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BARRIERS AND FACILITATORS IN THE IMPLEMENTATION OF UNIVERSAL HEALTH COVERAGE HEALTH VOUCHER MECHANISM AT TIKO DISTRICT HOSPITAL, CAMEROON

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ABSTRACT

Background: The Universal Health Coverage (UHC) Health Voucher Mechanism was introduced in Cameroon to reduce financial barriers to maternal and child health services. Despite its implementation, factors affecting its operational effectiveness at facility level remain inadequately documented.

Objective: This study assessed the barriers, facilitators, and strategies for strengthening implementation of the UHC Health Voucher Mechanism at Tiko District Hospital.

Methods: A mixed-methods cross-sectional study was conducted among 57 health workers and 40 beneficiaries selected through census and consecutive sampling respectively. Data were collected using structured questionnaires and a facility observation checklist and analyzed using SPSS version 20. Findings were presented in tables and charts.

Results: Implementation barriers were reported by all health workers (100%) and 92.5% of beneficiaries. Among health workers, delayed reimbursement (93.0%), high workload (68.4%), poor beneficiary understanding (52.6%), and inadequate training (47.4%) were predominant. Among beneficiaries, drug stock-outs (47.5%), administrative delays (47.5%), and poor explanation of procedures (45.0%) were leading challenges. Key facilitators included availability of trained staff (87.7%), supportive hospital management (77.2%), reduced cost of care (97.5%), and easy access to services (82.5%).

Conclusion: The UHC Health Voucher Mechanism was perceived favorably by most beneficiaries, although its implementation remains constrained by financial, workforce, logistical, and communication challenges. Strengthening reimbursement timelines, staff training, drug supply, and beneficiary awareness is essential to improve program effectiveness and advance Cameroon's progress toward Universal Health Coverage.

Keywords*:* Universal Health Coverage, Health voucher mechanism, Barriers, Facilitators, Maternal and child health, Tiko District Hospital

INTRODUCTION

Universal Health Coverage (UHC) is a global health policy priority aimed at ensuring that all individuals and communities can access the essential health services they need, when required, without financial hardship, as defined by the World Health Organization (WHO) [1]. Achieving UHC requires both the expansion of essential services and strong financial risk protection, particularly for vulnerable populations [2]. However, in many low- and middle-income countries, including Cameroon, access to healthcare remains constrained by financial barriers, geographical inaccessibility, and weak health system infrastructure [2]. In an attempt to address these challenges, UHC strategies such as innovative financing mechanisms has been put in place to provide everyone with access to adequate health services including prevention, promotion, treatment, rehabilitation, and palliation [3].

Health vouchers are demand-side financing tools that support universal health coverage (UHC) goals by providing targeted subsidies to specific population groups, enabling access to predefined health services while reducing out-of-pocket payments [4]. In Cameroon, the Health Voucher (Chèque Santé) initiative was introduced under the UHC framework to improve maternal and child health outcomes [4]. It targets pregnant women and children, covering antenatal care, delivery, postnatal care, and neonatal services at a subsidized cost, with beneficiaries contributing 6,000 Central African CFA francs [4]. The program has been fully implemented in several regions, including the North-West and South-West Regions, to improve service utilization and reduce financial barriers [4]. Evidence from similar low-resource settings indicates that voucher schemes can improve equity, increase service uptake, and enhance health outcomes among underserved populations [5].

In Cameroon, implementation has been supported by government efforts and development partners, particularly in rural and underserved areas [6]. Despite its potential, implementation of health voucher systems faces multiple challenges, including insufficient funding, reimbursement delays, weak coordination among stakeholders, inadequate staff training, and limited community awareness [7, 8]. Conversely, effective government commitment, community engagement, and strong monitoring and evaluation systems have been identified as key enablers of successful implementation and sustainability [9, 10]. However, limited empirical evidence exists on the specific barriers and facilitators affecting the implementation of health voucher mechanisms at Tiko District Hospital.

The current study therefore addresses this gap by systematically examining these factors, with the aim of informing policy and strengthening the implementation of UHC-related health voucher programs in similar rural settings.

METHODS

Study Design

This study employed a mixed-methods cross-sectional study design.

Study Area and Settings

This study was conducted at Tiko District Hospital, located in Tiko Subdivision of the South West Region of Cameroon.

Study Population and Sampling

The study population comprised health workers directly involved in the implementation of the UHC Health Voucher Mechanism and beneficiaries who accessed UHC voucher services at Tiko District Hospital during the study period.

A census sampling technique was used for health workers, whereby all eligible personnel directly involved in the implementation of the UHC Health Voucher Mechanism were invited to participate. Beneficiaries were recruited using consecutive sampling, whereby all eligible beneficiaries attending the facility during the study period were approached consecutively until the end of data collection.

Eligibility Criteria

UHC Workers directly involved in UHC health voucher implementation including Health personnel's and Hospital administrators with approved consent were included and beneficiaries who consented and who have accessed or attempted to access voucher services.

Data Collection and Analysis

Data was collected using structured questionnaires (two) and a checklist. Data was analyzed using MS Excel and Statistical Package for Social Sciences (SPSS) version 20.0 for windows. Descriptive statistics were performed and results were presented on tables and charts.

Ethical Considerations

This study was approved by the Ethics Board for Human Research of the Regional Delegation of Public Health for the South West Region.

RESULTS

Socio-demographic and Professional Characteristics of Respondents

A total of 57 health workers participated in the study. The socio-demographic characteristics examined included age, sex, professional qualification, years of experience, and involvement in UHC Implementation. Majority of respondents were aged 25–34 years and were predominantly female (84.2%). Midwives constituted the largest professional category (11%), followed by nurses and laboratory staff (18%). Regarding work experience, the highest proportion (23%) of respondents had between 1 to 5 years of experience (Table 1a).

Table 1a: Socio-demographic characteristics of health workers participants (n=57)

Variable	Category	Frequency	Percentage (%)
Age group (years)	< 25	12	21.1
	25–34	21	36.7
	35–44	14	24.6
	45–54	07	12.3
	50+	03	5.3
	Total	**57**	**100**
Sex	Male	09	15.8
	Female	48	84.2
	Total	**57**	**100**
Professional Category	Midwife	11	19.3
	Nurse	09	15.8
	Laboratory Staff	09	15.8
	Medical Doctor	07	12.3
	Pharmacy Attendant	07	12.3
	Administrative Staff	06	10.5
	Record/OpenIMIS Staff	05	8.8
	Cashier	03	5.3
	Total	**57**	**100**
Professional experience	<1 years	06	10.5
	1-5 years	23	40.4
	6–10 years	14	24.6
	>10 years	14	24.6
	Total	**57**	**100**

A total of 40 female beneficiaries of the UHC health voucher services participated in the study. The majority of respondents were aged 20–29 years (60.0%) and single (70.0%). More than half had attained secondary education (52.5%). Respondents were mainly traders (22.5%), farmers (20.0%), and self-employed individuals (20.0%). All participants had previously used the UHC health voucher services, with nearly half (47.5%) reporting a single usage (Table 1b).

Table 1b: Socio-demographic characteristics of beneficiary participants (n=40)

Variable	Category	Frequency (n)	Percentage (%)
Age group (years)	<20	03	7.5
	20–29	24	60.0
	30–39	11	27.5
	40-49	02	5.0
	Total	**40**	**100**
Marital status	Single	28	70.0
	Married	12	30.0
	Total	**40**	**100**
Level of Education	Primary	09	22.5
	Secondary	21	52.5
	Tertiary	10	25.0
	Total	**40**	**100**
Occupation	Trader	09	22.5
	Farmer	08	20.0
	Student	06	15.0
	Civil servant	04	10.0
	Self-employed	08	20.0
	Unemployed	05	12.5
	Total	**40**	**100**
Frequency of HV usage	Once	19	47.5
	2-3times	13	32.5
	>3 times	08	20.0
	Total	**40**	**100**

HV: Health Voucher

Barriers Affecting the Implementation of the UHC Health Voucher Mechanism at Tiko District Hospital

All health workers (100%) reported encountering barriers in the implementation of the UHC Health Voucher Mechanism, while 37 out of 40 beneficiaries (92.5%) reported experiencing at least one challenge when accessing voucher-supported services (Table 2). Delayed reimbursement was the most frequently reported barrier among health workers 53 (93.0%). Among the beneficiaries, lack of drugs and supplies and administrative delays emerged as the most frequently reported barriers, each cited by 19 respondents (47.5%).

Facilitators of the UHC Health Voucher Implementation Mechanism at Tiko District Hospital

The facilitators of UHC voucher implementation as reported by health workers and beneficiaries are presented in Table 3. Among health workers, availability of trained staff was the most frequently cited facilitator, reported by 50 respondents (87.7%), followed by supportive hospital management (n=44; 77.2%). Among beneficiaries, reduced cost of care was the most dominant facilitator,

reported by 39 respondents (97.5%), followed by easy access to services (n=33; 82.5%) and support from hospital staff (n=30; 69.8%).

Table 2: Barriers to UHC Voucher Implementation Reported by Health Workers and Beneficiaries

Barrier Category	HW Frequency	HW % of Cases	Ben. Frequency	Ben. % of Cases
Delayed reimbursement	53	93.0	—	—
High workload	39	68.4	—	—
Poor beneficiary understanding	30	52.6	—	—
Inadequate training	27	47.4	—	—
Inadequate staffing	14	24.6	—	—
Stock-out of drugs/supplies	13	22.8	19	47.5
Lack of motivation/incentives	10	17.5	—	—
Administrative bottlenecks/delays	05	8.8	19	47.5
Poor working conditions	05	8.8	—	—
Long waiting time	—	—	12	30.0
Poor explanation of procedures	—	—	18	45.0
Asked to pay additional money	—	—	08	20.0
Difficulties accessing service	—	—	07	17.5
Negative attitude of health worker	—	—	05	12.5

HW: Health Workers, Ben.: Beneficiaries; —: category not applicable to this group

Observation Checklist

The observation checklist findings revealed that the basic structures and systems required for implementation of the UHC health voucher mechanism were largely available at Tiko District Hospital. UHC guidelines, registration forms, reporting tools, service registers, verification documents, and reporting systems were present and functional. Evidence of supportive supervision and mechanisms for reporting implementation challenges were also observed.

However, some challenges were identified during the observation. Essential drugs required for certain UHC-covered services were not consistently available at the time of observation. In addition, no visible UHC information or awareness materials were displayed within the facility (Table 4).

Perceived Satisfaction Regarding the UHC Health Voucher Mechanism

Among health workers, 42.2% were satisfied or very satisfied with the implementation of the program, while 36.8% expressed dissatisfaction (Figure 1a).

Among beneficiaries, satisfaction levels were higher, with 62.5% reporting that they were satisfied or very satisfied with services received under the voucher scheme (Figure 1b).

Table 3: Facilitators of the UHC Health Voucher Implementation Mechanism at Tiko District Hospital as Reported by Health Workers and Beneficiaries

Facilitator	HW Frequency	HW % of Cases	Ben. Frequency	Ben. % of Cases
Supportive hospital management	44	77.2	_	_
Availability of trained staff	50	87.7	_	_
Functional verification system	27	47.4	_	_
Clear implementation guidelines	13	22.8	_	_
Community awareness	12	21.1	_	_
External supervision	29	50.9	_	_
Easy to access	_	_	33	82.5
Clear information from HW	_	_	18	45.0
Availability of services and drugs	_	_	09	20.9
Support from hospital staff	_	_	30	69.8
Reduced cost of care	_	_	39	97.5
Short waiting time	_	_	09	22.5

HW: Health Workers; Ben.: Beneficiaries; —: category not applicable to this group

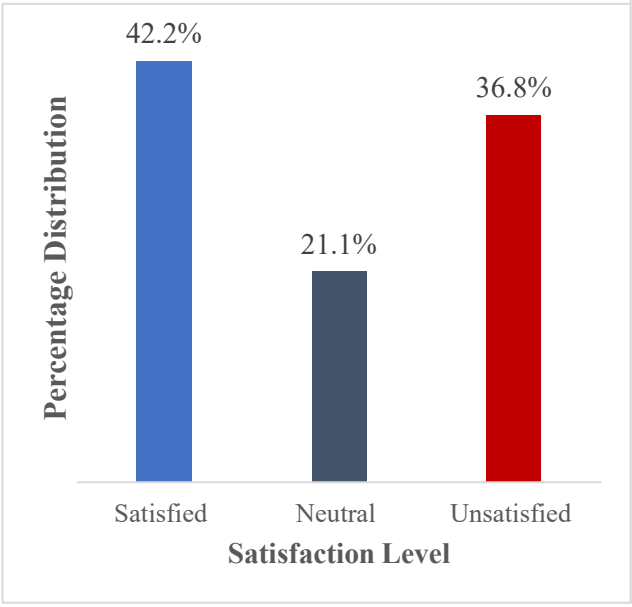


Figure 1a

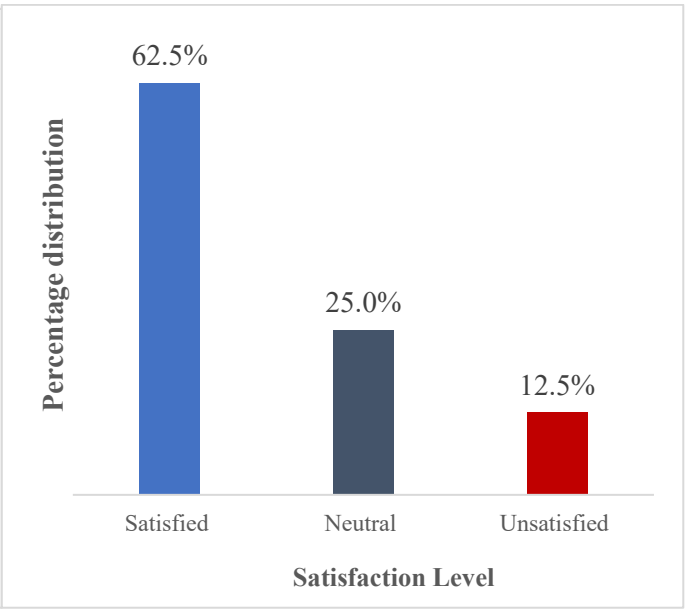


Figure 1b

Table 4: Observation Checklist Findings on the Implementation of the UHC Health Voucher Mechanism at Tiko District Hospital

Item No	Item	Observation		Comment
		Available	Not available	
1	UHC implementation guidelines/manuals at the facility	X		Soft copy available; not visibly accessible to all staff
2	UHC registration and voucher management forms	X		Forms available in-service units
3	Functional UHC registers and service documentation tools	X		Registers available and in use
4	Functional data recording and reporting tools for UHC activities	X		OpenIMIS and reporting tools available
5	Essential drugs required for UHC-covered services at the time of observation		X	Some essential drugs were out of stock during observation
6.	Essential supplies and materials required for UHC-covered services	X		Some items occasionally procured by clients
7	UHC service records are properly completed and maintained	X		Documentation generally complete and up to date
8	Evidence of voucher verification and approval documentation	X		Verification records and supporting documents observed
9	UHC information, education, or awareness materials are displayed		X	No visible posters or awareness materials observed
10	Staff assigned to UHC-related services	X		Staff present and providing services

DISCUSSION

Implementation barriers were reported by all health workers and most beneficiaries, indicating that challenges affecting the UHC Health Voucher Mechanism are systemic rather than isolated. Delayed reimbursement emerged as the principal barrier, disrupting facility cash flow, contributing to drug stock-outs, staff demotivation, and additional out-of-pocket payments by beneficiaries. Similar findings have been reported across sub-Saharan Africa, where irregular provider reimbursement undermines program implementation and financial protection objectives [11].

Human resource constraints also affected implementation. High workload and inadequate staffing corresponded with beneficiary reports of long waiting times and administrative delays, suggesting that increased service demand has not been matched by adequate workforce capacity. In addition, nearly half of health workers reported inadequate training, while most lacked access to written implementation guidelines. Similar challenges have been reported in South Africa, where inadequate operational knowledge limited effective program implementation [12].

Drug stock-outs and poor communication further constrained implementation. Beneficiaries reported medicine shortages more frequently than health workers, and the observation checklist confirmed intermittent stock availability. Poor explanation of program procedures and limited beneficiary understanding indicate persistent communication gaps that may reduce service utilization. Overall, these findings demonstrate that financial, workforce, supply chain, and communication barriers interact to weaken implementation, highlighting the need for integrated rather than isolated interventions.

Despite these challenges, the study identified important facilitators that provide a strong foundation for improving program implementation. Health workers highlighted the availability of trained staff, supportive hospital management, external supervision, and functional verification systems as key enabling factors. These findings were supported by the observation checklist, which confirmed the availability of documentation systems and OpenIMIS reporting tools. Similar evidence from Ghana identifies institutional leadership and supportive supervision as critical determinants of successful program implementation [13].

Among beneficiaries, reduced cost of care was the strongest facilitator, confirming that the Health Voucher Mechanism achieves its primary objective of improving financial access to maternal and child health services. Easy access to services and positive staff supports further reinforced program acceptability. However, limited availability of medicines and inadequate community awareness remained important weaknesses, indicating that financial protection alone is

insufficient without reliable service availability and effective beneficiary education. Overall, the findings suggest that existing institutional strengths can be leveraged to improve program performance and sustainability.

Conclusion

The implementation of UHC health voucher mechanism at Tiko District Hospital is constrained by financial, human resource, supply, and communication barriers but at the same time, supportive management, trained staff, and reduced cost of care emerged as important facilitators. Improving reimbursement, staffing, guidelines, and community awareness will be essential for sustainability of the Universal Health Coverage Mechanism.

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Conflict of Interest

Authors declare no conflict of interest.

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