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The Perception of Health Workers and Stakeholders Involved in the Process of Selecting Indigent in Burkina Faso

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Abstract

Background: Indigent selected for their health care is complex and poses enormous challenges. The actors involved have an influence on health actions and their perception is decisive for better care for the indigent. Little evidence exists on these perceptions and this paper has captured this. **Methods:** A case study involved 163 participants with a questionnaire and an interview guide. The quantitative responses were classified according to a measurement scale, proportions and overall indices of perception (I_p) and satisfaction (CSAT) were calculated. The relationship between variables was investigated using chi-square. Thematic analysis was used with qualitative data. The study met ethical requirements. **Results:** The participants had a positive perception of the selection: I_p = 0.77, but a minority (1/5) were dissatisfied with the selection. The perception of selection did not differ significantly depending on the experience of the actors. For the vast majority, the definition of indigent was satisfactory (CSAT = 91.4). The selection was done in a top down fashion and steps such as setting up committees, informing stakeholders, had shortcomings which negatively impacted the effectiveness of the selection. The needs of the participants included transparency in the indigent select process, matching the tools for selecting the indigent to the context, strengthening of local action, deconstruction of prejudices in terms of the indigent, power of actors to act, and importance for health services to reach out to the indigent. **Conclusion:** Considering the perception of the actors as well as their needs will improve the selection for effective care of the indigent.

Keywords

Perception, Community Selection, Indigents, Health Workers, Actors Involved, Burkina Faso

1. Introduction

Indigent selection poses enormous challenges in the implementation of policies [1]. Selection by community process is a complex intervention involving several factors such as health workers, social service staff and communities [2]. The actors in their environment, decide stimuli to remember in order to distinguish, according to their values and beliefs, in their experiences what is central to what is incidental [3]. They are therefore faced with tensions between what others expect of them and what they expect of themselves and their roles are central to a support effective indigent [4]. Their perception of the indigent selection is decisive for their performance in their care [5]. These actors have a strong influence on community interventions as well as on health structures at the peripheral level [6]. They feel a motivation for action, when their needs are met [7].

In the indigent selection, challenges are raised in the choice of the indigence criteria and the offer of care [8]. The devices are often little known to the public and health workers [9], making it difficult for beneficiaries [1]; also abuses and power issues are noted [10]. Indigence or even extreme poverty is always a major development's problem in Africa [11].

In Burkina Faso, where almost half of the population is poor, around 11% of this population is indigent [12]. In such a context, inequalities in access to health care persist [13]. Health, however, is one of the fundamental rights of citizens and is also recognized as one of the first concerns of man and is an essential element of well-being. Equity in health remains central to health systems in countries. These systems aim not only to improve their level of responsiveness and the level of health of the population in relation to its legitimate expectations, but also the equality of this responsiveness among the population and the equity of financial contributions [14].

More than three decades after the adoption of the Bamako Initiative, Burkina Faso still faces inequalities of access to health care for the indigent. Several actions such as healthcare subsidies and free healthcare have been developed to change these inequities [13].

In 2015, innovation has been undertaken by combining the performance-based financing (PBF) the indigent selection in order to improve their care [2]. This selection gave each indigent the right to a card allowing him to benefit from care in the event of illness. In 2019, the state of Burkina Faso decided to support the integration of the indigent into universal health insurance (AMU) [15]. Very lit-

tle evidence exists on the actors' perception of the indigent selecting process and their care [16] [17]. This paper aimed to understand the perceptions of health workers and actors involved in the indigent selection process in Burkina Faso and contribute to enriching knowledge about the care of the indigent.

Context of indigents' selection

Burkina Faso is a landlocked country in West Africa with an estimated population of nineteen million, mostly rural (77.3%) and female (51.7%), made up of around 45% of poor, and around sixty ethnic groups. Life expectancy at birth is 54 years, and nearly one in five children dies before the age of five [18].

The health system is decentralized, responds to a pyramid model, with the health district at the first level, which includes two levels of care. The second level of care is represented by regional hospitals. The third level of care is made up of university hospitals. The quaternary level is in the process of being structured with the announced opening of specialized hospitals (oncology, neurosurgery, traditional medicine, etc.).

There are other structures such as workers' health offices, health services, health services of the national social security fund, private care structures, the traditional medicine sub-sector. Community-based services are organized and form part of the community strategy of the ministry of health. Civil society supports these community-based structures.

In Burkina Faso, access to health care for the indigent remains quite low, especially in rural areas and for vulnerable populations. Under the PBF, Health Ministry has received funding from the World Bank (WB) to select the indigent following a community approach in order to improve the health care demand [2]. The universal health insurance scheme was decided with an emphasis on the indigent in order to improve their access to health care.

Indigent selection by community process

Community indigent selection, carried out in eight health districts, followed eight successive stages (**Figure 1**). The process used was inspired by a selection experiment conducted in the health district of Ouargaye as part of research conducted by the University of Montreal and SERSAP, the results of which have been taken up by NGOs [2].

Indigent definition

Indigent referred to as "someone who is extremely disadvantaged socially and economically, unable to care for himself (herself) and without internal or external resources" [19]. Three dimensions namely poverty, disability, lack of support were retained (**Table 1**).

2. Objectives

2.1. Main Objective

The study aimed to understand the perception of health workers and actors involved in the indigent selection by community process.

Source: Paper author.

Figure 1. Steps of indigent selection process.

Table 1. Content of the dimensions of indigence.

Dimensions	Content
Poverty	Lack of financial resources (unable to support themselves)
	Lack of goods (livestock, poultry, equipment, etc.) apidated dwelling
Inability	Physical disability
	Visual impairment
	Mental disorders
	Chronically ill
	Old age
	Dependency (widow; early childhood, etc.)
Lack of support	No help from relatives
	No help coming from people elsewhere
	Feeling of isolation within the community

Source: Paper author.

2.2. Specific Objectives

- Measure the level of satisfaction of stakeholders with the process of indigent selecting.
- Describe the assessment made by the actors on the process of indigent selecting.
- Identify the needs of actors in terms of indigent selection.

3. Method

3.1. Study Design

A case study approach [20] was used to better capture perceptions. It made it

possible to pay particular attention to a problem that has not yet been studied much [20]. This study has a quantitative and a qualitative component which are of varying importance.

3.2. Study Population and Data Collection

The data were collected from September 1 to 23, 2019 in the 8 health districts concerned spread over 4 regions. These are the districts which have carried out the indigent selection of under the PBF. Within these districts, will be included health facilities that have been randomized for the implementation of the PBF strategy with free care of the indigent.

Respondents were recruited from panels of health workers, social service and community workers as well as indigent selection committees. To reach these people, in each district, three health facilities were randomly chosen from among three groups and depending on the distance (located less than 5 km, 5 and 10 km, more than 10 km) that separates them from the headquarters of the district. In each health facility, in a reasoned way, health workers, social service and community actors as well as those from the indigent selection committees were selected.

In total 163 people were reached using a questionnaire and an interview guide in services for health workers, social service and community service providers, actors selection committees for the indigent and in homes for service providers. The questionnaire made it possible to identify perceptions of the selection process using a four-choice satisfaction measurement scale: very satisfied, satisfied, dissatisfied, very dissatisfied. The semi-structured interviews lasted between 1 hour and 1 hour 15 minutes. With the permission of the people, all interviews were recorded and notes were taken during the interview to supplement the material collected.

3.3. Data Collection Tools

The data collection tools were selected following the steps of indigents selecting process and indigent definition. Each step of the process and the definition were taken into account using a measurement scale in the questionnaire. In the interview guide, the opinions on each item have been listed as well as the needs.

3.4. Data Processing and Analysis

Quantitative data

The quantitative section made it possible to describe the perceptions of the actors. The responses were classified according to the measurement scale. Then, proportions have been calculated per respondent for each level of the scale. R and Excel software were used for data processing. The level of satisfaction was assessed through the proportions calculated according to the dimensions assessed. The very dissatisfied level has not been found, the scale was limited to three measurement levels. A perception index (I_p) of the selection process was calculated according to the following formula: the perception indicator (X_j)

was made dichotomous, X_j = 1 or 0

$$I_p = \frac{1}{n_P}\sum_j X_j \quad (1)$$

The closer the calculated index was to 1, the more the perception of the selection was positive, the closer the index was to 0, the more the perception of the selection was negative. An indicator of overall satisfaction (CSAT: customor satisfaction score) of the participants compared to the definition of the indigent was calculated according to the formula:

$$\text{CSAT} = \frac{1}{n}\sum_{ij} X_{ij} \quad (2)$$

X_{ij} = total of very satisfied and satisfied. More CSAT value was close to 100, the greater was the participant satisfaction. The chi-square test of independence was used to test the relationship between certain variables.

Qualitative data

Qualitative section made it possible to assess the perceptions of the interviewees. The interviews were transcribed in their entirety word for word in order to collect all the verbal material without sorting, then they were entered in the Microsoft Word software then in the NVivo version 10 software according to the codification grid established under "dictionary" format mode for this purpose. The words of the interviewees were compared within the district and according to the existing adequate contextual data. The verbatim have been broken down into complete sentences, in order to allow a better understanding of their context. The stories of the milestones in the selection process were organized by theme and oriented towards the objectives of the study, and the citations according to emerging themes. A triangulation of sources (scientific articles, reports from institutions, data collected, working documents) was carried out.

The data analysis was carried out according to a thematic approach based on a conceptual framework. In a research program, authors [21] have, through a meta-synthesis, developed a theoretical framework for the analysis of perceptions. This framework was adapted in the analysis of this study taking into account the specificity of the selection process. Thus, a framework was built according to three dimensions of the perception of the selection of the indigent: the selection process, the definition of the indigent, the needs in terms of the selection of the indigent. The needs would make it possible to understand the more or less satisfied situation of the participants, taking into account the aspirations and desires [22].

3.5. Ethical Considerations

The study received approval from the Ethics Committee for Research in Health of Burkina Faso (CERS No. 2018-11-136) and authorization of the health authorities of the four regions concerned: East Center (No. 2019-00191/MS/RCES/DRS), Center North (n° 2019-0 93/MS/SG/DRS-CN), North (n° 2019-324/MS/RNRD/DRS), South-West (n ° 2019-0 38/MS/R SUO/DRS). Participation in the study was volun-

tary. The anonymity of the data has been respected.

4. Results

4.1. Quantitative Section

Characteristics of participants

Among the 163 participants in the study, 12.3% are female and 87.7% are male. Health workers represent 22.1% against 28.8% of actors of social services and communities and 49.1% of actors of indigent selection committees (Table 2).

Level of stakeholder satisfaction with the indigent selecting process

Among the health workers, 19% were completely satisfied with the selection process against 30% of the social services and community players, and 13% of the actor of the selection committees. Negative assessments of the selection process are no exception. Just over one in five (1/5) study participants expressed dissatisfaction with the selection process (Table 3). The perception of the selection process does not differ significantly according to the health workers and the actors involved in the indigent selection ($p = 0.20$).

In total, 127 participants have been positively assessed the indigent selection process, giving an index $I_p = 0.78$.

Satisfaction with the selection process does not automatically lead to satisfaction with the definition of indigent employed. Actors of the selection committees were the most likely to be very satisfied with the definition of the indigent used during the selection against only 4% of the actors of social services and communities (Table 4).

Health workers are the most likely to be dissatisfied with the definition of the

Table 2. Characteristics of study participants.

Profile	Female	Male	Total
Health worker	2 (5.6%)	34 (94.4%)	36
Social service actors/Community actors	3 (6.4%)	44 (93.6%)	47
Actors selection committees for the indigent	15 (18.7%)	65 (81.3%)	80
Total	20 (12.3%)	**143 (87.7%)**	163

Table 3. Distribution of health workers and other actors according to their level of satisfaction with the indigent selection process.

Satisfaction level	Health workers/Actors involved			Total
	Health workers	Social service actors/Community actors	Actors selection committees for the indigent	
Very satisfying	7 (19%)	14 (30%)	10 (13%)	31
Satisfactory	21 (58%)	23 (49%)	52 (65%)	96
Unsatisfactory	8 (22%)	10 (21%)	18 (23%)	36
Total	36	47	80	163

indigent, followed by social service and community actors as well as those from selection committees.

Overall, study participants were satisfied with the definition of indigent used in screening: CSAT = 91.4.

Among study participants who were very satisfied with the process of selecting the indigent (Table 5), only 13% were satisfied with the definition of indigent used. More 3/4 were just satisfied. For those who said they were satisfied with the selection process, just over a third were very satisfied with the definition of needy and over half satisfied with this definition. Almost one in 10 was not satisfied with the definition of indigent despite being satisfied with the selection process. The vast majority of those who were dissatisfied with the selection process were satisfied with the definition of needy. Eleven percent of the participants were not only dissatisfied with the selection process, but also with the definition of indigent.

Perception of selection process does not differ significantly according to the experience acquired in the selection of the indigent ($p = 0.61$) although the majority of those who already had experience in the indigent selection was satisfied with the selection process (Table 6). More than a quarter of those who were dissatisfied with the selection process already had experience in selecting the indigent.

4.2. Qualitative Section

Selection process perception

Most of the participants believe that indigent selection process aims to reduce

Table 4. Distribution of health workers and other actors according to their level of satisfaction with the definition of indigent.

Satisfaction level	Health workers/Actors involved			Total
	Health workers	Social service actors/Community actors	Actors selection committees for the indigent	
Very satisfying	0 (0%)	4 (10%)	36 (90%)	40
Satisfactory	27 (24.8%)	40 (36.7%)	42 (38.5%)	109
Unsatisfactory	9 (64.3%)	3 (21.4%)	2 (14.3%)	14
Total	36	47	80	163

Table 5. Relationship between satisfaction with the indigent definition and that of the selection process.

Satisfaction level	Indigent definition			Total
	Very satisfied	Satisfied	Dissatisfied	
Very satisfied	4 (13%)	26 (84%)	1 (3%)	31
Satisfied	34 (35%)	53 (55%)	9 (10%)	96
Dissatisfied	2 (6%)	30 (83%)	4 (11%)	36
Total	40	109	14	163

Table 6. Distribution of health workers and other actors according to their level of satisfaction with the selection process and their experience in indigent selection.

Satisfaction level	Experience in indigent selection		Total
	Yes	No	
Very satisfied	7 (19%)	24 (19%)	31 (19%)
Satisfied	19 (53%)	77 (61%)	96 (59%)
Dissatisfied	10 (28%)	26 (20%)	36 (22%)
Total	36	127	163

inequalities among people and is a form of solidarity and social justice. They think that this has always existed within the populations but the poverty of the majority of the people hinders the manifestation of this solidarity. According to them, the selection process was decided and planned from the central level to be carried out as is at the local level. This has allowed people who are leading the process at each level to impose their vision for it is they who know the protocol to follow.

Establishment of structures

The setting up of structures at community level is not always understood by participants. According to them, the criteria which had been adopted for being a member of the selection committee were not rigorously respected. On this subject, a health worker said this: "*It had been said that the criteria used to be a member of a selection committee aimed to avoid any conflict of interest and minimize inclusion errors. However, the situation was quite different in certain places. How do you want the populations to be reassured*" [TeAs2].

In this regard, a selection committee actor saids: "*really we don't know what happened but we were surprised to see some people among the selection committee members and we wondered why*" [BabCs4].

Information stakeholders

Information on the selection is mainly limited to the regional or provincial level and failed to raise consistently the people in the villages and hamlets so they understand the selection process and objectives, as of obtain membership and of é avoid possible amalgams field. It is clear in the following words: "*several actions targeting vulnerable populations are conducted in the field in many fields such as food, agriculture or even in the field policy. Thus, when an intervention is neutral and targets the entire population, it is quite appropriate that this be well understood by the populations otherwise we are witnessing all kinds of interpretations that could have a negative impact on the implementation of this new intervention, especially if some known village leaders are involved in the execution of the said intervention*" [DgAc1].

Actors training

The training phase was positively perceived by the study participants. They find that the training has been well adapted to the communities. Also, the involvement of health workers and social action actors in the areas concerned was

very significant and also more reassuring according to the actors of the selection committees. Here is an example of what they say: "*we benefit all the time from the support of people from social action and health workers, so seeing them associated with this work which will allow us to make the selection of destitute, gives us confidence*" [OuCs3].

Indigent lists establishment

The registration of the destitute by village is considered by most of the participants as the stage which has experienced enough disturbances with various interactions: "*the selection took on the appearance of political activity in places, no one knows how this is done, also relatives of certain members of the selection committee have received indigent cards*" [BaLAc1].

Also, the selection committees strove to inevitably reach the expected proportion of indigent: "*... a number of indigent people were expected per village and it would have to be obtained at all costs, this must have led to false inclusions and discontent then later difficulties in taking charge*" [KaAc2].

A health worker described this step in the field as being uncontrolled in some villages. Here is what he said: "*I do not know if the members of the selection committees were afraid or what because there are people who have received cards of indigent because they are influential and we cannot understand; I think that we* (*health workers*) *should be more involved in the selection because we also know the populations quite well*" [AsI10].

Validation of indigent lists

The participants felt that the validation of the lists was the step that presented considerable limitations in terms of eliminating the bogus indigent. But the fact is that people show up in health facilities with a indigent card when they do not strictly meet the definition of indigent. This situation is described by a health worker as follows: "*We receive people with needy cards for treatment, yet we know them fairly well in the village and they do not meet the criteria for needy. This taints the care of the indigent*" [DiAs4].

Distribution of indigent cards

There were differences of opinion between the actors regarding the stage of the distribution of the cards. The actors of the selection committees gave the best assessments of the distribution of the cards. They find that this step took quite a while but was generally acceptable. This assessment is not shared by other stakeholders, as reflected in the following recurring comments: "*Cards remained for a long time in some health facilities without being distributed*" [GoAs2].

The organization of the distribution of destitute cards was not efficient: "*The way in which the cards should reach the destitute was not at all correct. First, the needy not only were not informed, also those who lived in remote areas far from health facility and village's centre, did not always benefit from a card*" [OhAc7].

Perception of indigent definition

According to the participants, indigent definition as used in selection does reflect what it is to be indigent, but its application is complex on the ground among a

population that is overwhelmingly poor.

Also, they believe that given the localities, the use of such a definition should not be subject to a proportion of expected needy (20%) as was the case during the selection.

For them, the definition should be accompanied by more precise elements of application in the field. This is the case with the concept of "absence of endogenous and exogenous support" which is difficult to interpret in terms of the support: type of support, its sustainability, the capacity of the support to change the indigent situation. The following remarks reflect the feelings of the vast majority of participants: "*This definition of the indigent, although complete resembles an ideal for our surroundings and its application is limited due to the general level of poverty of the population and of the periodic nature of certain indigent cases as well as of the values of the communities*".

Indigent selection needs and health care

From the needs analysis, five main themes emerged. It is about the importance of an adequacy of the tools of selection of the indigent to the context, of the importance of transparency in the process of selection of the indigent which appeared omnipresent in all the interviews, the importance for health services to reach out to the needy, the deconstruction of prejudices regarding the selection of the needy, the strengthening of outreach, the importance of updating the lists of the needy, importance of updating the lists of the indigent, the power of actors to act which, according to the participants, will strengthen their commitment and their capacity for innovation in the care of the indigent.

5. Discussion

This work addresses the perception of actors that is often neglected in the implementation of health interventions. Even if very little evidence looks at the issue in the field of health, the methodology used has made it possible to highlight the perception of health workers and actors involved in the community selection process of the poor with interesting avenues for the improvement of the care of the indigent. Also, more in-depth reflections that could take into account other types of actors and urban areas could enrich knowledge.

5.1. Characteristics of Participants

The male gender predominates among the participants (87.7%). This is explained by an under-representation of the female sex both among health workers and other actors involved. In rural areas, there is very little female presence among head nurses. During the establishment of the selection committees, one of the conditions was that there are at least two women on each committee. But this was not respected at all levels. These results conflict with the findings in Ouargaye where women were fairly represented on the selection committees. This study showed that the role of women was crucial for the success of the selection because they usually know the populations in the villages better

[23].

5.2. Perception of Indigents Selecting Process

The vast majority of participants have a positive perception of the community selection process for the indigent. This perception does not differ significantly according to the health workers and actors involved in the selection or their experience acquired in the selection of the indigent. Indeed, the community selection process is inspired by the results of research conducted by the University of Montreal and the Burkina Faso Ministry of Health in the health district of Ouargaye, and which have been tested by NGOs.

This research involved both health workers and social and community service players, the process selected seems to take into account several concerns of all these players. Also, the aim of the selection being to ensure care for the indigent who remains a concern for all these people, facilitates their membership, knowing that a bad perception of the selection process by the actors can lead to a failure of the care of the indigent. The same observation is found in the context of a study, where the selection of the indigent was well perceived by most of the people questioned because it took into account their value and was in line with the context [8].

Following another study, the authors came to different conclusions highlighting the influence of local elites which does not allow acceptance by all of the selection [8].

The shortcomings observed could be explained by the way in which the selection process is managed. Indeed, the guiding principle of the process was operated by the central team. While this top-down approach facilitates the conceptualization of the selection and the holistic view of the process, this is not the case for the full participation and ownership of stakeholders.

The step of setting up structures at the community level is not always understood by study participants. The criteria that had been established for being a member of the selection committee were not strictly observed. Indeed, within the populations, certain people had responsibilities with tasks according to the social organization in place and could exert an influence on community activities.

As a result, they impose themselves on issues related to their responsibility especially when they are adulated by leaders within the community although this "mechanical" organization seems no longer to be shared by the entire population. Thus, during the selection process, the application of the criteria to be a member of the selection committee was confronted with this form of influence at times despite the pre-established protocol.

The step of informing stakeholders about the selection was mainly limited to the regional or provincial level and did not make it possible to significantly sensitize the populations in the villages and hamlets. The information specifically targeted administrative and communal authorities, customary and religious leaders as well as resource persons.

This information is sometimes passed on during meetings with the actors concerned, always at regional, provincial and municipal level. As stakeholders can be positively or negatively affected as a result of the selection, information becomes a capital element that should allow relationships to be managed in order to avoid their opposition or to gain their support for the selection process, which is one of the key factors. The involvement of stakeholders is one of the conditions for the success of a public health intervention [6].

Also, improve the understanding of the populations given the coexistence of several interventions on the ground targeting vulnerable populations (nutrition, social safety nets, agriculture) and which sometimes lead to misunderstandings within the populations.

The registration of the destitute by village is seen by most of the participants as the step that has experienced enough disruption with various interactions. Following the selection approach, the recording was done during meetings between members of the selection committee and this sparked a lot of discussion depending on the perception of each other vis-à-vis the proposed cases. The many health activities at the community level (treatment campaign, vaccination, etc.) which mobilize certain members of the selection committees, to which must be added the socio-political crisis that the country experienced in 2014, also led to irregularities in the holding of meetings causing organizational difficulties within the selection committees. Information indeed shows the negative impact of socio-political crises on the implementation of health interventions [24].

The participants felt that the validation of the lists was the step that presented considerable limitations in terms of eliminating the bogus indigent. Indeed, this step should filter out any errors slipped during the establishment of the lists. Community breeding experiments have shown a very low probability that the proportion of needy exceeds 10%. Beyond that, especially in a context of great poverty, inclusion challenges arise given the limit of discriminating characteristics between individuals and between households, which causes false inclusions. Authors have shown that selection generates errors when the population is quite heterogeneous within villages [25].

There were differences of opinion between the actors regarding the stage of the distribution of the cards. Committee members are quite supportive of what happened on the ground. This is explained by the fact that they were responsible for this distribution. And not having received any financial compensation, they think the result has lived up to expectations. Health workers who observe on the one hand that some of the poor have not had their card and that some cards have remained within the health facility and on the other hand that many cards contain identity errors, consider that the distribution does not was not effective. In the experience of the indigence fund in Mauritania, the indigence card distribution system had worked relatively well. However, 23% of the households surveyed declared that they had never received a card [26].

5.3. Perception of the Indigent Definition

Overall, health workers and stakeholders are satisfied with the definition of the indigent used during the selection. The application of this definition according to them is complex in the field, especially among a population that is largely poor. The definition of indignant employed seems to have taken into account the multidimensional situation of destitution as well as the demands of many people on the issue of the indigent. This finding differs from the results of a study which revealed enough divergence between the actors concerning the definition of the indigent in an analysis situation where the concept of the destitute is sometimes assimilated to that of the indigent and which could lead to confusion, even conflicts during the selection of the indigent [27]. These authors nevertheless argued that in some groups, participants were unanimous on the definition of the indigent.

5.4. Selection Needs of Participants

The needs expressed by participants relate to are tools used for the selection of the indigent, the transparency in the selection process, the importance of services health to go to the needy, the deconstruction of prejudices regarding selection of the indigent, the importance of updating the lists of the indigent, the power of actors to act. These needs reflect a state of lack experienced by participants in relation to the indigent selection process.

These dissatisfactions could be at the origin of a lack of motivation regarding the care of the indigent. Undoubtedly, the actors are more motivated in their tasks when their needs are satisfied [7].

6. Conclusion

The perception of health workers and the actors involved in the community selection of the indigent is decisive for effective care of the indigent in health facilities because of their crucial role in the implementation of health interventions. Most of them have a positive perception of the community selection process for the indigent. Also, they are generally satisfied with the definition of the indigent used in the selection. From an operational point of view, some steps of the selection process deserve to be restructured. Also, with regard to the concept of indigent, the translation of dimensions such as the absence of endogenous and exogenous support is not always precise enough for all actors depending on the context. Considering the needs expressed by the participants in the study, in order to improve the selection of the indigent for their care, a strong involvement of grassroots actors in the design and implementation of the process is essential with the involvement of local communities.

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Authors' Contributions

All the authors participated in the study. Drabo K Maxime validated the method; Sidibe Souleymane collected and analyzed the data. All authors have amended and approved the submitted manuscript.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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Abbreviations

AMU: Universal Health Insurance
CERS: Ethics Committee for Health Research
CN: North Center
CNRST: National Center for Scientific and Technological Research
CSAT: Customer Satisfaction Score
DRS: Regional Directorate of Health
I_P: Perception Index
JKZ: Professor Joseph Ky Zerbo
MS: Ministry of Health
NGO: Non-Governmental Organization
PBF: Performance-Based Financing
RCES: Central East Region
RNRD: North Region
SG: General Secretariat
BM: World Bank