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Achieving Progress Towards Universal Health Coverage Through Community-Based Health Insurance: Considerations for Madagascar

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Local Health Systems Sustainability Project (LHSS)

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ACRONYMS AND ABBREVIATIONS

ANACMU	*Agence de la couverture sanitaire universelle du Sénégal* (Universal Health Coverage Agency of Senegal)
Ar	Ariary (Malagasy currency)
CBHI	Community-Based Health Insurance
DECAM	*Décentralisation de l'Assurance Maladie* (Decentralization of Health Insurance)
LHSS	Local Health System Sustainability
MDCEST	*Ministère du développement communautaire, de l'équité sociale et territoriale* (Sénégal) (Ministry of Community Development, Social and Territorial Equity)
MOH	Ministry of Public Health
UDAM	*Unité départementale d'assurance maladie* (Departmental Health Insurance Unit)
UEMOA	*Union économique et monétaire ouest africaine* (West African Economic and Monetary Union)
UHC	Universal Health Coverage
UNAMUSC	*Union nationale de mutuelles de santé communautaires du Sénégal* (National Union of Community Mutual Insurance Groups of Senegal)
USAID	United States Agency for International Development

BACKGROUND

The Government of Madagascar is committed to achieving universal health coverage (UHC) through implementation of the 2015 National Health Financing Strategy. This strategy plans to increase domestic financing for health and for the financial protection of health care users. In May 2022, the government announced its intention to promote the development of community-based health insurance (CBHI).[1]

To respond to this new policy, the UHC Support Unit, attached to the General Secretariat of the Ministry of Public Health (MOH), has initiated a participatory process to conceptualize and implement a CBHI model. It is doing so with the support of the Local Health System Sustainability Activity (LHSS)—USAID's flagship initiative to strengthen integrated health systems.

LHSS has worked with the UHC Support Unit in conducting a feasibility study of CBHI in Fénérive Est District, in the Analanjirofo Region of Madagascar. LHSS also led a study tour to Senegal so that the Malagasy delegation could learn from Senegal's experience with CBHI, one of the important pillars of its UHC system. The lessons learned from the study tour will inform the key features of the demonstration phase of CBHI that LHSS will support in Fénérive Est.

This technical brief presents options for the design and implementation of the demonstration phase of CBHI planned for Fénérive Est District, taking into consideration the lessons learned from the results of the CBHI feasibility study in Madagascar and the experiences that countries in sub-Saharan Africa—particularly Senegal—have had with CBHI. This brief complements other technical briefs that LHSS has developed for the UHC Support Unit to inform the process of establishing CBHI in Madagascar, including the Technical Note on the CBHI Model in Madagascar (LHSS 2022).

[1] In Madagascar, CBHI is called AMBC: *Assurance Maladie à Base Communautaire* and CBHI schemes are known as "*mutuelles de santé*."

CBHI FEASIBILITY STUDY IN FÉNÉRIVE EST

The objective of the feasibility study conducted in 2023 (MSANP 2024) was to (i) assess the socio-cultural, economic, and technical feasibility of CBHI in Fénérive-Est District, and (ii) inform the definition of key parameters of CBHI in Fénérive-Est (benefit package, premium amounts, governance structure, etc.). High-level findings from the feasibility study are provided below and details are available in the original report.

Although 94.7 percent of surveyed people had not heard of CBHI, 95.2 percent of households were interested in joining after they heard a brief explanation of how CBHI would operate. Forty-two percent of heads of households chose all the services at the primary health care level for the benefit package, and 34 percent chose medicines. Family enrollment is preferred by most of these respondents (64.1 percent), as its premiums are paid in installments. Among the heads of households, 49 percent would prefer to pay the contribution monthly, and 30 percent would like to do so semi-annually.

In view of the findings, several scenarios were presented in the feasibility study:

- CBHI covering primary health care services and medicines with no copayment (40 percent of households could afford to join this CBHI) or with 30 percent copayment (approximately 52 percent could afford to join this CBHI)
- CBHI covering primary health care services, essential medicines, and services at the Regional Referral Hospital, with or without 30 percent co-payment (43 percent of households could afford to join with the 30 percent co-payment).

Although households may have the capacity to pay, the contributions expected from both scenarios are beyond their willingness to pay. Consequently, to facilitate the enrollment of the population, it is important for the government to subsidize contributions when the CBHI program begins, especially for the poorest.

Populations condition their membership in CBHI on the scheme's strict adherence to good governance. During the study, households surveyed expressed their fear about misappropriation of funds and non-compliance with management rules. Distrust of managers or the management body of the CBHI was mentioned several times during the interviews. As a result, joint management with community members and government was preferred by 48 percent of the heads of household surveyed.

OBSERVATIONS FROM THE SENEGAL STUDY TOUR

The study tour to Senegal took place on September 19-23, 2023, and was designed to help the Government of Madagascar learn about the challenges in designing and implementing CBHI and possible strategies to deal with those challenges. Further details on the participants and places visited are in the Annex. The major observations from the study tour relate to the legal and institutional framework of CBHI in Senegal, the CBHI's membership base, and Senegal's strategy for promoting CBHI.

LEGAL FRAMEWORK OF CBHI

Among key requirements for CBHI expansion and success, there is a need for a country to have a clear legal/ regulatory framework that provides a recognition of the CBHI mechanism as a legal entity and an enabling environment for the expansion of CBHI, in complementarity with other insurance mechanisms.

In addition to Regulation No. 07/2009 on social mutuality in the West African Economic and Monetary Union (*Union économique et monétaire ouest africaine*, or UEMOA) zone, the legal framework that organizes health insurance activity in Senegal is based on two instruments. The first one is Law No. 2003-14 of 4 June 2003 and its Decree No. 2009-423 of 27 April 2009 relating to CBHI. A draft law that comprises provisions on "a general regime" of UHC is currently being prepared. Pending the adoption of these provisions, certain aspects of the general UHC regime are governed by the provisions of common law, particularly those relating to the purchase of health services, and by agreements between CBHI schemes and health providers. These agreements are in accordance with standard models developed by the UHC Support Unit and adopted by the Universal Health Coverage Agency of Senegal (*Agence de la couverture sanitaire universelle du Sénégal,* or ANACMU).

The agreements cover the following:

- CBHI and health posts
- CBHI and health centers
- CBHI and pharmacies
- Union of CBHI schemes and hospitals
- Union of CBHI schemes and pharmacies

Under these agreements, CBHI schemes have the status of government-delegated management authorities. The agreements define the benefits covered, the procedures for providing benefits, the terms and conditions for purchasing and reimbursing services, the applicable tariffs, and the methods of settling disputes.

However, this contractual framework governing the main UHC regime remains incomplete. The conditions for the role of CBHI in the national health insurance plan are insufficiently defined. There is no agreement between the government and CBHI schemes. The nature of the partnership between the two parties is poorly codified. Similarly, a health insurance system must include regulatory measures defining modalities for financing schemes, regulating scheme expenditures, defining the services available to CBHI members, guaranteeing the rights of insured persons, and granting them remedies in the event of refusal of services.

INSTITUTIONAL ARRANGEMENTS FOR CBHI

Senegal has a long tradition of CBHI schemes. In the 1980s, many non-governmental organizations, both national and international, supported the development of CBHI, and by 1997, there were 129 CBHI schemes. It was then that the Senegalese government also gradually became involved in the promotion and support of CBHI, by setting up support structures and policies to promote CBHI. These included the Support Program for CBHI in 1996; the Support Unit for CBHI, the Health Insurance Institute, and Health Committees in 1998; and a strategic plan for the development of CBHI in 2004. Moreover, in 2013, political commitment at the highest level resulted in the launch of the UHC program, which included CBHI, based on the conclusions of national consultations on health and social action.

Currently, the main institutions involved in the implementation of UHC reforms in Senegal are the following:

ANACMU was created by Decree No. 2015-21 of 7 January 2015. ANACMU is a public administrative institution, with two sources of supervision: financial supervision is provided by the Ministry of Finance and technical supervision is provided by the Ministry of Community

Development, Social and Territorial Equity *(Ministère du développement communautaire, de l'equité sociale et territorial*, or MDCEST). Until April 2019, the MOH provided technical supervision, but this moved to MDCEST to initiate the purchaser-provider split whereby MDCEST became responsible for purchasing health services and the MOH was responsible for the provision of contracted health services. ANACMU has a regional representation/service in each region of Senegal.

Local authorities: The law on decentralization stipulates that municipalities, cities, and departments "shall participate in universal health coverage." Although measures to operationalize this are not yet in practice, various initiatives exist.

CBHI organizations: CBHI schemes are the primary insurance fund to achieve progress toward CBHI schemes, which are as follows (starting at the local level):

- CBHI at community level
- Departmental Union of CBHI schemes
- Regional Union of CBHI schemes
- National Union of CBHI schemes

SOCIAL BASIS FOR CBHI

The social basis of CBHI refers to the target population—individuals and households—around which CBHI is organized. The social basis also can be an economic interest group (companies, cooperatives, agricultural sectors, pastoral sectors, transport groups, traders' groups, etc.), a socio-professional organization (such as an association of motorcycle taxi drivers), or a spatial and administrative entity (village, group of villages, urban district, local authorities, communes, departments, regions). The choice of the social base at which to target CBHI, and in this way expand UHC in the informal sector, is of great strategic significance.

Two options were identified in designing Senegal's CBHI policy, namely:

- Option 1: Use administrative units such as communes and departments as the base, which fits well with the existing administrative system
- Option 2: Use agriculture sectors such as tomato or rice farmers, traders, transporters, or other organized groups.

Each of the two options has comparative advantages. To choose the best option, criteria were defined to select the social basis of CBHI, including universality, and the decentralized administrative political and institutional environment. Universality is the ability to make all citizens who are in the target population members and beneficiaries of the CBHI scheme, without any form of exclusion. It is important because the objective is to use CBHI to extend UHC in the informal sector. The alignment of CBHI with the basic decentralized administrative structure/unit (i.e., the municipality/commune) provides a catchment area large enough to promote better risk sharing among members. Based on these criteria, Senegal favored the 'administrative unit' option. However, decision-makers described the strategies through which they would connect the sectors with the CBHI at the commune or department levels.

There are currently 652 CBHI schemes that align with Senegal's administrative structures. CBHI schemes have been promoted at the departmental, commune, and village level. The commune-level model is the most common; of the 552 communes, 474 have a single commune-wide

scheme, and 30 communes have two schemes each. Twenty-six other communes, in the departments of Koungheul and Foundiougne, are part of department-level schemes.

STRATEGIES FOR PROMOTING CBHI IN SENEGAL

The Government of Senegal used two strategies to promote CBHI.

The first was the Decentralization of Health Insurance (*Décentralisation de l'Assurance Maladie*, DECAM). It aimed to increase the number of CBHI schemes, first by creating strong momentum for CBHI and community ownership of the new policy, and then by creating the conditions for establishing a network of CBHI schemes to strengthen risk sharing. DECAM has been implemented in 43 departments.

Under the DECAM approach, CBHI schemes cover 80 percent of members' health post (or health center) bill and 50 percent of their pharmacy bill if the medicines are prescribed by the practitioner at the contracted health facility. CBHI schemes in the same department would join a union that covers 80 percent of members' hospital costs and 50 percent of the costs of medicines purchased at community pharmacies if prescribed by a hospital practitioner.

Under DECAM, the oversight of CBHI schemes and the departmental union is carried out by an executive board composed of elected representatives who volunteer their services. They are assisted in the day-to-day management by paid staff. Each CBHI scheme has a manager on duty who registers beneficiaries, issues letters of guarantee, checks invoices, and carries out all other administrative tasks entrusted to him/her by the committee.

The second strategy consists of professionally managed CBHI schemes established at the department level (*Unité départementale d'assurance maladie*, or UDAM). The UDAM model has been implemented in two departments. The UDAM model differs from the DECAM model in its geographic scale of risk pooling and its mode of governance. In the DECAM approach, risk pooling occurs at two levels, the department and the commune, whereas in the UDAM approach, all risks are shared at the department level. Also, in the UDAM model, a board of directors, elected by scheme members, oversees the schemes' activities, defines scheme direction, and supervises management, but salaried employees carry out all day-to-day operations of the CBHI scheme—including budget creation and execution—in complete autonomy. Elected CBHI committee members play a role only in supervision and social mobilization.

An assessment (Sakho 2021: 38-39) showed the UDAM model produces better results than the DECAM model, for two reasons: The first is the size of the department-level CBHI schemes, which are larger and less fragmented than commune schemes. This means risk is spread over a greater number of people, which helps ensure financial sustainability. The second is the greater professionalization of the UDAM staff; it has a salaried manager (which the municipality paid for the first two years) to oversee the day-to-day operations of the CBHI scheme, such as registering new members, reviewing invoices, and reimbursing contracted health facilities. This professionalization does not come at the expense of community participation: as mentioned above, the board of directors is elected by the members' general assembly.

Table 1 summarizes the roles and responsibilities of the different institutions involved in UHC implementation in Senegal.

Table I: Main institutions involved in UHC in Senegal

Main institutions	Nature of the institution	Main responsibilities	
General Delegation for Social Protection and National Solidarity (DGPSN) created in 2012 by Decree No. 2012-1311 of November 16, 2012	Autonomous management body, attached to the Office of the President of the Republic	Coordinates implementation of government policy on social protection and interventions of ministries that have a social protection mandate, including the coverage of social protection targets (labor, employment, family, children, and women).	
Universal Health Coverage Agency (ANACMU) created by Decree No. 2015-21 of January 7, 2015. ANACMU is under joint authority: of the Ministry of Finance for financial supervision and of the Ministry of Community Development, Social and Territorial Equity for technical supervision	Implementing agency (public establishment with legal personality and autonomy)	ANACMU oversees implementation of the national strategy on UHC. It defines the extension strategy of UHC and ensures the supervision of health insurance institutions and social welfare organizations.	
Local authorities	Government decentralized units	The decentralization law (articles 170, 306, and 307 of the Local Authorities Code) provides that communes, towns, and departments "shall participate in universal health coverage." Although the operationalization measures are not yet in practice, various initiatives exist.	
Community-based health insurance (CBHI)	Private non-profit legal entities, recognized as being of public utility.	CBHI schemes	Raises public awareness, advocates to local authorities, recruits members, and collects members' contributions. Ensures coverage of the basic service package at the primary health care level.
		Departmental union of CBHI schemes	Provides technical support to CBHI schemes and ensures coverage of hospital services.
		Regional union of CBHI schemes	Play a representational role and political role. They represent CBHI schemes in the National Union of Community Mutual Insurance Groups of Senegal (*Union nationale de mutuelles de santé communautaires du Sénégal*, UNAMUSC) board of directors. As such, they: • Bring together CBHI schemes, local authorities, health providers, and development partners to support the development of CBHI schemes (a framework for consultation/dialogue).

Main institutions	Nature of the institution	Main responsibilities	
			• Promote and/or support local initiatives of CBHI schemes in the region. • Establish a framework for consultation, exchange of experiences, and development and implementation of CBHI development plans.
		UNAMUSC	UNAMUSC responsibilities are as follows: • Establish a framework for exchange between regional unions. • Promote CBHI schemes; contribute to the implementation and monitoring of national health policies. • Participate in health promotion activities. • Support the management of common services/key functions and major risks. • Promote a strong partnership with stakeholders, technical and financial partners, local authorities, etc. • Defend the material and moral interests of CBHI schemes. • Contribute to the establishment of an efficient health system.

LESSONS LEARNED

COMMITMENT AND POLITICAL WILL AT ALL LEVELS TO SUPPORT IMPLEMENTATION OF CBHI

The election of President Macky Sall in 2012 gave new impetus to the expansion of CBHI, which had been stagnating for several years. He confirmed UHC as a government priority by including it in the country's socioeconomic policy framework documents, such as the “Emerging Senegal Plan” under its pillar No 2: “Human capital, social protection and a sustainable development.” His government also contributed to a conducive environment for the expansion of CBHI. This included establishment of institutional and legal frameworks and a general subsidy from the national budget to co-finance CBHI premiums, to make enrollment affordable and extend the benefit package for the general population, and a targeted subsidy to finance CBHI enrollment of poor and vulnerable groups.

Madagascar too needs strong political engagement at the highest level to boost the development of financial protection in the country. This political will should be translated into concrete actions such as making official endorsements and speeches in favor of financial protection and UHC, adopting laws, and providing adequate financial and human resources to drive the process.

A strong political will at the highest level will, no doubt, mobilize leadership at all levels to champion the CBHI vision in Madagascar, as it did in Senegal, Ghana, and Rwanda. Also, the involvement of local-level administrative authorities (mayors and fokontany leaders) will be crucial to ensure a wide mobilization of and outreach to the population to join CBHI.

ESTABLISHMENT OF A PUBLIC ENTITY TO BETTER SUPPORT THE CBHI POLICY

At the beginning of the UHC initiative in Senegal, an institutional framework was enshrined in the Order of the Prime Minister No. 18408 of 25 November 2013, and a Technical Committee was created, organized, and made functional to support the establishment of the Autonomous Universal Social Protection Fund. Further, to ensure prompt and effective action, ANACMU was created by Decree No. 2015-21 of 7 January 2015 with legal personality and management autonomy. The body was equipped with financial resources and qualified human resources to operationalize the national UHC strategy.

The importance of strengthening the institutional framework overseeing the implementation of UHC in the country is an important lesson for Madagascar to consider. Senegal’s establishment of a full-fledged, autonomous public body to coordinate the implementation of reforms to achieve progress toward UHC accelerated the creation of CBHI schemes. Currently, Madagascar’s UHC Support Unit attached to the MOH oversees this function, but it is limited in terms of financing, technical capacity, autonomy and personnel. And given the multisectoral dimension of UHC, it is necessary to elevate the management and supervision of UHC implementation to a much higher-level body, equipped with legal personality and management autonomy.

PURCHASER-PROVIDER SPLIT

Multisectoral policy actions are needed to accelerate progress toward UHC. Although Senegal’s Ministry of Health and Social Action (*Ministère de la Santé et de l’Action Sociale*) initiated and promoted UHC at the beginning, management now is the responsibility of other ministries. This administrative transfer of responsibilities enables the Ministry of Health to focus on its sovereign

responsibility for health care provision, while other ministerial departments carry out the purchasing function. This separation of functions lays the foundation for a healthy regulation of stakeholders.

PROFESSIONALIZATION OF CBHI MANAGEMENT

Comparing the outcomes of the two CBHI approaches in Senegal proves that the challenges of CBHI governance can be met by professionalizing CBHI management. Innovations in health insurance portability (access to services beyond one's place of residence), individualization of membership cards, collective/village membership, and strategic purchasing have only been made possible by building the skills of the management teams' staff. Likewise, the outcomes achieved in terms of CBHI penetration and collection of contributions clearly show that professionalization is the way to integrate the greatest number of people into CBHI. This should be supported by an appropriate communication strategy and tools to encourage people to join CBHI schemes.

Professionalization enables CBHI schemes to put in place effective strategies to optimize the system for collecting contributions and doing sound financial management.

COMMUNICATION AND OUTREACH

Raising awareness and providing continuous information to the population is important to mobilize them and encourage them to enroll, and stay enrolled, in CBHI schemes. This must be done at both local and national levels, using different communication channels, such as radio spots, television programs, and, at decentralized levels, awareness-raising meetings. Leaflets and posters on CBHI schemes will have to be distributed in health facilities and in places that people visit frequently.

RECOMMENDATIONS

Based on the study tour to Senegal and the feasibility study in Fénérive Est, the MOH UHC Support Unit should consider integrating the following in the demonstration phase of its CBHI model:

LEGAL, REGULATORY, AND INSTITUTIONAL ASPECTS

- The President's Office began a draft bill for the Provision of financial protection for users of health services in 2021. However, this did not advance, and it remains in the UHC Support Unit annual action plan. It is imperative and urgent to develop a law on financial protection that is comprehensive and inclusive of all financial protection mechanisms for the public sector, the formal private sector, and the informal sector.
- Financial protection and achieving UHC requires multisectoral intervention. To ensure compliance by each actor, it is important to adopt legislation that creates a regulatory body or gives an existing structure regulatory responsibility that is high enough to coordinate the different sectors.
- An institution should be created with legal personality and management autonomy to ensure the scale-up of financial protection mechanisms.
- The role of health care purchaser and provider should be split to facilitate the contractual relationship and improve the accountability mechanisms between the purchaser and the provider of health services.

OPERATIONAL ASPECTS

- Ensure a public subsidy, which is essential to increase coverage of poor and vulnerable people under CBHI.

CBHI scenarios presented above and in the feasibility study (MOH 2024) outlined annual premium contributions ranging from 13,837.36 Ariary[2] (Ar) per person/year to 25,250 Ar per person/year. However, data collected during the household survey on willingness to pay for CBHI showed that the average amount households are willing to contribute is 8,442 Ar per person/year. Whichever scenario is chosen, it is easy to see that the financial commitment that will be requested from each person per year is far beyond households' ability to pay. *Therefore, to guarantee wide support from the population, it is important to have the government subsidize contributions from the start.*

No country has achieved UHC by relying primarily on voluntary contributions to insurance schemes (Kutzin, Yip, and Cashin 2016). In Ghana, the National Health Insurance Scheme is financed mainly by the 2.5 percent value-added tax on goods and services at the national level. In Rwanda, government subsidies (via government budget and innovative sources) for CBHI financing have been strengthened since 2019. In Senegal, during the official launch ceremony of the UHC program, President Macky Sall announced the inclusion of FCFA 5 billion in the Ministry of Health and Social Action budget to finance the program. Similarly, communes and departments provide financial support to CBHI. *In Madagascar too, transfers of fiscal resources from government will be necessary to subsidize member contributions, because of people's unwillingness to pay the full enrollment, in order to offer an attractive package of services. Financial support from the government is also essential for subsidizing the membership of the poor.*

- Structure CBHI around a broad population base to facilitate risk pooling.

The law of larger numbers drives the concept of health insurance, because it allows cross-subsidization within the insurance (i.e., from rich/healthy to poor/sick). As in Senegal and elsewhere, risk pooling in Madagascar should initially be structured around geographical entities such as the commune and gradually move to umbrella structures at the district, regional, and national levels, as well as transition to the Health Insurance System at the national level (Public Health Insurance and Solidarity Body), as stated in the National Health Financing Strategy. *The commune-level CBHI should include the entire population of the commune (municipality) without distinction, including members of different sectors such as savings and credit groups or producers' cooperatives operating in the commune. The different arrangements for linking subsectors/value-chains with the commune-level CBHI should be promoted through CBHI promotion strategies.*

- Establish a co-management mechanism between the community and the government.

The results of the feasibility study conducted in Fénérive Est District show that co-management by the government and scheme members is the desired management mechanism of CBHI members in the district (48.4 percent of heads of household). In the assessment interviews, several people expressed their distrust of CBHI managers and management bodies; they fear the embezzlement of funds and non-compliance with management rules. Thus, they condition their membership on the application of (and adherence to) good CBHI governance.

[2] 1USD: 4,300 Ar.

If CBHI members decide to establish an CBHI scheme executive office at the commune level, the commune should support strengthening the management capacity of the executive office staff, to enhance its professionalism. Communes also should provide financial incentives for the executive office responsible for the day-to-day management of the scheme or make available at least two permanent paid staff (a secretary and an accountant) to support the day-to-day management of the scheme.

- Promote family membership.

Family membership was the preferred method of membership among household heads interviewed during the assessment (64.1 percent). Family membership will help avoid adverse selection. The average household size in Fénérive Est was found to be 3.8 people.

Most households heads (55.3 percent) would prefer to pay the CBHI contribution in installments. Although this is understandable given the limited means of many potential members, this payment method can raise the cost of scheme management and CBHI awareness-raising. It is therefore necessary to study the possible contribution payment periods carefully; since the main activity of many targeted households is agriculture, aligning payment with harvest periods, when rural residents have extra funds, may be advisable. *The number of installments should not exceed two per year to avoid onerous administrative and monitoring costs.*

- Conduct an actuarial study toward the end of the demonstration phase.

An actuarial and cost study should be done to calculate the contribution rates and subsidies needed to financially sustain the CBHI program or whatever financial protection mechanism the Government of Madagascar eventually chooses to scale up in the long term. The costing should include a significant and sustainable level of government subsidy that takes into account the populations' ability and willingness to pay.

- Ensure that existing CBHI initiatives are given sufficient time to continue operating in their current areas of coverage.

The government should give existing CBHI initiatives sufficient time to continue operating in their current coverage areas, especially since they are not numerous and cover little of the target population. This is to avoid inhibiting these community initiatives and, above all, to provide a basis for comparing the level of performance of different models of CBHI experiences. It is also expected that the existing CBHI schemes will come to understand the benefits of integrating into the new CBHI architecture, including the government subsidies.

STRATEGIC AND POLICY ASPECTS

- Lobby and advocate for strong support from the top level of the Government of Madagascar's political authority.

The implementation of CBHI requires significant financial commitment by the government. This commitment is only effective when the authorizing officer of the government budget is convinced that health financing is a long-term investment in the country's human resources that allows for economies of scale to be achieved.

ANNEX A: PARTICIPANTS AND PLACES VISITED DURING SENEGAL STUDY TOUR

The Malagasy delegation comprised 17 people and reflected the multisectoral aspect of UHC. They represented the following institutions:

- Head of Medical-Social Service/Office of the President of the Republic
- Director General of Resources/MOH, Head of delegation
- Technical Assistant to the General Secretariat /MOH
- Regional Director of Public Health Analanjirofo/MOH
- UHC Support Unit/MOH
- Director of the Budget/Ministry of Economy and Finance
- Director General of Population/Ministry of Population, Social Protection, and the Promotion of Women
- Technical Assistant/PIVOT, a health non-governmental organization (civil society)

During the trip, the delegation met with key actors from different administrative levels of the Senegalese administrative and health system who represented the institutions and structures listed below:

1) At the national level:
    - National Agency for Universal Health Coverage (*Agence de la Couverture Maladie Universelle*, ANACMU)
    - Directorate of Public Health Establishments
    - Directorate General of Social Action
2) At the peripheral level (regional and local)
    - Regional Health Directorate of Fatick
    - Regional UHC Service of Fatick
    - Fatick Departmental Health Insurance Unit
    - Departmental Health Insurance Unit of Foundiougne
    - Muscapo and Jappo CBHI schemes
    - Fann University Hospital
    - Fatick Regional Hospital
    - Philippe Maguilene Senghor health center

    Meetings with these various stakeholders allowed the Malagasy delegation to observe and discuss the implementation of CBHI and to draw lessons from them.

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