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Enrolment as Calculated Risk: Community Knowledge of Universal Health Coverage and the Limits of the Deficit Communication Model in Makueni County, Kenya

By

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Abstract

This article investigates the notion of enrolment as a calculated risk and its implications for universal health coverage in Kenya, focusing on Makueni County. Low enrolment in mandatory health insurance is conventionally diagnosed as a communication problem to be solved through better awareness campaigns. This article challenges that assumption. Drawing on a qualitative single instrumental case study of Makueni County, Kenya, with sixteen key informant interviews and five focus group discussions involving 48 participants analysed through reflexive thematic analysis, the study finds that community Universal Health Coverage literacy is broad but shallow. Awareness of the Social Health Authority is near-universal, but it is marked by three consequential knowledge gaps: an inpatient-only coverage limitation that leaves most common health needs unserved; an annual back-payment obligation discovered by many participants only at the point of hospitalisation; and a maternal-care regression following the withdrawal of a key maternity support programme. Information-channel trust follows a consistent hierarchy in which health workers are most trusted and politicians least, yet the Social Health Authority rollout relied most heavily on the least trusted channels. The central finding is that enrolment decisions are driven not by ignorance but by a calculated risk assessment of whether the scheme offers sufficient value relative to its cost, complexity, and reliability. Three structural features produce rational disincentives to enrol for informal-sector and vulnerable populations. The study concludes that low enrolment reflects a credibility and design problem that no communication strategy alone can resolve.

Keywords: Kenya, calculated risk; community knowledge; enrolment; health literacy; institutional trust; Makueni County; means-testing; Universal Health Coverage

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I. Introduction

When a government health scheme that has been extensively communicated still fails to attract enrolment, the standard institutional response is to communicate more. More barazas, more radio campaigns, more Community Health Promoter visits, more digital registration drives. The premise is straightforward: communities are not joining because they do not know enough, and the solution is more information. This article argues that premise is wrong, at least in Makueni County, where near-universal SHA awareness coexists with 34% enrolment (Government of Makueni County, 2025).

Kenya's UHC journey has been marked by repeated communication failures that preceded the Social Health Authority. The 2018 UHC pilot across Isiolo, Kisumu, Machakos, and Nyeri counties documented persistent challenges in community awareness, enrolment procedures, and the alignment between national communication design and local delivery capacity (Nyawira et al., 2024). The National Hospital Insurance Fund, SHA's predecessor, had achieved only 16% coverage of Kenya's working population by the time of its dissolution, with informal sector workers constituting fewer than 8% of NHIF membership despite representing approximately 84% of Kenya's workforce (Wamalwa et al., 2025). When SHA was launched in October 2024, it inherited not a blank slate but an accumulated institutional memory of insurance failure, selective disclosure, and benefit package inadequacy that communities had built up over years of direct experience with NHIF.

The enactment of the Social Health Insurance Act in 2023 was itself a communication failure before SHA's operational launch. The High Court of Kenya, in *Aura v Cabinet Secretary, Ministry of Health and 11 Others* [2024] KEHC 8255 (KLR), found that the public consultation process for the Social Health Insurance Fund Bill was constitutionally deficient: communities were given as little as two working days to comment on legislation that would fundamentally alter their healthcare financing obligations. This judicial finding confirms the central analytical argument this article advances: SHA's communication architecture was designed to produce the appearance of community participation rather than genuine deliberative engagement.

The communities of Makueni are not poorly informed about SHA. They have assessed it and, in many cases, concluded it is not worth the cost and risk. That conclusion, that low enrolment reflects rational scepticism rather than ignorance, has significant implications for policy. If the problem is that communities do not know about SHA, the solution is communication. If the problem is that communities know enough about SHA to conclude it does not reliably serve their needs, communication cannot help. What is needed instead is a different kind of evidence: that the scheme actually delivers what it promises, to the people it was designed to serve, at the point when they need it most.

Makueni County is the right place to examine this question. By 2018, the county had achieved 91% household health insurance coverage through MakueniCare, a scheme that charged a flat annual household premium, covered both inpatient and outpatient care, and provided free treatment for residents aged 70 and above (Kamau & MacNaughton, 2024;

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Nyawira et al., 2024). Under the national Social Health Authority, the same county has produced 34% enrolment (Government of Makueni County, 2025). Makueni is selected as a deviant case (Flyvbjerg, 2006): not because it is typical, but because its anomalous prior achievement and subsequent regression make visible the mechanisms that ordinary cases conceal. Throughout the interview and focus group data, participants spontaneously and consistently compare SHA to MakueniCare, and those comparisons drive their assessments of SHA's value.

The scholarly literature on UHC in Kenya has concentrated predominantly on health financing mechanisms, scheme design, and administrative implementation. Research examining the communicative conditions that shape community awareness, trust, and the knowledge-to-enrolment relationship is notably absent. Community members may be well-informed about SHA's benefit structure and still decline to enrol, not because of an information deficit but because their accumulated institutional experience provides rational grounds for scepticism that information provision cannot address (Gilson, 2003; Mulupi et al., 2013; Wagstaff et al., 2018). This article was motivated by the need to document and theorise scepticism on its own terms. It asks: What do community members know about Universal Health Coverage, and how does this knowledge shape their enrolment choices?

Statement of the Problem

Despite near-universal awareness of the Social Health Authority in Makueni County, SHA enrolment stands at only 34% (Government of Makueni County, 2025). The dominant institutional response to low health insurance enrolment in Kenya has been to intensify information campaigns, premised on the assumption that communities do not enrol because they do not know enough. This study challenges that premise. In Makueni County, which achieved 91% health insurance coverage under MakueniCare by 2018 through genuine community participation, low SHA enrolment cannot be explained by an information deficit. Communities demonstrate sufficient awareness of SHA to make enrolment decisions; what they lack is evidence that SHA reliably delivers value for informal-sector households, elderly residents, and vulnerable populations whose health needs the scheme's design does not adequately serve. This study addresses the misdiagnosis of low enrolment as a communication reach problem when it is, in fact, a credibility and design problem. That misdiagnosis leads to policy responses, more campaigns, more radio broadcasts, more CHP visits, that cannot resolve a deficit that is structural rather than informational.

II. Theoretical and Conceptual Framework

The central theoretical resource for this article is Gilson's (2003) framework of institutional trust as a social institution. Writing from the perspective of African health systems, Gilson argues that trust in health institutions is not simply a feeling within individuals that communication can instil or manage. It builds slowly through accumulated experience of reciprocal, respectful, and reliable interaction between communities and health workers, and it can be dismantled rapidly when institutions fail to deliver on their commitments. MakueniCare earned trust by delivering accessible, reliable services year after year at a price households could plan for. SHA inherited communities' hopes but not their proven track record. When people in Makueni hesitate to enrol, they make a sensible decision grounded in that contrast: waiting for evidence before investing their money in a scheme that has not yet shown it will serve them when they need it.

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This framework explains why the dominant communication-led approach to low enrolment is misdiagnosed. Waisbord (2020) identifies the diffusionist model of health communication as the paradigm that treats communities as audiences for expert messages, premised on the assumption that information provision leads to behaviour change. The diffusionist orientation, inherited from Lerner and Schramm's modernisation paradigm, has persisted in global health communication programming despite consistent evidence of its inadequacy. Waisbord documents how diffusionist approaches have repeatedly underperformed in health communication because they treat knowledge transmission as a sufficient condition for behaviour change while ignoring the social, institutional, and political conditions in which people receive, interpret, and act on information. In Makueni County, SHA's communication architecture exhibits this orientation throughout: its metrics are registration numbers rather than community comprehension; its channels are broadcast media and political forums rather than dialogical engagement spaces; and its information design foregrounds enrolment incentives while omitting information that might lead communities to question whether enrolment serves their interests. As Wagstaff et al. (2018), Mulupi et al. (2013), and Meessen et al. (2011) document across Kenya and sub-Saharan Africa, enrolment correlates far more strongly with prior institutional experience than with exposure to communication campaigns.

Nutbeam's (2000) typology of health literacy provides additional analytical precision. Functional literacy involves basic comprehension of health information sufficient to understand straightforward health messages. Interactive literacy involves more advanced cognitive and social skills enabling active participation in everyday situations and the extraction of meaning from different communication forms. Critical health literacy involves the advanced cognitive and social skills used to critically analyse information and to exert greater control over life situations and the social determinants of health. Government communication around SHA has operated at the functional level, broadcasting that SHA exists and that registration is required. MakueniCare's community engagement model reached the interactive and critical levels, enabling citizens to interrogate and shape UHC policy rather than simply receive it. The Nutbeam typology functions as a diagnostic instrument in this article: the level at which a scheme communicates indicates the depth of participation it can produce, and the depth of participation it produces determines whether communities develop genuine ownership or remain passive recipients.

Sripad et al. (2021), in a multi-country validation study of a client-trust-in-community-health-workers scale, show that community trust in health workers is measurable, varies systematically across delivery contexts, and shapes clients' willingness to act on health-worker advice. This finding is directly relevant to the Makueni context: the trust hierarchy communities hold is not an irrational disposition but a measurable, context-specific assessment of whose advice has proven reliable in the past. SHA's communication strategy has not engaged this trust infrastructure; it has bypassed it by relying on broadcast and political channels that sit at the bottom of the community trust hierarchy.

III. Methodology

The study was grounded in a relativist-interpretivist philosophical position, treating community knowledge and trust not as objective states to be measured but as meanings constructed through experience and social interaction (Lincoln & Guba, 1985). This study employed a single instrumental case study design (Stake, 1995; Yin, 2018). Makueni County's anomalous prior achievement and subsequent SHA regression make it a

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strategically significant deviant case (Flyvbjerg, 2006): the deviation from the expected pattern makes the mechanisms visible and analytically generative.

Four sub-counties were purposively selected: Mbooni, Kaiti, Makueni/Wote, and Kibwezi West, capturing geographic and socioeconomic variation across highland and semi-arid zones. Mbooni is characterised by a market-centred informal economy and relatively higher agricultural productivity. Kaiti lies in the transitional zone and carries a strong institutional memory of MakueniCare's ward-level consultation processes. Makueni/Wote encompasses the county headquarters with a mixed peri-urban and rural population. Kibwezi West represents the most geographically remote conditions, with limited communication infrastructure and significant pastoralist communities whose relationship to formal insurance schemes is shaped by mobile livelihoods and seasonal cash flow constraints.

The target population comprised community members, government and health officials, community health promoters, religious leaders, and civil society representatives directly involved in or affected by UHC communication and implementation. Forty-eight participants contributed through five focus group discussions involving thirty-two participants and sixteen key informant interviews across six stakeholder categories: three community health promoters, three ward administrators, two health and clinical officials, two religious leaders, two unregistered SHA community members, and four community and civil society representatives. The study deliberately included participants structurally marginalised within SHA's design: unregistered members, elderly residents, women market vendors, and youth in informal employment. Participant distribution across sub-counties was determined by stakeholder category coverage and participant availability rather than numerical quotas, consistent with Patton's (2002) purposive sampling logic.

Data collection continued until saturation was confirmed after the fifth focus group discussion, when no new themes emerged beyond those generated in earlier sessions. All data were analysed using reflexive thematic analysis across six phases: familiarisation with the data, generating initial codes, constructing themes, reviewing themes, defining and naming themes, and producing the written analysis (Braun & Clarke, 2006, 2019, 2022). The approach combined deductive coding from three theoretical dimensions with inductive openness to themes not anticipated by the framework. Trustworthiness was established through credibility via triangulation across three data generation methods, transferability via thick description of all four sub-counties and their participant profiles, dependability via a documented audit trail of all design decisions, and confirmability via a reflexive journal maintained throughout fieldwork and analysis (Lincoln & Guba, 1985).

IV. Ethical Considerations

The National Commission for Science, Technology and Innovation (NACOSTI), Kenya, granted ethical clearance for this study before data collection began (Licence No. NACOSTI/P/25/41170930). All participants provided written informed consent before participating in interviews or focus group discussions. They were clearly informed of the study's purpose, the voluntary nature of their participation, and their right to withdraw at any stage without consequence or penalty. No participant was subjected to any form of coercion or inducement. Confidentiality was maintained throughout: all data were anonymised using participant codes, and no personally identifiable information appears in any research output. The researcher stored audio recordings and transcripts on a password-protected device accessible only to the researcher. The researcher declared no conflict of interest in conducting this study.

V. Results

A. Broad but Shallow UHC Awareness

Across all five focus groups, participants demonstrated familiarity with at least one of the three UHC programmes referenced in the data: Kivutha Care, SHA, and MutulaCare. The government's communication strategies have clearly achieved surface-level reach; nobody in the study was hearing about health insurance for the first time. In every focus group, participants unprompted referenced MakueniCare as the benchmark against which they evaluated SHA. Participants recalled it with precision: a flat annual household fee of Ksh 500, later Ksh 1,000, comprehensive coverage including outpatients, diagnostics, surgeries, and medicines, and free treatment for residents aged 70 and above. SHA awareness, by contrast, is broad but fragmented, with near-universal recognition that SHA exists but no consistent understanding of what it covers, how contributions are calculated, or what to expect at a facility.

Three specific and consequential knowledge gaps emerge consistently across the data. The first is the inpatient-only coverage gap. Most participants understood SHA to cover hospitalisation, but the direct clinical consequence of excluding outpatient care was described by a health coordinator in terms that illustrate exactly who bears that consequence:

SHA is currently paying for inpatient services. Most of the time, our patients are outpatients. So, when they visit our facilities as outpatients, they cannot access any services. SHA cannot pay for it. This is more affecting our drug-resistant TB patients (KII-16).

The second gap is the annual back-payment surprise. Multiple participants described discovering, at the point of hospitalisation, an obligation that had not been disclosed at registration:

We were told it is monthly. However, if you are admitted to the hospital, you must pay for the whole year. For example, during childbirth through Caesarean section, we were told to pay for the entire year based on our category. At first, we were told we would pay monthly. We learned about paying for the whole year later (MAK-WOT-FGD3-P2).

This is selective disclosure: foregrounding the affordable monthly structure while omitting the annual back-payment obligation that applies at the point of hospitalisation. Under Habermas's (1989) framework, this constitutes strategic rather than communicative action, communication designed to achieve enrolment compliance rather than to enable informed decision-making. Guttman (2017) identifies selective disclosure as an endemic ethical failure in institutional health communication: the trust damage it produces is disproportionate to its financial magnitude because it confirms that the institution's communication was managed rather than honest.

The third gap concerns maternal care. Women in the Kaiti FGD demonstrated precise knowledge of the regression from universal free maternity support to SHA's conditional, contributory, and incomplete coverage:

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With Linda Mama, you did not even have to prepare for childbirth. When you delivered, you received diapers, a basin, and a baby blanket, and the mother received sandals. But now your pocket manages your healthcare. There is no point in getting married. (MAK-KAI-FGD2-P2)

These are not expressions of despair. They are rational calculations about reproductive life in response to a documented policy regression. Ochieng et al. (2022), in a qualitative study of Linda Mama implementation across western Kenya, found that the programme's unconditional coverage substantially improved facility delivery rates and changed community attitudes toward health facility-based maternity care. The withdrawal of this coverage has reversed those gains in communities that accurately understand what they have lost. No communication campaign can reach these decisions because they are not the product of misinformation; they reflect accurate knowledge of what the health system will and will not provide.

B. Trust Hierarchy of Information Channels

Community members in Makueni hold a clear and consistent hierarchy of trust in SHA information sources. Health workers, nurses, CHPs, and public health officers are most trusted because their information is grounded in professional clinical experience rather than institutional or political interest:

People trust the health officers more. Even though the Assistant Chief sends us to inform households, people believe the health officers because that is their professional job. As a village elder, I deal with many other matters. (KII-15)

Religious leaders carry moral authority derived from sustained community relationships. Radio and television are valued for reach but not trusted for depth or political neutrality. Politicians are the least trusted source. The direct policy implication is significant: SHA's rollout relied most heavily on broadcast media and political figures, the two least trusted channels, while under-resourcing sustained CHP household engagement and health worker-led community sessions, the two most trusted. Gilson's (2003) framework explains why: health workers sit at the top of the trust hierarchy because their track record of consistent, respectful, and clinically grounded interaction has earned a form of relational trust that broadcast media and political communication cannot replicate.

C. Affordability, Means-Testing, and Perceived Fairness

Community attitudes toward SHA are strongly shaped by how people experience means-testing. Registration was consistently described as opaque, confusing, and potentially punitive for honest respondents. Youth participants in Kibwezi West identified a specific and credible fairness concern: the use of M-Pesa transaction histories to assess income in a context where group funds, construction wages, and family remittances are routinely misclassified as personal wealth:

They look at our M-Pesa transactions. I followed up to find out about this. You see how you withdraw money; you might be working on a construction site, and then M-Pesa transactions come in every day, and they assume you are wealthy. That method is bad, seriously (MAK-KIB-FGD5-P1).

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These concerns are not unfounded. A peer-reviewed investigation by Kirigia et al. (2026), reviewed by academics at the University of Kent, Georgetown University, and Delft University of Technology, reconstructed SHA's AI means-testing algorithm from government data obtained through access-to-information requests. The investigation found that the algorithm was designed from the outset to systematically overcharge the poorest Kenyans while undercharging the wealthiest. The community's perception that means-testing is designed to extract rather than to assess is not misinformation; it is an accurate reading of a system whose design parameters produce inequitable outcomes regardless of how carefully a household responds.

D. Enrolment as Calculated Risk

Enrolment decisions in Makueni County are not primarily driven by ignorance or absolute financial incapacity. They are driven by a calculated risk assessment of whether SHA offers sufficient value relative to its cost, complexity, and reliability. An unregistered timber seller in Mbooni articulated the calculation clearly:

I have not registered, not out of bad intentions. I heard that when you register, some people pay a lot of money while others pay a little. Others say that even after registering for SHA, you still have to pay cash at the hospital. I asked why NHIF used to treat us without extra payments. After that, I just stopped and never went back (KII-10).

A Mbooni market vendor watched SHA work exactly as designed: a teacher's child's broken arm treated free, yet did not revise her assessment upward. Instead, she clarified it:

A teacher from Wote took a child to the hospital with a broken arm. I asked him, Teacher, did you enrol and pay for SHA? He said, 'Yes, I paid, and this arm was bandaged completely free, and I did not pay any extra money.' I realised that a certain category of people, like those employed, get significant help, while an ordinary person like me will get nothing. (MAK-MBO-FGD1-P6).

This response accurately identifies a structural feature of SHA's design: the scheme provides more reliable value for those with stable employment, consistent payment records, and acute inpatient needs than for market vendors with irregular income and primarily outpatient health needs. The market vendor has done the risk calculation and reached the correct conclusion for her specific situation. This is what this article means by calculated risk: not a failure to understand SHA, but an accurate inference about SHA based on available evidence.

E. Informal Coping Mechanisms as Collective Community Response

Communities in Makueni County have not simply disengaged from health coverage in response to SHA's gaps. They have developed informal collective mechanisms that partially compensate for what SHA does not provide. Women's savings groups across all four sub-counties pool contributions to cover members who cannot afford hospital access at the point of need, creating an informal, community-managed insurance function that operates entirely

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outside SHA's architecture. Community members in Mbooni and Kaiti described routinely bypassing public health facilities for private chemists when essential medicines are unavailable at SHA-contracted facilities, absorbing out-of-pocket costs that SHA was designed to eliminate. SHA-registered, paying members described facing additional out-of-pocket purchases for medicines during stockout periods, effectively paying twice for coverage they had already purchased through contributions.

These coping mechanisms are analytically significant for two reasons. First, they demonstrate that communities are not passive in the face of SHA's inadequacy: they are actively constructing alternative coverage arrangements that serve their actual health needs more reliably than SHA does. Second, they reveal that the community's social capital- the savings groups, mutual aid networks, and collective trust relationships that enabled MakeniCare's high coverage- has not disappeared under SHA. It has been redirected into informal mechanisms operating parallel to the formal scheme. Collins and Ison (2009) identify precisely this dynamic as the consequence of failing to harness community social learning in governance design: communities adapt to institutional gaps through informal means, creating parallel systems that the formal architecture cannot see and therefore cannot learn from.

VI. Discussion

A. Reframing Enrolment from Ignorance to Inference

The policy assumption that low health insurance enrolment reflects insufficient awareness is consistently wrong in contexts where communities have prior experience of comparable schemes. In Makueni County, the market vendor who witnessed a teacher's child receive free fracture treatment is not uninformed about SHA's potential value. She has direct, first-hand evidence of what SHA can do. She has also done what she should: assess whether that evidence applies to her own situation. It does not, and her conclusion that SHA serves people like the teacher more reliably than people like her is accurate. This is what this article means by calculated risk: not a failure to understand SHA, but an accurate inference about SHA based on available evidence.

The diffusionist model of health communication, as Waisbord (2020) analyses it, cannot account for this dynamic because it treats communities as information receivers rather than as evidence assessors. Better messaging could theoretically inform communities more accurately about SHA's benefit package. It could not change the market vendor's calculation because her calculation is not based on information about SHA; it is based on observing how SHA performs for people like her. The Makueni data validate and extend Mulupi et al.'s (2013) foundational Kenya finding and Meessen et al.'s (2011) cross-African evidence: prior institutional experience, not information exposure, is the binding constraint on health insurance uptake. Gilson's (2003) framework explains the mechanism: trust in health institutions is built through accumulated experience of reciprocal, respectful, and reliable interaction. SHA asks communities to trust it prospectively, on the basis of political promises, without the track record that Gilson identifies as the only mechanism through which institutional trust can genuinely be earned.

B. Three Structural Determinants of the Risk Calculation

The risk calculation driving low SHA enrolment rests on three specific structural features that produce rational disincentives to enrol. The means-testing mechanism systematically

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misclassifies informal-sector earnings as personal wealth, generating contribution rates that exceed the population's actual capacity to pay. Kirigia et al. (2026) confirm this at the national scale: the algorithm was not merely flawed in implementation but designed to produce this outcome. The inpatient-only coverage limitation means that SHA's expected value is very low for a population whose primary health needs are outpatient: chronic disease management, diagnostic tests, and the routine consultations that determine whether conditions escalate to hospitalisation. The annual back-payment surprise constitutes what Guttman (2017) identifies as an endemic problem in institutional health communication: selective disclosure aimed at achieving enrolment compliance rather than enabling informed, autonomous decision-making. The trust damage from this discovery is disproportionate to its financial magnitude because it confirms a pre-existing community suspicion that SHA's communication has been designed to manage enrolment rather than genuinely inform it.

C. National Corroboration

The calculated risk finding from Makueni County is not a local anomaly. A GeoPoll survey of 961 Kenyan respondents conducted in February 2025 found that the leading barrier to SHA registration was lack of trust in the system (34%), ahead of affordability (26%) and insufficient information (25%) (Adika, 2025). This hierarchy exactly mirrors the Makueni pattern: trust deficit as the binding constraint, affordability second, information last. The survey also found that 63% of enrolled members had not yet used their coverage, consistent with the Makueni finding of low perceived value rather than low awareness. SHA registration in Makueni County stood at 34% as of September 2025, with the county's own implementation guidelines acknowledging that SHA has not rolled out social protection for vulnerable and indigent members as intended (Government of Makueni County, 2025). These national data confirm that the dynamics documented qualitatively in Makueni reflect a systemic, rather than local, problem.

D. Implications for Health Communication Practice in Africa

The calculated risk finding has broader implications for health communication practice across sub-Saharan African contexts where mandatory contributory health insurance schemes are being introduced alongside prior voluntary or community-based schemes. The pattern documented in Makueni, near-universal awareness coexisting with low enrolment driven by rational scepticism rather than information deficit, is likely to be replicated wherever new national schemes replace locally trusted predecessor programmes without adequately addressing the trust infrastructure those predecessors built. Maritim et al. (2024), documenting NHIF engagement in rural Western Kenya, found that 63% of respondents were aware of NHIF but only 32% knew the benefit package and 93% were unaware of feedback mechanisms. This pattern confirms that the knowledge-trust gap documented in Makueni is not a Makueni-specific phenomenon but a systemic feature of Kenya's health insurance communication architecture.

The practical implication for health communication practitioners and policymakers across the region is that the standard response to low enrolment, intensified information campaigns, is not only insufficient but potentially counterproductive. When communities have already assessed a scheme and concluded it does not serve their needs, communication campaigns that do not address the substantive basis of their scepticism confirm rather than resolve their distrust. This context requires not better messaging but a fundamentally different relationship between institutions and communities: one in which community assessments are

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treated as legitimate feedback rather than problems of misinformation to be managed through improved campaigns.

VII. Conclusion

Community members in Makueni County know what SHA is. The government's communication strategies have achieved their information delivery goal. What they have not achieved, and cannot achieve through further communication, is the institutional credibility that would give communities a genuine reason to trust SHA with their money and their health. The inpatient-only coverage limitation is a scheme design failure. The annual back-payment surprise is a deliberate choice about what to disclose and what to withhold at registration. The maternal care regression is an accurately understood policy change that has directly altered women's reproductive decisions. Communities know these things. Telling them more clearly or more often about SHA will not change what they know.

The calculated risk finding has one direct implication for policymakers: communities in Makueni County will not enrol in SHA at the scale UHC requires until SHA consistently and demonstrably serves the needs of informal-sector workers, the elderly, and vulnerable populations. That evidence cannot be communicated into existence. It has to be built. The informal coping mechanisms communities have developed are not evidence of community failure to engage with SHA. They show community ingenuity in filling the gaps SHA has left, and health systems that treat those mechanisms as non-compliance rather than feedback will continue to produce the low enrolment they are trying to solve.

This study's findings are grounded in Makueni County's specific governance history, but their analytical implications are transferable to comparable devolved African health governance contexts. The mechanisms that produced the calculated risk finding, inherited institutional distrust, selective disclosure, design features that systematically exclude informal sector populations, and the absence of upward community feedback pathways are not unique to Makueni. They are structural features of health insurance communication systems that treat communities as targets of enrolment campaigns rather than as co-producers of health governance.

VIII. Recommendations

Three structural interventions follow from the analysis. First, the means-testing mechanism must be redesigned to accurately assess informal-sector incomes, and an independent technical audit of SHA's AI algorithm, as documented by Kirigia et al. (2026), should be commissioned and its findings made public. Second, SHA's benefit package must be extended to include outpatient care for the health needs communities actually present with; inpatient-only coverage makes SHA largely irrelevant to a population whose primary health burden is outpatient and chronic. Third, the annual back-payment obligation must be fully, clearly, and prominently disclosed at registration, not discovered at hospitalisation. Selective disclosure is not a communication strategy. It is an institutional ethics failure that destroys the trust SHA needs communities to extend to it.

None of these interventions is a communication strategy. All of them require SHA to change what it does rather than how it explains what it does. A fourth structural recommendation addresses the communication architecture itself: SHA must establish a formally institutionalised upward feedback pathway through which community experience of scheme performance reaches policy-makers on a regular, binding basis. The informal coping mechanisms communities have developed are, in effect, this feedback operating outside

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official channels. Making those channels official, domestically funded, and formally weighted in annual health planning decisions would transform SHA from a transmission system into a learning system capable of the mutual adaptation that genuine UHC governance requires.

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Competing Interests

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