Original Article

How could patient navigation help promote health equity in sub-Saharan Africa? A qualitative study among public health experts

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Abstract: The indigents have long been excluded from health policies in sub-Saharan Africa. Despite recent efforts by some countries to allow them free access to health services, they face a multitude of non-financial barriers that prevent them from accessing care. Interventions to address the multiple patient-level barriers to care, such as patient navigation interventions, could help reverse this trend. However, our scoping review showed that no navigation interventions in low-income countries targeted the indigents. The objective of this qualitative study is, therefore, to go beyond the lack of evidence and discuss relevant approaches to act in favor of health care equity. We interviewed 22 public health experts with the objective of finding out which actions related to patient navigation programs (identified in the scoping review for other target groups) could be relevant and/or adapted for the indigents. For each ability to access care described by Levesque and colleagues, we were thus able to list the potential opportunities and challenges of implementing each type of action for the indigents in sub-Saharan Africa. Overall, the experts all felt that patient navigation programs were very relevant to implement for the indigents. They emphasized the need for personalized follow-up and for holistic actions to consider the whole context of the situation of indigence. The recommendations made by the experts are valuable in guiding political decision-making, while leaving room for adaptation of the proposed guidelines according to different contexts. (Global Health Promotion, 2021; 28(Supp. 1): 75–85)

Keywords: indigents, patient navigation, qualitative study, access to health care, sub-Saharan Africa

Background

Following the promotion of the Bamako Initiative (BI) in 1987, the principle of cost recovery has been applied to most African health structures, requiring users to pay at the point of service delivery to help finance the functioning of the health centers. While the BI was supposed to have an equity component and include exemption measures for the indigents, these measures have often never been implemented (1). So, these user fees have long hampered the ability of the indigents to access care, as they have 'sustained incapacity to pay for minimum health care' (2).

An action research project was conducted in 2007, in the rural district of Ouargaye (Burkina Faso), with the objective of testing a community-based approach to

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identify indigents and to provide them with an indigence card to exempt them from user fees (3). The selection was restrictive but effective (4), and the pilot experience was then extended to eight districts in the country.

However, studies have shown that these payment exemptions have not significantly increased the use of health services by the selected indigents (5,6). These indigents, who are mainly unmarried adults and older adults (particularly widow(er)s and older women) (7), may face a multitude of other barriers such as psychological stress (8), social exclusion (9), or limitations in physical functioning (7) that prevent them from accessing health services. In the face of such challenges, we wanted to explore ways to enable them to overcome these non-financial barriers. We conducted a scoping review on patient navigation interventions for poor and vulnerable populations in low-income countries (LICs). Patient navigation interventions are multiplying in high-income countries (HICs) to support access to care for the most vulnerable. Based on 'navigators' who accompany patients throughout their care journey, these programs aim to address patient-level barriers to care (10).

The scoping review shows that there are no navigation interventions in LICs that specifically target the indigents (11). Since there is a lack of evidence, we decided to conduct the sixth stage of a scoping review: the consultation exercise (12). The objective was to find how the actions identified in the literature for other vulnerable populations might be relevant and adapted to implement for the indigents in sub-Saharan Africa.

Methods

During the months of June and July 2019, we carried out an exploratory qualitative research project in which we conducted 22 semi-directive interviews with public health experts who were selected because they have field experience in sub-Saharan Africa and an in-depth knowledge of the situation of indigence. Of the 22 people interviewed, 12 are researchers and 10 are experts from institutions specializing in health in African countries; eight are women and 14 are men; and 11 are Africans and 11 are Europeans. We used a snowball strategy (13) for the recruitment. We applied the principle of empirical saturation to determine the number of interviewees. The interviews were recorded, fully transcribed, analyzed using the Nvivo12 qualitative analysis software©, and then translated into English. The consolidated criteria for reporting qualitative research (COREQ) checklist (14) is available in the Supplementary File 1.

We analyzed data using a framework analysis approach (15) to compare the data with Levesque *et al.*'s framework (16). We chose this framework because it is relevant to analyze the navigation interventions found in the literature (11) and has, therefore, been used to conceive the interview guide. The coding on Nvivo was guided by the abilities described by Levesque *et al.*'s framework (16): ability to perceive, to seek, to reach, and to engage. We did not include the ability to pay in the study because this issue is sometimes resolved for the indigents (following the distribution of indigence cards), and because user fee exemption is a necessary pre-requisite for this category of population.

This study was approved by the Ethics Committee of Burkina Faso (deliberation n°2019-01-004), as part of the ORIGINE project (Territorial observatory of free health care for the indigents).

Results

What hinders indigents from accessing care?

The experts were first asked about non-financial barriers that could explain why indigents do not access health centers even when health care is free. The interviewees generally highlighted the fact that the indigents have other needs, often prioritized over health care, such as food or housing: 'Care is like a luxury. So when you're sick, the first thing you tell yourself is that it'll pass, and you try to put up with it for a while (Interviewee 3 (I.3))'. It was pointed out that the financial barrier was only one of many barriers encountered: 'There is financial exclusion, but there is also social, cultural, political exclusion, and so on. So, acting on one of the dimensions is relevant, but often not sufficient (I.9)'. Table 1 lists several barriers that could prevent the indigents from accessing health services despite their user fee exemptions. A detailed version with sample quotes to support each point is provided in Appendix 1, Table 2.

How could these barriers be overcome?

We then presented, for each ability to access care, the main types of action that were identified in the

Table 1. An overview of the non-financial barriers to access care experienced by the indigents.

Ability to perceive
- Perceived inaccessibility of modern health system
- Lack of information on their right to free health care and the usefulness of the indigence card (if one exists)
- Low perception of the need to go for care related to the representation of the disease
- Lack of knowledge of the rules of the health system's functioning
- Influence of rumors
Ability to seek
- Administrative constraints to be registered as indigent can be very strong in some countries
- Fear of being badly received, badly taken care of, or discriminated against
- Lack of self-esteem and self-confidence, feelings of shame, or self-stigmatization
- Gender barriers
Ability to reach
- Distance between health centers and places of residence for indigents and inability to pay the transportation costs (even more in case of additional examinations or visits to specialists)
- Lack of accompaniment due to their social isolation
- Characteristics of the indigents may prevent them from moving around
- Difficulties in navigating within health care facilities
Ability to engage
- Poor quality of care due to their unequal relationship with the providers
- Lack of food to take medicine

scoping review and asked the experts whether these actions seemed relevant to them to implement for the indigents and why (Appendix 1, Table 3). A detailed version with sample quotes to support each point is provided in the Supplementary File 2.

Ability to perceive

All of the navigation interventions acted on the ability to perceive (11). Those interviewed said that acting on this ability is an essential prerequisite. They explained that it is necessary to inform indigents of the actions that are implemented for them, the usefulness of the exemption card (if one exists), the rules for using the health facilities, etc. The interviewees emphasized that the messages must be of good quality; and that it is necessary to have a comprehensive approach to the situation of indigence, to try to involve the entourage, and to make a link with social action (involvement of social services if possible). Above all, they emphasized that, before giving any information or advice, one must always try to find out if and how the indigents could apply the recommendations.

However, several experts pointed out that this great attention given to information and awareness-raising could also come from an overly childish and reductive opinion of the poorest people. Some experts explain instead that people probably do not go to the health center because they are resigned, and not just because they are not informed or aware. It is important to see the information and sensitization as a first step in the care pathway, but also to address all the other barriers to access care:

> One underestimates the difficulties of use. And so, to incite them is just like: 'but listen, you didn't get it right, you have to use the health service! – Ah! I didn't know, now I'm going to go!' Maybe it's a little naïve. (I.9)

What emerged from our interviews is that the preferred approach for acting on this ability is a proximity approach. Regarding mobilizations at the community level, which are sometimes carried out via the radio or local newspapers, it was stressed that this would hardly reach the indigents, nor would large information meetings that they do not attend. An individualized approach, through home visits, therefore, seems to be preferred, since it would make it possible to understand the needs and specific situation of each indigent, to raise awareness among

the other people in the household (if there are any), and to provide all the necessary information while being sure to reach the targeted people. However, some experts expressed concerns about totally isolating the indigents by only carrying out specific actions towards them. Instead, several suggested that isolated actions should be carried out for the indigents as they are a very vulnerable group that requires dedicated resources, but that they should be included in comprehensive activities at the community level to avoid stigmatization and promote their social integration. With regard to actions to identify the sick within the community, it was pointed out that this could raise ethical questions, particularly depending on who was responsible for carrying out this task: 'If it's a social worker or someone who's really specialized in health, it's less of a problem for me than if it's someone in the community who knows everyone and who's likely to tell everyone 'so-and-so is sick' (I.11)'. With regard to diagnostic campaigns, they would not necessarily be suitable for the types of diseases suffered by the indigents:

> Home diagnostics are public health operations, but which mainly relate to actions to fight against epidemics or things of the sort. [...] And they are not without side effects, because these are health police operations, so you can also imagine what that can entail in terms of tracking, suspicion. (I.7)

Ability to seek

The ability to seek is the ability on which the fewest interventions act (11). The experts emphasized that these are dimensions that are very difficult to act on because they require long-term, intersectoral action, designing projects with a participatory approach; and that they require 'political courage' (I.22). The context of international aid does not favor this type of intervention, because it is not possible to measure its effects directly, while 'funders want a dollar – a result' (I.6) and since 'all these questions of personal values, culture, gender, autonomy, are very related to the direct context, and health interventions tend to be very standardized' (I.11).

Nevertheless, what was most supported to act positively on this ability, was to adapt community mobilizations to the different cultural groups and to the specific situation of indigence, because often during traditional community gatherings, no one thinks specifically of the indigents.

Opinions differed as to whether or not to help people fill in the administrative paperwork required to access care. Some experts found it important, even beyond the health field, to help have access to food, apply for social services, etc. Some felt that it was important to help with the administrative paperwork required to obtain health care, especially since indigents can be illiterate, but that it depended on the context because sometimes there are no administrative problems, or the health workers fill out the information themselves.

Acting on gender issue, for example, by raising men's awareness so that they encourage women to go to the health center, was described as relevant by experts but they stressed that this type of action was complex to implement as it was a sensitive subject and required more than one-off actions.

Ability to reach

The interviewees considered it particularly important to address the ability to reach, which severely hinders the indigents' access to health centers. However, they wondered how transportation and its logistics could be financed. They pointed out that setting up transportation for the indigents alone was not the most ideal because there are only a few per village, and because it could reinforce stigmatization: 'if you organize a transport system, there is the problem of equity, so it has to be accessible to everyone. But of course, the indigents are taken care of 100%: we make sure that they don't pay' (I.18). Several experts referred to the proposal to set up a community-wide fund to organize and finance transport, mentioning that such a fund had been set up in Niger, and that it could be replicated to provide access to care for the indigents (17). According to the experts, the best approach would be to implement a comprehensive and sustainable transport system that would also benefit the indigents, or at least try to integrate them into existing community transport mechanisms. The idea of distributing vouchers to the indigents was received differently. Some found it relevant and viable, since community members often have motorcycles or tricycles, even in the rural areas, which would allow them to transport the indigents

if they were compensated for their fuel. Others felt that the system was quite complicated to understand, that the transportation would be insufficient or not necessarily available when needed, and that, even then, individualized accompaniment was still necessary for the indigent to use the vouchers to get to the health center.

Indeed, accompaniment was often considered fundamental and necessary, beyond the provision of transportation: 'I think the key is really: there's a person in front of another person who's going to take that person by the hand, and who's going to say: 'here we go" (I.6). This accompanier could even stay with the indigents in the health facilities. Several people surveyed found this type of action very relevant because in addition to being able to guide them (especially in hospitals), it could promote better reception of the indigents who are often discriminated against.

Ability to engage

What was generally considered the most suitable way to act on the ability to engage was the implementation of an individualized support for the indigents, particularly through home visits. This individualized approach seemed more relevant than an approach mobilizing the formation of support groups, for example. Indeed, it was stressed that: 'Unlike what is often seen in some cases of pathologies, each indigent is a case. [...] this approach must be truly individualized, so as not to drown certain situations in others' (I.15). Although some experts expressed concern about the financial viability of such an approach, home-based support that includes information, personalized follow-up, psychological support, and discussions to understand the difficulties each person encounters in adhering to their treatment (and reflect on solutions), seems to be the most suitable option. It was also highlighted that it is important to explain the benefits of adherence to treatment as well as the potential side effects of taking medication.

Opinions differed on the specific content of these home visits. Some believe that it is necessary to observe the daily intake of medication, since the indigents can suffer from mental or other conditions that make it difficult to comply with the dosage. Other interviewees, on the contrary, found that the observation or daily reminder of taking medication was a form of 'paternalism' (I.6) or a kind of 'health police' (I.7), which only makes some sense in the context of epidemic diseases that need to be contained. It was specified that these visits should be carried out with a strong emphasis on listening, and without blaming the patient who did not follow his treatment or did not go to the health center.

In addition to the psychological support to be provided during home visits, some experts would also like to add material support, such as the distribution of food:

> Because if he [/she] takes the medication when he hasn't eaten, it's another illness. So, adding food support to psychological support has more effects than psychological support alone (I.12).

Discussion

While there have been long-standing pleas to take into account the indigents (2), and policies for universal health coverage are supposed to be designed with the idea of 'leaving no one behind', little has actually been done to address their specific needs. The user fee exemption alone, as well as programs linking performance-based financing and equity measures, have shown their inadequacy in increasing the use of health services for the indigents (5,6,18). There is a need to design and test interventions that are better adapted to their situation and that include support throughout their care pathway.

One of the lessons of this study is that actions successfully implemented to improve access to care for some target groups (such as pregnant women, children, people living with HIV) in sub-Saharan Africa must be adapted to the situation of the indigents. Given the context and the specific socio-demographic characteristics of the indigents, some actions were considered more relevant than others to implement. Indeed, faced with all the difficulties encountered by the indigents in accessing health services in sub-Saharan Africa, experts stressed that action on ability to pay was absolutely necessary, but that this action must go hand in hand with a more comprehensive intervention that takes other needs into account. In view of the situation of indigence, it will be necessary to have intersectoral, holistic action that takes into account all the needs of the indigents and that also considers the social determinants of health. To address these challenges, experts were all

interested in the idea of implementing a navigation-type intervention for the indigents and highlighted the need for personalized follow-up of the indigents, by creating a role of 'social worker', 'accompanier', or 'mediator' between the indigents and the health system. In patient navigation programs, this role is assumed by those called 'navigators', who take care of all activities related to this type of intervention, such as information activities, physical accompaniment to health centers, home visits, etc. They help link vulnerable populations to health systems by informing, assisting, and supporting them throughout their care pathway. Their role and proximity to patients enables them to have an action that goes beyond the strict field of health and allows them to better respond to people's needs. Numerous experiences have shown that navigators can help address health disparities (19) and issues related to social determinants of health (10) in HICs. However, there is very little research on this type of intervention in low and middle income countries. This empirical article and a scoping review (11) provide guidelines to adapt these programs to the contexts of sub-Saharan African countries and to the situation of indigence in order to promote health equity.

One of the limitations of this study is that we were scheduled to travel to southern Burkina Faso where we plan to discuss the findings in this context with communities and health professionals, but the travel was cancelled for security reasons. However, one of the strengths of this study is that the experts interviewed were not prescriptive, but they used their experiences to warn or, on the contrary, to support the benefits of certain actions. Thus, the recommendations may seem broad, but they provide valuable decision-making guidance while leaving room for specific local study of barriers to access, and for adaptation of the proposed guidelines to different contexts.

Conclusion

Public health experts found that patient navigation-type interventions were highly relevant to work towards improving access to health services for the indigents in Sub-Saharan Africa. This qualitative study allowed us to draw up a list of the benefits and challenges that could result from the implementation of each type of action, which can help in policy decision-making. To avoid the slogan 'leaving no one behind' still being chanted 20 years from now without having achieved any improvement, it is absolutely necessary to test these types of interventions in order to act in favor of equity and not to fail to include the indigents in policies for universal health coverage.

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Declaration of conflicting interests

The authors have no conflicts of interest to declare.

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Appendix

Table 2. An overview of the non-financial barriers to access care experienced by the indigents, with sample quotes.

Ability to perceive

- Perceived inaccessibility of modern health system
  "maybe they don't even believe in it, that it's true, that it's possible that there's a gratuity for everything, that it's not just a lure, just something and behind invoices will fall on them" (I.1)
- Lack of information on their right to free health care and the usefulness of the indigence card
  "they did not have enough information about everything that is being done for them in terms of access to care. As a result, it didn't change their usual behaviour, which was to not even go to health facilities because they couldn't pay for their care." (I.15)
  "For example, in Benin, [...] they were told 'if you're sick, you can use the card.' And they weren't sick, they were pregnant. So, these are small things, but sometimes they can explain the low level of use." (I.11)
- Low perception of the need to go for care related to the representation of the disease
  "a lot of people have very chronic health problems, and in their perception of these health problems, they don't necessarily link this to a solution in the modern health system" (I.12)
- Lack of knowledge of the rules of the health system's functioning
  "Usually, the person does not have the information that there are rules to follow at the health system level. [e.g. pyramid-shaped hierarchy of the health care structures]" (I.8)
- Influence of rumors
  "It just takes one person to say it didn't work for everyone to think it's not going to work, and so there's no point in trying" (I.11)

(Continued)

Table 2. (Continued)

Ability to seek
- Administrative constraints to be registered as indigent can be very strong in some countries
  "in Mali, obtaining this document is often very long, even if they are entitled to it and so on, the cards do not arrive quickly at their destination." (I.1)
- Fear of being badly received, badly taken care of, or discriminated against
  "one despises the poorest, we know that we are treated according to our standard of living, everyone has always known that." (I.1)
  "they're convinced they're going to be insulted, they're going to be told, 'you come with the card all the time, you like free care too much.'" (I.11)
- Lack of self-esteem and self-confidence, feelings of shame, or self-stigmatization
  "the indigents are in a situation where they have been deprived of many things, certainly including their self-esteem and self-confidence, which are decisive in going to seek care." (I.19)
  "Indigence is not only a lack of means, financial means or resources; it is also a kind of social indignity that makes people feel ashamed to appear in the public space and say they are poor and indigent." (I.7)
  "the psychological and behavioural hindrances of the indigents on the dimension, which I would classify as self-stigmatization, of saying to oneself 'I don't want to be associated with someone in need, and I'd rather not have access to it than to be identified as indigent.'" (I.16)
- Gender barriers
  "we saw that in matters of care, the decision was mostly up to the men and that they had to make the decision for the woman and children." (I.6)

Ability to reach
- Distance between health centres and places of residence for indigents and inability to pay the transportation costs (even more in case of additional examinations or visits to specialists)
  "usually the health centres aren't next door. [. . .] So, a health centre that is located ten kilometres away, for someone who is indigent and who has real difficulties sometimes to move around, to get food, he [/she] doesn't often see the need to travel ten kilometres to get treatment." (I.4)
  "Taking a motorcycle taxi or other, it's a cost. For an indigent it's really complicated." (I.21)
- Lack of accompaniment due to their social isolation
  "they don't have anyone to back them up. To bring him [/her] to the health centre, there's no one available, so he doesn't go because he doesn't even have the capacity. Even if he thinks about it, he doesn't have the capacity to go." (I.5)
- Characteristics of the indigents may prevent them from moving around
  "the people who have been selected sometimes have severe difficulties, either he [/she] has a physical handicap, or a mental handicap; or he is really old. So, it's people who have difficulty moving around." (I.5)
- Difficulties in navigating within health care facilities
  "For me, who is not indigent, there are moments when I go to the health centre and I am lost. Despite my money, I don't even know who to talk to." (I.12)

Ability to engage
- Poor quality of care due to their unequal relationship with the providers
  "the indigents often have access to very low-quality care, either because they are referred to primary health structures which offer insufficient quality care for lack of means, or because, in a certain way, they self-censor. That is to say that once they enter the care structure, their relationship with the provider means that they will ask few questions, they will have a certain mistrust, they will be in a position of dominated which will not facilitate the exchange between them and the provider." (I.6)
- Lack of food to take medicine
  "There are indigents who also talk about the food problem. They say, 'when I go to the health centre, I am given pills, and I am told that I have to eat before I take any, when I don't even have anything to eat. So, I don't go there anymore.'" (I.5)

Table 3. An overview of the relevance of each action in improving each ability to access care of the indigents.

Ability to perceive
Health promotion and awareness-raising activities at community level (information meetings, information campaigns via radio, local newspapers, etc.)
(+) Wide dissemination of information
(-) Indigents don't go to community gatherings
(-) Indigents often don't have radios or access to newspaper
(-) Indigents can feel marginalized
(-) Difficult to perceive individual needs
Health promotion and awareness-raising activities at the household level (home visits)
(+) Perception of the specific needs of each indigent/household
(+) Proximity approach and direct targeting
(+) Direct targeting is facilitated by prior identification
(+) Allows private identification of sick people
(-) Few indigents per village (isolated cases) so it can be difficult to implement
(-) May be stigmatizing if only the indigents are targeted and if the navigator is an "indigent-specific" one
(-) Can be expensive
(-) Some indigents don't have a home
Identification of sick people in the community
(+) Enables direct targeting
(-) Raises ethical questions
(-) Can be stigmatizing
Diagnostic campaign (in communities, in health facilities, or at home)
(+) Enables direct targeting
(-) Diagnosis alone is insufficient
(-) Diagnostic campaign at the community level will not attract the indigents
(-) Relevant for epidemic control but does not work well in the context of chronic diseases or specific health problems
Ability to seek
Adapting community mobilizations to different groups / Using specific cultural codes
(+) Often in the mobilizations no one thinks specifically of the indigents
(+) Improves comprehension and assimilation of messages
(+) Takes into account the cultural sensitivity of each ethnic group
(-) Difficult to adapt to each context
Raising men's awareness to encourage women to go to a health facility
(+) Important to take into account gender issues
(-) Sensitive subject
Help obtain and complete the administrative papers required for care
(+) Indigents can be illiterate and therefore need administrative support
(+) There is a need to help in completing paperwork even beyond the health field
(-) In some places, there is no need to complete administrative papers to access care, or there is someone to help
Ability to reach
Accompanying patients to health centres (via transport or on foot) and guide them inside
(+) For some diseases, there is a risk of denial and therefore a particular interest in accompaniment
(+) Psychological effect of the accompaniment helps to remove a barrier
(+) Provides social support, trust, empathy
(+) The fact of being accompanied will promote better reception of the indigent at the health centre
(+) The accompanying person is needed to get food, medication, etc., especially in the event of hospitalization
(+) Support does not necessarily have to be permanent but can be a trigger for seeking care
(-) The "return on investment" demanded by most funders will not necessarily be achieved
(-) Will the navigator always be available to accompany?
(-) Orientation of the indigents within health centres is not usually necessary in first-level health facilities
(-) Not necessary if the indigent is informed about how the health system works and staff are sensitized to receive and refer them

(Continued)

Table 3. (Continued)

Organization of a transport system (stretchers, ambulances, etc)
(+) Indigents often do not have the ability to move around, so their transportation must be provided
(+) It allows compensation for the low number of the health centres per inhabitant
(+) It could be integrated into a community-based system with progressive funding
(-) The budget has to ensure the maintenance of the means of transportation
(-) Health centres are already sometimes understaffed so having an ambulance driver available can be difficult
(-) Ambulances are often directly associated with someone who is in a state of near death or are in very poor condition
(-) Rather than setting up a new system, the first step should be to try to integrate the indigents into existing systems
Distribution of vouchers for patients to pay for their transportation
(+) The indigents can rely on people in the community who are able to provide transportation while giving them means to pay for this transportation
(+) The card could be used both to access free care at the centre, and to reimburse fuel
(+) It creates fewer problems of bias, maintenance, logistics, etc.
(-) In rural areas where there is no public transport, the voucher system may not work and be understood
(-) It is not sure that the indigents will use the vouchers, and that they will not be overcharged by the transporters
(-) Does not solve the problem of social isolation which prevents them from finding someone to take them to the health centre
(-) Requires a conversion site for vouchers
Set up a group or community-wide fund to organize and finance transportation to health care centres
(+) There are successful examples of the sustainability of this type of fund (e.g., additional incentive programme in Niger)
(+) The fund can be requested as soon as there is an emergency
(-) A fund like this is often not sustainable if it is financed by an NGO
(-) The community does not necessarily have the means to pay for a fund and to contribute for the indigents
Ability to engage
Raising awareness of the positive effects of treatment adherence
(+) It is important to raise awareness and to explain why it is important to follow the treatment plan
(+) Poor compliance is often the result of a lack of information
(+) It would also be necessary to raise the awareness of the entourage
(+) Some people take a treatment that has side effects, but as these effects have not been explained to them, they think the medicine makes them sicker and stop taking it
(-) Awareness raising is important but if we don't follow people to check that they are really taking the drugs, they will listen but not necessarily take it
Daily home visits to observe patients taking their medicines
(+) Important because indigents sometimes have mental health problems or are elderly and therefore have difficulty complying with the dosage
(-) Visiting every day is too much, it goes against the notion of empowerment and can be intrusive
(-) If the person does not have the capacity then there must be a guardianship arrangement but, in this case, there must be a well-defined criterion: "incapacity to. . ."
(-) Can be seen as treating them as children (infantilization)
Regularly remind patients of the dates of their medical appointments
(+) Can be done over the phone or when a mobile health worker visits the villages
(+/-) Important but should not be carried out in such a way that it looks like health policing
(-) May be counter-productive to remind patients of their appointments if they have a good reason for not coming, one should first try to understand these reasons
(-) Health centres may be overloaded or under-staffed so they cannot call people constantly
Psychological support (individual or via support groups) for patients and their caregivers
(+) In view of the situation of indigence, psychological support is essential
(+) It would be interesting to combine psychological and material support (distribution of food to take medicines).

(Continued)

Table 3. (Continued)

(+) The support should be individualised
(-) If it is done in groups, it should respect confidentiality
(-) Psychological aspect can be difficult to grasp
(-) The groups are poorly adapted for the indigent (some people may be intimidated or excluded)
(-) Psychological support does not mean that the person is going to enter the health system
Discussion of barriers to care adherence and implementation of solutions
(+) Very relevant for understanding the reasons why the person did not come (and act on) to the centre
(+) Empowers them by helping them to find solutions themselves
(+/-) This should rather be done by people other than health professionals (by people closer to the patient)
Home visits to ensure patient retention
(+) Many experiences of interventions with home visits to ensure retention have had positive effects
(+) Helps to encourage the person to continue his/her treatment
(-) Can be very expensive
(-) Visiting people's homes can be intrusive and stigmatizing
Tracking people who have not attended their appointments (phone call, home visit, etc.)
(+/-) Relevant, but must focus on listening and not making people feel guilty
(-) More relevant for diseases such as HIV or tuberculosis, where there are many people lost to follow up
(-) Health is a right and not an obligation, people should not be forced to do anything
(-) This sounds like paternalism or health policing (which is only conceivable in the context of epidemic diseases that are threats to the community)