Universal health coverage in Chad: evaluating the non-contributory scheme within the Central African subregional framework

Steffie Mbessa,[1] Mokhtar Mahamat,[2] Abel Dafogo Djibagaou,[3] Sabrina Atturo,[4] Vittorio Colizzi[3]

[1]European Biotechnology Group of the Tor Vergata Scientific Park, Cameroon; [2]University of Versailles and Saint-Quentin-en-Yvelines, Île-de-France, France; [3]Faculty of Medicine, Bon Samaritain Hospital, N'Djamena, Chad; [4]Fondazione MAGIS ETS, Rome, Italy

Abstract

Chad has adopted Law No. 035/PR/2019 establishing Universal Health Coverage (UHC), with a non-contributory scheme targeting vulnerable populations. This policy reflects a commitment to social justice and equity, but also raises concerns about its feasibility and sustainability. This article explores the key challenges and risks associated with the policy, including dependence on public resources, systemic weaknesses (governance, human resources, technical capacity) and the potential for hospital indebtedness. It also highlights the opportunities offered by the initiative, such as the inclusion of the most vulnerable groups, the reinforcement of state legitimacy, and the support of international partners. The successful implementation of UHC in Chad will require strengthened and operational capacities, and the exploration of innovative financing mechanisms.

Correspondence: Vittorio Colizzi, Faculty of Medicine, Bon Samaritain Hospital, N'Djamena, Chad.
E-mail: colizzi@uniroma2.it

Key words: universal health coverage, non-contributory scheme, Chad, health financing, equity, social justice.

Conflict of interest: the authors have no conflict of interest to declare.

Ethics approval and consent to participate: not applicable.

Availability of data and materials: the datasets supporting the findings of this review are available from the corresponding author upon reasonable request.

Funding: this article is part of the activities conducted within the development initiative "Italy-Chad Health Project: Training and Technological Innovation – AID 12582", implemented by Tor Vergata University and the MAGIS Foundation, with financial support from the Italian Agency for Development Cooperation (AICS).

Received: 18 July 2025.
Accepted: 6 August 2025.

Sahelian Journal of Responsible One Health 2025; 1:545
doi:10.4081/sjroh.545

Introduction

Since the adoption of the Sustainable Development Goals (SDGs) in 2015,[1] the global commitment to Universal Health Coverage (UHC) has intensified. Target 3.8 sets a clear ambition: "*To achieve universal health coverage, including financial risk protection, access to quality essential healthcare services, and access to safe, effective, quality, and affordable essential medicines and vaccines*." In this context, Chad, like many African countries, has placed UHC at the core of its national health strategy, particularly through the National Health Development Plan (2018-2022) and the National Health Policy (Figure 1).[2]

However, equitable access to healthcare remains a major challenge across the continent, and Chad is no exception. A landlocked country in Central Africa, Chad has an estimated population of over 19.3 million people. It faces widespread poverty, with the poverty rate rising from 42.3% in 2018 to 44.8% in 2022, amounting to around 7.76 million people living in poverty.[3] In rural areas, poverty affects nearly 87% of the population and is closely linked to household size, low education levels, and precarious employment. Despite significant natural resources, particularly oil, Chad remains one of the poorest countries in the world (ranked 189th out of 193 according to the Human Development Report 2024) with a gross domestic product (GDP) *per capita* of USD 1,119. This situation is compounded by persistent structural challenges such as security instability, weak health infrastructure, and inadequate public health financing.

To promote social equity and improve access to care, Chadian authorities initiated the implementation of UHC in 2019, beginning with the adoption of Law No. 035/PR/2019. This legal framework establishes three coverage schemes: two contributory and one non-contributory scheme targeting the most vulnerable populations. The latter, fully funded by public resources, was chosen as the starting point for the progressive operationalization of UHC. In addition, Presidential Decree No. 2607/PCMT/PMT/MDCCD-NACVG/2022 of August 19, 2022, created the Military Health Insurance Fund (CAMA, *Caisse d'Assurance Maladie des Armées*), a public entity with legal personality and administrative and financial autonomy, under dual supervision, technical by the Ministry of Defense and financial by the Ministry of Finance. CAMA is responsible for managing health coverage for defense and security forces and their dependents.

While this focus on the contributory scheme reflects a strong commitment to social justice, it also raises significant concerns. In a context marked by resource scarcity, increasing demographic

pressures, including the influx of refugees, and an underfunded health system, is this approach viable and sustainable in the long term? Might it lead to a traditional model of free care, ultimately resulting in hospital debt accumulation? What are the expected benefits, the potential risks of failure, and the limitations of this approach in building a truly universal health system in Chad?

To address these questions, this article is structured around four interconnected and complementary parts. First, we examine the regional and subregional environment of UHC to situate the Chadian case within broader African dynamics. Second, we analyze the national context along with the legal and institutional foundations of UHC in Chad. Third, we assess the strategic implications of beginning with the non-contributory scheme. Finally, we highlight the limitations of this approach and outline the conditions required for its success and long-term sustainability.

Materials and Methods

This article adopts a qualitative and analytical approach based on a documentary review of official reports, policy documents, and academic publications related to the concept of universal health coverage in the Economic and Monetary Community of Central Africa (CEMAC, *Communauté Économique et Monétaire de l'Afrique Centrale*) and, more precisely, in Chad. Moreover, it draws on insights from recent field studies conducted in Chad between 2022 and 2024. This study mobilizes a multidimensional understanding of fragility, encompassing institutional, social, and economic, to identify the political and structural determinants influencing the deployment of the non-contributory UHC regime. Through this framework, we are able to assess the risks and the conditions for the successful implementation of UHC in Chad.

Regional and subregional environment of the UHC

For several decades, universal access to healthcare has been a major goal for African countries. UHC is part of a continental dynamic driven by a convergence of international and regional commitments and national strategies.

The Bamako Initiative and its legacy

Faced with the material impossibility of providing free healthcare for all, local governments and international organizations such as UNICEF and WHO began advocating for an alternative approach. This approach focused on encouraging user contributions for health services and decentralizing the management of public health systems to foster conditions conducive to the development of a health market. It was formally introduced by James Grant, then Executive Director of UNICEF, under what came to be known as the Bamako Initiative. This initiative was grounded in several core principles:[4] i) separating funds allocated for medicines from those intended for other health system operations; ii) applying a small markup on essential medicines, procured affordably through generic supply chains and simplified import procedures; iii) reinvesting revenue from drug sales into restocking essential medicine supplies; iv) using any remaining surplus to support key operational needs, including preventive and promotional activities, facility maintenance, management tools, staff incentives, fuel and contingency reserves.

At its core, the Bamako Initiative marked a major paradigm shift in health financing across Sub-Saharan Africa. The first aspect of this shift involved assigning monetary value to healthcare services, distinguishing between services to be paid for directly by users and those to be covered through financial protection mechanisms such as health insurance. The second aspect

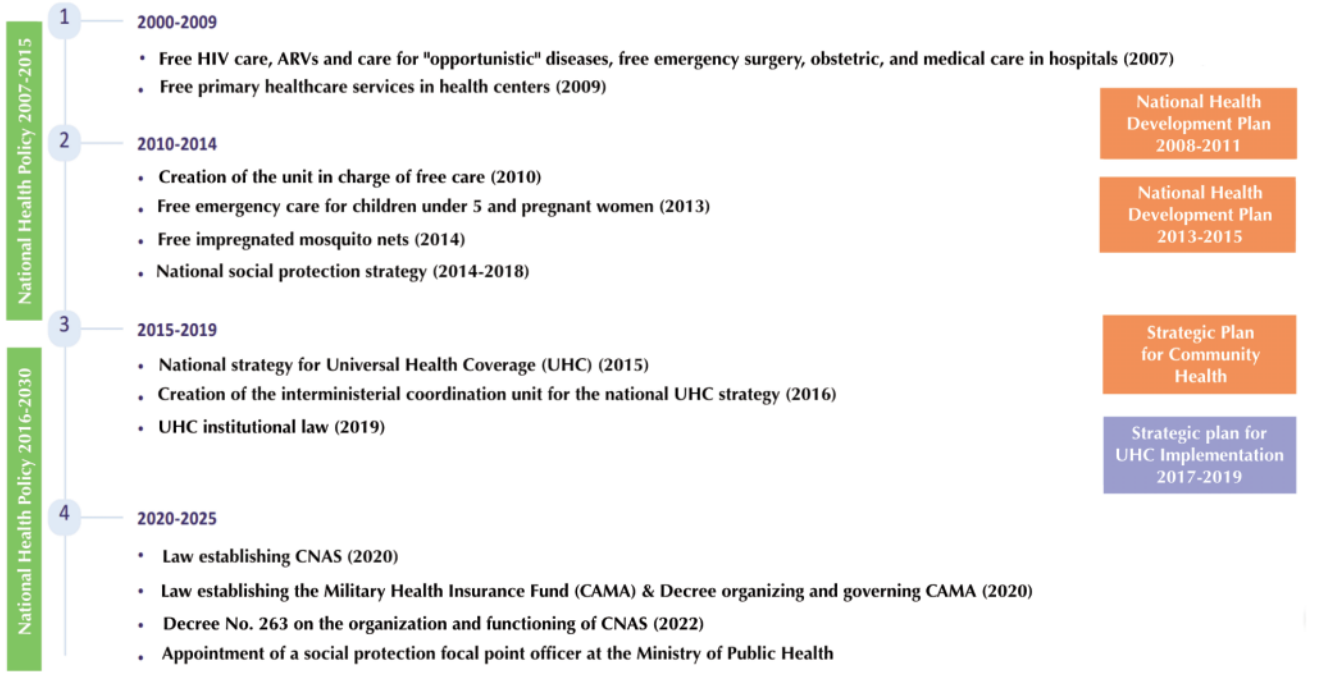

Figure 1. Chronological evolution of UHC in Chad.

sought to reinvest locally generated funds to improve service quality and ensure a more equitable distribution of public health expenditures. This also enabled governments to reserve scarce public funds for oversight functions, system improvements, and narrowing the information gap around population health for decision-makers (Tizi & Fiori, 1997).[5] Importantly, the initiative included an equity provision: 10% of any profit was to be used to cover the healthcare costs of the most vulnerable populations.[6]

According to Jean-Pierre Foiry (2001),[4] there were five initial objectives of the Bamako Initiative:

1. Financing minimum activity packages (MAP), including the Expanded Program on Immunization, basic disease management, antenatal and postnatal care, and birth monitoring.
2. Maximize decentralization of MAP implementation to improve local reach and responsiveness.
3. Reduce healthcare costs by promoting the use of essential generic medicines.
4. Encourage community-based co-management, including local oversight of medicines and finances and decentralized epidemiological monitoring.
5. Mobilize community co-financing to promote long-term sustainability.

While the Bamako initiative was intended to enhance both access to and quality of healthcare services, its outcomes have been mixed. In many cases, implementation involved supplying village dispensaries with an initial stock of essential generic medicines to be managed by local health committees. These medicines were then sold to patients, and the locally retained profit, combined with consultation fees, was intended to fund restocking and improve service delivery.[6] Although the use of generics reduced costs for those who could afford to pay, the initiative brought little change for those who could not.[7]

Despite its shortcomings, including inconsistent exemption mechanisms for the poorest and uneven community governance, the Bamako Initiative remains one of the earliest coordinated efforts in the region to improve healthcare access for vulnerable populations. It also sparked enduring debates on sustainable health financing and community engagement. Key elements of the initiative, such as decentralization, the use of essential generic medicines, and partial community-based financing, have since been incorporated, either explicitly or implicitly, into public health policies across numerous Sub-Saharan African countries, including Chad.

The Abuja Declaration

The Abuja Declaration (2001) represents a pivotal moment in the development of UHC in Africa and stands as one of the most significant political commitments to health made by African leaders for three key reasons.[8]

First, it marked the first time that African states collectively acknowledged the HIV/AIDS crisis as a continental emergency. In response, member states of the African Union pledged to intensify their efforts to combat HIV/AIDS, as well as other major infectious diseases such as tuberculosis and malaria.

Second, the declaration made a groundbreaking financial commitment: signatory countries agreed to allocate at least 15% of their national budgets to public health by 2015. They also committed to removing taxes and tariffs that hindered access to HIV-related services and products, supporting vaccine development, improving access to medical technologies, and mobilizing both domestic and international financial resources to combat the epidemic.[8] Third, the declaration emphasized the critical role of development assistance in health financing. While sustainable health systems cannot rely solely on foreign aid, external support has been essential in strengthening healthcare delivery across Africa. For instance, in 2014, Sub-Saharan African countries received nearly 33% of all global development assistance for health, even though 76% of health financing still came from domestic sources on average.[9]

The African Union's Agenda 2063

Adopted in 2015, the African Union's Agenda 2063 serves as the continent's strategic framework for inclusive and sustainable development by the year 2063. The agenda places strong emphasis on the right to health and universal access to essential services, urging member states to ensure equitable health coverage, particularly for women, children, and vulnerable populations.

Aspiration 1 of the agenda, titled *A prosperous Africa based on inclusive growth and sustainable development*, explicitly identifies UHC as a central driver of social transformation, reduction of inequality, and increased resilience of health systems across Africa.[10] In this sense, Agenda 2063 builds upon earlier commitments, such as the Abuja Declaration, while embedding them within a broader and more integrated vision of human development, one that is equitable, sustainable, and inclusive.

WHO Africa initiatives

In 2016, the World Health Organization Africa Office (WHO/AFRO) launched a Regional Strategy for UHC (2016-2030) aimed at guiding African countries in highlighting developing efficient, equitable, and resilient health systems. The strategy emphasizes good health governance, enhanced quality of care, reduction of health disparities, and sustainable health financing mechanisms.

In addition, WHO supports member countries through the UHC Partnership program, a cooperation mechanism that aims to facilitate national strategic health policy development, promote inclusive policy dialogue, and effectively mobilize technical and financial partners to support the implementation of UHC.[11]

Experience in the subregions

The CEMAC region consists of six member states: Cameroon, the Central African Republic, Congo, Gabon, Equatorial Guinea, and Chad. These countries have implemented reforms at different paces, aimed at enhancing and broadening access to healthcare.

Gabon: a pioneering experience

Gabon stands out as a pioneer of UHC within the subregion, with the establishment in 2008 of the National Health Insurance and Social Guarantee Fund (CNAMGS, *Caisse Nationale d'Assurance Maladie et de Garantie Sociale*).[12] This scheme operates a dual-regime architecture: a non-contributory system, fully funded by the state for economically vulnerable populations, and a contributory system targeting formal sector workers. A key feature of this model is its sustainable financing mechanism based on a 1.5% solidarity levy on the turnover of telecommunications operators, which generates stable resources.[13]

Cameroon: a progressive model of UHC

Cameroon's implementation of UHC is built on two complementary dynamics: ongoing interventions and projected reforms aimed at restructuring the health system. Existing measures are gradually integrated into the evolving institutional framework.

The government has defined priority vulnerable populations, including pregnant women, children under five, refugees, and internally displaced persons, ensuring them partial or full access to

certain services free of charge. The Expanded Programme on Immunization, launched in 1976 and scaled up in 1982, serves as a historical foundation. In 2011 and 2014, malaria diagnosis and treatment were made free for children under five and pregnant women.[14] Cameroon has also extended free access to antiretrovirals (ARVs), making significant progress toward the "95-95-95" targets (95.8%, 92.3%, and 89.2% in 2022).[15] Tuberculosis treatment is available free of charge in over 260 facilities, although dialysis remains costly despite partial subsidies.[16]

Institutionally, the National Technical Working Group for UHC[17] has proposed the creation of Universal Health Cameroon, a technical and financial management body founded on four principles: universality, solidarity, state responsibility, and mandatory enrollment. Its financing is based on three sources: the states (XAF 1,000 billion), households (XAF 350 billion), and technical and financial partners (XAF 50 billion). The 2023 Finance Law allocates 53.56 million to launch the first phase.[18]

The Central African Republic: building UHC in a post-conflict setting

Despite a severely weakened health infrastructure due to prolonged conflict, the Central African Republic has initiated measures to strengthen UHC. Under the SENI-Plus project, nearly 475,000 women and children have received essential care, and over 101,000 children were fully vaccinated between October 2022 and May 2024.[19] Free healthcare is provided to children under five, pregnant women, and victims of violence in high-risk security zones.[20]

Congo: pilot community approach

According to the WHO, access to healthcare remains limited for a large portion of the population in Congo-Brazzaville. In 2021, only 13.8% of the population had access to health services, due to high costs and insecurity in certain areas.[20] In 2022, the Ministry of Health, in partnership with WHO, launched a pilot project in 12 health districts: more than 70 Community Health Committees were trained to raise awareness, promote local health service management, and ensure access to free medicines.[21]

Equatorial Guinea: the reality of UHC

Equatorial Guinea has committed to UHC, a goal enshrined in its constitution. However, significant challenges remain on the ground. Key issues include improving equitable access to health services, particularly in rural areas, and strengthening health financing, which remains largely dependent on public funds. The country's UHC strategy focuses on community-based health mutuals, relying on voluntary membership and community management. This model faces considerable difficulties, particularly low enrollment rates and insufficient professionalization of management mechanisms. Beyond the institutional scope of CEMAC, a major initiative is unfolding within the broader framework of the Economic Community of Central African States (ECCAS), which includes eleven countries, including Chad. Despite significant economic, demographic, and institutional disparities among member states, ECCAS offers a relevant platform for integration and coordination, particularly in the health sector.

A memorandum of understanding between ECCAS and the Platform of Health Mutual Actors in Central Africa (PAMAC, *Plateforme des Acteurs Mutualistes d'Afrique Centrale*) is expected to be signed before the end of 2025. PAMAC, a subregional organization currently headquartered in Burundi, brings together mutual health organizations from across Central Africa. It aims to promote more equitable, inclusive, and coherent health social protection, notably by strengthening cooperation and knowledge exchange among mutual health actors.

Potential contributions of regional integration: cooperation, support mechanisms, and exchange of good practices

Subregional integration in Central Africa, especially through CEMAC, has substantial potential to accelerate the achievement of UHC. By going beyond purely national strategies, increased cooperation among states can act as a catalyst for enhancing and transforming health systems. Unstable financing systems, vulnerability to pandemics, and inadequate infrastructure remain common challenges across CEMAC countries, albeit to varying degrees. Technical cooperation offers a pathway to pool available expertise at the subregional level. Initiatives such as the CEMAC Public Health Experts Platform, or multilateral support mechanisms promoted by the WHO or the Organization for the Coordination of the Fight Against Endemics in Central Africa (OCEAC, *Organisation de Coordination pour la lutte contre les Endémies en Afrique Centrale*), can support the exchange of experts between countries, capacity building for national health policy development, and joint mechanisms for evaluating health system performance. The academic and training dimension is equally critical. UHC depends on the availability of qualified health personnel at all levels. Yet, medical and paramedical training remains unevenly distributed across CEMAC member states. Greater integration could allow for the expansion of regional university networks, mutual recognition of diplomas, and student mobility, as well as the creation of regional master's and doctoral programs in public health and related fields. It could also foster the development of centers of excellence in epidemiology and tropical diseases. Moreover, regional ownership of the global health agenda depends on the ability to adapt and contextualize global public health models to African realities. This can be achieved through support for regional and subregional research platforms, aimed at amplifying scientific work on these issues. Finally, Gabon's experience with the telecom tax to finance the CNAMGS, or Cameroon's efforts to build a universal health system by consolidating existing gains, can serve as valuable models for reform elsewhere, through the exchange of best practices.

Context and foundations of UHC in Chad

Legal framework and institutional architecture

Chad has taken a major step toward social justice in health with the promulgation of Law No. 035/PR/2019, establishing Universal Health Coverage. This legislation lays the foundation for a system structured around three complementary schemes: a contributory scheme for formal sector workers, a second contributory scheme for informal sector workers, and a non-contributory medical assistance scheme (AMED, *assistance médicale engagée discriminée*) designed to ensure free access to healthcare for poor and vulnerable populations, alongside the CAMA.

The operationalization of this legal framework is supported by an institutional architecture that is currently being strengthened, particularly through the creation of the National Health Insurance Fund (CNAS, *Caisse Nationale d'Assurance Santé*), which is responsible for implementing the different schemes. This is supplemented by several implementing decrees adopted between 2021 and 2022, which clarify the governance and management modalities of the system.

Choice of the non-contributory regime: motivations and national priorities

The Chadian government made the strategic decision to initiate UHC through the non-contributory AMED scheme, which is entirely financed by public resources. This choice reflects the

urgent need to address the structural exclusion of more than 80% of the population from traditional health insurance mechanisms.[22] This exclusion primarily affects rural populations and those working in the informal sector, who constitute the majority of the country and are particularly exposed to poverty and health-related vulnerabilities.[23]

Launching UHC with AMED also aligns with Chad's commitments to human rights and international development goals, particularly the SDG 3, which aims to ensure health for all and achieve universal health coverage. The official launch of AMED took place on February 28, 2025, in three pilot health districts (Abéché, Bongor, and Danamadji), marking the beginning of the registration and card distribution phase to 43,000 economically disadvantaged individuals, out of a total of 69,087 beneficiaries for this initial phase.[24]

This policy direction builds upon previous commitments such as the National Development Plan (NDP) 2013-2015, Vision 2030, and the National Social Protection Strategy (NSPS), developed in 2014. The latter is based on a three-pronged approach: health insurance for the formal sector, mutual health organizations for the informal sector, and free care for the poorest segments.[25] The National Health Policy 2016-2030 also calls for a stronger integration of UHC objectives through coordinated actions with the NSPS. It recommends conducting further studies to guide UHC implementation choices, including the identification of innovative financing mechanisms and hybrid models that combine free care for disadvantaged groups with contributory participation from socio-professional categories with payment capacity.

Internal constraints: economic, demographic, and health context

Despite the ambition behind the AMED initiative, several structural constraints weigh heavily on its implementation.

First, the current coverage level is extremely low, as over 80% of the Chadian population lacks any form of formal health protection, a situation exacerbated by the predominance of the informal economy and the country's largely rural nature.[22]

Secondly, health indicators are alarming. Chad has one of the highest maternal mortality rates in the world (860 deaths per 100,000 live births) and an infant mortality rate of 72 deaths per 1,000 live births, according to WHO (2023). These figures are largely due to unequal access to quality care and a health system struggling to deliver appropriate primary healthcare services.

Third, chronic underfunding of the health system remains a critical issue. Health expenditures are low relative to national needs, and out-of-pocket payments by households account for 60% of total health sector financing, further undermining equitable access to care.[26]

Also, socio-demographic pressures related to the massive influx of refugees and internally displaced persons, particularly from neighboring Sudan, are increasing the strain on health infrastructure, especially in border regions.[27]

Implications of adopting the non-contributory regime

Opportunities: inclusion of the most vulnerable, social justice, and state legitimacy

Chad's strategic decision to launch UHC through a non-contributory scheme aligns with the principle of equitable access to primary care and social justice, as advocated by the WHO[28] and SDG 3.8, which calls for universal access to essential health services. This approach prioritizes coverage for the most vulnerable groups: poor individuals, pregnant women, children, people with disabilities, and populations living in remote rural areas. In a country where over 40% of the population lives below the poverty line, this measure represents a significant improvement in access to healthcare. This targeted approach contributed to reducing inequalities in access to care and strengthening social cohesion. It embodies a national solidarity initiative in which the state asserts itself as the guarantor of the right to health. In a context characterized by low institutional trust, this policy direction can reinforce the legitimacy of the state through a visible social policy with tangible impacts on the daily lives of disadvantaged populations.[13] It also aims at improving public health indicators, notably by reducing maternal and infant mortality and ensuring better management of chronic diseases at the national level. Additionally, stimulating demand for healthcare may generate positive economic spillovers, such as job creation in the health sector and the strengthening of pharmaceutical supply chains.

International support and strategic partnerships

The implementation of Chad's non-contributory UHC schemes relies heavily on international support, both in the design and initial financing stages. Key actors include the Swiss Cooperation, the Islamic Development Bank, and the P4H Network (Providing for Health), which brings together the WHO, the World Bank, the French Development Agency,[29] and the German Corporation for International Cooperation. These partners play a pivotal role in shaping national health financing strategies across several African countries. In Chad, they act as key resources in supporting government stakeholders with institutional and legal frameworks, drafting strategic documents, and navigating donor procedures.[30] However, such external support is often temporary, and prolonged dependency on foreign aid exposes the scheme to risks of discontinuity. This highlights the need for a sustainable domestic resource mobilization strategy.

Lessons learned and challenges

Initial experiments with the non-contributory UHC scheme in Chad have generated key operational insights while revealing structural limitations that must be addressed to ensure sustainability. First, the beneficiary targeting process has proven particularly complex due to the absence of a reliable national registry. Community-based targeting methods, although adapted to the local context, raise concerns about equity, transparency, and standardization.[24]

Second, financial constraints significantly hamper the rapid expansion of the coverage. The scheme's launch has relied almost exclusively on public financing, in a context where health expenditures remain low (5.19% of GDP in 2021) and heavily borne by households (64.4% of total health financing).[21] While external aid is valuable, it remains limited in duration, increasing the risk of service interruptions. This aligns with WHO findings,[27] which stress that the viability of UHC depends on stable and progressive public financing. Thus, establishing a multi-year solidarity fund, backed by a national resource mobilization strategy – potentially including fiscal adjustments – becomes essential.[21]

Third, several structural weaknesses persist. Multisectoral coordination remains insufficient, even though UHC success requires strong collaboration between ministries (health, finance, social affairs, education), local authorities, and technical and financial partners. The lack of a shared operational framework undermines the coherence and alignment of interventions.[22]

Additionally, Chad's health system suffers from a severe shortage of qualified human resources, especially in rural areas,

which are home to more than 77% of the population. This shortage is exacerbated by inadequate infrastructure and uneven personnel distribution. Technical capacities also need improvement: health information systems for management, monitoring and evaluation, and planning remain weak, limiting the effective steering of the AMED scheme.

Despite these challenges, early data show encouraging signs, such as an increased utilization of health services, particularly among children and pregnant women, and growing community acceptance of the scheme.[24,31] However, without structural reforms, free healthcare provision could lead to a decline in service quality (medicine shortages, staff overload, long waiting time), undermining the gains achieved and slowing innovation and performance momentum.

Conclusions

Chad's strategic decision to initiate UHC with a non-contributory scheme reflects a strong political commitment to equity. In a context of limited economic resources and persistent inequalities in access to care, this approach seeks to guarantee a minimum level of health protection for the most vulnerable.

Nonetheless, this strategy remains fragile without sustainable financing, adequate infrastructure, and strengthened governance. The non-contributory scheme alone cannot support the full scope of UHC ambitions. Expanding it without broadening the tax base or leveraging innovative mechanisms (such as solidarity taxes, targeted subsidies, or public-private partnerships) may increase budgetary pressures and undermine service quality.

The main challenge lies in the gradual integration of contributory and non-contributory schemes, as envisioned in Law No. 035/PR/2019. This requires establishing practical linkages: progressive enrollment of informal sector workers through tailored incentives, a unified management system, and risk pooling mechanisms to enhance social solidarity. The Health Sector Support Project (PASST3, *Projet d'Appui au Secteur de la Santé*) in Chad, which focuses on maternal and neonatal health, can serve as a pilot for integrated approaches before broader national implementation.

Several key levers are critical for the success of this transition. First, reinforcing political will through concrete financial commitments and prioritization of health in the national agenda. Second, strengthening institutional and technical capacities to ensure effective reform management, monitoring, and evaluation. Lastly, exploring alternative financing solutions and subregional cooperation can act as catalysts by fostering experience-sharing and building system resilience.

In summary, UHC is much more than a technical objective. It is a significant political and societal endeavor, whose success will rely on the collective ability to turn political will into a structured, inclusive, and sustainable process.

References

1. United Nations SDG Partnerships. CAR commits to increase health sector spending from 9.7% to 15%. New York: ONE; 2021.
2. World Health Organization. National Health Development Plan (NHDP) 2018-2022. N'Djamena: WHO; 2018.
3. National Institute of Statistics, Economic and Demographic Studies (INSEED). Main Report of the Survey on Consumption and the Informal Sector in Chad – ECOSIT4. N'Djamena: Republic of Chad; 2023.
4. Foirry JP. The Bamako Initiative: What Benefits for African Populations? In: Rainhorn JD, Burnier MJ, editors. Health at Market Risk. Geneva: Graduate Institute Publications; 2001. p. 111-24. Also published in: Int J Health Serv 2011;41:175-84.
5. Tizio S, Flori YA. The Bamako Initiative: Health for All or Illness for Each? Tiers Monde Rev 1997;38:67-84.
6. Mbessa BS. Elevating Health Through Partnership: The Italy-Cameroon Model of International Development Cooperation in Sub-Saharan Africa [dissertation]. Yaoundé: Institute of International Relations of Cameroon (IRIC); 2025.
7. Ridde V. Is the Bamako Initiative still relevant for West African health systems? Int J Health Serv 2011;41:175-84.
8. UNAIDS. Abuja Declaration: 15 years of progress towards the commitment to invest 15% of national budgets in health. Geneva: UNAIDS; 2016.
9. World Health Organization. Public Financing for Health in Africa: From Abuja to the SDGs. Geneva: WHO; 2016. Report No.: WHO/HIS/HGF/Tech.Report/16.2.
10. African Union. Agenda 2063: The Africa We Want. Addis Ababa: African Union Commission; 2015.
11. WHO Regional Office for Africa (WHO/AFRO). Regional Strategy for Universal Health Coverage in Africa 2016–2030. Brazzaville: WHO/AFRO; 2016.
12. National Health Insurance and Social Security Fund (CNAMGS). Annual report. Libreville: CNAMGS; 2020.
13. World Bank. Gabon Health Financing Assessment. Washington, DC: World Bank Group; 2021.
14. Cameroon Malaria Control Programme. Evaluation report of malaria control interventions in Cameroon. Yaoundé: Ministry of Public Health; 2014.
15. National HIV/AIDS Committee. HIV/AIDS epidemiological assessment in Cameroon. Yaoundé: Ministry of Public Health; 2022.
16. National TB Program. Annual report on tuberculosis in Cameroon. Yaoundé: Ministry of Public Health; 2022.
17. UHC Technical Working Group (UHC-TWG). Strategic plan for the implementation of Universal Health Coverage in Cameroon. Yaoundé: UHC-TWG; 2020.
18. Republic of Cameroon. Finance Law of the Republic of Cameroon for the 2023 financial year. Yaoundé: Government of Cameroon; 2023.
19. World Bank. Aspiring to a resilient health system in the Central African Republic: SENI-Plus project. Washington, DC: World Bank Group; 2024.
20. P4H Network. Central African Republic health financing indicators. Geneva: P4H Network; 2021.
21. WHO Regional Office for Africa. Health committees mobilized to achieve universal health coverage in Congo. WHO/AFRO; 2024.
22. World Bank. National Health Financing Strategy in Chad: Technical Report. Washington, DC: World Bank; 2022.
23. UNICEF. Access to health care in humanitarian emergency areas in Chad. N'Djamena: UNICEF; 2022.
24. Ministry of Public Health of Chad. Evaluation report of the first phase of UHC in Chad. N'Djamena: Ministry of Public Health; 2023.
25. Republic of Chad. Law No. 035/PR/2019 establishing Universal Health Coverage in Chad; 2017.
26. UNICEF. Status of the community health system in Chad. N'Djamena: UNICEF; 2022.
27. UNHCR. Refugees and internally displaced persons in Chad: statistics and humanitarian interventions. Geneva: UNHCR;

2023.
28. World Health Organization. Health Systems Financing: The Path to Universal Coverage. Geneva: WHO; 2010.
29. African Development Bank. Strengthening Health Systems in Central Africa: Regional Report. Abidjan: AfDB; 2020.
30. P4H Network. Supporting non-contributory UHC schemes in West Africa. Geneva: P4H; 2022.
31. UNICEF. Report on health coverage of children and pregnant women in Chad. N'Djamena: UNICEF Country Office; 2022.