# Agreement for Performance of Work

Support services to enable country level collaboration for improved institutional frameworks in the area of health financing systems

## SENEGAL Summary

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*by*

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## 2. ANALYSIS :

### (i) Constitutional/Legal/Governance Challenges:

● Article 8 of the 2016 Constitution "guarantees to all citizens the fundamental individual freedoms, the economic and social rights as well as the collective rights. It expressively says that "These freedoms and rights are notably: …the right to health". Article 17 further states that "the State and the public collectivities have the duty to ensure the physical and moral health of the family and, in particular of the handicapped persons and of elderly persons. The State guarantees to families in general, and to those living in the

rural milieu in particular […] the access to the services of health and of well-being"[1].

● In line with these commitments, the Plan Senegal Emergent (PSE) has identified in 2014 the extension of social protection as one of the three top priorities of the country[2]. The Government of Senegal is now implementing the National Social Protection Strategy 2016 - 2035[3].

● Regarding the health sector, Senegal adopted its first national health policy in 1989. It is implemented through a national health sector development plan, the third of which was adopted in 2019 (*Plan National de Développement Sanitaire et Social - PNDSS 2019 - 2028*). The *PNDSS* is based on three major axes which are: (i) the governance and financing of the sector; (ii) the provision of health and social action services; and (iii) social protection in the sector.

● The objective of UHC was actually on top of the priorities of the political agenda of Senegal's President during his two electoral campaigns in 2012 and 2019[4]. One of the key pillars of Senegal's vision for UHC rests on Mutual Health Organizations - MHOs (or *mutuelles,* hereinafter) that provide health insurance to their members, and which are formed on the basis of an ethic of mutual aid, solidarity and collective pooling of health risks. Since then, UHC is mainly pursued through an improvement in terms of financial access through the Universal Health Insurance Policy (called *Couverture Maladie Universelle - CMU*). The coordination of the financial protection arm of UHC has been assigned to a separate *CMU* Agency. The *CMU Agency* was initially created under the responsibility of MoHSA but was transferred to the responsibility of the Ministry of Community Development, Social and

[1] Inscribed in the Constitution, the right to health creates positive obligations for the state to secure the effective enjoyment of it. Social rights and the right to health have thus a strong legal value in Senegal. The question thus arises as to whether there is a legally binding commitment towards UHC in the country, in which case citizens could claim it directly or indirectly before the authorities, especially the courts.

[2] The PSE defines social protection "as a set of measures to protect people against the occurrence of social risks. It integrates public social security schemes as well as private and community schemes".

[3] In Senegal, and in the countries formerly under French administration, social security emerged towards the end of the colonial period. Initially, the idea was to create minimal financial security which could compensate for the security provided by the institutions of traditional society, e.g. the family, the clan, the village, etc.

[4] However, the proportion of the population actually covered is still below the planned objective. By the end of June 2019, an estimated 45.39% of the Senegalese population was covered by some form of social protection scheme for health.

Territorial Equity in April 2019, in particular to improve the coherence of community development policies.

- A Strategic Development Plan for Universal Health Insurance Coverage has been launched in 2013 by the President of the Republic to cover the period 2013 – 2017, pointing out the political will at the highest levels of the Senegalese State. The strategy is composed of two pillars: (i) free health care for vulnerable groups, e.g. children, the elderly, the disabled; and (ii) the promotion of community-based mutual health insurance system, targeting specifically rural areas and the informal economy.
- To guarantee financial access to health care for those who were not eligible for the existing schemes, Senegal has progressively established through its *CMU* Programme a community-based health insurance (CBHI) scheme consisting of community-based organizations, e.g. *mutuelles*[5]. The CBHI scheme in Senegal is managed by non-profit community organizations and its enrolment is voluntary[6]. This scheme is unique in Western Sub-Saharan Africa and differs in several aspects from the traditional schemes set up in other LMICs with comparative revenue to the extent that the benefit package and insurance premium, together with other insurance management rules, are standardized by the national agency. Besides, the Senegalese Government fully subsidizes the insurance premium for poor households, identified by the National Family Security Grant programme and people living with disabilities[7].

[5] By the end of 2016, the programme had created 676 *mutuelles* in all 552 municipalities, covering the entire country. These non-profit community-based organizations are operated by part-time community volunteers who perform the following tasks (not exhaustive): registration of beneficiaries, awareness raising activities about the scheme, reviewing invoices and reimbursing health posts, health centres and private pharmacies for services used by members. The *mutuelles* apply the same rules with regard to premiums and benefit packages throughout the country. Besides, they are all affiliated to a secondary structure e.g. a union at the departmental level. These unions are tasked with overseeing the financial coverage for services offered in referral-based hospitals at departmental, regional and national levels.

[6] The community-based organizations are authorized to operate by the MoHSA under the regulation for social insurance organizations (Regulation no. 07/2009/CM /UEMOA), which was stipulated by the Western African Economic and Monetary Union (WAEMU). The Union sets rules for microinsurance, including community-based organizations: community-based organizations should be not for profit and household heads are required to enrol in an organization in the community of residence on behalf of his/her household. He/she is responsible for enrolling all the household members in the same organization. The premium contribution is 7000 Western African CFA Francs (about 12 United States dollars) per person and year, of which 3500 Western African CFA Francs is paid by the member. For poor households and people living with disabilities, the government subsidize user-fees in addition to the premium.

[7] The premium for all the other enrolees are 50% subsidized.

● These *mutuelles* are still facing huge difficulties, notably the irregular income pattern of those desiring coverage [8] and the relatively high contributions proposed, which can prevent people from joining them[9].

● Other initiatives to expand health coverage should be pointed out. Since 2013, the Senegalese Ministry of Labour has been examining the feasibility of creating a social protection scheme for entrepreneurs and workers in the informal sector, named "simplified regime of social protection for small taxpayers" (*Régime simplifié de protection sociale pour petits contribuables - RSPC*)[10].

● At national level, the implementation of the strategy has been delegated in 2015 to the Agency for Universal Health Coverage (ACMU[11]), which is supported by several bilateral and multilateral Development Partners (DPs).

● The coexistence between CMU on the one hand and RSPC on the other hand illustrates a key problem affecting Senegal's social protection system, which suffers from a multiplicity of actors, institutions, policies, strategies, legal frameworks and supervisory authorities. This leads to confusion and lack of institutional coherence. It is, for example, difficult to understand why the CMU and the RSPC are placed under separate ministries. e.g. health and labour, respectively, while targeting essentially the same group of beneficiaries and providing similar services. Likewise, while the Ministry of Health and Social Action (MoHSA) is responsible for expanding the supply of health services, the CMU Agency is in charge of coordinating the various financial protection regimes.

● There are currently four types of financial protection schemes in Senegal[12]:

(i) Compulsory health insurance: The compulsory schemes are mainly constituted, on the one hand, by a compulsory scheme for civil servants which is financed from the State budget (*imputation budgétaire* or budget item) which allows a partial coverage (80%) of medical care but not of

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[8] Income are gained from seasonal activities, and therefore are cyclical in nature.

[9] When contributions are too low the MHOs do not ensure effective coverage of hospital care.

[10] The RSPC was conceived primarily as a voluntary scheme but is envisaged to become compulsory over time. It was supposed initially to cover social risks related to health and old age and to offer health insurance coverage, as well as pension benefits, to urban informal economy actors. Then, it was supposed to expand to cover compensation for work-related accidents, as well as maternity benefits. Although designed in the first time in 2013, the RSPC is still in a trial phase.

[11] *Agence pour la CMU – Couverture Maladie Universelle.*

[12] By the end of June 2019, it was estimated that close to 50% of the Senegalese population was covered by some form of social protection regime, with close to 20% of the total population covered by CBHI.

drugs; while on the other hand, permanent employees of private companies and their beneficiaries are covered through Institutions de *Prévoyance Maladie*, which are a kind of social insurance and cover non-occupational diseases up to 50% to 80% of medical and pharmaceutical costs on social contributions[13]. Other compulsory schemes comprise, among others, the Senegalese Pension Fund covering retired employees and their dependents; the Social Security Fund covering accidents at work and occupational diseases; and a University Fund that takes care of students for routine care.

(ii) Medical assistance: Medical assistance relates to health services subsidised by the State and implemented by the MoHSA as well as exemption mechanisms for some categories of the population. Exemption mechanisms include the "Sesame Plan" which concerns people aged 60 and over, a package of free care for children under five (including consultation, medication and vaccination in public facilities, and emergencies in hospitals), and a solidarity fund to improve the state of health of poor people without medical and social coverage. In addition, several benefits and services are provided free of charge through Government subsidies: free Caesarean section, dialysis, antiretroviral therapy and anti-tuberculosis drugs. Some expensive medical conditions, such as diabetes and cancer, are also subsidised to make their treatment more affordable.

(iii) The voluntary health insurance scheme through community-based health insurance (CBHI) and *mutuelles*[14]: The target population for the CBHI is essentially households in the informal sector and in rural areas who are not affiliated to a compulsory health insurance scheme. Their benefit packages have been harmonised and extended thanks to 100% State subsidies for the poor (beneficiaries of family security grants, holders of equal opportunities cards) and 50% subsidies for the others. Some other indigent people are cared for by local authorities through mutual health insurance companies. Each municipality has at least one mutual health insurance

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[13] The *Institution de Prévoyance Maladie* (*IPM* or Sickness Insurance Institution) is a social welfare organization in charge of health insurance for public or private sector workers and their families. The *Institution de Prévoyance Retraite et Sociale (IPRES)* is a social health insurance for workers who previously held salaried jobs and their families. Creating an IPM business or becoming a member of a joint IPM is an obligation for all employers of more than 300 employees. These mandatory programs cover less than 20% of Senegal's population.

[14] The total number of *mutuelles* reached 676 in 2018, with 455,659 member households and close to three million beneficiaries. The annual premium amounts to 7,000 FCFA (13 US dollars) per person, 50 per cent of which are subsidised by the State (ACMU), which also subsidises 100% of the premium for the poorest households. The insurance covers 80% of the provision of care in public facilities and generic drugs, and 50% of the cost of drugs purchased in private pharmacies.

company, and each department has a union of mutual health insurance companies.

(iv) Commercial health insurance: These schemes generally cover individuals with a relatively high level of income. Despite the attractiveness of the benefit packages offered and the professionalism of the management, they cover a very small part of the population, so that the fragmentation of the risks covered, and the high premium levels limit the potential for private for-profit health insurance to make a significant contribution to extending health risk coverage[15].

● In practice, these four regimes are managed by various organisations without effective coordination so far[16].

**(ii) Political and Socio-Economic Challenges:**

● The COVID-19 pandemic situation has exacerbated the need to have a strong and resilient health system. Solutions have been proposed, especially those associated with expanding the supply of specialised health services to disadvantaged areas, and of harmonising, or possibly integrating, the different health insurance and medical assistance schemes. This is a major challenge which requires strong political will, and is constrained by lack of fiscal space, continued disparities in resource allocation and resistance to merging existing fragmented schemes.

● Overall, the health sector in Senegal has appropriate policies and institutions in place to allow for appropriate governance and to facilitate progress towards UHC. However, two important issues are still critical and weaken the health system: severe disparities in the way in which resources are allocated and managed in the sector and across regions; and the

[15] The micro health insurance pool (*Pool Micro-Assurance Santé - PMAS*) is a partnership of private insurance companies seeking to provide affordable health insurance to low-income people and workers in the informal sector. Six private insurers established PMAS in June 2012. PMAS acts as a third-party administrator of insurance products, which are offered to organized groups, associations, student groups, women's organizations, and others. PMAS contracts with a mix of public and private sector providers, and its products cover the basic services that are provided in public health centers and the complementary package offered in public hospitals. The PMAS model appears to be unique to West Africa. Enrollment has proven to be difficult: if PMAS offers similar coverage as CBHI schemes, it requires higher prepayments from enrollees because it does not receive the same subsidies as CBHI schemes.

[16] Yet, the CMU policy is constantly evolving so as to respond to the emerging challenges, especially to better integrate the various schemes, e.g., transfer of medical assistance schemes to State-subsidised CBHI affiliation.

fragmentation of the institutions in charge of managing and implementing the overall UHC policy.

- Though many institutions are now in place to deliver UHC, substantial disparities still characterise resource allocation in the health sector and health risk protection schemes are highly fragmented. Efforts are being made to better integrate the various schemes, especially the CBHIs, but a lot remains to be done. Besides, progress towards UHC is constrained by the difficulty to act on social determinants of health and a lack of fiscal space[17].
- Progress towards UHC in Senegal needs sound policy and planning documents, adequate supportive legislation, inclusive coordination mechanisms and enhanced accountability. Reducing out-of-pocket (OOP) payments[18], developing prepayment mechanisms and pooling, expanding the coverage of the CBHI scheme and the efficiency of its management and procedures, and shifting to strategic purchasing to improve financial management and health spending efficiency, are also core challenges. Last but not least, reducing the fragmentation of financial protection regimes has also been identified as important when it comes to reducing disparities and promoting equity in health financing.

**(iii) Financial Challenges:**

- Despite some progress, notably a slight increase in per capita current health expenditure[19], the Current Health Expenditure (CHE)[20] is below the international threshold of 5% of Gross Domestic Product (GDP), and social health insurance continues to represent a very small portion of CHE[21].
- In 2018, there was still a very important share of domestic private health expenditure in terms of total current expenditure[22] and particularly of OOP expenditure[23]. And the share of health insurance was very limited[24].

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[17] Social determinants of health are difficult to tackle because they need inter-sectoral action, which can only be achieved if accountability is also envisioned in a multisectoral way. All the departments contributing to the UHC policy should receive a clear mission statement with well-defined roles and responsibilities and should be held accountable for their results.

[18] Households spent the largest portion of their health care funds at private pharmacies, followed by spending at national public hospitals.

[19] Amounting to 55 USD in 2017.

[20] 4.13% in 2017.

[21] Less than 4% in 2017.

[22] Accounting for 65% in 2018.

[23] 54% of CHE in 2018.

● In addition, a weak prioritisation with regard to health provision in the State budget should be pointed out : Domestic General Government Health Expenditure accounted for only 3.89% of General Government Expenditure in 2017, far from the Abuja target and below its 2009 level.

- **Revenue Raising:**

● Raising more general revenue and increasing the budget for UHC are key strategies for the Senegalese Government, in particular to sustain full premium subsidy for the vulnerable populations.

● The UHC Strategic Plan is funded through a combination of Government subsidies, household contributions, and external funding from DPs. To streamline management of these funds, the Government has established two main entities: the National Health Solidarity Fund (*Fonds National de Solidarité Santé*) and the Independent Fund for Universal Social Protection (*Caisse Autonome de Protection Sociale Universelle*). These funds play a central role in strengthening the sustainability and improving the service packages of mandatory, community, and medical assistance schemes. They have become the primary financing instruments for expanding coverage in the informal sector by subsidizing free care for exempt groups.

● To overcome the fiscal difficulties to achieve and sustain UHC in Senegal, the *CMU* Agency and the ministry of Finance have started a dialogue to explore the fiscal space for the CBHI scheme. Innovative solutions include implementing tax on sugar-sweetened beverages and introducing social value added tax earmarked for Government health-care expenditure.

● Introducing results-based financing is also a strategic objective regarding health financing and a project is currently being piloted in six regions.

● A core objective is to increase the financial resources for the free health care initiatives, in particular *Plan Sésame*[25], which is funded through a Government budget line item[26]. But other free health care initiatives do exist,

[24] Voluntary Health Insurance amounted to 8% of CHE in 2017, while Compulsory Health Insurance comprised less than 4% of CHE.

[25] *Plan Sésame* has been established in 2006 and provides user fee exemptions for people aged 60 and over. Beneficiaries are required to present a national ID card at the point of service.

[26] The program also uses some funds from the *Institut de Prévoyance Retraite et Sociale*, the old-age pension fund, and the *Fonds National de Retraite* (the national contingency/pension fund for formal employees in the private sector).

financed by the Government, for which it is necessary to ensure financial sustainability[27].

● The Government and households are the biggest payers of health care services in Senegal. These payers, who can be divided into public (central/decentralized Government, *IPRES*, civil servants fund, and employers) and private entities (IPM, *mutuelles,* private insurance firms, households, employers, not-for-profit organizations, and donors), bear significantly different costs for health services.

● *Mutuelles* play a fundamental role in the mobilisation of resources, but their contribution is currently limited by factors such as low penetration rate of the target groups, low levels of contributions, inadequate marketing, or the fact that the dates for payment of contributions are not synchronised with the periods when incomes are available[28].

● Innovative measures should be developed to increase mobilization of resources. For example, increasing public revenue collection from the healthy and wealthy, in particular through CBHI, could enhance cross-subsidization and risk pooling. Likewise, efficient systems of taxation and premiums that would take into account individuals' income levels could also be implemented to eliminate payments at points of service delivery.

- **Pooling:**

● The various health insurance and medical assistance schemes in Senegal are still fragmented, each scheme having its own operating mechanism, thus contributing to reduce the overall efficiency of the system[29]. Substantial disparities characterise financing resource allocation in the health sector, and health risk protection schemes are highly fragmented (especially CBHIs), which means that the pooling of funds is not carried out at a sufficiently high level to ensure cross-subsidisation and the reduction of

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[27] These initiatives include caesarean sections in all Senegalese hospitals outside of the capital region, certain services for children under age 5, antiretroviral drugs and anti-tuberculosis treatment, and anti-malarial drugs. In addition, the "*Bajenu Gox*" program is a community health worker program established for the promotion of maternal, newborn, and child health. *Bajenu Gox* community health workers are part of committees targeting beneficiaries of *bourses de sécurité familiale* (family assistance grants) and also participate as committee members of CBHI schemes.

[28] It is very difficult to assess incomes, particularly in rural areas and in the informal sector. It is thus very complicated and indeed impossible to relate contributions to income levels. However, mutuelles contribute actively to equity in access to care in the regions where they operate.

[29] This is exacerbated by a lack of progressivity of the health financing system and especially, an insufficient targeting of the medical assistance system. For example, all children under five and all people above 60 are entitled to free healthcare, whatever their socio-economic status.

financial risk. These “upstream” constraints in terms of governance and resource allocation have negative effects on the rest of the health system.

● In the CBHI, the *mutuelles* are handling the insurance premium for health services and drugs that are provided or prescribed by health posts and health centres, e.g. at primary and secondary health care level[30]. The rest of the fund is pooled at departmental unions level for health services and drugs that are provided or prescribed by referral hospitals, e.g. for tertiary health care. For tertiary care, larger financial risks can thus be pooled by larger groups of people than each community-based organization.

● Efforts to organize or consolidate CBHI schemes into national health insurance plans are needed[31]. Actually, most *mutuelles* operate independently and therefore have no obligation to standardize costs or benefits. The National Health Solidarity Fund should provide a general subsidy for services offered through *mutuelles* and seek to promote overall membership.

● To address the challenges faced by the CBHI scheme, the Government has partly implemented two major reforms since 2018. The first reform involves a series of institutional reorganizations to raise the risk pool[32].

[30] Each level has its own administrative entity, which is in charge of coordinating and monitoring all health activities and care structures. The basic unit in the health pyramid is the health hut, where the village pharmacies are located. There are 1,384 such health huts in Senegal, which are often run by "community health agents" or by women, who often come from the local village. The next level of the pyramid comprises health posts and maternity centres. It is at this level that primary health care is provided. There are 768 such health posts, which play an extremely important role, since they constitute the infrastructure that is most widespread and thus most accessible to the various population groups. The intermediate level is the level where secondary health care is provided, the care unit being the Health Centre, which is run by a general practitioner with the assistance of a qualified midwife. The activities of the Health Centres range from consultations to in-patient hospital care. Senegal is thus divided into 58 health districts, each of which has a Health Centre. Each region of the country has a hospital, which is under the authority of the administrative unit known as the "Medical Region", which constitutes the second referral level for the public and private health facilities in the region. The University Hospital Centres form the top of the pyramid and constitute the third referral level of the health infrastructures in Senegal. In general, the five levels of the health pyramid are not often respected, since the population groups that can afford to consult a doctor directly prefer to do so. This situation results in an excessive workload for the hospital facilities, whereas certain complaints could be treated at the health post or health centre level, which would also be more cost-effective.

[31] Numerous CBHI schemes, or *mutuelles*, have been developed for rural and informal sector workers representing 80% of the population. There are 130 different CBHI schemes, but coverage remains low at 4% of the overall population and 14% of the targeted population. Plans and premiums vary by *mutuelles*, but coverage for primary care is most commonly offered.

[32] The limited ability for risk pooling is a key challenge of the community-based scheme, because a large part of the insurance premium remains to be pooled at community level. In addition, each organization has a limited budget to manage the insurance. By moving some of the community-based

● These reorganizations consist of transferring the risk pooling and part of the insurance management from the individual organizations to the departmental unions and transferring the operation and financial responsibility of the free health-care initiatives for vulnerable population to the community-based scheme. The second reform is the introduction of an integrated management information system for efficient and effective data management and operations of the scheme.

- **Purchasing:**

● Public health care providers are paid on a fee for service basis, with payment dependent on an annual global budget. Important backlogs of unpaid fees result in financial debt for the majority of public providers. Public health facilities struggle to manage financial constraints with a constant demand for services, often leading to demotivation among health providers and low quality services. With support from external donors, a performance-based financing (PBF) program has been introduced recently. Under this program, health facilities receive money based on the achievement of incentivized indicators.

● Regarding the purchasing of health services, the packages of services included are not adapted to the requirements of the extension of the *CMU* and to the evolution of the epidemiological profile[33]. In addition to contributing to increased coverage for the CBHI scheme and improved relations between health service providers and community-based organizations as well as departmental unions, the *CMU Agency* has a critical role to play to achieve the defragmentation of health service purchasing mechanisms, to unify financial flows and pooling resources, Improving the identification of the targeted beneficiaries for awareness campaigns and collection of fees and premium contributions is also a core task.

● Developing strategic purchasing is a core challenge. This implies to extend performance-based financing (PBF), to scale-up CMU and to provide support for health reforms and national capacity building.

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organizations' tasks, such as review of invoices, to the departmental union, decision-makers are expecting the scheme to be more efficient through the scale of economy. To ensure sustained community engagement, other functions, such as registration of beneficiaries and awareness campaigns remain at the community level. Reforming the community-based health insurance scheme by transferring the risk pooling and a part of the management tasks from the community to the department level is necessary for the sustainability of the scheme.

[33] For instance, because insufficient funding, e.g. less than 10% of total current expenditure, is dedicated to reproductive health.

**(iv) Collaborative Challenges:**

● Senegal is a party to various regional and subregional health initiatives and is a member of different steering bodies at international level (the West African Health Organisation (WAHO), Roll Back Malaria, Harmonization for Health in Africa (HHA), IHP+, Muskoka, Global Fund, GAVI, RMNH, Compact, Busan, Every Woman Every Child, etc.). It is the beneficiary of the technical and financial assistance mobilized by these initiatives. A number of technical and financial partners are supporting the Ministry of Health and Social Welfare, namely the United Nations, bilateral and multilateral cooperation bodies, and NGOs. A number of frameworks and mechanisms are in place to coordinate action by these partners, for example the United Nations Development Assistance Framework (UNDAF) 2012-2018, joint programmes, the health thematic group, G12, and G50. An RSS platform has just been set up. The Global Health Security and Regional Disease Systems Enhancement Project (REDISSE) have been launched to strengthen health security.

● The development of *mutuelles* has involved not only communities but also several national and international institutions. Cooperation agencies such as the ILO, USAID, the GIZ and the ANMC/WSM (Alliance Nationale des Mutualités Chrétiennes de Belgique/Solidarité Mondiale) have played a key role in this regard. The involvement of cooperation agencies, research structures and the State in the community has been critical in the development of mutual insurance in Senegal.

● The Access and Delivery Partnership (ADP) has collaborated with the MoHSA to establish a multi-disciplinary coordinating platform to identify and address barriers that limit or prevent the implementation of national disease control programmes. The platform, which involved Government policy-makers and technical experts from across national and sub-national agencies, prioritized support for the identification of health research priorities for integration into the new Health Research Strategic Plan for Senegal (2019–2024).

● The World Bank and USAID - though its Government to Government (G2G) initiative - are co-financing a package of services in six regions across the country. Using funding from the International Development Association (IDA), the World Bank is supporting this package in four regions, and USAID is funding it in two. The co-financing arrangement represents one of the first instances of donor harmonization in the Senegal's health sector, and the arrangement is quite straightforward. The Bank has created a trust fund (TF) for USAID's funding. All funding flows through the Bank, and complies with the

institution's fiduciary, financial management, and procurement rules and procedures. The Ministry of Finance receives the funds from the TF and then distributes them to the MoHSA. The MoHSA then allocates money to the health facilities based on their achievement of incentivized indicators. The co-financing arrangement has generally proven beneficial for the Bank, USAID, and the Government. For example, transaction costs have been reduced for all partners, especially the costs related to fiduciary rules and financial management. Co-financing has also developed economies of scale around what are typically high-cost inputs, like verification. For all pilots, technical assistance is provided by Abt Associates, a USAID contractor, which has an added benefit: increased funding that can be allotted to PBF payments[34].

**(v) Human Resources Challenges:**

● Like most sub-Saharan African countries, Senegal is experiencing a critical health workforce shortage. Human resource allocation is still inequitable in Senegal and does not reflect regional disparities in the burden of disease distribution. Health worker shortages, which are more marked in remote and rural areas, weaken health systems and compromises the population's access to health services. Various policy interventions can improve health workforce recruitment and retention in rural and remote areas and over the past few years, the MoHSA have adopted measures to improve the posting process and the recruitment and retention of health workers in rural and remote areas. Among them was the introduction of an innovative special contracting system for recruiting health workers. Although these outcomes are encouraging, the contracting system pertains to only a small share of the total health workforce in Senegal and is a source of short-term employment exclusively. Expanding the scheme by increasing the number of contracts and their length would require significant considerations of the fiscal sustainability of such an approach[35].

● In addition to contracting, other strategies to increase staff salaries were initiated in Senegal, together with measures to increase the number of

[34] One of the few weaknesses of the co-financing arrangement is the stringent nature of the Bank's procedures. The technicalities of Senegal's program have at times also presented challenges. The benefits of the co-financing arrangement have outweighed the negative, however, and other development partners, like Japan, are interested in PBF in Senegal.

[35] Although its overall impact has been positive, the contracting system is not enough to redress geographical health worker imbalances in Senegal, particularly because contracts are only for short-term employment.

trained health workers, especially by increasing the number of students from regions other than Dakar. Training centres were subsequently opened in Kaolack, Saint-Louis, Tambacounda, Thiès, Kolda and Ziguinchor, and this allowed for more local training and recruitment of health workers in various regions of the country. Measures have also been adopted to increase financial support for students in remote and rural areas. For instance, grants are now available for seventh-year medical students wishing to do internships in such areas. Unfortunately, few medical students actually take advantage of this opportunity, despite its potential to raise their awareness of rural health issues, and measures to highlight the benefits of internships in remote and rural areas are under discussion.

● Senegal is genuinely capable of increasing the number of health workers in remote and rural areas, thanks to existing measures for health workforce management and to its training capacity. Yet adopting additional measures and strategies would complement and strengthen the effect of those that have already been adopted, such as contracting, and would further improve health worker recruitment and retention in remote and rural areas. Such measures might include the development of a more equitable and transparent health workforce posting system, wider dissemination of information on health workforce management, task shifting, the training of individuals more likely to work in remote and rural areas and, finally, a more intersectoral approach.

● The Human Resource Directorate of MoHSA, which was created in 2003, has data on health worker density and the geographic distribution of health workers, which enables the authorities to follow the application of the health map staffing norms. The National Human Resources for Health Development Plan, covering the period 2011 - 2018, aimed at contributing to the achievement of UHC through an appropriate supply of qualified human resources throughout the country.

**(vi) Health Information Challenges:**

● In 2018, a computerised UHC management information system was established in Senegal, with seven components: (i) biometric identification and management of beneficiaries; (ii) a money processing centre for collection of premiums and other funding; (iii) a data warehouse; (iv) registration and monitoring of the beneficiaries; (v) information management for payments and bills; (vi) information management for insurance operations; and (vii) a mobile phone app for beneficiaries.

● The cost of implementation and maintenance of the integrated management information system is a financial concern today. In addition, the National Health Information System is characterised by a high degree of fragmentation resulting in a multiplicity of collection tools and software, causing an operational overload. When the MoHSA elaborated a Strategic Plan for the Health Information System 2012–2016, it already pointed out the multiplicity of data collection media due to a high number of priority health programs.

● The CMU Agency is developing its Integrated UHC Information and Management System, aiming to become an integrated window for following up health coverage and enabling transparency in terms of the services provided. A digital platform has recently been created to facilitate enrolment to CBHIs through electronic payment throughout the country. However, no digital accounting systems has been established at facility level, which would be critical to ensure appropriate resource management.

● National institutions, however, have developed strong capacity in health data analysis and regularly generate reports: the National Statistics Agency has relevant capacities, and it supports the MoHSA in regularly producing surveys which are available online. And population surveys that cover all priority health areas and risks have been set up[36]. Besides, the Directorate of Planning, Research and Statistics of the MoHSA is in the process of setting up a Health Observatory but it is not yet operational.

## 3. WHAT IS NEEDED?

### (i) Strengthening policy frameworks by:

● Elaborating costing frameworks:

- Testing of the Integrated Community Case Management (iCCM) Costing and Financing Tool in Senegal has proven to be a very interesting experience[37]. Through the Translating Research into Action (TRAction) project, funded by the USAID, Management Sciences for Health (MSH) was awarded a subgrant

[36] They include the Demographic and Health Survey (DHS) and more recently, the Continuous Survey on the Delivery of Health Care Services. However, routine health statistics are not yet publicly available.

[37] iCCM are very effective strategies for expanding the treatment of diarrhoea, pneumonia, and malaria, which are the leading causes of child mortality and result in nearly 44% of deaths worldwide in children under five years old.

to develop a costing and financing tool for iCCM. The iCCM Costing and Financing Tool was used to estimate the costs of Senegal's iCCM program from the baseline year of 2011 and project program costs through 2016, based on a target of increasing the number of districts covered from 65 to 72 and a related increase in the population covered from 1.6 million to 2.0 million (including population growth) by the final year[38]. The costing exercise pointed out in particular that the program would be expensive unless the numbers of services increase, or management and supervision costs are reduced. The analysis also showed that the analysis of costs may need to be accompanied by other studies that could indicate possible constraints to scaling up, such as a review of the impact of user fees and stock-outs.

- Promoting equity in health system financing[39]:

- Studies from LMICs generally explore the equity impact of UHC based on disaggregated data by geographical area, socio-economic status and gender. However, another key area in which inequity may arise is disparities in the quality of care and access to specialised clinical services[40].
- UHC programmes should focus first on increasing coverage and decreasing economic barriers to access among the most disadvantaged groups[41]. However, if country-specific documents usually focus on geographic and urban/rural inequities, there is no consensus on how to realise that objective.

[38] Senegal has a long history of using CHWs to provide services. Community-owned cases de santé (community health huts) have been providing treatment for diarrhoea and malaria since the 1950s and have been a staple of the Senegalese health system. Senegal's health system is mostly government run and comprises 20 referral hospitals, 77 health centers, 971 health posts, and an estimated 2,300 cases de santé. Senegal's current community health program is heavily supported by the USAID-funded Community Health Program (CHP), led by Child Fund International in partnership with the Ministry of Health and Prevention (MOHP). The MOPH does not provide significant financial support to the community health program, but it works closely with the implementing partners and plans to absorb components of the program in the near future.

[39] In Common Law systems, the term "equity" refers to a particular set of doctrines and procedures involved with civil law, which complement the statutory laws, but with no real connection to the meaning used in public health. In civil law legal systems, equity does not exist as a concept, but is comprehended through other concepts such as equality and non-discrimination, protection of minorities, minimum base, proportionality or ability to pay, or fiscal federalism. It can also be addressed through economic and fundamental social rights, including the right to health, which imply positive obligations on behalf of government.

[40] Other types of disparities in health services relate to race/ethnicity, culture, education, or other social advantages.

[41] Often refers as "progressive universalism".



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- The measurement of health inequalities is still challenging in Senegal[42]. While health sector policy documents often intend to reduce disparities, equity is often referred to a rhetoric principle, without sufficient consideration for concrete ways for implementation.
- Senegal's *PNDSS* clearly states that "priority is given to the equitable distribution of the supply of services and the financing of health demand" and that "the provision of a minimum supply of care per region and the judicious spatial distribution of diagnostic and treatment facilities will ensure more equitable care". This should be achieved through a "resource allocation system made more equitable" and a "greater attention given to the operationalisation of the health map".
- Senegal is actually facing an inequitable distribution of human, material and financial resources, especially between regions and living environments, but also between levels of care. If equity is critical to support decisions on the allocation of resources in order to democratise access to health services, it should be pointed out that no concrete action is taken to advance equity[43].
- On the supply side, Senegal commits itself to revise budget allocation procedures to ensure equity and efficiency and the UHC policy documents expressively mention the "health map", e.g. the norms in terms of infrastructure, equipment and personnel per level of care, as a concrete way to achieve it. On the demand side, Senegal recognises the problems arising from the fragmentation of financing schemes and considers setting up a common pool as an urgency.

  - Ensuring financial sustainability and the efficient use of resources:

- *Mutuelles* could achieve greater efficiency in the allocation of resources within the health sector by encouraging better use of preventive care and health promotion services, particularly by using a compulsory reference mechanism.
- The free health-care initiatives are actually having issues with financial sustainability and efficient use of resources. For example, the initiatives cannot control if health facilities are double claiming health-care expenses for

[42] Equity in health encompasses various dimensions, some related to means or processes, some related to ends or outcomes : equity in healthcare coverage e.g. access, use of services, often called horizontal equity provides for equal treatment for equal need; equity in health financing, often called vertical equity, aims at ensuring that everyone contributes to health financing according to one's ability to pay.

[43] Such as resource allocation criterion.



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people who both are eligible for an initiative and are having a health insurance[44].

**(ii) Strengthening legal and regulatory frameworks by:**

- Adopting robust legislations:

- Policies have to be translated into legal and regulatory frameworks to become effective and to be implemented.
- In Senegal, the legal and regulatory framework is not totally in line with the UHC policy. For example, achieving equity in health financing implies to determine to what extent financing is progressive or regressive. From this point of view, if Senegal claims to make health financing more progressive and to pool resources at a high level, no major progress has been achieved so far. Legal and regulatory texts in this regard are still lacking.
- The Government has yet already identified concrete opportunities to update and adapt its laws and regulations to the existing health financing landscape, and emphasis should be laid on some major improvements. For example, for several years now, Senegal has strengthened its fiscal policy and its fiscal transparency, notably through restructuring the legal framework governing public finance in line with West African Economic and Monetary Union (WAEMU) directives, making an extensive array of budget documents available to the public, and making sure that the medium-term budgetary framework now better informs the budget process.
- Likewise, to fully take into consideration the opportunities to involve private sector stakeholders in health system reforms, in particular through public-private partnerships, Senegal has recently adopted the new Law No 2021-01 of 22 February 2021 on public-private partnership contracts (the PPP Law - see section below)[45].
- But some improvements have to be made from a legal perspective. For example, the *Pool Micro Assurance Santé (PMAS)* is still facing huge difficulties in enrolling people due to competition from CBHI schemes that receive Government subsidies. Additionally, certain models for providing low-

[44] New reforms are under way to transfer the operation and financial responsibility of the free health-care initiatives for caesarean section and health care for children younger than 5 years of age and adults 60 years of age or older to community-based organizations and departmental unions.

[45] Large PPPs are envisioned between the MoHSA and the *Syndicat des Médecins Privés* as well as the MoHSA and the *Pool Micro Assurance Santé* (PMAS) for the reconstruction of the *Aristide Le Dantec* hospital for $160 million.

cost, unsubsidized health insurance such as *Transvie* may also be excluded from current regulations and subsidy programs[46]. Likewise, IPMs reportedly experience financial difficulty because they are legally obligated to offer a more generous benefit package than the risk pool can finance.

- To make the institutional environment more conducive to the development of *mutuelles*, the Government should now focus its efforts on establishing a specific legal framework. One core objective should be to clarify and regulate the relationships of community-based schemes with the support structures[47].

● Adopting implementing/regulatory measures:

- Senegal has already adopted several critical implementing/regulatory measures. At the operational level, for example, a number of institutions are in place to ensure clinical practice and quality control. Standards, norms and therapeutic protocols are in place in various fields and are regularly updated. In addition, there are mechanisms to authorise, audit, monitor and evaluate providers according to standards. A reflection is led on how to improve the respect of norms and the quality of services provided in private health care facilities in the context of the public-private partnership, which has been developed to enable expansion of the *CMU* policy.

**(iii) Strengthening institutional frameworks by:**

● Creating supportive environments:

- Senegalese *mutuelles* are at the core of the strategy towards UHC. However, they are facing today huge difficulties, and the question arises as to how improve their environment.

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[46] Transvie is a non-profit "mutuelle sociale." Unlike a *mutuelle de sant*é, which is limited to providing health insurance to its members, a *mutuelle sociale* provides a much wider range of financial products, including pension schemes and life insurance. Transvie was created as a non-profit mutuelles sociale in 2008 with technical assistance from the International Labour Union and 18 million CFA to start its operations. Since then, Transvie has not received any subsidies and has been able to build up a reserve from which it expects to fund the construction of a headquarters and expand into other countries. Currently it employs 40 professional staff, and it has 6,000 members from the transportation industry with approximately 25,000 beneficiaries. Transvie offers multiple levels of health insurance coverage, with annual premiums from 7,200 CFA to 25,000 CFA.

[47] Senegal has already taken original initiatives in this context such as the special scheme for *mutuelles* within the formal system, e.g. the Bamako Initiative, with respect to the financing of basic health care.

- To tackle this issue, emphasis is usually laid on technical and administrative issues. The institutional dimension is often neglected, which is problematic because Senegal has a proper institutional dynamic, with a strong influence of international donors, weak State intervention in the field of social policies, and a significant rise of civil society in taking responsibility for health and other economic and social areas. At the national level, the *mutuelles* fall in the scope of several ministries, mainly health, finance and economy, social and local governance although the *CMU* Agency is tasked with coordinating progress towards UHC. At the local level, decentralization has led to a transfer of competences in the field of health, resulting in the multiplication of actors and stakeholders: associations, unions, federations have emerged to support the development of *mutuelles*. But the main issue to be dealt with regarding the *mutuelles* is the debate relating to their very essence and nature. Two visions currently oppose: first vision relates to a private insurance model and is linked to economic and financial performance; second vision points out a system carried by the values of economic and social development, with solidarity, equity and governance at its very heart. The first framework is dominated by the vision of international donors, who must integrate management and performance-based methods geared towards competitiveness, with social objectives but above all profitability. The second framework is that of *mutuelles* actors of the social, equitable and economic development. They are considered here as intermediary institutions to pave the way for local democracy and strengthened governance in order to maximize impact on health policies.
- In addition, the Senegalese Government has to cope with the WAEMU legislation (in particular the one adopted in 2009) which is not always consistent with the international recommendations regarding progress towards UHC. For example, while WAEMU framework enshrines the voluntary nature of membership in *mutuelles*, the WHO forcefully asserted in its 2010 report on world health that achieving UHC is impossible with voluntary schemes. If the MoHSA itself questioned the voluntary nature of membership in *mutuelles* schemes in the preliminary documents of the CMU, Senegal is bound by WAEMU rules and must apply the decisions of the UEMOA. So far, no decision has been made in this regard and a lack of debate on major strategic issues such as the coexistence and potential conflicts between different mutualist models and the lack of development of national policies and guidance documents for sustainable *mutuelles* should be pointed out.
- Strengthening the governance and management of the health system is also part of the work to be completed to create a supportive environment for health financing. At the strategic level, the various mechanisms such as

*Renforcement du Système de Santé plus - RSS+* provided technical and financial support to the central bodies of the MoHSA for the development of various national policy documents, as well as support for the development of strategic documents such as the National Strategy for the Financing of the Health Sector. The setting up of the or Sustaining Health Outcomes through the Private Sector - SHOPS+ mechanism, specifically dedicated to better take into account the private sector, has also provided a very significant support to the MoHSA for the management and governance of private health structures[48].

- Support has also been provided for the ongoing development of the multi-year expenditure programme document for the period 2015-2017, the comprehensive strategic plan for sexual, reproductive, maternal, neonatal, child and adolescent health (SRMNIA) for the period 2016-2020, the implementation of the emergency plan to reduce maternal and neonatal deaths, the m-Diabetes project, the effective response to the nutrition crisis in northern regions of the country, the completion of the new health map, the incorporation of District Health Information System 2 (DHS 2) into the health information system, and the extension of sentinel surveillance sites for nutrition[49].

  - Establishing close monitoring and accountability for results:

- Since National Health Accounts (NHA) estimations supply critical inputs needed to calculate several of financial risk protection indicators and are thus an important component of the UHC monitoring system, the Government of Senegal should set the stage for making NHA a routine analysis.
- The previous national health sector development plan 2009 - 2018 included a Monitoring and Evaluation (M&E) Plan. The list of M&E indicators was selected in line with a broad consensus among the various stakeholders[50]. The new plan (PNDSS 2019 - 2028) establishes a new M&E plan with coherent indicators.
- The CMU policy specifies that private health facilities and pharmacies can apply for recognition by the CMU Agency, which may subsequently withdraw or suspend accreditation. There are mechanisms to represent the interests of

[48] The provision of a national map of private health structures was one of the most essential value-added elements of this support.

[49] Other priority areas include the Organ Transplant Act, the private-sector health alliance, stop smoking campaigns and decrees on enforcing the new Tobacco Control Act, and the national survey on tobacco use by adults

[50] Each of the 11 strategic orientations was represented by at least one relevant indicator.

patients and the population in general, as well as the interests of providers in the health system, notably a Civil Society Organisation platform (called CONGAD - *Conseil des Organisations Non Gouvernementales d'Appui au Développement*) and trade unions.

- Transferring powers and resources to local authorities (decentralization):

- During the past 20 years, Senegal's health system has gradually moved from a highly centralized program that emphasized curative care to one that now stresses primary health care and community participation. As part of that process, the MoHSA "deconcentrated" authority by transferring planning and administrative responsibility to district health officers who remained accountable to the central ministry.
- The Government has undertaken decentralization in the form of devolution, which involves the transfer of authority to semi-autonomous local Government units[51].
- At the local level, the former "health management committees" were replaced in 2018 by "health development committees" which provide a consultation framework between communities and the local elected officials with responsibilities in the field of health. Inter-sectoriality is facilitated at local level because the district working plans are integrated with the inter-sectorial annual local development plans[52].
- Each of the country's 76 health districts has at least one health center and several health posts, as well as a network of community-based health huts and outreach sites to extend services to communities that otherwise would have no access. To meet the costs resulting from this transfer of power and ensure that municipalities make contributions to provide health services, the Government created a grant referred to as the Decentralization Endowment Fund. The Government simultaneously transfers funds to the municipalities to support the financing of basic services, particularly health services.
- Strengthening the operational and financial management capacities of regions and districts is now a priority in Senegal. In the area of financial and accounting management, the RSS+ interventions in the regions of

[51] The process culminated in 1996 when the government transferred responsibility for nine sectors, including health, to 372 local elected councils (10 regional, 48 municipal, and 320 rural community councils).

[52] The district health management teams run monthly district coordination meetings, and communities participate in local health management committees. Health development committees now exist in every health centre and health post.

consolidation and those of Government Technical Assistance Provider - GoTAP Project in the Kaffrine region have led to a significant improvement in the capacities of the regional and health districts teams with the implementation of standardized tools enabling the harmonization of management practices[53]. Private structures have also benefited from the support of SHOPS+ through training and coaching activities in the areas of management and planning. However, the support and assistance remained very limited, confined mainly to the structures of the regions of Dakar and Thiès and, to a lesser extent, to some interior regions[54].

- Local councils will determine priorities and plan how health monies will be spent, with technical support from the district health officer. Local councils can also receive additional funds directly from donors, who will no longer be required to pass resources through the central-level ministries. Health committees will continue to manage funds generated through cost recovery. Management committees, composed of representatives of the local council, MOH personnel, and health committees, will ensure coordination at the community level.
- Funding is a major constraint[55]. Funds generated through cost recovery and managed by the health committees are generally much greater than those allotted for health in the decentralization funds[56]. Additional funds are available to the council through the collection of local taxes, although tax revenues are generally quite limited in rural communities. Besides, mayors are generally better informed than presidents of rural communities regarding the possibilities of support from international donors and local organizations[57]. Moreover, many donors and other agencies are still determining how to channel funds to the decentralized level.

- Developing Public-Private Partnerships (PPP) and "contractual arrangements":

[53] The USAID and Abt led Government Technical Assistance Provider (GoTAP) project builds on more than 20 years of health systems strengthening in Senegal. GoTAP supports the MoHSA and USAID in providing quality analytic, management, and logistic support services. GoTAP should accelerate and sustain health gains, strengthens local capacity to manage resources and provide incentives for domestic resource mobilization and help USAID strengthen the communication and MoHSA's use of data for decision-making.

[54] Notably Diourbel, Kaolack, Saint-Louis and Ziguinchor.

[55] The grants received by the local councils are relatively small: between US$245 and $1,700 in rural communities, and $1,800 and $68,000 in municipalities.

[56] However, they are primarily used to maintain the revolving drug fund and are not adequate to maintain the entire health post.

[57] However, even mayors have taken little advantage of alternative sources of funding.

- Senegal is a leader among West African countries with regard to public-private partnerships (PPPs), having already put in place important projects for both service management and infrastructure development[58].
- A new law has just been adopted: Faced with the objective of mobilising private sector financing, particularly through PPPs, combined with the complexity of preparing and developing PPP projects and the need to optimise financing schemes, Senegal adopted the new Law No 2021-01 of 22 February 2021 on public-private partnership contracts (the PPP Law)[59]. While the new PPP Law excludes certain sectors of activity such as energy, mining and electronic communications, defence, national security, which are subject to specific regulations, it does apply to sectors as diverse and varied as transport, agriculture, education, health, drinking water supply, sanitation and public health[60]. The new PPP Law represents a conscious move by the Government to create a robust, modern, and comprehensive PPP regime. In particular, it extends the PPP legal regime to public service delegations, revamps the PPP institutional framework, strengthens communication and cooperation between contracting authorities and private investors, and introduces new measures to foster private sector participation, specifically Senegalese and WAEMU companies. The new PPP Law unifies the legal framework for public service delegations and PPP contracts. Whilst the former PPP Law only applied to government-paid PPP contracts, the new PPP Law covers both government-paid PPP contracts and user-paid PPP contracts[61].

[58] PPPs are governed in Senegal mainly by Law 2006-16 amending Law No. 65-51 of 19 July 1965 on the Obligations of the Administration Code, Law 2014-09 of 20/02/2014 on partnership contracts (of which a draft bill relating to PPP contracts repeals all its provisions), Decree No. 2014- 1212 of 22 September 2014 on the Public Procurement Code as amended by Decree No. 2020-22 of 7 January 2020 and Decree No. 2020-876 of 25 March 2020.

[59] Partnership contracts may be awarded in three ways: by competitive bidding, direct agreement or a negotiated procedure, according to the conditions defined by this law. Besides, the PPP Law eases the terms and conditions for dealing with unsolicited offers to better capture investment opportunities, which is a significant change from the previous law of 2004.

[60] The Senegalese legislator has retained two types of PPPs. Firstly, PPPs with payment by the users in which the remuneration of the holder, in return for the missions entrusted to him or her, consists either in the right to exploit the work/service, which is the subject of the contract, or in this right accompanied by a price. A substantial part of the operating risk is transferred to the contractor. In addition, he or she assumes the operating risk when, under normal operating conditions, he or she is not assured of amortising the investments or costs he or she has borne, linked to the operation of the work or service. Secondly, there are PPPs with public payment, in which the remuneration of the holder is subject to the payment of a rent by the contracting authority according to the performance objectives assigned to the holder, linked in particular to the availability of the work, the services, the equipment or the intangible assets.

[61] Includes concession, affermage, and régie intéressée.

- The new PPP Law simplifies the existing PPP institutional framework via the establishment of key bodies[62]. The enactment of implementing decrees will be scrutinised by stakeholders for additional guidance on the new PPP Laws and the practical implementation of its provisions.
- It would be important for both the public authorities and the Senegalese legislator to perfect this PPP regulation, through the revision of the current code of obligations of the Administration, which was last modified in June 2006, the code of public contracts and some of its application decrees[63].

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[62] They include: the National PPP Support Unit (*Unité nationale d'appui aux partenariats public-privé* - UNAPP) which replaces the Infrastructure Council (*Conseil des infrastructures*). This body is conceived as being the technical arm of contracting authorities, mandated to monitor the portfolio of PPP projects, assess PPP proposals, and provide expertise in identifying, preparing, negotiating and auditing PPP projects; the Inter-ministerial Committee (*Comité interministériel*) is made up of representatives from several ministries and is mainly responsible for authorising contracting authorities to initiate procurement procedures for PPP projects; a priori Control Body, which will carry an a priori review of the procurement procedures for PPP projects; a Regulation and Dispute Resolution Body, which is tasked with ensuring active coordination with the regulatory authority whenever a PPP is implemented in a regulated sector; a PPP Support Fund, which will further foster PPP projects in Senegal by providing support and funding to PPP projects, which may lack the necessary resources to be launched.

[63] In particular such regulation should take into account not only the idea that concessions, affermage and régie intéressée are user-pay PPP contracts governed by the new PPP, but also materialise the new roles and responsibilities of the Comité de Règlement des Différends of the Autorité de Régulation des Marchés Publics in the framework of the appeal of PPP contracts and the settlement of disputes arising from the execution of this type of contract.