Towards Pro-Poor Health Planning
In the context of Macroeconomics and Health

Country Case Study Senegal
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**Acknowledgements**
*The author would like to thank ..........etc.*
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2 Introduction

Over the past years, poverty reduction has been explicitly driving the development agenda. In 1999, World Bank and IMF agreed that nationally owned participatory poverty reduction strategies should provide the basis for all concessional lending and for debt relief under the enhanced Heavily Indebted Poor Countries (HIPC) Initiative. The Poverty Reduction Strategy Papers (PRSPs) put this approach into effect and describe a country’s macroeconomic, structural and social policies and programs to promote economic growth and reduce poverty.

At the turn of the millennium world leaders agreed on ambitious targets for reducing poverty and improving lives by 2015: the Millennium Development Goals (MDGs).

In summary the MDGs focus on poverty eradication, improving access to primary education, enhancing gender equity, improving health (notably by reducing child mortality, improving maternal health and combating HIV/AIDS, TB, malaria and other diseases) and ensuring environmental sustainability. Since then most of the bilateral donor agencies also made poverty reduction and reaching the MDGs the main area for support.

The publication of the Report of the Commission on Macroeconomics and Health (CMH) in December 2001 marked a renewed interest in the specific relationship between poverty and disease, and inversely between economic growth and health. The Commission recommended that substantial investments be made in low and middle income countries, predicting that this would yield important economic returns. The additional investment should be used to scale up essential health and health-related services, and in particular reach the poor with these services. The Commission emphasised the need to simultaneously invest in the health systems of these countries, because many constraints that inhibit scaling up services are due to inadequately developed health systems. The additional investment, according to the CMH, should be financed both through increased domestic investment and increased donor support.

All these initiatives have been kick-started by the United Nations (UN), the International Financing Institutions (IFIs) and the bilateral donors at the global level. But the plans and activities necessary to access the funds and to reach the targets have to be produced at the national level or below. There is no blueprint for doing this, given the diversity of opportunities and constraints in countries. Different countries have shown an interest to receive support in bringing a poverty focus to their health program, besides their already existing activities on poverty-related diseases like malaria and tuberculosis.

WHO is supporting countries interested in embarking on a process towards poverty reduction by increasing cost-effective spending on health in ways which improve outcomes for the poor. This assistance aims to support:

- increased political support for investment in health
- strengthening of the health section in the poverty reduction strategy, medium term expenditure framework and other national development plans
- development of a comprehensive health sector strategy addressing the achievement of the MDGs and other essential health targets
- improving aid-effectiveness through development of sector-wide approaches (SWAps) and more effective management of global initiatives
- health policies and systems that better address the needs of the poor

While WHO is providing financial and technical support, countries themselves are driving the process, and will decide on priority investments, partnerships, health system changes and financing mechanisms.
The poverty reduction agenda is particularly relevant for Senegal, being of the poorest countries in the world. Senegal is receiving support from WHO and the Royal Tropical Institute in Amsterdam for pro-poor health planning in the context of macroeconomics and health work.

This report describes and discusses the work done in Senegal during the preparatory phase. It addresses in particular the opportunities and constraints expected to influence the work during the planning and implementation phase. It describes the process and modelling that enabled the MOH in Senegal to synchronise the different initiatives that address “health” and “poverty”. It also describes how Senegal intends to overcome the constraints and use the opportunities in planning for implementation. It is hoped that countries, wishing to embark on a similar exercise, can make use of the Senegal approach and experience.

<table>
<thead>
<tr>
<th>Macroeconomics and Health Agenda focuses on</th>
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<tbody>
<tr>
<td>• Achieving better health for the poor, thereby reducing poverty and stimulating economic growth</td>
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<td>• Eliminating financial constraints by increasing domestic and external investments in health</td>
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<td>• Eliminating non-financial constraints to providing a package of essential interventions to the poor</td>
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<th>From Global to Local Action</th>
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<tr>
<td>• The CMH report does not provide a blueprint for action</td>
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<td>• Each country to translate the findings of the CMH to its own context</td>
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<td>• Assess the health and poverty status</td>
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<td>• Develop a strategy to scale up essential health interventions and reach the poor</td>
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<td>• Cost the strategy, investments and consequent recurrent costs for scaling-up</td>
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<td>• Mobilise sufficient funds to implement it</td>
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<th>Three phases of work</th>
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<tr>
<td>• Preparatory Phase 6 months: mid 2004</td>
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<td>• Planning Phase 12-18 months: end 2005</td>
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<td>• Implementation Phase 10 years: end 2015</td>
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<th>Preparatory Phase</th>
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<td>• Advocacy on the importance of the findings of the CMH report</td>
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<td>• Identify institutional mechanisms to take Macroeconomics and Health work forward</td>
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<td>• Situational analysis on health and poverty</td>
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<td>• Identify financial and non-financial constraints</td>
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<td>• Make proposal for planning phase</td>
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A Commission on Macroeconomics and Health (CME&S) was formed under the responsibility of the Prime Minister in 2002. This CME&S is co-chaired by the Ministers of Health and Finance. The following institutions participate in the Commission:

- 21 Ministries which implement health related activities,
- The Commission for health in the National Assembly,
- The Association of Local Governments,
- The Trade unions representing the for-profit private sector
- The umbrella organisation for employers, and
- The umbrella organisation for national NGOs

This Commission is temporary till the Presidential Decree for the Committee ME&S will be signed. The full commission has so far met about once every two months – the focus of those meetings was limited to developing the institutional framework of the CMH-process. As the number of participants of the Commission is too large, and therefore, risks to limit its optimal functioning. Therefore a technical committee was formed to coordinate activities of the CM&S, consisting of one representative each from MoH, MoF, and the M of Plan.

So, first there is a Commission ME&S to prepare for the inauguration of the National Commission ME&S – the difference between the two is the signature of the Presidential Decree will make the Commission a National Commission. A proposition for such a degree has been made in November 2004, it has not been signed until this moment. The ME&H activities are foreseen to go hand in hand with the elaboration of a plan to develop the National Health Accounts.

**Terms of Reference for the Preparatory Phase**

Together with WHO this committee has identified the following issues to be addressed in the preparatory phase for Macroeconomics and Health:

1. Duplication and dissemination of Executive Summary of CMH report to all interested partners (donors and members of the CM&S) and different levels in the MOH (central, regional and district health authorities and stakeholders)

2. Different workshops for government officials, NGOs, EDPs and private organizations to disseminate the key findings of CMH and prepare recommendations for next steps.

3. Identify and contract consultants to carry out the situational analysis activities in the context of ME&H:
   - To define the communication strategies for each of the actors in the context of ME&H-advocacy activities;
   - To make a situational analysis of the existing institutional framework

4. Put the institutional arrangements in place: definition of the mandate of the different committees, inauguration of the National Commission ME&S

In July 2003 the CME&S submitted a work plan 2003/2004 to WHO with a budget of $46,828 as part of the Terms of reference for the Preparatory Phase. The long delay of approval of this proposal has caused a slow start of CMH-activities: the national TA that was foreseen in the plan could not be contracted and the central level of the MOH could not take the extra burden of work.
The Royal Tropical Institute (KIT) was invited by WHO-HQ to provide technical assistance in Senegal and Nepal to study “how to translate the conclusions of the CMH-report to country level”. KIT was asked to support the development of the situational analysis, and of an action plan for the second phase (the development of a ME&H plan, the so-called “investment plan”).

At the arrival of the first TA mission, no activities to come to a situation analysis had taken place yet as a consequence of a lack of funding of national TA. Not all information was available yet, however quite some information could be obtained from the MOH (the final evaluation of the first plan of work of the national health plan, the PDIS, had just been finalised) and from the Ministry of Finance. Most of the stakeholders in the CME&S could be interviewed individually. The report contains the most important information to lay out the broad lines of what may be undertaken to come to a ME&H plan.

Meetings were held with the CME&S, representatives of almost all members of the CME&S were present. It was explained what kind of information was lacking: specific information (volume, impact, funding) on the health activities of the “other” ministries, the private sector, and the NGOs. The national TA would complete this information, once the WHO-funding had arrived. The results of the situational analysis are to be found in a report called “Etat des Lieux”.

A second mission was carried out to provide support to the development of an Action Plan for the second phase, to come to the investment plan (now called “Plan for ME&H” to avoid the existing sensitivities – see below). This Plan for ME&H will contain a strategic framework, including an investment plan divided into appropriate phases with clear targets and milestones for scaling up essential health interventions, and for improving ‘close to client’ services in the light of the CMH report. It will be undertaken under the responsibility of the SCMH during the planning phase. The broad lines were set out, put in writing and agreed upon during a last meeting at the end of the mission. This draft “Plan d’Action” was to be finalised by the national authorities (e.g. adding the budget) before submitting it to WHO-Geneva.

Terms of Reference for the national TA and a list of lacking information were drafted.

Lessons learnt
In developing the Action Plan it appeared that some obstacles had to be removed. This had everything to do with sensitivities on the terminology “investment plan” for CMH. The national health plan (“PDIS”) was also called an investment plan, so there were worries about having two plans, leading to a lack of coherence. During a two-day workshop, a KIT policy discussion tool was used to allow the new partners to participate in health policy discussions for the first time.

It was clearly explained that there will not be a second plan, in stead there will be a ME&H-plan to support and reinforce the existing PDIS. This, in turn made the other Ministries hesitant: “the ME&H is not owned by the MOH (alone)”. So, it was decided that the MOH will have (of course) the stewardship, but that this does not mean that the MOH will hold responsibility for the implementation of all inter-sectoral projects to be developed. This represented a major step to continue with the ME&H process.

The absorption capacity proved to be limited. The national health authorities at central level are already overburdened with many activities. Not only because of their “own” activities, but also by donor programs in the SWAp context and many “global” initiatives, like PRSP, HPIC, Global Funds. CMH then comes in and this asks again for another number of activities. Central level teams in the MOH are usually too small for all those activities – additional person power is a must to obtain results. In Senegal this central team, the CAS/PNDS, counts with 5 persons only.

This does not only give an extra burden of work, but also confusion about the coherence between those global initiatives related to “poverty” and “health. In the end it was understood as follows (see figure below):

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The Millennium Development Goals are goals, no program is linked to them (yet – the Millenium Project is actually making an effort to develop one). The health-related MDG are to be attained through priority-setting in the National Health Plan that is financed by the Ministry of Finance and bi-and multilateral partners. PRSP and HPIC funding may increase financing for health if the condition is that there is a clear focus on the health of the poor. In health for the poor, Global Funds focus mainly on “poverty-diseases”, like malaria, tuberculosis and HIV/AIDS. The report of Macro Economics and Health provides an advocacy tool to the total of these processes – amongst others by convincing the existing partners to invest more in health, and by a “thinking out of the box”: interesting “other” partners to invest in the health of the poor too.

The following activities have been implemented during the preparatory phase in Senegal:

1. The Summary Brochure *Investing in Health* has been distributed and discussed with the partners of the MOH – this was regarded as a valuable tool for “advocacy”.

2. A situation analysis has been made, including a desk review of relevant studies, health financing data and policy documents.

3. “New” partners, besides the MOH have been identified to participate to increase investing in the health of the poor (see “opportunities”). Key issue here was the development of an appropriate institutional framework.

4. Different plannings workshops have been held to discuss and develop a draft Plan of Work for the planning phase of the Macroeconomics and Health work.
2. Senegal Context

The “Etat des Lieux” report provides an extensive executive summary (in French), which is attached to this report.

Poverty

Whatever criteria used (like the population earning less than $US 1,- a day), around 50% of the Senegalese population may be regarded as poor. Important differences do exist between regions (see table below) and between constituencies. Poverty pockets are quite well mapped: 2.500 villages are labelled as “poor”, so it is possible not only to address poverty diseases, but also to “target the poor” in health interventions. Inequalities in the distribution of the national wealth are very important – only in Dakar, the Gini-coefficient is 0,50 (see figure). Another important determinant for poverty: 45-55% of the population has an alimentary consumption deficit – which is distributed unequally between the regions:

<table>
<thead>
<tr>
<th>Population (thousands of hbs)</th>
<th>Dakar</th>
<th>Diourbel</th>
<th>Fatick</th>
<th>Kaolack</th>
<th>Kolda</th>
<th>Louga</th>
<th>St Louis</th>
<th>Tamba</th>
<th>Thïes</th>
<th>Ziguinchor</th>
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<tr>
<td>2245</td>
<td>875</td>
<td>619</td>
<td>1074</td>
<td>778</td>
<td>550</td>
<td>826</td>
<td>506</td>
<td>1276</td>
<td>530</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Proportion of poor in the region (%)</th>
<th>Dakar</th>
<th>Diourbel</th>
<th>Fatick</th>
<th>Kaolack</th>
<th>Kolda</th>
<th>Louga</th>
<th>St Louis</th>
<th>Tamba</th>
<th>Thïes</th>
<th>Ziguinchor</th>
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<tr>
<td>12</td>
<td>23</td>
<td>47</td>
<td>48</td>
<td>57</td>
<td>46</td>
<td>15</td>
<td>44</td>
<td>26</td>
<td>54</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Proportion of total of the national poor (%)</th>
<th>Dakar</th>
<th>Diourbel</th>
<th>Fatick</th>
<th>Kaolack</th>
<th>Kolda</th>
<th>Louga</th>
<th>St Louis</th>
<th>Tamba</th>
<th>Thïes</th>
<th>Ziguinchor</th>
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<tr>
<td>9,2</td>
<td>6,9</td>
<td>9,9</td>
<td>17,5</td>
<td>15,1</td>
<td>8,6</td>
<td>4,2</td>
<td>7,6</td>
<td>11,3</td>
<td>9,7</td>
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</table>

Health indicators and priorities

The health impact indicators are amongst the lowest in the world, as may be understood from the opposite table:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Rate</th>
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<tbody>
<tr>
<td>Crude birth Rate</td>
<td>48/1000</td>
</tr>
<tr>
<td>Crude Death Rate</td>
<td>19/1000</td>
</tr>
<tr>
<td>Chil Mortality Rate</td>
<td>58%</td>
</tr>
<tr>
<td>Under Five Mortality Rate</td>
<td>113%</td>
</tr>
<tr>
<td>Maternal Mortality</td>
<td>510/100,000 (Rural: 950, urbain 450)</td>
</tr>
<tr>
<td>Malaria</td>
<td>38%</td>
</tr>
<tr>
<td>Diarrhoeal diseases</td>
<td>5% of &lt;5 mortality</td>
</tr>
<tr>
<td>HIV/AIDS prevalence</td>
<td>1,4%</td>
</tr>
</tbody>
</table>

The health problems, and poverty follow the same geographical distribution and bring the national figures to the highest level in the global village. In the poorest area (Kolda) only 27% has access to piped water and 10% to toilets – the poorest live in the poorest sanitary conditions as one may conclude from the table below:
Another example of the relation between poverty and health is presented by the Under Five Mortality Rate (TMJ) as presented in the figure below.

It is shown clearly that in the regions where poverty is more important (first row), the TMJ (row behind) is too. When compared over time, it becomes evident that the TMJ increases especially in the poorest areas. The same tendencies are shown when the regional distribution of poverty is compared with the distribution of infant or maternal mortality rates.

The Health Sector

Policies and plans
Although the first plan of work (PDIS) of the national health program (PNDS) was able to attain an important progress in offering an essential package of health services to the population – it is clear that an important additional investment in health is needed. The improvements have been made in the areas where accessibility was less difficult, the most important public health constraints are to be found in the difficult to reach poverty pockets. Here not only geographical and financial accessibility are limited –but equally important is the social-cultural accessibility (dignity, status, exclusion from participation in health care planning, etc.). It should be noted that an action plan on poverty and health was produced to prepare for a second PDIS.
The delivery of health services takes place in 809 health posts, 53 health centres and 17 hospitals. These are figures of the public sector, and it results in 1 health post per 11,500 habitants, 1 health centre per 175,000 habitants, and 1 hospital per 545,800 habitants. However, this is only the public sector, the most important provider of health services, about the rapid growing private sector (which is concentrated around the capital) few data are present. From the evaluation of the 5-years plan of work of the national health plan we learn that the coverage of health services has improved. Of all health posts, 94% provides the essential package of care – although only 30% exercise the IMCI. The coverage of ANC has increased from 44 to 69 per 100 expected pregnancies, while the proportion of women that were professionally assisted during delivery increased from 31% to 55%. The EPI-coverage increased from 33% to 67%. The availability of essential drugs in the health posts has increased from 95% to 99%. Or, the MOH made good progress over the last 5 years. However – there is no reason to lean back. The part of the population that has not been covered in the figures above, is the population that is difficult to reach – and probably the poorest and under-served in the population. Also, some tendencies were negative, such as the number of diarrhoea cases (still one of the major killers in children) that were treated had declined from 56% to 46%.

Besides the MOH, the private sector (for profit or not) provide health services – coverage data are not available. The same counts for several ministries, other than the MOH, who provide health services, too. Like the Ministry of War, which does not provide services to its military personnel only, but also to the communities that live near. The Ministry of Justice provide services to the prisoners, etc. These services have not been integrated in the national health plan (PDDS).

The unequal distribution of services is demonstrated in the figure below.
3 Non-financial Constraints

For macroeconomics and health in Senegal to become a success, some bottlenecks should be overcome. Non-financial constraints are (besides the lack of health facilities mentioned above) above all related to the human resources. A lack of 33% in personnel was calculated for the existing health interventions in the final evaluation of the PDIS. This comes down to 3,300 on a total of 10,880 while only 236 are recruited each year. Of all available human resources 35% are concentrated in the capital, the city of Dakar, while in the poorest regions this proportion oscillates around 5% only. In facilities where personnel is available, there is often no right-skills mix. There are no plans for re-allocation of the existing personnel. Studies have shown that the motivation of the personnel is low because of low pay and poor working conditions.

The monitoring and evaluation system is not strong. This is not only a problem of reliability of the data, but also of the continuity data are produced. Little use is made of them for analysis at operational level, to determine priorities, strategies and approaches in the activity plans. No analysis takes place of health data disaggregated for poverty – so it will be difficult in the future to monitor if additional investments will lead to the desired results.

Apart from the constraints in health financing (see below), in the financial programming there are also constraints such as: the management and financing procedures, financial monitoring, and the complex and incoherent donor procedures. On the other hand, donors complain about non-respect of existing procedures, the little effectiveness in financial planning, the tender procedures and the lack of reliability of the financial information. This is recognised by the Senegalese authorities and improvements are foreseen for the second PDIS.

Hesitations existed on the CMH-process. The problem faced in the cross-sector approach may be a continuing obstacle – some people in the MOH stick to their opinion that in “health” the MOH is the only responsible and that the other ministries in fact should hand over all the responsibilities of their health programs to the MOH. The MOH does not have the absorption capacity to take over this additional workload. But even more important: the cross-sector approach represents many opportunities to increase the efficiency in the health sector, to
increase the absorption capacity (extra pairs of hands) and to develop interventions to improve the so-called “determinants of good health” (nutrition, hygiene, water and sanitation). So the MOH should not be the only actor in implementing the ME&H interventions. Another risk linked to an inter-sectoral approach is that most stakeholders seem to participate because they expect that there will be an important increased funding for health, in which they hope to receive their share. If such an increased funding will not arrive, it is not impossible that they will progressively lose their interest and may disappear from the scene.

For many the CMH approach suggests that if countries will increase their internal funding in health (and Senegal seems to be ready to do so), increased donor funding will follow. This expectation is reinforced by the MDG 8 (reliable partnership). So, questions then are: “what are the mechanisms, what is the forum, what are the guarantees that will take care of these expectations?” There are no signals that because of the CMH donors have decided to scale up there funding at country level.

Most important were the hesitations that existed in parts of the MOH about having a second ME&H plan would mean duplication and even competition with the national health plan (PDIS). This problem was solved by taken the decision that ME&H would provide support for scaling-up the PDIS (see below – the Action Plan).

**Financial constraints**

Constraints related to sources of funds

First to mention are the macro-economic conditions. The per capita income does not reach the 500 Euro per year, although the national income raised by 5% from ’94 onwards. Debt represents 74% of the BNP in 2000 (coming from 86% in 1994) and debt services take more than 25% of the national income.

The income of the national treasury deriving from taxes on consumption goods is still much more important than direct taxes (the recovery rate is low).

Senegal has fixed a number of objectives in the PRSP to overcome the macro-economic constraints – like increasing the economic growth from 5% to 8% to 15% in 2015 while the inflation rate should remain less than 3%. At the same time the debt rate should decrease from 74% to 60%, and investments should increase from 20 to 30% by 2015.

To reach these (quite ambitious) objectives, an additional 610 Milliard FCFA (1 Euro = 667 FCFA) is needed. The state would be able to finance 13.6% of this financial gap, the remainder is asked as a contribution from the donors.

So the potential of the national treasury to pay for health and the health sector is limited, to say the least. Still the expenditure on health did not rise with the same tendency as the national income did – other ministries (the army, foreign affaires, education) were more privileged as may be understood from the figure below:
The national budget for **functioning costs** has increased over 8 years (from 1994 to 2002) by 31% - for the MOH by 12%, but for the Ministry of Education and Higher Education this was 155%. This is at least partly explained by the (lack of) advocacy capacities in the MOH. But also because, as President Wade told the MOH, because the MOH does not know how to spend their money: in the PDIS period, of the money that was available the health sector only two thirds were spent.

There are several reasons to be mentioned explain this: the complex financing procedures, low utilisation of funds at the operational level (only 20% of the total expenditure in health!) because of a limited absorption capacity (like human resources), delay in arrival at this level of funds for operational costs, that are then too limited for their ambitious plans.

Even so, the country does progressively make an effort to increase its expenditure on health – more in capital costs than in recurrent costs. These additional efforts do not come from the treasury (which pays for more than half of the total expenditure) only, also from the population. Their contribution increased from 13 to 19% in 4 years, and their share is now more important than the one of the donors (!) – which did not increase (nor decrease) in nominal terms from 1997 to 2002.

The financial gap for health in the poverty reduction strategy is, according to the calculations in the PRSP, 50 out of the total of 60 billion FCFA needed: around 320 Million Euros need to be financed.

**Opportunities**

The “Plan d’Action” provides a broad outline (in French), which is attached to this report. It was decided at the start of the mission to try to “think out of the box”, to assess if opportunities existed for scaling-up, outside the usual sources of solutions.

Actually there are many global initiatives in place that are all related to poverty reduction, like PRSP, HPIC and the Global Funds. Macro Economics & Health provides an advocacy tool to scale up the funding for pro-poor health services. WHO is involved in all these initiatives at global level – it is therefore expected from WHO to play an important role in translating these global initiatives towards country level.

The health related objectives in the PRSP are highly ambitious (reduction of the maternal mortality from 510 to 200, 100% EPI coverage, e.g.) – with a financial gap of
which the country hopes that more than 80% will be financed by donors. This percentage is higher for health – probably because the experience learned that this part is most attractive to them.

The country has decided that financing of health will increase the **national budget** by an additional 0.5% each year – President Wade seems to be highly committed to health and to poverty eradication. Even so, of the HPIC funds (50 billion FCFA a year) only 10% is dedicated to health, and then only a third of the proposed budget was disbursed in 2003.

Several other ministries provide health services – integrating these would provide higher health outcomes for the same price. These ministries took place in the ME&H commission during the mission – **ME&H provides now the institutional framework for cross-sector activities the country was striving for many years.**

The commission of national enterprises (CNP) is planning to create a “responsible enterprise foundation” that foresees to invest in poverty reduction, amongst others in health. It barely needed an advocacy tool – **the CMH report came at a right time during the mission.** The CNP needs a monitoring instrument to trace the effects of health investments on the economy – an important challenge for CMH.

### The Action Plan

It is not only important to ensure increased funding for health, it’s also essential to organise a system that ensures that these funds indeed **arrive at the poverty pockets.** Hereto it is envisaged for Senegal to develop a number of mechanisms that should ensure that the poor will have better health care. The base for this is that there will be a scaling-up of funding of the national health plan (the PDIS).

The key issues in this strategic planning are:

- **Increased funding necessary for scaling-up:**
  - Research and data analysis for advocacy means to convince existing partners (MoF, donors) to increase their support to the health sector
  - Development of new partnerships to increase resources to invest in the health of the poor – such as the Assembly of Senegalese employers, the “other ministries” that provide health care
  - The new partnerships presents the need to adapt the institutional framework, ao. a reformulation of the stewardship role of the MOH;
  - Increased funding for the PDIS should be prioritised to target the poor and their health.

The additional funds will be used to scale-up the existing national health plan, the PDIS

Management, financing and procurement procedures will be improved to ensure that the additional funds will be used as efficient as possible – and therefore to convince existing and new partners to embark on the CMH process.

To ensure that additional funds will be used as effective as possible:

- The health coverage map of the country will be studied to identify the gaps in accessibility in the poverty pockets;
- Additional personnel will be needed for right-sizing of personnel and right-skills in the health facilities,
- Partly this problem will be solved by an increased number of personnel, partly by an increased efficiency as a consequence of integrating the services of the different ministries (here there is often an under-utilisation of health personnel), and partly by a reallocation of existing personnel to come to an equitable distribution of personnel;

To increase the absorption capacity:

- Health projects will be created at community level; - amongst others on water and saitation, nutrition, etc.
- Other health services providers will be identified to provide health services to the poor – such as the private sector;
- Additional alternatives for channelling the funds for health for the poor will be explored, such as the IPM and the AFDS

Monitoring and evaluation systems will be reinforced to track changes on the effectiveness of the interventions, in terms of health for the poor and macroeconomic effects.

This all is reflected in the figure below:
The private sector (be it for profit or not) provides already many health services – they may be contracted to provide pro-poor services. The IPM have a large experience in contracting services in the private sector for the enterprises. These could be used to contract the pro-poor services out to the private sector.

The AFDS, who provide technical assistance to development of integrated community programs, could be used to contract NGOs to develop pro-poor community projects.

This all would increase the absorption capacity for funding health interventions for the poor.

The Communes (Local Governments) received a transfer of authority, this may be an important opportunity to channel funds for health directly to poor Communes – if poverty criteria for allocation would be developed.

Most positive effects of a cross-sector approach are not expected at the central level, but on the operational level. This is easier to develop through the Local Governments, as these represent all line-ministries, and because it is easier here than at central level to target poverty pockets.

For advocacy means it is not enough to create a Commission for ME&H, it is also necessary that this commission has arguments in hands to convince the different types of decision-makers. An advocacy strategy has to be developed, including a communication strategy, a stakeholders analysis (which type of arguments to use for which stakeholder: what era their interests?) and a dissemination strategy.

Of course, the Commission needs concrete plans that may be financed. But most of all, it will need information – on the effects of poverty on health but also on the effects that will result from the investments on the (macro) economy. These effects (and their tendencies) need to be traced to convince the stakeholders to continue to invest (more) in health. Hereto one would need a baseline study – in Senegal it was decided no to carry out one, but to integrate poverty/health elements in the forthcoming DHS.

The new H/MIS system is in the final phase of development – indicators will be disaggregated for poverty (at least, this is the idea). It will be proposed to carry out annual studies on the effects of poverty on health, and of the improvements of health indicators on the economy based on intermediate (not impact!) indicators. This all, not only to trace the effects of the ME&H approach, but also to develop an information system that may enable the analysis of the health related MDG that are criticised for being to restrictive and based on national means (so hiding regional differences). It will however not be a small task to conceive such an information system.