Abidjan 2026 INTERNATIONAL CONFERENCE ON UNIVERSAL HEALTH COVERAGE (UHC)
Advancing a Holistic and Transformative Vision for Africa
Abidjan 2026

CALL FOR ABSTRACTS

Concept Note

The pursuit of Universal Health Coverage (UHC) in Africa is rooted in a historical legacy that must now be reassessed with clarity and intellectual honesty. Contemporary health policies across the continent largely derive from the orientations set forth at the **Bamako Initiative Conference (1987)**, convened under the auspices of WHO and UNICEF. That initiative had the merit of promoting community participation and decentralised management of primary health care through cost-recovery mechanisms and the provision of essential medicines. In a context marked by severe resource constraints and structural adjustment programs, it helped sustain basic services at a time when many state systems were retreating.

Nearly four decades later, however, the Bamako paradigm reveals its obsolescence in the face of contemporary health challenges. By institutionalising a financing logic heavily reliant on direct household payments, it undermined equitable access to care and entrenched chronic financial vulnerability for millions of Africans. According to the **WHO Regional Office for Africa Health Expenditure Atlas (2023)**, out-of-pocket payments accounted for an average of 35.8% of current health expenditure between 2012 and 2020, nearly double the 15–20% threshold recommended by WHO to ensure affordable access to care. This financial burden affects over 200 million people in the WHO African Region, pushing more than 150 million into poverty or deeper deprivation (WHO Africa, 2024). Even more concerning, the number of individuals experiencing catastrophic health expenditures, defined as spending more than 10% of household income on health, rose from 52 million in 2000 to 95 million in 2019, an annual increase of 2.5 million people.

Rural populations, women, and children bear the heaviest burden of this fragile architecture. More than 170 million people in sub-Saharan Africa live over two hours away from a hospital, and 40% live more than four hours away, rendering emergency care effectively inaccessible for the most isolated communities. Sub-Saharan Africa remains the region with the highest under-five mortality rate in the world 68 deaths per 1,000 live births in 2023 (UNICEF). A child born in sub-Saharan Africa is 18 times more likely to die before the age of five than a child born in Australia or New Zealand, and the region accounts for 58% of global under-five deaths. Crucially, this framework was

not designed to build integrated, resilient health systems capable of responding to pandemic shocks, as starkly demonstrated by the COVID-19 crisis. Nor was it conceived to anticipate the demographic and climate transitions already reshaping the continent.

As the 2030 horizon for the Sustainable Development Goals approaches and Africa aspires to genuine health sovereignty, the Bamako legacy appears increasingly insufficient. What is required is both an epistemological and political rupture: a shift from managing scarcity to investing strategically in systemic transformation.

This rupture begins with decisive mobilisation of domestic resources. Africa retains significant untapped fiscal space for health investment. More than two decades after the **Abuja Declaration (2001),** in which African Union Member States pledged to allocate at least 15% of national budgets to health, only three countries (Rwanda, Botswana, and Cabo Verde) have consistently met this target (WHO, 2023). In 2021, African governments allocated on average just 7.4% of national budgets to health, and approximately 95% of the continent's population lived in countries that had not honoured this commitment (Human Rights Watch, 2024). Per capita health expenditure in sub-Saharan Africa stood at only USD 92 in 2021, one-fifth of that in North Africa and the Middle East (USD 379).

Beyond increasing budget allocations, financing mechanisms must be reimagined through innovative sources. In its April 2025 strategy, **Africa CDC** proposed solidarity levies on airline tickets, alcohol, and mobile services, alongside mobilising a share of the USD 95 billion in annual African diaspora remittances. Blended financing instruments will be essential to unlock both public and private capital for investments in health infrastructure, digital health systems, and local production of vaccines and medical supplies. This urgency is heightened by projections that external health aid to Africa may decline by 70% between 2021 and 2025, while health emergencies have increased by 41%, rising from 152 in 2022 to 213 in 2024 (Africa CDC, 2025). Health sovereignty is not proclaimed, it is built through a continent's capacity to finance, produce, and govern its own health responses.

This ambition underpins the Abidjan Conference. The objective is no longer to correct the shortcomings of the Bamako consensus, but to transcend its conceptual framework and forge a new social pact for health, one grounded in the effective realisation of the right to health, intergenerational solidarity, and the conviction that Africa possesses the intellectual, human, and financial resources to shape the next chapter of its health trajectory.

This new pact is structured around ten interdependent thematic axes forming a roadmap rooted in Africa's realities, knowledge systems, and aspirations. Together, they converge on a guiding principle: African health sovereignty. The objective is not merely to "achieve" UHC by replicating external models, but to construct it by and for Africans, transforming power structures, knowledge systems, and economic models that have historically constrained equitable access to health.

The first pillar *(Axis 1)* is economic and financial. Africa can no longer rely on declining external aid or impoverishing out-of-pocket payments. Financial sovereignty must translate into operational models adapted to the continent's realities: risk-pooling schemes tailored to informal economies (community-based mutual health organisations, micro-health insurance), public-community partnerships, progressive taxation mechanisms capturing value from extractive and digital industries, and blended finance instruments integrating public, private, and diaspora capital. Successful experiences such as Rwanda's community-based health insurance and Ghana's National Health Insurance Scheme demonstrate that rapid progress is possible when political will aligns with endogenous financial architecture.

Health sovereignty must also manifest in resilient system architectures *(Axis 2)*. The COVID-19 pandemic exposed fragile supply chains and chronic health workforce shortages. Future resilience demands strategic management of human capital through training, retention, and motivation of health workers, alongside robust regional and local supply systems capable of withstanding global shocks. The transition must be from dependency to strategic domestic production and management.

Legitimacy and effectiveness require authentic health democracy *(Axis 3)*. UHC cannot be decreed from above; it must be co-constructed with citizens. This requires permanent social accountability mechanisms granting communities, particularly marginalised groups such as women, rural populations, and persons with disabilities, real power in monitoring, grievance redress, and service orientation. Equity must be intersectional, acknowledging and addressing compounded forms of discrimination.

The digital lever *(Axis 4)* presents a historic opportunity, provided technological solutionism is avoided. The priority is digital sovereignty: interoperable platforms adapted to local contexts, safeguarding citizen data, and genuinely improving access (e.g., telemedicine) and evidence-based decision-making. Health data must function as a public good for equity, not as a commercial asset or surveillance tool.

Strategic foresight *(Axis 5)* is indispensable. Anticipating pandemic, climate, and demographic shocks is no longer optional. Africa requires systemic foresight integrating ecological, social, and political dimensions to guide complex health transitions and avoid past policy pitfalls.

Structural reforms must also confront political economy dynamics. The political ecology of health systems *(Axis 6)* demands critical examination of who holds decision-making power and how elite interests, pharmaceutical corporations, and donors shape the UHC agenda. Without confronting these power asymmetries, technical reforms will falter. Decentralisation, often promoted as a solution, can exacerbate inequalities if not politically regulated.

Therapeutic sovereignty *(Axis 7)* is strategic. Africa's 70–90% dependence on imported medicines and vaccines constitutes an unacceptable vulnerability. Strengthening local pharmaceutical production through initiatives such as the Partnerships for African

Vaccine Manufacturing (PAVM) integrating traditional medicine scientifically and ethically, and promoting frugal innovation, are essential. Regulation must be African, independent, and anchored in a credible continental regulatory agency.

Planetary health and climate justice *(Axis 8)* are inseparable from UHC. Africa contributes least to climate change yet suffers its most severe health impacts. A "One Health" approach linking human, animal, and environmental health must guide policy, alongside advocacy for climate financing that prioritises resilient health systems.

UHC must also address the core of Africa's economy: informal workers *(Axis 9).* With over 85% of employment in sub-Saharan Africa being informal, innovative contribution models indexed to mobile transactions, market revenues, or agricultural cycles are necessary. Ignoring informal workers would confine UHC to a minority.

Finally, the foundation of this vision is epistemological *(Axis 10).* African health science must no longer mirror external paradigms. A decolonial production of knowledge valuing local expertise, participatory methodologies, and autonomous research agendas is essential for policy relevance and sustainability.

Collectively, these ten axes represent the pillars of a renewed social contract for health in Africa centred on human value rather than profit, and grounded in sovereignty and ingenuity.

The International UHC Conference in Abidjan (2026) holds the historic opportunity to catalyse this transformation. By adopting a holistic framework, it can move beyond repeated diagnostics toward transformative coalitions, concrete policy innovations, and a quantified post-2030 roadmap. It must also address cross-cutting priorities: mental health, antimicrobial resistance, demographic dividend and youth health, and retention of health professionals amid medical brain drain.

The Conference aspires to culminate in the adoption of an **Abidjan Declaration**, accompanied by an operational action plan, a continental monitoring mechanism, and measurable financial commitments. The stakes are clear: ensuring that every person in Africa, without distinction, can access needed health services without financial hardship, through systems that are equitable, resilient, and deeply anchored in the continent's identity and aspirations. Health for all in Africa is not utopian it is a generational responsibility within reach.

Axis 1: Mobilisation of Domestic Resources and Innovative Financing Mechanisms for Sustainable Universal Health Coverage in Africa

Axis 2: Resilient Health System Architectures: Human Capital, Supply Chain Systems, and Adaptive Governance

Axis 3: Health Democracy: Citizen Participation, Intersectional Equity, and Social Accountability

Axis 4: Digital Sovereignty and Transformative Data: Appropriate Technologies for Health Access and Decision-Making

Axis 5: African Health Foresight: Systemic Anticipation of Shocks and Health Transitions

Axis 6: Political Ecology of Health Systems in Africa

Axis 7: Therapeutic Sovereignty and Endogenous Innovation

Axis 8: Planetary Health and Climate–Health Justice

Axis 9: Political Economy of Workers' Health

Axis 10: African Epistemologies and Endogenous Knowledge Production in Health**

Terms and Conditions of Participation

Abstract proposals, ranging from 300 to 500 words and accompanied by five (5) keywords, may be submitted in any of the six official working languages of the African Union (English, Arabic, Spanish, French, Kiswahili, and Portuguese). Submissions must be sent no later than **02 May 2026 at midnight (GMT)** to the following email addresses: **cicsu.org@gmail.com** and **romeotchanga@gmail.com**.

Authors will be notified of the Scientific Committee's decision starting from **02 June 2026**.

Papers and posters will be selected based on their scientific quality, relevance to the conference themes, and originality. Proposals must strictly comply with the content and formatting guidelines. Authors are required to indicate the selected thematic axis and its corresponding number, as well as their institution/organisation, country of affiliation, and email address.

The conference is open to both academics and professionals

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