CHAPTER 11: The inequitable access of Plan Sésame by older population in Senegal, a qualitative analysis of the exclusionary processes

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Introduction

In most African sub-Saharan countries, the informal sector is not covered by the social security system. The elderly are no exception, with very few public policies specifically targeting them (Aboderin, 2008). In Senegal, the population aged 60 and over represented 5.2% of the total population in 2011 (ANDS, 2011). Among them, only 30% are officially covered in case of adverse health events (République du Sénégal, 2009). These latter are either affiliated to the Institut de Prévoyance Retraite du Sénégal (IPRES), the pension scheme for employees in the formal private sector, or to the Fond National des Retraites (FNR), the national pension fund for the civil servants. Besides their increased vulnerability to diseases, older people are also affected by a growing economic insecurity (Antoine, 2007). This insecurity is exacerbated by ongoing social transformations (youth unemployment, loss of solidarity), which negatively affect the support they traditionally received from their kin networks (Pilon, 1995; Antoine, 2007; Aboderin & Ferreira, 2009).

In 2006, these circumstances constituted the main arguments to justify the introduction of a health financing policy targeting the older population, named Plan Sésame1. This policy is of particular interest for the research community because it targets a widely under-studied category of population in Africa. There is an urgent need to redress this imbalance due to the rapid growth of the population of old people,2 which will create new policy challenges (Locoh & Makdessi, 2000; Golaz, 2012). The need for this study also arises from the results of a recent study showing that,

despite their increased need for health care, the older population have often not benefited from Plan Sésame (Leye et al., 2013). This chapter aims to analyse how social exclusion impedes both access to information on, and use of, the Plan by the older population. The concept of social exclusion (see Chapter one), mentioned throughout the analysis, made it possible to identify the main factors of inaccessibility to Plan Sésame.

Methods

The analysis builds on qualitative data collected through three methods: a review of the literature; in-depth interviews (IDIs); and focus group discussions (FGDs). For the review, we analysed the legal framework (bill, law, directive and decrees, from the government), various national policy documents and evaluation reports on Plan Sésame. Data derived from interviews and focus groups were collected in four different sites, both urban and rural. The corpus of qualitative material used for this analysis consists of 34 interviews with older persons, 54 interviews with stakeholders of various profiles and operating at different levels (Ministries, health structures, international organizations, communitarian or professional associations), as well as 19 focus groups conducted both with pensioners affiliated to IPRES and FNR and informal sector community groups3.

Data processing was conducted using the NVivo software. The interview data were analysed thematically following a deductive coding method. This deductive coding was followed by a thematic content analysis, which helped us refine the coding frame.

Results

Plan Sésame: low utilisation rooted in implementation limitations

In chapter four, we presented evidence on the low inclusiveness capacity of Plan Sésame. Indeed, since its inception, only a minority among the targeted age group have benefited from its coverage (see Chapter four). The analysis below shows how gaps in the communication strategy, as well as the absence of a sound payment mechanism, resulted in low utilization of the Plan.

The absence of a communication strategy

Interviews with the various stakeholders showed that the communication strategy was overlooked during the implementation of Plan Sésame. Indeed, after a few attempts to communicate on the Plan at inception, and exclusively through mass media, not much was done to maintain a sufficient level of awareness. This uncoordinated and fragmented communication strategy was ineffective, especially in rural areas where there is not much radio and television coverage:

In some areas, they do not even have a radio. So if you use this method to sensitize them [the target population|], you will not reach them. For example, those who live in Dindifélo, on the hills, they do not even have radio to keep them informed. (Social worker–Rural)

Moreover, the vast majority of the interviewed health workers admitted that communicating on Plan Sésame was not part of the general information given to the patients at the facility level.

“The Plan Sésame, nobody advertised it. By contrast, there is not a single day without advertising on HIV/AIDS, which we all fear. We do not advertise for Plan Sésame. Doctors do not talk about it. Social workers do not talk about it. Neighbourhood leaders do not talk about it... They hide Plan Sésame. “(FGD, Association of Disabled persons, Rural)

Because of this lack of information, nearly half of the targeted population – i.e. the older population – did not know about the existence of Plan Sésame (see Chapter 1). Furthermore, interviews and focus groups with the elderly show that even among the elderly who are informed, people did not fully understand the way Plan Sésame operates:

“I heard about Plan Sésame but we are not part of it; it does not exist in our neighbourhood; I don’t know how it works. I don’t know which way to go to it.” (Female, 60 years old, Rural)

This paragraph shows that the absence of explicit, structured and comprehensive communication strategies is an important weakness of Plan Sésame. Below, we explain how and why the lack of information particularly affected more vulnerable groups and compromised their use of Plan Sésame as soon as it started.

Hospital-centrism of Plan Sésame

Plan Sésame operates in all public health facilities at all levels of care: health posts, health centres and hospitals. It covers individuals who meet the eligibility criteria, including the ability to present their digital national identity card. Coverage is conditional on having passed through the referral system: a referral letter is a prerequisite to access higher levels of care. However, health workers, especially from the in-charge of lower level facilities, explained that health posts do not implement Plan Sésame:

“I have never implemented Plan Sésame at the post [...] I have the required papers with me, but when they come for consultations, I won’t give them free drugs. I do not do it, indeed.” (Nurse Head of a post, Rural)

This situation is due in large part to the way funds for Plan Sésame are allocated. Hospitals are pre-financed and paid on a fee-for-service basis, while lower level facilities (health centres and posts) are reimbursed by services in kind, especially by drugs from the National Drug Procurement Centre, the Pharmacie Nationale d’Approvisionnement (PNA). This has negatively affected the implementation of Plan Sésame at the health post level. Finally, hospitals provided most of the services covered by Plan Sésame (MEF, 2009) and therefore captured most of the resources allocated to the plan. Interviews with stakeholders and older people show that this came at the expense of the older people residing in rural areas, especially those who live at a distance from a hospital.

> *- Do you have trouble getting to [the hospital]?*
>
> *- [The hospital] is very far from our village... The roads are not good, there is no car, there are only carts and bicycles and an ill person cannot ride a bike [...]. If you fall sick and that you do not receive any help, then you do not have the means to move, to go to the district, and then from there to go to Tamba [the regional headquarters], is difficult. It requires means and you have meagre resources from agriculture.” (Male, 69 years old, Rural)*

It is clear that the non-implementation of Plan Sésame at health posts caused differences in access at the expense of the older people who do not have easy access to hospitals, and rural dwellers in particular.

Irregular implementation of the Plan since 2009

Funding problems have seriously affected utilization of Plan Sésame. The initial allocated budget was quickly exhausted, and no budget allocation or earmarked financing were planned to ensure the continuity in financing (MEF[2], 2009). The document analysis shows that, after the first year of implementation, hospitals no longer received pre-financing but operated on a cost-recovery basis with no certainty to be paid in the end. By 2009, the Plan was highly indebted, owing a total amount of over 4 billion F CFA to the health facilities (MEF, 2009).

Inconsistent funding caused several dysfunctions in the Plan Sésame implementation at the health facility level (Leye et al., 2013; Mbaye et al., 2013). The benefit package covered by the Plan was reduced in 2009 (Ministry of Health, 2009), while many facilities had already rationed it implicitly. These procedures restricted the coverage to consultations only and excluded any further investigations or additional examinations to the provided services. At the same time, some facilities simply decided to put Plan Sésame on hold:

"We no longer have the means to meet the demand. Either there is lack of supply, drugs are not available, especially since money transfers are rare. [...] We continue to support them [older people] depending on our capacity, but if the old person comes here and we do not have inputs to cover him, we do not take care of him." Hospital Director, Rural

Thus, three years after it started, Plan Sésame worked in an irregular way in many hospitals and health centres. Interviews with actors show while some facilities partially used Plan Sésame, others simply chose to ignore it. This implicit termination of Plan Sésame was strongly felt by the older people who were using it:

"I know Plan Sésame, but they said that Plan Sésame is stopped. I went to the hospital "Nabil Choucair" in Dakar, the doctor told me that policies related to Plan Sésame were over." (Male, 83years old, Rural) .

Implementation of Plan Sésame was thus highly irregular. The "randomness" in coverage affected the perception of the main beneficiaries: most of the older people have a negative opinion about it. Many interviewed old persons showed a high level of distrust in the programme and in those who initiated it. Therefore some of them, although being informed of its existence, did not use Plan Sésame.

"I did not go since I have to pay prescriptions myself. People went and came back without getting anything, they were even asked to pay their bills, so I did not go. [...] I was not even tempted to give it a try." (Female, 63 years, Rural)

The halt in the implementation of Plan Sésame in many health facilities brought the financial barriers back to the forefront; the costs of health services being seen as a great obstacle for the older population to access health care. Financial barriers related to access to health care services therefore remain a central issue for many of the interviewees:

"If we don't have money, we cannot be treated! Currently, if doctors say they give you free [drugs], they misinform you, nobody gives free drugs. "(FGD, Group of beggars, urban)

It clearly appears that due to the numerous gaps in design and implementation, Plan Sésame suffered from a great deficit in communication and ineffective implementation. Yet, despite these facts, some groups succeeded in benefiting from Plan Sésame while the great majority was excluded. The following section aims to explain how and why.

Implicit strategies to gain information and access to Plan Sésame services

Data extracted from focus group discussions, interviews with stakeholders and older people shows that the absence of a formal communication strategy was compensated by inappropriate implicit strategies, mainly within health structures. Indeed, during consultation, health personnel were expected to inform the patient on the existence of Plan Sésame and on the paperwork it required. However, our study shows that not everyone received the same quality of "interpersonal communication" and support on the Plan. The levels of information received varied greatly according to the social connections of the patient, some even stating that the information given by the health staff was mostly provided to their relatives or friends.

- Is there any special kind of older persons who use Plan Sésame more than others?

- Yes of course [...] the nurse can inform his relatives who can thus benefit from it, whiles others have to pay to be cured. (Social Worker, Rural)

Thus, these implicit strategies seem to benefit more the older people who are able to gather resources thanks to their socio-professional status or through their social networks. Analysis shows that this profile refers to specific categories within the older population: those who retired from the formal sector and those with strong social networks.

The status of being a retiree of the formal sector

The results show that being retired from the formal sector constitutes a clear advantage in accessing Plan Sésame resources. First, it appears that pensioners from IPRES and FNR are widely privileged vis-à-vis information on the Plan. Group discussions with them show that they are often well informed on Plan Sésame and have good knowledge about it.

This advantage that the formal sector retirees have in terms of information is explained by the fact that the lobbying efforts for a reduction of health care costs for the older population, which eventually resulted in the launch of the Plan, were led by associations of formal sector pensioners (Ministry of Health, 2007). Moreover, their representatives were involved at the design stage of the programme and often invited to take part in the working groups in charge of preparing the plan. The interviews of these representatives show that their involvement at the design stage facilitated the spreading of information among members affiliated to IPRES and FNR.

> *"Pensioners of IPRES and FNR better understood [the Plan] because they are aware, they belong to organizations where information flows and they knew how to proceed [to benefit from the plan]." (Social Assistant, Urban)*

This category is also privileged in terms of utilization. Indeed, interviews with stakeholders show that the status of being a formal sector pensioner also increased the odds of benefiting from Plan Sésame:

> *"- It was always those who had IPRES and FNR cards [that used Plan Sésame most]. The older people who live in the rural world seemed not to be able to enjoy favors which were offered to them." (Doctor Head of a District, Rural)*

It is important to note that retirees from the formal sector, both from the public or the private sectors, already have a formal coverage. Therefore, contacts with health personnel are far more likely than for those who have always worked in the informal sector and have never benefited from any protection. Besides this better access, they have more experience of the standard administrative procedures. For example, during interviews and focus groups, they showed a certain experience in using their cards to claim for their rights to free health services, which they often did to benefit from Plan Sésame. This ability partly explains the higher utilization rates of the programme among FNR and IPRES pensioners.

> *"We have a card on where it is written FNR. All the retirees from the civil service have that. That is what we generally bring along to the facilities [...]. For example, when I go to the hospital, that is the card I show, they allow me to get in and say: "Here is a retired civil servant, he can be treated here." (Male, 65 years, Urban)*

Social networks

Social relations, through professional status, are also strong determinants of the utilization of Plan Sésame. Interviews with older people show that those who have a strong social network benefited more from services and therefore captured more resources allocated to the Plan. It seems, therefore, that benefiting from Plan Sésame requires either to have contacts within the health facilities or to be supported by a third person to activate entitlements to Plan Sésame:

> *[...] In my opinion, Plan Sésame is only for some people.*

Why do you say so?

Because if you do not know how to proceed it will be difficult to benefit from it. In addition, you need to have connections to access formal papers, which allow you to get treated at the hospital. But if you have no one to help you, things will be very difficult. This is my opinion on Plan Sésame: if you do not have connections you cannot benefit from it. (Chairman of an association of Imams -Rural)

"I have used it (Plan Sésame) twice but it was thanks to my contacts. I know a head of unit, a medical in-charge, who after having consulted me, told me: 'My dear, I will do a Plan Sésame for you.' I used it twice, but it was not easy. The other guy told me: 'We'll do it for you just because the boss asked us to.'" (FGD, Retirees of FNR, Rural)

Thus, IDIs with older people show that to enhance the chances of benefitting from the Plan, some resorted first to visiting facilities in which they had contacts that could guide them towards accessing Plan Sésame, hence bypassing the referral system.

"[...] I went to "Hôpital Principal" where my niece works. She consulted me the very same day and diagnosed stomach pains. She got me an appointment with another Medical Doctor. She then asked me if I was 60, and since I was, she suggested me to use Plan Sésame through which I could get free care. It is through Plan Sésame that I undertook the medical check-up that identified a problem in my colon. (FG, Health insurance, Urban)

IDIs and the key informant interviews show that the level of participation in community associations was also associated with better information and better access to the services of the Plan. Indeed, a member of an association (typically the leader), if conversant with the operating procedures of the Plan, can help the other members to use his/her own social network to benefit from it. Interviews with the civil society leaders show that members of community associations can thereby be informed and guided in the pathway leading to Plan Sésame benefits:

"One of our elders who came from one of our villages called me to say that his eyes hurt him. Being part of the association, I told him to come here, that I would help him get treated [...] I helped him to benefit from Plan Sésame and this improved our relations. I knew him via the association and thanks to the association he won my trust.

[...] So, do you manage to accompany the members of your association who are aged of 60 and over and who are sick? Do you help them to benefit from the Plan Sésame?

I help them to get treatment by driving them up there [to the hospital]. Or I direct them to their dispensary. Or I ask them to come here and I take them to our dispensary, I get an official document here and then we go to Matam." (Head of a Community Association, Rural)

Thus, it seems that opportunities to know about and to benefit from Plan Sésame vary according to people's socio-professional status and their social network. That explains why some older people benefit from Plan Sésame in some cases without even knowing about its existence previously.

Psychosocial and financial barriers to access

Internalized discrimination: an obstacle to care for the older person

In the previous paragraphs, we showed that belonging to a specific socio-professional group,, or having a strong social network, were both linked with greater benefits from Plan Sésame. What the data analysis also reveals is that there is a category of older people who rarely (if ever) use health services due to internalized discrimination. Internalized discrimination was identified as a process through which discriminative practices and attitudes towards

members of a group/category – in this case an age category – are gradually considered normal by the members of the group themselves. This discrimination thus becomes a strong internalized barrier that hampers full participation in social life. Our findings show that the development of such feeling is strongly linked to the combination of three factors: the serious impoverishment of the older population, a deteriorating social status, and a growing issue of loneliness enhanced by an increasing challenge to complete daily tasks without support from others (see chapter one).

Precarious economic power and social status

Interviews with the elderly emphasize the importance of socio-economic status in the internalization of discrimination, which in turn limits the expression of their needs in health care. Indeed, aging generally was accompanied by a loss of economic power (see chapter 1):

> *"If we do not have the means to pay, why would we go to the hospital? Who is going to treat you? You can have money and do not receive adequate care, so it will be even worse if you have no money." (Focus group, Delegates of district, urban)*

This feeling is also noted among those with a status of formal retirees. Their financial situation gradually deteriorates as a combined result of low pensions – hence lower income – and familial responsibilities that remain high:

> *"The day we perceive our pension is the day we feel sicker. That day all our hibernating pathologies re-emerge. We spend all day trying to arbitrate between the bills and food rations. (FG, member of IPRES, Rural)*

> *"These [difficulties] come out when you are in charge of the whole family with your pension. You have children at home. You cannot eat without your children, without your nephews or your grandchildren. Distress starts from then on. And all the while, the pensions are not being increased. (FGD, FNR, Rural)*

Even if this category is privileged in terms of information and use of the plan, they are facing similar problems of accessing services, as they no longer have economic capital and are no longer able to maintain a strong and extended social network.

As mentioned above, the loss of economic power goes along with a change in the social status (see Chapter 1). Traditionally, older generations were considered the guardians of knowledge and authority. Today, their social role and position are less valued. They feel they do not receive as much attention from the younger generations as it used to be. For them, they are given less consideration and respect (see Chapter 1), as it was mentioned in most of the interviews:

> *"Our society has changed fast, it is still changing by the way. It is a society that does no longer give a role to the old person. In some families, the old person lives in a corner, is no longer invited to the debates, his/her voice is no longer important when there are familial issues to be addressed, because it is always said "Dafa magett , dafa naax " (S/he is old , S/he is senile) (health worker , Urban).*

Difficulties arising from the degrading economic situation and social support lead the elderly to internalize a discrimination that keeps them away from health services where they are not sure to receive attention and treatment they think they must have. The fact that they did not receive the same care in health services is seen as quite normative by some of them. "People like me cannot access Plan Sésame" is a widely repeated assertion that reflects the same perception. "People like me" refers here to the most economically and socially vulnerable groups. Indeed, this feeling is mainly perceived among those with the lower level of education:

> *My view is that they do not take care of people.*

> *Why do not they take care of you?*

I do not know, as long as they are more educated than me. (Female, 63 years, Rural)

This feeling is also found among those who are not part of the formal sector:

"I thought Plan Sésame was just for people in the administration. I thought it was only for people who have worked for the State." (FG, Association of taxi drivers, Rural)

Even community leaders in the informal sector have these perceptions:

"The Imam and the old person from FNR do not receive the same treatment. There is a big difference. In general, the imam who falls sick receives prayers at his mosque and they contribute during two or three days to pay his drugs. Let's not be foolish, we [the imams] cannot be supported in the same way [as FNR pensioners] when we fall sick." (FG, Association of Imams, Rural)

All in all, it is a feeling widely shared by those who identify themselves as poor people:

"If we do not have financial means, we cannot go to be healed; we do what the poor do: once we are at the hospital, if you do not have resources or someone to help you, you can do absolutely nothing ". (FGD, GPF, Rural)

Physical impairment and loneliness

Physical impairment is also one of the basic criteria of internalized discrimination. It was considered a serious obstacle to accessing Plan Sésame services, which are conditional on fulfilling official procedures. These procedures were perceived as challenging by most of the older interviewees, particularly those with a poor physical condition:

"If you cannot walk, you cannot do anything. As you can see, I have no teeth anymore and I also have cataracts. Now if you cannot move, or you cannot see, there is a problem, because you might get informed [about Plan Sésame], but you won't go anywhere. In this case you are alive, but life does not need you anymore" (male, 80 years, Urban).

Physical impairment, sometimes coupled with a lack of appropriate assistance, is particularly felt when health care is needed. Elderly with physical impairments sometimes evoke a sense of powerlessness over their own condition; consequently, they often choose not to attend health services:

I do not often go to the hospital

Is it far?

Yes it is far for me because I walk there; I do not have the means to take a taxi. So it's hard for me because I cannot walk long distances. I am quickly out of breath when I walk (Male, 72 years, Urban)

This feeling of inability is a real constraint, especially as it mostly reinforces the isolation of the elderly:

"I can absolutely do nothing more. I'm just like that, I stay seated all day long and I lie all the night. (Female, 80 years, Rural)

It is worth noting that even the elderly with no physical impairment also mentioned a sense of isolation. Quotes made by older people – supported by the key informants – show that loneliness of the elderly is increasing. A vast majority of older people interviewed had the impression of being "forgotten" – another way to express a feeling of growing isolation – which in turn contributes to internalized discrimination.

"Do you feel alone?

Very alone! Sometimes I do not go out all day long, my wife… does not even greet me. She stays, she talks with the children and sometimes I am forgotten". (Male, age 65, Urban).

Lack of access to health care is thus the fruit of a complex ageing phenomenon, characterized by intertwined issues building upon precarious socio-economic conditions, physical disabilities and a feeling of loneliness. All these facts lead some older people to experience aging as social abandonment. This feeling discourages them from using health services. These deprivations lead to an internalized discrimination, which does not only put a stop to the older people's social participation, but also prevents them from fulfilling their most basic right: the right to health.

Discussion

The limited implementation of Plan Sésame without regular funding has affected accessibility to free or subsidised care for the elderly. This is largely explained by the organizational set-up and the implementation of the programme, leading to severe dysfunctions and low utilization. Several other studies support this finding and have also shown that poor results of an exemption policy are largely rooted in the implementation gaps (Gilson & Di McIntyre, 2005). In several similar programmes, lack of funding hindered the implementation of the programmes and exacerbated the access issue (Witter et al., 2010; De Sardan & Ridde, 2012).

This low utilization of Plan Sésame is also due to the absence of a structured information strategy tailored to the need of the targeted audience. Information was hardly relayed by health workers, whose behaviour turned into passive resistance. This behaviour is often noticed in other policies that provide care free at the point of use or exemption programmes because such programmes are often considered a threat to the financial equilibrium of the facilities (Ba, M., 2011). This in turn triggers implicit information and access strategies, which are directed only to groups with a certain level of economic and/or social capital. Other studies have also shown how important economic status and social networks are to access health services, especially where social connections are central in the operations of the health system (Hours, 2006).

Thereby, the elderly with strong social capital were better at capturing resources allocated to the Plan. Social capital, defined here as a "set of actual or potential resources linked to the possession of a durable network of more or less institutionalized relationships" (Bourdieu, 1980) is seen as a key factor to access information and services of the Plan. The role of social capital in facilitating the access to health services (Swann & Morgan, 2002) and social health protection mechanisms (Mladovsky et al., 2014) has also been demonstrated by other studies. For example, in Senegal, households with higher levels of social capital were more likely to enrol in community health insurance schemes that aim to provide risk pooling and financial protection from the cost of ill health.

Plan Sésame, therefore, ideally reveals the complexity of access to health care for groups – such as the elderly in Senegal – who face social exclusion processes. Indeed, this population is subject to a growing social vulnerability, mostly because of the poverty that strikes the households in which they live. In low- and middle-income countries, the traditional solidarity model relying on the kinship network – long seen as the "social care provider" for the elderly – is now showing several shortcomings (Jong, 2005) and social solidarity systems are failing to fill gaps in formal social protection in general (Vidal, 1994; Lloyd-Sherlock, 2000).

This situation is exacerbated by a decline in the social status of the elderly, increasing social isolation and physiological weakening, which interacts with each other to enhance poverty, which is socially built (Simmel et al., 1907). This leads older people to show a sense of resignation in the face of a situation that is increasingly perceived as fatal. This is interpreted in this study as a form of internalized discrimination that prevents older people from seeking care and using public programmes, including those especially targeting them.

As a result of these processes, Plan Sésame has not drastically reduced the financial risk related to the elderly's access to health services, especially for groups subject to social exclusion. It neither considered nor tackled some of the structural factors embedded in the social environment of implementation (the unequal distribution of power and resources) that lead to social exclusion. Indeed, in its formulation and implementation, it did not take into account

the specificity of the aging process, which combines poverty and vulnerabilities. Heavy and lengthy administrative procedures and a bias towards hospital care are among the design factors that translate to social exclusion from Plan Sésame. Plan Sésame in its current format does not therefore seem adequate to address the needs of a largely illiterate population who mainly live in rural areas and face physical limitations and lack of public support. Because of all these facts, Plan Sésame did not trigger the transformative process (Michielsen et al., 2010) that one should expect from a social protection programme in health that targets vulnerable groups.

Conclusion

Social exclusion from Plan Sésame is associated with multiple factors. This exclusion is structural, rooted in some central features of the programme – i.e. the lack of funding and hospital-centrism that further widens the rural/urban gap. It is also social: Plan Sésame is operated in a system in which social connections are determinant in accessing health services. Information on the Plan and its utilization are largely dependent on implicit strategies that have turned the programme into an initiative that favours the urban, educated categories and those belonging to the formal sector. The vast majority of the elderly are actually excluded from a health policy that is specifically intended for them. This study unravelled a worrying phenomenon: the acceptance of discrimination by the "socially excluded". This discrimination has become normative for them, a phenomenon that often prevents them from seeking out health services. Plan Sésame as a mechanism of social protection has hardly managed to stop this process, and has even exacerbated it. Therefore, strengthening the inclusive capacity of Plan Sésame should be a top priority to reverse the social exclusion of the elderly in Senegal.

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Endnotes

1 Details of the design of Plan Sésame are presented in chapter four

2 In 2013, there were 60 million individuals aged 60 years and more in Africa. According to the United Nations, 212 million Africans will belong to this age group by 2050. Source: United Nations, 2013.

3 Further information on the data collection process is provided in chapter four.