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Culture, tradition and healthcare: exploring the Kisiizi Community Health Insurance scheme

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Abstract

In southwestern Uganda, a custom of health and social support has been managed through collective organizations known as *engozi* for centuries. Subscribers advanced help for those who were not able to provide for themselves and their households. Participants pooled financial and food resources, offered emotional assistance, and aided in transporting patients to hospitals. The institution of "free government health amenities" caused the decline of the *engozi* custom. However, with an insufficient annual health sector budget allocation, the state health services cannot satisfactorily meet the needs. The Kisiizi neighborhood, while depending on the *engozi* practice, arrived at a CHI system in 1996 as a self-help innovation to eliminate financial obstacles and enhance access to quality health amenities. Numerous studies on CHI have examined the structure, registration and memberships, health-related advantages, and monetary-related benefits, but little has been documented on how cultural beliefs and customs have affected its application. This study aimed to identify the role of culture and customs in tackling healthcare disparities via a CHI strategy. This study adopted a case study methodology and qualitative methods. The study utilizes Woolcock's social capital theory and Cultural competence theory as the analytical framework. It identifies Brotherhood, Solidarity, Belonging, Cooperation, Volunteering, Reciprocity, and Respect for Authority and Leaders as key values upheld by the *engozi* tradition, strengthening social capital and laying a solid

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foundation for successful CHI. This study also identified that societal values and traditions have significantly impacted the implementation of the Kisiizi CHI scheme, as evidenced by the influence on CHI leadership and governance, collecting premium fees from subscribers, mobilization and registration of participants, and information dissemination. Lastly, the study identified that CHI has positively affected healthcare challenges within the community, evidenced by increased utilization of healthcare services, improved access to antenatal care, health promotion and disease prevention initiatives, and improved quality of services due to user feedback.

Keywords Community health insurance · Health insurance · Healthcare inequities · Cultural values and traditions

Abbreviations

UBOS	Uganda Bureau of Statistics
HDI	Human Development Index
CHI	Community Health Insurance

1 Introduction

While earlier studies often overlooked the role of culture in economic growth (Guiso et al. 2006), contemporary development experts acknowledge its importance (Arestis et al. 2021). They understand that beliefs, customs, values, and perspectives are crucial for sustainable socioeconomic progress (Zheng et al. 2021). According to the United Nations (2009), culture encompasses observable and abstract components unique to each society. Abstract elements, like beliefs and affiliations, are non-material and often invisible, while observable elements include art and historical sites (Idang 2015). This article will explore the invisible aspects of culture and their potential to address current healthcare challenges.

1.1 Understanding Uganda's cultural heritage

Uganda is an inland country in East Africa bordering South Sudan, the Democratic Republic of the Congo, Kenya, Rwanda, and Tanzania. It covers 241,559 square km and has a population of 45.9 million (Uganda Bureau of Statistics 2016). It is labeled an impoverished country (World Bank 2016), with a poor Human Development Index (HDI) of 0.544, ranked 159th out of 189 countries (UNDP 2020), with 21.4% of the population living below the national poverty line of US$ 1.30 per day (UNDP 2020). Uganda is culturally diverse, shaped by

various ethnic groups and religions, but has experienced cultural erosion due to colonial influences and rapid urbanization (Wahab et al. 2012; Laruni 2015).

1.2 A new tradition: understanding the Kisiizi community's CHI scheme

The Kisiizi Community in South Western Uganda consists of six sub-divisions (Nyarushanje, Nyakishenyi, and Kebisoni in Rukungiri; Rutenga and Rugyeyo in Kanungu; and Kashambya in Rukiiga county) with a projected population of 178,750, over 85% of whom are impoverished small scale farmers (UBOS 2016). For centuries, collective organizations called *engozi* have provided health and social support to those in need, with 20 to 50 related households forming each group (Katabarwa 1999). Members share resources, offer emotional support, transport patients, and assist with childcare and gardening (Katabarwa 1999). Violations of group rules lead to expulsion (Katabarwa 1999). The introduction of free government health services reduced *engozi*'s role, limiting their functions primarily to burial support (Katabarwa 1999). However, inadequate government health funding (9.8% of the budget) fails to meet community needs, prompting the establishment of a Community Health Insurance (CHI) system, or Community-based Health Insurance (CBHI) system, in 1996 to improve access to quality care (Baine et al. 2018; Kakumba 2021). By the end of 2021, the Kisiizi CHI had 43,200 active members from 217 *engozi*, representing about 24% of the population (Kisiizi Hospital 2021). Members pay an annual fee of Ugx 11,000 to 17,000 (USD 3–4) and co-payments for specific services (Kisiizi Hospital 2021).

1.3 Understanding community health insurance

Community Health Insurance (CHI) schemes are "voluntary, community-based programs designed for informal sector workers to enhance their financial access to healthcare"(Basaza et al. 2010). They operate on a non-profit basis and focus on risk sharing with community involvement in their design and management (Basaza et al. 2010). Community Health Insurance (CHI) programs were established in the 1980s in Africa to provide financial protection for rural poor people against high medical costs, addressing the shortcomings of service fees, government schemes, and social security(Wiesmann & Jütting 2000; Carrin et al. 2005). CHI has gained popularity based on values like voluntary participation and risk sharing (Woldemichael et al. 2019). Research shows it reduces healthcare expenses, increases family income, and lowers borrowing for medical needs (Habib et al. 2016; Eze et al. 2023). CHI also enhances health outcomes, with a 40% higher likelihood of visiting clinics (Demissie & Gutema Negeri 2020; Alemayehu et al. 2023), a 4.3 percentage point decrease in growth retardation (Nshakira-Rukundo et al. 2020), and improved maternal and child healthcare access (Gebremedhin et al. 2022). Overall, CHI effectively improves family well-being.

1.4 Statement of the problem

Research on Community Health Insurance (CHI) has focused on its structure, registration, memberships, and related health and financial benefits (Rouyard et al. 2022; Namyalo et al. 2023). However, there is limited evidence on how cultural beliefs and customs impact its implementation. This study aims to explore and document the influence of culture on the effective execution of CHI, which serves to address health access inequalities, reduce households' vulnerability to high health costs, and improve access to quality healthcare in impoverished communities (Jalali et al. 2021; Sanoussi et al. 2023).

2 Methods

2.1 Purpose

This investigation aimed to understand the role of culture and customs in addressing healthcare disparities through a CHI strategy. We examined the relationship between communal values, CHI implementation and sustainability, and public perceptions of CHI's importance in healthcare issues in the Kisiizi Community. Finally, we documented lessons learned from implementing CHI in this community.

2.2 Study design and context

This investigation employed an interpretivist worldview, applying a case study approach to probe the significance of community beliefs and customs in resolving healthcare problems, considering the case of the Kisiizi CHI. This inquiry was exploratory and descriptive, exploiting qualitative techniques.

2.3 Theoretical framework

We utilized Woolcock's social capital hypothesis (Woolcock 1998) and Cultural competence theory as our theoretical foundation.

Woolcock's social capital hypothesis defines social capital as shared informal beliefs or regulations enabling group collaboration (Woolcock 1998). Social capital is categorized as Bonding (strong relations) or Bridging (weak relations) (Gannon & Roberts 2020). Bonding social capital refers to close relationships within one's family, friends, and cultural group, fostering collaboration and potentially influencing the desire to enroll in Community Health Insurance (CHI) (Donfouet & Mahieu 2012). Strong networks among close contacts enhance information sharing about benefits and enrollment, building trust in the program (Donfouet & Mahieu 2012). In contrast, bridging social capital connects individuals from diverse backgrounds, facilitating knowledge exchange that improves CHI interventions (Tahlyan et al. 2022).

Cultural competence theory highlights the need to integrate diverse cultural perspectives into healthcare (Stubbe 2020). It suggests that healthcare systems must adapt to the cultural contexts of the communities they serve to meet their health needs effectively (Stubbe 2020). For Kisiizi Community Health Insurance, this theory can help examine how the community's beliefs and practices influence their views and use of the health insurance program. It also provides insights into how respecting local traditions can enhance community engagement and trust in the CHI system, ultimately affecting its success and sustainability (Nair & Adetayo 2019).

Combining Woolcock's social capital theory with cultural competence theory creates a multidimensional framework that captures the complexities of healthcare dynamics in the Kisiizi Community. The social capital theory highlights the role of community networks and trust (Woolcock 1998), and cultural competence focuses on integrating local cultural perspectives (Nair & Adetayo 2019). Together, these theories facilitate a comprehensive understanding of how social and cultural factors interplay in implementing and succeeding community health insurance programs.

2.4 The study population

The study included CHI subscribers, non-subscribers, local opinion leaders, managers, and employees from two communities with varying CHI coverage: 'low assurance' (39% or below) and 'moderate assurance' (40% or more) (Kakama et al. 2020). This diverse participant mix enhanced the accuracy and reliability of the results (Johnson et al. 2017). A purposive sampling procedure was used for Focus Group Discussions (FGD), which selected participants who had lived in the community for at least ten years to ensure familiarity with local customs. Two FGDs were organized per village, separated by gender, and comprised nine to twelve members each, one for beneficiaries and one for non-subscribers. Key informants were chosen based on their roles and willingness to participate, while secondary participants were interviewed face-to-face using a guide. Most interviewees (82%) were over forty years and lifelong residents, contributing a broad range of experiences from both genders.

2.5 Data collection, management, analysis, and internal control

The researchers conducted eleven meetings with key informants and four group discussions ($n=45$) from March 5 to April 11, 2021, at community centers and participants' homes, lasting 1–2 h each. They explored traditions and customs related to health and social services, their influence on CHI implementation, and their effects on healthcare access.

Data analysis involved transcribing recordings, open coding, and identifying patterns (Sutton & Austin 2015). Investigators reviewed transcripts multiple times to highlight recurrent expressions, aligning themes with research objectives and participants' beliefs about CHI. The authors presented empirical evidence through participant quotes and conversation snippets to precisely portray results. Focus Group Discussion 1 (FGD 1) included insured individuals from a locality with average

coverage, FGD 2 had insured participants from a village with low coverage, FGD 3 consisted of uninsured individuals from a locality with moderate coverage, and FGD 4 included participants from a village with minimal coverage. Participant identities were kept anonymous for confidentiality.

To ensure data quality, the authors conducted pre-testing in the Rugarama sub-county, chosen for its proximity to Kisiizi Hospital and a mix of CHI subscribers and non-subscribers. Tools were refined to eliminate errors and improve clarity. Interviewers verified understanding by paraphrasing responses and ensured accurate recording through multiple audio reviews. They employed bracketing to set aside personal biases, and FGDs with subscribers and non-subscribers, along with key informant dialogues, facilitated triangulation.

3 Results

Fifty-six participants were involved in this study, including eleven key informants and forty-five focus group discussion (FGD) members. The participants comprised 33 males and 23 females, with key informants aged 31 to 69, including 3 directors, Kisiizi CHI staff, and 8 community leaders. Of the FGD members, 24 had subscribed to Kisiizi CHI for over 2 years, while 21 were non-subscribers. Twenty-seven participants were from communities with average insurance coverage, and 25 were from communities with slight coverage.

3.1 Examining communal norms linked to health services

This study explores the social values in the Kisiizi Community related to health and social services.

3.1.1 Belonging

Participants in all four focus group discussions (FGDs) agreed that each family should be part of a particular *engozi* gathering. KIs 6, 8, and 11 stated that families may feel isolated without a group. FGD3 noted that "belonging to a community association accords a certain social status and respect in the community." KI 10 added, "Families not in an *engozi* group could face difficulties during burials and wedding ceremonies." Lastly, FGD2 emphasized that "families strive to be part of a group to avoid any embarrassment or shame, particularly during funerals."

3.1.2 Cooperation

Group discussions highlighted that cooperation is vital for community success. FGDs 2 and 3 noted that "*engozi* members pool funds annually for timber and resources to make caskets and support funeral rites." Key informants KI 4, KI 9, and KI 11 stated that each family must contribute a set amount to the group's reserve fund. Key informant 2 used the proverb "two hands wash each other" to stress family collaboration.

Additionally, all discussions noted that cereals are pooled after harvests for sustenance during funerals.

3.1.3 Solidarity

Both fit men and women participated in transporting sick individuals to the hospital using a local bedframe called "*engozi*." Women aided by providing refreshments for the males who carried the sick person. One key informant noted, "Working together is the source of our strength." Participants in FGD 4 highlighted that the "*engozi* tradition has enabled peaceful coexistence and networking in communities of mixed clans despite the clan differences." Additionally, FGD 2 participants mentioned that death or misfortune can affect anyone, prompting community support and sympathy. Overall, the *engozi* tradition symbolizes community solidarity and comradeship amongst the community.

3.1.4 Brotherhood

Participants described the community as a large extended family that feels obligated to support one another in need (KI 4, 5, and 7). They stated it is a tradition to visit the sick in hospitals and bring aid (FGD 1). Similarly, FGD3 noted, "Community members must visit mourning households and assemble items and materials that facilitate funeral rites." Obligations include participating in burial ceremonies and suspending personal tasks during the funeral (FGD 1, 2, 3, & 4). The "males participate in constructing a tomb while females partake in cooking meals and drinks at the funeral" (FGD 2 & 4).

3.1.5 Volunteerism and reciprocity

It was mentioned that "females assisted each other with sowing, weeding, and harvesting sorghum or millet, while men helped neighbors build homes without expecting payment, relying instead on future reciprocity" (FGD1, 2, 3, 4). Community members also cared for the children of sick individuals and helped with farming tasks (FGD 2, 4). According to key informant 10, the community relies on one another for labor-intensive tasks like housebuilding, reflecting the high value placed on volunteerism and reciprocity.

3.1.6 Respecting and honoring authority and elders

Young people were required to honor elders (KI 3, 5, 10). During group discussions, community members expressed that they trusted and valued the decisions and counsel of elders (FGD 1, 2, 3, 4). KI 5 emphasized, "that community leaders instill discipline, enforce customs, and promote harmony". It was mentioned that "the duties of *engozi* elders include fostering reconciliation among individuals or households" (FGD 2, FGD 3). Key Informant 6 expressed that "my duty as an

elder of the *engozi* cluster requires mediating reconciliation among married couples." KIs 9 and 10 highlighted that "*engozi* leaders and members aid in resolving land disagreements." Participants in FGD 1 mentioned that "minor civil issues, like crop damage by cattle, are presented to *engozi* leaders for resolution."

Another finding revealed that these values in African communities stem from various sources, including customary laws, proverbs, religious ideals, traditional economic activities, and political values. For instance, KI 3, 5, & 6 mentioned that "customary laws prohibited stealing, murder and adultery, to regulate behavior and instill discipline." Proverbs such as "Nimutahi wawe arikubasa kukwagura omugongo," translated as "it is your neighbor who can scratch your back," emphasized kindness among neighbors. African religious ideals held that any wicked act committed against an individual or community was an act of evil against God, the creator. It was stated that "community members believed that they were a big extended family and members are obliged to look after one another" (KI 6). Traditional customs of farming, fishing, and hunting have fostered values of mutual assistance among friends and family. It was stated that "household heads are required to register their families with *engozi* association" (FGD 1, 2, 3 & 4), indicating that each household has a head. It was also stated that "each household was led by heads, and villages by elders, who enforced discipline and customary laws, and promoting harmonious living" (FGD 1, 2, 3, 4).

It was also established that the community members' practices have shifted from traditional to modern medicine. For example, KI 4 noted that "younger generations prefer modern medicine over traditional practices, and this has favored the adoption of practices that promote access to modern medicine." Similarly, KI 7 mentioned that "our grandfathers avoided clinics and relied on herbal remedies, but now many blend herbal and modern medicine." KI 9 added, "Our traditions have evolved; while traditional healers remain respected, many now turn to modern clinics for treatment."

3.2 Evaluating the influence of *Engozi* custom on CHI performance

This section displays discoveries about how society's customs and practices have influenced the performance of the Kisiizi CHI system.

3.2.1 Influence on mobilization and participant registration

The *engozi* groups positively impacted CHI scheme membership activation and participant registration. Key informants 2 & 4 noted that "*engozi* leaders help activate members and conduct sensitization campaigns at group meetings." Participants in FGD 1 mentioned that "we initially learned about CHI from their group leader when he invited us for a meeting with officers from the Kisiizi insurance scheme." Key informants 1 and 2 also stated, "We register members and families of already existing *engozi* to reduce the danger of unfavorable selection." Participants in FGD 2 also indicated, "We signed up for CHI as a whole group." Furthermore, Key informant 5

and non-insured participants in FGDs 3 and 4 confirmed that the insurance scheme registers individuals through *engozi* groups.

It was disclosed that *Engozi* organizations significantly contribute to savings, and members are asked to add a small amount to meet their family's premium requirements. During FGD 1, a participant noted, "We get most of our premiums from the group savings and then add some money to meet the fees." Key informants 2 and 3 also emphasized, "We encourage groups to save and use those funds to pay annual fees for members at the start of the year."

3.2.2 Influence on CHI administration and leadership

Participants indicated that the *Engozi* elders lead the CHI's governance. Key Informants 1 and 3 noted that "the CHI is regulated by a selected body representing diverse community groups." Members in FGD 1 stated that "the group chairman and secretary are our agents in CHI sessions." Key Informant 4 mentioned, "I was selected for the last three years to be a constituent member of the managing board of the CHI." Key Informant 5 declared that "insurance fees are regulated by the managing board, which comprises the members' agents." Additionally, it was disclosed that "the managing board carries out staff recruitment and periodically evaluates scheme performance" (KI 9).

3.2.3 Collecting annual premium fees

Engozi leaders collect annual premium fees from their groups and submit them to the CHI scheme office. For example, KI 1 and 2 stated, "The leaders were helping to update the member registration while working closely with the scheme managers." Focus group members noted that leaders collect money annually for the insurance scheme (FGD 1, 2). Additionally, uninsured participants in FGD4 acknowledged this, stating, "We have heard that the *engozi* chairperson collects money from each family to subscribe to the insurance scheme".

3.2.4 Dissemination of information

Engozi organizations have significantly facilitated the spread of information about the insurance scheme. Participants in FGD 2 noted that "beneficiaries share insights during group meetings." Additionally, Key informants 8 and 9 observed that "*engozi* members play a crucial role in sharing effective practices with the wider community, enhancing overall awareness of the scheme."

3.3 Community members' perspectives on the influence of CHI on healthcare services

This part presents the thoughts of the community members concerning the influences of CHI on healthcare services in the Kisiizi Community.

3.3.1 Facilitates a right to use high-quality treatment at a moderate cost

It was affirmed that CHI has enabled individuals and families to afford medical care and costly treatments like surgeries (KI 3 & 4). FGD 1 participants noted that "some members who could not afford fees for surgical procedures have been helped to get those treatments under the CHI cover," FGD 2 members mentioned that "*engozi* members rarely need to liquidate assets for medical costs." Even non-scheme members recognized this benefit, stating that some "scheme members receive free or low-cost services at Kisiizi Hospital" (FGD 3 & 4). A local leader (KI 5) also highlighted that individuals access quality care at lower rates at Kisiizi Hospital.

3.3.2 Encouraged individuals and families to seek medical attention as soon as they became ill

The CHI system significantly influenced its subscribers' medical-seeking behaviors. Key Informant 2 noted that "we do not get scheme members with serious ailments since most report early." Similarly, Key Informant 4 observed that "more CHI subscribers receive treatment from clinics and have fewer hospitalizations." FGDs 1 and 2 participants mentioned that "worries about hospital bills are alleviated since CHI covers most costs." Key Informant 3 added, "CHI members are advised to seek early medical attention for cost savings." Non-insured participants noted that insured individuals are more likely to seek treatment at the main hospital, while the uninsured typically buy medicines from local shops first (FGD 4).

3.3.3 Encouraged greater use of healthcare services

Participants noted an increase in hospital service use. For example, KI 2 reported that "there are more insured subscribers than non-subscribers in OPD, antenatal, and maternity units." Key Informant 7 observed that "women who previously gave birth at home can now afford hospital delivery." FGD 2 participants mentioned that "individuals who could not pay for services may now use the CHI system." Lastly, Key Informant 4 remarked that many expectant women are returning for antenatal appointments due to free prenatal care for CHI members.

3.3.4 Promotion of health and prevention of diseases

It was revealed that the CHI scheme provided mosquito nets to all participants, which was met with profound gratitude from members (FGD 1, 2; KI 1, 2, 3, 4, 6, 9), emphasizing the importance of health promotion and disease prevention for the scheme. Non-insured participants also noted that "the scheme provides free mosquito nets to its members" (FGD 3). The scheme has also collaborated with the Kisiizi Hospital nutrition project to promote backyard vegetable gardening, mass deworming campaigns, and nutrition sensitization to reduce child malnutrition (KI 1 & 2).

3.3.5 Encourages customer feedback on the quality of health services

It was stated that the feedback from insurance members regarding the quality of services at Kisiizi Hospital has been instrumental in improving the services provided (KI 1, 2, 3). For instance, key informant 2 reported receiving feedback regarding the patient waiting times at the clinics. Similarly, participants in FGD 2 reported that "we submit our grievances to the hospital through our leaders whenever services are not going well." Additionally, Key informant 1 reported that "we recently received complaints about some members of staff who were disrespectful to patients, and hospital management took appropriate action to address the issue."

4 Discussion

4.1 *Engozi* values and traditions paved the way for community involvement and subscriber registration in the CHI by enhancing social capital

In the Kisiizi Community, values and traditions enhance social capital through loyalty to *engozi* groups, leaving non-members socially isolated. Ahn & Davis (2020) show that belonging boosts social capital, while Akpa-Inyang and Chima (2021) emphasize that African customs prioritize community life over individual interests. Thus, promoting community-oriented values and traditions positively impacts the social capital for individuals and the community.

The ideals and customs espoused by the people of the Kisiizi Community fostered cooperation and teamwork toward common goals, with people pooling resources for times of need, such as sickness or death. The social capital theory supports that collaboration leads to societal success, as highlighted by Idang (2015) and Awoniyi (2015), who emphasize the African cultural emphasis on resource-sharing for individual needs. Reinforcing these values promotes interdependence, benefiting individuals and communities, and is crucial for the stability and longevity of African societies.

Values and traditions that fostered community solidarity and brotherhood enhanced social capital by creating a moral obligation for residents to support ailing and bereaved households (Kamwachale Khomba & Kangaude-Ulaya 2013). African customs require community members to consider each other's welfare (Awoniyi 2015). Since everyone belonged to a larger family, members acted as custodians of one another (Mafumbate 2019). Similarly, Mbaya (2010) emphasizes that social capital embodies 'brotherliness,' reflecting identity and interconnectedness among members. Solidarity and mutual support are central to the CHI philosophy (Shmueli 2021), viewing the CHI scheme's inception as a continuation of the *engozi* heritage. Thus, promoting values that enhance community solidarity is essential for building social capital and resilient communities.

Values and traditions are essential to African culture and social capital. *Engozi* members collaborated on building a house and cultivating land without compensation. Mati (2016) stated that volunteerism and reciprocity are integral to African

culture, with community members assisting each other with the expectation of future reciprocation (Madziva & Chinouya 2017). Volunteerism indicates social capital and helps build it (Stukas et al. 2005). Promoting these values is crucial for fostering a culture of volunteerism and reciprocity to strengthen trust and enhance collective welfare.

The values and traditions of the *Engozi* institution influenced the community's social capital, health, and services by fostering submission to authority and promoting harmony. Elders were critical in administering justice, reconciling disputes, and restoring order and were viewed as knowledgeable figures whose words were respected (Mbele 2004). However, Kanu (2010) argued that compliance was directed towards the institution rather than specific leaders, despite a general belief in the elders' guidance and moral influence. Research indicates that engaging local leaders enhances decision-making, connects projects with the community, secures funding, and serves as a vital source of information for development (Alimo 2013). Therefore, preserving values and acknowledging elders' roles is essential for building trust, social cohesion, and community compliance.

Engozi arrangements have enhanced community access and participant registration for CHI. First, the *engozi* gatherings offered an arena for stirring up and furthering the insurance agenda. Hendryx et al. (2002) note that CHI often utilizes social capital to engage families through community memberships. Similarly, Fadlallah et al. (2018) indicate that prior successes with village associations can influence CHI registration and implementation. Additionally, *engozi* leaders have been crucial in mobilizing the community and fostering acceptance of the scheme, supporting Obetta's (2021) finding that competent community leaders are vital for growth through effective communication and relationship-building. Furthermore, evidence shows that engaging village leaders is crucial for tailoring services to local needs, reducing grievances, and increasing the uptake of CHI services (Criel et al. 2004). The findings and evidence highlight the importance of social capital and collaboration in improving access to affordable healthcare.

It is worth noting that there was a cultural shift toward integrating modern healthcare with traditional medicine, with younger generations favoring modern approaches. This blend has improved healthcare access and equity, supported Community Health Insurance strategies that respect cultural practices, and enhanced community trust. This finding aligns with Hardy's (2008) findings that patients perceive modern and traditional medicine as having distinct strengths in cost, accessibility, diagnosis accuracy, treatment efficacy, and cultural understanding, highlighting the need for integration.

From a cultural anthropology perspective, *engozi* groups are vital cultural institutions representing practices of mutual aid, solidarity, and community welfare (Carstensen et al. 2021). *Engozi* leaders, acting as cultural brokers, facilitate knowledge about the CHI scheme and mobilize collective action through sensitization campaigns, promoting communal support and collective responsibility while encouraging participation in health initiatives (Alimo 2013). The discussions within *engozi* groups foster health literacy through shared experiences and addressing misconceptions, which creates a deeper understanding of health insurance, enhances acceptance of the CHI scheme, and reinforces community values by emphasizing

collectivism and care for one another. This finding is in line with Yagi et al. (2022) that health insurance literacy is a critical enabler to the effective utilization of healthcare services.

From a sociological perspective, the findings reveal community dynamics promoting CHI scheme participation. *Engozi* groups act as a social infrastructure for mobilization and resource-sharing, helping overcome insurance enrollment barriers. Focus group testimonies show that social structures influence individual decisions, as group enrollment reduces perceived risks and addresses adverse selection (Kebede 2024). While pooling resources for premiums demonstrates the strength of social capital, enhancing financial security and reinforcing social bonds (Endris et al. 2020), this collective strategy alleviates the financial burden of premiums and fosters belonging and mutual support. Encouragement from key informants for group savings highlights the link between economic practices and social relationships, showing how socio-cultural factors can improve access to health insurance (Fite et al. 2021).

From a health economics perspective, the *engozi* groups implement an innovative financing model for health insurance through collective savings, enabling individuals to share premium costs and enhance affordability. This cooperative approach reduces financial risks and improves health outcomes, leading to potential savings for the health system (Eze et al. 2023). By collecting premiums at the group level, *engozi* organizations effectively pool risks and manage resources, reducing individual financial vulnerabilities, a core principle of insurance economics (Eze et al. 2023). These findings agree with Derriennic et al. (2005) that Community-based health financing (CBHF) empowers communities to meet their health financing needs through pooled resources and collective decision-making.

From a public health policy perspective, the governance structure led by *engozi* leaders enhances community-led health initiatives by mobilizing participants and overseeing the CHI scheme's functionality. This decentralized approach fosters tailored services that build local trust and engagement (Fadlallah et al. 2018). As community members assume leadership roles, they gain skills in management, financial oversight, and healthcare administration, leading to sustainable public health solutions through active participation in decision-making (Fadlallah et al. 2018). Additionally, *engozi* groups act as crucial educational platforms, disseminating information about the CHI scheme and its benefits through peer to-peer education, which is more impactful than traditional healthcare messages (Shoghli et al. 2023).

4.2 The community was pleased with the advantageous influence of CHI on healthcare amenities

The people's views on Kisiizi CHI's impact on healthcare were mainly positive. Scheme members access premium services without worrying about high medical bills due to discounts for CHI subscribers. A previous study indicates that CHI participants are satisfied since it covers their medical costs (Kakama et al. 2020). Additionally, results showed that CHI encourages early healthcare-seeking, making treatment more cost-effective. Previous research shows that indemnity coverage

correlates with timely use of health services, leading to better outcomes (Aziz et al. 2022). Also, more people are seeking care at Kisiizi Hospital, predominantly CHI members. Studies demonstrate that insurance and social capital enhance the use of public and reproductive health services (Nshakira-Rukundo et al. 2021; Ananga et al. 2023). In summary, community perceptions of Kisiizi CHI were positive, as it improves access to quality healthcare and reduces costs.

5 Conclusions

1. The study demonstrated a strong sense of brotherhood and solidarity. Belonging to the *engozi* group is crucial for social status, respect, and avoiding embarrassment in the Kisiizi Community. Cooperation is highly valued, evidenced by communal activities like fundraising for timber, contributing to an emergency fund, and pooling cereals. Volunteering, reciprocity, and respect for leadership are important community values reflected in traditional practices such as assisting with planting and harvesting, building homes, and resolving disputes. Local proverbs highlight the significance of family cooperation. *Engozi* leaders and elders uphold these values by instilling discipline, enforcing customary laws, and promoting harmony.
2. The study findings show that societal values and traditions significantly influence the implementation of the Kisiizi CHI scheme. *Engozi* leaders comprise the governing board, collect annual premiums, activate and register participants, and encourage members to contribute to meet their families' premium requirements. They also update member registrations and collaborate with scheme managers. *Engozi* organizations effectively disseminate information about the insurance scheme and share best practices within the community, enhancing its visibility. Therefore, *engozi* organizations positively impact the Kisiizi CHI program's execution.
3. The findings suggest that the CHI scheme positively impacted community healthcare challenges, evident in increased service use, better antenatal care access, health promotion initiatives like mosquito net distribution, collaboration with Kisiizi Hospital's nutrition project, mass deworming campaigns, and enhanced service quality from user feedback.

5.1 Implications for practice and policy development

1. Traditional values and practices are vital for tackling healthcare inequities. By encouraging cooperation, volunteering, and reciprocity, communities can enhance their social capital and establish a strong base for community health insurance programs. Investing in social capital is crucial for the effectiveness and sustainability of these initiatives.
2. Involving community leaders in designing and implementing a Community Health Insurance (CHI) scheme is essential. Their participation ensures the scheme meets local needs and builds trust. Community leaders can also promote and manage

the scheme, create an appropriate benefits package, and facilitate communication among stakeholders.

3. Implementing a Community Health Insurance (CHI) program effectively by leveraging traditional practices and values reduces healthcare inequities. CHI removes financial barriers to quality care, increases service usage based on need, and promotes early healthcare-seeking behavior.

5.2 Strengths and drawbacks of this research

This research utilized two methodological approaches as its foundation. Selection of members from various societies with divergent grades of insurance coverage were involved. Secondly, the comparisons of the insured and uninsured respondents aided in triangulation.

However, this study had some limitations. For instance, during FGDs, some women did not feel comfortable expressing their thoughts among family elders. It was made explicit that the views shared are collective in nature and that health disparities concern elders and young people to minimize the above limitations. Additionally, the study employed qualitative techniques only, so more insight could have been gained by incorporating quantitative data. Nevertheless, the research team was conscious of the limited funds available and ensured that the budget was used responsibly.

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Authors' contributions AAK collected and analysed the data, interpreted the results, drafted and revised manuscript. AA and DK: analysed the data, interpreted the results, drafted and revised manuscript. All the authors read and approved the final manuscript.

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Availability of data and materials The datasets used and analyzed during the study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate The Research Committee of Kisiizi Hospital endorsed this study under minute number M07/2020. All participants were asked to sign a written consent form before the interview. The participants were also informed that they had the right to exit the interview at any time if they felt the need to do so. Additionally, the participants were informed that the study results could potentially be published and shared among a more extensive network of researchers.

Consent for publication Not applicable.

Competing interests The authors declare that they have no competing interests.

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Comments