

MANAGEMENT OF UNIVERSAL HEALTH COVERAGE IN CAMEROON

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ABSTRACT

Universal Health Coverage, (UHC), has proven to be an undeniable political and very ambitious health agenda aimed at ensuring that everyone has access to basic quality health care services irrespective of their socio-economic status and geographical location. The UHC concept is of utmost importance in Cameroon considering the very high levels of out-of-pocket health expenditures and fragile health systems. Achieving UHC in Cameroon will not only increase the life expectancy of Cameroonians but it will also increase the economic output of the country. Although Cameroon has set in place targets and agendas aimed at providing UHC to her citizens, they're far from being implemented. With the country having a huge pool of informal workers coupled with the high level of mistrust citizens have for the governments Community-based health insurance, (CBHI), the concept of UHC in Cameroon remains more of a theoretical than practical phenomena. To cost effectively achieve UHC; aside increasing trained health care professionals, intersectoral collaboration between government authorities, civil society organizations like non-governmental organizations, community health workers, religious and cultural stakeholders should be prioritized.

Key words: Health Systems, Health Insurance, Health Policy

INTRODUCTION

What is Universal Health Coverage?

Universal Health Coverage (UHC), as defined by the World Health Organization, (WHO), occurs when both the general and most disadvantaged population have access to essential health services when and where they need them, without financial hardship. These coverages of essential services include; maternal new born and child health, infectious diseases, non-communicable diseases and service capacity (1). According to WHO uhc 2008 report, three key points are suggested in moving forward towards achieving UHC which are; who is insured, which benefits are covered and what proportion of the cost is covered (2). Due to the fact that financial constraints have been identified as the major hurdle in achieving UHC,

addressing the three elements outlined above clearly puts stakeholders on the right path.

The notion of UHC is closely linked to Sustainable Development Goal (SDG) target 3.8, which aims to achieve UHC through focusing on health service coverage and expenditure (3).

In 2017, the WHO and the World Bank released a joint report revealing that at least half of the world's population still lacks access to basic health services. Furthermore, more than 800 million individuals throughout the world still spend more than 10% of their household budget on health care, and about 100 million people are pushed into extreme poverty each year as a result of excessive out-of-pocket medical costs (4).

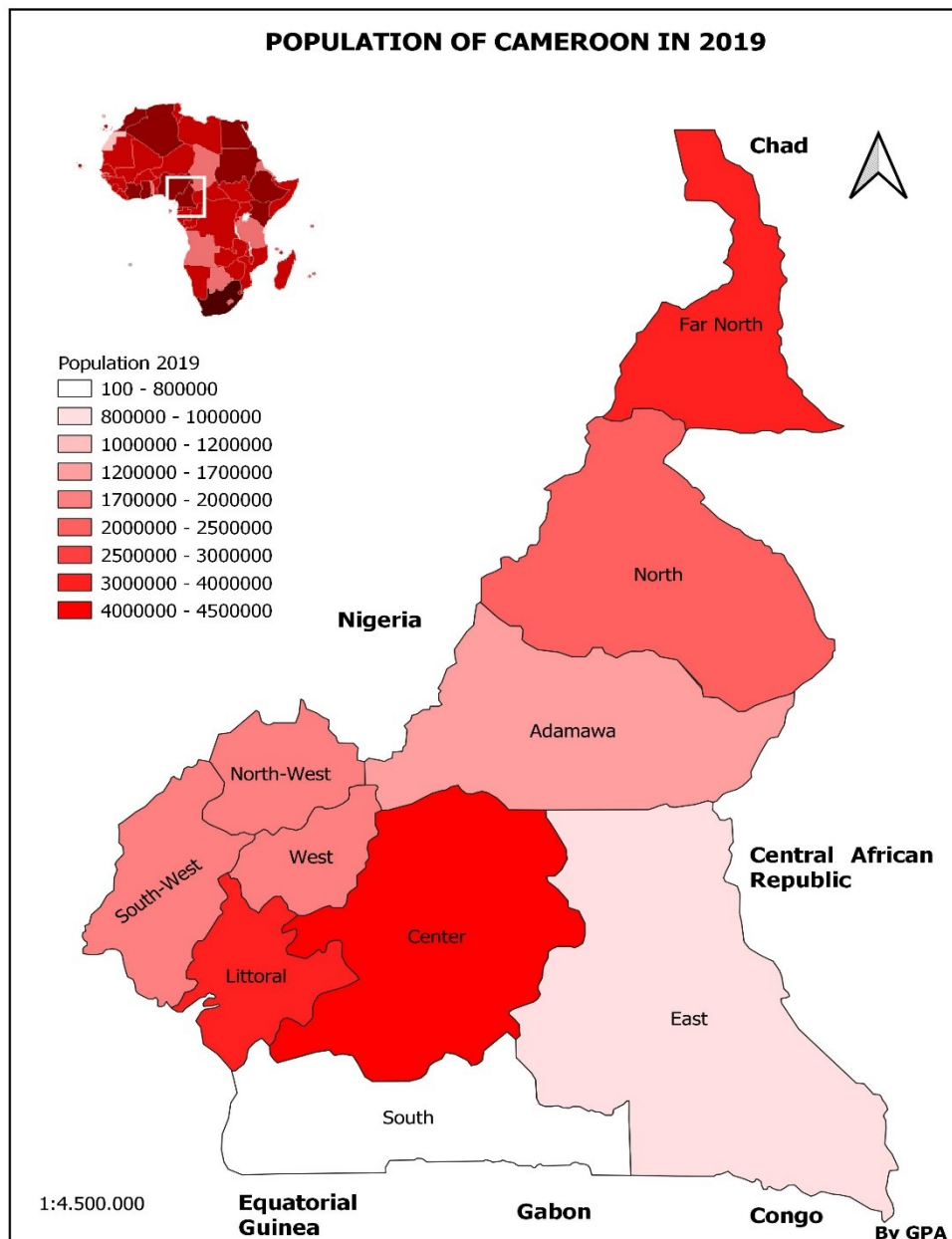


Figure-1: Map of Cameroon According to Populated Regions

As a consequence, there is no question that UHC is a key problem for the WHO, as well as the rest of the world, including Cameroon. To guarantee healthier populations, advocating for universal health is a worthwhile goal.

Brief socio-demographic description of Cameroon

Cameroon is located between Western and Central Africa, and its official languages are French and English. It has approximately 189 health districts and ten administrative regions, with its capital, Yaoundé,

located in the centre region, which is also one of the top three most inhabited regions (as shown in Figure-1). Cameroon has a centralized government, with the president exercising full administrative and legislative authority (5).

The population of Cameroon by mid-2020 was approximately 26,545,863 according to the United Nations, UN, data (6). The informal sector such as farming and local trade engrosses a larger percentage of the population than the formal sector. However, this sector is frequently overlooked, which reflects negatively on the country because individuals

in the formal sector enjoy the majority of health insurance advantages (7). With the following response, Raju Singh, the World Bank's Lead Economist for Central Africa, further confirmed the unfair management of the informal sector, <<"In Cameroon, informal agriculture will continue to be the main source of employment in the near and medium term, according to current predictions.>>" As a result, focus should be placed on increasing productivity in this sector, because despite its widespread neglect, the informal sector has the potential to bring a considerable boost to the economy if given greater attention (8).

Structure of the health system in Cameroon in terms of:

i. Finance

One of the fundamental pillars of every health system is health financing, which is a critical aspect in accelerating progress toward UHC. To achieve UHC, some governments rely on a single source of funding, while others rely on a variety of sources. Government, social, and private insurance schemes, local non-governmental organizations (NGOs), Community-based Health Insurance (CBHI), international aid, and household out-of-pocket payments are the main sources of financing in Cameroon's health sector (9). As an example, Cameroon's government got financial assistance from the World Bank and the United State's Global Financing Facility (GFF) in 2016 to boost reproductive, maternal, neonatal, and adolescent health care (10).

Cameroon's Gross Domestic Product (GDP) per capita health expenditure was \$54 (3.53 percent of GDP) in 2018, up from \$50 (3.49 percent of GDP) in 2017. However, this figure is still insufficient, motioning that more money must be devoted to the health care sector if UHC is to be realised (11).

As previously noted, the bulk of Cameroon's labour market is informal, with informality being more widespread in rural than urban areas. Cameroon's present social health protection system is built on two pillars: the government civil servants' scheme and the National Social Insurance Fund, NSIF, (Caisse Nationale de Prévoyance Sociale, CNPS) for workers covered by the labour code (12). The NSIF is compulsory for workers and civil servants but not compulsory for those in the informal sector. This already establishes a barrier as most of the active work force is informal. As a result, many do not recognize the need of taking control of their own

health by participating in these social insurance plans.

The CBHI systems are another key source of health financing that is really being encouraged in most low- and middle-income countries to assist mainly rural areas. In Cameroon, there were about 158 CBHI schemes in 2010, benefiting about 251,062 people, just about 1.3 percent of the population (13). Enrolment into CBHI is voluntary in Cameroon, which accounts for the low turnout because most people either do not recognize the benefits or see it as a product for the wealthy. Others, on the other hand, do not see the necessity to make regular payments for something they may never use because most people in rural areas rely on traditional medicines to treat themselves in case of disease or just do not trust the government's motivations for creating CBHIs (14). In a study conducted by Nathaniel Ojong (15) in certain rural villages in Cameroon's North West region, it was discovered that indigenes preferred monetary gifts and loans to enrolling in CBHIs as a means of affording health care for services; This is built on confidence, solidarity, and the give-and-take concept in these communities, where lenders know they will one day be borrowers and hence do not charge interest rates for such loans.

Another study conducted in the Bonassama Health District, which is located in an urban area, revealed that informal workers were unaware of CBHI schemes, with only 1.2 percent of them belonging to one. According to the study, workers would prefer that these CBHI projects be run by missionaries or persons from similar ethnic groups rather than government officials (16). This authenticates how citizens distrust the government when it comes to their health and are more at ease with CBHI initiatives run by religious organisations or persons of similar ethnicity. The CBHI system in Rwanda, on the other hand, has had a consistently high success rate since its inception in 2003, owing to strong community acceptance and leadership of these CBHI systems by community members themselves, a decentralized health system, and compulsory enrolment into these CBHI schemes (17). The key to success, especially in Cameroon's rural areas, is getting people to recognize the significance of a CBHI system. Another alternative is to direct some foreign aid toward promoting the CBHI agenda, putting in place procedures to avoid official fraud, and involving community members with similar ethnicity in the CBHI

system's administration. In Cameroon, there are a few private health insurance systems, although they only cover about 1% of the population. Furthermore, family planning is not included in these packages, and the annual subscription charge is significantly higher than in CBHI plans, thus favouring only the wealthy (18). The high out-of-pocket health costs in Cameroon are one of the most serious problems in the country's health care system. Out-of-pocket payment (OOP) refers to direct payments made by individuals to health care providers at the time of service usage, as well-defined by WHO's SDG agenda 3.8.2. (19). According to World Bank data, Cameroon's OOP for health care in 2018 was 78.38% (20). This has a negative impact on the health-care system, particularly on the poor and vulnerable people who cannot afford these high out-of-pocket costs.

In order for Cameroon to achieve UHC, the government must, therefore invest more resources in the health sector, particularly in rural areas where access to health care is limited.

ii. Health service

The availability of well-trained health care staff and health facilities is directly proportional to the quality of service provided. Cameroon's health system is supervised by the Ministry of Public Health (MOH). The healthcare administration structure is further fragmented into regional health facilities, district health facilities, private healthcare institutions, pharmacies, NGOs and traditional healers (21). Shortage and unequal distribution of health care personnel in Cameroon is a concern, especially in rural areas where health facilities are deficient. Lack of motivation, low pay, and under-equipped health facilities cause health care personnel to prefer to work in the urban environments (22). Although the quality of health care has increased since the implementation of Performance Based Financing (PBF), the situation is not the same in rural areas. Participants in a recent study (23) complained about inequities in drug distribution between areas, as well as inconsistencies in PBF payments. Geographic access to health care facilities is another major issue on the African continent, Cameroon inclusive; most people in rural areas resort to self-treatment due to the long distances they often have to travel to access health care services (24).

iii. Population

The majority of Cameroonians have not fully embraced the UHC concept. In Cameroon, trusting the government when it comes to health care is still a long way off, as many people do not trust or believe in the government's efforts to promote quality care. They perceive it as nothing more than a political agenda aimed solely at benefiting the administration (25). The ongoing "anglophone crises" in Cameroon's North West and South West regions have made the population more vulnerable, with many people becoming internally displaced, increased poverty making basic health care services more difficult to afford, and many health care workers losing their lives while trying to help distressed citizens (26). This crisis has had a significant impact on health because most people have fled their homes for safety, leaving behind a big pool of unfollowed cases in hospitals, particularly for those on specific treatment such as highly active antiretroviral therapy (HAART). People must be actively involved in the decision-making and implementation phases of health-care policies for UHC to flourish, as they are a crucial stakeholder. Community participation in Cameroon's strategy for achieving UHC should be increased through motivating Community Health Workers (CHWs) and cooperating with NGOs.

Primary Health Care in Cameroon

Primary Health Care (PHC), has been identified as the best route to achieving UHC. According to 2016 WHO primary health care systems report, vaccine coverage, malaria coverage, and HIV screening have all increased as a result of PHC. However, just 7% of the 189 health districts have been covered, which falls short of estimates. Weak monitoring, poor accountability, as well as inconsistencies in information systems, have been blamed for the low coverage (27). Cameroon's government created a growth and development strategy for 2017-2026 in 2009, which enclosed the health sector. Because PHC is administered at the district level in Cameroon, the focus should therefore be on developing and strengthening health facilities in the districts, particularly community-based health services, with the lone goal of achieving UHC. However, because Cameroon runs a centralized health system,

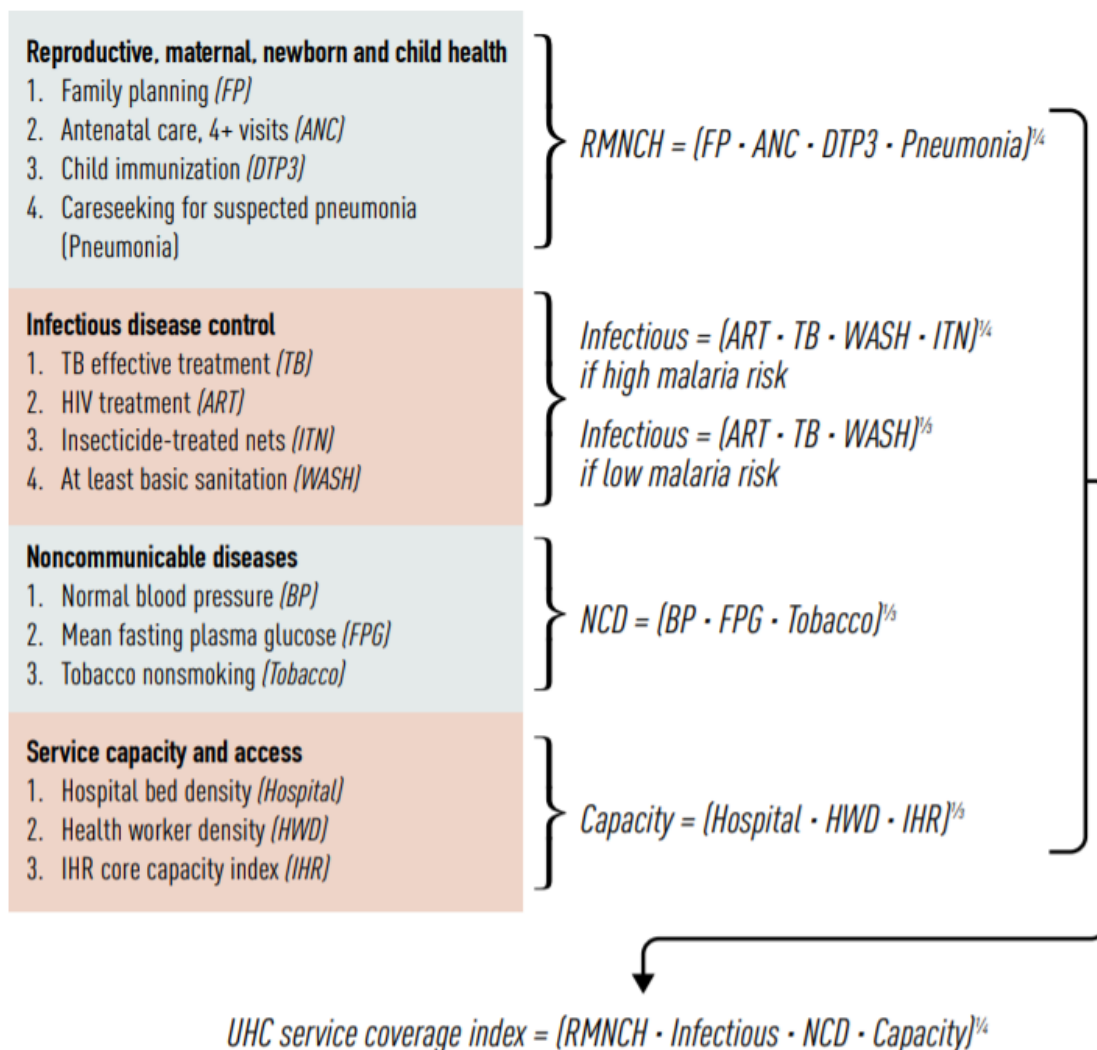


Figure 2. The UHC Service Coverage Index (SCI): Summary of Tracer Indicators and Computation

decentralization of this system has been long debated and faced with strong criticism because it will also mean decentralization of power (28).

Universal Health Coverage-Service Coverage Index

Setting targets to achieve UHC is insufficient if there are no guidelines for measuring each country's progress toward UHC. These guidelines, known as the UHC Service Coverage Index (UHC-SCI), are used to assess how much progress has been made and what areas need to be improved in order to attain UHC. The WHO monitors UHC based on the above-mentioned coverage of essential services. The indicator is often a unitless index with a scale of 0 to 100, calculated as the geometric mean of 14 tracer

indicators of coverage of these essential health services. The tracer indicators are; 1. Reproductive, maternal new born and child health 2. Infectious diseases 3. Non communicable diseases 4. Health service capacity (as shown in figure 2 below) with ideal data sources being household surveys, administrative data and special facility surveys with 2 to 3 years intervals (29).

Despite complaints about not having a clear answer on how to categorize various countries due to a lack of data from most countries and its inaccuracy, the World Bank Group and WHO continue to make efforts to offer information (4). According to a recent WHO and World Bank report, the UHC-SCI, which measures progress on SDG indicator 3.8.1, increased globally from 45 (of 100) in 2000 to 66 in

Table 1: UHC-Service Coverage Index per country for the year 2017

Country	UHC-SCI Index
Canada	89.00
United Kingdom	87.00
United States	84.00
Germany	83.00
Algeria	78.00
Turkey	74.00
Morocco	70.00
South Africa	69.00
Kenya	55.00
Gabon	49.00
Ghana	47.00
Cameroon	46.00
Nigeria	42.00
Democratic Republic of Congo	41.00
Benin	40.00
Chad	28.00

2017 (30). According to recent statistics, Cameroon had a UHC-SCI of 46 (below the 66 norm), while other African countries such as Algeria, Morocco, and South Africa had high scores of 78, 70, and 69, respectively, topping the WHO African region, as shown in table 1 (31).

Algeria is currently one of Africa's leading countries in terms of UHC coverage, not only because of government-subsidized health-care spending, but also because the government is investing extensively to ensure that its inhabitants have access to health care even in the country's most remote areas. The %GDP allocated for health in Algeria is 6.6% as opposed to Cameroon's 3.53% (32). Algeria is also one of the few African countries to be proclaimed malaria-free by the WHO, a great indication of a thriving UHC oriented health system. Health reforms in the country restrict citizens from being denied health care in an emergency because they lack the financial means to pay, and the implementation of e-health cards is another measure targeted at international profiling of the country's health system (32).

The Moroccan government spends 6.5 percent of GDP on health, which is also significantly higher than what the Cameroon government spends. The Moroccan government also offers a national insurance program that covers free immunizations, reproductive, maternal, and child health, as well as

dental and reconstructive surgeries to the poor and underprivileged in order to reduce out-of-pocket health costs (33).

Other African countries included in table 1 have low UHC-SCIs due to a lack of cash, poorly executed policies, religious and language diversities and over reliance on foreign subsidy to fund their health agendas.

Most developed countries, on the other hand, have a better-organized health-care system, more qualified health-care staff, and more resources dedicated to health. Their governments make significant investments in health-care plans that cover their citizens at various levels.

Turkey is one country that has implemented a variety of strategies to ensure that its citizens have access to high-quality health care at low or no cost, including the launch of the health transformation program, which ran from 2003 to 2013, and resulted in many positive changes in the health system governance, financing, and management (34).

Health Reforms in Cameroon

i. SUCAM

The Cameroon government has already started making efforts to achieve UHC. One of these proposals is the creation of an organization that will be in charge of implementing the UHC project known as SUCAM (Santé Universelle Cameroun), which will be mandatory in 2020 with a subscription cost yet to be determined (35). This is a collaboration between Cameroon's Ministry of Health and New Tech Management Cameroon (a South Korean company). The Korean corporation will manage SUCAM for 17 years before handing it back to the Cameroonian government, according to the collaboration agreement. This agreement only exists on paper and has yet to be put into action.

ii. Cameroon Vision 2035

Cameroon's Vision 2035, like that of most governments, is a highly political agenda with theme "An Emerging, Democratic, and United Country in Diversity" The key aims of this vision, dubbed "Emergence Cameroon," are to move Cameroon from a low-income to a middle-income country by 2035, reduce poverty to nearly non-existent levels, consolidate democracy, promote national unity, and invest more energy in becoming more industrialized (36). Although 2035 appears to be a long way off, many Cameroonians are looking forward to a more

developed and less impoverished Cameroon. Despite the fact that these plans have been documented, Cameroonians have yet to see any indication of them being implemented. If Agenda 2035 is effectively implemented, it will not only be a significant political step forward for Cameroon, but it will also be a potent weapon in achieving UHC. Raising people's financial standing enables them to not only meet their basic needs, but also to afford health care, as well as instilling a sense of trust in the government in the minds of most Cameroonians.

CONCLUSION

Low- and middle-income countries with low service coverage and high financial hardship, according to WHO recommendations, require in-depth reform of both service delivery and health funding arrangements, with emphasis on eliminating disparities. Cameroon falls within this category, according to the UHC monitoring report for 2017 and 2019 (30). UHC is undeniably a political agenda, and the government must play a key role in enforcing the right policies, having multiple revenue streams to cover the cost of health, and persuading Cameroonians of the importance of enrolling in insurance schemes, particularly the CBHI in rural areas, in order to achieve it. Furthermore, because it has been established that rural areas have been unfairly treated in the distribution of health resources, enforcing PHC will be the most cost-effective way for securing UHC. Improving health care facilities in rural areas and minimizing anomalies in health worker payments in this region are two further ways to address Cameroon's uneven distribution of health care professionals.

Decentralizing health care is also a good concept because it allows different regions and district health care institutions to make better and healthier decisions specific for their constituents. This could also help to address citizens' mistrust in the government when it comes to their health.

Furthermore, Cameroonians must take charge of their own health and approach health from a more people-centred perspective. Although achieving UHC in Cameroon may seem far-fetched, it is possible with multisectoral coordination between the government, NGOs, CHWs, Civil Society and faith-based organizations, traditional healers and international donors.

Recommendations:

1. The government should increase the health expenditure from 3.53% of GDP to more than 6%. This should be complemented by stringent openness and anti-corruption laws in order to maximize the utilization of any such monies.
2. Out-of-pocket health expenditures should decline from 78.38% to less than 50% by decreasing cost of health care.
3. More locals should be enrolled to spearhead and coordinate the various CBHI in order to regain the trust of the community.
4. Intersectoral collaboration between the government, NGOs, religious and cultural bodies should be encouraged.
5. Because the health challenges in each region differ, the UHC system being built should be decentralized. While keeping the basic goal of reaching UHC, this will better address the specific health concerns experienced in each region.

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REFERENCES

1. WHO. Universal Health Coverage. (Health Science and Health Care2. 2019) 2013 (cited 2021 Aug 18). Available from: https://www.who.int/health-topics/universal-health-coverage#tab=tab_1
2. Gauld R, Blank R, Burgers J, et al. The World Health report 2008 - Primary healthcare: How wide is the gap between its agenda and implementation in 12 high-income health systems? *Healthc Policy*. 2012;7(3):38–58.
3. UHC2030. SDG Indicator 3.8.1: Measure What Matters. 2020 (cited 2021 Mar 20). Available from: <https://www.uhc2030.org/blog-news-events/uhc2030-news/sdg-indicator-3-8-1-measure-what-matters-465653/>

4. WHO. Tracking Universal Health Coverage: 2017 Global Monitoring Report: executive summary. World Health Organization and International Bank for Reconstruction and Development / The World Bank. 2017 (cited 2021 Mar 20). Available from: <http://apps.who.int/bookorders>.
5. CountryReports. Cameroon government structure and political parties. 2017 (cited 2022 Feb 13). Available from: <https://www.countryreports.org/country/Indonesia/government.htm>
6. Worldometer. Cameroon Population - worldometer. 2021 (cited 2021 Mar 21). Available from: <https://www.worldometers.info/world-population/cameroon-population/>
7. Njoda Mathurin T, Ulrich Gaetan M. Labour Force Participation of Cameroonians in Informal Sector. *Int J Innov Econ Dev.* 2015;2(2):43–62.
8. World Bank. Report Urges a Rethink of Cameroon's Informal Sector as Nation Longs for Full Employment. World Bank. 2012 (cited 2021 Mar 21). Available from: <https://www.worldbank.org/en/news/feature/2012/02/21/report-urges-a-rethink-of-camerouns-informal-sector-as-nation-longs-for-full-employment>
9. USAID. Financing of Universal Health Coverage and Family Planning A Multi-Regional Landscape Study and Analysis of Select West African Countries: Cameroon. Usaid. 2017.
10. Global Financing Facility. First-of-its-kind development impact bond launched in Cameroon to save newborn babies. Global Financing Facility. 2019 (cited 2021 Mar 21). Available from: <https://www.globalfinancingfacility.org/first-its-kind-development-impact-bond-launched-cameroon-save-newborn-babies>
11. World Bank. Current health expenditure (% of GDP) - Cameroon | Data. 2018 (cited 2021 Apr 13). Available from: <https://data.worldbank.org/indicator/SH.XPD.CH.EX.GD.ZS?end=2018&locations=MX&start=2000&view=chart%0Ahttps://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=NP%0Ahttps://data.worldbank.org/indicator/SH.XPD.CH.EX.GD.ZS?locations=JP>
12. CNPS. Missions - Caisse Nationale de Prévoyance Sociale. 2014 (cited 2021 Mar 21). Available from: <https://www.cnps.cm/index.php/fr/a-propos/missions>
13. PROMUSCAM. La Mutuelle Communautaire de Santé de Yaoundé : Un mécanisme solidaire de financement collectif d'accès aux soins de santé de qualité. *ritimo.* 2011 (cited 2021 Mar 21). Available from: <http://base.d-ph.info/fr/fiches/dph/fiche-dph-8716.html>
14. Fokunang CN, Ndikum V , Tabi OY, et al. TRADITIONAL MEDICINE: PAST, PRESENT AND FUTURE RESEARCH AND DEVELOPMENT PROSPECTS AND INTEGRATION IN THE NATIONAL HEALTH SYSTEM OF CAMEROON. *Afr J Tradit Complement Altern Med.* 2011;8(3).
15. Ojong N. Healthcare Financing in Rural Cameroon. *Societies.* 2019;9(4):77.
16. Noubiap JJN, Joko WYA, Obama JMN et al. Community-based health insurance knowledge, concern, preferences, and financial planning for health care among informal sector workers in a health district of Douala, Cameroon. *Pan Afr Med J* 2013;16.
17. Kigali. RWANDA COMMUNITY BASED HEALTH INSURANCE POLICY. 2010
18. Nde CJ, Raymond A, Saidu Y, et al. Reaching Universal Health Coverage by 2035: Is Cameroon on Track? *Univ J Public Heal.* 2019;7(3):110–7.
19. Ke Xu, David B Evans, Kei Kawabata, et al. Household catastrophic health expenditure: A multicountry analysis *Lancet.* 2003 Jul 12;362(9378):111–7.
20. World Bank/WHO. Out-of-pocket expenditure (% of current health expenditure) - Ethiopia. 2018 (cited 2021 Mar 21). Available from: <https://data.worldbank.org/indicator/SH.XPD.OO.PC.CH.ZS?locations=ET>
21. MEDCAMER. The Health System – MEDCAMER – Cameroon Medical Doctors. 2020 (cited 2021 Apr 13). Available from: <https://www.medcamer.org/en/the-health-system/>
22. Tandji TE, Cho Y, Akam AJC, et al. Cameroon public health sector: Shortage and inequalities in geographic distribution of health personnel. *Int J Equity Health.* 2015;14(1).
23. Sieleunou I, Turcotte-Tremblay AM, De Allegri M, et al. How does performance-based financing affect the availability of essential medicines in Cameroon? A qualitative study. *Health Policy Plan.* 2019;(34): 4–19.
24. Falchetta G, Hammad AT, Shayegh S. Planning

- universal accessibility to public health care in sub-Saharan Africa. *Proc Natl Acad Sci U S A*. 2020;117(50):31760–9.
25. Id AH, Vogt V, Quentin W. Effect of corruption on perceived difficulties in healthcare access in sub-Saharan Africa. *PLoS One*. 2019;1–12.
 26. Saidu Y, Vouking M, Njoh AA, et al. The effect of the ongoing civil strife on key immunisation outcomes in the North West and South West regions of Cameroon. *Confl Health*. 2021;15(1):1–8.
 27. World Health Organization (WHO). Primary health care systems (PRIMASYS): case study from Cameroon, abridged version. Alliance for Health Policy and Systems Research. 2017 (cited 2021 Mar 20). Available from: <http://apps.who.int/bookorders.%0Ahttp://apps.who.int/bookorders.%0Ahttp://apps.who.int/iris.%0Ahttp://apps.who.int/bookorders>.
 28. Vinet L, Zhedanov A. CAMEROON – Growth and Employment Strategy Paper (GESP). *J Phys A Math Theor*. 2011;44(8).
 29. IndexMundi. UHC service coverage index 2020. (cited 2021 Mar 24). Available from: <https://www.indexmundi.com>
 30. WHO. Primary Health Care on the Road to Universal Health Coverage: 2019 Monitoring Report 2019. (cited 2021 Mar 24). Available from: https://www.who.int/healthinfo/universal_health_coverage/report/2019/en/
 31. World Bank/WHO. UHC service coverage index, 2017 (cited 2021 Mar 24). Available from: <https://data.worldbank.org/indicator/SH.UHC.SRVS.CV.XD?locations=CM>
 32. WHO. Algeria Country context* 1. eHealth foundations National policies or strategies Funding sources for eHealth Country response Global "yes" response eHealth capacity building Country response Global "yes" response Proportion** 2016. (cited 2021 Aug 16). Available from: <http://www.who.int/goe>
 33. Tinasti K. Morocco's policy choices to achieve Universal health coverage. *Pan Afr Med J*. 2015;21:1937–8688.
 34. Aran M, Rokx C. Turkey on the way of Universal Health Coverage through the Health Transformation Programme (2003-13). *World Bank Gr*. 2003.
 35. Christine M. Couverture santé universelle : le chantier est ouvert. *Cameroun Tribune*. 2020 [cited 2022 May 23]. Available from: <https://www.cameroun-tribune.cm/article.html/36491/fr.html/couverture-sante-universelle-le-chantier>
 36. Lutte D, Le Vih C. République Du Cameroun Republic of Cameroon Plan Strategique National. 2011;1–13.