SOCIAL HEALTH PROTECTION NETWORK

Institutional frameworks in the area of health financing systems

CHAD Summary

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CONTENTS

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1. BACKGROUND

1.1. Introduction

The P4H Network develops innovative collaborations in its role as an honest broker, whose mission is to promote, develop and strengthen exchange and collaboration for social health protection and health financing. In this context, a consultant, Virgile Pace, was engaged by the P4H Network Coordination Desk to review the institutional frameworks of ten countries. Virgile worked in countries where the P4H Network was engaged and collaborated with several members of P4H and P4H country focal persons (P4H-CFPs). The summaries Virgile produced were first intended to help familiarize P4H-CFPs with the countries and regions where they work to thus enhance their agency in facilitating their work with national stakeholders. The summaries will also be helpful to anyone interested in institutional frameworks related to SHP and HF in general and in the context of the selected countries.

1.2. Documents

- Constitution de la République du Tchad du 4 mai 2018, République du Tchad, 2018, 48 pages.
- Loi n°035/PR/2019 du 05 août 2019 instituant la Couverture Santé Universelle au Tchad, République du Tchad, ministère de la Santé publique, 5 août 2019, 21 pages.
- Loi n°026/PR/2020 du 31 décembre 2020 portant Création d'une Caisse Nationale d'Assurance Santé (CNAS), République du Tchad, ministère de la Santé publique, 31 décembre 2020, 2 pages.
- Loi n°006/PR/2002 du 15 avril 2002 portant Promotion de la Santé de Reproduction, République du Tchad, ministère de la Santé publique, avril 2002, 3 pages.
- Loi n°019/PR/99 instituant la Participation Communautaire aux Soins de Santé, République du Tchad, ministère de la Santé publique, 1999, 1 page.
- Note de Présentation de cinq décrets d'application de la Loi n°35/PR/2019 du 05 août 2019 instituant une Couverture Santé Universelle au Tchad, République du Tchad, ministère de la Santé publique, 2020, 4 pages.
- Projet de Décret portant Création, Attributions, Organisation et Fonctionnement d'un Organe de Régulation et de Gouvernance de la Couverture Santé Universelle, République du Tchad, ministère de la Santé publique, 2021, 8 pages.
- Projet de Décret portant Modalités d'Affectation des Ressources aux Organismes de Gestion de la Couverture Santé Universelle, République du Tchad, ministère de la Santé publique, 2019, 5 pages.
- Projet de Décret portant Prestations de Soins de Santé Garanties par la Couverture Santé Universelle, République du Tchad, ministère de la Santé publique, 2019, 8 pages.
- Projet de Décret portant Modalités de Fixation des Coûts des Paniers de Soins Couverts par les Régimes de la Couverture Santé Universelle (CSU), République du Tchad, ministère de la Santé publique, 2 pages.
- Projet de Décret fixant des Règles d'Affiliation et d'Immatriculation des Assujettis à la Couverture Santé Universelle, République du Tchad, ministère de la Santé publique, 2019, 8 pages.

- Projet de Décret portant Identification des Personnes Économiquement Démunies, République du Tchad, ministère de la Santé publique, 2019, 4 pages.
- Décret n°364/PR/MSP/2001 portant sur l'Organisation de la Participation Communautaire aux Coûts de la Santé, République du Tchad, ministère de la Santé publique, 2001, 4 pages.
- Arrêté n°4295/PR/PM/2017 portant Création du Cadre Institutionnel de Coordination pour la Mise en œuvre de la Stratégie Nationale de Couverture Santé Universelle (SN-CSU), République du Tchad, ministère de la Santé publique, 2017, 2 pages.
- Arrêté n°074/MSP/SE/DG/89 portant Création d'un Comité de Conception d'un Système de Recouvrement des Coûts de la Santé, République du Tchad, ministère de la Santé publique, 1989, 3 pages.
- Arrêté n°90-102/MSP/SE/DG/90 instituant le Système de Recouvrement des Coûts de la Santé, République du Tchad, ministère de la Santé publique, 1990, 3 pages.
- Arrêté n°003/MSP/DG/94 instituant la Participation Communautaire aux Coûts de la Santé, République du Tchad, ministère de la Santé publique, 1994, 3 pages.
- Plan National de Développement Sanitaire (PNDS3 2018-2021), République du Tchad, ministère de la Santé publique, janvier 2018, 135 pages.
- La Politique Nationale de Santé 2016-2030, République du Tchad, ministère de la Santé publique, mars 2016, 45 pages.
- Politique Nationale de Santé Communautaire, République du Tchad, ministère de la Santé publique, Direction de l'Organisation des Services de Santé, mai 2014, 30 pages.
- Stratégie Nationale de la Couverture Sanitaire Universelle du Tchad : Affirmer la Vision de la Couverture Sanitaire Universelle, Présidence de la République, Primature, 2015, 46 pages.
- Définir le Cadre Institutionnel du Régime AMED selon ses Fonctions et ses Processus Opérationnels, Rapport final, Institut Tropical et de Santé Publique Suisse (Swiss TPH) et Cellule Interministérielle de Coordination de la Stratégie Nationale de la CSU (CIC/SN-SCU), août 2021, 159 pages.
- Modèles des Prestations des Soins pour la Mise en œuvre de la Couverture Santé Universelle au Tchad, OMS et Groupe de l'OCDE, mars 2021, 56 pages.
- Stratégie Nationale de Protection Sociale du Tchad (2016-2020), Présidence de la République, Primature, ministère du Plan et de la Coopération internationale, juin 2015, 110 pages.
- Chad Public Expenditure Analysis, Markus Kitzmuller & Olanrewaju Kassim, 2019, World Bank, 95 pages.
- Challenges to Implementing Gavi's Health System Strengthening Support in Chad and Cameroon: Results from a Mixed-methods Evaluation, Globalization and Health, Global Access, 2017, 12 pages.
- Perceptions of the Usefulness of External Support to Immunization Coverage in Chad: an Analysis of the GAVI-Alliance Cash-Based Support, Pan African Medical Journal. 2013, 13 pages.
- The Efficiency of the Health System in Chad, Sumerianz Journal of Medical and Healthcare, 2019, Vol. 2, No. 2, 18 pages.

- State of Health Financing in the African Region, WHO, Regional Office for Africa, January 2013, 25 pages.
- A Public Private Partnership to Fight against Malaria along the Chad Cameroon Pipeline Corridor: Baseline Data on Socio-anthropological Aspects, Knowledge, Attitudes and Practices of the Population concerning Malaria, Bio Med Central, Open Access, 2013, 11 pages.
- Chad's Health System in Crisis: Better Primary Healthcare for Communities in Chad, TUM Better Health Insights, Policy Brief 1, 2021, 12 pages.
- The Right to Health, Health Systems Development and Public Health Policy Challenges in Chad, Bio Med Central, Open Access, 2015, Philosophy, Ethics, and Humanities in Medicine, 14 pages.
- Why Performance-Based Financing in Chad Failed to Emerge on the National Policy Agenda? Health Systems & Reform, 2017, 12 pages.
- Challenges and Opportunities for Healthcare Workers in a Rural District of Chad, BMC Health Services Research, 2018, 11 pages.
- Burden of Disease in Francophone Africa, 1990–2017: a Systematic Analysis for the Global Burden of Disease Study 2017, Lancet Glob Health 2020, 11 pages.

2. ANALYSIS

2.1. Constitutional/Legal/Governance Challenges

- Constitution of 4 May 2018 clearly states in Article 51: "Every person has the right to a healthy environment". Article 127 further clarifies that "The law defines the fundamental principles: […] of public health". Chad's Constitution thus clearly recognizes the right to health for every citizen.
- Legal provisions and legal framework regarding the health sector are however insufficient. Basic texts are still inexistent or not complete, for example concerning the private for-profit sector, which relies on obsolete texts (there is a lack of texts that guarantee the quality of private sector services, such as a true and efficient accreditation system). In addition, many laws adopted within the framework of the reform of the health sector are not implemented because of the absence of implementing texts (e.g., laws on regional health schools, reform of the health and social agents' national school, the hygiene code, texts regarding reproductive health or the fight against AIDS, hospital reform, etc.). Besides, the texts regarding the pharmacy sector have been adopted and published with a significant delay. In addition, there is no legal/legislative department in charge of monitoring the drafting/adoption/application of legal texts within the Ministry of Public Health (MoPH). The insufficient institutional capacity of the MoPH is indeed a recurring problem in Chad.
- If National Health Policy plans regularly developed by the MoPH address critical health issues and establish national programs regarding health and health care, weaknesses in policy frameworks and regulations often limit their implementation. A minimal essential package of health-service facilities is prescribed by the current National Health Policy, which includes the Minimal Package of Activities (MPA) for integrated healthcare centers and the Complementary Package of Activities (CPA) for district

hospitals. However, the provision of MPA and CPA remains ineffective in the country and do not ensure integrated, comprehensive and continued care, mainly because supply is very low and service delivery is incomplete, with significant differences from one district or region to another.

- To strengthen its health system and improve access to health care, Chad has adopted a national Universal Health Coverage (UHC) strategy in 2015. Chad's National Strategy for Universal Health Coverage (SN-CSU) places particular emphasis on issues related to prevention, financial protection, equity in access to health services, quality of services, development of human resources for health, strengthening of the health system and sustainability.
- The SN-CSU pointed out how critical it was to urgently develop mechanisms against financial risks, in particular in view of the importance of direct payments and Out-Of-Pocket (OOP) expenditure. The population's access to care remained actually insufficient despite the efforts already made by the Government (for example by building hospitals and health centers or by setting up free healthcare mechanisms) due to these financial obstacles. In 2016, just after the adoption of the SN-CSU, the population covered the existing insurance mechanisms was estimated at 14,223 (i.e. only 0.10%). Besides, health mutuals were still at the beginning of their experience and were limited to a few regions, covering a population of 50,988 (only 0.36%). From 2013 to 2016, the annual rate of the insured population and that of the population covered by mutual insurance, relative to the total population, did not reach 1%. The assistance mechanisms that exist were essentially free emergency care and free targeted care for pregnant women and children under 5 years old.
- To reduce financial risks and increase effective and equitable access to care for all, the SN-CSU has planned to develop mechanisms likely to drastically limit direct payment at the point of consumption. This should be done through insurance mechanisms (in particular health mutuals, compulsory health insurance, and harmonization of the two mechanisms) and assistance mechanisms (in the short term, poor populations will be targeted to benefit from assistance, and in the long term, priority will be given to the affiliation of poor and vulnerable populations to insurance mechanisms).
- This political will from the Government to make the right to health effective resulted in the adoption in June 2019 of the Law establishing UHC in Chad and its promulgation in August 2019. Law n°35/PR/2019 of August 5, 2019 (hereafter the UHC Law) establishes three schemes: (i) the Health Insurance for Salaried Employees (ASS) scheme, which covers salaried workers in the public, para-public and private sectors; the Health Insurance for the Self-Employed (ASI) scheme, which covers all self-employed workers in the commercial, liberal, crafts and agricultural professions; and the Medical Assistance (AMED) scheme, which covers the economically disadvantaged. It is planned to operationalize this insurance system gradually, starting with the scheme dedicated to poor people (AMED).
- Five implementing texts (decrees) have been drafted through a participatory and intersectoral process to implement effectively and efficiently the Law: a Draft Decree Fixing the Rules for Affiliation and Registration of People eligible for Universal Health Coverage; a Draft Decree on the Terms and Conditions for the Allocation of Resources to the Universal Health Coverage Management Body; a

Draft Decree on Health Care Benefits Guaranteed by Universal Health Coverage; a Draft Decree regarding the Procedures for Fixing the Guarantee Costs of the Healthcare Provisions covered by the Universal Health Coverage Schemes; and a Draft Decree identifying Economically Vulnerable Persons. So far, these decrees have not been yet adopted, occasioning significant delays in the implementation of the Law.

2.2. Political and Socio-Economic Challenges

- Chad is a low income country whose health expenditures account for 4.49% of total Gross Domestic Product (GDP). The population is approximately 16.4 million and is considered to have a rapid growth rate. Chad also hosts more than 450,000 refugees from Sudan, the Central African Republic, and Nigeria who represent about 4% of the country's total population. Only 23% of Chadians live in urban areas with striking disparities for rural areas. Chad's health indicators are relatively worse than other countries in Sub-Saharan Africa due to many reasons such as civil conflict, healthcare shortages, and lack of maternal and child health[1]. Child and Infant mortality has decreased significantly in the last few decades, but numbers are still extremely high[2]. In addition, oil is the main source of export earnings, accounting for over 90 percent of total exports. This exposes the country to fiscal and balance of payment shocks stemming from oil price volatility. Oil revenues significantly increased fiscal space but resulted in commodity dependence and exposure to oil cycles.
- The COVID-19 pandemic has dramatically changed Chad's macroeconomic outlook. The country fell back into recession in 2020, with GDP contracting by an estimated 0.9% compared to the pre-pandemic projected growth rate of 4.8%, and per capita GDP by 3.8%. In the short term, support is urgently needed for the poorest and most vulnerable population groups that could be disproportionately impacted by the fallout from the pandemic.
- Access to basic health care is limited in Chad and the country has a high prevalence of malnutrition, malaria, and outbreaks of disease. The country experiences relatively negative health indicators with

[1] Chad has experienced more frequent and severe conflict than any other country in the Central African Economic and Monetary Community (Communauté économique et monétaire de l'Afrique centrale - CEMAC) region. In fact, 61 percent of post-independence years have been characterized by conflict and violence. This percentage represents more than four times the regional average. Chad is also affected by neighbourhood conflicts (Sudan, Niger and Nigeria) and currently hosts more than 450,000 refugees.

[2] Despite improvement in recent years on key health outcome indicators, trends in progression remain slow in relation to development targets. The maternal mortality ratio dropped from 1,450 per 100,000 live births in 1990 to 856 in 2015 (with an SDG target of 70 for 2030). In addition, the under-five mortality rate fell from 213 per 1,000 live births in 1990 to 131 in 2015 (with an SDG target of 25 by 2030). Chad had the world's sixth highest national under-five child mortality rate in 2015. Mortality rates remain higher in Chad compared to LMICs average rates, to Sub-Saharan Africa's average rates, and to CEMAC's average rates. This slow progress reflects inadequate public expenditure, even across regional and structural comparators. According to the WHO National Health Accounts database (2016), Chad's health expenditure stood at CFAF 272 billion (4.5 percent of GDP) while the average for Sub-Saharan Africa (SSA) and LMICs countries stood at 5.1 percent and 5.7 percent respectively. In per capita terms, Chad spent $32 per inhabitant while SSA and LMICs countries spent $82 and $35 dollars, respectively. In comparison to structural peers, Chad is only better than Democratic Republic of Congo (DRC) with a per capita health expenditure of $21. This weak expenditure reflects another challenge in the supply of medical products. Current health expenditure is calculated as unit price (costs) multiplied by quantities of the goods and services used. Knowing that the prices of medical goods and services are usually high, low health expenditure thus implies low availability of medical goods and services.

few options to improve due to weak health policies and healthcare shortages. The primary causes of death in Chad include lower respiratory infections, malaria, and HIV/AIDS. The country's HIV/AIDS prevalence rate is well above the world average but similar to that of some neighbouring countries. The under-five children immunization coverage remains low, suggesting the health system's inability to reduce infant mortality and morbidity from preventable diseases. The health system in Chad has also not been able to reduce maternal mortality.

- Despite the efforts deployed by the Government to improve health status in Chad, access to basic care remains a major challenge to most people, due to socioeconomic and geographical reasons. To access care, patients travel an average of 9 miles. Complementary strategies to provide hard-to-reach and marginalized population groups with adequate health services and infrastructures are poorly developed or non-existent. Although Chad had made progress on poverty reduction, with a decline in the national poverty rate from 55% to 47% between 2003 and 2011, the number of poor increased from 4.7 million in 2011 to approximately 6.5 million in 2019. In 2018, 42% of the population was living below the national poverty line.
- To gradually decrease the share of direct payments in health expenditures, as well as catastrophic expenditures and the rate of impoverishment linked to the payment of health services, setting up health insurance schemes is becoming a core priority in the country. Three health insurance mechanisms will be developed in accordance with the provisions of the UHC Law : (i) the Compulsory Health Insurance Scheme for the formal sector; (ii) the Voluntary Health Insurance Scheme for the semi-formal sector; and (iii) the Health Insurance Scheme for the poor and vulnerable people.
- The implementation of these health insurance schemes will be done within the framework of the National Strategy for Universal Health Coverage. The first two schemes will be contributory. With regard to the Compulsory Insurance scheme, the contributions will be paid by the affiliates and their employers in the form of withholding tax. Concerning the second scheme, the contributions of the affiliates will be made mainly through mutual health insurance (gradually extending the mutual health system to all regions of the country is a core objective). The third regime will be financed largely by the Government and interested partners. It should encompass the free healthcare services currently implemented in the country and will benefit from the innovative financing that will be mobilized.
- So far, the current economic situation as well as the experience of implementing free healthcare (for which the resources available in the state budget for 2017 are only 15.82% of their 2013 level) limit the effective and efficient implementation of health insurance schemes. Mutual health organizations will be used to set up the Voluntary Insurance Scheme for the semi-formal sector. However, they are still at their embryonic level in the country. Currently, a few health mutuals are being tested in four regions of the country. The promotion of their development becomes an essential lever for the establishment of health insurance in Chad. Positive experiences will be scaled up to cover the entire national territory, but this scaling up will require both technical and financial support from the Government and from the Development Partners (DPs). Evaluating and consolidating the mechanisms

of assistance to vulnerable populations and the indigent currently implemented in the country is becoming critical in this regard.

- Ongoing assistance mechanisms are in the process of being assessed and streamlined to take into account the Government's resource mobilization capacity. The objective is to draw lessons from the implementation of free healthcare programs, particularly with regard to the target populations, the care packages offered, the government's ability to pay and the capacity for health services to withstand the pressure that will result from a significant increase in demand. The results of these ongoing evaluations should allow to readjust and consolidate the existing programs before launching the various health insurance schemes mentioned above. Lastly, the assistance mechanisms will be extended to the indigent for whom a national solidarity fund could be set up. This involves identifying the indigent and their ability to pay, another core objective for the Government.

2.3. Financial Challenges

- In Chad, access to care is provided through four main mechanisms: direct payment, free access to selected services, health insurance and health mutual. The OOP payment is the most common mechanism of healthcare financing, as it represents about 50% of total health expenditure. Free health care concerns emergency surgery, obstetric and medical care. Financed entirely by the State with the support of its partners, this measure was introduced in hospitals in 2008 as part of the new social policy by the head of state. Other measures of gratuity are applied to selected diseases (chronic malaria, AIDS, tuberculosis, etc.) and specific population groups such people living with HIV, under-five children and pregnant women.
- Private health insurance, used by less than 2% of the population, is provided as part of contracts by large corporations for the benefit of employees. Health mutuals, currently being implemented in the southern regions, are in experimental phase as of 2015 and there is little to no information or data on them.
- The experience of mutual health insurance is a unique insurance system in Chad that has permitted to organize communities to pool their resources in order to deal with the financial risk. Developing a functional health insurance system ranging from affiliation to the payment of care services, through a contractual system establishing the control of rights, the supervision of the services covered, their price and their quality, invoicing, and administrative and medical verification of benefits before payment, was not an easy task to do. If the foundations for the operation of mutuals have been established, with transparent and rigorous management, a lot remains to be done to expand health mutuals all over the territory. Of significant interest is the increase in contractualization with *Formations Sanitaires* (FOSA), which has largely contributed to the establishment of better relations with Health Centers and District Hospitals[3].

[3] The NGO CIDR56 set up a project team that became a local association at the end of 2019 called the Center for the Promotion and Management of Social Risks (CPG). The CPG provides ongoing support to mutuals and negotiates agreements with the health authorities that formalize the relationship between mutuals and FOSA.

- The lack of a global and credible strategy for health financing is still a concern in Chad. The country does not yet have a National Health Financing Strategy (SN-FS). The health sector is still underfunded at 37 USD per inhabitant and per year, while the first estimates place the needs to make progress towards UHC at 86 USD per inhabitant and per year. In addition, there has been a constant decline in the State budget dedicated to health since 2013 with a drop of 22.84% from 2013 to 2016. This situation increases dependence on external resources in a context where countries must rely first on domestic resources to fund UHC and attain the SDGs. Besides, the share of direct household payment in total health expenditure is still very high (52% according to CNS 2011). It is more than twice the limit set by the WHO (20%).
- In addition, inefficiency in the use of health sector resources is growing. This inefficiency takes several forms: (i) the absence of true and genuine results-based management, which does not allow for the production of more health with the current resources; (ii) The allocation of financial resources to regions and districts is not done equitably. Indeed, there are no criteria or key for the distribution of resources (domestic and external) that would promote equity in the supply and use of services between regions and districts.

Revenue Raising

- The public health sector is financed through four main sources: (i) the State, (ii) partners; (iii) households; and (iv) private financing. However, only State and partners funding is included in the MoPH budget. The State finances health expenditure, through the allocation of a budget to the MoPH. The Finance Act distributes the General State Budget annually to the various ministerial departments, in particular that of health, on the basis of the central Medium-Term Expenditure Framework (MTEF), while considering national priorities and orientations, as well as the macroeconomic context of the country. In addition to state funding, the MoPH receives funding from partners in the form of grants and loans.
- Government expenditure represent 54.1 percent of total health expenditure (THE), while private spending makes up the rest. However, 96.2 percent of private health expenditure is paid out of pocket, with only 0.4 percent of private health expenditure (PvtHE) coming from insurance companies and the remainder coming from non-profit entities, charities, and non-governmental organizations (NGOs). The country is heavily reliant on humanitarian aid to cover a huge portion of its healthcare costs. Nearly 10 percent of total health expenditure in Chad comes from external funding from global organizations, such as the World Health Organisation[4].

[4] The analysis of the curve of the MoPH budget shows that health expenditure since 2013 is in full decline in general with a sharp drop in 2015 while the needs of the population are growing on the one hand and, on the other hand, other by adoption by the country of the UHC strategy requires greater health expenditures. These reductions occurred following the economic and financial crisis caused by the fall in the price of a barrel of oil worldwide. The health budget fell by 22.84% between 2013 and 2016. Compared to the commitments made in Abuja by African Heads of State in 2012 to devote at least 15% of the overall state budget to the sector of health, the available data show an erratic evolution with a general downward trend. However, it should

- If the budget of the MoPH has increased by 10% each year from the 2016 budget, revitalizing political dialogue to mobilize more domestic resources for the health sector is now a strategic objective[5]. The objective of this dialogue is to mitigate the decline in public resources for the health sector during the period of economic and financial crisis that the country is going through and to reverse the trend from 2018[6].
- With low public spending, Chad's health system remains largely financed by direct payments from households. In fact, household spending account for more than 61 percent of current health expenditures compared with less than 19 percent from the government and less than 15 percent from external sources. There is thus an elevated risk of strong prevalence of expenditures that are catastrophic and impoverishing for households.
- There are delays in the budget preparation while public procurement remains cumbersome. Due to its institutional weakness, the MoPH usually does not have time to prepare its budget and to negotiate the proposed amount with the Ministry of Finance. Every fiscal year, the structures, institutions and health units of the MoPH only function thanks to the donations and the funds granted by the international partners and the direct payments of the users (cost recovery in the health facilities). Public procurement process takes an average duration of more than one year[7].
- Increasing resources allocated to the health sector is critical to finance the insurance schemes, to recruit additional health professionals, to invest in health infrastructure and to increase the purchase of pharmaceuticals products. Improving the budget planning process by involving the MoPH in the budget preparation and encouraging better coordination between the direction of finance and the direction of technical planning is also critical.
- In order to mobilize financial resources for UHC, public funding, whether internal or external, have to increase but above all to diversify. This is all the more concerning as non-oil revenue mobilization remains weak, with Chad having one of the lowest revenue collection rates among the region. Though the Ministry of Finance have introduced several mobilization reforms, non-oil fiscal revenues have stagnated at about of 5.9 percent of GDP over the period 1986 to 2016. This is the second lowest revenue collection rate across resource rich, Sub-Saharan Africa countries[8]. This means that there is significant scope to improve mobilization efforts and diversify the fiscal revenue base.

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be noted that the other departments of the State carry out health expenditure which is not controlled by the MoPH. These include the Ministry of National Defense (Medicine and Military Health), the Ministries of Higher Education and National Education (school, university, and sports medicine), and the Major Presidential Projects (infrastructure and equipment).

[5] The allocation of financial resources for health in recent years (2013-2016) was often made without taking into account the real needs expressed by the MoPH. In addition, drastic cuts were systematically done during budget reviews (19% in 2013, 3.36% in 2014 and a total abolition in 2015).

[6] This political dialogue can take several forms: it can be a direct dialogue between the MoPH and the Ministry in charge of Finance, advocacy with the National Assembly, or support from the DPs.

[7] This is mainly because any project above 10 million CFA Francs (17,000 US Dollars) requires the approval of the Presidency.

[8] after Nigeria.

- Development aid has been reduced in Chad since the country's rise to the rank of oil producing and exporting countries in 2003[9]. While it is true that countries will have to rely more on domestic resources to hope to make progress towards SDGs, the fact remains that the current situation requires an increased mobilization of external resources to deal with the crisis situation that the country is going through. Mobilizing more external resources for the health sector through bilateral and multilateral cooperation is still a priority. Global health initiatives (in particular Global Fund, GAVI-Alliance, Bill & Melinda Gate Foundation, PEPFAR) will also be leveraged.
- Limited effectiveness of tax policy and administration contributes to low domestic revenue mobilization. Chad's tax policy arrangements partially explain limited non-oil revenue collection as tax legislation is overly complex, with high tax rates and a narrow base. A poorly administered value added tax (VAT) compounded by a plethora of exemptions also weighs on total collection. Due to lack of technical and human resources, tax administration performance is poor. Despite modest efforts undertaken by financial and technical partners and the government to address these challenges, results remain subdued due to shortfalls in discipline, management, and limited use of information and communication technology (ICT).
- Setting up innovative financing for the health sector is critical. The introduction of taxes on certain products harmful to health ("sin taxes") such as alcohol, tobacco, sugary drinks is currently under review to determine the potential fiscal space available to the health sector. Taxes on mobile telephony and financial transactions will also be used for the health sector.

Pooling[10]

- There is not a true and genuine risk pooling through pre-payment mechanisms in Chad. Establishing pooling mechanisms is however under way, in particular for the resources needed to cover the beneficiaries of the AMED Regime (*Assistance médicale pour les personnes reconnues économiquement démunies* - AMED). Article 31 of the UHC Law actually specifies that the three Schemes (ASS, ASI and AMED) are managed separately. However, Article 42 clearly states that "by virtue of the principle of solidarity, the financing of one scheme by another is possible. The terms and conditions of this funding are set by decree issued by the Council of Ministers". Likewise, article 45 of the Law n°026/PR/2020 establishing the CNAS (hereafter the CNAS Law) points out that "by virtue of the principle of solidarity promoted by Universal Health Coverage, the financing of one fund by another is possible". It is thus possible for example to co-finance the contributions of scheme 2 (ASI) and/or co-finance the AMED scheme by the surpluses of scheme 1 (ASS).

[9] External financing takes the form of support (grants and loans) from Technical and Financial Partners mainly for projects and programs. In absolute value, external aid for health increased between 2013 and 2016 even though it fell in 2014. Thus, the increase in the share of international aid in the allocation of the MoPH, from 16.7% to 39.7% is both more linked to the increase in international aid (in absolute value) and a decline in domestic resources devoted to health.

[10] Pooling is the accumulation of funds for health care on behalf of a population before they get sick. The main rationale for pooling of funds is that health care costs are unpredictable.

- In the medium or long term, a mechanism for pooling resources will be thus set up in order to create the conditions for a better sharing of risks between the different schemes, but also to ensure equity in access to care between the affiliates who come under different schemes. Arrangements will be made to ensure that the administrative costs of the respective schemes remain within acceptable limits.
- Priority is given to set up Scheme 3. Financial sources aimed at financing AMED include: revenue from taxes allocated to UHC by the 2021 Finance Law; the State budget, in particular part of the funds that were used in the context of free healthcare admission; the State's targeted free healthcare funds, which could gradually be managed by the National Health Insurance and Solidarity Fund (CNAS - *Caisse nationale d'assurance santé*); the contributions of Technical and Financial Partners (TFPs) which will require as a prerequisite that a cooperation framework be defined; donations and legacies from individuals, companies and associations. This pooling could take the form of a Trust Fund (TF) for which a study has just been conducted and whose recommendations are still under review. The earmarked taxes should be the main source of funding for the AMED in light of the economic and budgetary contexts. Besides, it is of the utmost importance to put in place the CNAS (and to adopt the related implementing decrees) since it is expected to play a crucial role to mobilize additional funds[11]. Besides, as the AMED is a non-contributory scheme, the State takes the place of the insured persons for the payment of the contributions necessary to finance Scheme 3 (article 46 of the UHC law). In the event of failure of the State and therefore non-availability of funds to finance this scheme, the risk is significant of not being able to apply article 51 of the UHC Law according to which, "the CSU [...] is managed according to the principles of financial balance between the resources and expenditure of each Scheme".
- In addition to the resources which are pooled within the Public Treasury, other resources for health are pooled within the National Social Security Fund (CNPS - *Caisse Nationale de Prévoyance sociale*)[12], private insurance companies and mutual health insurance companies.

[11] The Fund should ensure better orientation of the tax effort of the State towards the poor, vulnerable and marginalized people, while bringing together resources of those who have the financial capacity to contribute in order to guarantee solidarity and equity. In addition, the Fund is tasked with strengthening governance in the management of the health sector through the control and verification of the quality of services before any payment is processed.

[12] Law No. 7/66 of March 4, 1966, on the Labor and Social Welfare Code established, in addition to family and maternity benefits, professional risks (work accidents and occupational diseases) managed by the National Social Security Fund (CNPS). Resources for the CNPS come from employers' (16.5%) and workers' (3.5%) compulsory contributions. Unfortunately, in practice, these deductions are not paid to the beneficiaries, in particular contracted employees and decision makers. The CNPS is not accessible to people from the informal sector and does not offer any flexible pension plan or health insurance.

Purchasing[13]

- In Chad, the functions of purchasing supplier and service provider are mainly assumed by the MoPH. There is no strategic purchasing in place. Neither performance, nor efficiency in the use of resources is measured effectively and efficiently. Accountability and Monitoring and Evaluation (M&E) mechanisms are not in place. Yet, results-based financing - RBF (or performance-based financing - PBF) was experienced with funding from the World Bank for a two-year period between May 2011 and June 2013[14]. However, despite promising results and the Government's stated commitment to ensure its continuation after the World Bank's departure, PBF failed to come onto the national policy agenda. The main reason was a lack of resolute policy entrepreneurs, resulting in a weak actual ownership of the policy by national authorities and key stakeholders.
- According to the Law instituting the CNAS, the purchaser of care is the CNAS in the AMED scheme[15]. The CNAS is in charge of affiliating the employers and tasked with the registration of the insured persons. Collection of revenues is core to its mandate as well as the control of the quality of the services provided. In addition, the CNAS carries out medical and administrative controls and proceeds to payment for services rendered. Article 23 of the CSU Law limits the scope of the agreement to public or private health care providers defined in the context of national and/or specific agreement(s).
- For the purchase of health care and services, two options are possible: option 1 is centralized management with only the CNAS entitled to manage the AMED; option 2 is delegation of management, in accordance with article 32 of the UHC Law that points out that the organization responsible for managing UHC (the CNAS) may entrust some of its powers (functions) to delegated management bodies.
- Over the past few years, experiments have been conducted in strategic health care purchasing. The institutionalisation of a strategic purchasing centre is ongoing, which should strengthen primary health care. Strategic health purchasers actually use information and policy levers to decide which interventions, services, and medicines to buy, from which providers, using which contracting and payment methods to encourage efficient behaviours and decisions among both providers and service users. When implemented well, strategic purchasing can thus generate efficiency gains and free up resources to cover a larger share of the population with more generous service packages and greater financial protection.

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[13] Purchasing is the process of allocating prepaid resources from pooled funds to providers for service benefits. Closely linked to purchasing are decisions on benefits (what services, and at what level of cost coverage) and provider payment methods. The way purchasing arrangements are set up will have significant implications for provider behaviour and efficiency.

[14] The pilot covered eight health districts in four Regional Health Delegations and a new phase started in January 2015, covering eleven Health Districts.

[15] The adoption and promulgation of Law N°026/PR/2020 creating the National Health Security Fund constitutes a decisive step in the establishment of the institutional framework of the Health Insurance system and makes it possible in particular to accelerate the implementation of the CSU scheme (AMED) dedicated to the poor in 2021.

2.4. Collaborative Challenges

- The MoPH has a multitude of coordination and consultation bodies, namely (not exhaustive) the National Health Council, the MoPH Consultation Meeting, the Steering Committees, the PNDS and *PACTE* Monitoring Committees, the Political Dialogue Monitoring Committee, the Inter Agencies Coordinating Committee (CCIA - *Comité de Coordination Inter Agences*), the Regional Health Delegation (DSR - *Délégation sanitaire régionale*) and the Health Districts Steering Committees. Revitalizing these platforms by merging certain coordination mechanisms and clearly redefining their role as well as the periodicity of the holding of sessions in order to make them more effective is today critical.
- Collaboration with DPs should be further enhanced, even if it is already efficient and operative, with a focus on aligning different programmes and fundings with the strategic objectives of the SN-UHC. For example, World Bank Group engagement in Chad is guided by a Country Partnership Framework (CPF) that is reassessed and renewed on average every four years[16]. Aligned with the Government's priorities, the current CPF aims at improving public resources management, strengthening human capital (health, nutrition, education) and reducing vulnerability[17].
- Agreements are signed between the Government and partners as opportunities arise. These partnerships were strengthened with Chad's accession to the International Health Partnership and Related Initiatives (IHP+), followed by the signing in 2014 of a Pact between the Government and its partners to facilitate the execution of PNDS 1 and 2.
- Multisectorality is not evident due to the lack of involvement of other Ministries in health related issues. Similarly, the MoPH is still not involved in the development of sectoral policies of other ministerial departments. This constitutes missed opportunities to strengthen the health-in-all-policies approach. The non-profit public and private partnership (NGOs and faith-based organizations) has been further strengthened thanks to the contractual policy adopted in 2001 and revised in 2014. However, concerning the for-profit private sector, it is practically not involved in decision-making. In addition, this sector is not well organized and well monitored by the MoPH. Strengthening legal and

[16] The last CPF covered the period 2016-2021. The preparation cycle for the new strategy began with the update of the assessment of the economic and social situation in Chad. The new strategy is expected to be approved by the board of directors in the current fiscal year.

[17] Through the International Development Association (IDA), the World Bank Group is currently financing sixteen operations: 10 national projects for a total commitment of $534.95 million and six regional projects totalling $406.7 million. The World Bank disbursed $16.9 million in emergency financing on April 28, 2020, to help the government respond to the COVID-19 pandemic and is providing support for food security and livelihoods. These interventions, which are estimated at $21.7 million, are accompanied by emergency budget support for economic stabilization. To help Sahelian countries stabilize the region and expedite their development, the World Bank became a member of the Sahel Alliance launched in July 2017, with the goal of enhancing coordination among partners to provide aid more rapidly, effectively, and better targeted to vulnerable zones. The International Finance Corporation (IFC), the private sector arm of the World Bank Group, has invested in the mobile telecommunications (Milicom) and health (Clinique Providence) sectors as well as in industries and services. In collaboration with the World Bank, IFC is helping the Government of Chad with the implementation of reforms needed to improve the business climate.

regulatory frameworks is thus critical to foster cooperation with the private sector without jeopardizing the public health policy objectives.

2.5. Human Resources Challenges

- The health sector is still characterized by insufficient qualified health personnel, affecting adequate health care delivery. According to NHDP-3 (2017-2021), the MoPH had 8,149 health personnel at the end of 2016. The density of health personnel at the national level is estimated at 0.58 per 1000 inhabitants in 2016, whereas the standard recommendation by the WHO is 2.3 per 1000 inhabitants for the achievement of the MDGs. In the context of the SDGs, the density was raised to 4.45 health personnel per 1000 inhabitants. At the regional level, 18 provinces out of 23 have a density of less than 0.6. Only the provinces of Tibesti-Est, Ennedi-Ouest and N'Djamena have relatively high densities - 5.57, 1.49 and 3.05 respectively. While the high figures in the two provinces in the extreme north are explained by relatively low population, N'Djamena stands out to the extent that it has around 46 percent of the total number of health personnel while representing only 9 percent of the population of the country.
- The MoPH has already made substantial efforts to control the workforce, but still insufficiently. In particular, measures have been taken for the assignment of agents in the hinterland[18]. As part of the implementation of the Strategic Plan for the Development of Human Resources in Health (PSDRHS - *Plan Stratégique de Développement des Ressources Humaines pour la Santé*) and for better management of the workforce, the country has initiated since 2012 the implementation of the provisional management of Human Resources for Health - HRH with the IRHIS tool. However, this software is not yet operational because of the slowness in feeding the personnel database.
- The situation is all the more concerning as health workers shortages and weak health system have led to a lack of preventive and curative health care services and health promotion programs in various parts of the country, making it difficult for the country to improve health indicators.

2.6. Health Information Challenges

- The need to effectively monitor and evaluate initiatives to accelerate progress towards UHC has led to actions to strengthen the National Statistical System (SSN - *Système Statistique National*) and the Health Information System (SIS - Système d'Information en Santé). Since the SIS is recognized as a pillar of the monitoring and evaluation system for all health development policies and strategies, it receives special attention from the MoPH and its technical and financial partners. Key challenges

[18] Among these measures, the most characteristic are: i) Decree No. 903 of 12 October 2006 taken to establish the special status of civil servants in the health and social action sector. This decree defined a staff loyalty strategy which is based on safety and professional promotion; ii) The memorandum of understanding signed in December 2011 between the social partners and the government granting the payment to health personnel of several types of allowances and advantages from 2012 (housing, transport, austere zones, liability, on-call bonus, etc.) ; iii) the decree of April 17, 2013 on the index scale, which defines the procedures for the reclassification of bodies and the transfer of civil servants. Despite the implementation of all these legal mechanisms, the results of these strategies are not visible. There is still a high concentration of agents in the large urban centers and especially in N'Djamena where about 46% of all health personnel are found for 9% of the total population.

include weak coordination and planning linked to the non-functionality of the national SIS commission, insufficient resources, low quality of the data produced, inadequacy of the collection tools produced by the SIS, low completeness and timeliness, insufficient decentralization of the SIS in the regions, and the multiplicity of parallel data collection systems in the field. The absence of operational research to supplement routine data and the non-institutionalization of certain surveys such as the SARA survey and the National Health Accounts (CNS - *Comptes Nationaux de la Santé*), accentuate the weakness of the National Health Information System. However, it should be pointed out that the current health information systems, which benefited from a broad consensus between all the stakeholders during the revision of the tools in 2013, remain relatively well suited to ensure good production of quality data for the health sector. The availability of appropriate human resources in number and quality will be a key element in the further development of the health information system, as financial and material resources.

- The involvement of the MoPH in order to develop a strategic plan for the better management of the health information system is also critical. Routine information, epidemiological surveillance, surveys should be established or strengthened, and the conditions allowing for a better alignment of DPs with the SIS should be developed.

3. WHAT IS NEEDED?

3.1. Strengthening policy frameworks by

Adopting conducive policies and strategic plans

- Chad released its first National Health Plan in 2008. The 2nd National Health Plan 2013 -15 was prolonged to 2017, and a Plan National de Développement Sanitaire - PNDS 2018-2022 was produced. In 2016, the National Health Plan (PNS, 2016-2030) was developed in particular to enhance the extension of mutual health insurance companies (they cover about 50,000 members or 0.36% of the population). In 2017, the National Health Development Plan (PNDS3, 2018-2021) was adopted with the identification of sixteen innovative health financing options[19].
- A National Community Health Policy (NCHP) was adopted on May 21, 2014. It provides stakeholders in the health sector with a framework for community involvement in health system strengthening and financing efforts. Strategic orientations and effective mechanisms for monitoring and evaluation are provided therein. Any health program released in Chad must be consistent with the Community Health Policy.

[19] Technical and financial partners in the health sector have signed a pact (2019-2021) to strengthen the implementation of health policies. The pact aims to improve the effectiveness of development in the health sector by creating a framework that clearly defines responsibilities and priorities.

- The development of the National Social Protection Strategy (SNPS, *Stratégie nationale de Protection Sociale*, 2016-2020) was a critical step towards UHC, clearly pointing out that the Government of Chad was effectively committed to strengthening the social protection of its citizens through the development of a national strategy aimed at improving equitable access to basic social services[20]. Social protection aims at the mobilization and promotion of human capital and the reduction of inequalities, poverty, and social exclusion[21]. Social protection is considered in Chad as a central pillar in the fight against poverty and vulnerability[22]. It plays an important role in increasing the resilience of individuals and households to social, environmental, food and economic shocks and risks. In a significant way, several services, and mechanisms at the MoPH are responsible for implementing the Government's social policy[23].

Promoting equity in health system financing[24]

- The distribution of the MoPH resources between the regions and districts does not consider the specificities of each region and especially the population covered. Lack of coordination between the different services of the MoPH and the State, and between the DPs, also leads to duplication of tasks and waste of resources. For example, the establishment of new infrastructures and the provision of health equipment at local and regional levels are not always accompanied by Human Resources for Health (HRH) plans or policies, jeopardizing their optimal use.
- Equity in the distribution and allocation of resources is thus becoming a core priority. It is urgent to define at all levels of the health system objective criteria for an equitable allocation of financial resources before any decision is made. These criteria should take into consideration, among other

[20] The specific objectives of the SNPS are as follows: provide social assistance to vulnerable groups by promoting their social inclusion; ensure a minimum income for people of working age, by promoting employment and an extension of social security coverage as well as an increase in the level of benefits; ensure that everyone living in Chad has enough quality food to be able to eat normally at all times in order to lead an active and healthy life; facilitate access to quality basic social services, including education and health care, particularly for vulnerable people.

[21] Significant resources are needed to finance social protection in Chad. They need to be predictable and sustainable. In particular, there is a need to move to a formal and more coordinated system of resource mobilization that can generate sufficient funds to meet the needs of the categories of people who depend on the formal and informal sectors. The current social protection financing system is characterized by: contributory insurance for salaried workers and civil servants (civilian and military) supplemented in some cases by employer contributions; a low level of voluntary contribution from the informal sector through mutuals; the system's dependence on *ad hoc* funding from rarely coordinated projects.

[22] Priority actions include: Social Protection Expenditure Review (SPDR) or the development of a social budget that provides information on both current expenditures and future costs of expanding social protection programs; the establishment of a mechanism allowing the financing of a program or financing through a comprehensive approach (SWAP); The inclusion in the sectoral budgets of the next National Development Plan (PND - *Plan National de Développement*) of a budget line for social protection and / or the next PND indication of budget items considered to be related to social protection; The creation of a National Solidarity Agency for the collection and management of funds for social protection; An analysis of the potentialities of the oil sector to provide funds for social protection.

[23] For example, the Free Emergency Care Management Unit.

[24] It is generally accepted that the burden of health financing should be distributed according to an individual's ability to pay, that is, the burden should increase as household income increases.

things, the size of the population targeted in the beneficiary region or health district, the level of health development (health coverage), essential health indicators, and existing resources. Interventions with maximum impact should be prioritized.

Ensuring financial sustainability and the efficient use of resources

- Results-based management and accountability are not effective in Chad. Yet, a pilot was conducted in a few regions in recent years, and the Government recognized the potential of PBF to address the challenges facing the Chadian health system, Nonetheless, PBF failed to move from the governmental agenda to the decision agenda. Program budget managers are still not accountable for the results of their respective programs, jeopardizing the efficient use of resources and the maximization of results.
- Using resources more efficiently and equitably is a strategic objective, in particular in view of the implementation of the UHC Strategy which requires new and complementary financing. Improving the efficiency of current health spending in order to free up resources that can be used to cover more people or services is not an easy task to do. Studies have first to be initiated to identify inefficiencies in health financing and propose solutions to improve resources for health. These studies should also identify areas where rational use of resources can help generate savings that can be used to produce more health outcomes.
- Advocacy for an effective mobilization in time of the resources allocated by the State to the MoPH will be carried out. Expected outcome is to create the conditions for the effective and efficient implementation of results-based program budgets by the MoPH.

Improving data availability to inform policy and decision making

- The lack of detailed and comprehensive budget data in Chad requires rigorous and in-depth analysis of public expenditures. Despite several attempts, it is still problematic to obtain detailed disaggregated data from the Ministry of Finance to build an adequate and effective database. Budget data are only available by economic and administrative classifications while there is no formal functional classification for both planned and actual expenses. Executed expenditure is available by spending classification but not administrative classification. Chad thus still faces huge challenges regarding the reporting and monitoring of budgeted and actual expenditure data. Several inconsistencies are regularly found for planned and actual expenses according to the reporting sources. For instance, Approved Budget Laws and budget execution reports published online rarely match with data reported by internal systems as the latter does not include external financing.
- Despite the presence of international organizations and NGOs, there are surprisingly few sophisticated studies on Chad's health system. It is all the more concerning as information technologies can provide crucial information on the health system's performance and improve coordination and cooperation amongst the country's different health stakeholders. This can foster efficient synergies amongst international NGOs, state policy-makers, physicians, and nurses and is an important step for providing patients with adequate health care.

3.2. Strengthening legal and regulatory frameworks by

Adopting robust legislations

- The process of implementing the National UHC strategy accelerated in 2019 with the adoption and promulgation of Law n°035/PR/2019 of August 05, 2019, establishing UHC in Chad. With a view to a gradual implementation and in a spirit of equity and social justice, Chad had planned to start the Health Insurance Scheme in 2020 through scheme 3. However, delays have to be pointed out. The identification of economically poor people is a crucial step, but if implementing decrees have already been prepared and drafted, they have not been adopted yet. The process of affiliation of future AMED policyholders, supposed to start with the poor and the vulnerable, is complex. Its success is conditioned by the combination of the efforts of the CNAS, the CIC-CSU, the DMOs but also other civil society organizations (community-based organizations such as mutual health insurance) in relation to this target audience. The procedure for the affiliation of the other targets of the AMED (orphans, students, prisoners,) is not yet sufficiently documented and would intervene in a second stage.
- The 2020 and 2021 Finance Laws provided for the collection of revenues to finance AMED. But so far, there is no related account at the level of the Public Treasury and the UHC funds are therefore not mobilized, nor available on an account opened for the UHC. Instead, applying the principles of the unity of cash and the fungibility of funds at the level of the Public Treasury, these revenues have been used to pay other expenses of the country. The creation of a Trust Fund is thus recommended to secure the resources to finance the AMED.
- Institutional and legal framework for drugs, other health and laboratory products is still concerning. In accordance with the roadmap for the reform of the Pharmaceutical sector, the National Authority for Pharmaceutical Regulation has embarked on a reform process since 2012 by passing from a technical directorate to a general directorate (Decree N° 1644 / PR / PM / MSP / 2014 on the organization chart of the MoPH). However, Law N° 24/PR/2004 relating to Pharmacy in Chad is not yet fully applied. Indeed, it has already been the subject of seven implementing decrees. twenty-five decrees. There are still additional decrees to be drawn up for its full application.
- Regarding community participation in health financing activities, the strengthening of the legal and regulatory framework have been a priority for the Government in recent years. Main texts are Law n°019/PR/99 instituting Community participation in health care, and consisting of involving the Community in the costs, planning, management, and evaluation of health services at all levels and decree n°364/PR/MSP/2001 relating to the organization of community participation in the definition of health costs. For example, the Government now authorizes health facilities to directly use their financial resources for the renewal of stocks of medicines and to cover operating costs[25].

[25] To this end, MoPH's Order n°362/MSP/SG/DGAS/DPML/03 harmonizes the pricing of procedures and drugs in Regional Supply Pharmacies, Hospitals and Health Centers.

Adopting implementing/regulatory measures

- A lot remains to be done regarding the implementation of the UHC Strategy and its related Law, in particular for establishing the AMED regime: essential structures such as the CNAS are not yet in place; the services to be covered, their costs and their tariffs are still at the stage of proposals and have not been formally defined; human resources are to be recruited and trained; the volume of funding that can be mobilized is still unclear, and communication with the CIC/SN-CSU authorities is low. And, most importantly, the implementing decrees of the UHC Law have not been adopted yet.

  Implementing decrees still to be adopted are the following:

  I. Decree on the creation, attributions, organization and functioning of a regulatory and governance body for Universal Health Coverage, taken in application of the provisions of articles 33, 34 and 59 of the UHC Law. A regulatory and governance body called the "Regulation and Governance Agency for Universal Health Coverage" is created. The UHC Regulation and Governance Agency is a public institution with legal personality and financial and management autonomy in the execution of its missions. It is responsible for monitoring and evaluating the application of the UHC Law and the Law establishing the CNAS. It can propose, in the form of an opinion, proposal or recommendation, any legislative or regulatory measure likely to improve the system, with a view to economy, transparency and efficiency. It is also tasked with coordinating the development of normative and regulatory texts and ensure their application. Other missions include: to ensure the adequacy between the operation of the UHC and the objectives of the State in terms of health and social protection; to support the various stakeholders in the negotiations of agreements relating to the UHC and ensure the arbitration of disputes arising from the application of said agreements; to propose the measures necessary for the regulation of the UHC system and in particular, the appropriate mechanisms for controlling the costs of UHC schemes and ensure that they are respected; to provide technical support to management bodies and delegated management bodies for the establishment of a permanent system for evaluating healthcare services and products provided to beneficiaries of UHC schemes; to ensure governance of the management and financing functions of UHC; to ensure the standardization of management tools and documents relating to UHC and keep consolidated statistical information on UHC on the basis of the annual reports sent by each of the management bodies; and to draw up and distribute an annual global report describing the resources, expenditures and data relating to the medical consumption of the UHC schemes.

  II. Decree on the procedures for fixing the guaranteed costs of the baskets of care covered by the Universal Health Coverage Schemes, taken in application of the provisions of article 16 of the UHC. The basket of care covered by a UHC scheme is defined as all the services guaranteed to the beneficiaries of the said scheme and provided by the healthcare providers according to the terms and conditions determined in this decree. The management body of the UHC in its capacity as third-party payer replaces the affiliate for the payment to the service providers of

the care services guaranteed. The affiliate ensures payment, in the form of co-payment, of the difference between the actual cost of the service and the amount reimbursed by the management body. The level of co-payment is fixed by service or by category of services by a ministerial order from the Technical Supervision Ministry.

III. Decree setting the rules for affiliation and registration of those subject to Universal Health Coverage, taken pursuant to the provisions of Article 30 of the UHC Law. It is intended to set the rules for affiliation and registration of persons subject to the UHC schemes. The following persons are registered with the National Health and Solidarity Insurance Fund under the AMED regime: the person recognized as economically poor, vulnerable or marginalized; the Chadian student from poor families up to the age of 20; the orphan and the abandoned child placed in orphanages and specialized structures; the person in detention in penitentiary establishments; and the vulnerable person supported by the municipalities.

IV. Decree on health care benefits guaranteed by Universal Health Coverage, taken in application of the provisions of the UHC Law. The costs of any care basket should include the costs of healthcare services as well as the management costs of the said scheme. It should be determined per person and per year and is fixed by joint order of the ministers in charge of health and finance. The costs of the care basket of a given scheme serves as the basis for determining the contributions and subsidies necessary to finance this scheme.

V. Decree on the definition of the methods fused to identify the economically disadvantaged people, taken in application of the article 6 of the UHC Law. Economically disadvantaged persons are understood to mean any person who does not have the necessary resources to ensure or satisfy their vital needs on their own, in particular food, clothing, housing, health care and education and who are supported in this regard by nobody. Economically disadvantaged persons live in total economic, financial, material, and relational deprivation.

VI. Decree on the terms and conditions for the allocation of resources to the Universal Health Coverage Management Body, taken in application of the UHC Law. Resources allocated to UHC are mobilized by UHC management bodies, contributions from private and semi-public employers and local authorities, contributions from employees, financial products, loans, sponsorships, donations and legacies, financial penalties, resources from DPs and Government services, employers state contributions, innovative financing, dedicated taxes and State subsidies, in particular those used for free healthcare mechanisms. The decree authorizes the establishment of a special account of the public treasury dedicated to UHC. Resources from the dedicated account are exclusively allocated to the expenses identified in the annual budget prepared by the organizations managing UHC and approved by the related governance and regulatory bodies.

3.3. Strengthening institutional frameworks by

Creating supportive environments

- Community Participation has been in place since the Bamako Initiative. Communities were involved in the management of health services through Health Committees (COSAN) and Management Committees (COGES). Unfortunately, abuses emanating from these bodies (lack of transparency and accountability, and tenure of officials) have been criticized on several occasions following the supervisions carried out by the Regional Health Delegations (DSRs - *Délégations Sanitaires Régionales*) and the Districts Chiefs Doctors (MCDs – *Médecins Chefs de Districts*). This situation led the MoPH to adopt a National Community Health Strategy in 2015 in order to better involve the communities in solving their health problems and to increase effectively and efficiently ownership and accountability.
- In order to create a supportive environment for health financing, the Government is also working on developing an implementation mechanism articulated with that of the national social protection strategy through steering and technical committees. An operational support unit, of an intersectoral nature, should be responsible for close monitoring of the implementation of the UHC.
- Creating a service responsible for drafting legal texts and monitoring their adoption and application within the MoPH is also a priority. Actors concerned (technical departments of the MoPH, DPs, other Ministries, civil society organizations and the private sector) should be involved at each step of the process. The expected outcome is to accelerate the adoption of the implementing decrees regarding existing health laws, e.g., hospital reform, reform of health schools, reform of the pharmaceutical sector, reform of the private sector, UHC Law, community health, etc. Once the texts have been adopted, the service will be responsible for popularizing them at the different levels of the pyramid.
- Strengthening documentation and communication capacities regarding the health sector is also critical. The MoPH will centralize and distribute national reference documents relating to the laws, policies, strategies, and plans concerning the health sector. The dissemination of these strategic documents to all interested health actors should at the same time enhance transparency, accountability, and coordination and reaffirm the leadership of the MoPH. It should assist the MoPH in encouraging the different partners and stakeholders to adhere to the priorities defined by the Government and to harmonize their contributions and their support with the UHC strategy.

Advocating for new investments

- Public spending cuts have constrained investment, highlighting the need to boost domestic revenue mobilization and resilience. Because of the 2014/15 oil price shock, public spending in Chad decreased from 22.9 to 14.5 percent of GDP between 2013 and 2018, a level well below oil exporting peer countries. Cuts in investment expenditure are particularly costly given Chad's low capital stock and subsequent low social sector performance. Spending on social sectors is among the lowest, while

security spending ranks among the highest when compared to oil and fragile peer countries[26]. Public investment in social sectors is highly dependent on external support as only 25 percent was financed domestically in 2018. As a result, Chad is lagging regarding education and health outcomes. Thus, it is essential to rethink the current allocation of public resources to increase spending in social sectors. In addition, the overall PFM systems (budget preparation, execution and control) remain weak, contributing to poor budget execution aggravating inefficiencies of public spending.

Establishing close monitoring and accountability for results

- There is an urgent need to clarify the roles between the Interministerial Coordinating Unit for the UHC Strategy (CIC/SN-CSU - *Cellule interministérielle de Coordination de la Stratégie CSU*), effective in practice but which critically lacks adequate resources, and the CNAS, which is not yet operational, whereas it is supposed to support the development of the AMED.
- A service exclusively dedicated to monitoring and evaluating progress towards UHC should be established within the MoPH. Rigorous programming at the beginning of each year, involving the DPs and other actors concerned, validation by the parties involved at each stage of the process, should be core elements. In addition, a mechanism should be set up for the systematic control of the management of health services at all levels and for sensitizing public officials on governance aspects. Besides, the MoPH, through the General Inspectorate, will strengthen the control of resource management at both central and regional levels on a permanent basis.

Transferring powers and resources to local authorities (decentralization)[27]

- Since the 1980s, health services have been decentralized with a delegation of power to the Regional Health Delegations (DSR) and health districts. The number of health districts is constantly increasing[28]. The lack of effective decentralization limits decision-making at local and regional levels impeding to improve the involvement of communities in health issues. Likewise, local authorities are decentralized, but they do not always have decision-making power over health services because of the delay in the application of decentralization texts in general and the absence of a clear definition of their responsibilities.

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[26] In 2018, resources allocated to the Ministry of Defense accounted for 7.8 percent of total budget while allocations to the Ministries of Health and Social Protection represented only 4.8 and 0.5 percent, respectively.

[27] Decentralization is a process by which political, administrative and fiscal authority, responsibilities and functions are transferred from the central government to the state/region governments. There are at least three aspects of decentralization: devolution, deconcentration and delegation. Devolution is the transfer of authority and responsibility from central government ministries to lower-level, autonomous units of government through statutory or constitutional provisions that allocate formal powers and functions. Deconcentration is the transfer of authority and responsibility from central government ministries in the country's capital city to field offices of those ministries at a variety of levels (region/state or local). Delegation is the transfer of authority and responsibility from central government ministries to organizations not directly under the control of those ministries, for example, non-governmental organizations, and/or autonomous region/state and township governments. In Myanmar, devolution should be sought rather than deconcentration or delegation.

[28] 138 in 2015.

Developing Public-Private Partnerships (PPP) and "contractual arrangements"

- Promoting public-private partnerships in Chad is critical. The development of private healthcare providers will increase access to healthcare. Establishing a framework for dialogue and consultation with the private sector is urgent. The private sector, whether lucrative (clinics, surgeries, warehouse pharmacies, etc.) or non-profit (health facilities, NGOs, etc.) plays actually a very significant role in health coverage and should adequately complement public providers of healthcare.
- The MoPH should develop contracting policies in order to control the private sector and regulate its activities, but also to get maximum benefits from this collaboration. The MoPH should also develop implementation guides and tools to accompany this process. Adequate complementarity between the public sector and the private sector will enhance the development of the health sector.
- As of May 2022, the PPPs Legal and Regulatory Framework in Chad is made of Ordonnance n°06/PR/2017 instituting the legal foundations for PPPs and Decree n°1154/PR/MMDICPSP/2019 determining the modalities of implementing the 2017 Ordonnance. The use of public-private partnerships is authorized after a preliminary assessment made by the PPP Support and Coordination Unit. The assessment should always include a comparative cost-benefit analysis and a risk and performance evaluation of the project.