



Crowdsourcing Community-Based Health Insurance for the informal sector in Uganda



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Key takeaways:

The Munno mubulwadde scheme is designed to reach rural communities directly and has adapted its systems to reflect local contexts and needs. As a result, it has improved the predictability of medical expenses and catastrophic health expenditures have significantly reduced among participating households. The programme's sustained implementation over the past 20 years is a further testament to its effectiveness and long-term viability.

Reform objectives:

Munno mubulwadde ("your friend indeed") is a community-led Community-Based Health Insurance (CBHI) scheme operating in the Luwero District of rural central Uganda. Established in 2006, it is structured as a union of ten individual CBHI sub-schemes that signed a cooperative agreement to pool risks and achieve economies of scale. Unlike many other schemes in Uganda that are run by hospitals, Munno mubulwadde is non-provider based, meaning it was initiated and is managed by the community members themselves.

Context:

Nearly 30% of Ugandans live on five dollars or less a day, and more than a third of the poor do not seek medical care when ill due to costs. Furthermore, 7.7% of poor households face catastrophic health expenditure (CHE), which can force families to sell assets to pay for care since Uganda has some of the highest out-of-pocket (OOP) costs in the region, estimated at 38%. The scheme was established as an alternative financing mechanism to mitigate these high OOP costs.

The scheme

Organisational structure	Munno mubulwadde is a union of ten individual sub-schemes that signed a cooperative agreement for risk pooling. This allows the small community groups to achieve economies of scale.
Household-based enrolment	Unlike individual insurance, recruitment is household-based. A standard premium covers one to six household members, with an additional fee required for any members beyond that number.
Premium payments	Annual premiums range from \$17 to \$50 depending on the selected package. To make these costs more affordable for low-income farmers, the scheme allows for instalment payments through community saving groups or micro-financing institutions. Once the premium is paid, members are issued a health access card.

Service delivery	The union has contracted 13 private health facilities in the Luwero District. Members present their access cards at these facilities, which often feature special desks to ease the triage process for insured patients.
Co-payment system:	In addition to the annual premium, members must pay a "co-payment" fee during every facility visit. This is a strategic measure intended to prevent system abuse by encouraging members to use free public clinics for minor ailments and reserving the insurance coverage for more serious medical cases.
Livelihood support	Because the membership is largely agrarian, the scheme administrators also conduct vocational and income-enhancement trainings to help family heads maintain their capacity to pay future premiums.

Achievements

- Munno mubulwadde is community-led and managed, representing a rare and successful model that has remained operational for nearly two decades.
- The scheme has successfully contracted private health facilities in the Luwero District. This is a major achievement as members perceive these private providers to offer better quality care, fewer stock-outs of commodities, and less congestion compared to local public facilities.
- Membership serves as a valuable financial cushion that reduces of catastrophic health expenditure. One member highlighted saving 160,000 shillings (\$44) on a single scan and x-ray bill due to their coverage.
- The scheme has successfully integrated with community saving groups, allowing members to pay these premiums in small installments rather than a single lump sum.
- The scheme is particularly effective for households with children under five, who are frequently prone to febrile illnesses like malaria. Parents reported that the scheme allows them to "relax for a full year" regarding medical bills for their children.
- The scheme's copay system has been successful preventing system abuse and encouraging members to use it for substaincial medical emergencies.

Policy recommendations

1. Support non-provider-based, community-led models. While many community-based health insurance (CBHI) schemes are run by provider-based hospitals, governments should encourage community-led and member-managed unions.
2. Policy interventions should ensure that premium collection is synchronised with seasonal livelihoods in the informal sector. For example premiums can be scheduled for harvest seasons for agrarian households when farmers have liquid cash, rather than fixed calendar months. This can help bolster retention of scheme members.
3. Governments should implement macroeconomic protection strategies such as price stability of agricultural produce and support farmer cooperatives to ensure that fluctuating crop prices do not lead to mass attrition from health insurance schemes.
4. To achieve Universal Health Coverage (UHC), policy-makers should create frameworks that allow community schemes to contract high-quality private health facilities.
5. Policy should focus on expanding the network of accredited providers in rural areas to mitigate barriers of physical access.

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Method: The study reported qualitative findings from a larger mixed-methods study, conducting in-depth interviews with 18 insured members and 12 scheme administrators, and four gender-disaggregated focus group discussions with 38 participants, with data analyzed inductively using a thematic approach supported by NVivo version 10 software.

Evidence: Nabanoba, C., & Zakumumpa, H. (2024). Experiences of membership in munno mubulwadde (your friend indeed) - a novel community-based health insurance scheme in Luwero district in rural central Uganda. *BMC Health Services Research*, 24(1), 89. <https://doi.org/10.1186/s12913-023-10517-4>

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