

Design and Implementation of Community-Based Health Insurance Schemes in Northern Uganda: Evidence and Policy Implications

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Abstract *Achieving Universal Health Coverage remains a global challenge. Globally, over 100 million people are pushed into poverty annually due to high out-of-pocket expenditures. In Uganda, community-based health insurance penetration remains low. The gap is widest in post-conflict Northern Uganda, where poverty is high and health financing is fragile. This study investigated the status, design and implementation of community-based health insurance schemes in Northern Uganda. A descriptive cross-sectional study was conducted in Northern Uganda between March and May 2026. Using purposive and stratified sampling, 27 participants were engaged through Key informant interviews, In-depth interviews and Focus group discussions to generate qualitative data. Data were analyzed thematically using Braun and Clarke's framework. Four themes and 12 related sub-themes emerged. By status, schemes were mainly characterized by operational discontinuity. By design, participants proposed shifting from a member-managed to a provider-managed model, but implementation relied mainly on costly grassroots mobilization. Findings showed that scheme sustainability is structurally dependent on donor subsidies, and the recent withdrawal of support compromised operations. The absence of the National Health Insurance Scheme and formal regulation has weakened the schemes, while expectations of free care remain a major socio-cultural barrier. Community-based health schemes in Northern Uganda remain trapped in a cycle of weak design, low enrollment, and donor dependence. The sector needs to transition to legally recognized, government-subsidized, provider-managed schemes with expanded benefits and integrated governance.*

Keywords *Community-Based Health Insurance, Donor Dependence, Health Financing, Health Insurance Models, Universal Health Coverage, Uganda.*

Introduction

Globally, achieving universal health coverage remains a challenge. The World Health Organization estimates that 150 million people face financial catastrophe annually due to health payments, and over 100 million are pushed into poverty [1].

Community-based health insurance (CBHI) schemes globally operate on the principle of risk pooling through regular members' premium contributions, reducing out-of-pocket payments, but they differ in design [2, 3]. Three broad models exist: the basic model implemented as member-managed, provider-managed, or third-party-managed; the modified Basic model with user fees, subsidies and expanded pooling; and the Nationwide model requiring political commitment and integration into national financing [4, 5].

In sub-Saharan Africa (SSA), the challenge is compounded by a high burden of disease, low public health spending, and large informal economies. Most household pay directly for care, leading to delayed treatment and financial hardship [6]. CBHI has been promoted across the region to extend financial protection to rural and informal populations. Evidence from Burkina Faso, Cameroon, and other SSA countries indicates that CBHI can reduce costs and improve access, but low enrollment, high dropout, weak governance, and sustainability challenges have constrained implementation [7].

In East African, CBHI has been piloted as part of national Universal Health Coverage (UHC) strategies. Rwanda and Kenya have integrated community schemes into national systems, while in Tanzania and Uganda, CBHI remains largely fragmented and partner-driven. However, results vary, and issues of low take-up and retention threaten viability. In Uganda, CBHI began in the mid-1990s and has largely operated under Basic and Third-Party managed models through NGOS (Non-Governmental Organizations), CBOs (Community-based

Organizations) and VSLAs (Village Saving and Loan Associations) with pilots in Amuru, Gulu, Kabale and Kasese [8, 9]. Despite over three decades, penetration remains negligible at 1.1% against a 25% policy target [10]. The gap is widest in high-need areas like the Acholi sub-region in Northern Uganda, with poverty at 63% and post-conflict vulnerabilities [11-13]. The commitment to UHC is undermined by a fragile and inequitable health financing system. And, only 68.5% of total health expenditure is covered through domestic public and pooled financing [10]. Furthermore, 82% of Ugandans report concern about affording essential care and 68% have foregone needed treatment because of cost, highlighting serious gaps in access and equity [14].

Implementation has occurred without a clear legal framework, producing policy contradictions that have impeded scale up [10, 15]. Despite CBHI's long presence, critical gaps persist in evidence on whether existing models, design structures and implementation arrangements align with community needs in undeserved settings. This limits understanding of the root causes of low enrollment, restricted benefits, financial instability and inequities. As Uganda prepares to introduce a National Health Insurance scheme, the absence of robust evidence on CBHI performance including Northern Uganda risks excluding community mechanisms from national planning and service delivery. Therefore, this study aims to investigate the status, performance and design of CBHI schemes in Northern Uganda to generate evidence for policy and practice.

Materials and Methods

Study Design and Setting

Uganda is a geographically and culturally diverse country split into administrative units including regions and sub-regions. A community-based cross-sectional multiple-case study was carried out between March and May 2026, in Acholi sub-region of Northern

Uganda. The study was conducted among two schemes: Karin and Amuru-Kilak CBHI schemes. The “Karin” CBHI scheme was first introduced in 2010, as part of post-conflict health financing interventions located in Gulu city. Whereas the Amuru CBHI scheme was first introduced in 2011 in Amuru district. The district is located 60km northwest of Gulu city. Gulu City is the largest city in Northern Uganda about 340 Km north of Kampala Capital City. The region experienced a 20-year armed conflict from 1986 to 2006 which resulted in low socio-economic development.¹⁸ The economy is predominantly informal, with about 80% of residents engaged in subsistence farming and small-scale trade.

Sample Size and Sampling Procedure

Participants were selected using purposive sampling. Data saturation determined the minimum number required for the interviews. Stratified sampling ensured representation from both scheme members and non-members, across age groups, education levels, and geographic areas, to capture variation in scheme experiences. VHTs (Village Health Teams) were sampled from the VHT register obtained from health facilities, while VSLA members were sampled from group records. A sample size of 27 participants was determined.

Data Collection Methods

Primary data were collected using semi-structured guide for Key Informants, Focus Group Discussions and In-depth interviews. Secondary data were obtained through a desk review of relevant documents. The KIIs were conducted with scheme managers, healthcare providers, local leaders, and officials from the Uganda Cooperatives Health Alliance to obtain information on revenue collection, risk pooling, governance, premium levels, enrolment criteria, provider networks and member satisfaction. We conducted FGDs separately with VSLA members and VHTs to capture diverse perspectives on scheme design

and implementation. IDIS were conducted with enrolled community members and healthcare providers. A desk review was also done for policy documents, scheme registers, annual plans, committee minutes, the National Health Insurance Bill 2021, and relevant national and international literature on CBHI. To ensure validity and reliability, the interview guides were pretested on 5% of the target population on a setting similar to the study area before the main data collection. Four research assistants (RAs) with graduate level training in research and public health, conducted the interviews. The RAs were based in Gulu City and unaffiliated with the scheme in the study sites. Data collectors were proficient in the local language, Acholi, and English, received training and were closely supervised to maintain quality. Supervisors and the principal investigator conducted daily oversight of field activities to ensure adherence to protocols.

Data Processing and Analysis

Data was analyzed using thematic approach manually following Braun and Clarke’s framework [16], which involves transcription, coding, theme identification, and categorization. The interviews were transcribed verbatim in English, translated from local language “Acholi” to English by those proficient in the local language and checked for consistency. Data was coded and insights and emerging patterns were identified. Data was summarized and synthesized, keeping the key expressions of respondents as illustrative cases to express major contextual observations in this study. Triangulating FGDs, IDI and KIIs achieved interactive comprehension.

Ethical Considerations

The Research and Ethics Committee of Nsambya Hospital, a teaching hospital of Uganda Martyrs University, approved the study. Permission to conduct the study was sought from Texila University in George Town,

Guyana. Administrative authority was obtained from the City Health Officers of Gulu. The participants were briefed on the study and informed consent was granted. Information obtained was kept confidential and securely stored. With the aim of preserving anonymity and privacy of study participants, full names of participants are not disclosed, nor did we collect data on participants' age, or gender. Data collectors and researchers had no prior relationship with the study participants.

Results

Description of Study Participants

In total, 27 participants were interviewed: three Focus Group Discussions (FGDs) comprising of five members (VSLA Group Leaders in Amuru district, VHTs from Unyama and Agonga wards in Gulu City), five In -Depth Interviews (IDI), and seven Key Informant Interviews (KII) in table 1. To avoid duplication of information, each respondent participated in only one data collection activity-either the FGDs, IDI or KII.

Table 1. Characteristics of Study Participants

Position	Interview type	Location
CBHI Focal Person	KII	St. Mary's Hospital Lacor, Gulu City
Health In-charge	KII	Gracious Medical Centre, Amuru District
CBHI Official	KII	Uganda Cooperatives Health Alliance, Kampala Capital City
City Health Officer	KII	Gulu City
District Health Officer	KII	Gulu District
Village Health Team personnel	FGD	Gulu City
Billing Manager	IDI	St. Mary's Hospital Lacor, Gulu City
Director	KII	Karin Clinics, Gulu City
CBHI Focal Person	KII	Unyama Ward, Gulu City
VSLA Group Leader	FGD	Amuru District
Health Facility In-charge	IDI	Agonga Ward, Gulu City
CBHI Focal Person	IDI	Agonga Ward, Gulu City

The Status, Performance and Design of CBHI schemes in Northern Uganda

Four main themes with 12 related sub-themes emerged from analysis of the interviews. The main themes were: (i) status of community-based health insurance schemes,

(ii) design of CBHI schemes, (iii) implementation experiences, and (iv) sustainability and policy environment. Respondents' quotations are indicated by the prefix of their position, and each has a unique numerical suffix. The themes and related sub-themes are summarized in Table 2.

Table 2. Summary of Theme, Sub-theme and Code Framework

Major Theme	Sub-themes	Codes
Theme 1: Status of CBHI scheme	Operational continuity	Suspension and "On Hold" status
	Limited management systems & Integrity	Internal fraud and Accountability
	Weak institutionalization and Poor leadership commitment to CBHI	• Lack of policy mandate • Low facility Uptake

Theme 2: Design of CBHI scheme	Financial viability challenges of CBHI at facility level	• Failure to manage financial crisis • Health financing reform (Shift from member managed to Provider managed)
	Premium structure & Pricing	Low premiums against high utilization costs (Tiered pricing)
	Benefit package & Exclusions	• Coverage limits • Inclusion of chronic care
Theme 3: Implementation experiences	Mobilization & Advocacy	• Grassroots engagement • Leveraging "Success stories" and peer advocacy
	Service delivery challenges	Staffing Issues
	Community behavioral barriers of value for money	• "Refund" Mentality • Prioritization of death over health
Theme 4: Sustainability and Policy environment	Financial dependence on external subsidies	• Subsidy requirements • Donor withdrawal impacts
	Policy & Governance frameworks	• Lack of formal regulation • Absence of National Health Insurance Bill (NHIS) • Adoption of government absorption models
	Socio-cultural barriers to sustainability	• Community mindset and Expectation of free health services

Theme 1: Status of Community-Based Health Insurance Schemes

Operational continuity

Suspension and "On Hold" Status

In this study, status of CBHI scheme was expressed by participants as the main theme in understanding the critical gaps in the existing CBHI models. Operational continuity in the administration of CBHI services to scheme members was regarded as continuation for the functioning of the scheme. The suspension and "On Hold" Status of the scheme reflected a lack of operational continuity. One of the IDI respondents expressed that:

"We decided at some point to first put CBHI on hold so that we can just try and see what is

going on. we put it on hold like for almost a year." (Health Managers, Karin Gulu City)

Similar expressions were reported by FGD respondent:

"The program started very well. but the program was no longer there. I don't know what happened to stop." (VSLA, Amuru District)

Limited Management Systems and Integrity

Internal Fraud and Accountability

Some members asserted that to some extent internal fraud and accountability compromised management and integrity of the scheme. Subsequently, contributing to the poor status of the CBHI scheme. This was asserted by an IDI respondent:

“Along the way there was also a lot of fraud in the CBHI program. Where We found out that communities or groups who paid money to some staff it was not declared.” (Health Managers Karin, Gulu City)

Weak institutionalization and Poor leadership commitment to CBHI

Lack of Policy Mandate

Some participants noted the lack of government policy and regulation on CBHI has resulted in poor official support from local leaders. Thus, limited government ownership was mentioned as a critical gap in the development of scheme that align with community needs and pooling of financial resources. This was highlighted by an IDI participant:

“Although some leaders have joined individually and benefit from the scheme, they cannot act as public ambassadors for CBHI due to the absence of formal government backing.” (Health Managers, Karin Gulu City)

Low Uptake

However, some participants expressed low uptake was due to poor leadership commitment and not merely weak government institutions. The KII respondent said ardently that:

“Some political leaders and government officials attend meetings only caring about how much they will be paid, and they don’t communicate the information back to their councils, and out of 25 facilities trained only seven actually engaged communities and developed MOUs ”(Uganda Cooperatives Health Alliance Official)

Theme 2: Design of CBHI Schemes

Financial viability challenges of CBHI at Facility level

Manage Financial Crisis

Study participants described the challenges of health financing landscape and nature of support preferred to strengthen the role of CBHI in the provision of health services as i)

technical capacity building and, ii) provision of tools and supplies. One IDI participant lamented that financial sustainability problem exist due to low enrolment:

‘CBHI works with numbers. So, when we do not have adequate numbers, we run a loss. and that has happened a lot of times.’ (Health Managers, Agonga Ward Gulu City)

Then expressed the need for a partnership and support to easily manage financial crisis particularly external funds so as to subsidize service costs and avert operation capacity gaps at the facility level. The IDI participant said:

“We also realize that for a local initiative like ours, CBHI needed a partnership for support....software that can help us easily manage it.” (Health Managers, Karin Gulu City)

Health Financing Reform

Some participants indicated a critical gap in the design of the existing community prepayment model (member managed) - indicating such schemes tend to cover a limited geographical area; dependence on social solidarity and trust amongst community members may undermine the establishment and continuity of such schemes. Some members proposed a shift from member-managed to provider-managed. One key informant participant said:

“We are now redesigning to shift from one in which community share their input to a provider - driven redesign with limited community management..... enabling providers to primarily cover expensive inpatient and offset operational costs.” (Health Managers, Karin Gulu City)

Premium Structure and Pricing

Tiered premium

Some participants reported that the current CBHI model uses a tiered premium structure with pooled billing and donor subsidies which presents a viability challenge of low member

contributions against high service costs. One IDI participant said:

“A key financial challenge was that the tiered premiums collected were too low to cover the actual cost of care, creating dependence on donor subsidies. With small, age categorized contributions pooled by groups of 30 or 40..... ages 0-5years paid about 2,500UGX (US\$0.66), ages 6-12years paid 5,000UGX (US\$1.33), and adults paid 7,500UGX (US\$1.99).” (CBHI Focal Person, Agonga Ward Gulu City)

Then added:

“The person would come to seek care when they have paid a premium of 2,500 UGX (US\$0.66), but you would get treatment worth 40,000UGX (US\$10.63) Sometimes they would get surgical procedures. As such, the scheme had to bill the hospital quarterly, or the provider sought and sought external support to bridge the gap between member payments and hospital expenditures.” (CBHI Focal Person, Agonga Ward Gulu city)

Benefit Package and Exclusions

Coverage Limits and Inclusion of Chronic Care

Participants reported a critical design gap in the benefit package, describing it as having defined limits and not fully covering all services, particularly chronic care. They noted that when care must be outsourced, beneficiaries must make additional out-of-pocket contributions on top of their premiums, which undermines financial protection. This was expressed vividly by a key informant.

“On package limits and extra contributions.... we implement in packages and inform beneficiaries of the limits. If a service is outsourced, they may need to contribute on top of the package.” (KII-Health Managers, Karin Gulu City)

Participants also reported that excluding chronic care for non-communicable diseases such as hypertension and diabetes from the

benefit package is a design fault. In a community with high poverty and already low enrollment, this gap led to dropouts because members with long-term conditions could not get the care they need despite paying premiums. Thus, weakens risk pooling.

“Lessons show that even if it means the premium goes up, you must include a benefit package for chronic care.” (Uganda Cooperatives Health Alliance Official)

Despite the challenges, many participants indicated members perceived value in the CBHI premiums because they reduced out-of-pocket costs when illness occurred frequently. Speaking her mind, an FGD surmised:

“Many members feel the co-payment of 5,000UGX (US\$1.33) is affordable. Within three months, a child is likely to fall sick, so the amount we spend is much less compared to paying the full price each time.” (FGD-VSLA Amuru District)

From another perspective, the IDI noted that enrollment was feasible in school settings. This is because the premium was framed as a relocation of an existing fee rather than an extra payment.

“Students have a medical fee of 20,000UGX (US\$5.32); the scheme requires only 10,000UGX (US\$2.66). As such, cutting the direct health cost by 50% avoids adding a new financial burden.” (CBHI Focal Person, Agonga Ward Gulu City)

Theme 3: Implementation Experiences

Mobilization and Advocacy

Grassroots Engagement

The findings showed there is a major implementation gap due to heavy reliance on labour intensive, face to face mobilization to drive enrollment. Teams had to move to households spread apart which is costly and difficult to sustain.

“We move village to village Monday to Monday mobilizing people from local markets and VSLA groups to enroll.” (FGD-VSLA Amuru District)

Leveraging Success Stories and Peer Advocacy

Findings from this study indicate community uptake of CBHI remained a challenge due to low buy-in from key decision makers and skepticism about the insurance model. Men, as heads of households, were often reluctant to enroll and community members questioned the value of paying premiums if they did not fall sick, reflecting a poor understanding of risk pooling. Despite this, the scheme's strength came from peer influence. Some participants described the enthusiasm of pioneer clients (friends and relatives who were already enrolled in the scheme) referred to as “Karin Friends”, shared testimonies of accessing surgery and other services, and their success stories became the main driver that convinced others to join. Participants said endorsements from trusted individuals had a profound influence. One Key informant participant said that:

“Success stories from those that made it to surgery.... made other people come.” (CBHI Focal Person, Unyama Ward Gulu City)

This was supported by another KII participant:

“The scheme uptake is low. Men are often not buying in as heads of households, which is a challenge..... However, 'Karin friends' inspiring positive testimonies changed the narrative towards CBHI's.” (Health Managers, Karin Gulu City)

Service Delivery Challenges

Staffing Issues

Findings showed staff turnover was an implementation challenge which disrupted continuity and increased costs. One KII reported that:

“When you equip a team and they move, you have to reinvest resources to retrain a new team, which affects continuity.” (Health In-charge, Amuru District)

Community Behavioural Barriers of Value for Money

The "Refund" Mentality

Some participants revealed that a major barrier to retention was poor understanding of how insurance works. Many community members expected direct refunds if they did not use services, and saw premium payments as a loss rather risk pooling. This perception made them reluctant to renew, especially during periods when no one in the household fell sick. An IDI participant narrated that:

“The biggest complaint was If I don't fall sick, will my money be given back?.” (VHT Gulu City)

Prioritization of Death over Health

Findings show that the community has not appreciated the role CBHI plays. Interestingly, participants reported that many people drew parallels between saving for health and death. A participant said that:

“Many find it difficult to save money for health when they are not sick. But, save for death. If I don't fall sick, where does my money go? People have joined "death groups" where they save money for funerals—buying a coffin, food, and music—but it is difficult for them to save money for healthcare to delay death.” (KII-Uganda Cooperatives Health Alliance Official)

Theme 4: Sustainability and Policy Environment

Financial dependence on external subsidies

Subsidy requirements

Finding shows the scheme could not sustain itself on member premiums alone. Even the lowest premium levels were unaffordable for many households in high-poverty communities, so without external subsidies the hospitals and providers would incur losses. This created a

structural dependency where CBHI could only function if outside funding filled the gap between what members paid and the actual cost of care. One KII participant said:

“No, they cannot manage without subsidy. Even, the lowest premiums....are a struggle for some. Without subsidy, the hospitals and providers would suffer...” (CBHI Focal Person, Agonga Ward Gulu city)

Then added:

“If there’s no one from outside to pay, it cannot work.” (CBHI Focal Person, Agonga Ward Gulu City)

Donor Withdrawal Impact

The withdrawal of donor support has created a major financing gap for CBHI implementation at community level. Respondents reported that previously, key health promotion based CBHI activities and community mobilization were supported by USAID and other health partners. With the current absence of funding, these essential activities have stopped completely. This loss of external funding has left local health teams without resources to sustain awareness, recruitment, and day-to-day CBHI operations, making it difficult to maintain momentum and coverage for the scheme.

“At present, we have no funding. Essential activities like printing flyers and leaflets require financial resources. In the past, this was provided by USAID, health partners and other donors. But that funding has now ceased.” (KII-Health Managers, Karin, Gulu city)

Policy framework and governance frameworks

Lack of formalization and Political buy-in for CBHI

Participants reported that a critical barrier to scale-up was the absence of formal government recognition for CBHI. Respondents noted that community members viewed health services as

a government responsibility and were resistant to paying premiums, making it difficult to gain traction from the community level upward.

“CBHI.....is not being adopted by our local leaders because its is not a policy. it’s not a government regulation or government policy. The government needs to formalize somethings as a policy because starting from down here, people are very stubborn, they know government provides everything.” (KII-Health Managers, Karin Gulu City)

Absence of a National Health Insurance Scheme (NHIS) Undermining CBHI Viability

Many participants noted lack of a formal National health Insurance Scheme was a major structural challenge to CBHI viability. Without an NHIS framework, CBHI operated as an isolated community project with no legal mandate, guaranteed funding, or integration into the public system. Political processes further destabilized progress- an insurance bill that could have provided government support stalled due to elections. Respondents emphasized that if government started paying facilities directly, enrolled members could actually access care, but until NHIS is in place, CBHI remains fragmented, donor dependent, and vulnerable to political delays:

“There was an insurance bill connected to the government, but it was affected by the elections. Now that elections are done, if the government pays those facilities, people who have subscribed can access care.” (KII-Health Care Leader, Gulu City)

Adoption of Government Absorption Models

Respondents identified government absorption as the key pathway to making CBHI viable and equitable. They proposed that government should take ownership of the scheme, similar to the Parish Development Model (PDM), and roll it out to the grassroots where community structures already exist. For financial sustainability and equity, participants recommended that government prioritize and

pay premiums for vulnerable groups-the elderly, persons with disabilities, and the poorest- who cannot afford to contribute:

“ if the government can absorb the program, like the PDM program, and take it to the grassroots.....it might work. ”(KII-CBHI Focal Person, Agonga Ward Gulu City)

Similarly, another FGD expressed that:

“The government should prioritize the vulnerable, the elderly, and the disabled. They should pay the premiums for those who cannot afford them. ”(FGD-VHT's, Karin, Gulu City)

Socio-Cultural Barriers to Sustainability

Community Mindset and Expectation of Free Health Services

Some respondents reported prevailing community mindset round healthcare a fundamental barrier to CBHI adoption. Many people were accustomed to receiving free services through government facilities and donor programs, and therefore resisted the idea of paying premiums. Respondents noted that without deliberately addressing this attitude, any insurance-based intervention would struggle to gain acceptance. Shifting perceptions from “*health is free*” to “*health requires shared contribution*” was identified as the first and most important step for CBHI to succeed.

“We have to fight the mindset first.... because people are used to free things.....the mindset needs to be worked on for any intervention like that to succeed.” (KII-Health Care Leaders, Gulu District)

Discussion

Community based health insurance is promoted globally as a mechanism for risk pooling to reduce catastrophic health expenditure [17]. However, findings from Gulu city and Amuru district show CBHI in Northern Uganda remains fragile, poorly designed and unsustainable.

Status of CBHI Schemes

The CBHI schemes were characterized by operational discontinuity, with frequent suspension for months due to financial collapse. The absence of a government policy mandate limited leadership support, as leaders could not act as “public ambassadors ”without formal backing. Internal fraud was also reported, eroding member trust. This aligns with sub-Saharan Africa evidence where CBHI collapses due to weak governance and lack of state integration [18]. In Uganda, with penetration at 1.1% against a 25%target and poverty at 63% in Acholi, the lack of institutionality has constrained scale up [19].

Design of CBHI Schemes

Three design flaws emerged. First, the member-managed model was financially unviable due to low enrollment:”CBHI works with numbers.” Respondents proposed a shift to provide-management to cover inpatient costs and improve pooling, consistent with reforms in Rwanda and Kenya that improved financial stability [20]. Second, premiums were structurally underpriced. A tiered premium of 2,500-75,000 UGX (US\$0.66-9.94) could not cover treatment costs of 40,000 UGX (US\$10.63), creating dependence on donor subsidies. With only 68.5% of Uganda’s health expenditure from domestic pooled funds, this model could probably be unsustainable [21]. In contrast, previous studies found that subsidies increased health insurance uptake. Thus, it is sustainable [22]. Third, exclusion of chronic for NCDs led to dropouts. This contradicts UHC principles of comprehensive coverage [23]. However, members still perceived value in co-payments, suggesting demand exists if benefits align with community needs.

Implementation Experiences

Implementation relied on costly, labor-intensive multiplication, Low male buy-in and skepticism about risk pooling were common, consistent with findings from Ethiopia and

Nigeria [24]. However, peer advocacy through “*Karin Friends*” faith positive testimonies drove enrollment, confirming that visible benefits are key drivers of uptake. This similar to a Tanzanian study done in 2020 among informal workers [25]. Behavioral barriers included a “*refund mentality*” and prioritization of “*death group*” over health savings. As such, behavior change communication could improve implementation of CBHI schemes.

Sustainability and Policy Environment

Schemes were structurally dependent: If there’s no one from outside to pay, it cannot work. Withdrawal of USAID and other donors halted core activities. This reflects sub-Saharan Africa evidence on donor volatility undermining CBHI [26, 27]. The absence of NHIS and legal framework left CBHI isolated. Respondents proposed government absorption, similar to PDM, with subsidies for vulnerable groups. This aligns with the nationwide CBHI model requiring political commitment and leadership and the expectation of free care remains a major socio-cultural barrier [28].

Strength and Limitations of the Study

The study captured a wider range of experiences and perspectives by including health providers and experts from health insurance and facilities. Also, a mixed use of focus group discussions, in-depth interviews and key informants added methodological depth that improved the study’s rigour, reflexivity, trustworthiness and analytical richness. Social desirability bias may have affected some responses during data collection; however, using multiple sources enhanced the study’s reliability and credibility.

Conclusion

The CBHI in Northern Uganda is in a cycle of weak design, low enrollment, and donor dependence. For CBHI to contribute to UHC, it must transition to integrated, provider-managed schemes within a national framework. Priorities

include formal regulation, actuarial premiums with subsidies, expanded benefits, and investment in governance. As Uganda develops NHIS, community mechanism should be reformed and integrated rather than abandoned.

Recommendations for Policy and Practice

Policy

Absence of a policy mandate limits leadership support and scale up. There is a need to fast-track the National Health Insurance Bill and formally recognize CBHI as a complementary UHC mechanism under Ministry of Health regulation.

Adopt government subsidies for the vulnerable. Premium are unaffordable and schemes cannot survive without external funding. Government should pay premiums for the elderly, PWDs, and poorest household similar to the PDM model, to ensure equity. Shift to Provider managed models, as member managed schemes seems to have failed due to low numbers, weak management and sustainability.

Practice

We suggest redesigning financing, addressing underpriced premiums, and removing the exclusion of chronic care, which are contributing to financial losses and dropouts. Conduct actuarial pricing and expand benefits to include NCDs (non-communicable diseases). And frame premiums as a reallocation of existing costs in schools and VSLA groups.

Also, strengthen governance and accountability by engaging in digital systems, regular audits, and train managers on financial and insurance principles. Finally, use peer-led mobilization and health education, including peer success stories, to drive district-wide enrollment. For CBHI to contribute to UHC, it must be legally recognized, government-subsidized, provider-managed and community-driven. Without these reforms, CBHI will

remain fragmented and unable to protect poor households from catastrophic health costs.

Conflict of Interest

The authors declare that they have no competing interests, financial or otherwise, that could have influenced the conduct, analysis, or publication of this study.

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Ethical Approval

The Research and Ethics Committee of Nsambya Hospital, a teaching hospital of Uganda Martyrs University, granted ethical approval for this study. Administrative permission was obtained from relevant local

authorities in Gulu City, Gulu and Amuru Districts. We obtained written informed consent from all participants before data collection. The study maintained confidentiality and anonymity throughout.

Data Availability

The datasets generated and analyzed during the current study are not publicly available due to the qualitative nature of the data and the need to protect participant confidentiality. De-identified data may be made available by the corresponding author upon reasonable request.

Author Contributions

HO conceptualized the study, designed the methodology, coordinated data collection, conducted analysis, and drafted the manuscript. EO, JK, MO, and RKB contributed to study design, interpretation of findings, critical review of the manuscript, and approval of the final version. All authors read and approved the final manuscript.

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