World Journal of Biology Pharmacy and Health Sciences
eISSN: 2582-5542
Cross Ref DOI: 10.30574/wjbphs
Journal homepage: https://wjbphs.com/

Policy implementation barriers in Universal Health Coverage (UHC) programs: A qualitative synthesis of structural, financial and governance challenges

Ikenna Samuel Uzoka [1, *], Evan Chidiogo Chukwuogu [2], ROSITA CHINECHELUM ANALIKE [3] and Christian Ogundu Obiagwu [4]

[1] *Department of Public health, Medical Statistics and epidemiology, University of Lagos, Abuja Nigeria.*
[2] *Medical Laboratory Sciences, Abia State University, Abia Nigeria.*
[3] *Faculty/ department: Medical Laboratory Science, Nnamdi Azikwe University, Anambra Nigeria.*
[4] *Department of Medical Laboratory Sciences, Faculty of Health Science and Tech, Enugu Nigeria/ University of Nigeria, Enugu Campus.*

World Journal of Biology Pharmacy and Health Sciences, 2024, 19(01), 520-529

Publication history: Received on 18 May 2024; revised on 20 July 2024; accepted on 26 July 2024

Article DOI: https://doi.org/10.30574/wjbphs.2024.19.1.0381

Abstract

Universal Health Coverage (UHC) seeks to ensure that all people receive needed quality health services without financial hardship. Yet, many low- and middle-income countries experience persistent implementation gaps, despite formal adoption of UHC policies. This qualitative synthesis draws on empirical and review literature up to 2023 to examine structural, financial, and governance barriers to UHC implementation and access. Structural barriers include fragmented, hospital-centric systems, weak primary health care, shortages and maldistribution of health workers, inadequate infrastructure, and sociocultural constraints that reduce effective utilization. Financial barriers comprise high out of pocket payments even under insurance schemes, shallow benefit packages, fragmented and donor dependent financing, and difficulties extending pooled prepayment to informal workers. Governance barriers involve weak regulation, corruption, fragmented authority, limited stakeholder and community participation, and insufficient accountability and coordination across sectors. The thematic analysis shows that these domains interact: governance failures permit unfair financing arrangements and fragmented delivery, which in turn sustain financial hardship and service gaps, particularly for poor and marginalized groups. The findings support four analytical hypotheses: (1) under-resourced and fragmented delivery systems limits effective coverage; (2) design and implementation failures in health financing leads to persistent financial risk; (3) governance deficits and political economy dynamics are central determinants of UHC implementation; and (4) structural, financial and governance barriers are mutually reinforcing rather than isolated technical problems. The study concludes that progress toward UHC requires integrated reforms that strengthen primary care and health system foundations, redesign financing for equity and financial protection, and improve health systems governance through clearer stewardship, regulation, and inclusive participation, tailored to country context.

Keywords: Universal Health Coverage; Health Systems Governance; Health Financing; Out-Of-Pocket Payments; Primary Health Care; Policy Implementation; Low- And Middle-Income Countries; Financial Risk Protection; Health System Strengthening; Political Economy.

1. Introduction

Universal Health Coverage (UHC) aims to ensure that all people obtain needed health services without financial hardship, yet many low- and middle-income countries (LMICs) remain off track despite extensive reforms and global commitments (Ranabhat et al., 2023). Persistent implementation gaps not just policy design failures hinder progress,

* Corresponding author: Ikenna SamuelUzoka.

including weak primary care systems, fragmented delivery, high out-of-pocket (OOP) spending, and inequities in access (Perdana et al., 2022).

Experiences recorded from Bangladesh, Ghana, India, Iran, Indonesia, Nigeria, South Africa, Uganda, and others show that legislation and political commitment alone do not guarantee or ensure effective UHC implementation; instead, structural, financial, and governance barriers shape access and coverage.

1.1. Statement of Problem

Although many countries have adopted UHC related laws, health insurance schemes, and financing strategies, implementation is hindered by:

- Structural barriers: Such as, fragmented and hospital-centric systems, human resource shortages, weak infrastructure, and sociocultural barriers.
- Financial barriers: Financial barriers such as, high OOP payments, shallow benefit packages, weak financial protection, and regressive financing models.
- Governance barriers: Barriers such as, weak stewardship, fragmented authority, corruption, poor regulation, and limited stakeholder engagement.

These barriers collectively limit equal access, effective coverage, and financial risk protection, which are the core dimensions of the UHC "cube" (Ranabhat et al., 2023).

Objectives of the Study

This study aims to achieve the following:

- To identify structural challenges affecting UHC implementation and access.
- To examine financial barriers limiting financial protection and service utilization.
- To analyze governance related constraints shaping policy implementation and program performance.
- To synthesize cross-country qualitative evidence on how these barriers interact to produce implementation gaps.

1.2. Significance of the Study

The study contributes a qualitative, implementation focused synthesis that moves beyond normal UHC design toward understanding why policies fail in practice. It offers:

- A consolidated framework of barriers relevant to LMIC policymakers and implementers.
- Empirically grounded hypotheses for further country specific research.
- Practical entry points for reforms in financing, governance, and system organization.

1.3. Scope of the Study

- Temporal scope: Evidence up to and including 2023.
- Geographic focus: Primarily LMICs in Africa and Asia, with selected middle-income examples (e.g., China, Iran, South Africa).
- Substantive focus: Study is focused on the Structural, financial, and governance barriers to implementation of UHC policies and programs, not the clinical effectiveness of specific services.
- Methodological scope: Qualitative and mixed-methods studies, narrative and scoping reviews emphasizing implementation experiences.

1.4. Research Questions

- RQ1: What structural barriers constrain effective implementation of UHC programs and equal access?
- RQ2: What financial barriers limit financial risk protection and contribute to continued OOP spending under UHC schemes?
- RQ3: How do governance and political economy factors hinder or distort UHC implementation?
- RQ4: How do structural, financial, and governance barriers interact to sustain implementation gaps?

1.5. Hypotheses

- H1: Fragmented and under-resourced delivery systems are key structural barriers reducing effective population coverage under UHC.
- H2: High OOP payments and weak risk pooling persist due to design and implementation failures in health financing and insurance, hindering UHC financial protection.
- H3: Weak governance and political constraints including fragmented authority, limited accountability, and corruption are critical determinants of UHC implementation failure.
- H4: Structural, financial, and governance barriers reinforce each other, producing path dependent implementation gaps rather than isolated technical problems.

1.6. Definition of Key Terms

Universal Health Coverage (UHC): Is defined as a health system goal in which all people have access to needed promotive, preventive, curative, rehabilitative and palliative health services of sufficient quality, without suffering financial hardship (Ranabhat et al., 2023).

Structural barriers: Is defined as health system organization and capacity constraints such as service fragmentation, hospital-centrism, weak primary health care, shortages of health workers, inadequate infrastructure, and sociocultural/demand-side obstacles that limit access and quality (Sanogo et al., 2019).

Financial barriers: Is defined as the constraints related to how health care is funded, this includes high out-of-pocket expenditures, shallow or poorly defined benefit packages, fragmented and unsustainable financing mechanisms, and weak pooling and prepayment, especially for informal workers (Ifeagwu et al., 2021).

Governance barriers (Health Systems Governance): Is defined as the weaknesses in the rules, institutions, and processes through which health systems are steered, including poor policy formulation, lack of regulatory capacity, corruption, limited transparency and accountability, and ineffective coordination across actors and levels (Debie et al., 2022).

Out-of-Pocket (OOP) payments: Is defined as direct payments made by individuals at the point of service, after any reimbursements, which can lead to catastrophic or impoverishing health expenditures when high relative to income (Derkyi-Kwarteng et al., 2021).

Financial Risk Protection (FRP): Is defined as the protection of individuals and households from catastrophic or impoverishing health spending through prepayment and pooling mechanisms (taxes, insurance) in line with UHC goals (Bhatia et al., 2022).

Primary Health Care (PHC): Is defined as the first contact, community oriented, comprehensive and continuous health care that forms the foundation of an effective and equitable health system and is critical for achieving UHC (Ranabhat et al., 2023).

2. Literature, empirical and systematic review

2.1. Conceptual and Historical Perspectives on UHC

The evolution from "Health for All" to the SDG-framed UHC agenda has broadened focus from primary health care to insurance based strategies and financial protection, while raising concerns about conceptual clarity, measurement, and resource allocation (Ranabhat et al., 2023). Inappropriate financing models and misaligned resource allocation are highlighted as persistent bottlenecks. Political analyses emphasize that UHC is inherently political, shaped by interests, ideas, and institutions rather than by technical design alone.

2.2. Structural Barriers

- Fragmented and Hospital-Centric Systems
    - China's progress is constrained by a fragmented, hospital-centric delivery model, shallow insurance benefits, and weak integration of "health in all policies" (*Yip et al., 2023*).
    - Ghana's NHIS struggles with incomplete renewal and low active enrollment; scheme design, frontline implementation practices, and contextual factors shape client experience and disengagement (*Agyepong et al., 2016*).

  - Many LMICs face weak primary health care (PHC), human resource shortages, and unequal infrastructure distribution, particularly in rural areas (*Kodali, 2023*).
- Human Resources and Service Delivery Gaps
  - In Bangladesh, implementation shortfalls include human resource constraints, political interference, and weak monitoring and supervision (*Joarder et al., 2019*).
  - Across African settings, implementation research identifies inadequate human resources, infrastructure gaps, and perception of implementation as additional workload as recurrent barriers to UHC related interventions (*Nnaji et al., 2021*).
  - Indonesia's push to achieve UHC is hindered by uneven distribution of providers and inadequate infrastructure, contributing to subnational inequalities in coverage and access (*Perdana et al., 2022*).
- Sociocultural and Demand-Side Constraints
  - Bangladesh exhibits sociocultural disinclination, historical mistrust, and lack of community empowerment, which depress demand even where services exist (*Joarder et al., 2019*).
  - Sociocultural barriers and mistrust of institutions are reported more broadly in African implementation research, affecting uptake of financed services (*Nnaji et al., 2021*).

2.3. Financial Barriers

- High Out-of-Pocket Payments Under Insurance
  - In Sub-Saharan Africa (SSA), insured clients frequently pay OOP for services nominally covered by insurance, through both formal and informal payments, reflecting a policy implementation gap.
  - These payments are linked to resource constraints, conflicting policy objectives, provider coping strategies, and corruption complexes, often framed as "practical norms" at the frontline (*Derkyi-Kwarteng et al., 2021*).
- Inequitable and Unsustainable Financing Models
  - Iran's reforms expanded coverage but left major gaps: difficulty collecting contributions from informal workers, incomplete enforcement of compulsory coverage, and large tariff gaps driving OOP spending (*Doshmangir et al., 2021*).
  - Many LMICs show low public spending and high OOP expenditure, with weak financial risk protection, especially for poor households.
  - Bangladesh's rigid public financing system and colonial era budget structures constrain flexible allocation for UHC (*Joarder et al., 2019*).
- Financial Protection and Benefit Package Limitations
  - China's shallow benefit packages and rising costs limit financial risk protection for lower-income households (*Yip et al., 2023*).
  - Governance reviews identify inadequate and poorly designed financing, including one-size-fits-all modalities that neglect context, as a core challenge to UHC and health security (*Debie et al., 2022*).

2.4. Governance and Political-Economy Barriers

- Weak Governance, Fragmentation, and Policy Incoherence
  - Governance reviews highlight weak regulatory frameworks, corruption, fragmented institutions, and inadequate accountability as major obstacles to UHC and health security (*Debie et al., 2022*).
  - In Nigeria, horizontal and vertical fragmentation of authority, frequent leadership turnover, and lack of high-level political backing impeded implementation of primary care and UHC reforms (*Croke & Ogbuoji, 2023*).
  - Nigeria's broader UHC preparedness is hindered by poor policy implementation, limited policy awareness, low health spending, and poor inter-agency coordination (*Ogundeji et al., 2023*).
- Policy Design–Implementation Mismatch
  - Ghana's NHIS illustrates how policy intent (universality) is undermined by enrollment and renewal practices and local implementation arrangements, leading to stalled coverage (*Agyepong et al., 2016*).
  - South Africa's proposed National Health Insurance is challenged by legislative anomalies, role ambiguity, and insufficient involvement of key stakeholders, raising doubts about implementation feasibility (*Naidoo et al., 2023*).

  - HSG (health systems governance) reviews emphasize that "one-size-fits-all" governance approaches fail; decentralization and context-specific rules are necessary but often weakly executed (*Debie et al., 2022*).
- Power, Interests, and "Street-Level" Implementation
  - In SSA insurance schemes, frontline workers' coping strategies, practical norms, and corruption mediate how UHC policies are experienced, generating informal payments even under "free care" regimes (*Derkyi-Kwarteng et al., 2021*).
  - Political economy analyses show that in competitive clientelist systems, attempts to move from clientelistic to programmatic UHC policies face entrenched opposition and inconsistent enforcement (*Croke & Ogbuoji, 2023*).

2.5. Empirical and Systematic Review

- Narrative and conceptual reviews document broad categories of UHC barriers such as, weak PHC, financing gaps, governance weaknesses, demographic and epidemiologic pressures and call for context-specific reforms.
- A scoping review of implementation research in Africa shows growing use of qualitative and mixed methods to identify contextual facilitators (political support, funding, collaboration) and barriers (resource gaps, socio-cultural barriers, weak incentives) relevant to UHC (*Nnaji et al., 2021*).
- A key informant study in India identifies lack of a comprehensive systems approach, fragmented public private sectors, poor regulation, and inadequate and inefficient financing as major barriers to UHC (*Kalita et al., 2023*).
- Country specific qualitative work (Bangladesh, Ghana, Nigeria, Indonesia, South Africa, Iran) provides detailed narratives of barriers and potential reforms.

3. Methodology

3.1. Study Design

This research is a qualitative synthesis of published empirical and review literature on barriers to UHC implementation up to 2023. The approach is closest to a narrative and thematic qualitative synthesis, drawing on methods used in similar reviews of UHC challenges and implementation research.

3.2. Data Sources and Search Strategy

Electronic databases (e.g., PubMed, Scopus, Web of Science) and selected grey literature sources (e.g., WHO, World Bank) were searched in line with strategies used by prior narrative and scoping reviews of UHC and governance. Search terms combined concepts related to:

- "Universal health coverage", "health insurance", "health financing"
- "Policy implementation", "governance", "health systems", "barriers", "challenges"
- "Low- and middle-income countries", "Africa", "Asia", "developing countries"

3.3. Inclusion Criteria

- Peer-reviewed empirical qualitative, mixed-methods, or implementation studies; or narrative/scoping/structured reviews with an explicit focus on UHC implementation or UHC-related reforms.
- Focus on LMICs or relevant middle-income contexts.
- Explicit discussion of structural, financial, or governance barriers affecting UHC implementation, access, or financial protection.
- English language publications.

3.4. Exclusion Criteria

- Studies focusing solely on clinical effectiveness or disease epidemiology without a direct link to UHC policy implementation.
- High-income country only analyses unless used conceptually (these were largely excluded to preserve LMIC relevance).
- Commentaries or opinion pieces without empirical or structured analytical content.

3.5. Data Extraction and Management

Following approaches used in implementation research scoping reviews, key data items were extracted into an analytical matrix:

- Country/region and income level.
- Type of UHC program (e.g., national health insurance, PHC reform, financial protection scheme).
- Study design and methods (key informant interviews, focus groups, document review, mixed methods).
- Reported structural, financial, and governance barriers.
- Suggested strategies or reforms.

3.6. Qualitative Analysis Approach

A thematic content analysis approach guided the synthesis, akin to methods used in Ghana's NHIS qualitative analysis and policy barometer work:

- Initial coding: Barriers and contextual factors were coded inductively from study findings (e.g., "fragmented governance", "informal payments", "weak PHC").
- Thematic grouping: Codes were organized into higher-order themes under the pre-specified categories of structural, financial, and governance barriers, while allowing cross-cutting themes (e.g., political economy, sociocultural demand-side constraints) to emerge.
- Analytical integration: Themes were compared across countries and study types to identify convergent patterns and interactions, drawing on political economy frameworks and the UHC cube.

3.7. Trustworthiness and Limitations

The methodology mirrors established qualitative and review approaches but has some limitations:

- Dependence on published literature may under-represent unpublished implementation experiences.
- Variability in definitions of UHC and scope across countries complicates direct comparison.
- The synthesis is interpretive rather than statistically generalizable; it aims to generate analytical generalizations and hypotheses, consistent with qualitative research traditions.

4. Data analysis and discussion

4.1. Overview of Included Evidence

4.1.1. Cross-Country Barriers to UHC Implementation

Table 1 Synthesis of dominant UHC implementation barriers across LMICs

Barrier	Recurrent Themes	Example country evidence	Citations
Structural	Fragmented hospital centric systems, weak PHC, Human Resource for Health (HRH) shortages, sociocultural barriers	China, Ghana, Bangladesh, Indonesia, multiple African settings	*(Yip et al., 2023; Agyepong et al., 2016; Joarder et al., 2019; Perdana et al., 2022; Nnaji et al., 2021)*
Financial	Persisting OOP under insurance, shallow benefits, low public spending, regressive models	Sub-Saharan Africa (SSA) insurance schemes, Iran, India, global tracking, LMIC reviews	*(Derkyi-Kwarteng et al., 2021; Doshmangir et al., 2021; Kalita et al., 2023; Kodali, 2023)*
Governance	Fragmented authority, weak regulation, corruption, limited participation, poor coordination	Nigeria, South Africa, multi-country HSG review, political analyses	*(Croke & Ogbuoji, 2023; Naidoo et al., 2023; Debie et al., 2022; Ho et al., 2022; Ogundeji et al., 2023; Nnaji et al., 2021)*

5. Discussion

5.1. Testing the Hypotheses Against the Qualitative Evidence

5.1.1. H1: Structural Barriers and Coverage Gaps

Evidence strongly supports that fragmented and under-resourced systems hinders effective coverage. Ghana's NHIS shows stalled population coverage due to scheme design and frontline implementation arrangements that affect client experience and renewal (*Agyepong et al., 2016*). Bangladesh faces human resource gaps, weak supervision, and demand side mistrust, despite comprehensive policies and pilots (*Joarder et al., 2019*). China's hospital centric system and inadequate integration of chronic disease prevention limits UHC performance (*Yip et al., 2023*). Reviews highlight weak PHC, infrastructure deficits, and human resource for health (HRH) shortages across LMICs.

Conclusion on H1: Supported. Structural deficiencies systematically limit access and quality, this hinders effective UHC coverage.

5.1.2. H2: Financial Barriers and Continued OOP Spending

The narrative review of OOP in Sub-Saharan Africa (SSA) shows insured clients routinely paying for supposedly covered services due to stock-outs, informal charges, and provider coping strategies, representing a clear implementation gap (*Derkyi-Kwarteng et al., 2021*). Iran's reforms increased coverage but left high OOP expenditures due to tariff gaps, partial enforcement of compulsory insurance, and weak expenditure control (*Doshmangir et al., 2021*). Broader tracking and review reports confirm persistently high OOP and insufficient financial protection in many LMICs.

Conclusion on H2: Strongly supported. Design and implementation failures in financing and insurance lead to persistent OOP and weak financial protection under UHC programs.

5.1.3. H3: Governance and Political Economy Constraints

Governance reviews identify corruption, weak regulatory systems, inadequate funding, and poor accountability as central challenges to UHC and health security (*Debie et al., 2022*). In Nigeria, competitive clientelist politics and fragmented authority hindered implementation of primary care and UHC reforms, with sporadic disbursements under the National Health Act and incomplete institutionalization of programs (*Croke & Ogbuoji, 2023*). Another Nigerian qualitative study highlights limited policy awareness, weak data systems, poor inter-agency coordination, and low government spending as barriers to UHC progress (*Ogundeji et al., 2023*). South African policy developers express concerns over legislative inconsistencies, stakeholder exclusion, and role ambiguity under National Health Insurance (NHI), threatening implementation (*Naidoo et al., 2023*). Political analysts argue that interests, ideas, and institutions systematically shape UHC trajectories and can stall reforms without sustained coalitions (*Ho et al., 2022*).

Conclusion on H3: Strongly supported. Governance weaknesses and political dynamics are central, not peripheral, to UHC implementation failure.

5.1.4. H4: Interaction of Structural, Financial, and Governance Barriers

The literature consistently shows that these domains interact. For example:

- In Sub-Saharan Africa (SSA), resource constraints (financial), human resource shortages and stock-outs (structural), and corruption/practical norms (governance) combine to produce informal OOP payments under insurance.
- In Ghana, national level policy design (governance), scheme rules and renewal processes (financial/structural), and frontline practices co-produce low active enrollment.
- In Iran, limited mechanisms for collecting contributions from informal workers (structural/financial) intersect with inadequate priority setting and weak expenditure control (governance) to jeopardize sustainable UHC.
- Governance reviews highlight how "one-size-fits-all" HSG approaches and weak regulation allow inequitable financing and fragmented service delivery to persist.

Conclusion on H4: Supported. Barriers are mutually reinforcing and path-dependent, not isolated technical flaws.

Answering Research Questions

- RQ1 (Structural): Fragmented service organization, hospital centrism, weak PHC, HRH shortages, and sociocultural barriers are widely reported across Asia and Africa as limiting access and effective coverage, even where UHC policies are ambitious.
- RQ2 (Financial): High OOP under insurance, shallow benefits, low and inefficient public spending, and weak mechanisms for pooling contributions especially for informal workers, are key underpinnings of financial barrier persistence.
- RQ3 (Governance): Governance failures such as fragmented authority, weak regulation, corruption, inadequate stakeholder engagement, and limited policy awareness, shape how UHC reforms are implemented and sustained.
- RQ4 (Interactions): Multi-level interactions between structural, financial, and governance factors drive implementation gaps. Implementation research in Africa and multi-country analyses underscore the need for integrated, context-sensitive approaches that align policy design with frontline realities.

6. Conclusion

Across LMICs, UHC implementation is hindered less by the absence of formal policies and more by structural weaknesses, financial constraints, and governance failures that interact to produce persistent implementation gaps. Fragmented and under resourced systems, continued OOP payments under nominally protective schemes, and weak, politicized governance arrangements collectively undermine equitable access and financial protection. Achieving UHC will require addressing these interlocking barriers, not isolated technical fixes.

Recommendations

- Strengthen Primary Health Care and System Integration
    - Reorient delivery systems from hospital-centric to PHC-focused, integrated models, with clear referral pathways and accountability for continuity of care.
    - Invest in HRH distribution, infrastructure, and service quality, particularly in underserved regions.
- Reform Health Financing for Equity and Protection
    - Expand and deepen risk pooling mechanisms, especially for informal and vulnerable populations, ensuring enforcement of compulsory coverage where mandated.
    - Reduce OOP spending by clarifying and enforcing benefit packages, addressing stock-outs, and tackling informal payments through incentives and accountability.
- Improve Governance and Accountability
    - Clarify roles and reduce fragmentation across ministries, agencies, and levels of government; institutionalize intersectoral coordination platforms.
    - Strengthen regulatory capacity, anti-corruption mechanisms, and transparent monitoring of UHC indicators, including equity metrics.
    - Embed implementation research within policy cycles to generate real-time evidence on barriers and facilitators.
- Engage Stakeholders and Communities
    - Involve frontline providers, local governments, civil society, and communities in design, implementation, and evaluation of UHC reforms.
    - Address sociocultural barriers through sustained community engagement, patient education, and empowerment efforts.
- Adopt Context-Specific, Political-Economy-Aware Strategies
    - Recognize UHC as a political project; build broad coalitions and manage interests to sustain reforms across electoral cycles.
    - Avoid one-size-fits-all models; adapt financing, governance, and delivery reforms to local institutional and political contexts.

Compliance with ethical standards

Disclosure of conflict of interest

No conflict of interest to be disclosed.

The authors declare that there is no conflict of interest regarding the publication of this article. The research was conducted without any financial, commercial, or personal relationships that could perceived as influencing the study outcomes.

Statement of Ethical Approval

Ethical approval was not required for this study because it was based entirely on secondary data obtained from publicly available, peer reviewed publications, institutional reports, and policy documents. No human participants, animals, or identifiable personal data were involved in the conduct of this research.

Statement of Informed Consent

Informed consent was not applicable for this study, as it did not involve any direct interaction with human participants, collection of primary data, or use of identifiable personal information.

References

[1] Joarder, T., Chaudhury, T., & Mannan, I. (2019). Universal Health Coverage in Bangladesh: Activities, Challenges, and Suggestions. *Psyche; a Journal of Entomology*, 2019. https://doi.org/10.1155/2019/4954095

[2] Derkyi-Kwarteng, A., Agyepong, I., Enyimayew, N., & Gilson, L. (2021). A Narrative Synthesis Review of Out-of-Pocket Payments for Health Services Under Insurance Regimes: A Policy Implementation Gap Hindering Universal Health Coverage in Sub-Saharan Africa. *International Journal of Health Policy and Management*, 10, 443 - 461. https://doi.org/10.34172/ijhpm.2021.38

[3] Agyepong, I., Abankwah, D., Abroso, A., Chun, C., Dodoo, J., Lee, S., Mensah, S., Musah, M., Twum, A., Oh, J., Park, J., Yang, D., Yoon, K., Otoo, N., & Asenso-Boadi, F. (2016). The "Universal" in UHC and Ghana's National Health Insurance Scheme: policy and implementation challenges and dilemmas of a lower middle income country. *BMC Health Services Research*, 16. https://doi.org/10.1186/s12913-016-1758-y

[4] Croke, K., & Ogbuoji, O. (2023). Health reform in Nigeria: the politics of primary health care and universal health coverage. *Health Policy and Planning*, 39, 22 - 31. https://doi.org/10.1093/heapol/czad107

[5] Hongoro, C., Rutebemberwa, E., Twalo, T., Mwendera, C., Douglas, M., Mukuru, M., Kasasa, S., & Ssengooba, F. (2018). Analysis of selected policies towards universal health coverage in Uganda: the policy implementation barometer protocol. *Archives of Public Health*, 76. https://doi.org/10.1186/s13690-018-0258-4

[6] Kodali, P. (2023). Achieving Universal Health Coverage in Low- and Middle-Income Countries: Challenges for Policy Post-Pandemic and Beyond. *Risk Management and Healthcare Policy*, 16, 607 - 621. https://doi.org/10.2147/rmhp.s366759

[7] Kalita, A., Carton-Rossen, N., Joseph, L., Chhetri, D., & Patel, V. (2023). The Barriers to Universal Health Coverage in India and the Strategies to Address Them: A Key Informant Study. *Annals of Global Health*, 89. https://doi.org/10.5334/aogh.4120

[8] Naidoo, V., Suleman, F., & Bangalee, V. (2023). Policy developer's perceptions on the implementation of National Health Insurance in South Africa: a qualitative study. *Journal of Pharmaceutical Policy and Practice*, 16. https://doi.org/10.1186/s40545-023-00564-x

[9] Yip, W., Fu, H., Jian, W., Liu, J., Pan, J., Xu, D., Yang, H., & Zhai, T. (2023). Universal health coverage in China part 2: addressing challenges and recommendations.. *The Lancet. Public health*, 8 12, e1035-e1042. https://doi.org/10.1016/s2468-2667(23)00255-4

[10] Doshmangir, L., Bazyar, M., Rashidian, A., & Gordeev, V. (2021). Iran health insurance system in transition: equity concerns and steps to achieve universal health coverage. *International Journal for Equity in Health*, 20. https://doi.org/10.1186/s12939-020-01372-4

[11] Perdana, N., Adhasari, G., & Mahadewi, E. (2022). Challenges and Implementation of Universal Health Coverage Program in Indonesia. *International Journal of Health and Pharmaceutical (IJHP)*. https://doi.org/10.51601/ijhp.v2i3.97

[12] Nnaji, C., Wiysonge, C., Okeibunor, J., Malinga, T., Adamu, A., Tumusiime, P., & Karamagi, H. (2021). Implementation research approaches to promoting universal health coverage in Africa: a scoping review. *BMC Health Services Research*, 21. https://doi.org/10.1186/s12913-021-06449-6

[13] Ranabhat, C., Acharya, S., Adhikari, C., & Kim, C. (2023). Universal health coverage evolution, ongoing trend, and future challenge: A conceptual and historical policy review. *Frontiers in Public Health*, 11. https://doi.org/10.3389/fpubh.2023.1041459

[14] Debie, A., Khatri, R., & Assefa, Y. (2022). Successes and challenges of health systems governance towards universal health coverage and global health security: a narrative review and synthesis of the literature. *Health Research Policy and Systems*, 20. https://doi.org/10.1186/s12961-022-00858-7

[15] (2021). Tracking Universal Health Coverage. **. https://doi.org/10.1596/36724

[16] Ho, C., Khalid, H., Skead, K., & Wong, J. (2022). The politics of universal health coverage. *The Lancet*, 399, 2066-2074. https://doi.org/10.1016/s0140-6736(22)00585-2

[17] Ogundeji, Y., Tinuoye, O., Bharali, I., Mao, W., Ohiri, K., Ogbuoji, O., Orji, N., & Yamey, G. (2023). Is Nigeria on course to achieve universal health coverage in the context of its epidemiological and financing transition? A knowledge, capacity and policy gap analysis (a qualitative study). *BMJ Open*, 13. https://doi.org/10.1136/bmjopen-2022-064710

[18] Kaiser, A., Rotigliano, N., Flessa, S., Ekman, B., & Sundewall, J. (2023). Extending universal health coverage to informal workers: A systematic review of health financing schemes in low- and middle-income countries in Southeast Asia. *PLOS ONE*, 18. https://doi.org/10.1371/journal.pone.0288269

[19] *Journal of Health Policy and Management*, 10, 443 - 461. https://doi.org/10.34172/ijhpm.2021.38

[20] Syaddam, M. (2021). Universal Health Coverage in Developing Countries: Barriers and Strategic Reforms. *Journal of Health Literacy and Qualitative Research*. https://doi.org/10.61194/jhlqr.v1i2.533

[21] Debie, A., Khatri, R., & Assefa, Y. (2022). Successes and challenges of health systems governance towards universal health coverage and global health security: a narrative review and synthesis of the literature. *Health Research Policy and Systems*, 20. https://doi.org/10.1186/s12961-022-00858-7

[22] Nannini, M., Biggeri, M., & Putoto, G. (2021). Health Coverage and Financial Protection in Uganda: A Political Economy Perspective. *International Journal of Health Policy and Management*, 11, 1894 - 1904. https://doi.org/10.34172/ijhpm.2021.116

[23] Jaca, A., Malinga, T., Iwu-Jaja, C., Nnaji, C., Okeibunor, J., Kamuya, D., & Wiysonge, C. (2022). Strengthening the Health System as a Strategy to Achieving a Universal Health Coverage in Underprivileged Communities in Africa: A Scoping Review. *International Journal of Environmental Research and Public Health*, 19. https://doi.org/10.3390/ijerph19010587

[24] El-Jardali, F., Fadlallah, R., Daouk, A., Rizk, R., Hemadi, N., Kebbi, O., Farha, A., & Akl, E. (2018). Barriers and facilitators to implementation of essential health benefits package within primary health care settings in low-income and middle-income countries: A systematic review. *The International Journal of Health Planning and Management*, 34, 15–41. https://doi.org/10.1002/hpm.2625

[25] Ifeagwu, S., Yang, J., Parkes-Ratanshi, R., & Brayne, C. (2021). Health financing for universal health coverage in Sub-Saharan Africa: a systematic review. *Global Health Research and Policy*, 6. https://doi.org/10.1186/s41256-021-00190-7

[26] Endalamaw, A., Gilks, C., Ambaw, F., & Assefa, Y. (2022). Universality of universal health coverage: A scoping review. *PLoS ONE*, 17. https://doi.org/10.1371/journal.pone.0269507

[27] Jamal, M., Aziz, A., Aizuddin, A., & Aljunid, S. (2022). Successes and obstacles in implementing social health insurance in developing and middle-income countries: A scoping review of 5-year recent literatures. *Frontiers in Public Health*, 10. https://doi.org/10.3389/fpubh.2022.918188

[28] Bhatia, D., Mishra, S., Kirubarajan, A., Yanful, B., Allin, S., & Di Ruggiero, E. (2022). Identifying priorities for research on financial risk protection to achieve universal health coverage: a scoping overview of reviews. *BMJ Open*, 12. https://doi.org/10.1136/bmjopen-2021-052041

[29] Osoro, A., Atitwa, E., & Moturi, J. (2020). Universal Health Coverage. *World Journal of Social Science Research*. https://doi.org/10.22158/wjssr.v7n4p14

[30] Sanogo, N., Fantaye, A., & Yaya, S. (2019). Universal Health Coverage and Facilitation of Equitable Access to Care in Africa. *Frontiers in Public Health*, 7. https://doi.org/10.3389/fpubh.2019.00102

[31] Yeoh, E., Johnston, C., Chau, P., Kiang, N., Tin, P., & Tang, J. (2019). Governance Functions to Accelerate Progress toward Universal Health Coverage (UHC) in the Asia-Pacific Region. *Health Systems & Reform*, 5, 48 - 58. https://doi.org/10.1080/23288604.2018.1543521