EXPANDING FINANCIAL PROTECTION BY ADDRESSING NON-FINANCIAL BARRIERS

SENEGAL CASE STUDY

Local Health System Sustainability Project

Task Order 1, USAID Integrated Health Systems IDIQ

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Local Health System Sustainability Project

The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support access to universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year, $209 million project will build local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

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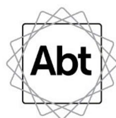

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CONTENTS

Acronyms ... iii
1. Introduction ... 1
2. Background and Country Context ... 3
3. Objectives ... 5
4. Methodology ... 7
5. Scope of this Case Study ... 9
6. Global UHC ... 11
6.1 Description of the Intervention ... 11
6.2 Community Involvement ... 13
6.3 Non-Financial Barriers and Challenges ... 14
6.4 Solutions to Non-Financial Barriers ... 17
6.5 Results ... 17
6.6 Recommendations ... 18
7. The Family Security Grant ... 21
7.1 Description of the Intervention ... 21
7.2 Community Involvement ... 22
7.3 Non-Financial Barriers and Challenges ... 22
7.4 Solutions to Non-Financial Barriers ... 23
7.5 Results ... 25
7.6 Recommendations ... 25
8. The Equal Opportunity Card ... 27
8.1 Description of the Intervention ... 27
8.2 Community Involvement ... 28
8.3 Non-Financial Barriers and Challenges ... 28
8.4 Solutions to Non-Financial Barriers ... 30
8.5 Results ... 30
8.6 Recommendations ... 31
9. Discussion ... 33
10. Bibliography ... 35
Annex A: List of Key Informants ... 39
Annex B: Discussion Guide for Key Informant Interviews ... 41

List of Tables

Table 1. What was done to address non-financial barriers with CBHI? 17
Table 2. Number of children 0-5 reached by the initiative...18
Table 3. What was done to address non-financial barriers with PNBSF?...23
Table 4. What was done to address non-financial barriers with CEC?...30

ACRONYMS

ACMU	*Agence de la Couverture Maladie Universelle* (Universal Health Coverage Agency)
ANSD	*Agence Nationale de Statistique et de la Démographie* (National Agency for Statistics and Demography)
CBHI	Community-based Health Insurance
CBO	Community-based Organizations
CEC	*La carte d'égalité des chances* (Equal Opportunities Card)
DECAM	*Décentralisation de l'Assurance Maladie* (Decentralization of Health Insurance)
DGAS	*Direction* Générale *de l'Accion Sociale* (General Directorate for Social Action)
DGPSSN	*Délégation Générale à la Protection Sociale et à la Solidarité Nationale* (General Delegation for Social Protection and National Solidarity)
IPRES	*Institut de Prévoyance Retraite du Sénégal* (Senegal Retirement Pension Institute)
MOH	Ministry of Health
MSAS	*Ministère de la Santé et des Affaires Sociales* (Ministry of Health and Social Action)
NGO	Non-governmental Organization
PNBSF	*Programme National de Bourses de Sécurité* (National Family Security Grants Program)
RNU	*Registre National Unique* (National Single Registry)
SDoH	Social Determinants of Health
UDAM	*Unité Départementale d'Assurance Maladie* (Departmental Health Insurance Unit)
UHC	Universal Health Coverage
USAID	United State Agency for International Development

1. INTRODUCTION

Health inequities are systematic differences in the health status of population groups; social factors, such as education, employment status, income level, gender, and ethnicity influence an individual's health (WHO 2017). Addressing health inequities is important because it not only affects the groups facing disparity, but also impacts the quality and cost of care, as well as the health of the broader population. One mechanism to address health inequities is extending financial protection schemes to the entire population, including the underserved and socially excluded groups (e.g., rural, poor, elderly, disabled, pregnant women, children, etc.). Low- and middle-income countries often grapple with extending financial protection schemes to the entire population. Countries commonly focus on measures addressing the financial constraints to enrolling the poor and most vulnerable, but many other challenges exist. In addition to financial constraints, there are behavioral challenges that need to be considered to optimize coverage of the poor and vulnerable. These challenges include identifying methods for increasing enrollment and retention in risk-pooling mechanisms as well as increasing access to and utilization of health services.

This case study contributes to the literature and previous work on health equity by the World Bank (World Bank 2018), United States Agency for International Development (USAID) (R4D 2019; Orach 2009), and others (Zelelew 2012), to identify promising approaches and strategies from Senegal's experience to ensure more equitable financial protection, particularly for underserved and socially excluded populations.

2. BACKGROUND AND COUNTRY CONTEXT

Senegal is located at the westernmost point of the African continent. It covers an area of 196,712 square meters with a western coastline of over 700 kms. According to projections by the National Agency for Statistics and Demography (ANSD), its population is estimated at 17,738,795 in 2022, with a population growth rate of 2.5 percent (ANSD 2019). The country is characterized by a disparity in the distribution of the population between the cities of the 14 administrative regions of the country. The proportion of inhabitants is 23.5 percent in the city of Dakar, 20.3 percent in the other cities, and 56.2 percent in rural areas (ANSD 2019).

The illiteracy rate is estimated at more than 50 percent of the population, with 62.3 percent of women and 46.3 percent of men estimated as illiterate (ANSD 2021a). The latest Harmonized Survey on Households Living Standards accounts for a poverty index of 37.8 percent in 2018/2019, a decrease in the poverty level by five points from 2011 (42.8 percent). Despite this decline in the poverty rate, the number of people living in poverty has increased in Senegal (5,832,008 in 2011 compared to 6,032,379 in 2018). Poverty is higher in rural areas than in urban areas (53.6 percent in rural areas compared to 19.8 percent in urban areas). The survey results also show a rise in extreme poverty from 6.8 percent to 12.2 percent over the same period (ANSD 2021a).

In terms of health, Senegal is marked by high rates of morbidity and maternal mortality (236 per 100,000 live births) (MSAS 2018) and infant and child mortality (56 per 1,000 live births) according to the 2017 Demographic and Health Survey (ANSD 2018); a persistence of the communicable diseases burden, despite significant progress over several decades; a rapid increase in the burden of non-communicable diseases, most of which are chronic diseases (diabetes, cancer, hypertension, kidney or liver diseases, etc.) with costly care. The incidence of these diseases within the Senegalese population has a negative impact on the financial resources of households and on labor productivity. To reduce the disease burden, the government has implemented a policy of universal health access for all categories and segments of the population, regardless of where they live. The health system consists of public and private providers with a pyramidal organization at three tiers: central, intermediate, and peripheral. A package of services is provided by a structured community system composed of health huts and community sites. This scheme, which incorporates a referral system and a counter-referral system, is supplemented by the private sector and the health facilities of other sectoral ministries at all levels of the health pyramid.

Senegal's health system funding is supported by several sources of funding, including households, which is the main source of funding (50.3 percent), public administrations (23.2 percent), non-governmental organizations (NGOs), other sources such technical and financial partners (20.2 percent), businesses (5 percent), and local authorities (0.8 percent) (MSAS 2020).

In Senegal, social protection remains a priority for public policies to fight against poverty and improve access to basic social services. To this end, improving the socio-economic conditions of vulnerable groups is one of the major challenges of social protection because access to health care and basic services are less accessible to them and represent a real financial burden due to high costs. The lack of social protection reduces the ability of already poor households to break the cycle of poverty and threatens households that are not yet in poverty with a real risk of falling into poverty.

In the *Plan Sénégal Emergent*, Senegal adopted a vision based on a competitive economy supported by strong and inclusive growth that values human capital, an educated, well-trained, and committed population at the local and national community levels, good governance, and dynamic and balanced territorial development (République du Sénégal 2014). The Government of Senegal has therefore made significant efforts to develop and implement several public policy instruments to support the social protection system. The long-term goal of these efforts is to build a social protection system that is

accessible to all Senegalese, providing everyone with a guaranteed minimum income and health coverage, as well as a comprehensive safety net that ensures the resilience of people suffering from shocks and crises that can drive them into poverty.

After at least two decades of efforts by Senegal to extend social and health protection to its general and most vulnerable population, particularly underserved and socially excluded populations, it is clear that the system designed and implemented through its various mechanisms faces many challenges and bottlenecks, as do other countries that have taken this path. Moreover, the reduction of financial barriers to access services is often the central or essential link in the various mechanisms, with insufficient or even absence of consideration for non-financial barriers, which are therefore less explored and insufficiently addressed.

3. OBJECTIVES

The objective of this Senegal case study is to identify promising approaches and strategies that have been implemented or are being implemented in the country to ensure more equitable financial protection, especially for underserved and socially excluded populations. The case study explores the context and political economy surrounding the barriers (particularly non-financial) to expanding financial protection and focuses on practical experiences and lessons for ensuring more equitable financial protection. This study focuses on community participation and how community platforms, awareness-raising, and health promotion messages have been used to identify and reach poor and vulnerable beneficiaries.

4. METHODOLOGY

This case study employed two qualitative methods: secondary analysis from a literature review and key informant interviews. Data collection took place between January and March 2022.

The literature review covered a wide range of documents including evaluation reports on social protection mechanisms, survey reports, strategy documents on universal health coverage (UHC) and social protection, policy documents and development plans of national and international organizations, other consultation reports, articles, and webography. This documentary review and the initial investigations made it possible to identify the main social protection mechanisms to be analyzed and to highlight the analysis and specificities targeted in the case study.

Interviews were conducted with 22 key informants across three groups: (i) government administrative authorities and their technical and financial partners, (ii) national operational social protection bodies, and (iii) beneficiaries and community organizations (Annex A). The interview guide (Annex B) used to collect information was structured around several sections describing: the overview of the social protection mechanism, the context and political economy surrounding the decision to improve equity, the design of the intervention and the stakeholders, the identification of non-financial barriers addressed by the mechanism, the level of community engagement, the difficulties and challenges encountered in reaching the target populations, and, finally, the results achieved by the mechanism and useful lessons from the intervention. Key informants were appraised of the objectives of the study and their consent was obtained before proceeding with the survey. Individual and group interviews were recorded on a digital medium. These audio-recorded interviews were then transcribed, processed, and analyzed.

5. SCOPE OF THIS CASE STUDY

In Senegal, social protection mechanisms targeting the general population and particularly the most vulnerable, underserved, and socially excluded are varied and involve several sectors. In general, non-financial barriers to people using social protection schemes to access health care services are closely related to social determinants of health (SDoH); therefore, some of the initiatives in this case study aim to describe how Senegal is trying to address these SDoH related to their impact on demand for health.

This case study explores three social protection schemes in Senegal:

- Community-based Health Insurance (CBHI) program, which provides general financial protection through mutuelles and includes free health care mechanisms (free caesarean section, free care for children under five years old, free dialysis under Plan Sesame).
- National Program for Family Security Grants (*Programme national de bourses de sécurité familiale* (PNBSF)), which provides regular monetary transfers to targeted families below the poverty line and facilitates the enrollment of these vulnerable populations in CBHI.
- Equal Opportunity Card (*La carte d'égalité des chances* (CEC)) program, which aims to reduce inequalities faced by people with disabilities by providing them subsidized access to basic social services and facilitating their enrollment in CBHI schemes.

Beyond financial protection, the PNBSF and CEC programs address certain non-financial aspects that have an impact on the demand for care, such as access to transportation, access to employment, and poverty, which generally prevents certain populations from using the free health care services made available to them in health facilities because they are unable to forego the income from a missed working day.

6. GLOBAL UHC

6.1 DESCRIPTION OF THE INTERVENTION

6.1.1 COMMUNITY- BASED HEALTH INSURANCE COVERAGE

CBHI is the main mechanism of Senegal's UHC program. CBHI falls under the responsibility of the Universal Health Coverage Agency (ACMU), which was created by presidential decree in 2013. The basic principle of CBHI is for its member beneficiaries to better manage risks related to sickness. The first CBHI schemes (*mutuelles*) were set up in 1988 (Fandene CBHI in the region of Thiès) (MSAS 2013).

At the start of the UHC program, there were two CBHI strategies. The first was called Decentralization of Health Insurance (DECAM). It was based on the expansion of CBHI, following the example of the CBHI strategy implemented in Rwanda. The objective of DECAM was to create a strong CBHI movement and community ownership of the new policy, and then to create the conditions for networking among CBHI schemes to strengthen risk sharing. The second strategy consists of creating professionally managed CBHI departments (Departmental Health Insurance Unit or UDAM), in which communities play only a supervisory and social mobilization role (MSAS 2013).

DECAM was implemented in 43 departments (out of 45 in the country) and the UDAM model was implemented in the other two departments. The models differ in their territorial scale of pooling of resources and mode of governance. In DECAM, there are two levels of pooling, the department and the commune (or an intra-communal level), whereas in UDAM, all risk is shared within the department. Regardless of the strategy, benefits are targeted at all social levels and a primary member must be at least 18 years old. Each member can have up to 18 beneficiaries. With an exemption ranging from 50 to 100 percent depending on the benefit, the basic package of care covered by CBHI extends from the health post to the health center. The departmental unions of CBHI schemes cover a complementary package of more extensive care that is provided at the hospital level or EPS (public health facility) and requires a letter of guarantee. Based on a reference form, the beneficiary receives a letter of guarantee from their CBHI scheme that allows them to access the hospital package at public and private health care facilities in return for their antecedent share (20 percent for the public and 50 percent for the private facility) (MSAS 2013).

The ACMU, the health care purchaser responsible for the implementation of the UHC program, is a powerful institution that allows the government to put in place an efficient health financing system. The financing is done mainly through government subsidies and members' contributions. Through the public treasury, the government pays half of members' annual CBHI contributions of FCFA 3,500 per member. The other half of the annual contribution and the membership fee of FCFA 1,000 are paid by the member. In addition, there is financial support from the government's financial partners, such as the French Development Agency, USAID, and the Japan International Cooperation Agency. These financial partners contribute to subsidize the fees of certain targeted groups and give financial support to operational activities, and studies and assessments of the UHC policy (MSAS 2017).

For community health care coverage, the decision-making process involves several parties including the government through line ministries, particularly the Inter-Ministerial Committee (the Ministry of Health and Social Action (MSAS), the Ministry of the Budget, the Ministry of Labor, the Ministry of Local and Regional Authorities, the Ministry of Informal Sector, and the Ministry of Community Development, Social and Territorial Equity, and the General Delegation for Social Protection and National Solidarity (DGPSSN)), partners, and local and regional authorities. The National Forum, which is attended by all the above ministries and other stakeholders involved in social protection, is an annual springboard for deciding on the CBHI main orientations.

CBHI schemes have a general assembly, which provides policy directions to the scheme. Each scheme has a board of directors that identifies strategies for implementing the policy directions. Once the activities are identified, the scheme's technical team and the executive committee implement and report on them. The technical partners participate in management of CBHI schemes by sharing advice and best practices based on their experience (MSAS 2013).

6.1.2 FREE INITIATIVES

The ACMU also manages free health care initiatives in Senegal, based on a clear political incentive to facilitate access to health care for certain sections of the Senegalese population.

The introduction of free caesarean sections was phased in, starting in 2005 in the regions of Kolda, Ziguinchor, Fatick, Matam, and Tambacounda and extended to the entire country in 2014. Any Senegalese woman who is pregnant and whose health or that of the fetus requires delivery by caesarean section is eligible to receive the procedure free of charge in any public health facility in the country that can perform the procedure, namely hospitals and health centers with operating theaters or Emergency Obstetric and Neonatal Care (EmONC). Health facilities were initially reimbursed FCFA 55,000 per caesarean section; this amount increased to FCFA 85,000 in 2014 and includes pre-operative examinations or assessments, the kit, and the operating procedure (ACMU 2020).

Free dialysis in public health facilities for patients suffering from chronic renal failure was instituted in April 2010 by MSAS. MSAS provided the dialysis kit to the health facilities which, in return, agreed to reduce the price paid by the patient, that is, FCFA 10,000 instead of FCFA 50,000 (and FCFA 36,000 instead of FCFA 860,000 for peritoneal dialysis). These copayments were abolished in 2012 in public health facilities with the continued involvement of private health facilities in the treatment. The following services are free of charge for patients who undergo dialysis at a public facility:

- The dialysis treatment
- The hemodialysis kit or the peritoneal dialysis kit

To benefit from this free treatment, the patient must register on the waiting list of a public facility dialysis center.

The Sesame Plan aims to ensure that Senegalese aged 60 and over receive eligible health care at public health facilities. This coverage is 100 percent for persons who do not benefit from any pension or other health coverage. The Sesame Plan does not cover those who benefit from coverage under the Senegal Retirement Pension Institute (IPRES), a scheme primarily for private sector employees, the National Pension Fund (FNR) for governmental and public sector employees, and those affiliated with any other compulsory insurance scheme or private insurance. Sesame Plan has been in place since September 1, 2006. Initially, it was intended to be effective in all public health facilities, but it seems to only be operational in hospitals. Over the years, Sesame Plan has undergone other changes:

- For retired civil servants, the Sesame Plan complements the budget allocation and covers the 20 percent co-payment fee borne by the patient.
- Essential drugs are covered by the Sesame Plan since the budget allocation does not reimburse drugs.
- For IPRES retirees, Sesame Plan provides access to all public health facilities, in accordance with an agreement signed between IPRES and the MOH on April 19, 2006, granting IPRES preferential rates in public facilities.

Free health care for children under five years of age began October 1, 2013. Any Senegalese child who holds a health record, a birth certificate, a vaccination record, or any other civil status document that can attest to the age of the child is eligible. It was established by a notice from the

Minister of Health on September 26, 2013, and grants an exemption from payment at the level of health posts, health centers, and hospitals for different types of services. A second circular, on March13, 2014, specified the financial terms of the plan and the content of the benefits covered and excluded according to the level of the health pyramid. All public health facilities in the country (health posts, health centers, and hospitals) are covered by this free health care. At the health post level, the following are free: (i) consultation, (ii) generic medicines (Bamako initiative), and (iii) vaccinations. In addition to the free package, hospital fees (including hospital stays) are fully covered at the health center level. As for the hospital level, the exemption from payment relates to emergency consultation and consultation for referred cases (ACMU 2020).

6.2 COMMUNITY INVOLVEMENT

In both the DECAM and UDAM strategies, community involvement is at the heart of the mechanism for CBHI set-up the CBHI, decision-making, functioning, and evaluation. A former CBHI member interviewed recalls that the DECAM program is based on the principle that "*these are CBHIs by the beneficiaries, for the beneficiaries and with the beneficiaries.*"

After the creation of a CBHI scheme, it is up to the community to set up a general assembly, and decide on the management system and appoint the managers. The management of CBHI schemes and departmental unions in DECAM and UDAM is carried out by an executive office, made up of elected and voluntary representatives. The announced greater professionalization of the UDAM bodies, compared to those of the DECAM, is not to the detriment of community participation. The CBHI activity is supervised by the board of directors, elected by the general assembly from among the CBHI members.

Findings suggest that community participation remains a challenge, especially in decision-making and accountability processes. Beyond the decision-making bodies, community involvement can be seen in awareness-raising, training, and monitoring contributions in the locality. With the support of a delegation consisting of representatives of the regional union and the departmental union of CBHI, the community is involved in raising awareness about CBHI and in enrolling the population. However, the role of the community in the implementation and management of CBHI initiatives has shortcomings:

- Key factors like poverty or vulnerability of the population, as well as financial and non-financial barriers, are often not sufficiently considered. This results in gaps in the participation of the population in the daily activities of CBHIs.
- Beneficiaries' assessing of the quality of services still needs improvement. The communities should defend the interests of the beneficiaries. They should ensure that community complaints are taken seriously and that deficiencies and gaps in achieving the CBHI scheme's objectives in terms of enrollment and credibility are addressed.

The voluntary involvement of the communities in the management of the CBHIs sometimes affects the performance of the unpaid and poorly trained staff. This has contributed to the weakening of some of the operating mechanisms of the CBHI schemes. It also hinders schemes from achieving their objectives. Actions are increasingly being taken to financially motivate and develop the management and leadership skills of CBHI staff hired by the local and national authorities. This professionalization of CBHI schemes is an important aspect that does not detract from community involvement in the schemes. On the contrary, it should strengthen community involvement in the scheme management.

Community involvement in the management and implementation of free initiatives remains mixed and fragmented, depending on the scheme. For certain schemes, there are organizations, associations, or federations of beneficiaries that monitor and supervise activities in favor of the care of beneficiaries, such as free dialysis. Generally, the more targeted the initiative (like free dialysis) the easier and more

efficient it is to involve the community. However, for other schemes and services such as caesarean sections and for children under five, community involvement is still linked to the management and coordination framework set up by the ACMU in accordance with the global UHC plan. Beneficiary associations carry out several actions including awareness-raising to help address the barrier caused by lack of information about the existence of social health protection and the services offered by these mechanisms. These associations also collect data to monitor service delivery in health facilities to help address barriers to care, like long wait times, low perception of quality of care, and frequent stock-outs of important medical goods. The associations help resolve problems and bottlenecks in collaboration with the ministries involved and the ACMU. In addition, they manage communication with stakeholders, manage complaints, intervene in resource mobilization advocacy activities, and convince other actors and partners to support the free programs. Their actions have produced important results including mobilizing authorities, philanthropists, and even donors for significant contributions and funding. An example of this in Touba involved the religious leader granting land worth FCFA 30 million for a hemodialysis center and contributing FCFA 1 billion to its construction. The beneficiary associations' managers intervene on a voluntary basis and without apparent compensation, which nonetheless does not impact their level of performance. The limited resources for the functioning of these associations come from the contributions of the members themselves, who are often already financially burdened by expenses related to illnesses.

6.3 NON-FINANCIAL BARRIERS AND CHALLENGES

The implementation of the UHC global strategy through CBHIs, as a basic mechanism to facilitate access to care and free health care initiatives, still faces non-financial barriers that limit its effectiveness. These challenges include:

Program steering and coordination

- **Lack of stakeholder consensus**. A rupture in the initial consensus between actors in the UHC program (the government, CBHIs, societies, partners) occurred due to institutional instability and inadequate management, the lack of documentation on the results obtained during the 2014-2017 period of program implementation, and the adoption of a new approach at the institutional level with readjustment difficulties.
- **Challenges with inter-ministerial coordination**. The DGPSSN, previously attached to the Presidency of the Republic, has been demoted to the rank of sub-directorate of the Technical Directorate for Social Equity. This demotion hinders DGPSSN's role in coordinating inter-ministerial bodies and conferences for social security.
- **Social protection mechanisms are fragmented across several ministries.** The fragmented nature of social protection mechanisms around several ministries and institutions (including the technical and financial partners) causes difficulties in coordination and funding. For example, the MSAS carries out disease prevention and health promotion activities without always coordinating with the UHC system or free-of-charge mechanisms. This lack of coordination leads to incoherence and limited coordination in population guidance and awareness-raising.

Benefits package design and communication

- **Insufficient communication strategies to reach beneficiaries**. Populations are not always well informed about the existence of the health protection mechanisms available in their communities and the services offered by these mechanisms. This lack of awareness is due to shortcomings and difficulties in mass communication and beneficiaries' limited geographic access to health facilities, which further limits their exposure to information about the local CBHI scheme. There are insufficient communication strategies to overcome the lack of awareness on insurance for

certain populations, who still rely on family and community solidarity during an episode of illness. Some CBHI schemes have tried to implement innovative and ambitious communication strategies with appropriate, targeted, and convincing messages to strengthen the CBHIs membership. They have worked to involve local and regional authorities in the dissemination of messages to raise awareness for CBHIs. But more progress needs to be made in this area.

- **Socio-cultural and religious messages.** Socio-cultural and religious factors continue to impede the use of health services and indirectly affect adherence to CBHI, especially in environments (like rural areas) where traditional medicine remains the first recourse to care. Additionally, there is false information about the non-functionality of the universal health insurance system and free health insurance initiatives.
- **Lack of an insurance culture**. Messages like "*why contribute when you are healthy,"* and *"contributing for a healthy person to take care of him in the event of illness attracts bad luck"* are given by some populations.
- **Low benefits package coverage**. The UHC health care package is not attractive, particularly in view of the increased incidence of non-communicable and chronic diseases, which UHC does not explicitly cover.
- **Misunderstanding of what is covered by the free services**. The free-of-charge services only cover the medical intervention and some drugs (in some cases). Other treatment-related costs continue to be the patient's responsibility. For example, in the case of caesarean sections, only the kit, the pre-operative examinations, and the surgery are covered at 100 percent. The other direct and indirect costs are paid by the patient; they include medical control analyses, certain drugs and consumables outside the kit, food, and transportation expenses for accompanying persons.
- **Challenges in accurately targeting beneficiaries.** There are administrative costs associated with putting in place elaborate arrangements to assess beneficiary eligibility. Additionally, challenges in targeting the beneficiaries of financial risk protection mechanisms, with inclusion errors in the non-eligible segments of the population, can lead to poor performance in the financial viability of programs. For example, some elderly beneficiaries of IPRES go to hospitals to benefit from Plan Sesame. There are no mechanisms for systematically checking whether the parents of a child have any other forms of coverage.
- **Limited geographic accessibility.** Geographical access to CBHI services is still limited. This is especially true for rural populations for whom transportation to services is often unpredictable, such as road inaccessibility, particularly during the winter. The physical distance between rural populations and the nearest health facilities, particularly hospitals, is another problem. For example, patients face significant challenges accessing free dialysis because public dialysis centers are mostly located in large cities and do not cover the entire country; in addition, contracting with the private sector for dialysis is inadequate—only one private facility is involved. Yet another problem is the lack of portability of benefits, that is, the inability of a CBHI scheme beneficiary to access services outside that scheme's catchment area. Schemes cannot afford to offer portable benefits, which discourages mobile populations from joining.
- **Information systems**. Computerization and interconnection of the different sectoral information systems is inadequate to achieve interoperability between the software used by the supply and demand of care. Addressing this challenge could allow nationwide portability so that members of each CBHI scheme can access care in any health facility in Senegal.
- **Need to address other factors that influence SDoH**. While CBHI and the provision of free services support access to health services and promotes social health protection for vulnerable and socially excluded groups, health issues are only one of many challenges facing these groups. In

parallel with social health protection, other financial and non-financial support measures need to be considered to help address other factors—including education, literacy, and employment—that ultimately influence good health outcomes.

- **Provider discrimination against vulnerable and socially excluded populations**. Vulnerable and socially excluded beneficiaries of the UHC policy often face differentiated treatment and sometimes even poor reception by providers. This results from the cash flow difficulties experienced by those health facilities because of the delay in the repayment of debts for benefits billed to the ACMU.
- **Perception of low quality of care and frequent stock-outs**. Large households' size, head of households' low levels of education and income, and the perception of poor quality of care still hinder access to and use of CBHI services. The perception of poor quality of care discourages utilization of services. Additionally, there are frequent stock-outs of important products for the management of free services, such as dialysis. There are difficulties in supplying kits and drugs (anti-rejection drugs) for transplant patients.
- **Administrative bottlenecks**. The waiting time and the cumbersome administrative procedure to obtain letters of guarantee discourage the use of free services. An inferiority complex among people with low levels of education, who are put off by the administrative procedures required to join CBHI, discourages joining.

Financing

- **Lack of cost data**. There is a lack of precise data on the estimated real costs of the UHC policy and its various components. This information gap constrains the objective of progressive adaptation of the social protection package and negatively affects the solvency of the UHC policy.
- **Need for strengthened financial support from local authorities**. Strengthened financial support from local authorities, in a context of decentralization, is needed to improve CBHI viability. For example, local authorities could provide support by covering some CBHI costs expenditure, such as compensation of managers.
- **Delays in payments and reimbursements**. Delays in payment of the state grant contributions to schemes and the reimbursement of the exempted (free) services affects the entire health care purchasing chain and causes tensions between the beneficiaries, CBHI schemes, and providers. The real cash flow problems that this situation causes at the level of CBHI schemes and providers constitute a major risk for the sustainability of the UHC policy.
- **Resource mobilization**. There is need to identify ways to expand fiscal space for health and innovative resource mobilization strategies to facilitate the expansion of protection mechanisms and the inclusion of more beneficiaries. For example, in the case of the municipality of Foundiougne, the leaders of the CBHIs in collaboration with the local authority increased the price of consumer goods by a few cents; the revenue earned in this way covered most of the contributions for the most vulnerable. In Médina Cissé village, Karine commune, CBHI leaders set up a "smart contribution" system by increasing the price of water collected at the fountain by FCFA 5 per container. This amount was used to pay the villagers' contribution to reach 100 percent coverage.

6.4 SOLUTIONS TO NON-FINANCIAL BARRIERS

Table 1. What was done to address non-financial barriers with CBHI?

Non-financial barrier	What was done to address the non-financial barrier?
Lack of information about social health protection **Socio-cultural and religious barriers**	Community involvement has been critical for awareness-raising about CBHI and in enrolling the population. Some CBHI schemes have tried to implement innovative and ambitious communication strategies with appropriate, targeted, and convincing messages to strengthen the schemes' membership. They have worked to involve local and regional authorities in the dissemination of messages to raise awareness of CBHI. But more progress is needed in this area.
Perception of low quality of care (including frequent stock outs) **Administrative bottlenecks (including delays in payments and reimbursements)**	Beneficiary associations collect data to monitor health care in various health facilities to help address the barriers around long waiting times, low perception of quality of care, and frequent stock-outs of important medical goods. The associations contribute to the resolution of problems and bottlenecks in collaboration with the ministries involved and the UHC agency.

6.5 RESULTS

Changes in the UHC policy are encouraging from the point of view of geographical coverage overall, but coverage still varies from one region to another. Also, efforts still need to be made to achieve objectives such as the mobilization of additional resources and, above all, the expansion of the UHC package of services to make it more attractive and adaptable to the needs of each potential member.

Financial viability: According to the key informants, the UDAM model[1] produces better results than the DECAM model. The proportion of UDAMs in deficit was 0 percent in 2019, whereas the proportion of DECAMs in deficit was 32.35 percent according to a report the Consortium for Economic and Social Research on the "the evaluation of the Universal Health Coverage program in Senegal" 2020 (CRES 2020a).

Population coverage: Regarding the coverage rate, the UDAM in the department of Foundiougne records 194,283 beneficiaries out of a target population estimated at 364,800 as of December 31, 2021, for a coverage rate of 53 percent. In the department of Kaolack, UDAM has 176,446 beneficiaries for an estimated target population of 625,022, for a coverage rate of 28 percent. (CRES 2020b). There are two reasons for this situation:

- The large size of the UDAM CBHIs at the department level, which means less fragmentation
- The greater professionalization of UDAM bodies than those of the DECAM. Actions are increasingly being taken to financially motivate and develop the management and leadership skills of CBHI staff hired by the local and national authorities, to further strengthen community participation. The board of directors, elected by the CBHI members' general assembly, still defines the CBHI directions.

[1]It should be recalled that there are only 2 UDAM-style CBHI in Senegal against more than 2,000 CBHIs with the DECAM model.

The report on UHC states that the provision of free health care for children under five years of age has reached an average of 2,229,080 children covered in 2017–2019. In terms of reaching the target, these results are satisfactory and are improving over time (ACMU 2020). The percentage of sick children treated in relation to the targeted number has increased from 97.71 percent in 2017 to 105.11 percent in 2019 (Table 1) (ACMU 2020). This potentially shows better targeting of the children covered. The number of children targeted each year is a projection made based on the number of sick children treated the previous year, and on the assumption of a single episode of illness per child. This method of projection led to an underestimation of the number of children expected in 2019, which was exceeded (105.11 percent) and can be explained by the fact that the children would have contracted several diseases during the period (ACMU 2020). This observation can be easily supported when we know that children can develop several conditions during a given period.

Table 2. Number of children 0-5 reached by the initiative

	2017	2018	2019
Number of children treated	2,635, 509	1,822, 651	1,965, 881
Number of sick children targeted	2,697, 309	2,635, 509	1,870, 368
Percentage	97.71%	69.16%	105.11%

Source: ACMU (2020)

Equity of access: Based on a report by the Consortium for Economic and Social Research (CRES 2021), the Sesame Plan, free health care for children under five, and free dialysis are used more by men than women. The urban/rural difference shows that the rural areas benefit more from free health care initiatives (53.7 percent against 46.3 percent for the urban area). More specifically, free health care for children under five and free dialysis are more available in rural areas, because people in rural areas are considered to be more vulnerable, particularly in access to basic social protection. However, urban areas benefit more than rural areas from the Sesame Plan free caesarean sections (CRES 2021).

6.6 RECOMMENDATIONS

The following recommendations emerged from the analysis of our key informant interviews:

- To guarantee the sustainability and financial viability of the social protection system, which also requires a capacity to mobilize significant contributions, several key informants recommended that the state should consider a "compulsory membership" and that, for example, to ensure compliance, proving CBHI coverage could be a requirement to apply for a driver's license or national identity card. Note that this option may risk further restricting access to services for already vulnerable populations.
- To avoid the fragmentation of interventions and mechanisms, a cross-cutting entity should be set up dedicated to the coordination of the social protection sector for more visibility, convergence, and synergy. It should comprise representatives of the various social protection organizations and mechanisms (PNBSF, CEC, ACMU, etc.).
- To strengthen inter-ministerial coordination, organizational capacity development should be provided to the Ministry of Community Development, Social and Territorial Equity to fulfill its leadership role and responsibilities in terms of implementing the UHC policy. This ministry should be able to fully carry out the effective coordination of social protection in Senegal.
- To enable community actors to participate more effectively in social protection mechanisms, the leadership capacities of community actors should be strengthened and communities given a central role in the social protection system, through technical and financial support for citizen accountability bodies such as community-based organizations (CBOs) and professional associations. Through these actions, community actors will be able to participate more effectively in the implementation of social

protection strategies. Examples of effective community actors' participation include the collection of contributions through the CBOs, and grouped contributions through the Economic Interest Groups (GIE).

- To address the challenges around benefits package coverage, the UHC program must prioritize the process for updating the content of the social protection package based on the financial, technical, and human resources available. This process should align with the priority needs of the various population groups, and the cultural and social aspects of the country. There will be tension between meeting all the priority needs and working within the resources available.
- To address the challenges to awareness and communication, it is necessary to develop an inclusive communication strategy with the participation of community actors who are in direct contact with the community and can disseminate messages effectively, while also involving local authorities who can include information on CBHI in their interventions and recurring activities related to other sectors such as education, environment, and sanitation.
- To make the social health protection schemes more attractive to beneficiaries, CBHI must expand its packages to include other services, such as supporting funeral costs, retirement, maternity, and work accidents, to become a socially based health insurance organization. In accordance with West African Economic and Monetary Union regulation 007-2009, it is through this vision that the federation of CBHIs, via its strategic plan, intends to carry out actions to better consider non-financial aspects and other non-health services to shift from CBHI to socially based health insurance organizations.
- To address resource constraints, substantial domestic financial resources need to be mobilized based on alternative, innovative, and intelligent financing models. This strategy can be implemented at the national level by levying taxes on gambling, additional taxes on drivers licenses or biometric passports, and at the local level by revenues from collective income-generating activities (collective fields, collective fisheries, etc.). The resources mobilized can be allocated to strengthen CBHI and other social protection mechanisms to fill gaps in coverage and expand the package of services.
- To reduce stock-outs of essential free health products, it is necessary to empower the National Supply Pharmacy to supply inputs, kits, and medicines needed for the free health care services.
- To address challenges related to geographic accessibility, the CBHI schemes should increase the population's access to certain free health care services by recruiting appropriate staff, especially in health facilities serving rural populations. For example, dialysis centers should be supported by putting in place adequate personnel and equipment. This should include training of specialists and paramedical personnel, training of maintenance technicians, orientation of medical students for specializations such as nephrology, and granting scholarships to motivate them.

7. THE FAMILY SECURITY GRANT

7.1 DESCRIPTION OF THE INTERVENTION

Until 2013, social assistance in Senegal focused on vulnerable populations and included only food voucher and cash transfer programs focused on child nutrition supported by the World Food Program. Since 2013, there has been remarkable progress thanks to the government's assertive political leadership in favor of social protection and the launch of far-reaching programs to reduce poverty and empower families, such as the PNBSF. The objective of the PNBSF is to provide regular monetary transfer to targeted families and facilitate the enrollment of these vulnerable populations in CBHIs. PNBSF also helps build the resilience and livelihoods of vulnerable poor households. PNBSF is now considered a priority program of the Senegalese government (ACMU 2020).

The overall objective of the program is to fight against vulnerability and social exclusion of families through integrated social protection aimed at strengthening their productive and educational capacities. Hence, PNBSF aims to: (i) put an end to intergenerational poverty, (ii) prevent short-term vulnerability to financial shocks and contribute to the development of human capital, (iii) improve household productivity, and (iv) reduce inequalities (ACMU 2020).

The specific objectives of PNBSF are the following: (i) provide 300,000 vulnerable households with a family security grant of FCFA 100,000 per year, (ii) contribute to the development of a Single National Registry (*Registre National Unique*, RNU) to facilitate the targeting of households living in vulnerability and/or extreme poverty at the national, regional, and local levels, (iii) promote the enrollment and retention of children in school and civil registration, and (iv) develop monitoring and evaluation mechanisms to assist families in benefiting from the security grants (presentation of the PNBSF, DGPSSN 2016). The RNU has a cross-cutting objective to harmonize targeting of beneficiaries across all social protection mechanisms (ACMU 2020; DGPSSN 2016).

Through PNSBF, other challenges such as the civil registration of children from beneficiary households, the enrollment and retention of these children at school, and the protection of children's health through mandatory vaccination coverage are being addressed.

Operating the mechanism and targeting beneficiaries

PNBSF is a conditional cash transfer program with a national scope. It aimed to reach 300,000 vulnerable families in 2017 (according to the *Plan Sénégal Emergent*) and involves all the communes of the 14 regions of Senegal (République du Sénégal 2014). The main recipient of the grant must be the mother. The mother receives FCFA 25,000 every three months for five consecutive years. The recipient has two months to withdraw the money at the post office (main cash transfer operator). The allowance is fixed regardless of the size of the household. The beneficiaries of PNBSF are also enrolled in a CBHI scheme and the government, with the support of its financial partners, pays the total contribution for these beneficiaries, i.e., FCFA 7,000 per year per person (République du Sénégal 2014).

The tool used to target beneficiaries is the RNU. The main objective of the RNU is to promote the efficiency and coordination of social services through a single mechanism for identifying and targeting the various populations eligible for these services. For PNBSF, there are three stages. First, according to the budget allocated to the social safety net program, the ANSD maps poverty at the regional, departmental, and communal levels. Second, community surveys are conducted with the collaboration of village chiefs or community leaders, local elected officials, religious and traditional leaders, CBOs, and administrative authorities. Third, a category-specific targeting is carried out to select households eligible for PNBSF. The priority beneficiaries of the program are the most vulnerable households with children aged from 6 to 12. For social policy equity, the government chose to allocate PNBSF to all Senegalese

living in extreme poverty and throughout the country from the first year of implementation of the mechanism in September 2013. As a result, vulnerable households were targeted in all communes and villages when the program was implemented (ANSD 2014).

PNBSF is housed within the Ministry of Community Development, and Social and Territorial Equity and benefits from several coordination and decision-making bodies: (i) the Technical Committee for Implementation Support at the national level, which has an orientation and implementation mission, (ii) a committee integrating all actors at the regional level, and (iii) the Monitoring, Targeting and Validation Committee at the departmental level. The idea is to promote the participation of beneficiaries, administrative authorities, and development actors in the steering and decision-making bodies. An important component in reference to the complaints mechanisms is the development of instruments such as a hotline and listening mechanisms.

Financing

The estimated funding needs for PNBSF are established based on the list of PNBSF beneficiaries enrolled in each region and consolidated at the central level. The State of Senegal mobilizes 80 percent of the direct financing, including the personnel and the amount for the transfers. The contribution of the technical and financing partners is about 20 percent and covers expenses such as program management costs and monitoring and evaluation activities (ACMU 2016).

7.2 COMMUNITY INVOLVEMENT

There is significant community participation in PNBSF at the operational level, particularly in the targeting and periodic monitoring phases of the program. In addition to geographic targeting and category-specific targeting, there is also community targeting, which involves the Village Targeting and Monitoring Committees and the Neighborhood Targeting and Monitoring Committees. These committees draw up lists of the poorest households in the community. The committees consist of a minimum of five members, including the village chief (or the neighborhood delegate), representatives of the CBOs (youth representatives, women's representatives), the imam or the priest, the community health correspondent/Badianou Gokh, parent representatives, and so forth. The Communal Targeting Committee, under the authority of the territorial administration (sub-prefect, prefect of the subdivisions), ensures the distribution of quotas by neighborhood or by village and the control of household lists. Once validated, the lists are aggregated at the communal level and submitted to the prefect or sub-prefect of the district. There is also strong involvement of the community in the mobilization and sensitization of the population on PNBSF, particularly through communication campaigns.

Alternatively, there is a lack of community involvement at the program coordination level. This demonstrates the need for capacity development of the community to implement decentralized management bodies.

7.3 NON-FINANCIAL BARRIERS AND CHALLENGES

There are several non-financial barriers and other challenges to the implementation of the PNBSF:

- **Administrative challenges**. Difficulties in collecting the grant, including distance of some beneficiaries from the place of payment, confusion about who the grant holder is, and errors.
- **Lack of information around the program.** Insufficient knowledge of the mechanism and eligibility criteria caused by the lack of awareness and information of the populations involved, and often accompanied by inconsistencies in communication.
- **Limited geographic accessibility.** To address constraints around geographic accessibility, the PNBSF has developed "close payment sites" to manage the issue of remoteness, that is, bringing

financial services closer to beneficiaries and ensuring there is no charge for either transportation or payment collection to the beneficiaries.

- **Resource mobilization**. The resources invested in the program are still insufficient to significantly improve human capital, increase the resilience of the most vulnerable, and contribute to inclusive growth. Since its launch, PNBSF has reached 300,000 households and the annual allocation of FCFA 100,000 is low compared to the Guaranteed Interprofessional Minimum Wage (SMIG), which is set between FCFA 640,911[2] and FCFA 409,712[3] (DGTSS 2019)
- **Challenges in accurately targeting beneficiaries.** Errors in the targeting of beneficiaries cause inclusion and exclusion errors, as well as access and registration challenges to the mechanism due to the low levels of education of beneficiaries, who find it difficult to follow the program administrative procedures. For the implementation of PNBSF, there is still work to be done in the development of certain procedures, such as administrative processes, nomenclature, certifications, traceability of resources, the claims system, management of identification numbers, and protection of personal and health data from risks of disclosure or leakage of sensitive information. Other mechanisms use the RNU, but its optimization is not yet achieved in terms of the computer system needed for better targeting and interventions between PNBSF, the ACMU, and other social protection programs. There are significant challenges to the development and proper functioning of RNU, including the implementation of a management information system developed in technical coordination with the State Information Technology Agency (ADIE).
- **Need to address other factors that influence SDoH.** The impact of PNBSF on non-financial barriers to access to health services is limited. Even though PNBSF families are members of health insurance organizations, the challenges related to additional household expenses (transportation, food, etc.) still represent obstacles to the provision of health care.
- **Insufficient community involvement**. The level of involvement of communities remains insufficient, as they do not yet play a key role in the management of PNBSF. This limits the communities' capacity to ensure the accountability of the program.

7.4 SOLUTIONS TO NON-FINANCIAL BARRIERS

Table 3. What was done to address non-financial barriers with PNBSF?

<table>
<tr><th>Non-financial barrier</th><th>What was done to address the non-financial barrier?</th></tr>
<tr><td>Lack of information about social health protection</td><td rowspan="2">Community involvement has been critical for awareness-raising about CBHI and in enrolling the population. There is also strong involvement of the community in the mobilization and sensitization of the population on PNBSF, particularly through communication campaigns.</td></tr>
<tr><td>Socio-cultural and religious barriers</td></tr>
</table>

[2] On the basis of FCFA 333.808 per hour for workers subject to legal working hours of 40 hours per week. Source: Ministry of Labour, Social Dialogue, Professional Organizations and Relations with Institutions.
[3] On the basis of FCFA 213.392 for workers in agricultural and similar enterprises. Source: Ministry of Labour, Social Dialogue, Professional Organizations and Relations with Institutions.

<table>
<tr><th>Non-financial barrier</th><th>What was done to address the non-financial barrier?</th></tr>
<tr><td>Need to address other factors that influence SDoH</td><td>To address other factors that influence SDoH, trainings focused on micro-investment have been conducted to help some beneficiaries create income-generating activities using their PNBSF and thereby create more wealth in their families.

Beyond financial protection, the PNBSF and CEC programs address certain non-financial aspects that have an impact on the demand for care, such as lack of access to affordable transportation, and jobs that pay poverty-level wages, which precludes them from taking time off to seek care and use the free health care services made available to them.</td></tr>
<tr><td>Provider discrimination against vulnerable and socially excluded populations</td><td>PNBSF accountability mechanisms have been established: a hotline, listening group at the beneficiary level, etc. Since 2015, a complaint system has been in place to facilitate reporting of information and handle complaints. Complaint forms are filled out by the correspondents at the village level and are then forwarded to the territorial administration. The General Delegation for Social Protection and National Solidarity gathers the complaints and handles them on a case-by-case basis.</td></tr>
<tr><td>Geographic accessibility</td><td>To address constraints around geographic accessibility, the PNBSF program has developed "close payment sites" to manage the issue of remoteness. The “close payment sites” bring financial services closer to beneficiaries and ensure that beneficiaries incur no costs for either transportation or payment collection.</td></tr>
<tr><td>Perception of low quality of care (including frequent stock outs)</td><td rowspan="2">Beneficiary associations collect data to monitor health care in various health facilities to help address the barriers around long waiting times, low perception of quality of care, and frequent stock-outs of important medical goods. The associations contribute to the resolution of problems and bottlenecks in collaboration with the ministries involved and the UHC agency.</td></tr>
<tr><td>Administrative bottlenecks (including delays in payments and reimbursements)</td></tr>
<tr><td>Challenges in accurately targeting beneficiaries</td><td>There is significant community participation in PNBSF in the targeting and periodic monitoring phases of the program. In addition to geographic targeting and category-specific targeting, there is also community targeting, which involves the Village Targeting and Monitoring Committees and the Neighborhood Targeting and Monitoring Committees. These committees draw up lists of the poorest households in the community. The committees have a minimum of 5 members, including the village chief (or the neighborhood delegate), representatives of the CBOs</td></tr>
</table>

Non-financial barrier	What was done to address the non-financial barrier?
	(youth representatives, women's representatives), the imam or the priest, the community health correspondent/Badianou Gokh, and parent representatives. The Communal Targeting Committee, under the authority of the territorial administration, ensures the distribution of quotas by neighborhood or by village and the control of household lists. Once validated, the lists are aggregated at the communal level and submitted to the prefect or sub-prefect of the district.

7.5 RESULTS

"Social protection is a political, social, but also a technical project," said the RNU Director to the DGPSSN.

As of August 2016, there were four generations of recipients (the fourth is in the process of receiving its allocation). The number of beneficiary households that received a transfer since 2013 reached almost 200,000 households in 2015 (50,000 households in 2013, an additional 50,000 households in 2014, and an additional 100,000 households since 2015) (DGSPN 2016). According to DGPSSN data (2016), 267,331 households are listed in the RNU and 73.2 percent of households listed in the RNU receive the family grant. On average, scholarship households currently represent 1.45 percent of the total population of Senegal. The regions of Dakar, Ziguinchor, and Kolda have the largest number of grant recipient households. While Dakar's ranking is easily explained by its population density, the Ziguinchor and Kolda areas have been particularly targeted by the program. This overrepresentation of beneficiaries in the Kolda region can be explained by the high poverty rates in this region. The targeting of the Ziguinchor region responds to the government's desire to act in favor of Casamance, a region with great potential but long penalized by armed conflict (DGSPN 2016). According to the National Survey on Food Security and Nutrition (ANSD 2013), the natural region of Casamance (Sédhiou, Kolda, Ziguinchor) is more affected by food insecurity than other regions of the country. Analysis of the ratios between beneficiaries and the total population confirms a strong concentration of the program in these regions (ANSD 2013).

In 2021, the government paid close to FCFA 2 to 3 billion in contributions to health insurance organizations to cover approximately 2 million beneficiaries of the family security grant. Periodic evaluations have shown the benefits of PNBSF to its beneficiaries. An evaluation of PNBSF in 2017 revealed that the grant appears to be a shock absorber (including episodes of illness) that the most vulnerable households regularly face. Also, PNBSF contributes to increasing immunization coverage in the country because a condition of enrollment and continuation in the program is the immunization of the children in the household (Ferre 2017).

7.6 RECOMMENDATIONS

- To address resource mobilization challenges, policy makers should look into investing additional tax revenue in this program as well mobilizing resources through different sources, like the private sector and their Corporate Social Responsibility programs, and through local authorities' funds.
- To address challenges around lack of awareness of the program, there is a need to implement innovative and expansive communication strategies to strengthen the population's understanding of the social protection policy and benefits.

- To address other factors that influence SDoH, trainings focused on micro-investment have been conducted to help some beneficiaries create income-generating activities using the PNBSF and to be able to create more wealth in their families.
- To address challenges around targeting beneficiaries, it is necessary to implement a harmonized management information system to improve and systematize the targeting of PNBSF beneficiaries and the monitoring of their situation regarding medical care, the registration of their children in civil registers, and their enrollment in school.
- To improve community and local authorities' involvement, there are programs that these local authorities can offer, such as financial support to the most vulnerable. For example, in the case of long-term hospitalization, local authorities can provide financial support to the most vulnerable subject to the presentation of a certificate of residence.
- Accountability mechanisms are improving but there is still work to be done (hotline, listening group at the beneficiary level, etc.). Since 2015, a complaint system has been put in place to facilitate reporting of information and handle complaints. Complaint forms are filled out by the correspondents at the village level and are then forwarded to the territorial administration. The DGPSSN gathers the complaints and manages them on a case-by-case basis.

8. THE EQUAL OPPORTUNITY CARD

8.1 DESCRIPTION OF THE INTERVENTION

The CEC program was initiated by political will and materialized by the Social Orientation Law n°2010-15 on July 6, 2010, on the promotion and protection of people with differing disabilities. It was signed in 2012 by the Head of State in the implementation decree 2012-1038, establishing the CEC. The CEC program aims to reduce inequalities and facilitate equity for people living with disabilities. Part of the strategic objective 4 of the National Strategy of Social Protection is "Establishing an integrated social security system for people living with disabilities." The strategy organizes its initiatives around the CEC program. Within the framework of medical-social assistance, a 2015 presidential directive promoted the structuring of the CEC program in line with UHC and PNBSF. In this sense, the CEC program allows the integration of SDoH in its health policies for more equity.

The creation of the CEC program is also in line with the will of the Government of Senegal regarding the United Nations Convention on the Rights of Persons with Disabilities article 4, to put in place an inclusive development policy that ensures disability care.

The CEC program is a social protection mechanism that has two roles assigned to it by law:

- Identification function, which allows us to have reliable statistics on this segment of the population.
- Service or social protection function. The card allows its holder, a disabled person, to have much easier access to basic social services.

The CEC program mentions a set of seven services: employment, finance, health, education, training, transportation, and functional rehabilitation. As a social protection mechanism, the seven services, as originally designed by the law, are non-financial, that is, they are without direct financial transfer or payment aspects. Nevertheless, they contribute, in theory, to reducing financial barriers to access.

Today, out of the seven services, only three are implemented according to the authorities. These three are the financial service, which is currently attached to PNBSF; the health service, which is attached to CBHI; and the transportation service, which facilitates access for people living with disabilities to the public transportation system free of charge (the transportation service is not yet very effective). The structuring of the CEC program in line with CBHI and PNBSF is an instruction from the President of the Republic at the launch of the card in 2015. The person with the disability holding the card and considered financially vulnerable must benefit from registration to a health insurance organization and from the financial allowance provided within the framework of PNBSF, that is, FCFA 25,000 per family per quarter.

The CEC program is managed by the government through the MSAS under the technical supervision the Directorate for Disabled Persons housed at the General Directorate for Social Action (DGAS).

The CEC program frameworks are governed by decree 2012-1038, establishing departmental technical commissions. In each department, there is a multi-sector technical commission in charge of examining the CEC applications. These commissions, chaired by the prefects of the departments, have as reporters the Departmental Services of Social Action, which is responsible for examining the application files and validating them. The validated files are sent to the central level for registration and then printing of the cards. However, there remains the issue of the functioning of the commissions in the departments, most of which have not been set up and are not functional.

The CEC program is financed by the government, which can mobilize additional resources from its cooperation partners.

8.2 COMMUNITY INVOLVEMENT

There are still gaps in community involvement. According to the law and the cross-cutting nature of the CEC program, departmental technical commissions should be set up in each department in a participatory and multisectoral manner. The commission should be chaired by the prefect and include the education inspector, the head of the social action department at the local level, the representative of people with disabilities organizations, the chief medical officer, and other representatives of related development sectors. However, the fact that these commissions do not function or even exist as required by law limits the number of people who have access to the CEC and the participation of the communities that should assist these commissions. The lack of resources necessary for these commissions is the main obstacle to their functioning, which negatively affects regular meetings that lead to the validation of CEC application files and the production of the card.

For all the people who have the card, the application procedure is the same for all applicants . However, the procedure in use is different from that established by the law. The applicant must visit the office of the regional chief medical officer, who will issue a certificate of disability. Then the file is sent to the DGAS office at the regional level to carry out the investigation, after which the form is completed and sent to the central level. This process is in contradiction of the law, which states that a multisectoral technical commission must meet, study the file, and determine not only the type of disability but the level of disability (e.g., 80, 70, 50, or 30 percent). This process will allow the multisectoral technical commission to identify the type and level of service adapted to the person with disability and the additional support (financial or other) required. Because in most cases these commissions are neither functional nor constituted, community participation is limited. In the basic CEC program model, the communities are important actors in the implementation of the mechanism, particularly in supporting the commissions in communication, awareness-raising, referral, and targeting potential beneficiaries.

8.3 NON-FINANCIAL BARRIERS AND CHALLENGES

Since its establishment by law in Senegal, the CEC program target population faces a number of non-financial obstacles that directly or indirectly hinder access to services, including health services. The first set of challenges are related to the identification function:

- **Administrative challenges with the production of the required number of cards.** There are administrative delays in producing the card. The rate of production is low with insufficient offices and staff. For a target population estimated at 2 million, only 69,768 cards have been produced in seven years. The annual production of cards is about 10,000, even though the law states that eventually all people with disabilities must have the card. This production capacity is not adequate to reach the quantitative and qualitative objectives. Human, material, and technical resources are still a major challenge in setting up and operating the bodies and authorities responsible for card production. For example, the contracting for the printing of the card is still progressing, at a slow pace.
- **Challenges with multisectoral coordination**. More than 90 percent of the multisectoral departmental technical commissions are neither functional nor constituted, thus limiting community participation.
- **Information systems.** There is a lack of tools, equipment, and technologies for an effective information management system to increase portability so that people with disabilities in any department and anywhere are registered in the database and the system systematically generates their card.
- **Challenges in accurately targeting beneficiaries.** There is a need to harmonize the framework for estimating the number of people living with disabilities in Senegal, as there are various sources

for estimating the common denominator for measuring effective indicators. For example, the ANSD counts 800,000 people with disabilities in Senegal, 4 percent of the population, while the WHO counts 3,500,000 disabled people, 15 percent of the population (Association handicap 2014).

The second set of challenges are related to the service function of the CEC program:

- **Lack of information about the CEC program.** The CEC program actors and target communities have limited awareness of the CEC program services. The population is not well informed about the CEC program services and benefits. As a result, beneficiaries are not enrolled in CBHI or do not benefit from the PNBSF.
- **Accessibility challenges for the disabled**. Accessibility to CEC registration sites is a problem for people who are blind or have mobility problems. In the absence of local access to the CEC, people with "severe" disabilities are more likely to have difficulty reaching the registration sites.
- **Limited availability of services.** To date, only three of the seven services are functional and even the coverage of these three services remains insufficient. The challenge is to ensure that all services are effective. The mobilization and commitment of other government sectors involved in the operationalization of the various other benefits of the card remain a major challenge. The low levels of programmatic implementation of the CEC limit its effectiveness. The card is, generally, not useful because the services are not really effective and are slow to materialize. This discourages membership.
- **Restriction of benefits to only the people with disabilities and not their families.** Unlike PNBSF beneficiaries, where the whole family is enrolled in the CBHI scheme, only the person with disabilities with a CEC is enrolled in the associated scheme. This restriction means that family members of people with disabilities still lack social and health protection.
- **Inadequate services offered by health insurance organizations**. A major challenge lies in the packages of services offered by health insurance organizations, which are restrictive for the CEC beneficiaries. The lack of CBHI coverage for treatments such as physical and functional rehabilitation, and for medical equipment, is a major health challenge for people with disabilities. Most people with disabilities need prostheses, devices to improve their living conditions and mobility (crutches, braces, carts, other technical aids ordered, etc.), but UHC program benefits do not include such care and are limited mostly to medicines, first aid, and hospitalization.
- **Delays in payments and reimbursements.** ***"Personally, I received my card two years ago, but I never gotten paid?"*** CEC program beneficiary. Based on these delays, the function of the card seems only to identify the target population.

Currently, a working group has been set up to draft the implementing regulations of the social orientation law, which will then be submitted to the authorities for validation to ensure the effectiveness of the CEC program services. Under this scheme, the financing of the services will be ensured by the competent ministries. The MSAS will produce the CEC cards and give them to the other ministries that implement the services with resources from their own budgets.

In addition, to mitigate the underperformance related to the registration of people with disabilities in the program, the ministry implements the Equal Opportunity Card Acceleration Program (PAPCEC). In this program, the ministry often involves representatives of disability organizations in the regions in the implementation of advanced strategies. Beneficiaries' organizations contribute to targeting, information flow, awareness campaigns, and so on.

8.4 SOLUTIONS TO NON-FINANCIAL BARRIERS

Table 4. What was done to address non-financial barriers with CEC?

Non-financial barrier	What was done to address the non-financial barrier?
Need to address other factors that influence social determinants of health	The CEC program addresses certain non-financial aspects that have an impact on the demand for care, such as lack of access to affordable transportation, and jobs that pay poverty-level wages, which precludes them from taking time off to seek care and use the free health care services made available to them.
Perception of low quality of care (including frequent stock outs)	Beneficiary associations collect data to monitor health care in various health facilities to help address the barriers around long waiting times, low perception of quality of care, and frequent stock-outs of important medical goods. The association contribute to the resolution of problems and bottlenecks in collaboration with the ministries involved and the UHC agency.
Administrative bottlenecks (including delays in payments and reimbursements)	
Limited availability of services	For the CEC program, a working group has been established to develop commitment for a regulatory and legal framework for the correct implementationn of the CEC program and to ensure that services listed in the program are actually available.
Accessibility challenges by the disabled	To mitigate underperformance related to the registration of people with disabilities in the program, the ministry implements the Equal Opportunity Card Acceleration Program (PAPCEC). In this program, the ministry often involves representatives of disability organizations in the regions in the implementation of advanced strategies. Beneficiaries' organizations contribute to targeting, information flow, awareness campaigns, etc.

8.5 RESULTS

Results show that the Government of Senegal, under MSAS, has produced 69,768 CEC cards out of a target of 90,000 cards to be produced by the end of 2021, a production rate of 76.9 percent (DGAS 2021).

On the other hand, in 2021, the population of people living with disability in Senegal was estimated at one million people, a prevalence rate of 5.9 percent (ANSD 2021). Although these are the official figures, people with disabilities' organizations agree that the ANSD's data collection mechanism or tool seems to be incomplete, leaving out certain categories of disabilities. The World Report on Disability stated the disability prevalence rate in Senegal as 15.5 percent (WHO 2011). The average of this percentage and ANSD's 5.9 percent is a prevalence rate of 10-11 percent. This average applied to the Senegalese population of about 18 million in 2021 gives an estimate of 2 million people with disabilities. In this target population of approximately 2 million people, 69,768 people currently hold the CEC card, a coverage rate of approximately 6 percent (ANSD 2013).

There are 25,614 people with disabilities holding the PNBSF card. The number of people with disabilities registered in CBHIs is estimated at 24,728. There are 633 people with disabilities who have free access to transportation (DGAS 2021).

The card is produced at the MSAS level, but access to services is managed by other ministries. The processes are slow and the intersectoral indicators are not managed at the MSAS level.

In financial terms, PNBSF is estimated to have cost about FCFA 10 billion since 2014. The COVID-19 2020 financial data show that 54,219 people with disabilities received emergency food kits in the resilience program, corresponding to a financial impact of FCFA 3.5 billion, for a value of FCFA 60,000 per kit. The NGO Plan International also offered hygienic kits to young girls and women with disabilities in Guédiawaye, valued at FCFA 11 million. Many other isolated interventions not directly linked to the CEC program include the distribution of equipment and school support. However, directives are now given for all services and free initiatives of these programs to be attached directly to CEC.

There is not yet a large-scale study on the beneficiaries' side because mechanisms such as the CEC program do not have a quantitative external evaluation of users' satisfaction with quantified levels. However, positive feedback has been obtained from focus groups organized by the DGAS, where many people with disabilities appreciate the government's effort and would like it to be reinforced.

8.6 RECOMMENDATIONS

Disability organizations working to defend and protect the rights of people with disabilities made proposals to the government to address the challenges related to the two functions of the CEC card.

- To address the challenge around insufficient production of CEC cards, it is necessary to develop a budget and plan for the mobilization of financial resources to facilitate the timely production of the cards at the unit cost. For the overall implementation of the program at scale, it will be necessary to put in place measures and means for sound planning, an effective organizational and management system, and effective multisectoral coordination of interventions.
- To address the challenge around multisectoral coordination, it is recommended to organize a Presidential Council. The council will convene a high-level meeting with the concerned ministries to inform them, sensitize them, and give them guidelines for the effective implementation of the services listed under the CEC program, for example, making schools accessible for people with disabilities in terms of adequate infrastructure, making curricula accessible, and sensitizing teachers to the needs of students with disabilities. These actions are in line with the obligations of the government to enforce and apply the provisions of the law through its various divisions.
- To address the challenge of inadequate services offered, there is need to develop a strong commitment to put in place a regulatory and legal framework for the correct implementation of the program, the implementation protocol, and mobilize the necessary resources to fund the program.
- To address accessibility challenges for people with disabilities, associations of people living with disabilities and vulnerable people need to advocate to the government through the ministries to achieve concrete actions for the implementation of mechanisms and non-financial services they are entitled to.
- To address the challenge around lack of information about the CEC program, it is recommended to mobilize the community and the beneficiaries living with disabilities through CBOs, neighborhood delegates, and community actors. Doing so will inform, sensitize, and train the actors and the CEC program target population to fight against the misinformation people have about the card.
- Finally, the establishment of the CEC program as a national program could improve the provision of resources (logistical, technical, human, and financial) to facilitate the geographical, physical, and financial accessibility of the card to people with disabilities.

9. DISCUSSION

The implementation of the social protection policy in Senegal described in this case study covers health insurance mechanisms through CBHI, free health care initiatives, PNBSF, and the CEC program. The objective of these programs is to improve access to health and basic social services for vulnerable, underserved, and socially excluded populations. Senegal's social protection policy is innovative, committed, and ambitious, but also fragile in terms of achieving its results. Regarding the coverage of the social protection policy, the results are mixed from a geographical perspective and from one mechanism to another. For example, there is high participation and demand for medical assistance (free services), but low enrollment in CBHI.

The study shows fragmentation of mechanisms, functions, and missions, with different government entities implementing the described initiatives. Consequently, there is insufficient coordination, and alignment in implementing and institutionalizing interventions particularly at a high level.

This domestic fragmentation is exacerbated by certain technical and financial partners who fail to coordinate their support of the national social protection policy, regardless of their common interest, and this misses opportunities for alignment and coordination between the policies. Senegal should adopt a single national approach to social protection with sub-mechanisms that clearly define vision and direction within a single institutional, legal, and steering framework. Despite this fragmentation, there is some integration of benefits across the programs because both PNBSF and CEC beneficiaries are enrolled in the CBHI scheme.

At the end of each analysis above, a set of recommendations on how to overcome non-financial barriers in a way that involves the community is provided to achieve the expected results of assisting the vulnerable groups. Additionally, several best practices from the Senegal experience were documented in this case study that may be useful for other countries that are looking to expand social protection to vulnerable populations:

1. **Instituting a system to help identify the poor and vulnerable population for social protection services.** The Government of Senegal has implemented an RNU that includes geographic information system mapping, a claims management system, and a mechanism to allow beneficiaries and communities to share their feedback, which fosters accountability and transparency. Continuing to strengthen the effectiveness of the RNU has many advantages. It will improve the efficiency of the social protection system, especially in monitoring beneficiaries through the different operational management bodies. It will also improve the integration and interconnection of the different mechanisms, including managing beneficiaries of the free health care initiatives within the MSAS, and the evaluation of the impact of the programs on the vulnerability of PNBSF and CEC beneficiaries for their eventual exit from the system.
2. **Promoting professionalized community involvement.** In Senegal, the community plays an important role in identifying eligible populations and this has strengthened the implementation of the country's social protection schemes. The community participation, contribution, and leadership is important but needs to be better leveraged and strengthened through professionalization. People who have management skills must be recruited and contracts with them duly signed and respected.
3. **Decentralization of health services**. The involvement of local and regional authorities remains an important asset in some localities in Senegal. For example, in Foundiougne, local authorities are members of the departmental scheme's general assembly and board of directors; as such, they contribute to the enrollment and care of poor families.

4. **Use of digital payments.** Bringing payment mechanisms closer to beneficiaries removes geographical and financial obstacles.
5. **Focusing on SDoH.** Some schemes offer beneficiary training on savings and investment for income generation, which aims to empower beneficiaries in terms of the production of assets. The integration of other non-financial aspects into the social protection package such as the CEC providing training around new professional working skills or the PNBSF ensuring that beneficiaries enroll their children in school are key to achieving a holistic approach.
6. **Ensuring political will.** Support of the President of the Republic remains intact and is an asset for Senegal. The expansion of CBHI schemes, PNBSF, and CEC are key ways in which the government can respond to social needs.

Finally, sustained actions must be continued by all the actors, including the communities, to mobilize domestic resources to achieve appropriate financing to cover the estimated needs of social protection in Senegal.

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ANNEX A: LIST OF KEY INFORMANTS

	CATEGORY /INSTITUTION		NAME
	G1: Administrative and Health Authorities/ Donors and their Implementing Partners		
	Ministry of Community Development and Social and Territorial Equity		
1.	Agency for Universal Health Coverage (ACMU)	Focal point for the capitalization of experiences	Mr. Mamadou MBAYE
2.		Operations Directorate/ MOH Technical Assistant Division	Mr. Magor SOW
3.		Operations Directorate/ PEC Division for Indigent and Vulnerable Groups	Mrs. Marie Rose SECK
4.	General Delegation for Social Protection and National Solidarity	Director of the Single National Registry	Dr. Ousseynou DIOP
5.		Program Director, Social Security Grants	Mr. Pape Malick GNINGUE
6.		Strategy Director	Mr. Ousmane BASSE
	Ministry of Health and Social Action		
7.	General Directorate of Social Action	Directorate for the Promotion and Protection of Persons with Disabilities	Mr. Mamadou Lamine FATY
8.	DPRS (Planning, Research and Statistics Directorate)	Health Economics Unit	Mrs. Thiané DIAW
	Technical and financial partners-Donors		
9.	USAID/ chemonics	Technical advisor in charge of financing	Mr. Farba Lamine SALL
10.			
11.		Deputy Team Leader	Mr. Mame COR NDOUR
	G2: Health insurance operational bodies		
12.	National Union of Community-Based Health Insurance (UNAMUSC) et GRAIM	President	Mr. André DEMBA
13.	Community Based Health Insurance Departmental Union /Technical Management Unit	Rufisque	Mr. Djibril GUEYE (President) Médinatou ou Léontine
14.	Community Based Health Insurance I	Rufisque	
15.	Oyofall pajj	President	Mrs. Lobbé CISSOKHO
16.	UDAM (Belgian cooperation)	Fatick/UDAM FOUDINOUNE	Mrs. SANE

	CATEGORY /INSTITUTION		NAME
	G3 : Bénéficiaires et organisations communautaires		
17.	Sesame Plan(elderly people)	Senegalese National Elderly People's Council	Mr. Mame Birane (President)
18.	(The Equal Opportunity Card) People living with disabilities [1]	Senegalese National Federation of People with Disabilities (FNPHS)	Mr. Yatma Fall
19.	Senegalese Association of Hemodialysis and Renal Insufficiency Patients [4]	A.S.H.I.R / General Secretary	Mr. SECK
20.	People living with HIV/AIDS	Senegalese National Network of People Living with HIV	Madjiguene
21.	Regional head of UHC/ retired	Forerunner of CBHI	Mr. Cheikh WILANE

ANNEX B: DISCUSSION GUIDE FOR KEY INFORMANT INTERVIEWS

LHSS Core Activity 12: Expanding Financial Health Protection to Underserved and Socially Excluded Populations

Senegal Case Study: Discussion Guide for Key Informant Interviews

Introduction & Consent to Participate

I am working on a case study around Senegal's efforts to expand financial health protection to underserved and socially excluded populations (for example, populations like rural, poor, elderly, disabled, pregnant women, children, etc.). This case study is an activity of the USAID-funded Local Health System Sustainability (LHSS) Project implemented by Abt Associates (Abt).

As part of this case study, I would like to ask you questions about your experience with initiatives to expand financial protection in Senegal. I very much appreciate your participation in this interview. The interview will take about 1 hour to complete.

The results of this case study will contribute to the global knowledge on approaches countries have used to ensure more equitable financial protection. Your participation is voluntary; there is no direct benefit to you for participating.

The information you provide will be kept confidential and will be shared only with the case study team. Your name will not be used in the case study nor be associated with any of the information you provide. If you wish to skip certain questions or sections, just tell me, and I will go on to the next question. Also, if you wish to stop the interview at any time, just let me know.

If you have any questions or concerns pertaining to your participation in this case study, you may contact Heather Cogswell (Heather_Cogswell@abtassoc.com), the Activity Lead for this work.

Attach the Case Study Fact Sheet: *A one-page fact sheet on the Senegal case study offering details on the case study scope, methodology, and other relevant information will be attached to emails for prospective interviewees to review.*

Background Information:

Date of interview: ____

Name of person interviewed: ______________________________________

Title & organization of person interviewed: ____________________________

Phone number and email: ____

Section I: Overview of Financial Protection Mechanisms

Briefly describe Senegal's current financial health protection mechanisms addressing financial and non-financial barriers.

Questions/English	Questions/Français	G1	G2	G3
1. How do you define what types of people are vulnerable in terms of health equity?	Comment définissez-vous quels types de personnes sont vulnérables en termes d'équité en santé ?	x	x	
2. What are the challenges and gaps with current financial protection mechanisms?	Quels sont les défis et les lacunes des mécanismes actuels de protection financière ?	x		
3. Are there financial health protection mechanisms that focus on the vulnerable and socially excluded?	Existe-t-il des mécanismes de protection financière de la santé qui se concentrent sur les personnes vulnérables et socialement exclues ?	x		
4. Are there financial health protection mechanisms that also incorporate aspects of addressing non-financial barriers?	Existe t-il des mécanismes de facilitation de l'accès aux soins et de protection financière intégrant aussi des aspects de lutte contre les obstacles non financiers ?	x		

NOTE TO INTERVIEWER: If there are multiple answers to questions #3 and 4 above, then the following questions in the following sections need to be asked for each financial protection mechanism that targets the poor/vulnerable.

Section II: Political Economy and Health Equity

Briefly describe the context and political economy surrounding the decision to improve health equity.

Questions/English	Questions/Français	G1	G2	G3
5. What was the motivation for health reforms to expand financial protection?	Quelles étaient les motivations des réformes de la santé pour étendre la protection financière ?	x	x	

Questions/English	Questions/Français	G1	G2	G3
6. Who initiated and championed the selected reform?	Qui a initié et défendu la réforme choisie ?	x	x	
7. Were any additional types of financial protection schemes considered? If so, why was the selected scheme chosen?	D'autres types de régimes de protection financière ont-ils été envisagés ? Si oui, pourquoi le schéma sélectionné a-t-il été choisi ?	x	x	

Section III: Intervention Description

Describe the intervention design and stakeholders involved.

Questions/English	Questions/Français	G1	G2	G3
8. Please describe the initial design and approach of the intervention, and reason for those approaches.	Veuillez décrire la conception et l'approche initiales de l'intervention, et la raison de ces approches.	x	x	x
9. What population or population groups does the intervention cover?	Quelle population ou quels groupes de population l'intervention couvre-t-elle ?	x	x	x
10. How is the intervention financed?	Comment l'intervention est-elle financée ?	x	x	x
11. What non-financial barriers were addressed by the intervention?	Quelles barrières non financières ont été levées par l'intervention ?	x	x	x
12. What interventions were employed (if any) to address behavior-related challenges to accessing health care services or achieving better health in general?	Quelles interventions ont été utilisées (le cas échéant) pour relever les défis liés au comportement pour accéder aux services de soins de santé ou parvenir à une meilleure santé en général ?	x	x	x
13. Indicate the timeline for designing and executing the intervention.	Indiquez le calendrier de conception et d'exécution de l'intervention.	x	x	
14. Who were the stakeholders involved in the decision-making process?	Quelles ont été les parties prenantes impliquées dans le processus de prise de décision ?	x	x	x
15. Note how decisions were made for the reform design (e.g., what was the process for decision-making?) and any changes in the implementation of the reforms.	Notez comment les décisions ont été prises pour la conception de la réforme (par exemple, quel a été le processus de prise de décision ?) et tout changement dans la mise en œuvre des réformes.	x	x	x

Section IV: Non-Financial Barriers

Briefly identify the interventions implemented for the reduction of non-financial barriers.

NOTE TO INTERVIEWER: Ask question #16 and request the respondent to rank their answer in terms of importance (i.e., 1 being most important). Possible answers are: 1) distance from health facilities (geographical accessibility); 2) the opportunity cost in relation to a carried out economic activity; 3) behavioral and reception problems in health structures; 4) lack of information on the benefits and rights to access care; 5) administrative and bureaucratic requirements and delays; 6) lack of confidence in social protection programs; 7) persistent socio-cultural factors.

Questions/English	Questions/Français	G1	G2	G3
16. Beyond the direct financial aspects of accessing care, can you name at least 2 categories of non-financial barriers faced by vulnerable groups?	Au-delà des aspects financiers directs à l'accès aux soins pouvez-vous me citer au moins 2 catégories d'obstacles non financiers dont font face les groupes vulnérables?	x	x	x
17. How do these barriers manifest themselves, from what you are aware of?	Comment se manifeste ces obstacles selon les situations dont vous avez connaissance ?	x	x	x
18. In your opinion, what are the consequences and impact of these obstacles on the health of the population in general, and on access to care specifically for vulnerable people (provide figures if possible)?	Quels sont selon vous le conséquences et l'impact de ces obstacles sur la santé des population d'une manière générale et l'accès aux soins particulièrerement des personnes vulnérables (fournir des chiffres si possible)?	x	x	x
19. What mechanisms and means have been designed and implemented to reduce these non-financial barriers at the national, regional, and local levels?	Quelles sont les mécanismes et les moyens qui ont été conçus et mise en œuvre et pour réduire ces obstacles non financiers au niveau national, au niveau régional et au niveau local ?	x	x	x
20. Who were the beneficiaries (direct target populations of these interventions)?	Quels ont été les bénéficiaires (populations cibles directs de ces interventions) ?	x	x	x
21. How were decisions made for the design of the mechanism (e.g., what was the decision-making process?)	Comment les décisions ont été prises pour la conception du mécanisme (par exemple, quel a été le processus de prise de décision ?)	x	x	x
22. How was it funded (who funded it, who were the other stakeholders?)	Quel a été son mode de financement (qui l'a financé, quels ont été les autres parties prenantes ?)	x	x	x
23. With reference to the previous question, what actions have been	(En référence à la questions précédente), Quelle ont été les actions	x	x	x

Questions/English	Questions/Français	G1	G2	G3
developed and implemented in conjunction with each of the following actors and stakeholders, as appropriate, to find answers to these non-financial barriers? Please describe them in each case. • *Community groups (associations, local NGOs, etc.)* • *MS and MS Unions* • *Administrative and health authorities at regional level* • *State structures and organizations in charge of social protection issues (DGAS, ANACMU, deguation, General Delegation for Social Protection, etc.)* • *Technical and financial partners*	developpées et mises en œuvre en lien avec chacun des acteurs et parties prenantes suivants, selon le cas, pour trouver des réponses à ces obstacles non financiers ? Veuillez les décrire dans chaque cas? • *Les groupements communautaires (associations, ONGs locales, etc)* • *Les MS et les Unions des MS* • *Les autorités administratives et sanitaires au niveau régionale* • *Les structures étatiques et organisations en charge des questions de protections sociale (le DGAS, l'ANACMU, la délégation, La délégation général à la protection sociale, etc)* • *Les partenaires techniques et financiers*			

Section V: Community Involvement

Briefly identify the community actors involved in the intervention.

Questions/English	Questions/Français	G1	G2	G3
24. Have community groups or leaders been involved in the process of developing and implementing the intervention? What was their level of involvement (management, awareness, promotion, etc.)?	Les groupements ou responsables communautaires ont-ils été impliqués dans le processus de développement et de mise en œuvre de l'intervention ? Quelle a été leur niveau d'implication (gestion, sensibilisation, promotion, etc.) ?	x	x	x
25. What role have they played in reaching their populations and members, and ensuring their involvement and adherence to the program or health mutuelles?	Quel rôle ont-ils joué pour atteindre leurs populations et leurs membres, et assurer leur implication et adhésion au programme ou au mutuelles de santé ?	x	x	x
26. Did they receive any payment or financial motivation to play this role?	Ont-ils reçus un paiement quelconque ou une motivation financière pour jouer ce rôle ?	x	x	x

Section IV: Intervention Challenges and Enabling Factors

Briefly describe any challenges faced in reaching target populations.

Questions/English	Questions/Français	G1	G2	G3
27. What was the reaction of the target population?	Quelle a été la réaction de la population cible ?	x	x	x
28. Were there challenges in reaching the target population?	Y a-t-il eu des difficultés à atteindre la population cible ?	x	x	x
29. Note the challenges faced and strategies that may have been used to address those challenges.	Notez les défis rencontrés et les stratégies qui peuvent avoir été utilisées pour relever ces défis.	x	x	x

Section V: Intervention Outcomes

Briefly describe the outcomes and useful lessons from the intervention.

Questions/English	Questions/Français	G1	G2	G3
30. In your opinion, how effective was the intervention design and implementation?	À votre avis, quelle a été l'efficacité de la conception et de la mise en œuvre de l'intervention ?	x	x	x
31. What steps were taken to ensure sustainability of the intervention/is the intervention anticipated to last beyond the initial period?	Quelles mesures ont été prises pour assurer la durabilité de l'intervention/l'intervention est-elle prévue pour durer au-delà de la période initiale ?	x	x	x
32. What are the remaining gaps to ensure financial protection for the target population? (For example, harmful gender norms prohibit women's control over household income and spending decisions, etc.)	Quelles sont les lacunes restantes pour assurer la protection financière de la population cible ? (Par exemple, les normes de genre néfastes interdisent aux femmes de contrôler les revenus et les dépenses du ménage, etc.)	x	x	x
33. What actions are being taken by the communities to ensure the sustainability of the intervention?	Quelles sont les actions impulses par les communautés pour assurer la durabilités de l'intervention ?	x	x	x
34. What are some useful takeaway lessons for other countries similarly undergoing financial protection reform?	Quelles sont les leçons utiles à retenir pour d'autres pays qui subissent de la même manière une réforme de la protection financière ?	x	x	x

Thank you for your time and valuable contribution to this process. Do you have additional recommendations for people to connect with to learn more about Senegal's efforts at expanding financial health protection to underserved and socially excluded populations?

List name, title, and contact information:

____

List name, title, and contact information: ____

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