SENEGAL

FINANCING OF UNIVERSAL HEALTH COVERAGE AND FAMILY PLANNING

Financing of Universal Health Coverage and Family Planning

A Multi-Regional Landscape Study and Analysis of Select West African Countries: Senegal

January 2017

This publication was produced for review by the United States Agency for International Development.
It was prepared by Jenna Wright, Karishmah Bhuwanee, Ffyona Patel, Jeanna Holtz, Thierry van Bastelaer, and Rena Eichler for the Health Finance and Governance Project.

The Health Finance and Governance Project
USAID's Health Finance and Governance (HFG) project helps to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. The five-year, $209 million global project is intended to increase the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG supports countries as they navigate the economic transitions needed to achieve universal health care.

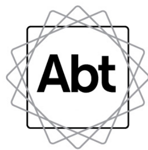
January 2017

Cooperative Agreement No: AID-OAA-A-12-00080

Submitted to: Scott Stewart, AOR
Office of Health Systems
Bureau for Global Health

Eleonore Rabelahasa,
Senior Health Systems Strengthening and Policy Advisor
USAID West Africa Regional Health Bureau

Recommended Citation: Wright, Jenna, Karishmah Bhuwanee, Ffyona Patel, Jeanna Holtz, Thierry van Bastelaer, and Rena Eichler. 2016. *Financing of Universal Health Coverage and Family Planning: A Multi-Regional Landscape Study and Analysis of Select West African Countries*. Report prepared by the Health Finance & Governance Project. Washington, DC: United States Agency for International Development.



Abt Associates | 4550 Montgomery Avenue, Suite 800 North | Bethesda, Maryland 20814
T: 301.347.5000 | F: 301.652.3916 | www.abtassociates.com

Avenir Health | Broad Branch Associates | Development Alternatives Inc. (DAI) |
| Johns Hopkins Bloomberg School of Public Health (JHSPH) | Results for Development Institute (R4D)
| RTI International | Training Resources Group, Inc. (TRG)

FINANCING OF UNIVERSAL HEALTH COVERAGE AND FAMILY PLANNING

A MULTI-REGIONAL LANDSCAPE STUDY AND ANALYSIS OF SELECT WEST AFRICAN COUNTRIES

SENEGAL

CONTENTS

Acronyms.....iii
Acknowledgements.....v
Executive Summary.....vii
8. Senegal.....11
8.1 Country Snapshot.....11
8.2 Background.....15
8.3 Senegal's Health Financing Landscape.....15
8.4 Progress Toward Universal Health Coverage and Universal Access to Family Planning.....18
8.5 Opportunities in Health Financing.....19
8.6 Sources.....20

List of Figures

Figure 1: Senegal Country Snapshot.....13

ACRONYMS

ANAM	*Agence Nationale d'Assistance Médicale* / National Agency for Medical Assistance (Mali)
ANAM	*L'Agence Nationale de l'Assurance Maladie* / National Health Insurance Agency (Benin)
APSAB	*Association Professionnelle des Societés d'Assurances du Burkina Faso* / Professional Association of Insurance Companies of Burkina Faso (Burkina Faso)
CAMNAFAW	Cameroon National Association for Family Welfare (Cameroon)
CAMS	*Cellule d'Appui aux Mutuelles de Santé* / CBHI Technical Support Cell (Cameroon)
CANAM	*Caisse Nationale d'Assurance Maladie* / National Health Insurance Fund (Mali)
CBHI	community-based health insurance
CNPS	*Caisse National de Prévoyance Sociale* / Social Security (Cameroon)
CNSS	*Caisse Nationale de Sécurité Sociale* / National Social Security Fund (Burkina Faso, Guinea)
CONSAMAS	*Concertation Nationale des Structures d'Appui aux Mutuelles et Assurances de Santé* / National Coordination of CBHI Schemes and Health Insurances (Benin)
CPS	*Cellule de Planification et de Statistique* / Planning and Statistics Unit (Mali)
DHS	Demographic and Health Survey
FCFA	West African CFA franc (Burkina Faso)
FP	family planning
GIZ	*Deutsche Gesellschaft für Internationale Zusammenarbeit* / German Corporation for International Cooperation (Cameroon)
HFG	Health Finance and Governance Project
HIV/AIDS	human immunodeficiency virus / acquired immunodeficiency syndrome
HSDP	Health and Social Development Plan (Mali)
INAM	*L'Institut National d'Assurance Maladie* / National Agency for Medical Assistance (Togo)
INSD	*Institut National de la Statistique et de la Démographie* / National Institute of Statistics and Demography (Burkina Faso)
IPM	*Institution de Prevoyance Maladie* / Sickness Insurance Institution (Senegal)
IPRES	*Institut de Prévoyance Retraite et Sociale* / Institute of Social Welfare and Retirement (Senegal)
IUD	intrauterine device

MPHH	Ministry of Public Health and Hygiene (Mali)
MPSWSS	Ministry of Public Service Work and Social Security (Burkina Faso)
MS	*Ministère de la Santé* / Ministry of Health (Togo)
MSHA	Ministry of Solidarity and Humanitarian Action (Mali)
MWCFP	Ministry of Women, Child and Family Promotion (Mali)
NGO	non-governmental organization
NHA	National Health Accounts
NHFS for UHC	National Health Financing Strategy toward Universal Health Coverage / *Stratégie nationale de financement de la santé vers la CSU* (Guinea)
PDS	*Plan de Développement Sanitaire* / Health Development Plan (Niger)
PMAS	*Le pool micro-assurance santé* / The micro health insurance pool (Senegal)
PNDS	*Plan National de Développement Sanitaire* / National Health Development Plan (Benin, Guinea, Togo)
PRODESS	Programme for Social and Health Development (Mali)
PROMUSCAM	*Plateforme des Promoteurs des Mutuelles de Santé au Cameroun* / Platform for the Promotion of CBHI (Cameroon)
RAMED	*Régime d'Assistance Médicale* / Medical Assistance Mechanism (Mali)
RAMU	*Régime d'Assurance Maladie Universelle* / Universal Health Insurance Plan (Benin)
RH	reproductive health
ST-AMU	*Secrétariat technique de l'assurance maladie universelle* / universal health insurance technical secretariat (Burkina Faso)
STI	sexually transmitted infection
TB	tuberculosis
UEMOA	*L'Union Economique et Monétaire Ouest Africaine* / West African Economic and Monetary Union (Niger)
UHC	universal health coverage
UN	United Nations
USAID	United States Agency for International Development
UTM	*Union Technique de la Mutualité Malienne* / CBHI Technical Unit (Mali)
WARHO	West Africa Regional Health Office
WHO	World Health Organization

ACKNOWLEDGEMENTS

This study was funded by the United States Agency for International Development (USAID), and implemented by the Health Finance and Governance Project.

Mr. Abdoulaye Ba, Senior Health Financing Consultant, supported data collection and key informant interviews in Cameroon, Guinea, Mali, and Senegal. Dr. Birahime Diongue, Senior Health Financing Consultant, supported data collection and key informant interviews in Benin, Niger, and Togo. Dr. André Zida, Senior Health Financing Specialist, supported data collection and key informant interviews in Burkina Faso.

The leadership, support, collaboration, and input of USAID/West Africa Regional Health Office (WARHO) colleagues were critical in completing this landscape study and analysis. The authors are grateful for the support provided by Dr. Eleonore Rabelahasa, Senior Health Systems Strengthening and Policy Advisor (WARHO), and Ms. Rachel Cintron, Health Office Director (WARHO). The authors recognize the active participation and collaboration of USAID Missions and multiple implementing partners and non-governmental institutions in Benin, Burkina Faso, Cameroon, Guinea, Mali, Niger, Senegal, and Togo. The authors are also grateful for the input and collaboration provided by Ministries of Health and other government agencies in these countries. The authors are grateful to all the key informants, who shared their time and wisdom (see Annex C for the list).

Finally, the authors are thankful to Bry Pollack (Abt Associates) for editing, Alain Schuster and Julie Verbert (ASJV Associates) for translating, and Erin Miles and Audrey Hanbury (Abt Associates) for designing the report.

EXECUTIVE SUMMARY

Recognizing that a healthy population promotes economic development, resilience, and strength, many governments have started pursuing a universal health coverage (UHC) agenda. The international community, national governments, and private organizations and individuals are converging on the principle that universal access to family planning is a goal worthy of increased financial investment. Improved access to family planning is also important for a country's economic development, and it helps countries improve key population health outcomes for mothers, newborns, and children.

The reality of limited resources for health care has brought increased scrutiny of how health care is financed. To reach UHC, governments are looking to pursue more and better spending mechanisms for health care and to promote financial protection for households. While there is no single or perfect model for financing health care, the health policy community can draw on international experience to identify best practices.

The purpose of this report is to present findings of a landscape study of observed trends and lessons learned from fifteen countries across multiple regions. We conducted detailed analyses of eight countries in West Africa: Benin, Burkina Faso, Cameroon, Guinea, Mali, Niger, Senegal, and Togo ("core countries"). We reviewed the health financing landscapes of seven additional countries at various stages of achieving UHC to draw lessons learned and inform potential strategies: Ethiopia, Ghana, Indonesia, Kenya, Malaysia, Nigeria, and South Africa ("reference countries").

Parties interested in the report may include Ministries of Health or national UHC agencies, regional governments, UHC stakeholders in the West Africa region, the United States Agency for International Development / West Africa Regional Health Office and country Missions, and the private sector.

Chapter 1 of the report discusses the landscape study findings from an analysis across the fifteen countries. Chapters 2–9 of the report present in-depth findings from the eight core countries, including descriptions of each country's health financing landscape and its government's strategies for UHC and family planning, a discussion of the country's health financing challenges and strengths, and potential opportunities for high-impact interventions that could improve the country's health financing landscape for UHC and family planning.

Government Strategies to Pursue Universal Health Coverage and Universal Access to Family Planning

All fifteen governments mentioned UHC or a similar concept in major government health sector strategies, although most countries do not intend to reach universal coverage during their strategy's timeframe. Instead, governments generally plan to implement measures to increase population coverage under existing or new initiatives with a gradual scale-up. In general, countries' UHC strategy documents embrace the concept of progressive universalism, as described by Gwatkin and Ergo (2011) and adopted by the 2013 Lancet Commission on Investing in Health (Jamison et al. 2013). That is, they include multiple strategies to improve coverage for the poor, the informal sector, and the formal sector (and imply this will happen simultaneously). Most countries had specific strategies for engaging the private sector under their umbrella UHC strategy. Family planning, however, was often absent from the main policy documents and was often addressed in separate family planning or reproductive health strategy documents. Governments with separate strategy documents for family planning appear to have more concrete and specific action plans for family planning, whereas governments that mention family planning in a broader health system strategic plan demonstrate less detailed plans.

Although the fifteen countries vary in terms of coverage and use of family planning, many of the strategies for improving access to family planning are common to all of them, such as increasing awareness and demand through social marketing, task shifting to allow for community-based distribution, and increasing the number of distribution points for family planning services.

Health Financing Mechanisms in Core and Reference Countries, and Private Sector Engagement

Even in the least fragmented health care systems, health services are financed through a plurality of mechanisms. Most or all of the health financing mechanisms described below are included in the health financing landscape of all fifteen countries. Levels of service coverage, population coverage, and financial protection varied.

These coverage levels are a key way to measure a country's progress toward UHC and universal access to family planning. To assess the latter, one can evaluate the degree to which health financing mechanisms cover family planning services (i.e., seek to ensure their delivery), the percentage of the population who can and do access those services under each mechanism, and what degree of financial protection is provided for family planning.

Chapters 2–9 of this report elaborate on each of these mechanisms in the eight core countries; lessons from the seven reference countries are woven into the multi-regional analysis of Chapter 1.

Government-financed provision of health services exists in all study countries. Government funding to facilities allows them to operate without charging patients the full cost of providing services. The government often does the purchasing; in some countries, community committees are established to have a say in how facilities spend available funds. In many low- and middle-income countries, the purchasing mechanism employed by government purchasers is *input-based financing* (e.g., paying for health worker salaries, commodities, and infrastructure). Governments often pair such direct financing for health services with *demand-side financing* (e.g., paying for services on behalf of patients to reduce financial barriers to accessing care) to improve equity of access to health services.

User fee waivers or vouchers are two examples of pro-poor financing mechanisms, reducing cost sharing by poor and vulnerable households. Malaysia's experience as an upper middle income country with near-universal health coverage through the public health delivery system provides valuable lessons for West African countries as economies grow, health systems mature, and governments face new challenges arising from an epidemiological transition and an aging population. Governments can implement legal frameworks now to enable health system reforms to address changing needs.

In general, at least some family planning commodities are provided free in facilities and by community health workers who receive public financing, but these distribution systems can be improved. A voucher scheme in Kenya provides targeted subsidies for safe motherhood, long-term family planning methods, and gender-based violence recovery services. These subsidies benefit households as well as public and private providers. They may be applicable in the West African context, where governments are seeking to reduce financial barriers to priority services such as family planning, and to encourage demand and quality improvements among public and private providers.

Social health insurance is often part of a government strategy to purchase health services for members by mobilizing and pooling funds from public and private sources and based on members' ability to pay. Many governments plan to implement or scale up social health insurance schemes and have passed laws to this effect. However, mobilizing the required resources to adequately subsidize even basic benefits for citizens with limited or no ability to contribute can be a challenging and much longer process.

The rollout of Indonesia's ambitious single-payer system starting in 2014 is partly a result of a legal action brought by citizens to hold the government accountable for the 2004 law on the National Social Security System. Nigeria's Basic Health Care Provision Fund needs to receive annual budget appropriations to ensure it gets implemented. In 2012, legislation addressing Ghana's National Health Insurance Scheme reform required inclusion of family planning to be determined by the Minister of Health, but three years later, the government had yet to provide the policy directive and implementation guidelines necessary to make family planning methods part of the scheme. South Africa's government is in advanced preparations to scale up National Health Insurance in a multi-phased approach that is expected to span more than a decade.

Governments need to allocate significant funding to scale up social health insurance, so many countries focus social health insurance programs on employees in the formal sector, where administration is most feasible. However, unequal financial protection between the formal sector (often the wealthier households) and the rest of the population can create a cycle of inequity and higher levels of fragmentation in the health system.

Community-based health insurance (CBHI) is often included the UHC strategies of low- and middle-income countries because of its perceived comparative advantage in targeting and enrolling underserved, uninsured, and largely informal-sector populations into risk-pooling schemes. While increasing the number of CBHI schemes may seem feasible for governments in the short term, the model often leads to government-sponsored health financing mechanisms. For example, in Ghana, community members initially volunteered to manage the schemes; however, eventually they migrated into a more professional management arrangement, and the scheme managers became salaried government staff.

Enrollment in CBHI schemes is often voluntary or not enforced, so schemes are often vulnerable to *adverse selection*, where disproportionate enrollment by high-risk individuals accompanies non-participation by low-risk individuals. CBHI initiatives such as Ethiopia's may eventually evolve into larger risk pools once that transition is operationally feasible for the government. That transition could be beneficial for ensuring CBHI scheme members get financial protection for health services provided by regional or national hospitals.

Private health insurance is a health financing mechanism present in the fifteen study countries, although its role varies from country to country. Private health insurance tends to target wealthier households and workers in the formal sector. There are, however, a few rare examples of private health insurers and private CBHI schemes targeting lower-income households or workers in the informal sector. Some private companies voluntarily offer employees premium subsidies or other health benefits for private health insurance in order to attract and retain skilled people, in Kenya and Nigeria, for example. In general, this model does not contribute significantly to population coverage in countries with small formal sectors.

Household out-of-pocket spending means households pay providers directly for health goods and services at the time of service. This is the dominant financing mechanism in most of the fifteen study countries. Households in all countries invariably pay out of pocket for some health services or commodities, as seen even in Malaysia, where most services are provided free or at very low cost through a strong network of public health facilities. In countries with low levels of other health care financing and risk-pooling mechanisms, out-of-pocket spending on health care accounts for the majority of household spending, and household spending as a proportion of total health expenditure is generally quite high.

There is growing interest in mobilizing private financing. Because household spending is already a large proportion of total health spending and core countries have relatively small formal sectors, this study did not identify many examples of how to engage the private sector in health financing. However,

governments can improve equity and increase efficiency by implementing health financing mechanisms that spread risk among a large pool and protect households from catastrophic costs. Governments must continually reform the health system to pursue better and more-equitable coverage for the population, and the path to UHC needs to evolve over time as population needs and demands change.

Government-subsidized programs that lack the resources to cover all citizens will by necessity or design cover a subset of the population. This can undermine social solidarity and equity, however, and potentially derail the goal of *progressive universalism*. Smaller-scale or more-targeted health financing mechanisms can promote more-equitable access to essential services. Additionally, ensuring universal access to family planning through UHC initiatives is critical.

Many governments of the core countries in this study envision simultaneous interventions to improve financial protection for health care and pursue UHC: finance health facilities with public funds, scale up social health insurance, and encourage the establishment of CBHI schemes to contribute to population coverage of hard-to-reach populations. With relatively small formal sectors, core countries will need to dramatically grow the number of CBHI schemes in order to reach near-universal enrollment among their populations. Population coverage of CBHI and other forms of insurance is low in most of them.

This study's review of health financing landscapes in all core countries reveals several opportunities for each to expand on, or introduce, new health care financing mechanisms that can increase coverage for health care and family planning.

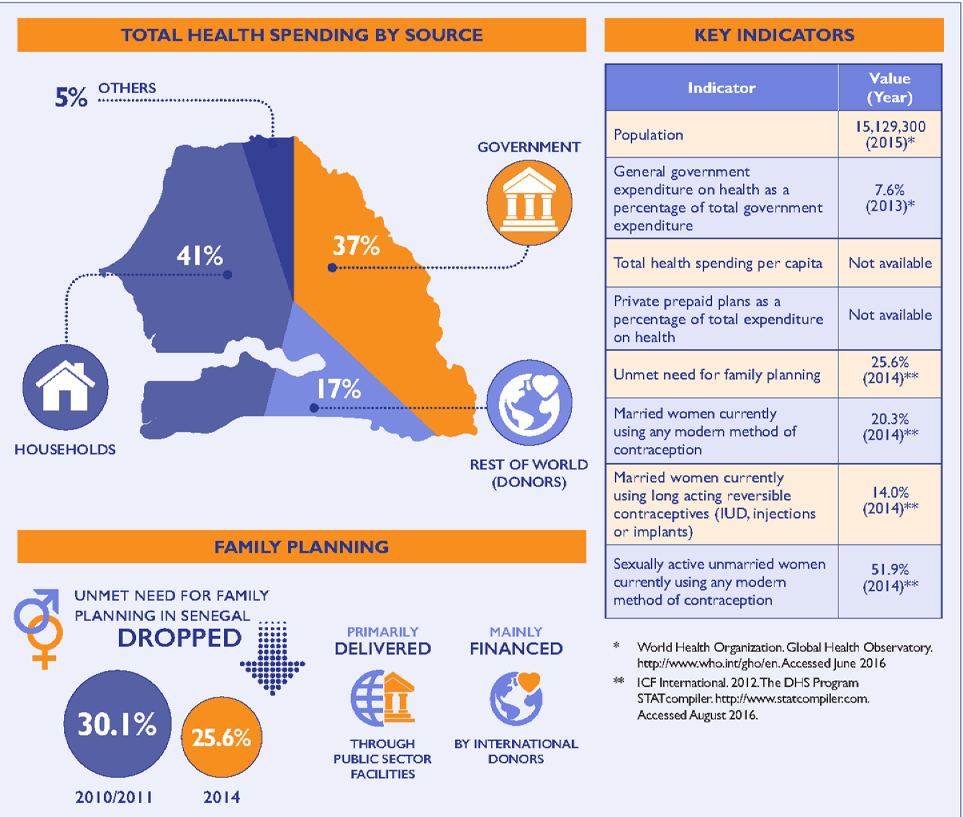
8. SENEGAL

8.1 Country Snapshot

Figure 1: Senegal Country Snapshot

FINANCING STRATEGIES FOR ACHIEVING UNIVERSAL HEALTH COVERAGE AND ACCESS TO FAMILY PLANNING

Senegal's Strategies for Improving Coverage of Health Services



KEY INDICATORS

Indicator	Value (Year)
Population	15,129,300 (2015)*
General government expenditure on health as a percentage of total government expenditure	7.6% (2013)*
Total health spending per capita	Not available
Private prepaid plans as a percentage of total expenditure on health	Not available
Unmet need for family planning	25.6% (2014)**
Married women currently using any modern method of contraception	20.3% (2014)**
Married women currently using long acting reversible contraceptives (IUD, injections or implants)	14.0% (2014)**
Sexually active unmarried women currently using any modern method of contraception	51.9% (2014)**

* World Health Organization. Global Health Observatory. http://www.who.int/gho/en. Accessed June 2016

** ICF International. 2012. The DHS Program STATcompiler. http://www.statcompiler.com. Accessed August 2016.

Senegal adopted a universal health coverage (UHC) strategic plan covering 2013 – 2017. The strategic plan acknowledged that while the country has decades of experience with delivering care through public health facilities and providing coverage through mandatory social health insurance, the informal sector and the poor (approximately 80% of the population) continue to face barriers to access care.[1] In 2012, the Ministry of Health launched a National Consultation on Health and Social Action to build national consensus on reforms in the health and social welfare sector. Based on these consultations, Senegal is pursuing universal health coverage by: a) expanding basic health coverage through community-based health insurance; b) improving the government's ability to target certain populations and monitor progress; c) improving access to care for disabled people; and d) improving financial protection.

Senegal's family planning strategy aims to generate demand for family planning and increase distribution of commodities through the private sector. The majority of family planning users in Senegal obtain commodities and information from a public sector source. Unmet need for family planning dropped from 30.1% in 2010/2011 to 25.6% in 2014.

Challenges and Opportunities

Senegal faces challenges with low enrollment in community-based health insurance schemes by the informal sector and rural households, likely due to a mismatch between the benefits offered by schemes and community needs, making schemes unattractive to potential members. These and other social and private health insurance schemes had enrolled approximately 13.6% of the population in 2012, well below the target of 65.5% by 2017 established in the National Economic and Social Development Strategy 2013 – 2017. Nonetheless, spending through private pre-paid insurance schemes is significant (21.1% of total health expenditure in 2013) due to government regulations that require large private employers and employees to participate in a social insurance scheme managed by private insurers. Public spending is still low. In 2011, the World Health Organization deemed that Senegal had made insufficient progress toward reaching the Abuja target of allocating 15% of its annual budget to improve the health sector.[2] The country has opportunities to further reduce out-of-pocket spending by increasing enrollment in insurance and expanding subsidies for health services.

1 Ministère de la Santé et de l'Action Sociale, République du Sénégal. 2013. Plan stratégique de développement de la Couverture Maladie Universelle au Sénégal 2013-2017. Dakar.

2 World Health Organization. 2011. The Abuja Declaration: Ten Years On.

Public and Private Sector Roles in Health Financing

The public and private sectors contribute to three main health financing functions:

RESOURCE MOBILIZATION	RISK POOLING	PURCHASING
THE PUBLIC SECTOR'S ROLE IN HEALTH FINANCING		
• General tax revenue collected by the central government (37% of THE) • Grants or loans from development partners (17% of THE)	• Health services available at public facilities • Health services available from community health workers • Social health insurance scheme for civil servants pools risk at national level • Social health insurance scheme for retirees pools risk at national level • Community-based health insurance schemes pool risk at the community level	• Central government purchases services from public and private primary, secondary and tertiary health facilities • Central government pays for services through: » User fee exemptions and vouchers for some essential services, and full exemptions for certain groups » Purchase of services by publicly-managed social health insurance schemes on behalf of enrollees » Purchase of services by community-based health insurance on behalf of enrollees
THE PRIVATE SECTOR'S ROLE IN HEALTH FINANCING		
• Household out-of-pocket payments (41% of THE) • Household voluntary prepaid contributions • Premiums paid by private employers to social health insurance schemes	• Private health insurers pool risk at the scheme level • Community-based health insurance schemes pool risk at the scheme level	• Households purchase health services through direct payments for services or through prepaid contributions • Private employers purchase insurance on behalf of employees and their families

Health Financing Mechanisms by Population Segment

Health financing mechanisms available to population segments will vary:

PUBLIC SECTOR

	POPULATION SEGMENT:		
	FORMAL SECTOR	INFORMAL SECTOR: NON-POOR	INFORMAL SECTOR: POOR/ VULNERABLE
Publicly-financed health services	✓	✓	✓ (including enhanced subsidies for certain sub-populations)
Mandatory social health insurance	✓		
Voluntary community-based health insurance		✓	✓ (including premium subsidies for the poorest households)

PRIVATE SECTOR

	POPULATION SEGMENT:		
	FORMAL SECTOR	INFORMAL SECTOR: NON-POOR	INFORMAL SECTOR: POOR/ VULNERABLE
Mandatory social health insurance	✓		
Voluntary private health insurance	✓	✓	✓
Out-of-pocket spending	✓	✓	✓

ABOUT THE SERIES

This country snapshot is one in a series of 15 produced by the Health Finance & Governance Project. The snapshots capture information on public and private financing programs for family planning and health services that support country plans to reach universal health coverage. View the series and a summary report at: www.hfgproject.org.

8.2 Background

Health financing is a core building block of a health system and a key enabler of progress toward universal health coverage and universal access to family planning. Governments often use a plurality of health financing mechanisms to advance toward universal health coverage. In Chapter 1, we presented trends across the health financing landscape across fifteen countries in multiple regions and drew lessons that may be applicable in Senegal and other West African countries. This chapter describes the health financing landscape in Senegal and identifies opportunities where the government and other stakeholders can develop, strengthen, and expand their health financing mechanisms to progress toward universal health coverage and access to family planning.

Health financing specialists from USAID's Health Finance and Governance project collected the information presented below. HFG performed desk research and in-country data collection (key stakeholder interviews, policy and planning document collection) to map public and private health financing mechanisms in the country and identify potential opportunities where the government might expand population, service, or financial coverage for health and family planning services.

8.3 Senegal's Health Financing Landscape

Senegal uses six major health financing mechanisms. Each mechanism is described in more detail below.

8.3.1 Government financing for health services

Government financing for health services is an important mechanism for providing the population financial protection from health costs in Senegal. Results-based financing is being piloted in six regions. The government offers several enhanced subsidy programs for certain vulnerable populations and for certain services. A recent government policy document mentioned an intention to increase the financial resources for the free health care initiatives in the country.

One of the largest such programs is *Plan Sésame*. Established in 2006, *Plan Sésame* provides user fee exemptions for people age 60 and over. Beneficiaries are required to present a national ID card at the point of service. A study from 2011 reported that there was no formal communication plan to promote the scheme at that time. Even so, 48% of surveyed older people were actually enrolled in *Plan Sésame*; those who were vulnerable and more likely to be socially excluded were less likely to be (Parmar et al. 2016). *Plan Sésame* is funded through a government budget line item. The program also uses some funds from the *Institut de Prévoyance Retraite et Sociale*, the old-age pension fund, and the *Fonds National de Retraite* (the national contingency/pension fund for formal employees in the private sector) (Parmar et al. 2016).

Other free health care initiatives financed by the government include caesarean sections in all Senegalese hospitals outside of the capital region; certain services for children under age 5 (vaccinations, provision of therapeutic foods to treat malnutrition, free Vitamin A supplements, and parasite removal); anti-retroviral drugs and anti-tuberculosis treatment; and anti-malarial drugs.

The "*Bajenu Gox*" program is a community health worker program for the promotion of maternal, newborn, and child health. Through the program, 12,000 community health workers are responsible for identifying pregnant women and promoting pre- and post-natal care, child immunization, and family planning. *Bajenu Gox* community health workers are also part of committees targeting beneficiaries of *bourses de sécurité familiale* (family assistance grants) and also participate as committee members of CBHI

schemes. *Bajenu Gox* will soon join the *Alliance du Secteur Privé de la Santé du Senegal* (Private Sector Alliance for Health of Senegal).[A]

Government financing for health services is a critical financing mechanism for supporting distribution of family planning commodities and delivering family planning services in Senegal. The public sector is the main provider of modern methods of family planning. Some 85% of modern method users obtained their family planning method in the public sector in 2013-2014 (Brunner et al. 2016).

8.3.2 Social health insurance

There are three major forms of social health insurance in Senegal. The *Institution de Prévoyance Maladie* (IPM; Sickness Insurance Institution) is a social welfare organization in charge of health insurance for public or private sector workers and their families. The *Institution de Prévoyance Retraite et Sociale* is social health insurance for workers who previously held salaried jobs and their families. *L'imputation budgetaire* (budgetary allocation) is a mechanism by which the state pays 80% of cost of health care for civil servants.

Creating an IPM business or becoming a member of a joint IPM is an obligation of employers of more than 300 employees. IPMs cover 40% to 80% of the cost of covered medical care and drugs. In total, IPMs managed 41% of health spending by all insurers, according to the 2005 NHA report, although IPMs covered only 24% of the total insured population. For comparison, private insurers managed 26% of health spending by all insurers but covered only 8% of the total insured population; *l'imputation budgetaire* for civil servants managed 24% of health spending by all insurers but covered 40% of the total insured population. These statistics imply that IPMs manage and spend less money per enrollee than do fully private insurance schemes, but they manage and spend more money per enrollee than does *l'imputation budgetaire.*

IPRES was established by decree in 1975. In this scheme, a sickness contribution is regularly levied on pensions; in return, IPRES partially covers medical expenses of its beneficiaries.

These mandatory programs cover less than 20% of Senegal's population. According to the Ministry of Health and Social Action, coverage under these social health insurance schemes is only partial and requires significant patient cost sharing.

8.3.3 Community-based health insurance

CBHI schemes have been active in Senegal since the early 1990s, and over the last 20 years have undergone periodic reform. In 2009, the government issued regulations for CBHI schemes, and then in 2012 established a central support unit for them. There is currently a push to implement at least one CBHI scheme in each community and one union of CBHI schemes in each department as part of the government's universal health coverage strategy. (The section "Current Efforts and Strategies to Progress toward Universal Health and Family Planning Coverage" below describes this reform effort.)

Some CBHI schemes in Senegal are sector based. *Transvie,* for example, is a large CBHI scheme available to workers in the transportation sector. However, *Transvie* does not receive any support from the government, and therefore does not appear to fit within the government of Senegal's framework for CBHI recently defined in its UHC strategy. Key informant interviews determined that sector-based CBHI schemes such as *Transvie* are seeking more clarity from the government to confirm whether they are subject to regulations for CBHI.

[A] It is not clear whether the government pays these community health workers and whether they are considered part of the public sector delivery system, given that they are joining the private sector alliance.

Family planning is listed as a service under the basic benefits package that the CBHI schemes regulated through the government of Senegal's framework are required to cover.

8.3.4 Private health insurance

Participation in private health insurance in Senegal is voluntary. Private insurers generally offer generous benefit packages for wealthier households. In 2005, private insurers covered just 8% of the insured population in Senegal but collected and paid out a quarter of all insurance health funds.

According to the draft 2008 NHA report, private health insurers pay out the most money to private pharmacies, followed by public hospitals, private clinics, and laboratories for analysis and medical imaging.

The micro health insurance pool (*Le pool micro-assurance santé,* PMAS) is a partnership of private insurance companies seeking to provide affordable health insurance to low-income people and workers in the informal sector. Six private insurers established PMAS, registering it as an association in June 2012. PMAS acts as a third-party administrator of insurance products, which are offered to organized groups, associations, student groups, women's organizations, and others. PMAS contracts with a mix of public and private sector providers, and its products cover the basic services that are provided in public health centers and the complementary package offered in public hospitals.

The PMAS model appears to be unique to West Africa. The project was designed to provide health insurance products to 108,000 people, but sales and enrollment have proven difficult; to date only about 5,000 people are covered. PMAS offers similar coverage as CBHI schemes but requires higher prepayments from enrollees because it does not receive the same subsidies as CBHI schemes. To be viable, PMAS would require 20,000 enrollees. It is currently operating at a deficit, and the private insurers bear the financial risk. The experience of Senegal could inform how to replicate the model with greater success in other settings.

8.3.5 Household out-of-pocket spending

Households are important financiers and managers of health care funds in Senegal, according to the draft 2008 NHA report. Private sector sources financed 46% of total health expenditure in 2008, and 87% of private sector financing comes from households. Some 13% of household health funds were managed by insurers (IPMs, CBHI schemes, or other private insurers), and the remainder was managed by households in the form of out-of-pocket spending for goods and services.

Households spent the largest portion of their health care funds at private pharmacies, followed by spending at national public hospitals. Nearly 50% of household health care funds were spent on medicines in 2008. Hospital inpatient curative care (excluding drugs, lab services, and radiology) was the next largest portion at 20%. Household spending on family planning services was not specified in the draft 2008 NHA report.

8.3.6 Other health financing mechanisms

Worksite health programs are also part of Senegal's health financing landscape and appear to be unique to this country in the region, based on HFG's literature review and in-country data collection. In *2006, the government decreed that companies with more than 400 employees must have a full-time doctor on site to provide preventive care and avoid occupational, sanitary, and other health risks. Companies in the same vicinity with fewer than 100 workers may share a worksite doctor.*

Companies must provide the doctor's services free of charge. Many companies also provide free services to family and community members. In reality, many worksites employ just a full-time nurse, and a doctor might come once or twice a week. At worksites with many women, a gynecologist might also visit from time to time. However, enforcement of this government decree is weak, and services tend to be quite limited (Brunner et al. 2016).

8.4 Progress Toward Universal Health Coverage and Universal Access to Family Planning

The government of Senegal aims to improve the depth of health coverage that the population currently enjoys through either free and subsidized care programs (Sésame and other free care programs) or compulsory insurance schemes for formal sector workers. IPMs in particular have faced administrative and financial sustainability challenges. An update of the legal framework for IPMs in 2012 aimed to adapt IPM regulations to better position the schemes in the current economic and social context.

The government has also adopted strategies to expand population coverage to reach 100% by 2017 through CBHI. The Ministry of Health and Social Action's Strategic Plan for the Development of Universal Health Coverage in Senegal (2013-2017) describes how the government will promote the growth of coverage through a new governance framework for CBHI. The government created a Universal Health Coverage Agency to implement and oversee the framework. Basic CBHI schemes at the community level will cover entire families and will provide a minimum benefit package. The governance framework also establishes risk pools at the department level through department-level unions. Department-level unions manage benefits provided at level 1 hospitals and provide technical support to CBHI schemes. A regional CBHI union then pools risk at the regional level and manages benefits provided at regional and national hospitals.

To streamline management of newly mobilized UHC funds, the government will establish two financing instruments: the National Health Solidarity Fund (*Fonds National de Solidarité Santé*) and the Independent Fund for Universal Social Protection (*Caisse Autonome de Protection Sociale Universelle*). The funds will become the primary financing mechanisms for expanding coverage in the informal sector by transferring funds to subsidize free care for exempt groups. They will fulfill the following functions: (i) provide subsidies to CBHI schemes to help them expand their benefit packages and promote risk pooling at the local level; (ii) provide targeted subsidies to cover indigent and vulnerable groups through CBHI; and (iii) promote group enrollment by supporting partnerships between CBHI schemes and decentralized micro-financing institutions.

HFG interviews with key stakeholders revealed that the government sees the following next steps for advancing its UHC strategy: establish a legal framework and institutional support; strengthen and professionalize communication surrounding the UHC strategy; and strengthen management of existing CBHI schemes. Despite the National Consultations on Health and Social Action initiative in September 2012 to build consensus on reforms in the health sector and social action, interviews revealed that private sector insurers and associations consider the level of communication and engagement weak.

Compared with other countries in West Africa, the size and scope of Senegal's private health sector is relatively large and is growing. The Ministry of Health and Social Action is currently implementing a contracting policy. The most commonly cited examples of the implementation of this policy were the contracts given to *Santé Familiale* (an NGO that supported workplace clinics) and Action and Development (an NGO with polyclinics in multiple locations) to offer health services with reimbursement schemes. The Private Health Sector Alliance of Senegal (*Alliance du Secteur Privé de la Santé du Senegal)*, created in 2014, helps private health sector organizations including associations and unions form a unified voice (Brunner et al. 2016). A memorandum of understanding was signed between the Alliance and Ministry of Health and Social Action on May 10, 2016.

As part of signing on to the Family Planning 2020 movement, the government of Senegal is implementing its *Plan d'action national de Planification Familiale* (National Action Plan for Family Planning) 2012-2015. The major objectives of the *Plan d'action* are to reposition family planning, help meet the Millennium Development Goals, and reach 27% contraceptive prevalence. Many of the fifty-one strategic actions laid out in the *Plan d'action* relate to strengthening and broadening family planning distribution within the private sector:

- Establishing a multi-sectoral structure dedicated to public-private partnerships
- Broadening the range of social marketing products
- Effective implementation of product delivery by the *Pharmacie Nationale d'Approvisionnement*
- Systematic integration of private data
- Setting up mobile units
- Establishing social franchises
- Increasing the number of points of service in the private sector
- Improving the regulatory framework
- Better regulating the market
- Direct training of private actors, especially for long-lasting methods
- Insurance support for family planning services by CBHI and social security

The plan also noted the desire to revitalize the *Bajenu Gox* program to improve community-based distribution of family planning services.

8.5 Opportunities in Health Financing

HFG's analysis of the health financial landscape in Senegal revealed several areas where the government might focus efforts to develop, strengthen, and expand health financing mechanisms to progress toward UHC and access to family planning.

The government has an opportunity to improve efficiency of the health sector by increasing enrollment in health insurance schemes. While Senegal's rate is higher than in many countries in the region, only about one-fifth of the population has health insurance. The enrolled population comprises mainly formal sector workers and wealthy households. Cost-sharing requirements remain significant under many of these schemes, which may pose a barrier to households seeking promotive and preventive services. The informal sector and poor/vulnerable populations have few options for insurance. The government is implementing an ambitious plan to ramp up coverage to 100% through CBHI, as well as to expand the benefit package available to members of CBHI schemes, by 2017. The government is in the process of mobilizing funds to provide subsidies to CBHI schemes and to department-level CBHI unions.

The government may also identify opportunities to update and adapt government laws and regulations to the existing health financing landscape. PMAS, the organization attempting to bring private health insurance products to the informal sector, has faced difficulties enrolling people due to competition from CBHI schemes that receive government subsidies. Additionally, certain CBHI models such as *Transvie* may also be excluded from current regulations and subsidy programs. IPMs reportedly experience financial difficulty because they are legally obligated to offer a more generous benefit package than the risk pool can finance.

Finally, the government has an opportunity to involve private sector stakeholders in health system reforms. Senegal has relatively robust civil society engagement in health system management, but communication and engagement surrounding CBHI reform could be stronger.

8.6 Sources

Brunner, Bettina, Jeffrey Barnes, Andrew Carmona, Arsène Kpangon, Pamela Riley, Erin Mohebbi, and Leslie Miles. 2016. *Senegal Private Health Sector Assessment: Selected Health Products and Services.* Report prepared by Abt Associates. Washington, DC: United States Agency for International Development, Strengthening Health Outcomes through the Private Sector (SHOPS).

Parmar, Divya, Gemma Williams, Fahdi Dkhimi, Alfred Ndiaye, Felix Ankomah Asante, Daniel Kojo Arhinful, and Philipa Mladovsky. 2014. Enrolment of Older People in Social Health Protection Programs in West Africa—Does Social Exclusion Play a Part? *Social Science & Medicine* 119: 36-44. http://dx.doi.org/10.1016/j.socscimed.2014.08.011.