

## CHAPTER 4: Senegal and Plan Sésame

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This chapter describes and analyses Plan Sésame, an exemption scheme from healthcare payments targeted at the elderly in Senegal, from a social exclusion perspective. We first describe the general background of Senegal and its social security system with a focus on social health protection. We then briefly discuss Plan Sésame and our study methods. After presenting and discussing our study results, we explore the possibilities of making Plan Sésame more inclusive.

### Background

Senegal is a relatively small country (196,712 km<sup>2</sup>) bordering the Atlantic coast in West Africa. Its population of roughly 13 million (ANSD, 2013) is concentrated in the west of the country, with 7,748 inhabitants/km<sup>2</sup> in the capital region of Dakar and only 15 inhabitants/km<sup>2</sup> in the eastern region of Tambacounda. Senegal has a young age structure, with 42.1% of the population under 15 years and only 3.5% over 65. Today, the urban population (58%) outnumbers the rural population. While being a multi-ethnic society, Islam is the predominant religion (94%) with Islamic communities typically organized in Sufi orders or brotherhoods and playing a key role in social life.

In mainstream economical terms, Senegal is classified as a low-income country with a high poverty headcount. Applying a broader concept of development, Senegal is still categorized as a low-human development country: its Human Development Index ranks it at 154th place among 186 countries (UNDP, 2013). Men have on average six years of schooling; women score lower with four years of schooling. Overall, gender disparities – including schooling – exclude women from decision-making and deprive them of employment opportunities. More than two thirds of all workers are to be found in the informal sector; 34% of all workers earn less than \$1.25 PPP a day. Again, poverty is highest among women, and concentrated in rural areas. Social security coverage as percentage of employment is only 5.1% (ANSD, 2011; ANSD, 2013; RdS-MEF, 2004; RdS-MEF, 2006; World Bank, 2013).

Not unsurprisingly then, the greater part of the Senegalese population lacks access to basic social amenities. In rural areas, more than half of the population is in a precarious situation with nearly 40% having no access to tap water. While some improvements have been made over the last decade – for example in access to education – inequalities between regions, between urban and rural areas, between socio-economic groups and between men and women are still manifest (RdS-MEF, 2009; Diagne, 2012).

Access to health services is particularly difficult for large segments of the population. In rural areas, over 58% of the population is more than 30 minutes from the nearest accredited health facility; even in the capital region, this is the case for nearly 43% (RdS-MEF, 2004). Barriers to access to care are numerous, but transport difficulties related to distance and poor quality of roads remains a major constraint.

Despite this bleak picture, the Senegalese still value solidarity and mutual assistance as core values. Each individual is connected to a network of communities that evolve around a standard of cultural life and religious beliefs. The proliferation of all kinds of associations contributes to the development of relational networks and social networks. The more one broadens the horizon of his personal, family, or ethnic brotherhood, the more one gives oneself ways to escape from poverty. However, traditional Senegalese society has a strong hierarchical organization that does not promote equality of opportunity and reduces the potential dynamic of solidarity and support. Most ethnic groups still have caste-like social stratification. In rural Senegal, the expanded family is still the norm, whereas in urban areas an evolution towards nuclear families and individual lifestyle is noticeable (Pilon et Vignikin, 1996). Massive rural-to-urban migration often means that the elderly become house guardians in many villages (Demonsant, 2007).

## **Social health protection in Senegal**

Social health protection in Senegal places great emphasis on the formal sector, while 70% of the workforce operates in the informal economy. Three sub-systems can be distinguished: formal social security, alternative systems of healthcare financing (community health insurance and targeted exemptions), and informal mechanisms of social protection.

Formal social security is compulsory for civil servants and private-sector wage earners and managed by either the Ministry of Economy and Finance or mutual companies called Disease Providence Institutes.

Two types of alternative health-care financing systems operate in Senegal. First, and for more than a decade now, Community Health Insurance (CHI) schemes aim to offer coverage to those left aside by formal social security and is based on voluntary contributions. While more widespread than in other West African countries, CHI in Senegal still only covers 4% of the total population (Soors et al., 2010) Second, the government has started various subsidised targeted exemption programmes with the ambition of reaching the most vulnerable groups. These interventions, however, have great difficulties in reaching their recipients: a significant proportion of the poor continue to be excluded from health services. Informal social security mechanisms can still be found in villages as well as urban communities. These solidarity funds are used to help members cover medical or funeral expenses.

To this scattered and inefficient amalgam of social health protection initiatives is added a health service delivery system that is characterised by a lack of staff, in both qualitative and quantitative terms, and predominantly focused on maternal and child health. The combined deficiencies of the Senegalese social health protection and health service delivery systems generate barriers to access to care for the population in general and for the elderly in particular. The elderly – defined as people over 60 in Senegal – today constitute less than 5% of the total population due to a lower life expectancy, but are expected to make up 9% by 2050. In spite of their greater need for health care, most elderly do not have any health protection coverage.

## The elderly and Plan Sésame

Since 1980, associations representing the elderly have voiced their demand for free access to health care. Two decades later, in 2006, the government announced Plan Sésame. It thereby responded to the precarious socio-economic situation of this population group, as widespread household poverty in households no longer encourages communities and families to take care of their elderly.

Plan Sésame targets all Senegalese citizens aged 60 and older, whether they are retirees of the formal sector or not. Nearly 70% of its beneficiaries are old people without shared financial resources, with neither pension nor health coverage. Plan Sésame is financed by both the government and the private sector (IPRES, Institut de Prévoyance Retraite du Sénégal, a private institution, under state supervision, responsible for pensions in the formal sector). Launched as an initiative of the Presidency, a range of actors are involved in the management and implementation of the plan: the central Ministry of Health, regional and district health offices, hospitals, and the national medical stores. Access to services through Plan Sésame is based on the possession of a national identity card. Services are covered at government health posts, health centres and hospitals, following the habitual reference procedures of the health care delivery system. The initially comprehensive benefits package – including diagnostic tests, hospitalization, surgery and drugs – was substantially scaled down from 2009 due to a lack of financial resources.

## Methods

Within the Health Inc consortium, we adopted the SEKN concept of social exclusion as a dynamic and multidimensional process. We studied social exclusion within Plan Sésame along its four dimensions – social, political, economic and cultural – applying the SPEC-by-step tool developed by the research consortium as described in Chapter 2. This has facilitated the analysis of differential access to care, the identification of groups of elderly excluded at each stage of the process, and an explanation of how these people come to be excluded.

Adapting the general Health Inc research framework to the local context, based on the main assumption that lifting financial barriers is not necessarily sufficient to counteract social exclusion, six general and four specific research questions were formulated:

- (1) What are the reasons for the poor performance of Plan Sésame as a health financing mechanism?
- (2) What does social exclusion of the elderly in Senegal mean and how is it manifested? What are its key indicators?
- (3) Is social exclusion an obstacle to the development of health-care financing for the elderly who work in the informal sector, and – if yes – to what extent?
- (4) Does the implementation of Plan Sésame reduce social exclusion of the elderly or, on the contrary, increase it?
- (5) To what extent has Plan Sésame been able to reduce social exclusion in Senegal?
- (6) What is the ability of policymakers to increase social inclusion through health-care financing in Senegal?
- (7) How has Plan Sésame been perceived at different levels and in different sectors of the health system?
- (8) To what extent did information on Plan Sésame reach the intended users?
- (9) What was the effect of Plan Sésame in the use and quality of health care?
- (10) What was the effect of Plan Sésame on household expense in health care?

To answer our research questions, we applied a mixed-methods approach, encompassing literature review, actor mapping, household survey, semi-structured interviews and focus group discussions. Quantitative and qualitative data and analysis were combined to deal with all dimensions of exclusion and older people's access to care.

We conducted our field research in four administrative regions: Dakar, Diourbel, Matam and Tambacounda. The sites were selected following rational criteria relevant to the subject of our study: (1) urban/rural stratification; (2) access to a health facility; (3) poverty levels; (4) size of the population aged 60 and over; and (5) existence of a hospital to take care of Plan Sésame beneficiaries. The selected sites have both urban and rural areas (with the exception of Dakar) and are culturally and ethnically diverse. They include 41% of the population, 29% of total area and 38% of the elderly in Senegal.

## **The household survey**

The household survey was intended to find out who, among the elderly, was excluded and from what parts of access exactly. We used random sampling, ending up with 2,998 households with at least one old person in every household. Our sample is representative of the population aged 60 years and over and was allocated proportionally to the number of the old people living in each site.

The framework of the National Agency of Statistics and Demography (ANSD, Agence nationale de la statistique et de la démographie) was used to distribute households within the sites. This framework divides each department into several census districts. Within the selected households, we targeted the head of household and one person aged 60 and over living in the household. Informed consent was obtained from each targeted individual. Of the total sample, 98% were completed, corresponding to 2,933 elderly among 31,710 household members. For data entry we used CSPro software; for data analysis (descriptive statistics and statistical inference), SPSS.

## **Semi-structured interviews and focus group discussions**

We conducted a total of 80 semi-structured interviews – 34 with individual elderly and 46 with health system actors – and 19 focus group discussions with members of associations or groupings of elderly. The semi-structured interviews and focus group discussion were intended to find out how and why the elderly are still excluded. In a sequential mixed-method setup, the qualitative strand (semi-structured interviews and focus group discussions) of our research was thus designed to make sense of, and deepen the results of, the quantitative strand (the household survey). Informed consent was obtained.

We performed an essentially qualitative data analysis of all 99 transcripts applying deductive coding using NVivo software.

## **Results**

The households we surveyed are large, each with an average of 10.8 members, and relatively young: members aged under 34 represented 68% of the total. The elderly make up 12% of all members. The masculinity ratio (number of men per woman) is 0.93. Heads of household are relatively old: 74% of them are aged 60 or over while only 7% are under 40. Living conditions in households are difficult: 38% of household heads earn less than €127 per month, while the monthly food expenditure of more than half of them already exceeds this amount. Average household monthly health care expenditure does not exceed €13 for half of the households.

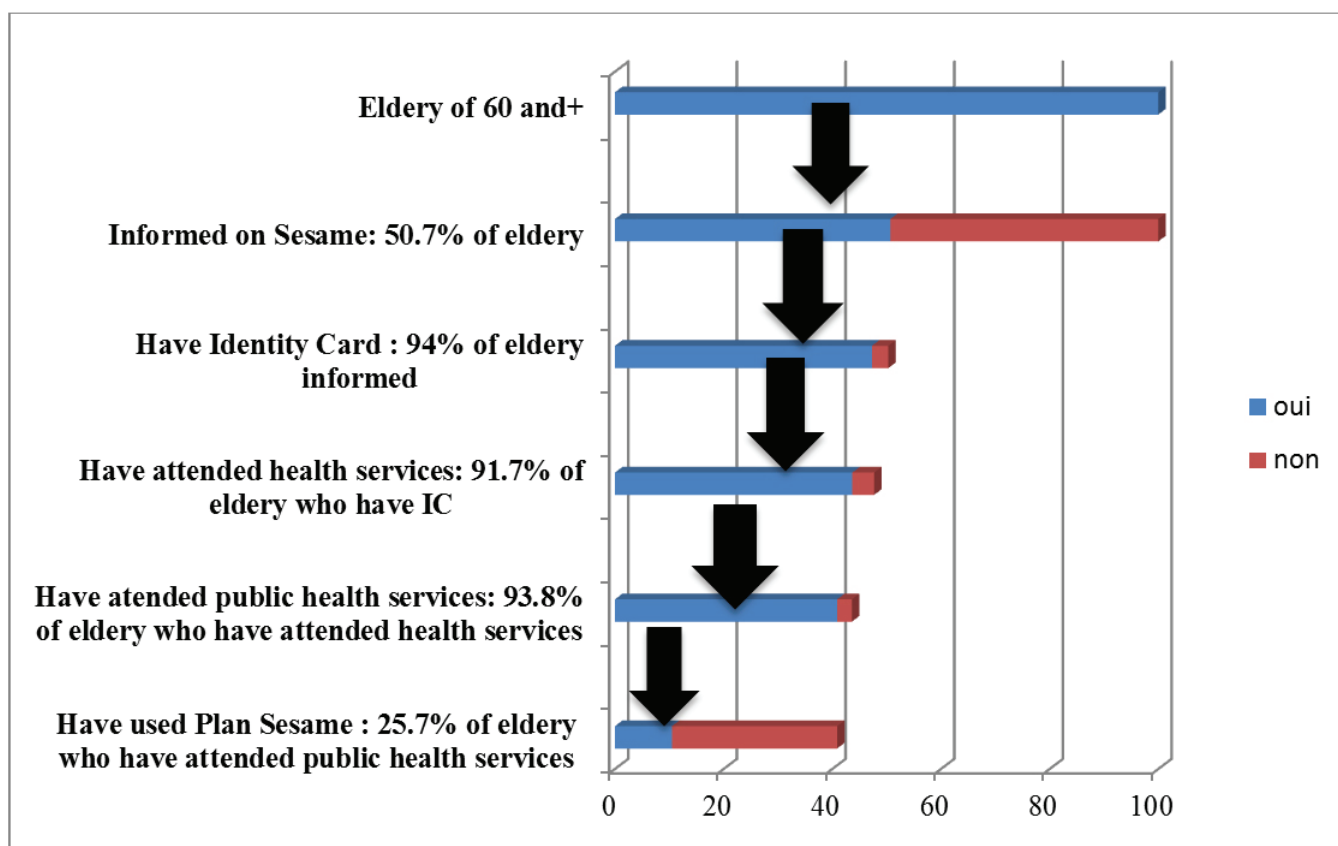
Slightly more than half (51%) of the older people we surveyed live in rural areas, 59% are married and 37% are widowed. Most of them are illiterate (73%). Nearly 60% are less than 70 years old; 12% are over 80, and most of the dependent elderly are to be found in this age group. They live with their grandchildren, siblings, relatives, stepsons and stepdaughters, or with unrelated persons who constitute 40% of the household members.

Of the elderly surveyed, 42% still earn a living from agriculture or small business, and 45% claim to be self-supportive. However, 73% of the are fully or partially supported by their children. Only 63% of the elderly receive a pension, which is less than 50,000F CFA (€76) a month. Of all older people surveyed, 20% have a monthly income of less than 50,000 F CFA (€76) and 62 % less than 100,000 F CFA (€152). Nearly 70% of the elderly do not have any monetary or in-kind savings. A large part of the elderly’s expenditure is dedicated to food (39%) and health care (23%).

The health status of the elderly surveyed is clearly a reason for concern: 52% were ill or injured in the two weeks preceding the survey; 24% suffer from a chronic condition; and 10% have a disability. A narrow majority of elderly (58%) has therefore sought medical attention, mainly in public health facilities (71% of visits). Health posts, health centres and hospitals are all visited with health posts being the most frequent first resort (35%) followed by hospitals and health centres. When visiting a health facility, outpatient care was rated satisfactory by 52% of users and inpatient care by 67%. Access to health care is not always easy for the elderly: 42% could not access any health facility, of which 12% had unmet hospitalisation needs. Lack of financial resources was the most mentioned reason for not accessing health services (57% forwent outpatient care; 74% forwent inpatient care). Overall, only 5% of the elderly declared they were able to financially support their health care needs. Distance is another problem: in rural areas, a majority of the elderly judged the nearest health facility too far to walk (hospital 65%; health centre 54%). The elderly frequently referred to feeling helpless, facing long queues in the health facilities and repetitive appointments causing endless and painful back-and-forth journeys.

To understand how and to what extent Plan Sésame did or did not remedy the access deficit of the Senegalese elderly, a closer and more structured look is needed, which is provided by applying the SPEC-by-step tool (see Figure 1).

Figure 1: Plan Sésame’s SPEC-by-step



At first sight, our SPEC-by-step tool reveals that Plan Sésame performed badly from the very start, largely lacking the necessary material to inform its potential beneficiaries. Nearly half of the elderly are unaware of the plan's existence. Among those who were informed, 67% still do not know how the plan operates and, particularly, what services are offered. In the end, only 10.5% have received needed and covered services.

Remarkably, the typical profile of an old person who received a full benefit of Plan Sésame is that of an educated man in an urban area, retired from the formal sector. This should be interpreted as a typical example of the so-called Matthew effect or inverse care law, referring to more uptake of services by those who need it less, and less by those who need it more (Deleeck et al., 1983; Tudor Hart, 1971).

Of those who ultimately benefited, 83% judged that Plan Sésame had reduced their health spending. This might explain why Plan Sésame is seen as a useful initiative by a more vocal part of the population, whereas it suffers from a negative image among the poor elderly whom we surveyed.

## Discussion

Our study has allowed us to better understand the marginalisation and exclusion of the elderly in Senegal. There is no doubt that the specific social, political, economic and cultural circumstances of the elderly, as a social category, make them particularly vulnerable and easily marginalized. In addition, the social status of the elderly is gradually deteriorating in terms of respect received from younger people and in terms of social participation. The traditional role of the elder head of household, proudly assuming responsibility for his offspring, is waning. Economic crisis and subsequent impoverishment and deepened poverty are a heavy burden for the traditional solidarity networks and particularly affect social support for the elderly within the family, as witnessed by several of the interviewed. Most importantly, one in two of the elderly people interviewed expresses suffering from loneliness as a major concern, despite still being surrounded by a family.

To this core social dimension is added the political dimension of exclusion, where policymakers dedicate insufficient resources for the specific needs of the elderly – thereby maintaining structural and agency-related causes of access deficits. Illiteracy remains unaltered. Space for civil and political participation of the elderly seems not to be widening, but narrowing.

As mentioned before, the elderly not only face economic difficulties, they often are economically dependent on others, be they family (73%) or not, which again increases the likelihood of marginalisation in times of financial hardship and shifting societal values.

Culturally, the elderly have a hard time. They have considerable difficulties to cope with, such as the effects of urban migration and the gradual loosening of family ties. Besides expressing loneliness, one in two are pessimistic about the future of their offspring. Nearly three in four seek refuge in religious activities, mosques and churches as a last resort.

## Can Plan Sésame be made more inclusive?

It is clear from the analysis that the mechanisms – in the social, political, economic and cultural spheres described above – that increase marginalization of the elderly and ultimately reinforce their exclusion are equally at work in society at large as within Plan Sésame. Bringing down incidences of social exclusion among the elderly will thus need multi-sectorial and sustained efforts over and above improvements in Plan Sésame. In the health sector itself, substantial improvements are also needed on the supply side.

That said, there is certainly room for improvement in Plan Sésame, that until now has been seriously underfunded, poorly implemented and resulted in improved access for a very limited proportion of Senegal's elderly – i.e. not representing those most in need. Funding and implementation can certainly be improved provided there is political will. The number of beneficiaries should then be increased, with particular attention to be paid to the elderly from households in the informal sector who today still have no health coverage at all.

The key actors from Plan Sésame we interviewed all agree that improving Plan Sésame only is not sufficient: such effort must be complemented by other social policies. They also voice a number of major recommendations.

First, they stress the need to fight against the economic insecurity in which older people live. Government and associated pension institutions must contribute to improve the living conditions of the elderly by generalizing and increasing pensions. They also see a role for private actors, associations and NGOs to target social programmes at the elderly, particularly the poorest.

Second, facilitating the elderly's access to health services is also seen as an urgent need – beyond the financial contribution of Plan Sésame. To do so, the government could develop a specific programme for the elderly to improve hospitality in the health facilities, as well as the availability and affordability of drugs in health-care facilities, specifically so for those chronic conditions most suffered by the elderly

Third, the training of health staff should be enhanced in order to take better care of the basic needs of both health care and social support of the elderly. It is hoped for that staff will then be more empowered to respond adequately to the needs of the elderly, including the outcomes of marginalisation and exclusion.

Finally, with regard to Plan Sésame, all actors agree on the need to resume and maintain funding on the one hand and to establish a dedicated and effective administration on the other. This agreement reached, it is now time to deliver.

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