



Master of Public Health

Master International de Santé Publique

Health financing mechanisms and Equity:

A case study on Plan SESAME in Senegal

Margot NAULEAU

MPH 2 /2011-2012

Location of the practicum

Centre de REcherche sur les POLitiques Sociales, Dakar, Senegal

Professional advisor

Alfred Inis Ndiaye, CREPOS

Academic advisor

Tamara Giles-Vernick, Institut Pasteur

Acknowledgement

I would like to thank all the stakeholders involved in the Health Inc project, in particular:

- The CREPOS team: Alfred Inis NDIAYE, Maymouna BA, Macaire BAKEU and Penda WONE for their welcome and more specifically Alfred Inis NDIAYE for his supervision
- The Institute of Tropical Medicine (ITM Antwerpen), especially Fahdi DKHIMI for advising and encouraging me during my internship

I would like to thank also my academic advisor, Tamara Giles-Vernick for her guidance.

Finally, I would like to thank my family, friends and all the people I met in Senegal, who gave me the strength to achieve this work.

Table of contents

TABLE OF CONTENTS	3
LIST OF TABLES AND FIGURES	4
LIST OF ACRONYMS	5
ABSTRACT	6
I. INTRODUCTION	8
II. BACKGROUND	11
A. EQUITY IN THE HEALTH CARE SECTOR.....	11
B. THE VULNERABILITY OF THE ELDERLY IN SENEGAL	13
III. MATERIAL AND METHODS	15
A. MATERIAL.....	15
1. <i>Literature review</i>	15
2. <i>Qualitative analysis</i>	16
B. METHODS.....	19
1. <i>The policy-making framework</i>	19
2. <i>Analysing a public health policy</i>	20
IV. RESULTS	21
A. ELDERLY CARE COVERAGE: FROM IDEA TO POLICY PROPOSAL.....	21
1. <i>Framing of the elderly health and social issues</i>	21
2. <i>Politics and presidential elections</i>	23
B. THE FORMULATION PROCESS OF PLAN SESAME	24
C. AN UNACHIEVED IMPLEMENTATION.....	29
1. <i>Institutional implementation</i>	29
2. <i>Operational implementation</i>	30
V. DISCUSSION	35
BIBLIOGRAPHY	40
APPENDICES	44
A. <i>The health care system in Senegal</i>	45
B. <i>Interview Guide</i>	47
C. <i>Brief overview of the politics in Senegal</i>	49
D. <i>SPEC-by-step Hypotheses</i>	51

List of tables and figures

Table 1: Stakeholders analysis

Figure 1: Mapping of stakeholders interviewed for this study

Figure 2: The three dimensions of Universal Health Coverage

Figure 3: The theoretical UHC dimensions of Plan SESAME

List of Acronyms

CAFSP:	Cellule d'Appui au Financement de la Santé et aux Partenariats
CREPOS:	Centre de REcherche sur les POlitiques Sociales
DHS:	Demography and Health Surveys
ESAM:	Enquête Sénégalaise Auprès des Ménages
EWC:	Elderly Without Coverage
FNR:	Fond National de Retraite
IPRES:	Institut de Prévoyance Retraite du Sénégal
LMIC:	Low and Middle-Income Countries
MoH:	Ministry of Health
NHDP:	National Health Development Programme
PRSP:	Poverty Reduction Strategic Paper
UHC:	Universal Health Coverage
WHO:	World Health Organisation

Abstract

Over the previous decades, there has been a proliferation of health financing reforms in low and middle-income countries, which aim to introduce prepayment schemes at affordable prices for low socio-economic groups, indigent populations and other vulnerable groups. The Health Inc project, carried out in Senegal, Ghana and India, explores the effects of social exclusion on various health care financing arrangements. In Senegal, the Centre de REcherche sur les POLitiques Sociales (CREPOS) has examined the Plan SESAME, a state-sponsored programme introduced in 2006 to provide free access to health care services to all citizens over age 60.

The present analysis focuses on the key factors that played a role in the design and the implementation of the Plan SESAME, financial arrangement that aims to reach Universal Health Coverage for the elderly in Senegal. More specifically, it allows citizens above 60 years of age to be exempted from user fees at the point of use within the network of public health facilities. The research consists of a multi-sectoral stakeholders analysis that aims to investigate three questions: how the issue of elderly access to health care services was brought onto the political agenda; how equity was genuinely embedded into the scheme design; and how the operational difficulties have constantly challenged this equity concern in the implementation phase.

I conducted interviews with government agents, associations' leaders, physicians and international organizations staff members. Their narratives provide insight into the process that led to the Plan SESAME's development and implementation, as well as its day-to-day management.

Results show that from the 1980s, key Senegalese associations for the elderly gradually transformed a social fact, aging, into a social problem. The Plan SESAME is a major success for these associations, which campaigned for years to obtain free access to services for the elderly. However, economic and political constraints within Senegal have stymied the Senegalese state's ability to confront equitably all of the health concerns of its elderly. Thus far, lack of funding, a dearth of trained personnel, health care resources and facilities, and administrative loopholes and inconsistencies limit Plan SESAME's capacity to respond equitably to the health concerns of Senegal's elderly population.

Résumé

Mécanismes de financement de la santé et équité : le cas du Plan SESAME au Sénégal

Ces dernières décennies, on constate une récente prolifération des réformes de financement de la santé visant à introduire des systèmes de prépaiement ou de subventions facilitant l'accès aux soins des groupes vulnérables. Le projet Health Inc, conduit au Sénégal au Ghana et en Inde, explore les effets de l'exclusion sociale sur les divers systèmes de financement de la santé. Au Sénégal, le Centre de Recherche sur les Politiques Sociales (CREPOS) étudie le Plan SESAME, programme de gratuité des soins pour les plus de 60 ans mis en place par le gouvernement en 2006.

Cette analyse se concentre sur les facteurs qui ont influencé la formulation et la mise en œuvre de ce Plan SESAME qui a pour but d'offrir une couverture médicale universelle pour les personnes âgées au Sénégal. Plus précisément, il permet à tous les citoyens de 60 ans et plus d'être exemptés des frais d'usagers au point d'entrée des établissements de santé publics. La recherche consiste en une analyse multisectorielle des acteurs dont l'objectif est d'investiguer : comment la question de l'accès aux services de soins des personnes âgées a été mise à l'agenda politique, comment le concept d'équité a été intégré dans la conception du programme et enfin, comment les difficultés opérationnelles ont constamment remis en cause cette équité.

J'ai conduit des entretiens avec des agents gouvernementaux, des présidents d'associations, des médecins et des organisations internationales. Leurs récits donnent un aperçu du processus qui a conduit au développement du Plan SESAME et à sa mise en œuvre, ainsi que de sa gestion quotidienne. Les résultats montrent que depuis les années 1980, les principales associations de personnes âgées sénégalaises ont progressivement transformé un fait social, le vieillissement, en problème social. Le Plan SESAME est un succès majeur pour ces associations qui ont milité pendant des années pour obtenir un accès aux soins gratuit pour les personnes âgées. Cependant, des contraintes économiques et politiques ont réduit la capacité de l'Etat sénégalais à affronter équitablement tous les problèmes de santé de ses personnes âgées. Jusqu'à présent, le manque de financement, une pénurie de personnel qualifié et de nombreuses incohérences ont limité la capacité du Plan SESAME à répondre équitablement aux préoccupations de santé des seniors au Sénégal.

I. Introduction

Under the coordination of the London School of Economics (LSE), six research institutions – the Institute of Public Health (India), the Tata Institute of Social Sciences (India), the Institute of Statistical, Social and Economic Research (Ghana), the Institute of Tropical Medicine (Belgium), the Centre de Recherche sur les Politiques sociales (Senegal) and LSE – have established a research consortium to explore how successful the different health financing arrangements currently promoted in Low and Middle-Income Countries (LMIC) are in extending coverage toward the poorest and the most vulnerable groups. Field research is conducted in four countries/states: Ghana, Senegal and Maharashtra and Karnataka in India.

The main hypothesis of Health Inc is that social exclusion participates to the limited success of recent health financing reforms. Social exclusion and its determinants can explain why people do not access health care while services are free of charge. Disrespectful, discriminatory or culturally inappropriate practices of health professionals and their organisations constitute one explanation. Thus, removing financial barriers through exemption programmes will not necessarily lead to equitable access to health care.

Social exclusion can also explain barriers to accessing the health financing mechanism itself. In many cases, programmes are designed to provide services free of charge to the most vulnerable groups. However, socially excluded groups do not necessarily enrol in these financing schemes, which often benefit more powerful, wealthy groups who are not targeted recipients of such programs. The result is an exacerbation, not an amelioration, of inequities in the health financing system. Underlying social, political and cultural reasons such as differential access to information and bureaucratic processes can explain the differences between financing schemes' aim and their results¹.

In Senegal, the CREPOS is investigating the Plan SESAME, which it has selected for two reasons:

- First, because the Plan SESAME is a health care financing program initiated by the Senegalese government, without financing or administrative support from international donors or organisations.
- Second, the Plan SESAME has never been studied by social scientists, whereas other initiatives, including free deliveries, caesarean sections, or antiretroviral therapies (ART) have received much scholarly attention.

¹ Jehoel-Gijsbers G. and Vrooman C. Explaining Social Exclusion. A theoretical model tested in the Netherlands. The Netherlands Institute for Social Research/scp The Hague, July 2007.

This study will examine the Plan SESAME design, initial objectives and evolution through the lens of equity². The main research question is: To what extent the concept of equity has been integrated into the conception and implementation of the Plan SESAME?

The study's aim was to analyse the formulation and design of Plan SESAME, as well as its evolution since 2006. The study's specific objectives are:

- To analyse how particular agents and institutions politicized and gave programmatic shape to the goal of providing free health care for the elderly in Senegal
- To evaluate the early design of the Plan SESAME
- To assess the Plan SESAME's implementation in Senegal
- To identify the accomplishments and limitations in achieving equitable access to care and equitable care for elderly Senegalese

In so doing, this study provides the Health Inc project and the CREPOS team insight into the contemporary historical development of this health scheme, and will offer a broader policy context in which they can situate the findings of their quantitative and qualitative investigations.

Most health-financing options taken at the turn of the new century have been strongly influenced by the paradigm of equity. McIntyre and Gilson³ explain how public health reforms moved away from efficiency considerations to focusing on equity. Indeed, the predominance of efficiency issues resulted in excluding the poor from access to health care and thus equity became progressively one of the main arguments put forward to justify any intervention or initiative in the field of health financing, especially in low-income countries. Equity has been for long externally pushed by the donors' community, and thus was thus a necessary concern. It has however gained momentum in most of the LMIC and most of the decision-makers in health have now embraced the concept.

However, more subtle forces may explain the emergence of new health financing mechanisms. If the Plan SESAME was easy to justify from an equity perspective, behind its declared objective of solidarity may have lied other interests. The complex consensus that led to agenda setting and policy formulation is one aspect. Indeed, although the Plan

² The initial research proposal was built around the household survey that CREPOS is to conduct on 3,000 households in 4 different regions, in order to identify who does not use the plan SESAME and why. This survey was to begin March 2012, but delays in elaborating a questionnaire and training personnel to conduct it, as well as in the ethical review of the project necessitated that I reorient my project. In consultation with Alfred Ndiaye, I therefore shifted the study to investigate the conceptualization, planning, and implementation of the Plan SESAME had addressed equity.

³ McIntyre and Gilson. Putting equity in health back onto the social policy agenda: experience from South Africa. *Social Science & Medicine* 54 (2002) 1637–1656

SESAME rationale was based on the assumption that Senegalese elderly have lower access to health care, it seems that this policy did not succeed in achieving greater equity in the distribution of health services. Certainly there were some limitations in both its formulation and implementation. The Plan SESAME not only developed from an interest seeking to reduce inequities in elderly populations' access to biomedical health care. The Wade government used the Plan SESAME to curry political favour with elderly constituents on the eve of a critical election. In addition, the absence of feasibility study prior to the launching of Plan SESAME has restricted the scope and effectiveness of the policy.

The second aspect relates to how the policy has been constantly adapted, reformulated under specific circumstances and constraints. This pathway explains the current characteristics of the plan SESAME. The financial issues resulting from a structural underfunding and the lack of institutional capacity for implementation and delivery of Plan SESAME services seriously weakened the policy.

II. Background

This section aims first at defining the concept of equity and explaining how it has been addressed in the health care sector, in low and middle-income countries. Then, I will provide insight on how broader inequalities in Senegal's demographic, socioeconomic, and global health context as well as in its overall healthcare system either reflect and/or shape the long-term inequities that elderly people have experienced within the health care system.

A. *Equity in the health care sector*

Improving health system is a constant concern in most of the countries of the world. However, in the LMIC, the resource constraint is a major determinant of what can be or cannot be achieved. Health financing reforms are hence one of the major policy strategies activated in the recent years to improve health systems in poor resource settings. One of the main challenges is how to organise resource mobilisation under the specific circumstances of each country, so as to respond to the permanent equity concern, concept that has gained gradually momentum over the past decade.

In the classical Aristotelian concept of equity, horizontal equity refers to equal treatment of equals ("treat like cases alike") while vertical equity refers to the unequal treatment of unequals ("give appropriate unequal treatment to unequals")⁴. In the field of health, the definition given by WHO is the reference:

Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoid ⁴.

Practically, a *fair opportunity* implies the avoidance of catastrophic expenditure that threatens the welfare of the citizens, as well as a fair distribution of health services throughout the country, notably based on health care needs of the population. In the literature, there is general agreement that health inequity results from differences in health outcome between groups that are unnecessary, avoidable and unfair⁵. One of the main drivers of inequities in

⁴ Culyer, A.J., Equity- some theory and its policy implications. *Journal of Medical Ethics* 2001; 27:275-283

⁵ Whitehead M., The concepts and principles of equity in health. Discussion paper prepared by the Programme on Health Policies and Planning of the WHO Regional Office for Europe 1990

health is the introduction of user fees at the point of service, which has been proved to be a regressive health financing option. Several studies⁶ have shown that out of pocket payments are more inequitable than any other method of financing health care, “capturing higher proportion of income among poor households than wealthier ones”⁷, hence the need to strengthen social protection in health, with a special attention to the poorest and the most vulnerable.

Referring to the last category, governments in LMIC have recently engaged themselves in number of interventions to enhance vertical equity. After several years of failure to extend formal social insurance schemes⁸ to people in the informal sector, governments have decided to reintroduce health financing mechanisms specifically aiming at lifting up financial barriers to access to health care for specific categories of patients or socio-economic groups. When it comes to coverage for the most vulnerable, various strategies have been piloted and implemented at different scales:⁹:

- *Exemption from payments*: chosen by numerous African countries, it consists of exempting specific groups or pathologies from fees.
- *Differentiation of prices*: consists in lowering prices for the poor and indigent and can be based on demographic, geographical factors, socio-economic status, on factors concerning the health status. The criteria of age and gender are usually applied since international funding organizations frequently give priority to maternal child health.
- *Targeted subsidies, Subsidizing specific services*: strongly recommended for activities that yield a high level of externalities, such as child immunization and treatment of infectious diseases, but also increasingly used in the field of maternal health (maternity vouchers)

However, these strategies present many difficulties. Exemption policies usually do not provide sufficient practical direction on how they should be implemented. They raise the problems of identifying the persons or services that should be exempted; and differentiation of prices is also difficult to design and to implement because it requires good managerial capacity and a strong information system.

⁶ Xu K. et al, Household catastrophic health expenditure: a multicountry analysis, *Lancet*, 2003, 362: 111-17

⁷ Gilson & McIntyre, Removing user fees for primary care in Africa: the need for careful action. *BMJ* 2005; 331:762-5

⁸ Many citizens in low and middle-income countries do not have access to social security system. For example, in Senegal, only 8% of the population in Senegal have access to a health insurance scheme according to the last Demographic and Health Survey.

⁹ Stierle et al. Indigence and access to health care in Sub-Saharan Africa. *Int J Health Plann. Mgmt.* 14, 81-105 (1999).

In Senegal, the government pursues a three-fold strategy:

- Developing a Social health insurance scheme for the formal employees, both of the public and the private sector
- Extending Community Health Insurance for those in the informal sector who have some sort of ability to pay
- Piloting a patchwork of specific schemes for the poorest and the most vulnerable

B. The vulnerability of the elderly in Senegal

One of these specific schemes targets the so-called “Elderly”, exempting them from payment of user fees at the point of service: the Plan SESAME.

In common sense, an elderly person is a person whose age is advanced and has physiological and social attributes of old age such as represented in a given society. In African contexts, seniors enjoy a valued social status; old people are considered as the guardians of collective memory and traditional values. However, from a more practical point of view, later life is also characterized by both a lowering and mental and body functions and termination of employment. In this study, a person will be considered as being an elder from the age of 60, as it is the limit for retirement in Senegal since 2002.

According to the Senegalese Household Survey (ESAM 2002), the elderly account for 6% of the population, corresponding to 625,512 persons. The proportion of seniors is higher in rural than urban areas (56% of those aged 55 and over in 2005¹⁰), this phenomenon is the consequence of the strong rural exodus of young people, with as direct consequence on villages that experience a strong age group gap, i.e. very few active adults remain in rural areas. Economically, the continuing crisis has increased poverty (the ESAM revealed that 65% of the households consider themselves as poor) and the difficulties of living conditions for seniors. In addition, retirement usually leads to a decrease in financial resources for the elderly and their families, creating a feeling of insecurity and worthlessness.

Traditional intergenerational safety nets⁹, defined as children taking care of housing for their parents, providing systematic or punctual financial support and usually paying for food and health have been undermined by both cultural and economic changes in the Senegalese society¹⁰.

¹⁰ Vandermeersch and Kouevdjijn. La situation des personnes âgées de 55 ans et plus en milieu rural ivoirien et sénégalais in Antoine, 2007.

Finally, in campaigns, the elderly experience difficulties in access to care inherent to deficiencies of the health infrastructures and personnel in rural areas. Senegal's health care system (see appendix A) suffers from a severe shortage of health care personnel as demonstrated by comparing the situation in the country with the standards established by the World Health Organization (WHO):

- 1 physician per 11,000 inhabitants¹¹ (including private sector) v.s. 1/10,000 inhabitants,
- 1 nurse per 4,200 inhabitants v.s. 1/300 inhabitants
- 1 midwife per 4,000 Women in age of reproduction v.s. 1 / 300 WAR

In addition, in 2002, the Senegalese Household Survey reported that 86.4% of Dakar inhabitants live within 30 minutes¹² of an accredited health facility, while only 41,2% of its rural population does so, due to lengthy distances, poor road conditions, and unreliable public transport.

The social and economic phenomena associated with aging, coupled with personnel and resource shortages within the Senegalese health care system, contribute significantly to make the elderly vulnerable.

¹¹ National Health Development Programme 2009-2018

¹² The study does not precise the means of transportation but it is usually by foot.

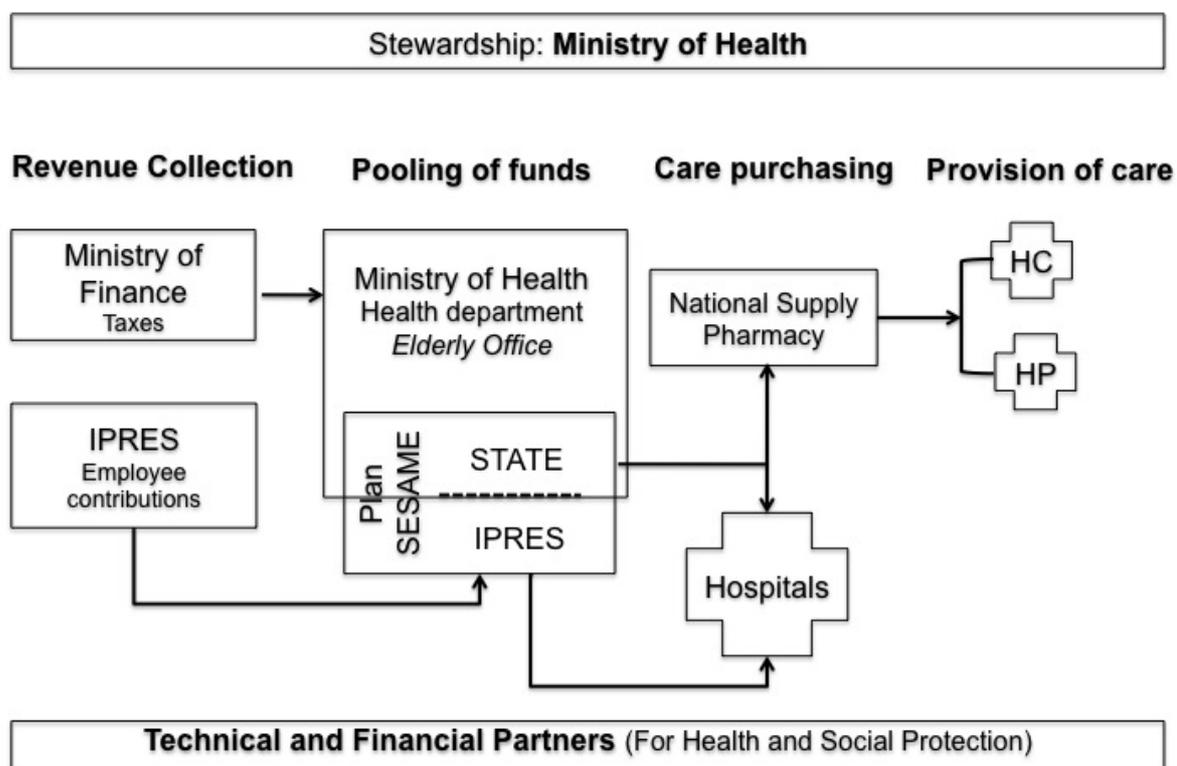
III. Material and methods

A. Material

1. Literature review

The aim of this thesis was to analyse a particular health policy, the Plan SESAME, not to identify and synthesize all research evidence regarding health financing mechanisms and equity. Although systematic review of literature has not been conducted, I did carry out a document analysis to formulate hypotheses and develop a stakeholders mapping. Documents reviewed include working papers, evaluation reports, policy documents from the MoH, government, international and national agencies. The electronically published papers were searched in English and French through Sciences Direct, combining (using the conjunction AND) the following keywords: equity, health financing, elderly, aging, poverty, health costs, Africa.

Figure 1: Mapping of stakeholders interviewed for this study



2. Qualitative analysis

Sampling and Data collection

The stakeholder mapping, synthesized diagrammatically here above, allowed me to identify all the potential key informants, but also to shortlist the key respondents to be interviewed for data collection, regarding my time constraints but also the contacts established by the CREPOS team during the exploratory stage of the Health Inc project or via my personal networks created during the first months of my internship.

The shortlist was a starting point: using the snowball effect technique, I added new stakeholders in my sample, following advices given by the first set of respondents, so as to improve the representativeness of my sample. I used the snowball technique up to saturation - i.e. no more "new" information collected - and collected information from most of the relevant categories of actors.

In total, nine key respondents accepted to answer a set of open questions. Although respondents were given room to answer freely to the questions, I designed in-depth interview guidelines (see appendix B) to structure the discussion.

Transcription

All the interviews were carried out in French and were recorded upon formal consent from the respondents using a Dictaphone. All the interviews were then transcribed in French.

Analysis

I coded all the transcriptions using NVIVO 9 software. The coding was developed along the lines of the interview guide, and themes and sub-themes were differentiated and coded as proceeding in the analysis. In addition, while the sources have been anonymized, a stakeholders' analysis (see Table 1) has been carried out and will help the reader to contextualise and interpret the narratives.

Table 1: Stakeholders analysis

ID Number	Position & Organization	Internal / External	Knowledge		Position			Interest	Alliances	Resources		Power	Leader
			1. Level	2. Definition	1. Self	2. Others	3. Final			1. Quantity	2. Ability to mobilize		
					S, MS, N, MO, O	S, MS, N, MO, O	S, MS, N, MO, O			3, 2, 1	3, 2, 1	3, 2, 1	
1	Medical Chief, Maadji Clinic	External	3	"Everyone should take possession of Plan Sésame"	S	n.a.	S	Provide social support for the elderly through health structures, interested in issues related to the elderly	IPRES	2	2	2	Yes
2	National coordinator, Elderly Office	Internal	3	"Answer to a strong social demand", "it's political", "it's electoral"	S	S (ID #1,4,6, 8)	S	Leader of the initiative	MoH, Specialists in geriatrics	3	2	2	Yes
3	Technical Assistant, MoH	Internal	1	"Do not work very well"	N	n.a.	N	Not really interested in Plan Sésame, follow more deeply initiatives related to mother and children health	Service de Cooperation et d'Action Culturelle (SCAC) of the French Embassy in Senegal	2	2	2	No
4	Chief Social Policy division, UNICEF	External	2	"Politicking measure", "put down the health system"	O	n.a.	O	Plan Sésame is damaging their action towards children	Financial and Technical Partners involved in social protection, Ministry of Family	3	2	2	Yes
5	Country coordinator, CIDR	External	2	"Good idea", "cover for those exposed to health risks", "favour urban classes and intellectuals"	MS	n.a.	MS	Interested in all health financing mechanisms but not in particular in Plan Sésame	None	1	1	1	No

ID Number	Position & Organization	Internal/External	Knowledge		Position			Interest	Alliances	Resources		Power	Leader
			1. Level	2. Definition	1. Self	2. Others	3. Final	Advantages/Disadvantages	Organizations mentioned	1. Quantity 3, 2, 1	2. Ability to mobilize 3, 2, 1	Resources average 3, 2, 1	Yes or No
6	President, Third Age Volunteers Body	External	3	"Answer for elderly access to health services"	S	S (ID #4)	S	Involved in policy-making and potential beneficiary of Plan Sésame	Elderly associations	3	3	3	Yes
7	President, Association of retired, IPRES	External	3	"Do not have the means of its politics", "excellent but to be done again"	S	S (ID #6)	S	Involved in policy-making and potential beneficiary of Plan Sésame	Elderly associations	1	1	1	Yes
8	Advisor in Health Economy, WHO	External (previously Internal)	3	"Two main issues: targeting and management", "incomplete"	S	n.a.	S	Involved in Plan Sésame implementation and had a personal interest for the question of equity in health	Ministry of Health, USAID	3	2	2	Yes
9	Director, Dakar Geriatric Centre	External	3	"Political initiative", "system of solidarity", "medical"	S	S (ID #6)	S	Specialist in geriatrics, involved in campaigns to advocate for the elderly	SONATEL Foundation, MoH	3	3	3	Yes

B. Methods

1. The policy-making framework¹³

The process of policy making is supposed to follow the model of rational action, which follows five steps: Problem definition, Objective choice, Solutions identification, Solutions evaluation and Selection of the optimal solution.

However, according to Kingdon, policymaking is neither a rational action nor a linear process. It is a set of actions that are traversed by three streams:

- Problem: a stream that can emerge in several ways such as indicators or a crisis. Several types of actors can participate (elected officials, experts, members of interest groups or individual citizens) but some of them are more powerful (entrepreneurs).
- Policy: a stream that is more restrictive, experts have a major role in policies formulation. To be selected, solutions should be feasible and attractive for public opinion.
- Political: a stream that depends on the general context i.e. national mood, public opinion, and electoral context for example.

When these three streams joined, it creates what the author names a policy window. Depending on the reactivity of the policy entrepreneurs – i.e. those who push their solutions or attract attention on their special problems – the policy making process is (or is not) impacted and the institutional environment modified accordingly.

I adopted this framework because it is less linear than the classical three-stage model (agenda-setting, formulation and implementation) and gives more attention to the agenda-setting stage that is crucial to interpret the process of policy-making. However, in the case of Plan SESAME, Kingdon's framework cannot be used alone. A focus on the implementation stage is also necessary to understand the limits encountered by Plan SESAME in responding equitably to the health concerns of Senegal's elderly population.

This policy analysis will thus be undertaken by: analysing the process that led to the definition and framing of the issue "access to health care of the elderly", identifying all the

¹³ Lemieux V., *L'étude des politiques publiques: les acteurs et leur pouvoir* (4th ed.) 2002 Québec: Les Presses de l'Université de Laval.

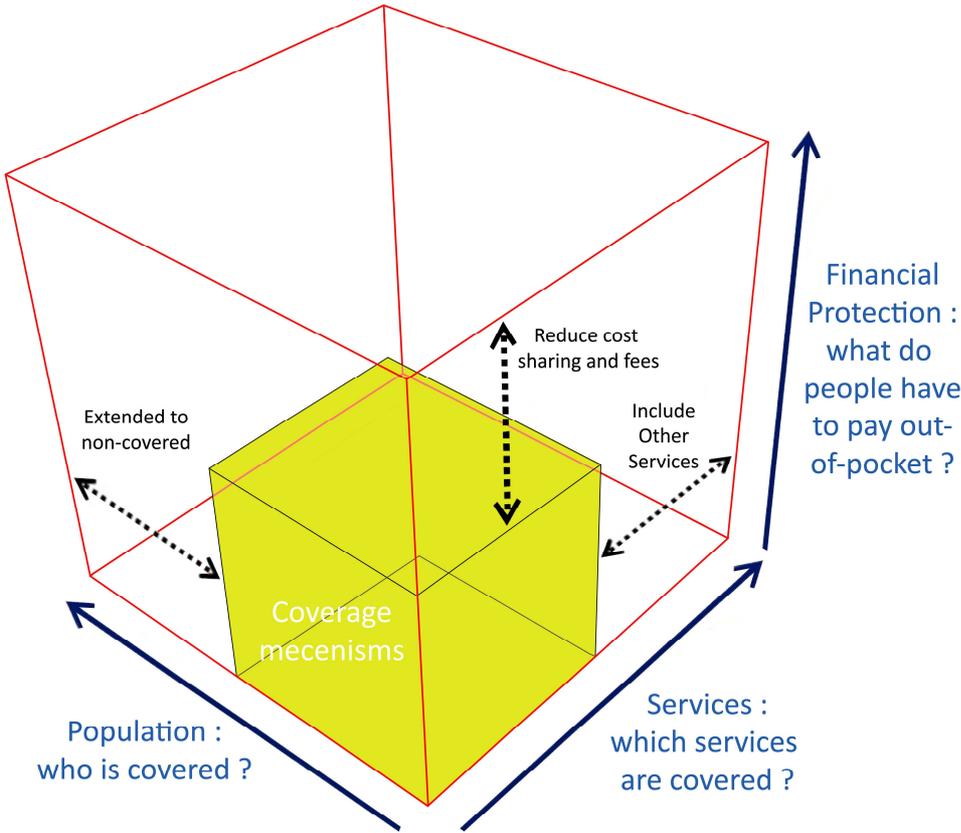
stakeholders who took part in the process, analysing the data and arguments used to frame the problem, analyzing the decision-making and implementation process.

2. Analysing a public health policy

This study aims at analysing the equity of a public health policy and thus will refer to the concept of horizontal and vertical equity, explained previously, as an analysis framework:

In addition, in its design, Plan SESAME targets all the elderly aged 60 and over, and thus has a “universal” scope. Universality, meaning that everybody have the same opportunity to access health care services, is often considered as the gold standard for equity. The three dimensions of Universal Health Coverage (UHC) will also be used as a framework.

Figure 2: The three dimensions of Universal Health Coverage (UHC)



Source: Adapted from Durairaj & Evans: Health systems financing: the path to universal coverage (p6). Calgary: Health Care Forum 2011

IV. Results

A. *Elderly care coverage: from idea to policy proposal*

1. Framing of the elderly health and social issues

When looking in-depth into the Senegalese context, it seems that the elderly are a national concern and the political commitment for their wellbeing has a long history.

First, Senegal was already present at the First United Nations General Assembly on Aging in Vienna in 1982 and it organised the First African Conference of Gerontology that was held in Dakar in 1984. In 1987, following the recommendations of these events, the government instituted a National Day for the Elderly¹⁴ and created a National Committee for Aging¹⁵.

These actions were supported from the beginning by numerous third age associations such as the Federation of Associations of Retired and Third Age Persons (FARPAS) and the National Union of the Retired of Senegal (ANRS). From the 1980s, they carried out several studies that revealed that the elderly in Senegal had two main priorities: access to a minimum revenue and access to health services. Members of the civil society explained these points:

When you look at what is happening in developed countries, increasing problems, trends regarding the care of people of third age, it is becoming more important as the population is aging. So it means that we had to take it into account to think about it and define policies that would certainly help to cope with these current situations. The other important feature is that today, investigations have shown, when you look at the Senegalese families that consist of a minimum of 10 persons, many young people, the Senegalese population is relatively young, you will see that because of the economic situation, out of 8 or 9 family members, all young people are unemployed and it is the old man who continues to support the household needs. (Civil society)

To put it in a nutshell, the issues of the elderly are: revenues to face their problems, access to care for its own health, to face later life diseases but also, as the head of the family, how to make his family access to care. (Civil society)

Since then, they have campaigned for the implementation of a broad “social security system” for the elderly that would include a wide range of services.

The election of Abdoulaye Wade in 2000 was an important step in the recognition of vulnerable groups in Senegal, notably through the promulgation of a new Constitution in

¹⁴ Décret 87/712 4 juin 1987

¹⁵ Arrêté n°13272/MDS/DBEF 24 septembre 1987

January 2000. In the preamble, the political and cultural influence of the newly elected President, who considered himself a herald of Pan-Africanism, is clearly apparent. The text emphasises the notion of national union and cultural values specific to Senegal. Article 17, dedicated to the family, is symbolic of this new Constitution because it makes a special obligation to the government and local authorities “to look after the physical and mental health of the disabled and the elderly”, in particular those living in rural areas “the State guarantees to families in general and those living in rural areas in particular, access to health services and wellbeing”.

From 2001, the government took several measures to improve the living conditions of the elderly: the organisation of an Interdepartmental Council on "social policies and aging issues in Senegal" (2001), the raising of the retiring age for civil servants (2002), and the creation of the Third Age Volunteer Body (2003). Regarding the Interdepartmental Council, several projects were not implemented such as the creation of a fund for the promotion and protection of the elderly, the elaboration of a scheme that would have facilitated the integration of geriatric ward into the health system and the implementation of a priority card, called “SESAME”, to give access to health services to the elderly.

In 2002, Senegal attended the Second United Nations General Assembly on Aging in Madrid where several recommendations were grouped into three themes: Elderly and development; Creation of a favourable and empowering environment; Health promotion and wellbeing of the elderly. This conference had a strong impact at the national level and led to several developments.

First, in 2004, The Ministry of Social Development came up with a “Projet d'Appui à la Promotion des Aînés” (PAPA) that aim at improving living conditions of seniors through capacity building and subsidized loans for income generating activities. Then, the Ministry of Health organized the same year an Interdepartmental Technical Committee, which was responsible for the elaboration of a card SESAME that would provide free access to healthcare for the elderly.

It should be pointed out that these projects were in line with the recommendations made by the associations of elderly since the 1980s. Indeed, they always had a strong influence on policy-making and managed to give directions to successive governments for the implementation of several social policies dedicated to the elderly. A physician involved in Plan SESAME design explained that “generally, all the aging policies have been imposed to the government by the associations of elderly”.

First, these associations were officially recognised by the government in 1984, and frequently participated in the processes of policy-making targeting the elderly. For example, the Third Age Volunteer Body is the leader of the Civil Society Commission for Development, in charge of the evaluation and follow-up of the Poverty Reduction Strategy Paper. Secondly, capitalizing on widespread conceptions of elders as sources of wisdom and authority, many of these associations' leaders had had very lengthy experiences in the government and had developed significant networks of influence. One especially experienced leader described his own professional experience in this way:

I am a Civil Service Administrator of special class in retirement. I am also an economist by training before joining the Ecole National d'Administration; I was also before that, founder of rural leadership in Senegal in 1958/59. I was deputy governor of the region of Thiès, responsible for development, and then technical advisor of President Senghor in charge of the "Comité Permanent de l'Arachide", director of foreign trade, founder and director of the "Caisse de Péréquation et deStabilisation du PRI" from 72 to 82, adviser for Ministers of Economy and Finance until 94/95 and project coordinator for institutional support of the CAP in Senegal at the Ministry of Economy and Finance. (Civil society)

2. Politics and presidential elections

The idea of implementing a card SESAME for facilitating access to health services for the elderly was raised both in 2001 and in 2004 but the political context of the Presidential elections presented an opportune moment, because it mobilized critical political support for the Plan's creation.

The President's statement in April of 2006 was seen as an answer to the strong mobilisation of the associations of elderly who were supported in their campaign by medical doctors, notably the two specialists in geriatrics of the country. In April of 2006, Wade announced the launch of Plan SESAME in a message to the nation:

As you know, I have decided to **give free access to drugs to the elderly**. This act reflects the ideal of solidarity between generations that is so characteristic of our people. Indeed, everyone has a secret dream of living with his parents and take care of them. But when, by force of circumstances, this dream cannot be achieved, **it is the duty of the Nation to take care of it**.

This is why I have instructed the Minister of Health and Medical Prevention to develop, with partners like the Institute of Retirement Pensions of Senegal (IPRES), the National Retirement Fund, the Faculty of Medicine of Dakar and local authorities, a **medical coverage plan for seniors to benefit from free healthcare in hospitals, health posts and centres selected across the country**.

A grant of 700 millions F CFA on the State capital will be released for this purpose, to cover this new system of solidarity called "SESAME".¹⁶

¹⁶ Extract, President speech to the Nation, 4th of April 2006.

Wade's speech offers several clues to the politics in play during the 2006 elections. First, his speech heavily emphasized medicines. Medicines represent a substantial proportion of households' health expenses (60,6% of total households' health expenditures⁴). Wade's commitment responded primarily to the interests of FNR pensioners, for whom medicines were not covered by the publicly managed social health insurance. FNR pensioners and leaders reportedly have substantial influence in rural areas, but also within families. Wade further explained that medical coverage would be provided to seniors who did not benefit from intergenerational solidarity or pensions and thus could not afford health services. Finally, the system of solidarity SESAME was limited to a range of selected health facilities across the country.

In Senegal, this presidential decision has been analysed as a vote-getting move, notably because the elderly represent 4% to 6% of the electorate, but also because they are a highly influential political group. However, the fact that this initiative has been taken in a global health context of issues raised on aging and consequently on access to health services for the elderly can mitigate this point of view.

B. The formulation process of Plan SESAME

As explained by both physicians and members of elderly associations involved from the beginning in the elaboration of social public policies for the elderly, the initial project "SESAME" was both social and medical:

The baseline study was broader than that because we had targeted health services of course but also transport, electricity, just like the "carte Orange" in France. (Civil society)

Before 2000, we imagined a priority card "SESAME", which should allow the elderly, the card holder, to access health services, specific care, there was a package of care included on the medical aspect, there was a package of services included on the social aspect, from housing, leisure, transport... (Physician)

However, the development of this project from 2001 to 2006 showed that it was clearly a health coverage plan. Stakeholders criticized the policy because it reflected a simplistic view of elderly needs, reducing them exclusively to health. As a geriatrician said, "we feel that the old person is associated much more to diseases issues". However, it seems that they have not taken into account the fact that the role of the Ministry of Health is to focus essentially on health issues. In addition they might have forgotten that the Ministry of Social Development was already dealing with elderly socio-economic issues through the PAPA project.

In 2006, the President gave the responsibility to the Health Department, within the Ministry of Health, to design this Plan. They came up with a “project of a system of solidarity “SESAME” for people aged 60 and over in Senegal”. Since 2002, the retirement age has been set at 60 years old in Senegal; the government has chosen not to follow the WHO recommendations (65 years old) to better adapt its policy to the national context.

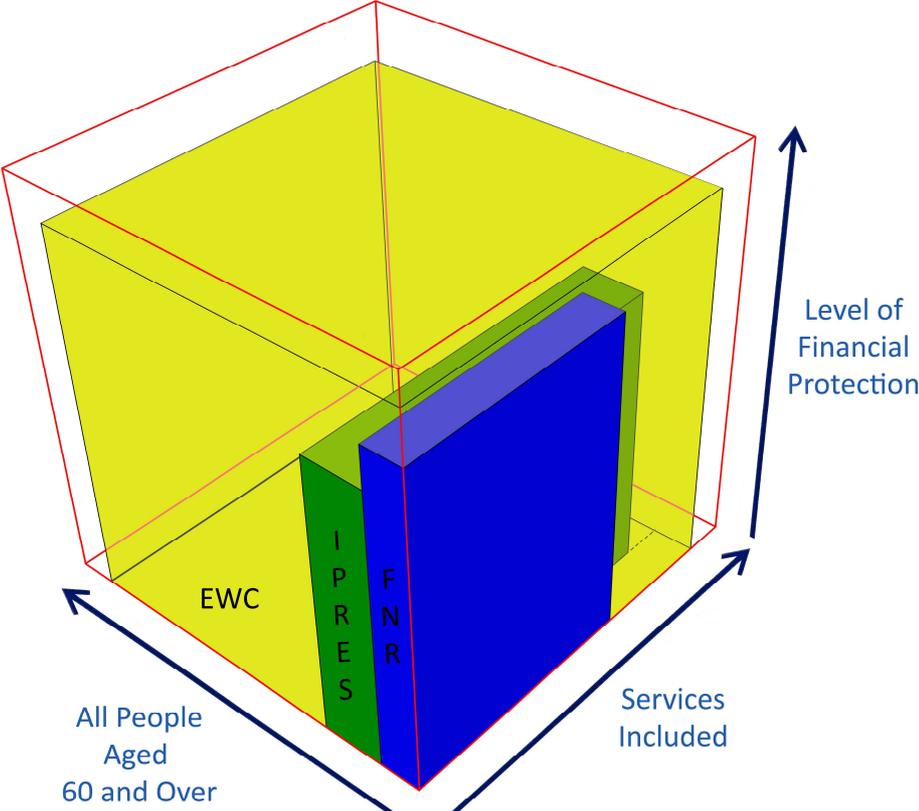
The Health Department did not exactly follow the guidelines developed in the President’s speech and proposed instead to give free access to health care services, including drugs, to all elderly aged 60 and over in all health facilities throughout the territory. In fact, in its initial formulation, the “system SESAME” seemed to target primarily third age persons who did not have the means to pay for care. This design would have implied to put in place a mechanism of differentiation between the categories of elderly, the card SESAME.

Indeed, the elderly in Senegal are not a homogeneous group. Some are retired from the public or private sectors and thus keep a health insurance via their respective pension schemes, and others, who belong to the informal sector, do not benefit from any coverage in case of health-adverse event and thus have to pay to access health services. The original scheme integrated these differences in health coverage in the Plan SESAME design by developing three specific benefit packages:

- One track for the above 60 who did not benefit from any health coverage (Elderly Without Coverage). These latter are fully supported by the Plan SESAME.
- One track for those retired from the Civil Service (FNR) whose medical bills were already covered at 80% by the State through a non-contributory scheme. Plan SESAME thus offers a complementary coverage to this category of elderly by covering the remaining 20% of the medical treatment costs.
- One special track for the IPRES members, i.e. the retired from the formal private sector. The organisation has its own medical structures, called medico-social centres, where IPRES members and their family members are provided health care services free of charge. However, these IPRES-owned facilities do not have all the medical technologies and equipment: IPRES subscribers hence need sometimes to be referred to other facilities – often public hospitals, especially to undertake specific, complex treatment. In other words, IPRES members did not benefit from a comprehensive coverage. The Plan SESAME offered the opportunity for IPRES to fill this gap and to extend the medical coverage of its members through contracting with public facilities. IPRES signed pre-financing agreements (IPRES finances its own Plan SESAME) with a range of selected public hospitals throughout the territory and thus allows its patients aged 55 and over to be treated for free, even for hospital care.

As represented in Figure 3, in the formulation of Plan SESAME, all citizens (but not refugees and immigrants) aged 60 and over are covered not only the indigent. In terms of services included, Plan SESAME focuses exclusively on health care but includes a wide range (not all) of services. In addition, Plan SESAME has been designed in a way that it provides a financial protection to all beneficiaries by offering health coverage to those who had none and complementing coverage for the FNR and IPRES. However, Plan SESAME does not provide a full financial protection because it does not include indirect costs and some diseases or treatments that are covered by other mechanisms of exemption such as TB drugs or diabetes.

Figure 3: The theoretical UHC dimensions of Plan SESAME



The idea of designing a specific card SESAME for identification of the three categories of beneficiaries was however rapidly discarded. As explained by a stakeholder involved in Plan

SESAME implementation, the government realized that the delivery of electronic cards was too expensive and thus chose to use the digitized national identity card as a proof for eligibility.

An electronic card, it costs billions and I do not even speak about services financing. It was ideal but it was a dream. It was at the time of the change of power that the digitized national identity card was created. Well, it was a great idea; we took the opportunity of this card to move from a card SESAME to Plan SESAME, to take in charge only health services. (Ministry of Health)

As a result, technicians in charge of the design of Plan SESAME within the Health Department elaborated three different ways of accessing health services free of charge:

As regards EWC, the patient should respect the referral system and hence progresses through the health system from the health post, at the bottom of the health pyramid, onward. If the patient is treated at this level, the head nurse should fill a form that include the patient identification, diagnosis and prescription. When the patient is referred to the health centre, the head nurse has to deliver a referral document. The physician who receives the patient at the health centre should also fill a form with the same information. If the patient needs to be treated at the hospital, he will need a referral document and a guarantee letter signed by the regional medical chief. All these papers constitute the documentary evidence used by the Elderly Office to start the reimbursement process.

Former Civil Servants should follow the same progression than EWC but they have first to go to the Ministry of Economy and Finance in Dakar or to one of its branches in region to obtain a guarantee letter that will allow the health professionals to identify him as a FNR patient and thus charge only 20% of the total cost of care to Plan SESAME.

IPRES patients have first to visit one of the IPRES-owned medico-social centres; there is one in each region. If they need to be referred to one of the "on contract hospitals", IPRES will deliver a guarantee letter, in addition to the patient IPRES card, to allow the hospital to identify the patient as an IPRES member and thus charge the expenses to the Plan SESAME "IPRES" and not to the Plan SESAME "State".

The design of Plan SESAME contradicts its initial goal: developing a universalist scheme for the elderly. The Plan SESAME provides access to health services to all the elderly and thus respects the concept of horizontal equity. However, its design does not fully take into account the notion of vertical equity. Indeed, while Plan SESAME should be oriented towards the most vulnerable, in the practicalities, there is no pooling from those who have more resources to the others. For example, the IPRES, which has many resources, finances its own Plan SESAME that benefit only to its subscribers. It creates significant differences

between the retirees of the private sector, who benefit from more services such as in-patient drugs and the access to care for their families, and the others. In addition, there is also a gap between the FNR and the others because they benefit from a non-contributory social protection (80% of health costs supported by the State) in addition to the Plan SESAME (20% of health expenses). It might have been more equitable to make them contribute to the health coverage of the elderly without coverage by pooling those 20% in the Plan SESAME.

Before implementing public policies, feasibility studies are usually put in place in order to assess the potential of reforms to reach their goals. It is also very useful to find out information on the target population taking into account the context, evaluate the current situation (utilization rates, epidemiological study, avoidable deaths...), estimate the costs of the programme, create indicators for monitoring and evaluation and estimate the impact of the programme (sustainability, cost-effectiveness...). Feasibility studies are hence an appropriate means of informing and involving stakeholders who will be in charge of programme follow-up at the local level. In other words, they are part of the programme management cycle, and help the different stakeholders to gain ownership.

In the case of Plan SESAME, the Ministry of Health did not conduct a feasibility study, mostly because the Plan SESAME was supposed to be operational before the elections that were planned for February 2007. A member of an elderly association confirmed this attitude:

We dashed, but strategically it wasn't a bad thing because we held on to the Plan, we said now we have it, we would not let it go. This is perhaps the fault; the fault committed was that we did not evaluate before implementing. (Civil society)

In addition, local authorities, which received transfer of competences in the health sector and thus are supposed to participate to public health programmes' design and implementation (see appendix C), were never involved in the elaboration of Plan SESAME. This attitude is also a factor in the failure in the equitable distribution of Plan SESAME resources.

To conclude this section, Plan SESAME results from a long process, engaged by several stakeholders for years. However, the process was not matured enough at the time of its launch, noticeably because of budgetary restrictions and political timing.

C. *An unachieved implementation*

Two important considerations should be kept in mind as we evaluate why the Plan SESAME has not turned out to be an equitable program. First, Senegal as any other developing countries is under very pressing financial constraints as well as significant political pressures. Consequently, it seems likely that the inequities revealed in this stage are tied to some problems that are exceedingly difficult to resolve, such as finding sufficient funds for staffing and sufficient resources to expand health care coverage and personnel in rural areas.

In addition, the broader political environment of Senegal can explain the difficulties in Plan SESAME implementation. During the two terms of Abdoulaye Wade, ministerial instability plagued the country. For example, in twelve years, Senegal had not less than ten ministers of health:

A major challenge of the reforms or measures among the initiatives taken under the governance of Wade, one of the major issues is that governmental instability has had an impact, a very strong impact on the implementation of the reforms. (Ministry of Health)

Each new minister of health did not necessarily have a political and personal interest in improving the implementation of the Plan SESAME and had to act in an unstable context, since they knew that their mandate might last only a few months. The Plan SESAME reform is rather cumbersome and time consuming, and as a result, was not included in their priorities. This economically and politically unstable situation jeopardized the capacity of the government to implement on-going reforms.

1. Institutional implementation

Plan SESAME should have been accompanied by the implementation of a strong control of prescriptions to ensure that all prescriptions are justified; a control of invoicing to ensure that only people aged 60 and over are covered by Plan SESAME, at reasonable cost and a control of reimbursement delays to ensure that health structures receive their subventions and drugs on time. The absence of such mechanisms in the implementation of Plan SESAME and its day-to-day functioning present many difficulties that jeopardize the principles of equity.

In fact, the Plan SESAME was launched in 2006 but the first decree instituting the Plan, was signed in 2008 (Decree n°2008-381 07 April 2008). It was followed by several measures to organize the implementation of the Plan, notably the creation of the Technical Committee in charge of Plan SESAME orientation and follow up and the Management Unit of Plan

SESAME (Decree n°1504/MSP/DS/SP 18 February 2010 and decree n°1583/MSP/DS/SP-AC 17 February 2009) but also a list of care excluded from Plan SESAME (Bill n°007169 MSPHP/DS/SP-AC 11 August 2009). While the decrees have been created, most of the bodies in charge of the control of Plan SESAME had not been put into place. To date, the sole existing structure is the Elderly Office, which has only two full-time agents.

2. Operational implementation

a. Identification of the elderly

The process that allows differentiating between the categories of elderly is not sufficiently controlled by health facilities. It has led to inappropriate behaviours of the beneficiaries and consequently to an unjustified debt of Plan SESAME

As regards to retirees of the FNR, they are asked to acquire a paper from the Ministry of Economy and Finance to justify their situation of retirees, though some may have to undertake a lengthy, costly journey to do so. As a result, many FNR beneficiaries do not disclose their retiree status, and instead they follow the same process as Elderly Without Coverage.

The process of delivering guarantee letters is respected within the IPRES but if the medical chief refuses to deliver the letter to one patient, that patient can easily go directly to a public health facility and to pretend not to have coverage (not showing his IPRES card). As one physician explained,

In addition, according to several physicians, retirees (FNR and IPRES) are more aware of the services that can be provided by the hospitals, notably because they are frequent users of such health facilities¹⁷, and sometimes they ask for many medical tests whose costs are charged to Plan SESAME. One of the physicians noted highlighted these inequities:

These persons who come, they ask for an electrocardiogram, electrocardiography, this test, that test, 10 medical tests while the old person in rural area only has paracetamol. (Physician)

The consequence of such behaviours is that Plan SESAME bears most of the costs that should be charged to the FNR and IPRES. Although SESAME benefits should reach the

¹⁷ The ESAM revealed that populations in urban areas go more frequently to public hospitals and dispensary (33%) while in rural areas, patients prefer to consult in health centers (44%).

most vulnerable elderly populations, wealthier patients' practices, as well as a lack of oversight, undermines this aim.

b. Financing and purchasing care

The Plan SESAME receives its funding from two sources: the State (FNR and Elderly Without Coverage) and IPRES. The Plan SESAME "STATE" is financed by the Ministry of Health budget, although I could not determine the origins of the funds invested. The Ministry of Economy and Finance is supposed to release about 700 million Francs CFA each year to finance the Plan SESAME. But according to several interviewees, this amount was included in the budget only once:

Resources that should come from the State, and in part from the IPRES, the State contributed, fixed at 700 million francs, it has been done only once. {...} The State budget planned only once this amount in its budgeting. On the other hand, there are difficulties for releasing this money. {...} This is what happened, you can have the inscription in the financing law but the Ministry of Economy and Finance for some reasons did not make available the money expected. (Civil society)

The Plan SESAME IPRES conducts its own, revenue collection through IPRES employee and employer contributions. IPRES invests 300 million FCFA per year for its Plan SESAME.

The process of purchasing care, it varies according to the type of health facilities.

Hospitals benefit from a pre-financing system, the State and the IPRES provide subsidies to hospitals, allowing them to treat all persons aged 60 and over for free. Hospitals must then return the required documents to the Elderly Office (or IPRES), located within the Health Department, for verification of the amounts spent. A staff member verifies the amounts according to the decree of 21 February 2005, which fixed maximum and minimum rates of hospitalization, consultation, outpatient care and transfer.

Health post and centres offer consultations free of charge: medicines are reimbursed through transfer from the National Supply Pharmacy. The district orders the amount of drugs corresponding to its expenses and then sells the drugs received in order to recover its costs (Bamako Initiative). But because no consultation fees or product prices have been set at the national level, costs can vary from one region to another, leading to inequalities in the distribution of Plan SESAME resources.

In addition, because these schemes are neither sufficiently controlled nor managed by the Elderly Office, health facilities and hospitals take advantage of the Plan SESAME to obtain

more resources. A former employee of the Ministry of Health responsible for Plan SESAME implementation explains this process:

So, in this meeting, some explained, we had 5 million FCFA and we consumed 11 million, for example. The, someone else said, gave an incredible figure. We would have transformed the entire population of his area into third age persons we would not have used such an amount of money. Well, I said no, wait, it's impossible. After he said yes but it was a way to have a few more grant for the hospital, you see.

Finally, by jeopardising the functioning of health facilities, reimbursement delays hinder the smooth delivery of health services to the elderly through the Plan SESAME. A physician and a potential user of Plan SESAME gave example of the "survival" strategies adopted by health facilities to deal with those delays:

The structures are indebted but those responsible for these structures find survival strategies {...} people act sparingly, meaning that out of 10 patients, they take two for Plan SESAME. Or, another strategy, because I carried out a survey at the national level, is that people make appointment very late in time. {...} or another strategy, you are asked a third party payer, meaning that if the scan was to cost 5000, you are asked 2000 francs and the other part is charged to Plan SESAME. (Physician)

Currently for example, for eye surgery {...} you go hospital Principal, they say ok we can operate you with Plan SESAME but you will have to pay 20 000 francs. So they tell you, we operate, the surgery costs 200 000, they ask me to give 20 000 francs, I rush to give them and I take the surgery. Plan SESAME is still on but hospitals cheat. The day they will have to make the invoice the hospital will charge 200 000 francs and will not say that the patient gave 20 000. (Civil society)

c. Provision of services

From 2006 to 2009, all health services were free in all facilities. In 2009, the government realised that new medical devices such as Magnetic Resonance Imaging (MRI) and scanner were too expensive to be included in the sample of services exempt of charges. A physician confirmed:

Everyone knew that Plan SESAME was launched in 2006 but in the meantime, some hospitals were equipped with scanners, MRI, it (those new equipment) was excluded and people abused it. (Physician)

Since 2009, the services excluded from Plan SESAME are: dialysis, pace maker, implants except ocular, prosthesis, medical evacuations, MRI, scanner, plastic surgery, beauty care, systematic health checks, hospitalization in 1st and 2nd categories (in more comfortable rooms).

In addition, a physician explained that medicines used to treat pathologies associated with aging are not included in the national list of essential medicines. Indeed these medications are mostly patented; essential medicines most frequently are produced as generics.

The implementation should have been accompanied by the review of the list of essential drugs to include the list of drugs such as glaucoma, cataract, prostate etc. But we have not really updated the list of essential medicines and that too is a problem. Therefore it gives the feeling that drugs are not included, because most of the diseases of the elderly are specific pathologies and the drugs needed are in-patent drugs. You prescribe one drug and the other three at the pharmacy. (Physician)

d. Communication

The office responsible for health education and communication has not been mobilised to create a national communication plan. In order to communicate on Plan SESAME, its national coordinator financed the association of retired from a national radio:

It is the role of the national service for health education to communicate on health programmes but it did not fulfil its duty. Everything that people were doing, everything that could be done in terms of communication, I assumed it with the association of retired from the RTS, which has a local programme.

However, the absence of a national campaign is likely to have led to variations of populations' knowledge and use of the Plan SESAME. While the results of the CREPOS households' survey have not yet been released, the field investigators revealed that most of the elderly interviewed in the rural regions did not know that Plan SESAME existed. A Health economist added some reasons explaining asymmetric information between rural and urban areas:

When they give the information that people aged 60 and over are supported, those who are in town they have the information, those who are educated have the information, they can use the health facilities because they have the cultural ability to do so, they have a network, relationships, they are aware of the information. But if we take an old man in a village in Tambacounda, who does not have access to the information, even if this project is also for him, he does not know it. (Civil society)

In addition, according the national coordinator of Plan SESAME 50% of the consultations within Plan SESAME in 2010 took place in Dakar. This statement reveals that the elderly living in urban areas benefit more from the services offered by Plan SESAME than the ones living in rural areas. This argument can be reinforced by the fact that Dakar centralized most services for the elderly. Indeed, the country's two geriatric specialists are located in the capital and the technical equipment of health centres and hospitals is much more developed

there than it is in the rest of the country. Older people, who usually suffer from complex medical conditions requiring specific treatment, cannot find appropriate equipment and personnel in rural areas. However, there are no statistics available to assess exactly how many people have benefited from Plan SESAME.

To conclude, Plan SESAME, as it is implemented, falls short in its attempt to deliver health services equitably to all citizens aged 60 and over. People from FNR and IPRES do not respect the rules of Plan SESAME utilization and thus sap part of the resources dedicated to the most vulnerable. A physician who conducted recently a study on health services utilization in rural areas attested that:

The elderly in rural areas are really left out of the Plan SESAME {...} Meaning that in the Plan SESAME, elderly living in rural areas suffer much more than the elderly in urban areas. Especially since in urban areas are literate people; who know Plan SESAME and who can come. Besides these are the persons who weighted Plan SESAME aid (Physician)

All stakeholders agreed that defects in implementation diverted Plan SESAME from its initial objective, which was to offer health coverage to elderly people who had none. All the respondents recommended specific changes to make Plan SESAME more equitable. First, they suggested that creating “a *card SESAME impossible to forge*” or another targeting system to distinguish between different groups of elderly people, specifically those who have some form of health coverage and those who do not. The State, however, cannot afford such a measure. Affordable medicines are also of major concern because those most frequently used to treat pathologies associated with aging are not included on the national list of essential medicines. This year, geriatric specialists successfully included some of these medicines on the national list. Access to care in rural areas also remains a major concern. Informants suggested meaningful rural reforms to increase the number of rural health centres as well as their equipment and personnel, so as to improve equitable access. Other informants proposed an intermediate solution, which was to target the treatment of certain diseases with a high prevalence among people over 60 years old. This measure would necessitate strengthening health centres but to a lesser extent.

V. Discussion

The first part of this section discusses the main limitations of the available evidence, which is important when interpreting the results. The second part addresses debates over universal coverage versus targeted health financing in Senegal.

The limitations of this study are several. First, there is no systematic stratification by age group in standard surveys (DHS for example), and thus very few statistical data available to assess the socioeconomic context of the elderly, but also to evaluate their level of access and utilization of health services. The management and information system of the Plan SESAME should be strengthened in order to conduct this sort of analysis. In addition, the lack of transparent monitoring and evaluation, reporting system on Plan SESAME made it difficult to get access to data at all, so that I had to leave aside the analysis of Plan SESAME utilisation by type of enrolment (IPRES, PNR, PAF).

Secondly, as an intern working in the country for only four months, the lack of time and credential restrained my ability to access many different stakeholders involved in the policy process. The period of time dedicated to the qualitative study was even shorter because, as explained previously, I first started to work on the quantitative part of the project. I elaborated hypotheses to be integrated into the research protocol (see appendix D) and participated in the drafting of the questionnaire and the training of field investigators. I finally had to reorient my project after two months of internship because of accumulated delays.

However, the atmosphere of secret or “taboo” surrounding Plan SESAME was beneficial for this short timing because only few people were involved in the policy process. Nonetheless, according to the mapping of stakeholders, additional interviews could have been conducted with: the National Supply Pharmacy, the Ministry of Economics and Finance and someone from the technical team in charge of Sesame management. For such a topic, I would also have needed to interview elderly people who used the Plan SESAME. Nevertheless, people are not only difficult to identify because of administrative problems. It is also very challenging to interview elderly who may not be used to in-depth interviews and might not be able to discuss in French. The targeted public may thus be hard to reach, and it requires a long-term field experience.

Thirdly, in this study I conducted in-depth interviews and my position, both as a person and researcher, might have influenced the discussions. For example, because of my status of

outsider and the “silence” surrounding Plan SESAME, interviewees may have not been free to speak openly despite guarantees of confidentiality. Indeed, the senior government officials, international organization staff members, physicians interviewed may have suppressed some information or opinions because of their positions.

Finally, in this thesis, I used a methodology that is rather standard, a chronological framework, which does not always allow to soundly describe the non-linear processes underlying policy making. However, Walt¹⁸, drawing from Gilson and Raphaely’s review,¹⁹ has rightly noted that, there is an “absence of explicit conceptual frameworks, little detail on research design and methodology, and a preponderance of single case studies on particular issues.” This research certainly fits into the latter category of a case study. Currently, at the international level there is an attempt to set some guidelines²⁰ to carry out policy analyses but those guidelines are still very complex and difficult to implement. I thus opted for something simpler and more feasible to carry out.

The second questions addressed focuses on whether we can have universal coverage in a context of scarce resources? Is targeting a solution? If so, who should be targeted and according to which criteria?

Universal Health Coverage has been described as a gold standard for ensuring equitable access and utilization of health services²¹ but it is quite difficult to implement because it requires focusing on the three health system functions: revenue collection, pooling of contributions and purchasing care.

Universal coverage of elderly people, proposed in the earliest iterations of the Plan SESAME, was an ambitious goal. Representatives of elderly associations clearly demonstrated that their concern was for all elderly Senegalese. However, budgeting and management constraints in the Plan’s implementation adversely affected the equitable distribution of health services among the elderly.

It seems that the government, in implementing Plan SESAME, did not consider sufficiently the first two dimensions. Achieving universal coverage implies first finding ways of implementing a prepayment system so that the financial risk of ill health is spread (equitably)

¹⁸ Walt et al (2008) “Doing” policy analysis: methodological and conceptual reflections and challenges, *Health Policy and Planning* 2008;23:308–317

¹⁹ Gilson L., Raphaely N. 2008. The terrain of health policy analysis in low and middle income countries: a review of the literature 1994-2007, *Health Policy and Planning* 2008;23:294–307

²⁰ Gilson L., *Health Policy and Systems Research : A Methodology Reader*. World Health Organization 2012

²¹ Carrin G. and al. Universal coverage of health services: tailoring its implementation. *Bulletin of the World Health Organization*, November 2008, 86 (11).

throughout the population. However, implementing such a process is not easy in countries where most workers are in the informal sector. In addition, universal coverage requires raising significant funds, and it is unlikely that countries with unstable economic situations and high unemployment rate manage to domestically finance such a project.

In a context of scarce resources, it is easy to argue that investments should be concentrated on those in need, and targeting is perceived as a good way to make the “needy” benefit the most from health financing mechanisms. However, issues such as high administrative costs and the need for appropriate data to measure poverty and identify the population-target remain difficult for developing countries. Many evaluations of exemption and voucher policies have shown the limits of targeting. It includes under-coverage, notably due to access to health services, and leakage, so that many of the better-off benefit more from those schemes than indigent people²². For example, an evaluation of the free delivery and caesarean policy²³ put in place by the Senegalese government in 2005, revealed an increase in the use of maternal services, but reported leakage, meaning that while the policy was supposed to benefit the most to the poor, estimates show that they represent only 5% of the clients. The author also describes delays in the reimbursement process and inadequate repartition of the funds and kits across the country, leading to inequitable access and utilization of the maternal services. In addition, according to McIntyre, fragmentation of the health system into several health financing mechanisms (risk pools) reduces the possibilities for income and risk cross-subsidization and thus reduces equity. Targeting is a problematic process, and it requires both sophisticated administrative structures, strong political will and stewardship.

Targeting not only raises logistical problems but implies that the governments must address equity and identify who should be targeted and according to what criteria. In these contexts, the choice of targeting the elderly is not straightforward. Indeed, while in Western countries the issue of aging has become part of the reflexions in the field of public health, it is usually not the case in Africa. First, because the continent has a population that is still relatively young, and because most countries receive aid from donors, their policies are frequently shaped by international donor priorities. In the context of the Millennium Development Goals and the centrality of poverty in policy discourse, the predominant focus remains on maternal and child health.

²² Mkandawire T., Targeting and Universalism in Poverty Reduction. United Nations Research Institute for Social Development, Social Policy and Development Programme Paper Number 23 December 2005.

²³ Witter S. and al. The National free delivery and caesarean policy in Senegal: evaluating process and outcomes. *Health Policy and Planning* 2010; 25:384-392.

The government of Senegal decided to implement a national policy for the elderly. This idea can be first justified by the role of old people in Africa. In West Africa, the elderly often live with their children and benefit greatly from traditional solidarity systems²⁴, although the traditional safety nets of the extended family have been undermined by urbanization and economic crisis and have thus become less effective and reliable for the elderly.^{12, 25}

“Here, people respect a lot the elders, it is not perhaps the same in the West where at the time of retiring, we put you in a, what is it called again, a kind of asylum, here people live with us, they are associated and predominant, some still have resources, you see, so it is a target that is much respected in our African contexts.” (Health economist)

Moreover, old age is associated with the development of several diseases²⁶, which generally constitute a financial burden for the elderly. Indeed, some studies have shown that population aging increases the health costs of the economy exponentially²⁷. These arguments lend support to Plan SESAME’s underlying goals. However, its justification in terms of equity would require a contextualised in-depth study of the social and economic impact of targeting old persons versus other categories of the population.

²⁴ Antoine P., *Les relations intergénérationnelles en Afrique - Approche plurielle*. Centre Population et Développement, 2007.

²⁵ Kakwani and Subbarao, *Aging and Poverty in African and the Role of Social Pensions*. Social Protection Unit, Human Development Network, The World Bank. June 2005

²⁶ Lloyd-Sherlock P., *Population ageing in developed and developing regions: implications for health policy*. *Social Science & Medicine* 2000 887-895.

²⁷ World Bank, *The World Development Report, Investing in Health*, 1993.

Conclusion

This policy analysis of Plan SESAME revealed that many hurdles in the Plan formulation and implementation hindered the translation of the concept of equity into practice. Aware of the difficulties encountered by the Plan SESAME, the Ministry of Health signed a decree in December 2011 to reorient the policy toward Elderly Without Coverage. The recent change of political power seems to have suspended the implementation of this decree and left pending the future of the Plan SESAME.

Nevertheless, the new government of Senegal is currently evaluating the feasibility of a broad project of social protection, the “Caisse Autonome de Protection Sociale Universelle (CAPSU)”. The implementation of the CAPSU should be undertaken under the institutional rules of the West African Economic and Monetary Union²⁸. In addition, a project “Fond National de Solidarité Santé” is currently discussed within the Ministry of Health. It would consolidate all exemption and subvention initiatives, including Plan SESAME, to ensure their follow up and smooth development.

Exemptions programmes aim at facilitating access to health care services for specific groups and improving the equitable distribution of resources within the general population. In Senegal, several constraints such as ministerial instability and limited resources prevented Plan SESAME from reaching these objectives.

²⁸ Règlement N°07/2009/CM/UEMOA portant réglementation de la mutualité sociale au sein des états de l'UEMOA

Bibliography

Articles:

Aboderin I., Ageing in West Africa. *International Handbook of Population Aging*, 2009.

Aboderin I., Modernisation and ageing theory revisited: current explanations of recent developing world and historical Western shifts in material family support for older people. *Ageing & Society* 24, 2004, 29–50. 2004

Barrientos A., Gorman M., Heslop A., Old Age Poverty in Developing Countries: Contributions and Dependence in Later Life. *World Development*, 2003, Vol 31, N°3, pp. 555-570.

Carrin G. and al. Universal coverage of health services: tailoring its implementation. *Bulletin of the World Health Organization*, November 2008, 86 (11).

Culyer, A.J., Equity- some theory and its policy implications. *Journal of Medical Ethics* 2001; 27:275-283

Gilson L., Raphaely N. 2008. The terrain of health policy analysis in low and middle income countries: a review of the literature 1994-2007, *Health Policy and Planning* 2008;23:294–307

Gilson & McIntyre, Removing user fees for primary care in Africa: the need for careful action. *British Medical Journal* 2005; 331:762-5

Jehoel-Gijsbers G. and Vrooman C. Explaining Social Exclusion. A theoretical model tested in the Netherlands. The Netherlands Institute for Social Research/scp The Hague, July 2007.

Lloyd-Sherlock P., Social policy and population ageing: challenges for north and south. *International Journal of Epidemiology* 2002; 31:754-757.

Lloyd-Sherlock P., *Population ageing in developed and developing regions: implications for health policy*. *Social Science & Medicine* 2000 887-895.

McIntyre D. and al., Beyond fragmentation and towards universal coverage: insights from Ghana, South Africa and the United Republic of Tanzania. *Bulletin of the World Health Organization*, November 2008, 86 (11).

McIntyre and Gilson. Putting equity in health back onto the social policy agenda: experience from South Africa. *Social Science & Medicine* 54 (2002) 1637–1656

Rispel et al, Can social inclusion policies reduce health inequalities in Sub-Saharan Africa? A rapid policy appraisal. *Journal Health Popul Nutr* 2009, 27(4) : 492-504

Popay et al. Final Report to the WHO Commission on Social Determinants of Health. From the Social Exclusion Knowledge Network February 2008.

Stierle et al. Indigence and access to health care in Sub-Saharan Africa. *Int J Health Plann. Mgmt.* 14, 81-105 (1999).

Witter S. and al. The National free delivery and caesarean policy in Senegal: evaluating process and outcomes. *Health Policy and Planning* 2010; 25:384-392.

Walt et al (2008) “Doing” policy analysis: methodological and conceptual reflections and challenges, *Health Policy and Planning* 2008; 23:308–317

Whitehead M., The concepts and principles of equity in health. Discussion paper prepared by the Programme on Health Policies and Planning of the WHO Regional Office for Europe 1990.

Whitehead et al, Equity and health sector reforms: can low-income countries escape the medical poverty trap? *Lancet* 2001; 358: 833–36

Xu K. et al, Household catastrophic health expenditure: a multicountry analysis, *Lancet*, 2003, 362: 111-17

Reports:

Annycke P., *Analyse des prestations et des indicateurs de résultats de la protection sociale au Sénégal*. Département de la Sécurité Sociale Bureau international du Travail - Genève Mai 2008

Annycke P., *Extension of social insurance coverage: A review of statistics and some country experiences*. Working Paper No. 13, International Social Security Association, Geneva, 2009

Antoine P., *Les relations intergénérationnelles en Afrique – Approche plurielle*. Centre Population et Développement, 2007.

De Sardan O. and Ridde V. *Une comparaison provisoire des politiques d'exemption de paiement dans trois pays sahéliens (Burkina Faso, Mali, Niger)*. Etudes et Travaux n°89, LASDEL. September 2011

Gilson L., *Health Policy and Systems Research : A Methodology Reader*. World Health Organization 2012

Kakwani and Subbarao, *Aging and Poverty in African and the Role of Social Pensions*. Social Protection Unit, Human Development Network, The World Bank. June 2005

Mkandawire T., *Targeting and Universalism in Poverty Reduction*. United Nations Research Institute for Social Development, Social Policy and Development Programme Paper Number 23 December 2005.

Mbengue Cheikh S.A., Yann Derriennic (Health Systems 20/20), Fodé Diouf (Groupe Issa), Demba A. Dione (ISED), Lamine Diawara (OMS) et Abdoulaye Diagne. *Evaluation du système de santé du Sénégal*. Abt Associates Inc. Septembre 2009

Niño-Zarazua et al., *Social protection in Sub-Saharan Africa: getting the politics right*, World Development Vol. 40, No. 1, pp 163-176, 2012.

United Nations Department of Economic and Social Affairs/Population Division, *World Population Ageing*, 2009.

World Bank, *The World Development Report, Investing in Health*, 1993.

Books:

Lemieux V., L'étude des politiques publiques: les acteurs et leur pouvoir (4th ed.) 2002
Québec: Les Presses de l'Université de Laval.

Seydou Madani Sy, *Les régimes politiques sénégalais de l'indépendance à l'alternance politique 1960-2008*. Iroko-Karthala-CREPOS, 2009

Official Documents:

Décret n°2008-381 MSP/DS/SP-AC 7 Avril 2008, instituant un système d'assurance "SESAME" en faveur des personnes âgées de 60 ans et plus

Décret n°1583/MSP/DS/SP-AC 17 Février 2009, portant création du Comité Technique en charge de l'orientation et du suivi du Plan SESAME

Lettre circulaire n°007170 MSPHP/DS/SP 11 Août 2009, bulletin de référence et autorités médicales en charge de la délivrance des lettres de garantie

Arrêté ministériel n°2794 MSP/DS/SP-AC 22 mars 2010, définissant les services éligibles au Plan SESAME

Décret n°1504/MSP/DS/SP 18 Février 2010, portant création de l'Unité de Gestion du Plan SESAME

Accord cadre entre le Ministère de la santé et de la prévention médicale (MSPM) et l'Institut de Prévoyance Retraite (IPRES) pour la prise en charge hospitalière des allocataires de l'IPRES

Manuel des procédures opérationnelles - Plan "SESAME" de soins gratuits pour les personnes âgées de 60 ans et plus au Sénégal

Appendices

List of appendices

Appendix A: The health care system in Senegal

Appendix B: Interview Guide

Appendix C: Brief overview of the politics in Senegal

Appendix D: SPEC-by-step Hypotheses

A. The health care system in Senegal

In Senegal, the health policy is based on primary care and mainly guided by the objectives set by the Millennium Development Goals. It included the following points²:

- Access to quality health care guaranteed to all citizens regardless of their socioeconomic status
- Deepening of decentralization and local governance in health matters
- Promotion of insurance coverage for health risks
- Protection of vulnerable groups
- Strengthening public-private partnership
- Promoting a multisectoral approach
- Alignment of external assistance to national health priorities

Since the implementation of the law 96-06 in March 1996, Senegal has three types of local authorities: regions, cities and rural areas. The Health care system follows the administrative repartition and is based on three tiers:

- **District level:** It includes at least one health centre and a network of health posts. The geographic zone can cover a department or a part of it. However, a department may have several districts. When a department has several health centres, the reference health centre is called District hospital and has hospitalisation capacities in medicine, surgery and gynaecology. (69 health districts)
- **Regional level:** The Medical Region is a coordination structure at the regional level, constituted of several health districts. It follows the regional administrative boundaries. (14 medical regions)
- **Central level:** constituted of the Ministry of Health and Prevention

There are also numerous health posts at the community level to provide first line, basic care. They are usually implemented by community initiatives but the Ministry of Health provides technical support/backstopping, for the training of community health workers for example.

In 2010, Senegal had 34 hospitals, 89 health centres and 1195 health posts (1035 functional), 76 private Catholic clinics and 1,603 functional health posts. However, in terms of health infrastructure coverage, Senegal has not yet reached the standards²⁹ advocated by WHO. The public architecture is complemented by the private sector at all levels of the pyramid. It includes confessional non-for-profit structures, for-profit organizations,

²⁹ WHO standards : 1 health post per 10,000 inhabitants, 1 health centre per 50,000 inhabitants and 1 hospital per 150,000 inhabitants.

associations and NGOs. It should be noted, in addition, the significant role of traditional medicine in the health sector.

In Senegal, national health expenses are relatively high with a total of 254 billions F CFA in 2005³⁰. The public sector spent 134 billions F CFA and the private sector expenses have been estimated at 110 billions F CFA including 85 billions F CFA by households direct payments. The National Health budget increased from 5,7%³¹ in 2000 (29 billions CFA) to 10,4% en 2010 (108,4 billions CFA)⁵. However, if the health budget is relatively high, it suffers from a low-level of budget implementation, in particular for the budget dedicated to investment, with less than a third actually spent (30%).

Malaria remains the leading cause of reported morbidity and mortality in Senegal. According to the DHS V, it represents 31.6% of the top ten diseases, followed in order by Acute Respiratory Infections 19.8% and Cough/Cold 9.2%. Although infant and child mortality, have decreased drastically, it remains relatively high (72 ‰ in 2010 against 121‰ in 2005). Maternal mortality rate is 401 per 100,000 live births. These results are quite satisfactory compared to neighbouring countries.

Table: Selected health outcome indicators - comparison with neighbouring countries - 2009

Health Outcome Indicators	Senegal	Mali	Mauritania	Guinea
Life expectancy at birth	59	51	58	53
Crude birth rate (per 1,000 people)	38	47	34	39
Crude death rate (per 1,000 people)	9	15	10	13
Infant mortality rate (per 1,000 live births)	51	101	75	84
Maternal mortality ratio (per 100, 000 live births)	410	830	550	680
Notified cases of malaria (per 100,000)	7,077	25,366	17,325	40,585
HIV prevalence (% of population ages 15-49)	0.9	1.0	0.7	1.3

Source : World Bank, 2009

³⁰ CAFSP, Comptes Nationaux de la santé du Sénégal, 2005.

³¹ Share of health budget (operating + investment) in the state budget excluding debt

B. Interview Guide

Health financing mechanisms and equity: A case study on “Plan SESAME” in Senegal

Interview guide: Stakeholders

APRIL-MAY 2012

To bear in mind

1. Introduction

2. Elaboration process of the public policy: Plan SESAME

a. Agenda-setting

Is the interest of the government for elderly health evidence-based? Are there any studies used to support Plan SESAME formulation?

b. Formulation

Who were the main stakeholders who participated to the formulation? What was their role?

c. Implementation

What are the processes and tools used in the implementation of Plan SESAME? Are the tools adequate to the objectives?

d. Adaptation of the programme

What is the role and position of the stakeholders who pushed for Plan SESAME implementation?

INTRODUCTION

Since when do you work for {STRUCTURE NAME}?

What is precisely your role within {STRUCTURE NAME}?

What is your perception on the situation of the elderly in Senegal?

ELABORATION PROCESS OF PLAN SESAME

a. Agenda-setting

Can you explain from where the idea of targeting the elderly comes?

Whose idea is that?

What were the main arguments in favour of this initiative? Is there, in the international and Senegalese context, any proof of the issue of access to health services and vulnerability of the elderly?

Were some people against Plan SESAME? Who and why did they raise their voices? Did Plan SESAME benefit from the support of international organizations or NGO?

b. Formulation

Who were the stakeholders involved in Plan SESAME formulation?

What was their role and contributions?

What were the initial objectives of the Plan SESAME? Were they modified between the initial project and its implementation? What are the objectives today?

c. Implementation

How were the amounts dedicated to Plan SESAME calculated?

How was the package of services defined?

Who decided of the actual design?

How the scheme of reimbursement should be understood?

How is organised the Ministry of Health communication? What were the channels for communication on Plan SESAME? Where people sufficiently informed?

How many persons have benefited from Plan SESAME in 2011?

Is there a specific monitoring system? If so, can you describe it?

Do we know to whom Plan SESAME benefit the most? Is there any analysis of Plan SESAME utilization per category of elderly (FNR, IPRES, PAF)?

What were the difficulties in Plan SESAME implementation? How did you handle it?

d. Adaptations du programme

What were the adaptations of Plan SESAME? Why?

CONCLUSION

What are the main assets and successes of Plan SESAME?

What are its main defaults and failures? What are the reasons for failure? Do you have solutions to submit?

Do you think that Plan SESAME is sustainable?

C. Brief overview of the politics in Senegal³²

Senegal has experienced two political regimes: parliamentary and presidential. The first constitution promulgated in January 1959 founded the Republic of Senegal and established a parliamentary system. The new constitution (Law No. 63-22 of 7 March 1963) implemented a presidential system. Both the President of the Republic and the Members of the Parliament (MPs) are elected by direct universal suffrage. The President is elected for a term of seven years and defines and implements national policies.

Revisions to the 1963 constitution have been aimed at deepening democracy and the rule of law. Nowadays, and particularly since the last presidential elections, Senegal appears to be a democratic, multiparty system and promoting the freedom of the press.

In March 2000, the country experienced a change of government and a change in the management of power. On 22 January 2001, Senegal adopted a new constitution that extended the role of the President. The functions of Parliament have thus been reduced, in practice, in a mission of ratification of executive decisions.

Behind this political and constitutional architecture lies a political reality: all powers have been concentrated in the hands of the only President of the Republic for years. He is always the head of the ruling party, draws up the lists of candidates MPs, senators and councillors, and appoints the Prime Minister and his ministers. It is extremely difficult for Parliament and Local Government to make decisions independently, whether national or local, without consulting the Head of State.

In 1972, the Government introduced decentralization and the principle of free administration of local authorities³³. The desire to fully empower local communities has resulted in the enactment of legislation transferring certain powers to the regions, municipalities and rural communities³⁴. There is therefore an institutional framework to promote the participation of populations and communities. However, today, this participatory system faces two major constraints: a lack of resources and the weak capacity of community leaders.

While the Code of Local Government proposes a transfer of resources (corresponding to new skills) from central to local government, the latter have few self-managed resources. They are therefore dependent on funds allocated to them by central government. Moreover,

³² Seydou Madani Sy, *Les régimes politiques sénégalais de l'indépendance à l'alternance politique 1960-2008*

³³ Law n° 96-06, 22 march 1996, Code of Local Authorities

³⁴ Including health, education, environment, urbanism, housing, culture, youth and sports.

most of the democratically elected community leaders do not have the capacity to manage their local communities.

Under the Code of Local Authorities, the region provides management and maintenance of regional and district hospitals and the management, maintenance and equipment of health centres in rural communities. Its duties also include the implementation of measures prevention and hygiene. Cities are in charge of management, maintenance and equipment of urban health centres, and the construction, management, maintenance and equipment of urban health posts. Finally, rural areas are responsible for the construction, management and maintenance of rural health posts, maternities and health huts.

Local authorities are in charge of many aspects related to the development and maintenance of the health system in Senegal, thus still struggling to fully meet the mission entrusted to them.

D. SPEC-by-step Hypotheses

Hypothèses du SPEC-by-step : Niveau Individuel

Estimations Annuaire Sanitaire 2009 : les personnes de 60 et plus représentent 6% du total d'activités du secteur de la santé

Hypothèse générale : L'âge est un facteur de risque favorisant le processus d'exclusion sociale. Les personnes de 60 ans et plus sont donc plus vulnérables face à celui-ci.

STEP 1 : Groupes de personnes âgées ou individus informés/non informés sur le Plan Sésame

Hypothèse : Les stratégies de communication ne se sont pas montrées aussi efficaces pour tous

Sous hypothèse 1 : Genre

- Les femmes sont moins alphabétisées que les hommes
- Le taux de participation des femmes aux rencontres publiques est moindre
- Elles s'intéressent par contre davantage aux problématiques de santé

Sous hypothèse 2 : Privation matérielle

- Les personnes ayant de faibles ressources ne bénéficient pas d'un accès optimal aux moyens de communication et donc ne reçoivent pas certaines informations.
- Ces personnes vivent plus éloignées des centres
- Ces personnes en situation de faibles ressources ne peuvent pas se permettre de perdre des heures ou journées de travail pour assister à des réunions d'information.

Sous hypothèse 3 : Niveau d'éducation

- Les personnes ayant un niveau d'éducation faible sont moins à même de recevoir et d'utiliser correctement l'information.
- Elles s'intéressent moins aux informations en provenance des autorités publiques
- Elles n'ont pas de perspective à long terme en ce qui concerne leur santé et donc ne se sentent pas nécessairement concernées.

Sous hypothèse 4 : Fracture Rural/Urbain

- Les personnes résidant en milieu rural sont moins alphabétisées
- Elles vivent plus loin des lieux publics de rencontres
- Elles ont moins accès aux médias (fracture numérique)
- Elles sont plus sceptiques face à la médecine moderne

Sous hypothèse 5 : Isolement social

- Les personnes vivant seules ont un réseau social limité et donc participent moins aux débats publics et rencontres au sein de la communauté.
- De cela peut résulter un manque de confiance envers les instances publiques

Sous hypothèse 6 : Intégration culturelle et acquisition des normes sociales

- Appartenance culturelle : les personnes parlant exclusivement une langue minoritaire sont susceptibles de ne pas être informées.
- Mode de vie : les populations nomades ne bénéficient pas d'un accès optimal à l'information du fait de leurs constants déplacements
- Religion : le facteur religieux peut expliquer le différentiel d'information

Sous hypothèse 7 : Recours aux pratiques alternatives en santé

- Les personnes qui n'utilisent pas les services de soins sont moins susceptibles d'aller chercher l'information.

STEP 2 : Groupes de personnes ou individus avec/sans une carte valide

Hypothèses:

- Parmi les personnes informées il existe une différence entre ceux possédant une carte d'identité et ceux qui n'en possèdent pas, ces derniers n'ayant jamais eu besoin de l'utiliser.
- Parmi celles qui en possèdent une, nombre d'entre elles possèdent une ancienne carte non numérisée, qu'elles n'ont pas jugée nécessaire de renouveler.

Les raisons pour lesquelles la carte d'identité numérisée est nécessaire sont :

- financière i.e. nécessaire pour les retraits d'argent
- politique i.e. nécessaire au vote

Les motivations diffèrent selon le statut des personnes âgées.

Sous hypothèse 1 : Genre

- L'engagement politique est moindre chez les femmes
- Les femmes ne sont généralement pas bénéficiaires des transferts d'argent et donc ont un besoin moindre de la carte d'identité.

Sous hypothèse 2 : Privation matérielle

- Les personnes ayant un faible revenu ont moins d'intérêt financier à avoir une carte valide car moins de soutien de l'extérieur par membre de la famille émigré (transferts d'argent).

Sous hypothèse 3 : Niveau d'éducation

- L'intérêt et la participation à la politique sont moindres chez les personnes ayant un faible niveau d'éducation
- Les personnes ayant un faible niveau d'éducation manquent de connaissance sur les procédures administratives nécessaires à l'acquisition/renouvellement de la carte d'identité.

Sous hypothèse 4 : Fracture Rural/Urbain

- Les démarches administratives sont plus complexes en milieu rural notamment à cause de la plus grande distance aux structures publiques.
- De nombreuses personnes résidant en milieu rural ont une carte non valide.
- L'intérêt et la participation politique sont moindres en milieu rural.

Sous hypothèse 5 : Isolement social

- Les personnes isolées reçoivent moins d'aide de la part de leur famille ou communauté pour les démarches administratives.
- Les personnes ayant un faible réseau social participent moins à la chose publique et ses expressions politiques.

Sous hypothèse 6 : Intégration culturelle et acquisition des normes sociales

- Appartenance culturelle : certains groupes culturels font face à plus de difficultés pour obtenir leur carte d'identité (délais et langue par exemple)
- Religion : certains groupes religieux font face à plus de difficultés pour obtenir leur carte d'identité.

- Mode de vie : les populations nomades vivent généralement loin des établissements publics administratifs. Du fait de leurs déplacements réguliers, ils ne peuvent pas nécessairement accepter les délais administratifs (souvent longs). Ils ont également moins besoin de carte d'identité numérisée (intérêt politique, transfert d'argent...)

STEP 3 : Approchent/N'approchent pas les services de santé couverts par le Plan Sésame

Hypothèse : Parmi les personnes possédant une carte valide, certaines ne sollicitent pas les services de santé couverts par le Plan Sésame :

- Certaines personnes n'utilisent pas les services de santé dits standards.
- Parmi celles qui utilisent les services de santé dits standards, deux modalités :
 - o Exclusion volontaire : utilisation des services de santé privés
 - o Exclusion sociale

Sous hypothèse 1 : Genre

- Les hommes et les femmes refusent généralement d'être consultés par un médecin du sexe opposé.

Sous hypothèse 2 : Privation matérielle

- L'accès aux centres de santé est conditionné par des coûts indirects qui ne sont pas nécessairement supportables pour des personnes ayant un faible revenu.
- Les ménages ayant un faible revenu ont davantage tendance à se sentir incapable de faire face aux coûts générés par l'accès aux soins.

Sous hypothèse 3 : Niveau d'éducation

Sous hypothèse 7 : Parcours thérapeutique

- Les personnes âgées ont une condition physique amoindrie qui réduit leur capacité à accéder aux services de santé couverts par la Plan Sésame (invalidité physique).
- Le vieillissement dans ses dimensions physique et psychologique crée un terrain propice à la honte, barrière à l'accès aux soins des plus de 60 ans. Cela est encore plus vrai quand les maladies touchent des parties du corps moralement très marquées.

Sous hypothèse 4 : Fracture Rural/Urban

- Les personnes résidant en milieu rural sont plus loin des centres de santé couverts par le Plan Sésame.
- Les compétences en gériatrie et le plateau technique sont concentrés en milieu urbain, essentiellement à Dakar.

Sous hypothèse 5 : Isolement social

- Les personnes vivant seules ne peuvent se déplacer jusqu'aux centres de santé sans accompagnant.

Sous hypothèse 6 : Intégration culturelle et acquisition des normes sociales

- Appartenance culturelle :
 - o La communication peut s'avérer difficile si le personnel de santé et le patient ne parlent aucune langue commune.
 - o Certains impératifs culturels peuvent limiter l'accès des personnes âgées aux services de santé (nudité d'une femme âgée face à une jeune infirmière par exemple)
- Religion : certains impératifs religieux peuvent limiter l'accès des personnes âgées aux services de santé (nudité d'une femme face à un personnel soignant masculin par exemple).

- Mode de vie : les populations nomades vivent loin des centres de santé et ne sont pas fidélisés dans certaines structures (la fidélisation renforce le sentiment de confiance)

Sous hypothèse 8 : Recours aux services de santé

- Les services (compétences et consommables) en gériatrie sont limitées au Sénégal, le système de santé étant essentiellement centré sur la santé maternelle et les maladies transmissibles (réalité technique)
- Certains centres de soins ne disposent pas des conditions adéquates pour l'accueil des patients (proximité avec des lieux de rassemblement, manque de confidentialité...)
- Les personnes âgées ne considèrent pas les soins de santé adaptés à leurs besoins (perception)

STEP 4 : Utilisation/Non utilisation du Plan Sésame

Hypothèse : Parmi les personnes approchant les services de santé couverts par le Plan Sésame, certaines ne bénéficient pas de l'exemption financière prévue.

Sous hypothèse 0 : Âge

- Les personnes âgées auront plus tendance à oublier d'amener ou d'utiliser leur carte d'identité numérisée.
- Refus des personnes âgées d'être labélisées « assistées ».

Sous hypothèse 1 : Genre

Sous hypothèse 2 : Privation matérielle

Sous hypothèse 3 : Niveau d'éducation

- Les personnes ayant un niveau d'éducation faible ne sont pas toujours aptes à comprendre les mécanismes administratifs et les conditions de prise en charge.

Sous hypothèse 4 : Fracture Rural/Urban

Sous hypothèse 5 : Isolement social

- Les personnes isolées manquent d'information concernant les conditions pour pouvoir bénéficier du plan Sésame (échelon de la pyramide sanitaire, nécessité de présenter la carte d'identité...)

Sous hypothèse 6 : Intégration culturelle et acquisition des normes sociales

- Appartenance culturelle
- Religion
- Mode de vie

Sous hypothèse 9 : Design et fonctionnement du Plan Sésame

- Non activation du Plan Sésame par les services de santé due à l'incertitude entourant la compensation financière promise par l'Etat.
- Restriction dans les services couverts par le Plan Sésame
- Les patients ne comprennent pas toujours la nécessité d'accéder d'abord aux postes de santé pour pouvoir gravir les échelons de la pyramide grâce aux bulletins de référence et lettre de garantie.

Hypothèses du SPEC-by-step : Niveau méso

Le niveau méso correspond aux facteurs de risques organisationnels de types formels et informels ainsi qu'au cadre social dans lequel évoluent les individus.

Hypothèse générale : Les difficultés liées aux contextes locaux et régionaux et à la mise en œuvre du Plan Sésame (notamment au niveau des structures de soins) ne permettent pas à la population de bénéficier pleinement des services du Plan.

STEP 1 : Groupes de personnes âgées ou individus informés/non informés sur le Plan Sésame

Hypothèse : Les stratégies de communication ne se sont pas montrées aussi efficaces pour tous.

Sous hypothèse 1 : Mise en œuvre inadéquate du programme

- La stratégie de communication mise en place par les autorités n'a pas été relayée au niveau local par les autorités et les structures de soins.
- Les structures de soins n'ont pas été suffisamment informées sur le fonctionnement et les conditions de mise en œuvre du Plan Sésame.

Sous hypothèse 3 : Obstacles financiers

- Les autorités locales ne disposent pas des moyens adéquats pour relayer l'information auprès des populations (transfert des ressources limité)

STEP 2 : Groupes de personnes ou individus avec/sans une carte valide

Hypothèses: La mise à disposition des cartes d'identité numérisées n'est pas systématique.

Sous hypothèse 1 : Mise en œuvre inadéquate du programme

- L'information concernant la nécessité de renouveler la carte d'identité n'est pas optimale.

Sous hypothèse 2 : Temps d'attente

- La lenteur administrative liée à une forte bureaucratisation décourage les citoyens dans leurs démarches.

Sous hypothèse 3 : Obstacles financiers

- Le manque de moyen des administrations publiques ne leur permet pas de délivrer les documents dans des délais et à des coûts raisonnables.

Sous hypothèse 4 : Discrimination, stigmatisation

- Il existe un différentiel dans la prise en charge des demandes au sein des structures administratives.

STEP 3 : Approchent/N'approchent pas les services de santé couverts par le Plan Sésame

Hypothèse : Les *incentives* mis en place par les autorités locales et les structures de soins ne sont pas suffisants pour que la population se déplace jusqu'aux structures de soins.

Sous hypothèse 1 : Mise en œuvre inadéquate du programme

- Les structures de santé ne prennent pas toute en charge des patients dans le cadre du Plan Sésame.

Sous hypothèse 2 : Temps d'attente

- Les délais d'attente dans certaines zones pauvre en structures de soin peuvent être long et donc décourager les populations.

Sous hypothèse 3 : Obstacles financiers

- Il n'y a pas suffisamment de structures sanitaires sur le territoire pour que la population puisse s'y rendre moyennant des frais raisonnables.

Sous hypothèse 4 : Discrimination, stigmatisation

- Le personnel soignant ne se comporte pas toujours de façon adéquate face aux patients.

STEP 4 : Utilisation/Non utilisation du Plan Sésame

Hypothèse : Toutes les structures de santé ne sont pas disposées à prendre en charge des patients dans le cadre du Plan Sésame.

Sous hypothèse 1 : Mise en œuvre inadéquate du programme

- Les unités en charge de la mise en œuvre du Plan n'opèrent pas un contrôle suffisant des structures de santé.
- La mise en œuvre du Plan n'est pas décentralisée (traitement des demandes de remboursement par exemple)

Sous hypothèse 2 : Temps d'attente

- Les délais de remboursement des soins pratiqués sont très longs et dissuadent les personnels de santé de prendre en charge des patients dans le cadre du Plan Sésame.

Sous hypothèse 3 : Obstacles financiers

- Les autorités locales ne disposent pas des moyens nécessaires au bon fonctionnement du plan

Sous hypothèse 4 : Discrimination, stigmatisation

- Le personnel de santé n'est pas toujours impartial en ce qui concerne la prise en charge des patients.

Hypothèses du SPEC-by-step : Niveau macro

Le niveau macro correspond à des facteurs de risques dont la source se situe au niveau central, c'est à dire aux niveaux gouvernemental et sociétal.

Hypothèse générale : Les contextes politique et économique ne permettent pas au Plan Sésame d'être accompagné des moyens humains, matériels et financiers nécessaires à son bon fonctionnement.

STEP 1 : Groupes de personnes âgées ou individus informés/non informés sur le Plan Sésame

Hypothèse : La mise en œuvre du Plan Sésame n'a pas été accompagnée des mesures et moyens nécessaires à la dissémination des informations concernant le Plan.

Sous hypothèse 1 : politique publique inadéquate

- Le design de la stratégie de communication n'était pas adéquat pour atteindre l'ensemble de la population

Sous hypothèse 2 : ressources disponibles insuffisantes

- Le manque de moyens alloués à la communication du Plan Sésame est un facteur explicatif de l'échec.

Sous hypothèse 3 : changements économiques et sociaux (urbanisation, migration, individualisation)

- Les changements sociaux (individualisation par exemple) qui s'opèrent ne favorisent pas le partage d'information.

STEP 2 : Groupes de personnes ou individus avec/sans une carte valide

Hypothèses: La mise à disposition des cartes d'identité numérisées n'est pas systématique.

Sous hypothèse 1 : politique publique inadéquate

- Le renouvellement de la carte d'identité n'a pas été mis en place de façon systématique, il s'agit d'une démarche individuelle.

Sous hypothèse 5 : bureaucratisation

- Les délais pour faire établir la carte d'identité numérisée sont longs

STEP 3 : Approchent/N'approchent pas les services de santé couverts par le Plan Sésame

Hypothèse : Le système de santé ne répond pas entièrement aux besoins de la population (maillage, coûts, compétences...).

Sous hypothèse 2 : ressources disponibles insuffisantes

- Le ralentissement de la croissance au niveau national et le manque de moyen alloués aux services sanitaires et sociaux expliquent le déficit en infrastructures et personnels de santé.

Sous hypothèse 3 : changements économiques et sociaux (urbanisation, migration, individualisation)

- L'urbanisation et l'exode rural favorisent la concentration des structures sanitaires au niveau de la capitale et des grandes villes.

Sous hypothèse 4 : accès aux services insuffisant

- Le plateau technique des structures diffère sensiblement en fonction des localités et régions.
- Les centres gériatriques ne sont pas assez nombreux et le personnel compétent en gériatrie indisponible (curriculum non adapté).

STEP 4 : Utilisation/Non utilisation du Plan Sésame

Hypothèse : La mise en œuvre du Plan Sésame n'est pas accompagnée des mesures et ressources nécessaires à son bon fonctionnement aux niveaux local et régional.

Sous hypothèse 1 : politique publique inadéquate

- Le Plan Sésame est géré au niveau central et ne possède donc pas d'antennes régionales et locales qui faciliteraient sa mise en œuvre.

Sous hypothèse 2 : ressources disponibles insuffisantes

- L'enveloppe budgétaire allouée au Plan Sésame est insuffisante.
- Il n'existe pas de règle pour l'harmonisation des tarifs des prestations et donc certaines structures de soins en profitent pour demander des montants qui ne sont pas toujours raisonnables.

Sous hypothèse 5 : bureaucratisation

- Les conditions et documents à fournir pour les demandes de remboursement sont une charge trop lourde pour les structures de soin.