SOCIAL INNOVATION IN HEALTH INITIATIVE

ISHAKA HEALTH PLAN COMMUNITY-BASED INSURANCE SCHEME

CONTINENT	Africa
COUNTRY	Uganda
HEALTH FOCUS	Primary Healthcare, Health Financing
AREAS OF INTEREST	Community Ownership, Financial Integration, Strategic Partnerships
HEALTH SYSTEM FOCUS	Health Financing

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ISHAKA HEALTH PLAN
COMMUNITY-BASED HEALTH INSURANCE SCHEME

The scheme facilitates access to quality and affordable health services among rural communities in Bushenyi District, Uganda

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CONTENTS

ABBREVIATIONS

CBU	Christian Brothers University
CBHI	Community-based Health Insurance
CHE	Catastrophic Health Expenditure
DFID	Department for International Development
HIV	Human immunodeficiency virus
HPV	Human Papilloma Vaccine
MOH	Ministry of Health
OPD	Out Patient Department
OVC	Orphans and Vulnerable Children
PFP	Private for Profit
PNFP	Private Not for Profit
SHU	Save for Health Uganda
TB	Tuberculosis
UBOS	Uganda Bureau of Statistics
UCBHFA	Uganda Community-based Health Financing
VSO	Volunteer Service Overseas
WHO	World Health Organization

CASE INTRODUCTION

Uganda's health system operates under a decentralised structure, with services delivered through national, regional, district, and community levels. The Ministry of Health provides policy direction, while districts manage implementation. Health services are offered by public, private-not-for-profit, and private-for-profit providers. There are 4 national referral hospitals; 16 regional referral hospitals; 62 general hospitals; and 215 Health Centre IVs, supported by over 1,500 Health Centre IIIs and more than 4,000 Health Centre IIs. Despite progress in expanding primary healthcare and disease control programmes, the system faces challenges such as inadequate financing, human resource shortages, and limited infrastructure.

Ishaka Health Plan (IHP) is a community-based health insurance scheme which aims at improving access to quality and affordable healthcare services to low-income earners in rural communities in Bushenyi District, Uganda. The scheme reduces out-of-pocket expenditure among its members through risk pooling and prepayment mechanisms. Previous studies have reported that about 16% of the households in Uganda suffer from catastrophic health expenditure due direct costs, while about 27% of them suffer catastrophic health expenditure due to both direct and indirect costs. Although evidence has shown that community-based health insurance schemes increase utilisation of healthcare services and reduce catastrophic health spending, these schemes are affected by low membership and drop-outs, which in turn result in reduced risk pooling.

Ishaka Health Plan works by mobilising members from pre-existing community groups and schools/tertiary institutions. It ensures that more than 60% of the members of the pre-existing group are enrolled into the scheme to avoid adverse selection. To ensure that scheme members are retained and are able to pay the premium, they are supported to start income-generating activities, engage in agriculture, and to form village saving groups. The groups' leadership owns and runs the scheme and they are responsible for collecting premiums from their members on a quarterly year basis. Scheme members pay a co-payment of UGX 5,000 at the health facility when accessing the healthcare services.

Annual membership of the IHP scheme has remained constantly high, ranging from 4,000 to 5,000 people for the period 2010–2019. Utilisation of health services by scheme members has also remained high, around 4,000 patients annually, over this period. The IHP scheme comprises 15 burial groups, 3 primary schools, 2 secondary schools, and 2 tertiary institutions. The scheme covers a wide range of illnesses like malaria, tuberculosis, surgeries, HIV/AIDS, accidents, and cancer.

This case study demonstrates strategies which could be implemented to improve enrolment and retention of members in community-based health insurance schemes to ensure increased risk pooling.

1. INNOVATION PROFILE AT A GLANCE

Organisation details

Organisation name	Ishaka Health Plan
Founding year	1999
Founder name	Mr. Daniel Kakunta
Founder nationality	Ugandan
Current head of organisation	Mr. Daniel Kakunta
Organisational structure	Non-profit Organisation
Size	8 team members

Innovation Value

Main value proposition	Ishaka Health Plan is a community health insurance scheme that facilitates easily accessible, quality, and affordable health services to low-income earners in rural communities in Bushenyi District
Beneficiaries	Pre-existing community groups in a rural setting
Key Components	1. Utilization of already established, pre-existing community groups 2. Capacity building of pre-existing groups 3. Income-generating activities 4. Health education and promotion 5. Micro health research
Main income streams	Some jigger-directed donations from Young Living Foundation and participation in jean shoe house cutting parties from individuals
Annual expenditure	USD 281,081 as of 15 October 2024

Operational Details

Main income streams	Revenue from premiums and other income generating activities
Annual expenditure	UGX 190,013,896
Cost per person served	UGX 37,000

Scale and Transferability

Scope of operations	Bushenyi District, South Western Uganda
Local engagement	Bushenyi District local government, 3 primary schools, 2 secondary schools, 2 tertiary institutions, 15 burial groups and Save for Health Uganda (another community health insurance scheme)
Scalability	For scale up, the following criteria should be considered • Working with pre-existing groups • Over 60% of members in pre-existing groups should show commitment and enrol into the scheme • Self-motivated staff including volunteers
Sustainability	Ensuring involvement of pre-existing groups in scheme operation activities (such as determining premium to pay and its collection) improves community ownership of the project and sustainability.

2. CHALLENGES

Despite a global call for countries' health systems to ensure that all citizens have access to quality health services that they need without suffering financial hardship (Universal Health Coverage), around 926.6 million people worldwide suffered catastrophic health expenditure exceeding 10% of household budget in 2015 (WHO and World Bank, 2019). A recent study in Uganda indicates that there is inequity in the distribution of health care benefits (Kwesiga et al., 2015) and catastrophic health expenditure (CHE) is evident as 16% of households experience CHE from direct costs and 27% from direct and indirect costs (Yap et al., 2018).

Over the last 20 years, Uganda has had various health reforms aimed at improving access to quality and affordable health services for her citizens. These reforms include the introduction of user fees at the point of care in public health facilities in the late 1980s, in order to generate funding for health facilities. Due to low utilisation of health services by the poor (people living on less than USD 1 per day per person), user-fees were abolished in the 1990s. Decentralisation to devolve primary health care responsibilities to districts was also undertaken in the 1990s, with the intention of improving health service delivery and financial management.

Despite implementation of the above health reforms for improved access and affordability of health services in Uganda, out-of-pocket payment has remained high (estimated at 50%) (Orem et al., 2013). Additionally, about 30% of the patients suffer catastrophic health expenditure of more than 10% of their estimated annual expenses and over 70% of these sell property or borrow money to pay for health services (Anderson et al., 2017). This undermines the efforts towards Universal Health Coverage.

In order to reduce out-of-pocket expenditure and achieve universal health coverage, people must be able to participate in health financial risk pooling and prepayment mechanisms (WHO, 2010). Community health insurance is a general term for voluntary health insurance schemes organised at community level and characterised by community members pooling funds to offset the cost of healthcare (Criel et al., 2004; Soors et al., 2010). Community health insurance reduces catastrophic health expenditure through prepayment and pooling funds (Lu et al., 2012). These community insurance schemes have been shown to improve utilisation of health services and scheme members are two to ten times more likely to utilise outpatient care services compared to non-members (Demissie and Negeri, 2020; Haven et al., 2018). The schemes have also been shown to reduce the risk of under-five child mortality by 36% (Haven et al., 2018).

Community health insurance schemes have been operating in Uganda since the early 1990s and most of them are hospital-based. Despite the fact that community health insurance schemes have the capacity to improve utilisation of health services and financial protection, schemes in Uganda face a challenge of low enrolment of members, which in turn affects their sustainability (Basaza et al., 2007). Low scheme membership leads to reduced risk pooling, incapable of benefiting all members, (WHO, 2003) and to increased dropouts (Mebratie et al., 2015). Studies have indicated that inability to pay premiums, lack of trust in scheme management, lack of knowledge on the schemes' design and operation (Basaza et al., 2008, 2007), distance to the service provider, quality of care provided (Turyamureba et al., 2019), and belief that government has a policy to provide free health care to all (Baine et al., 2018) are responsible for the low engagement of Ugandans in community-based health insurance (CBHI) (Basaza et al., 2007).

This Ishaka Health Plan (IHP) community health insurance scheme case study provides insights into how insurance schemes reduce dropout rates and improve enrolment of members.

3. INNOVATION IN INTERVENTION

Ishaka Health Plan is a community-based health insurance scheme operating in Bushenyi District, South Western Uganda. It started as a hospital-based scheme in 1999 and later transformed into a community-based health insurance scheme in 2004. Its vision is "through community collaborations to impact the health of underserved Ugandans in the Bushenyi District, including orphans and vulnerable children, (OVC) and people living with and affected by HIV/AIDS". IHP was founded by Mr. Kakunta Daniel who is a retired Seventh Day Adventist religious leader and has worked with the communities for a long time.

The establishment of the Ishaka Health Plan (IHP) is attributable to the founder, Mr. Kakunta Daniel, whose professional background is rooted in a deep commitment to social justice and community development. Holding a diploma in Social Work and Social Administration, his early experience as an Assistant Community Development Officer in Bushenyi District during the 1990s was formative. It was here that he witnessed the devastating consequences of late-stage healthcare seeking, a practice driven by affordability barriers and health-related ignorance. This phenomenon often led to catastrophic financial expenditures by poor families who were forced to liquidate assets to access care for preventable conditions. While community self-help mechanisms, such as burial groups, existed, Mr. Kakunta identified the absence of a formalised health component within these organised networks. This observation became the primary driver for his commitment to a sustainable community health financing solution. His love for others and desire to serve the poor people motivated him to start IHP:

"I think it came from my theological background. In theology you study a lot about community service. From my background, I want to serve the poor, the unprivileged, the vulnerable. These people are kept in my heart…but I think it's love for others. It is volunteerism, it is a service delivery visa with a desire for money". (IHP Founder Ishaka Health Plan).

The path to operationalising the IHP innovation began in 1998 when Mr. Kakunta, while working at Ishaka Adventist Hospital (IAH), received training on the Kisiizi Hospital Community-based Health Insurance model, Engozi. This exposure was quickly leveraged into his involvement in a DFID-funded baseline survey at a national level to adapt the CBHI model, and his appointment to the first national team that established CBHI operations in Uganda—the Uganda Community-based Health Financing Association (UCBHFA). This early, high-level engagement with institutional partners like the Ministry of Health (MoH) and development agencies cemented his expertise and credibility.

The founder's ability to forge and sustain relationships was critical to the scheme's survival. In 1999, he was recruited by IAH's Medical Director to manage the Ishaka Hospital Health Plan (IHHP), leveraging his community engagement expertise. This institutional relationship provided the essential operational mandate. When initial DFID funding ceased in 2001, his commitment became evident when he volunteered his services for five years to maintain the scheme. Demonstrating strategic organisational flexibility, he ceded the formal management title to a VSO volunteer (Ingrid Vanthoff), an action that secured Dutch funding and resources

(a vehicle from Dutch partners). This collaborative, adaptive approach not only secured the scheme's immediate future but enhanced community trust, leading to increased enrolment by local burial groups and schools.

The enduring IHP is built upon a core philosophy of organisational continuity and voluntarism. This vision culminated in 2006 with the strategic transition of the hospital-based IHHP into the community-owned Ishaka Health Plan (IHP). The scheme is designed around the principle of tying the wanted with the unwanted, where accessing loans, which is the desire of the community, is linked to the health insurance, which they do not desire; and then the two are offered concurrently. Utilising design thinking, the scheme links participation in the health plan to a community-identified need, such as strengthening income-generating activities for household financial liquidity. Recognising that healthcare is typically an emergency priority in the Ugandan context, this approach makes CBHI participation a functional tool for holistic well-being rather than just a reactive insurance product. This model is sustained by a broad collaborative network that Mr. Kakunta built, encompassing local politicians, faith-based organisations, and international academic partners. His long-term commitment is further evidenced by his continued voluntary mentorship of staff since 2012, ensuring the principles of volunteerism and community ownership remain at the core of IHP's operations.

The scheme gives its members an opportunity to access timely and affordable quality healthcare services. The beneficiaries of the scheme access health services from Ishaka Adventist Hospital and Kampala International University Teaching Hospital. IHP is a member of Uganda Community-based Health Financing Association (UCBHFA).

3.1 COMMUNITY ENGAGEMENT APPROACH THROUGH PRE-EXISTING GROUPS

The Majority of the community health insurance schemes in Uganda are hospital based (run and managed by a health facility), however, Ishaka Health Plan is among the few community-based health insurance schemes (run and managed fully by community) that have been in operation for a long time. The scheme provides two benefit packages, that is, for pre-existing community groups and then for institutions.

IHP utilises the presence of pre-existing community groups such as village burial groups, which are managed by the villagers themselves, and then engages them in the health insurance program:

"*If you went to any village here, there is a burial group. They manage it themselves, they contribute when they want to buy items, when there is loss of a member. They always have some money and these things (village burial groups) have been there for decades, so we can actually build on that".* (District Health Officer, Bushenyi District)

Other pre-existing groups which IHP works with include schools, employees of companies/business, and cooperatives. IHP enrols at least 60% of the group members so as to control adverse selection. Since the majority of the members in these groups work in the informal sector, premiums are paid on a quarterly basis. Currently, the scheme has about 15 pre-existing groups with a total of 3,097 individuals. With regards to the institutions, Ishaka Health Plan has 3 primary schools, 2 secondary schools, and one tertiary institution, all with a total of 2,038 individuals. The total membership is 5,135 members. Enrolling students and pupils in IHP is really important both to the school administration and the parents:

"We started with them (IHP) since we started the school. Because most of our pupils are boarders (in the boarding section) and parents are very far, if you don't have this (health plan), then you don't have alternatives. But because we partnered with a health plan, any child who gets sick immediately you take him to the hospital and then call the parents and they find the child in the hospital and it helps us also". (IHP beneficiary, Director, Busy Bee nursery and primary school)

3.2 MICRO HEALTH RESEARCH

"We did a mini study to analyze all the data of our clients and we realised that 60% of them had chronic illnesses, those who had turned up. So when we realised that there was a chronic challenge, then we engaged community by community to negotiate with them that (in order to) we put a surcharge for chronic illnesses". (IHP, Scheme Manager)

Ishaka Health Plan conducts small studies and the findings are used to inform the funders and different stakeholders, as well as of changes in the scheme's operations. Initially the scheme never catered to people with chronic illnesses. However, following a study that was conducted among the beneficiaries, it was found that most of them had chronic diseases. Through community consultations, chronic diseases were included among the conditions covered by the insurance scheme. One of the beneficiaries who had cancer is among the people that has benefited from this reform;

"Several testimonies have been given. Someone suffered from cancer, a local person, they had to cut off his leg at a cost of one million (shillings). So they simply told the man to pay ten thousand (shillings) and go home". (IHP, Employee).

3.3 CAPACITY BUILDING OF PRE-EXISTING GROUPS

"When we started with the Kyakabizi community, we first wanted to develop their economic status. We could not ask them for money for premiums when we have not raised their economic status". (IHP founder)

Other than providing health insurance benefits, IHP empowered its members to have income and be able to pay the premium by engaging them in income-generating activities. Members of IHP receive training in improved agricultural practices to enable them earn more, save more, and spend less. They are taught how to rear livestock such as cows and goats and how to grow vegetables. The money generated from sale of these agricultural produce is used to pay premium and meet household needs, with part of it saved in the micro finance groups. One of the members of IHP reported that she was able to educate all her children through goat rearing:

"I used to be very poor. I was among the members who went to Kampala to receive training on goat rearing. So when I came back from the training, I built a pen for the goats. By that time I had children who were in primary 7, 6, 5, and 4, and they were all girls. Just like the way I was trained, I looked after the goats well, I put them in a pen, fed them with grass, and they multiplied and I started selling them. All my four daughters studied at a good school in our district. As I speak now all of them have graduated, they have degrees". (IHP beneficiary, female)

IHP supports its burial groups to form micro finance groups so as to improve people's livelihoods and assist them to become financially secure. Through these micro finance groups, pre-existing groups have been able to purchase land and build buildings in town councils of Bushenyi District. Members who are unable to pay premium, also borrow money from the micro finance groups to pay the insurance premium.

"I would like to thank the health plan because it supported us to start micro finance. After we had started micro finance, it attracted other members to join. We started collecting small money from our members and putting it in our micro finance. In case one fails to pay the premium, he can borrow from the micro finance, pays the premium and pays us back later". (IHP beneficiary, male)

3.4 INCOME-GENERATING ACTIVITIES

In 2017, IHP established the revolving fund program, which is a loaning scheme to its members so that they may be able to access health services and other immediate health needs. In return IHP collects an interest of 2% per month. Eighty percent of the interest is used to pay the medical bills, whereas 20% is for reinvestment to support running the scheme's activities. Since its inception, the recovery rate from the revolving fund is estimated to be more than 98%.

Access to electricity is important since it is a main pillar for education and healthcare. In 2012, accessibility to grid electricity by households in Uganda was 15% while that of solar power was 10.6%. In addition to that, about 22.7% of schools in Western Uganda had access to solar power and load shedding was more prevalent (Ministry of Energy and Mineral Development, 2014). IHP saw an opportunity to generate income by providing solar power to communities and schools in Bushenyi. From 2012 to 2016, IHP partnered with Barefoot Power and distributed solar lamps at a subsidised rate. The income generated from the sale of these solar lamps was used by IHP to pay the medical expenses of the scheme's members and also cover management and administrative costs. Through this project, families were able to access lighting and their income increased since costs incurred on paraffin for lamps were no longer there.

"I have not actually talked about what we got from this scheme. As a school here we also get facilitation. We even have a panel (solar panel) that was contributed by the health plan. Really we have enjoyed the services". (IHP beneficiary, Head teacher Ishaka Adventist Secondary School)

"It was around 2014 when we realised a problem of load shedding in the school. By that time, it was not like now when you know that power can't take two days off. By that time it would even take more than two days. So I personally installed the solar system from Barefoot Power Limited, there were four lamps so that we could solve that challenge of load shedding". (IHP, Employee)

3.5 HEALTH PROMOTION AND EDUCATION

Disease prevention is one of the areas of focus of IHP. IHP together with the health workers of Ishaka Adventist Hospital teach the communities on nutrition with the aim of improving people's health and minimising hospitalisations. Communities were taught to feed mostly on vegetables and encouraged to have vegetable gardens at home.

"We used to take our children to hospitals for treatment because we never knew how to feed them nutritious food. The health workers taught us that we should feed on vegetables, egg plants because food is medicine. As a result, there was a reduction in the frequency of falling sick and seeking treatment". (IHP beneficiary, male)

In efforts to reduce the frequency of people falling sick especially from malaria, IHP distributed treated mosquito nets not only to its members but to most of the communities in Bushenyi District. These nets were sold to people at a reduced price and they were taught how to sleep under nets so as to prevent them from getting malaria.

"Ishaka Health Plan helped a lot because we benefited from mosquito net distribution. As a result, people no longer suffer from malaria like they used to do in the past because we were taught how to use mosquito nets". (IHP Beneficiary, Female)

4. IMPLEMENTATION

4.1 INNOVATION IN IMPLEMENTATION

Recruitment and selection

Ishaka Health Plan mobilises members through pre-existing community groups such as burial groups, schools, cooperatives, and staff of companies or businesses to pool funds. Before a pre-existing group is enrolled and registered into IHP, more than 60% of its members must commit to join the scheme. This requirement helps to control adverse selection since the scheme is fully financed by its members. In order to ensure that more than 60% of the members of the pre-existing group are willing to join the scheme, IHP (together with the chairperson of the group) reviews the group's documents such as registers to confirm the members. Once the members have been verified, they are given identity cards which they must carry every time they go to the hospital. When a member comes to seek healthcare services at the hospital, he/she has to first be verified by IHP staff. This is to confirm whether the client paid the premium for the period he is seeking healthcare. Once premium is confirmed, he/she is given a receipt to proceed to the hospital. However, members have to make a fixed co-payment for every hospital visit.

Provision of health insurance benefits to students and pupils in schools and tertiary institutions is another package of IHP. In order to enrol at a school/tertiary institution, IHP comes into agreement with the school/tertiary institution administration. Once the institution is enrolled into the scheme, it is made a requirement for every student/pupil to pay the premium and parents are informed about this. A list of students/pupils to join the scheme is then compiled and these are mainly those in the boarding section. Then IHP uses the bio-data of the students/pupils to create student health charts. Students pay the premium per term, and when they fall sick while at school, they are able to access the healthcare services at Ishaka Adventist Hospital. Schools enrolled in the Ishaka Health Plan must have sick bays so that the school nurse only refers serious cases to the provider. IHP pays back a percentage of the schools' collections by equipping the schools' sick bays with medicines such as antimalarials and pain killers.

Institutional partnerships to improve access to healthcare

The United Kingdom's Department for International Development (DFID) provided both financial and technical support to IHP through the Uganda Community-based Health Financing Association (UCBHFA) from 1999 to 2002. The funds used to come directly from DFID to IHP and these catered the scheme management, administration, and community mobilisation.

Save for Health Uganda (SHU) is a non-for-profit non-governmental organisation which was formed in 2003 with the mandate to implement activities aimed at improving people's access to quality healthcare services in Uganda. SHU empowers community-based health insurance schemes and is involved in capacity building. It operates in 10 districts in Uganda, that is, Luwero, Nakaseke, Nakasongola, Kampala, Mityana, Mubende, Masaka, Bushenyi, Sheema, and Mitooma. In 2006, SHU provided technical support to IHP during the transformation process from a hospital-based health insurance to a community-based health insurance scheme.

Christian Brothers University (CBU) is a private university that was founded in 1871 by the members of the Institute of the Brothers of Christian Schools, an international Roman Catholic religious teaching congregation. The mission of CBU is to foster academic excellence in a range of programmes to prepare students from all faiths and backgrounds for careers and lives informed by the Lasallian values of faith, service, and community. In 2003, IHP received research interns from CBU who were

interested in exploring ways that health care micro insurance influences malaria treatment-seeking behavior in Uganda. The study gave recommendations that improved the performance of IHP. This relationship is maintained until today, with interns visiting IHP annually.

Volunteer Service Overseas (VSO) Netherlands is an independent international organisation that works through volunteers to empower communities in developing countries. For over 25 years, the organisation has been sending volunteers to developing countries. Due to limited awareness on cervical cancer and the human papillomavirus (HPV) in Bushenyi District, IHP partnered with VSO Netherlands to close this gap. Since 2019, IHP, with VSO Netherlands support, has provided a series of educational workshops for [1] health practitioners, [2] community leaders, and [3] Parents-Teachers Association members of primary schools in Bushenyi. These workshops promote awareness among youth populations and facilitate discussion between health practitioners about understanding HPV and cervical cancer in terms of transmission, protection, and treatment.

4.2 BUSINESS MODEL

Ishaka Health Plan is a non-profit organisation which is currently not receiving any form of funding but only relies on premiums contributed by its members. Premiums are collected on a quarterly basis and the amount paid is determined by the number of people in a family. Table 1 illustrates this. A family member pays a co-payment of UGX 5,000 for outpatient services and UGX 10,000 for in-patient treatment services. IHP has a ceiling of UGX 100,000 and any charges about this amount are met by the patient. Each group chairperson is responsible for collecting premiums from the respective groups.

Table 1. Premium for community groups

Number of people per family	Quarterly (UGX)
1–4 people	30,000/-
5 people	37,500/-
6 people	45,000/-
7 people	52,500/-
8 people	60,000
9 people	67,500
10 people	75,000/-
11 people	82,500/-
12 people	90,000/-

However, a family having a person with chronic illness pays an extra UGX 30,000 per quarter in addition to what is indicated in Table 1. The co-payment fee for people with chronic illness is UGX 10,000 and their health visits are limited to once a month.

For primary and secondary schools, each student pays UGX 10,000 per term, whereas the rates for tertiary institutions depend on the number of students enrolled in the scheme:

a) For institutions with 100–300 students, the students pay UGX 40,000 per year
b) For institutions with 300–500 students, the students pay UGX 30,000 per year
c) For institutions with more than 500 students, the students pay UGX 25,000 per year

5. OUTPUTS AND OUTCOMES

5.1 IMPACT ON HEALTHCARE DELIVERY

Over a period of 10 years, there has been moderate growth in IHP membership from 3,873 members in 2010 to 5,135 members in 2019, which indicates 32.6% growth of scheme membership. From 2010 to 2014, the scheme membership increased from 3,873 to 4,493 members indicating a growth of 16.0%. Scheme membership increased from 4,493 members in 2014 to 5,135 members in 2019 indicating a membership growth of

14.3%. Figure 1 summarises this information.

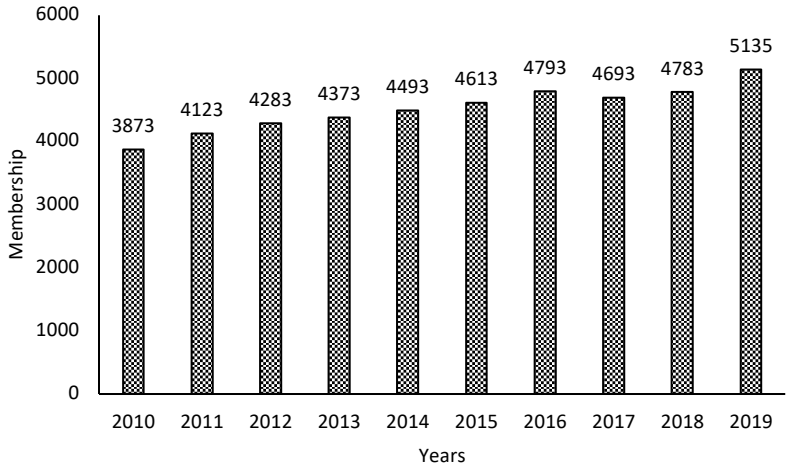

Figure 1. Scheme membership over 10 years

The community health insurance scheme covers a wide range of health conditions such as malaria, tuberculosis (TB), surgeries, HIV/AIDS, accidents and cancer. Overall, data show an increase in the total number of patients/beneficiaries accessing health services from 3,909 in 2017 to 4,257 in 2019. Statistics from 2017 to 2019 showed a 15.4% increase in the number of IHP members treated for malaria (377 to 435), 43.9% increase among those accessing HIV/AIDS services (57 to 82), and 55.6% increase among those receiving cancer treatment services (27 to 42). The number of people who received surgery services increased from 30 in 2017 to 41 in 2019, indicating a 36.7% increase. Over the last three years, accident victims were also able to receive treatment, 4 in 2017, 11 in 2018, and 5 in 2019.

Table 2. Number of patients accessing healthcare services for 2017-2019

Patients accessing healthcare services	2017	2018	2019
Total patients for the year (by addition but several are return cases)	3909	4160	4257
Number of people treated for malaria	377	418	435
Number of people treated for HIV	57	61	82
Number of people treated for cancer	27	21	42
Number of people treated for accidents	4	11	5
Number of people treated for surgeries	30	39	41

5.2 COMMUNITY AND BENEFICIARIES' EXPERIENCES

Financial Risk Protection

"Before I joined [the] health plan, I would fall sick and keep quiet, fearing to tell my husband because I well knew that there [was] no money at home… I had a problem with two pregnancies, I was almost dying of them in the village because I didn't have money to access treatment from the hospital". (IHP Beneficiary, female)

As of 2019, about 5,135 individuals from pre-existing community groups and schools were benefiting from the scheme. However, before joining the scheme, most people used to face financial difficulties, to the extent of selling property or borrowing money to access health care

services. IHP has helped people to access quality healthcare services in time, without selling land and other properties. Women and their children were also able to utilise health care services even when their husbands were not available.

"I fell sick with my child and at that time my husband was in the field/garden. We could [not] wait to tell him, so we rushed to the hospital because I knew the health plan would cater for the bills. We were admitted for two weeks and both my child and I paid 6000 shillings only each. The health plan has helped me not to beg my husband to sell our piece of land to cater for our medical bills". (IHP Beneficiary, female).

It was reported that out-of-pocket expenditure of members of the Ishaka Health Plan was reduced. One of the beneficiaries indicated that he had to pay only UGX 80,000 instead of around UGX 500,000 to UGX 1 million after 12 days of hospitalisation of his sick father:

"I had my father who was around 80 years old. He fell sick one day and I took him to hospital and we spent 12 days there but in the end I paid little money. Instead of paying about 500,000 to 1 million shillings, I was asked to only pay 80,000 shillings. So for me I am happy since I pay money earlier and I am able to get treatment when I fall sick". (IHP beneficiary, male)

The communities have confidence in IHP and are happy about the scheme because they are able to access quality and affordable healthcare services. Members of IHP paid only UGX 5,000 at OPD, whereas other patients paid more than UGX 50,000. The people also perceived the scheme as a way of saving their land and property by contributing only a small premium:

"So now the members contribute to the health plan because they know that is the only way to save their land". (IHP beneficiary, female)

The Bushenyi District health team acknowledged the work done by IHP in providing healthcare services in the district. The scheme was able to assist the district in providing health education services to the communities, and subsequently led to the improvement of utilisation of healthcare services. Although there was no statistics to support this, the district health team reported that community-based health insurance schemes such as IHP improved the district's health indicators through provision of quality healthcare services.

"Bushenyi District health indicators being high is not by accident. To me I feel personally that the existence of these health insurance schemes contribute a lot to the health sector". (Bushenyi District health team)

5.3 ORGANISATIONAL MILESTONES

Ishaka Health Plan (IHP) is among the few community health insurance schemes that have been in existence since 1999 and its milestones include:

- In 2018, IHP received funding from VSO to create awareness of HPV and the HPV vaccine in communities in Bushenyi District.
- From 2012 to 2014, IHP received support from Matre Group Incorporation to distribute treated mosquito nets to its beneficiaries.
- Ishaka Health Plan partnered with Barefoot Power Limited from 2012 to 2016 to distribute solar lamps to its beneficiaries and the other communities in Bushenyi District. It also partnered with CBU to improve enrolment of members in the scheme in 2003. The scheme partnered with Ishaka Adventist Hospital and the Kampala International University Teaching Hospital to provide health services to its beneficiaries.

6. SUSTAINABILITY

Ishaka Health Plan ensures that pre-existing groups are involved in decision making processes, for example in premium settings. This has ensured that the premium set is affordable to the people and the communities feel they have ownership of the scheme.

"We identify pre-existing groups, we sit with them, we find out how much the hospital charges and then we find out what is the economic status of the people. At the end of the day we decide affordable premiums. When we do that, they think it is them that have decided and they appreciate". (IHP founder)

Financial sustainability is important in community-based health insurance schemes. Ishaka Health Plan supports its member groups to raise their economic status. Scheme members receive training in agriculture and the groups are supported to start micro finance groups. This ensures continuity in the premium payment. The scheme complements premium income with other income-generating projects like a revolving fund project where the scheme lends money to the members and it is able to get interest on loans.

7. KEY LESSONS

7.1 IMPLEMENTATION LESSONS

The experience of the Ishaka Health Plan (IHP) offers actionable insights for policymakers seeking to scale and sustain community-based health insurance (CBHI) initiatives across Uganda and other similar low-resource settings. The IHP's survival hinges on a model that prioritises community ownership, financial integration, and strategic partnerships, moving beyond reliance on external donor funding.

Actionable Insight 1: Getting Started

The IHP case demonstrates a pathway for ensuring the continuity of access to affordable healthcare following the withdrawal of donor support. Initially starting as a hospital-based scheme funded by DFID through UCBHFA, the scheme faced collapse when the funding ceased by 2004. The strategic shift, championed by Mr. Kakunta, involved transforming it into a community-based health insurance scheme.

Policymakers should consider incentivising the transition of institutionally-backed schemes (started by NGOs or hospitals) into autonomous, community-owned entities. This transition can leverage existing social capital, such as the IHP's successful strategy of enrolling and retaining members through pre-existing solidarity groups (like burial groups, VISLAs ...). Technical support, as received from partners like Save for Health Uganda (SHU), is critical during this transition phase.

Actionable Insight 2: Maintaining Efforts

The IHP's adoption of a holistic approach highlights the need to address both the supply (healthcare provision) and demand (affordability) sides of health financing. The scheme integrated agricultural activities into its operations. This is crucial in rural settings where household income is variable and often linked to farming, as articulated by a beneficiary:

"We are farmers and we already have income. From the income we get from our farms we are able to get money for the health plan." (IHP beneficiary, male)

Supporting members to generate a stable income, the IHP ensured they had the means to pay premiums, significantly improving member retention. Furthermore, providing health education and promotion reduced hospitalisation rates, enhancing the scheme's financial sustainability.

Government initiatives supporting CBHI should strongly encourage the integration of financial literacy and income-generating components (agriculture,

financial groups) into their scheme design. Subsidies or technical assistance should be directed toward schemes that demonstrate this holistic approach, effectively tying health contributions to economic empowerment.

Actionable Insight 3: Building Credibility through Partnerships

The IHP's experience demonstrates that trust and credibility are the strongest defenses against market competition and community confusion. When facing challenges from competing schemes, IHP focused on deepening engagement and empowering its members. This was achieved by involving members in key scheme activities, such as the premium-setting process. Building a strong working relationship with the Ishaka Adventist Hospital was also paramount, ensuring members had access to quality healthcare services—a non-negotiable factor that builds confidence and trust in the scheme's value proposition.

Policymakers should prioritise scheme governance models that ensure member participation and transparency (benefit design and premium setting). Furthermore, establishing and maintaining strong, formal referral and service provision relationships between CBHI schemes and quality healthcare providers is essential for scheme credibility and long-term viability. Finally, schemes should be encouraged to proactively address operational weaknesses, such as the IHP's engagement with Mbarara University of Science and Technology to improve documentation and records management, ensuring efficient operation and accurate reporting.

7.2 PERSONAL LESSONS

Ishaka Health Plan has been providing easy access to affordable and quality healthcare services to its members since 1999. A community health insurance scheme requires ample time and self-motivated staff who are committed and willing to offer voluntary services on a small stipend for it to develop and thrive. People enrol and are retained into community-based health insurance schemes if they trust its management.

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