

Original Paper

Implementation of Universal Health Coverage Program in Kisumu County, Kenya: Importance of Social Marketing Strategies

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Abstract

Universal Health Coverage is where communities have access to all needed health services without financial hardship. In Kenya, Universal Health Coverage (UHC) program was launched in December 2018, through a presidential decree. This study aimed to understand population needs, acceptability, and perceptions about UHC implementation. The study was undertaken in four pilot counties of Kisumu, Machakos, Nyeri and Isiolo between February and March 2019, using exploratory qualitative data collection techniques. However, this paper focuses on the County of Kisumu which was selected due to its high prevalence of infectious diseases. Respondents included women of reproductive age, men, youth, and elderly persons. In-depth interviews were conducted among health care providers and managers. Scientific and ethical approval was obtained from the Kenya Medical Research Institute's Scientific and Ethical Review Unit (SERU). Consenting to participate was individualized. Analysis was done thematically. Findings suggest that UHC was understood variously by different groupings. Sensitization about the UHC programme was done through electronic media, by CHVs, education sessions, political class and outreaches. Planning for the programme was done by holding meetings, trainings for community registration and developing budgets. However there was a lot of misunderstanding, confusion and misconcepts about the UHC concept as it was seen as a means to seek for votes by politicians. Barriers for successful implementation included critically understaffed facilities.

Keywords

Universal Health Coverage, social marketing principles, misconceptions, barriers, behavior change

1. Background

The right to health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition. This message has since been repeatedly reinforced; perhaps most prominently in the 1978 Declaration of Alma-Ata (WHO, 2010). Since the turn of the century, the quest for Universal Health Coverage has gained momentum in numerous countries and in the global health community. In 2005, the member states of WHO endorsed UHC as a critical goal and stated that health systems must be further developed in order to guarantee access to necessary services while providing protection against financial risk. Accordingly, all UN Member States agreed to achieve UHC by 2030, as part of the SDGs. Many countries are already making progress towards UHC (WHO, 2007). Experiences have shown rising incomes, increasing total health expenditures and an expanding role for government in improving access to health care (William et al., 2011).

1.1 Social Marketing as an Important Tool in UHC Sell out

Social marketing is widely used to influence health behavior (Evans, 2006). Social marketers have often used this tool in a wide range of health communication strategies based on mass media; use of mediated (interpersonal) and marketing methods such as message placement promotion, dissemination, and community level outreach to sell a health program. Social marketing is therefore defined as the application of proven concepts and techniques drawn from the commercial sector to promote changes in diverse socially important behaviors such as drug use, smoking, sexual behavior. This marketing approach has an immense potential to affect major social problems if it is learned how to harness its power (Evan, 2006). By proven techniques, it means methods drawn from behavioral theory. Behavioral theorists believe that a better understanding of human behavior at work, such as motivation, conflict, expectations, and group dynamics, improve productivity. Persuasion psychology, and marketing science with regard to health behavior, human reactions to messages and message delivery, and the marketing mix or four Ps of marketing, i.e., place, price, product, and promotion, are the key principles in social marketing (Borden, 1964). These methods include using behavioral theory to influence behaviour that affects health; assessing factors that underlie the receptivity of audiences to messages, such as the credibility and likeability of the argument; and strategic marketing of messages that aim to change the behavior of target audiences using the four Ps (Petty, 1986). Importantly social marketers use a wide range of health communication strategies based on mass media; they also use mediated, for example, through a healthcare provider, interpersonal, and other modes of communication; and marketing methods such as message placement for example, in clinics, promotion, dissemination, and community level outreach. All these strategies are common in social marketing. But as communication channels for health information have changed greatly in recent years, a multimodal transactional model of communication

(Backer, 1992) has been suggested as the most effective way to reach audiences about health issues (Hornik, 2002).

In India, during the swine flu H1N1 pandemic in 2009, a simple strategy of social marketing to prevent it by thorough hand-washing with liquid soap and water (added with commercial marketing of soap products) gained publicity with a high level of acceptance (Aras, 2009). Social marketing approaches therefore have been shown to have positive impacts for example smoking and alcohol-related problems, especially when they are carefully designed to engage specific groups (Perese, 2005). Needless to say that they gain a lasting effect when combined with a mix of additional educative, policy, legislative and intervention measures (Perese, 2005).

In Kenya, Universal Health Coverage (UHC) program was launched in December 2018 through a presidential decree, with an ambition to position Kenya as a leader in achieving quality and affordable healthcare in the African continent that would mark a key milestone and historic journey for the nation as it inched closer towards the realization of health for all.

This study sought to understand population needs, acceptability, perceptions and the extent of incorporating social marketing principals for the success of the UHC programme in Kisumu County.

2. Methodology

2.1 Study Design

This was an exploratory qualitative study that collected data using in-depth interview techniques on population-driven needs for an effective UHC program; phenomenology and case studies approaches were used. Phenomenology involves describing situations as they appear, while experiences are an integral part of the study population. Exploration of causation (events, decisions, periods and policies) were discussed with a view to understanding the underlying principles. The main reason for choosing qualitative method is that derived data can help to develop an intervention (Bradley et al., 1999), it can also develop an understanding of how the intervention works and who it might be most effective for (MRC, 2000) and qualitative methods are important when it is intended to address vulnerable voices at community level as this study targeted also vulnerable populations.

2.2 Study Sites

The study was conducted in four UHC pilot counties of Isiolo, Kisumu, Machakos and Nyeri that the Government of Kenya had selected based on their unique health burden representation. Isiolo was selected for being among the top 15 counties with high maternal mortality rates and to represent pastoral population who are mostly mobile in search for pasture and water for their animals. Kisumu was selected based on its high prevalence of communicable diseases such as HIV and malaria. Machakos on the other hand was selected because of the burden of road traffic accidents and trauma experienced due to its proximity to Mombasa highway, while Nyeri was selected due to the high prevalence of non-communicable diseases such as hypertension, diabetes and cancers (Vision 2030;

GoK, 2008). Each County had unique findings and therefore these findings are from Kisumu County. The findings from the other counties will be published in other papers.

2.3 Study Population

Data was collected from women of reproductive age (including pregnant women and caretakers of children under 5 years), men, youth, and elderly persons as consumers of healthcare services at the community level in Kisumu. In addition, information was also collected from healthcare personnel including County Health Management teams, facility-in-charges, hospital departmental heads, and healthcare service providers. The study also targeted other key stakeholders in the healthcare system including partners, policymakers and Politicians particularly Members of Health Ccommittee at County level.

2.4 Community Entry and Facility Selection

In the current devolved county government systems, the entry point into the community was facilitated through the County Executive Committee (CECs) of Health to inform about the study and seek County administrative approvals, as well as establish linkages with Community Health Strategy Focal Persons (CHFP) to support community mobilization, in consultation with the local leadership.

The selection of health facilities for the UHC study activities was done through a consultative process between the study team and the CHMT in Kisumu. Considerations for selected facilities included; representation of all facility levels, facility workloads (targeting high and low volumes) and facility accessibility by the community members among other considerations. Focus Group Discussion (FGDs) participants were randomly selected from community units of the selected facilities.

2.5 Data Collection

2.5.1 Qualitative Interviews

Data collection was carried out by social scientists with expertise in qualitative data collection techniques. Interview guides for each category of participants were developed and used based on the information required from the different population groups. Key informant interviews targeted those in administrative roles in Kisumu County and health facilities, mainly, medical superintendents, facility in-charges and health facilities' departmental heads, County Executives and representatives of implementing partners in the County. Questions asked inched on preparedness of the program at county level, understanding of UHC and foreseeable challenges.

Focus Group Discussions (FGDs) on the other hand were conducted among women of reproductive age (including caretakers of children under the age of 5 years and pregnant women), youth, men and elderly persons. In addition, one FGD was conducted using guides that were developed to address key issues amongst members of health committee at the County level. At primary care level, FGDs were conducted among community health volunteers.

Besides field notes, Key Informant interviews and FGDs were audio-recorded with consent from the participants. Overall, the study conducted one FGD for each of the population groups and two FGDs for the CHVs and one FGD among health committee members at the County Assembly. A total of 23

KIIs and 8 FGDs were conducted in the County of Kisumu. Questions asked was geared towards understanding of UHC programme, preparedness, perceptions and possible barriers that would make the program unsuccessful. Table 1 provides a detailed description of the study population, their selection criteria and data collection methods used.

Table 1. Description of the Selected Study Population

Category	Informants	Description	Selection criteria	Data Collection Methods
Community	The Elderly Population	Community members aged 65 years and above	Randomly selected	FGD
	Women of Reproductive age	Women aged between 18 to 49 years and not pregnant at the time of the study	Randomly selected	FGD
	Pregnant Women	Expectant women at the time of the study	Randomly selected	FGD
	Care takers of children >5years	Person who are primary caretakers of children >5years	Randomly selected	FGD
	Men	Male population aged between 25 to 64 years	Randomly selected	FGD
	Youth	Persons of both gender aged between 18 to 24 years	Purposively selected / grouping of the gender	FGD
Service providers	Director of Health services	The county Directors of health	Purposively selected the relevant person	KII
	CEC	County executive committee member of health	Purposively selected the relevant person	KII
	CHMT	County health management team composed of program heads and	Purposively selected the	KII

		the UHC coordinators	relevant person	
	Facility In charges	Health personnel in charge of hospitals, health Centre and dispensaries	Purposively selected the relevant person	KII
	Health facility heads of departments	Personnel in charge of various departments within the health facilities	Purposively selected the relevant person	KII
	Hospital administrators	personal In charge of administration, finances and human resource	Purposively selected the relevant person	KII
	Health care providers	This included Medical Officers, Clinical officers, Nurses, Nutritionists, Social workers, Pharmacists, laboratory personnel involved in actual service delivery	Purposively selected the relevant person	KII
	CHVs	Community health volunteers linked to the selected health facilities	Randomly selected	FGD
Stakeholders	County UHC implementing partners	Organization supporting implementation of UHC at County level	Purposively selected the relevant person	KII
	County Assembly Health committees	Members of the health committee, County assembly	Purposively selected the relevant person	FGD
	Special group representation	Associations representing special groups	Purposively selected the relevant person	KII

Table 2. Population Groupings for FGDs

S/NO	RESPONDENTS	METHOD	NO. OF INTERVIEWS
1	Members of County Assembly	FGD	1
2	CHVs	FGD	2
3	YOUTH - MALE	FGD	1
4	YOUTH - FEMALE	FGD	1
5	MEN	FGD	1
6	WRA	FGD	1
7	ELDERLY	FGD	1

Table 3. Key Informant Interview Respondent Groups

	Respondents	No.
1	County Executive Committee Member	1
2	Director of Health Services	1
4	Community Focal Person	1
5	Medical Superintendent	2
6	Medical officer of health	1
7	Hospital Administrators	2
8	Community Focal Person	1
9	Health Records & Information Officer	2
10	Public Health Officer	2
11	Registered Clinical Officer	2
12	Nurse	1
13	Laboratory In charges	2
14	Pharmacist	1
15	Nutritionist	1
16	Coordinator- People who are abled differently	1
17	Implementing Partner	1
18	UHC Coordinator	1
	Total	23

2.5.2 Data Management and Analysis

Data was transcribed word by word and translated to English. Atlas-ti Software was used to organize the data. Data was analyzed thematically using the Frame work method, (Gale et al, 2013) by querying for specific themes and subthemes developed from responses and based on emerging themes for each

of the study objectives. Comparison across the collected data by source of information was made while collating similar and varied opinions of the themes relevant to the research objectives.

2.6 Ethical Clearance and Considerations

The study got approval and letter of support from the Ministry of Health, while scientific and ethical approval to conduct this study was obtained from the Kenya Medical Research Institute's Scientific and Ethical Review Unit (SERU) prior to study implementation. Written permission was also obtained from the County Director of Health. Consenting to participate either in the KIIs or FGDs was individualized.

3. Findings

3.1 Social Demographics

A total of 8 FGDs and 23 Key Informant Interviews were conducted in Kisumu County drawn from various categories of the study respondents. The minimum age of the participants was 27 years and the maximum age 59 years. In terms of gender distribution, 27 were females while 50 respondents were male.

3.2 Understanding of Universal Health Coverage

Universal health coverage means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care. This definition of UHC embodies three related objectives: Equity in access to health services—everyone who needs services should get them, not only those who can pay for them; the quality of health services should be good enough to improve the health of those receiving services; and people should be protected against financial-risk, ensuring that the cost of using services does not put people at risk of financial harm. Universal health coverage cuts across all of the health-related Sustainable Development Goals (SDGs) and brings hope of better health and protection for the world's poorest (WHO, 2019).

This study explored how communities and health workers understood UHC, the planning and sensitization process at county level which gave us an opportunity to interrogate the understanding of Universal Health Coverage (UHC) initiative by various study populations and divergent views emerged. From the focus groups discussions conducted among Community Health Volunteers (CHVs) it was noted that UHC was the initiative of the Government to help the poor to access health care: “... ***our opinion is the government wants to help people within the community who are less fortunate and those who could not pay for health services***” *FGD-CHV*. Phrased differently but in agreement, the health personnel understood it as a walk in-walk-out initiative and therefore a non-discriminatory platform for accessing health, “...***it is a system whereby patients walk in a hospital, gets served and goes back home without paying anything.....getting services free without discrimination irrespective of age***” (*IDI-Health Worker*). Additionally, it was also envisaged as a program for those who could not afford National Health Insurance Fund (NIHF) as reported by Community health volunteers (*CHVs*): “...***UHC is a pilot program that the government has brought to help those who cannot***

afford to pay NHIF so that they can get healthcare services”, (FGD-CHVs). Information from the health workers indicated that UHC was about financial protection. The question to be answered, however, was clarity for the utilization of UHC as alluded to below by a health worker: *“...UHC is about financial protection: It’s a universal package for all to access healthcare. It’s not specific but for all, be it for children or adults, the vulnerable population or the elderly. But it only covers 4 counties, meaning when I go to Migori county I won’t be covered”. IDI-HW.* On the other hand it was replacing NHIF as alluded by the youth: *“...UHC is universal health coverage and it’s like a free health care which was provided by the government to cater for our health issues, I think it’s replacing NHIF but I am not sure” FGD-Youth).* UHC was also seen as a subsidized health care: *“..Universal health coverage according to my understanding is subsidized health care given by the government, in the sense that government pays for the citizens of Kisumu County the health coverage so that they can get the essential health care without a pinch in their pocket. (IDI, HW)”.* From the WHO perspective, *“UHC is when the Government is providing all health services to all people without out of pocket expenditure”: “....that the government would provide 100% of all the health services that were required to all the citizens without out of pocket expenditure, so that will be universal health care which is being confused with universal health coverage. So universal health care is when you are providing all the services to all the people without out of pocket expenditure” IDI, WHO Rep.*

We also sought to understand sources of information on how UHC program was unveiled to the community to ensure uptake. Various sources of approaches were employed to inform the population of this new and exciting venture in health care in the country. From the youth it was heard from the president: *“...we heard about it when the president came to Kisumu and launched it officially” FGD-Youth Male.* Others learnt of it from the electronic media: *“...we heard about it on Citizen TV and also I got to know about it from those who were creating awareness”, FGD-male youth.* Others heard it from the politicians: *“....We heard of it from our MP who was announcing that people should go and register’ FGD-Female Youth”.*

There were thoughts that the county government could subsidize the health care and if this was done, it could be an opportunity to make the programme a success.

*“...before the national roll out , the governor had actually made a plan on how to go out and register and we started the pilot in Seme sub county where we had gone to register people under super cover., The plan was that households would pay 500 shillings per month for a whole coverage under what we call **super cover** by NHIF and the county government was going to pay for households or persons who could not afford to pay this 500 shillings” (KII-HW).*

From the views of the diverse groups interviewed there was little understanding of what UHC was all about, what it entailed and for what purpose.

3.3 Planning for UHC at County Level

We learned that at facility level some health workers were involved in the planning stage and this was critical because it ensured ownership of the programme. On why planning was important: ***“...the plans in place were to ensure that the system was ready for implementation. The second was to define the package of services that would be provided to the population as part of UHC in Kenya. Number three was to get the resources to implement the defined set of services across the country”*** KII-CHMT (Executive member, Health Management Team). Additional staff were quickly employed and trainings carried out to sensitize the community: ***“...some staffs were employed and there were trainings that were carried out to continue sensitizing those who were offering services.”*** (KII-HW). Departmental managers were involved in series of meetings and were also tasked to inform staff under them about the new initiative: ***“..., when the initiative was being brought on board we were called for series of meetings concerning the same. We were also tasked with sensitizing the health staff on the same and also sensitizing the community on the same”,*** KII-CHMT In similar meetings budgets were discussed more so for the purchase of essential medicines and commodities as patients were projected to double. Laboratory in-charges were required to budget even for tests: ***“...the laboratory in-charges were taken to do budgeting, in Naivasha somewhere in October. So each and every in-charge especially laboratory were supposed to go with the lists of the tests they do and do a budget estimation”*** (KII-HW). At the same time the health management information system that was UHC friendly was developed. On equal strength bed coverage and work load were planned on how to manage the would be increasing patients. The electronic coding system was also managed so as to ensure billing records were kept even though bills were not paid. This was critical to understand the costing per patient: ***“... We have an electronic medical records system, prior to that we had our services that were coded with the prices, so when the UHC came now our clients were not supposed to pay. So we are just billing them but they are not giving the money So our system was programmed so that it gives a receipt for the services we give the client but they do not pay the money. So at the end we get a report of what has been offered to the client”*** (KII-HW).

3.4 Registration

Kisumu County signed a Memorandum of Understanding for technical assistance with Pharm Access Foundation to offer digital technology for healthcare. The partnership with Pharm Access was to ensure access to quality programs and loans for healthcare providers to strengthen the availability and quality of medical services in Kisumu. The county aimed to use the digital platform that included a mobile health wallet to help achieve Universal Health Care in a cost effective and transparent way. The mobile technology, was therefore to enable the county community health volunteers to enroll the population onto UHC. By harnessing the power of mobile technology, Kisumu was leading in the frontline of healthcare innovation. So Registration was a key event in the UHC implementation process. It included having an ID card and birth certificates. Youths and CHVS were recruited and trained to register community members for the program in order to speed up the exercise.

“...we started off with the registration....., so if a patient walks in into the hospital there is a UHC agent, who confirms whether patients are registered because currently the patients who registered don't have the cards yet and we don't have the system like the NHIF to confirm if somebody is registered but the agent is able to confirm whether somebody is registered via the app in their phone”- (KII-HW).

“...So for members of the public to access care, they have to be registered members and NHIF was given the mandate by the ministry of health to register households so that they have the card and they can produce that I am insured under universal health coverage” (KII-HW).

“... We had agents who were walking from home to home, some were in market centers and others were in the chief's camp. They initiated the people to the UHC program. The agents are facilitated by CHVs because the CHVs know home to home. And also there is health promotion team who travel from place to place advocating for UHC” KII, HW.

“...there is need to do a more vigorous and thorough registration of the beneficiaries so that they can be identified at the delivery point” (KII, WHO Rep.).

3.5 Involvement of Community Health Volunteers (CHV) in UHC Implementation

The concept of community-based health volunteer system has gained its popularity in developing countries to overcome the increasing demand for health care services and the shortage of formal health care providers. It was evident that Community Health Volunteers (CHVs) were not optimally utilized in the UHC roll out: *“for me I think we were not involved the way we expected because we are the bridge between the community and the facilities. ... Registration did not succeed because the youths that were engaged do not know the structure of the community, so some of the community members were not registered. (FGD, CHV).* Community health volunteers are a resource that is critical especially in sensitization of the community about a new health programme as alluded to by an implementing partner: *“...CHVs is a resource that needs to be tapped into, but again I think it is an area that we have to be careful in terms of the whole agenda of community health services”, (KII_Implementing Partner).*

3.6 Sensitization Process

Community Empowerment (CE) is the process by which relatively powerless people in the community work together to attain control over the events influencing their life (Joader, 2013). The reason for any sensitization is to enable the intended community access to information, participate in decision-making forums, ability to demand accountability from decision makers and to have the capacity to work in partnership with public service (Narayan, 2002). Community empowerment has been shown by Laverack to improve health outcomes in various settings and through different pathways. For example, in Nepal participatory learning exercises in women's groups helped reduction of maternal mortality; in Samoa neighborhood-based self-help system helped improvement of sanitary and health facilities; in Central Asia (Kazakhstan, Kyrgyzstan, and Uzbekistan) sensitizing and involving the local village leaders helped improve water supply; in Florida among the African-American women formation of

mothers' circles helped reduction of infant mortality; and many more (Laverack, 2011). Sensitization was adopted in this program as a strategy for UHC success. The study therefore sought to understand how it was done and by who and the medium used. It was noted that notice boards, health education sessions and outreaches were employed.

"...when the patient comes, to the facility, we start by health education before they seek care so our staff come as early as seven and give health education to our patients and the key areas that we need to educate them and we also have a community unit, a community unit linked to the facility composed of the community health workers that go to the community and educate them" **KII-HW**,

"...We also had vehicles going around sensitizing the community about the ongoing process of UHC registration. It enhanced the information ... at least it reached the villages...went to the local media stations and we interacted with the public" **(FGD-Health Committee)**

"...We engaged the public during public participations and we also have some Whatsapp group that we get the views of people" **(FGD-Health Committee)**

"...We also had vehicles going around sensitizing the community about the ongoing process of UHC registration. It enhanced the information ... at least it reached the villages...went to the local media stations and we interacted with the public" **(FGD-Health Committee)**

"...preparations included capacity building of the health care workers, we are trying to boost our blood donations system so that we can monitor how much blood we have in the system, improve on our disease surveillance and reporting, specifically for disease surveillance and response where right now Kisumu is ranked second or third in terms of reporting of (DSR) in the country." **(KII-HW)**

3.7 Misconceptions about UHC Programme

It was noted that the community had misunderstanding of the UHC concept as they saw it as a means to seek for votes by politicians: *"...when the people who were registering were walking around the community the people were coming to ask us as CHVs if it's legit or it's a scheme to steal other people's votes."* **(CHV FGD)**. The communities were not sure about the free health services that were being advertised about: *"...there are some people in the community that are still afraid to be registered, there is a program of give directly that is going around and its free so people do not want to associate themselves with free things. And other people are asking if they will be told to pay for the services later on. So they are still doubting the program"* **(FGD-CHV)**. The program was even seen to be *illuminati* because of its freeness: *"...we can say that most people have not registered because they think the program is for *illuminati*. So there should be proper education on the program so that those people can stop thinking that way and register"* **(FGD-CHV)**. Unclear definition of what UHC was hindered passing on of correct information to the community by the CHVs: *"...like now we are not well equipped with information about UHC, we don't know which services are covered under*

UHC. We don't even know the ceiling amount of UHC, so at least we should be well equipped with information about UHC....”

“...Another thing is that there is rumors that the government is just blackmailing the community, that there will come a time that people will be needed to pay KS 500. So if we are equipped with the right information we as CHVs can dilute those rumors in the community.” (FGD-CHV). This programme also caused fear among communities as it was linked to “666” *“.....They doubted it at first and when they doubted it some of them came to try and when they realized it is free they went and spread the news, but some of them feel like no I don't want this card , it is associated with 666 , the end of times is coming , people want to trick us, they want to trap us to give us a card to get everything for free so it is mixed reaction.” KII-HW;*

“...The ones who are doubting are saying that it's just for free for a certain period of time, afterwards they will be asked to pay. And also there are those people who are afraid of free things, they say free is expensive”, WRA

3.8 Barriers

Although the initiation of UHC has positive prospects, there were barriers that needed immediate attention and strengthening. There were sentiments from various respondents that most facilities were critically understaffed. *“...The facilities are still understaffed. Like now Katito is a sub county hospital but due to understaffing problem they don't offer services as from 5pm up to the following day. So concerning the preparation with the staff, there is still understaffing. (FGD-CHV). Workload is also unmanageable: “we are still experiencing high work load, with low staff. We have few staff”...(KII-Requisite equipment and tools are enablers of UHC provision. There was hunger for improvement in materials and equipment supplies. “...availability of essential equipment and tools, ties to human resources for health once you have the health work force in place you must have the requisite tools to enable them deliver on their functions. (KII-HW).* It was noted too that services for people with special needs required strengthening because health care is a human right: *“...someone suffering from paralysis, these are people who will require appliances for the rest of their time and this is very expensive. So if UHC can go to a level where all these can be taken care of and then the appliances that are supposed to be given are there, then we will be comfortable that the people living with disability is taken care of under the UHC...” (KII-PLWD).* Although there was indication that KEMSA had supplied most commodities, there was need to plan for adequate and timely deliveries. There was also need to increase facility infrastructure to cater for storage concerns: *“...One of the challenges am overseeing is the constant supply of commodities. There will be a time that there will be shortage. As UHC is rolled out the number of patients increases and if the commodities are not there it can bring commotion between the staff and the community” KII-HW.*

Sustainability of the programme was in question and it was an area that needed a lot of answers for the success of UHC: *“.. For us my fear is that UHC should not do to us in health what free primary education did to public primary schools. We all know that when they introduced free primary*

education it was very good, you know, schools, they went down. And we no longer hear about them. All we hear about are private schools. We hope that will not happen to health”, KII, CHMT.

4. Discussion

From the findings above it can be concluded that the UHC implementation programme was not well thought out and highlights the importance of application of social marketing strategies for the success of a new program. For example the community did not understand the concept of UHC. Some defined it as NHIF and others said it was a government health subsidy. While health workers were not given an opportunity to participate from a bottom-up point management perspective. They instead received orders to implement the program without adequate resources. The concept did not define the UHC package and enough time was not given for planning, training and sensitization.

Social marketing uses behavioral, persuasion, and exposure theories to target changes in health risk behavior. Social cognitive theory based on response consequences (of individual behavior), observational learning, and behavioral modelling is widely used (Railton, 2001). Persuasion theory indicates that people must engage in message “elaboration” (developing favorable thoughts about a message’s arguments) for long term persuasion to occur (Last, 2001). Exposure theorists study how the intensity of and length of exposure to a message affects behaviour (Perese et al., 2005).

There are basically six stages in a social marketing strategy namely: developing plans and strategies; selecting communication channels and materials based on the required behavioral change and knowledge of the target audience; developing and pretesting materials, typically using qualitative methods; implementing the communication programme or “campaign”; assessing effectiveness in terms of exposure and awareness of the audience, reactions to messages, and behavioral outcomes and refining the materials for future communications. This involves creating a continuous loop of planning, implementation, and improvement (WHO, 2003).

Marketers view the marketing problem as one of developing the right *product* backed by the right *promotion* and put in the right *place* at the right *price* (Lazars, 1949). These key variables in the marketing mix have been named the four Ps by McCarthy (1968). This can be considered by designing an appropriate strategy of managing the 4Ps and can be used in implementing a UHC program. The Product can be either desired behavior, benefits of behavior itself or a tangible object or intangible service. In the case of UHC program the product could have been a package of specific health services to be offered to the communities. The Price would have been all those costs associated with the implementation of the program. For instance costs for essential medicines and commodities, costs for planning meetings, purchases of extra beds, trainings for those officers to do registrations, transport and advertisements. Costs related to the patients would include travelling, waiting time and opportunity costs. The third P connotes Place and it includes making it convenient—for instance for UHC registering people at household level, market places, churches and facility entry points thus arranging for accessible outlets which permit the translation of motivation into actions. The last P stands for Promotion: It is the

communication persuasion strategy and tactics that will make the product familiar, acceptable, and even desirable to the audience. In the case of UHC, fliers, chiefs Barazas (community meetings), announcements in the church, outreaches, women groups, recreational areas electronic and print media targeting specific audiences, thus informing about the upcoming UHC project. It is noted in this study that information about the implementation of UHC was passed to the communities variously. The message was not targeted and the channels were not suitable. For example politicians went round villages telling people to register for UHC using loud speakers on their vehicles, a practice that is synonymous with sensitization during election periods. The interpretation from the community was that UHC was a pathway to steal votes. This inverted messaging minimized acceptability of the programme. Messages by the electronic media was not clear both to the community and health workers and this caused confusion of what UHC was all about. For instance communities did not understand the term “free health care” as it was communicated, and this led them to misinterpret the whole program linking it to “illuminate” (Witchcraft). People’s attitude and acceptability for the behavior change also need to be assessed. Their capacity and interest towards the expected behavior change is important. For instance the health workers were not optimally involved in the roll out, time was not negotiated and it was not a bottom-up approach for project ownership and motivation. Among other considerations was the need for problem description and rationale to the health workers followed by strategic team formation and more importantly carry out SWOT analysis. A research plan is important to understand target audiences characteristics, attitudes, beliefs, values and behaviors (Radha, 2011), for example persons who are abled differently, the elderly and the youth—these are audiences with special needs. Development of a marketing strategy becomes critical in order to identify target audience and their specific needs, budget and resource allocation. Planning for the next course of action—the intervention, in this case develop policies, SOPs and work plans by departmental managers and develop monitoring mechanisms are key areas for the successful UHC implementation. All these parameters would have been captured if social marketing techniques were employed.

5. Conclusion

There were misconceptions and misunderstanding of what UHC entailed both to the community and to health care workers. Planning and sensitisation was inadequately done and barriers to effective implementation of UHC were noted. The communities were confused about the program and its importance. There is ample evidence to suggest that social marketing can be an effective tool not just in health care treatment but also when introducing a new program in health care, to educate both providers and consumers, just as it has been in health promotion and disease prevention. The evidence on social marketing suggests that its underlying principles of behavior change can be used to influence health care provider behavior and consumer decision making through multiple message strategies and channels. As the remaining 43 Counties of Kenya plan to roll out the UHC program, it is important to adopt the principles of social marketing to improve program outcomes.

Competing Interests

The authors declare that they have no competing interests.

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