9% associated mandatory contributions with taxation. There was a significant association between technical English-language materials and lower comprehension (chi-square = 34.28, $p < .001$, Cramer's V = .586), while Sheng-based materials generated superior comprehension. Interpersonal channels generated a five-fold comprehension leverage ratio compared to mass media broadcasting. Inferential analysis revealed a positive correlation ($r = .363$, $p < .001$) between message comprehension and institutional trust. Demographic variables showed no protective effect against confusion. The convergence of quantitative,

qualitative, and content-analytic findings supports a central interpretation: the awareness and trust deficits documented in this study are not primarily demographic or informational in nature, but reflect specific, addressable failures in communication design.

Conclusion

The recognition-comprehension paradox observed here directly replicates Jehu-Appiah et al.'s (2011) findings in Ghana, and carries clear theoretical significance under the Health Belief Model: recognition alone constitutes only a weak cue to action, incapable of generating the perceived benefits or self-efficacy required for enrollment (Champion & Skinner, 2008). From a Social Marketing perspective, this indicates that SHA's current communication strategy is being evaluated and has largely succeeded against a reach metric, while remaining misaligned with the comprehension metric that actually predicts behavioral uptake.

The finding that 100% of English-language digital artifacts were coded as unclear, against uniformly clear Sheng materials comprising only a tenth of the sample, indicates that language exclusion functions here as a structural design choice rather than an incidental resource constraint. This is consistent with Mwiti et al.'s (2025) finding that language exclusion undermines the inclusivity of public health messaging in Nairobi's informal settlements more broadly, and reinforces recent calls for multilingual SHA communication strategies (Aldousari, Alhajeri, & Kithinji, 2025). Under Social Marketing Theory's Promotion dimension, messages must be delivered in the language most accessible to the target audience; the present pattern inverts this principle, expecting the audience to meet institutional English halfway. This inversion is especially consequential given that the informal sector workforce this scheme is intended to reach is, by definition, the population least likely to hold the institutional or bureaucratic fluency that technical English communication implicitly assumes. The disproportionate clarity advantage of Sheng-language materials, despite their minimal share of the artifact sample, suggests that the constraint is not one of translation capacity but of institutional prioritization: Sheng materials evidently could be produced clearly when they were produced at all, yet accounted for only a tenth of the communication output examined.

The channel investment misalignment identified in Section 4.4, where CHVs generated five times more comprehension impact than their reach share, echoes Barasa et al.'s (2017) argument that mass media alone is insufficient for extending health insurance literacy to the informal sector, and Mwinuka's (2024) broader argument that closing the informal sector's insurance coverage gap requires targeted education communication strategies to address insurance misconceptions. Evaluated against Social Marketing Theory's Place dimension, which demands channels be assessed by functional effectiveness rather than aggregate reach, the current channel mix appears poorly calibrated, over-investing in broadcast media relative to its demonstrated comprehension yield.

Perhaps the most practically significant finding is the positive correlation between comprehension and trust ($r = .363$, $p < .001$). This puts institutional trust, which is typically considered a different PR issue, into a new perspective as more a matter of communication design itself. Informal worker households also seem to think that the use of ambiguous technical language in explaining contribution mechanisms is a sign of institutional untrustworthiness, evoking previous experiences with NHIF and triggering mistrust. This is not the only path experienced by Kenya. As reviewed in Section 2, Rwanda's trust-centered, community-anchored communication model has been credited with strengthening voluntary uptake (Lu et al., 2012). Similarly, Gabon’s Caisse Nationale d’Assurance Maladie et de Garantie Sociale (CNAMGS) has seen the steady extension of health-care coverage to the

country's different socioeconomic groups, bringing everyone under one social health insurance roof (Humphreys, 2013). This success has been credited to extensive publicity and community engagement reinforcing the same underlying mechanism observed here: clear, locally anchored communication is not merely a precondition for comprehension but the very mechanism through which institutional trust is negotiated and secured.

Last, and most significant, no demographic factors (educational or age) have any significant impact on comprehension or trust, which is notable as a policy indicator. It implies that scaling down messages and designing channels effectively to give a youth an easy-to-understand message about the scheme is likely to fail without the underlying structural changes at the supply side; even the well-educated respondents in this sample struggled to understand the scheme message as well. The finding also relates more broadly to the ongoing debates on the means of establishing UHC financing, which often expect it to be a function of population-level economic and/or educational readiness, rather than the communicative systems that actually explain UHC to their intended beneficiaries (Jung, 2021).

But these results need to be understood in the light of several limitations. Given the cross-sectional survey design, which measures awareness and trust only at a specific point in a very dynamic policy transition, the conclusions about the relation between comprehension and trust should therefore be considered as associational rather than causal. The sample, though appropriate for the exploratory goals of this study, was limited to a single urban informal settlement, and results may not be applicable to other informal sectors in rural communities with different infrastructure and language context issues. Lastly, there is social desirability around self-reported comprehension and social trust measures, especially for a politically charged measure of public appreciation and trust in an as yet unpopular financing transition (Kamau et al., 2025).

Recommendations

These findings lend to five recommendations. First, SHA and the Ministry of Health should create and scale up communication materials using Sheng and Kiswahili as the main languages, because the gap between English-language and Sheng- and Kiswahili-language communication materials is quite clear. Second, efforts to rebalance communication budgets should invest even more heavily in Community Health Volunteers and other interpersonal approaches, the impact of which greatly exceeds their current funding. Third, means-testing and contribution communication should be conceptualized using plain language, relatable examples, and should clearly and repeatedly separate and differentiate between SHA contributions and taxation. Fourth, campaigns need to incorporate real beneficiary storytelling to create a web of trust in the community and overcome any lingering skepticism that may have been engendered by NHIF.

Fifth, the study also recommends that health-financing research treat communications design as an independent explanatory variable under the pathways of the Health Belief Model's cue to action pathway instead of including it as a generic awareness measures that obscure the comprehension and trust mechanism identified in the study.

Future research can build on this study in a number of ways: longitudinal studies could provide further evidence of how trust and awareness evolve as SHA steps beyond this transitional period; and comparative studies are needed to assess whether or not the results reported here are generalizable to other communities in informal-sector/poor countries outside the urban context, for which there are growing cross-national comparative studies, see those of Rwanda and Gabon's parallel contributory health-financing reforms.

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