Budapest International Research and Critics Institute-Journal (BIRCI-Journal)
Humanities and Social Sciences
ISSN 2615-3076 Online)
ISSN 2615-1715 (Print)
www.bircu-journal.com/index.php/birci
Budapest Institute

Defeating Poverty: An Analysis of Private Health Investment in Rural Béguédo and Ouarégou in Burkina Faso

Maurice Sarigda[1], Yisso Fidèle Bacye[2], Adama Kiemde[3], Fatoumata Badini-Kinda[4]
[1,3]*Thomas SANKARA University / Tenkodogo University Center ; Society, Mobility and Environment Laboratory, Joseph KI-ZERBO University.*
[2]*Thomas SANKARA University / Tenkodogo University Center, Gender and Development Laboratory, Joseph KI-ZERBO University.*
[4]*Gender and Development Laboratory, Joseph KI-ZERBO University*

Abstract

In Burkina Faso, more than three out of four private health facilities are located in urban areas, 90% of them in Ouagadougou and Bobo Dioulasso. In terms of economic profitability, a private health service is more profitable in urban than in rural areas. And yet, private health facilities have been set up in rural areas, notably in Béguédo and Ouarégou in Burkina Faso. What explains private health provision in rural areas? A qualitative method was adopted to answer this research question. As in urban areas, profitability is the driving force behind the choice of rural areas by promoters, but promoters also cite reasons other than economic ones: altruism, reciprocity, awareness of saturation and increased competition in urban areas. These logics allow us to deconstruct the macroeconomic analysis of poverty, which does not take into account the specificity of each rural locality.

Keywords
Private health provision; logics of action; migration; Burkina Faso

I. Introduction

The private health sub-sector plays an important role in improving people's differentiated access to healthcare and thus contributes to achieving universal health coverage in low-income countries (Montagu and Chakraborty, 2021). It is the set of healthcare providers existing outside the public sector, whether their objective is philanthropic or commercial, and whose mission is the treatment of disease and its prevention (A. Mills et al., 2002).

In Burkina Faso, two interdependent factors are driving the dynamics of this private health sub-sector. The first is the health reforms undertaken following the adoption of the primary health care policy and its operationalization through the Bamako initiative (Ridde, 2011). These exogenous reforms were initiated under pressure from institutions such as the World Bank and the World Health Organization (Ridde and Mbow Sane, 2021). The second factor is linked to galloping urbanization, which is constantly creating a hiatus, a mismatch between healthcare demand and supply (Cadot and Harang, 2006; Meunier-Nikiema, 2015). As a result, it should be noted that the two major cities Ouagadougou and Bobo-Dioulasso are home to three-quarters of the country's private health establishments (World Bank 2012). By 2020, these figures were estimated at nearly 90% (Ministry of Health, 2020), confirming the link between urbanization and increased private health provision (Meunier-Nikiema, 2015).

Access to health care offered by private facilities depends on where people live. The city is seen as a place where people are economically well-off, whereas rural areas are characterized by apparent economic deprivation. Financial deprivation, difficulties linked

DOI: https://doi.org/10.33258/birci.v7i4.7988

to health organization, and many other socio-cultural obstacles are the major constraints limiting people's access to health services (Khalifeh 2024). In 2021, the incidence of poverty was estimated at 43.2%, including 16.6% in urban areas, compared with 52.7% in rural areas (INSD, 2022). This situation is not specific to Burkina Faso. Since 1979, Kayser has noted that there are many more poor people in rural than in urban areas. He draws attention to the fact that this statement is not the result of statistical truncation, but derives from several observations. This macro-economic reading of poverty sees the city as a privileged space for the development of business opportunities, in particular the establishment of private healthcare facilities.

As far as poverty is concerned, it's worth noting that the systematic characterization of the rural environment as poor follows the same logic of classifying countries as “Third World countries, other countries, so-called underdeveloped countries”. This conceptualization, which highlights the domination of these countries, translates into a similar domination of the urban over the rural. Poverty thus takes on an economic-political dimension (Kayser 1979). While the rural environment has always conformed to this conception of poverty, an analysis of the behaviour of social actors, particularly private health promoters, reveals a contrast. The rural environment, usually described as poor, receives for-profit investments in the healthcare sector, while these investors are driven by the quest for profitability. Yet more and more private healthcare promoters are setting up in rural areas, even though there are few statistics on this.

The localities of Béguédo and Ouarégou in the Centre-Est region are experiencing an influx of private healthcare facilities. The health area of the Béguédo CSPS covers five villages, with a population of 1,908 in 2024. The Ouarégou CSPS covers 10 villages, with a population of 18,979 in 2024. This number of public CSPSs per village falls short of current health standards, which call for one CSPS per 7,500 inhabitants (Ministry of Health, 2012). At the same time, the number of private health facilities has increased in the two rural localities, which have more private than public health facilities. Of the six private health facilities in the Garango health district in 2024, four are located in Béguédo and Ouarégou (Ministry of Health, 2024).

Studies on the private health sector carried out in Burkina Faso focus more on the urban environment (Cadot and Harang, 2006; Meunier-Nikiema, 2015). There are few studies on the establishment of private healthcare facilities in rural areas. So, what are the rationale behind the choice of the villages of Béguédo and Ouarégou as sites for private for-profit healthcare investment?

The complexity of this choice cannot be understood by simply analyzing poverty. The economic analysis of the choice of setting up private healthcare facilities in rural areas is the leitmotiv behind promoters' decision to invest in rural areas. This decision translates into a deconstruction of the financial destitution of rural populations. In view of these considerations, attachment theory proves relevant to the appropriation of this research object. From an epistemological point of view, attachment theory (Paugam 2016) reveals the extent of social actors' sources of capability. Protection refers to all the supports that the individual is likely to mobilize in the face of life's hazards (family, community, professional, social resources, etc.), “recognition refers to the social interaction that stimulates the individual by providing proof of his or her existence and value in the eyes of the other(s)” (Paugam 2016, 127). Taking this theory as a starting point, the decision to open a private healthcare center should be treated as stemming from an analysis that integrates the duties of social recognition and protection as capitals of sociability. Promoters thus integrate social attachment with economic analysis, deconstructing poverty in the process. Their involvement is based not on an analysis of the economic capital of the

resident population, but on consideration of the social capital and social ramifications of the players to whom they offer their services.

II. Research Methods

Three essential elements are presented in the research methodology: study sites, method of investigation, data processing and analysis, and ethical considerations.

2.1 Study Sites

The study was carried out in Ouarégou and Béguédo, in the Boulgou province, Centre-Est region of Burkina Faso. The Ouarégou and Béguédo CSPSs are under the technical supervision of the Garango health district. Administratively, the Béguédo CSPS is attached to the commune of the same name, while the Ouarégou CSPS comes under the Garango commune. This organization is in line with the texts governing the deconcentration of the healthcare system and the transfer of competencies from State resources to communes in the healthcare field (Zerbo, 2016). The investigation of the two sites does not postulate a comparative approach. The two sites provide a common analytical framework for this research. They are neighboring sites, geographically difficult to distinguish and sharing the same cultures, similar habitus. There is virtually no social distance between these two sites, hence the interest in treating them as a geographical unit of investigation.

2.2 Investigation Method and Study Population

The aim was to identify the logics and motivations of social actors making choices in an economic environment. As a result, the qualitative method proved highly relevant.

The study population was made up of promoters of private health structures. This population was joined by a group of resource persons made up essentially of returnees, as this group proved to be relevant in focusing the analysis on social attachment theory. As a result, returnees have been instrumental in repatriating funds for the health care of their families. They are therefore an appropriate group for data collection.

The sample was made up of three promoters and one manager from private health establishments, and three returnees.

Two types of sampling were used. Exhaustive sampling for the selection of promoters from private health centers and snowball sampling for the selection of returnees.

Documentary research and interviews were the main data collection techniques used. For the operationalization of the interviews, two individual semi-directive interview guides were used as tools for collecting data from the study population. Data were collected either in Bissa or in French, in accordance with the norms of precedence laid down in this respect (Olivier De Sardan, 2003). All were audio recorded with their permission, and additional notes were taken.

2.3 Data Processing and Analysis

The recordings were first transcribed in their entirety. During transcription, particular attention was paid to the heel (Combessie, 2007). The interviews were then coded as follows: E for interview followed by a number representing the respondent's number. For the corpus analysis, the thematic content option was favored (Paillé, and Mucchielli, 2012), following a deductive and inductive approach. During this phase, NVivo 11 software was used. During analysis, the verbatims used were followed by the respondent's code and status.

2.4 Ethical Considerations

Data collection was authorized by the Chief Medical Officer of the Garango Health District, the authority representing the Minister of Health in the zone. Respondents' anonymity, data confidentiality and free consent were respected.

III. Results and Discussion

3.1 Characteristics of Respondents

All the promoters/managers of the private health establishments in the two localities were men. Three out of four are owners of their establishments, against one who is in charge of the center as an employee of the promoter. This situation can be explained by legal constraints, which stipulate that the promoter of a private health facility in Burkina Faso may not be a clinician, but is obliged to appoint one to head the establishment. Two out of four respondents were Bissa, from either Ouarégou or Béguédo. The common characteristic of the other two promoters is that they have spent almost their entire professional career as public health workers in these localities.

3.2 Health Services and Pricing of Procedures

There are two types of private health establishments in the two localities. The first are nursing practices (CSI) run by professional nursing promoters. The second type of private health center is a Medical Center (CM), run by a general practitioner. The administrative and technical organization of the healthcare system is highly hierarchical, with each level corresponding to a package of healthcare activities. CSIs and CMs are the most decentralized operational level of Burkina Faso's healthcare system (Zerbo, 2016). According to this organization, IHCs are at the first level and implement the minimum package of activities (PMA) (Harang and Varenne, 2008). The three IHCs offer routine services such as curative nursing consultations, minor surgery (dressings, sutures, incisions for abscesses and panaris), nursing care (injections, infusions, urinary catheterization) and patient observation. In addition to these care services, only one IHC has a maternity unit offering prenatal care, postnatal care, deliveries and certain modern contraceptive methods. As for the CM, which has a general practitioner and a laboratory, it offers, in addition to the services mentioned above, general and specialized medical consultations (gynecology, cardiology, gastroenterology, etc.), medical imaging including ultrasound scans and biological tests (blood, urine, stool, etc.). All these services are provided by public health establishments in these areas. However, these private health establishments do not offer vaccination services as part of the Expanded Program on Immunization, which targets children aged 0-23 months and women of childbearing age (Ministère de la Santé et de l'Hygiène Publique, 2023). No doubt this exception can be explained by the fact that this service is not priced. The fact that it is free is contrary to the motivations of the private sector.

In terms of pricing, the costs of nursing services are virtually identical for all types of private healthcare establishment. A curative nursing consultation, for example, costs 1000 F CFA, or around US$2, in all these establishments. The difference in pricing between these establishments can be seen in the definition of procedures. In the CSIs, all nursing acts are priced. This is the case for injections, the insertion of infusions and urinary catheters, and the incision of abscesses and panaris, the costs of which appear on the posters. At the CM level, these procedures are not included in the posted prices. According to the doctor in charge, these procedures are included in the cost of the nursing or medical consultation. At the CM, a medical consultation with a general practitioner costs 3,000 F

CFA (US$5). This cost rises to 6,000 F CFA (US$10) with specialist doctors. The cost of ultrasound scans ranges from 8,000 F CFA (US$14) for obstetrical or pelvic scans to 20,000 F CFA (around US$34) for Doppler scans.

The people we interviewed felt that these costs were affordable. The head of the CM illustrates this point by saying: “Our prices are set in such a way that the average Burkinabè can afford to be treated here. A consultation with a general practitioner costs 3,000 CFA francs. Well, I'm not advertising it, but I think it's reasonable all the same” (E4, CM manager, employee). This statement indicates that service costs are similar to general practice in private facilities. What emerges is that these costs are only accessible to certain social categories of the population, notably those with migrants abroad, civil servants, especially from the private sector, who work in the area, and shopkeepers. Families with migrant members are recognized as having much greater access to private health services. Clearly, thanks to remittances, these families are in an advantageous financial situation, enabling them to improve their living conditions (Tapsoba, et al. 2022).

The comparatively short waiting time for care in public health centers is also an element of relevance to the opportunity. In view of the waiting time, the private sector is thus positioned as an elective alternative for this category of the population.

This argument corroborates the results of a study on the satisfaction of beneficiaries of healthcare services in Burkina Faso, which showed that patients who consulted a private healthcare facility waited less time for access to care than they did in the public sector (INSD, 2023a). The availability of private health services in these rural areas suggests that the legendary poverty of rural areas conceals inter- and intra-rural differentiation (Dit Ndongo Dimé 2002). Dit Ndongo Dimé cites the case of Côte d'Ivoire, where rural areas are relatively wealthier than the economic capital Abidjan (Dit Ndongo Dimé 2002) (Bamba 2001). These results show that Béguédo and Ouarégou are perceived as rural areas that escape the systematic economic domination of the urban over the rural.

3.3 Integrating Homecare into the Package of Services Offered

The provision of homecare services within the healthcare system is complex, as the contours of its practice have not been clarified. In the course of this study, private health establishments integrated homecare into their package of activities, even though these were defined by the health system according to its hierarchical position. All respondents acknowledged that they provide home care. This home care is more expensive than that provided in the health facility. However, the arguments developed by the providers surveyed to justify this practice in some cases relate to altruism, the feeling of doing a good deed, and the social proximity between certain caregivers and those seeking home care. In the interviewees' speeches, the financial argument is often relegated to second place, or even deliberately concealed. Because of the humanitarian nature of their field, healthcare providers awkwardly try to exclude themselves from the quest for financial benefits. For some patients, however, treatment monitoring is essential, especially for infusions, whether at the health center or at home, and requires the presence of a clinician. The question then arises as to how a professional driven by the spirit of an economic operator can use his time, invest in travel and pretend to neglect the financial aspect? The integration of homecare, which is not contained in the approach of public structures, therefore appears to be an innovation.

3.4 Promoters' Motivations for Private Healthcare Investment in Béguédo and Ouarégou

The promoters of private for-profit healthcare establishments justify their decision to invest in rural areas through a number of different rationales. These social logics are not

isolated from one another, but intertwined in the Sardonian sense (De Sardan, 2001). For the sake of theoretical clarity, however, they will be presented in isolation.

a. Altruistic Posture as a Source of Motivation

Altruism is one of the rationales used by promoters/managers of private health care facilities to justify their choice of the rural environment. The decision to set up a facility is motivated by the desire to help improve the health services available to the population, and thus save lives. The decision to set up a private healthcare facility in Béguédo or Ouarégou is presented as an action whose primary aim is not to make a profit. A few words to illustrate this altruistic reading:

> People living in rural areas also need treatment. Should we abandon them? I think the choice was right. What's more, I've worked with them for over 20 years, so why not do something for them to help them, that's what motivated me (E1, Registered Nurse, owner-developer).

In the same vein, another promoter asserts: “Some people are looking for health, so why not come and help them rather than crowd into the city” (E2, State-qualified nurse, promoter-owner). In Algeria, altruism figures among the motivations stimulating the emergence of private clinics (Zehnati and Peyron, 2015).

However, drawing on Marcel Mauss's conceptualization of the gift, it appears that this altruism is an alibi for socializing the economic motive underlying these promoters' investment decision. Triangulation of these data with the waiting time for health services shows that these areas are analyzed as presenting business opportunities in terms of migrant remittances. Numerous studies have shown that financial motivations, in particular the search for profitability, are at the root of the expansion of private, for-profit healthcare provision (Zehnati and Peyron, 2015; Konan, Oura, and Fournet, 2022).

As a reminder, the particularity of the research areas lies in the fact that they have a strong community in international migration. Few households in these localities do not have at least one migrant in Italy, where the Bissa are the most numerous among the Burkinabe diaspora (Bredeloup and Bertoncello, 2016). This strong migration of the Bissa to Italy and other countries has contributed to the social and economic development of these localities (Bancé, 2021). Rural migration contributes to improving living standards. Data from three surveys carried out in Burkina Faso show that “the higher the proportion of migrants in a household, the higher its standard of living. Migrants from poor backgrounds transfer more money, and their transfers contribute significantly to the upward mobility of their families back home” (Tapsoba, et al. 2022, 98). Analysis of the profile of the poor in the Centre-Est region shows that in 2021, the incidence of poverty in the commune of Béguédo was 10% (the lowest in the region), compared with a regional average of 49%. The commune of Béguédo is the lowest contributor to regional poverty at 0.5% (INSD, 2023).

Moreover, the rural status conferred on these sites underscores the need to “re-examine” the dynamics of these societies. Thus, Ouarégou and Béguédo constitute a limit to the characterization of the rural environment as “poor” on the one hand, and the conceptual paradoxes of urbanity on the other. For example, Béguédo, which has all the definitional characteristics of a town, is still considered by the administration to be a village rather than a town (Bredeloup and Bertoncello, 2016). In 2019, the commune of Béguédo had 28,094 inhabitants, including 21,894 in the commune's chief town (78%), and the village of Ouarégou had 3,126 inhabitants (INSD, 2022).

b. Reciprocity as a Motivation for Choosing the Village Where to Locate the Private Healthcare Facility

Contrary to altruistic logic, which presents the choice of social action as disinterested, reciprocity assumes the opposite. This is a form of gift and counter-gift supported by Mauss. In the present study, it's the direction of giving and counter-giving that varies according to each promoter's personal history. For the natives, the village gave them everything, and they in turn had to give something back.

> He's from Ouarégou, and as the saying goes: charity begins at home. Hence the choice of this site for the center. This is where his roots are, this is the village that made him what he is, so if he's going to do something, it's got to be here first (E4, CM manager, employee).

This point of view fits in with the theory of social attachment and its recognition dimension. For the respondents, since the base community has offered protection to its individuals, it's up to them to show their gratitude in return by putting their skills at the service of this community. It should be noted, however, that this line of argument comes from a CM manager who believes that the promoter's logic is one of social recognition. In the same vein, this respondent assert: “When I look at my village, I see that the population is large, yet there are only two CSPSs. That's why I set up this structure there, because it has given me everything and I had to do something in return” (E2, State-qualified nurse, property developer). This posture is taken into account in what Paugam (2016) calls the duty of recognition useful for social integration.

For non-native promoters, the reverse is true. In fact, it's the village that should give back to them, in view of their personal investment in the health of the population, since they have spent almost their entire professional career in these villages. The arguments behind this vision of the counter-gift are perceptible in the speech below:

> I've been in this village for over 20 years, and I gave my best when I was CSPS major. Everyone knows me, and many people encouraged and supported me when I wanted to open my own practice. So, it's because of what I've done for them and for the village, that they've supported me (E1, qualified nurse, promoter-owner).

In reality, the respondent conceals his own motivations. He fails to analyze the context, which is favorable to the development of a private healthcare business. His knowledge of the environment studied served to measure the feasibility of his business opportunity. The frequentation of his center could be explained by the existence of patient demand. Another factor to consider is the development induced by migrants through investments in their localities of departure, notably Béguédo (Bredeloup and Bertoncello,2016). These actions increase the population's purchasing power, predisposing them to resort to private centers for healthcare. It is with regard to the capital internalized in rural areas through migration that Tapsoba et al. (2022) formulate the hypothesis of the significant importance of migration in reducing inequalities both between environments of residence and between individuals. This hypothesis confirms the importance of economic analysis in the decision to invest in rural areas.

c. Taking into Account the Saturation of Urban Health Centers

When it comes to the supply of private health services, the literature shows that urban environments are centripetal. In Burkina Faso, whatever the data source, urban areas concentrate more private health facilities than rural areas (World Bank, 2012; Ministry of Health, 2020). Competition between private health facilities is severe, particularly in certain central districts of the city (Cadot and Harang, 2006). This fact is taken into

account in the promoters' analysis of the location of their facilities. Three out of four respondents cited the high number of private healthcare facilities in urban areas as a reason for choosing rural locations. Taking saturation and the resulting social competition into account is a logic that prompted the promoters to choose the rural environment over the city: “As far as I'm concerned, I've seen that crowding into the city isn't a good idea, because there are already a lot of private facilities there. It's better to stay here (Béguédo)” (E3, surgical health attaché, owner). The choice of Béguédo or Ouarégou appears to be a choice where competition is still weak, but demand for private services is strong. Thus, the factors that motivate the decision to invest in this environment derive from the evaluation of social attachment as well as economic capital.

The players interviewed pretend to conceal economic profitability as a source of motivation for setting up a facility in a rural environment. When they do allude to it, they defend themselves by pointing to the induced financial burdens that justify not only the definition of care packages, but also the tariffs for such care. However, a cross-analysis of the different rationales behind this choice reveals not only a financial rationale, but above all a concern for profitability. Factual elements such as investing in rural areas to avoid the increased competition in the city (Cadot and Harang, 2006) and choosing localities where they have social connections support this analysis.

These results confirm that, whatever the location, the logic of profitability underpins the creation of private healthcare establishments (Konan, Oura, et Fournet, 2022), and this logic is achieved through a detailed analysis of the environment, departing from the official constructs attributing a poor face to rurality.

d. Methods of Payment for Private Health Services

Access to health care in private, for-profit facilities is conditioned by payment for the various procedures. While direct payment for health care is the most common method of payment used in the facilities surveyed, a post-payment system is also applied. This strategy concerns patients whose healthcare costs are paid for by international migrants, especially from Italy. Procedurally, three practices can be described. The promoters of private care centers report directly to the migrants, who then reimburse the care-related expenses. This option is mainly applied by IHC promoters, whose main characteristic is that they are not natives of the locality. The natives, on the other hand, prefer the post-payment approach, reporting to the migrants who, instead of paying directly, transfer the costs of care to their families, who then reimburse them. This procedure adopted by natives owning private health centers is designed to avoid conflicts due to their closer social ties with migrant families. Direct payment to promoters without going through the family is less tolerated, as it is perceived as interference in the family's health management.

> For me, you come, you consult and he or I can report back. But more often than not, if you deal directly with them [migrants], it can create problems with the family. Those in the village may say that you're doing business with their migrant brother. For the reimbursement of treatment costs, the transaction goes through their brother or family member to reach me (E3, surgical health attaché, owner).

This procedure is also an information mechanism, skilfully disseminated through generosity, which consists in informing the family of the burdens borne by the emigrant.

Finally, recourse to the two post-payment procedures, although rare according to the respondents, is mainly applied by promoters who are not natives of the two localities.

These three payment methods were recognized by the returnees interviewed. When they were abroad, they most often intervened with health center managers in the event of health problems in their families:

> When I was on an adventure, it was common to call the person in charge of the health center to say that a member of the family is coming for treatment, and then I'll pay. Often, it's the manager who takes stock and I pay, and sometimes it's the family who takes stock and I send the money for reimbursement (E6, returnee).

This logical action, whatever its form, is not free of social constraints. The implementation of this differentiated post-payment system with patients whose members are international migrants supports the idea of a rational analysis of the environment prior to investment. The adoption of this payment method enables them to increase the volume of their patient base (Zehnati and Peyron, 2015), which is the main source of revenue for private healthcare establishments. This post-payment system adopted in all the private centers visited targets households with international migrants, thus confirming the relationship between migration and the promoters' choice to locate their private healthcare structure in these two localities.

IV. Conclusion

Promoters of private health establishments prefer to locate their facilities in urban areas. The logic of profitability explains this preference. However, analysis of data from the Burkina Faso Ministry of Health shows that more and more private health centers are being set up in rural areas, which are considered to be poor. The aim of this study was to identify the motivations behind private health investments in so-called poor environments. Using a qualitative approach, this research identified the rationale behind the choice of rural areas for the installation of private healthcare facilities, whose ultimate aim, like that of urban areas, remains profitability. Promoters don't systematically brandish this argument, but the fact remains that an investment in principle aims to make a profit. In the case of the rural environment, social attachment is the capital from which the profitability analysis is conducted, thus contributing to the “reconsideration” of the poor character of the rural environment.

Patients who attended private health centers were not included in this study, in order to gather their opinions on the sources of financing for care, the services they received, their assessment of their satisfaction, etc. This is an inerrant limitation of the study. This inerrant limitation of the study's objective is presented as a perspective that will complement the present study in order to apprehend private health provision in rural areas from a holistic perspective.

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