

***The Use of Research for Decision-making in the health
sector***

**The case of “Shared Care”
in Burkina Faso**

Ansgar Gerhardus*, Karina Kielmann*, and Aboubakry Sanou**

Submitted in January 2000

*Department of Tropical Hygiene and Public Health, University of Heidelberg,
Germany

**Centre de recherche en santé de Nouna, Burkina Faso

Table of Content

I.	Introduction	1
II.	Chronology and content of shared care	4
III.	Methods	6
3.1	Document analysis	
3.2	Semi-structured interviews	
3.3	Focus group discussions	
3.4	Data analysis	
IV.	<i>Shared Care</i> : Research and its context	8
4.1	Research underlying the <i>shared care</i> agenda	8
4.2	The researcher's position	10
4.2.1	Researcher's statement of the problem	
4.2.2	Research dissemination and communication	
4.3	Decision-makers' perceptions of the research	11
V.	The decision-making process: The context and the stakeholders	12
5.1	The context	12
5.1.1	Macro-level	
5.1.2	Micro level	
5.2	Stakeholders, their interest, influence, and involvement	13
VI.	Conclusions and recommendations:	22
6.1	Factors relevant for research use and non-use	22
6.1.1	External factors for research use	
6.1.2	Internal factors for research use	
6.2	Recommendations	25
	References	26
	Annex	28

Tables and figures

Tables

II-1	Chronology and content of <i>shared care</i>	4
IV-1	Research underlying the concept of <i>shared care</i> in Burkina Faso	9
V-1	Stakeholders, their interest, degree of involvement and activities	19

Figures

V-1	The stakeholder-oriented model of decision-making	14
V-2	The stakeholders involved in the decision-making of <i>shared care</i>	18

I. INTRODUCTION

The COHRED Working Group "Research to Policy" aims to analyse and improve the use of research for rational decision-making and the promotion of equity in the health sector. One of the strategies chosen is to support country-case studies which are focussing on the research to policy link.

We have chosen to investigate the issue of *shared care* in Burkina Faso.

The concept of *shared care* is built on the idea that mothers and health workers can jointly assume and complement each other in informed recognition, care-taking and treatment-seeking for childhood illnesses. The concept was proposed by a group of researchers, who had done a series of studies on health services, medical care-giving at the household level, and inter-household distribution of disease.

Apparently there seemed to be good reasons for implementing the concept of *shared care*. In rural Burkina Faso, child morbidity and mortality remain extremely high, the quality and the utilization of the existing services are low, while costs for treatment are out of reach especially for the most vulnerable groups. However, while being on the agenda for more than ten years, *shared care* has not been put into action up to today.

As the cause for this non-implementation did not appear to be obvious to us, we had decided to analyse this case in order to learn more about the constraints keeping research recommendations from being put into action.

The study was conducted between July and December 1999.

The purpose and the objectives of this study were as follows:

Purpose

To increase the use of research for policy-making for the ultimate purpose to reduce morbidity and mortality in children under-fives.

Overall objective

To elucidate factors constraining or conducive to the translation of Solenzo research results into interventions in shared care.

Specific objectives:

- 1) To describe the decision-making process in the health sector in Burkina Faso.
- 2) To describe the environmental conditions (e.g. perception of the problem by stakeholders, studies on related subjects) from the time when the topic got on the agenda.
- 3) To identify stakeholders, their role in defining the problem and the research question, their goals, their means to pursue their goals, their influences, and networks.
- 4) To determine whether the research conducted to date is adequate for the process from a stakeholders' perspective.
- 5) To assess communication and dissemination of the research results.
- 6) To determine the conditions for establishing research to policy and a policy to research link.

Following this introduction we will describe briefly the history of *shared care* and its context. After explaining the methodology used, the research that lead to the suggestion of *shared care* will be presented in chapter IV. As the decision-making process depends on people and institutions, an extensive stakeholder analysis was done and its results are described in chapter V. In the concluding chapter we analyse and discuss the results, in order to identify the lessons to be learnt from this case.

The following hypotheses which had been formulated before the onset of the study:

- 1) The concept of *shared care* can only be implemented if it fits into the cultural, political and economic context.
 - 1.1. Health System: Mothers have to be accepted as equal partners in health care by the representatives of the professional health system.

- 1.2. Gender: Women will have to agree on the additional workload and responsibility.
 - 1.3. Economics: Current pressure for cost control in the health sector will push the adaptation of *shared care*.
 - 1.4. Men are often the decision-makers at the household level and will control the expenses for drugs and training (money and time).
- 2) The researchers' implicit list of stakeholders has not been exhaustive. Especially the goals and needs of stakeholders who are decisive for the *implementation* of *shared care*, like health centre staff and mothers, have not been taken sufficiently into consideration.
 - 3) From the stakeholders' perspective the research conducted is not adequate to start a broad-based implementation of shared care.
 - 3.1. It has not been sufficiently clarified who will do the training.
 - 3.2. Incentives, logistical and material support for the trainers was not considered.
 - 3.3. There is insufficient evidence that mothers will be able to carry out the new tasks adequately.
 - 4) To make *shared care* sustainable, institutionalized channels of communication and co-operation among key-stakeholders have to be installed.
 - 5) Decision-makers did not express and specify their research needs, thus making it difficult for researchers to do research according to the decision-makers requirements.

II. CHRONOLOGY AND CONTENT OF *SHARED CARE*

The history of collaboration between the University of Heidelberg and the Ministry of Health, Burkina Faso spans nearly 20 years. The following table presents significant events related to the *shared care* research agenda during these twenty years.

Table II-1: Chronology and content of *shared care*

Time period	General Political and Health Policy Context	Specific events related to <i>Shared Care</i> agenda
1979-1983	Implementation of the CHW programme in Solenzo (1980)	First request from MOH to evaluate primary health care quality
1983-1987	National Council of the Revolution Plan Populaire de Developpement (PPD) Opération un village un PSP	Research conducted in Solenzo (1985)
1987-1991	Bamako Initiative	Planning workshop on operational conclusions of the Solenzo study (1988) during which results of the study concerning factors influencing health care utilisation were discussed. Intervention-based research proposal submitted (1989)
1991-1999	Concentration on sector reform issues, like decentralisation, quality of care, reform of the financing of the health sector Establishment of pharmacies providing essential drugs in project area.	Intervention-based research proposal submitted to BMBF (1993) Interface conference (1997)

1983-87 In 1985 the MOH commissioned a study on the primary health services utilisation and quality which was conducted in Solenzo, Banwa Province, Burkina Faso. The Solenzo study marks the beginning of scientific co-operation between Heidelberg University and the MOH. During this period, research was conducted on the utilisation of CHW's, TBA's, and traditional healers, as well as the quality of MCH services and seasonal, gender and age variations in household allocation of resources for illness. A summary of the published findings resulting from this study is shown in Table IV-1.

1987-1991 The results of the research conducted in Solenzo were discussed at a workshop in 1988, organised jointly by the MoH and the University of Heidelberg. In the course of this meeting, researchers proposed the strengthening of the interface between mothers and peripheral health care posts (CSPS) as a strategy to reduce the morbidity and mortality in children under-five.

1991-1995 In 1991, the MOH chose the health districts of Nouna and Tougan, in Kossi and Sourou Provinces respectively, as project zones for research contributing to the identification of major causes of morbidity and mortality and the strengthening of district health services. A principal focus of interest continued to be how to provide low-cost, but effective care to children under five. Hence, the ideas of improving mothers' skills in home treatment as well as their access to health services remained important and were reformulated in a research proposal submitted to the German Ministry for Education and Science (BMBF) in 1993. The proposal construed *shared care* as a combined action-research intervention trial. In the intervention phase, mothers were to be trained by the health centre staff to diagnose and treat common childhood diseases and to identify situations when a referral to the professional health services was needed. This included a re-definition of the role of health centre staff, as they were to train mothers and accept them as partners in the treatment of the children. Training was supposed to be stratified for women who were already leaders in specific women's groups, mothers in general and mothers of at-risk households. The research phase was to involve the monitoring of output indicators through the health information system.

1995-1999 In the following years several studies about the quality of care and the perception of childhood illnesses were conducted, which indirectly contributed to a better understanding of child health in the project area. During 1997, the interface conference held in Ouagadougou offered researchers another opportunity to reflect on the feasibility of *shared care*. At this time, researchers felt that it would be beneficial to limit the scope of *shared care* activities to target areas that 1) were the most common complaints in the area; 2) were already in the MOH agenda and 3) for which MOH management guidelines and relatively low-cost, low-tech care options exist. Diarrhoea and fever (most commonly associated with malaria) matched these criteria and were thus chosen as the target childhood illnesses to concentrate on. However, until the present day, the concept of *shared care* has not been implemented. Hence, the main question underlying the following chapters is:

What were the factors constraining the implementation of intervention-based research related to shared care, as proposed in 1989 and again in 1993?

III. METHODS

3.1 Document analysis

In order to identify the major stakeholders in *shared care* and to better understand the *shared care* agenda as proposed by the researchers, we compiled and reviewed the following documents:

- Published articles and monographs resulting from collaborative research conducted by the University of Heidelberg and the MoH, Burkina Faso;
- Research proposals on *shared care* submitted by the University of Heidelberg researchers;
- Minutes and reports of meetings and workshops conducted during 1988 and 1999 regarding the development and activities regarding *shared care*.

3.2 Semi-structured interviews

Semi-structured interviews were conducted with decision-makers and researchers in order to get a better sense of the environmental context at the time *shared care* was launched, to determine the stakeholders' relative involvement and influence in the process and to determine to what extent research results played a role in the decision-making around *shared care*. A list of all interviewees as well as the guidelines for interviews with decision-makers and researchers are included in Appendix 1.1, 1.2 and 1.3 respectively.

3.3 Focus group discussions

Focus group discussions (FG) were conducted with target groups, including health centre (CSPS) staff, women's groups and groups of mothers. Since these groups had previously not been included in the discussions around *shared care*, the focus groups had the purpose of finding out to what extent these groups were aware of the ideas of *shared care*, and whether they felt the ideas were practicable. CSPS staff was interviewed in Bourasso and Toni, the FG with women's groups and mothers were held in Dara and Sobon. The guidelines for interviews with the health staff, women's groups and mothers can be found in Annex 1.4, 1.5, and 1.6 respectively. The FG were conducted by Aboubacry Sanou in Djoulya language.

3.4 Data analysis

The stakeholder analysis followed partly the method proposed by Reich (Reich and Cooper 1996).

IV. SHARED CARE: RESEARCH AND ITS CONTEXT

4.1 Research underlying the *shared care* agenda

By research underlying the ideas of *shared care*, we refer to baseline research that was conducted in Solenzo between 1985 and 1988 and funded by the European Commission. As already noted, actual research implementing and evaluating the *shared care* approach has not been carried out to date. Table IV-1 presents the seven publications based on the Solenzo study, that are cited by the researchers, and to a far lesser extent, by the decision-makers, as providing justification for the *shared care* approach.

Table iV-1 Research underlying the concept of shared care in Burkina Faso

Authors/date	Main research question(s)	Source of funding/Type of research	1 Operational and policy recommendations 2 Recommendations for further research
1. Sauerborn, Nougara and Diesfeld 1989	Utilisation of CHW's in relation to other sources of health care	EC/Household survey	(1) Withdraw from concept of CHW as provider of basic curative care; improve skills of mother as providers of care and those of peripheral professional health services, CHW remains a community-based contact and resource person.
2. Nougara, Sauerborn, Oepen and Diesfeld 1989	Determinants of utilisation of TBA's versus professional health workers	EC/ Household survey	(1) Sensitisation of the population to benefits of MCH care should be linked to improving the quality of care package. (2) <ul style="list-style-type: none"> • Study of impact of gov't CHW programme on utilisation of MCH services • Gap between mothers' and professionals felt needs for surveillance of health.
3. Sauerborn <i>et al</i> 1989a	Acceptability of MCH services	EC/ <ul style="list-style-type: none"> • Time and motion study • User survey 	(1) Technical and organisational changes in delivery of services
4. Sauerborn <i>et al</i> 1989b	Effectiveness of MCH services in identifying mothers and children at risk	EC/ Time and motion study	(2) Identification of valid and operationally sound cut-off points for risk factors in MCH care needed
5. Sauerborn and Nougara 1992	Utilisation of traditional healers and traditional home remedies	EC/ Household survey	(1) Focus on mothers rather than traditional healers; Use social marketing to improve their knowledge and skills in providing home-based care
6. Sauerborn, Berman and Nougara 1996	Are household resources for health care allocated along gender or age criteria?	EC/Household survey, time allocation study, qualitative interviews	(1) Reduce costs of effective child health interventions (cross-subsidies, health insurance)
7. Sauerborn, Nougara, Hien and Diesfeld 1996	Seasonal variation in perceived illness, health seeking behaviour and household expenditures on illness	EC/Household survey	(1) Strengthen health care capabilities within village and households.

4.2 The researcher's position

4.2.1 Researcher's statement of the problem

Childhood illnesses and deaths are not spread regularly throughout the families, but are often concentrated in at-risk households (Sauerborn, Adams and Hien 1996). They perceived to be more severe than adult illnesses, however, professional biomedical care is preferentially allocated to adults, while children are treated at home (Sauerborn, Berman and Nougara 1996). Mothers are the primary care-givers in the case of childhood illnesses. They are the first persons to make the diagnosis and often confuse illness entities with symptoms (Pagnoni et al. 1997). In the majority of childhood illnesses, mothers use traditional methods to treat the child (Sauerborn and Nougara 1992). Village health workers, who were put into place as a link between the population and the health services, are not used (Sauerborn, Nougara and Diesfeld 1989). Health services remain inaccessible for children, especially during the rainy season. This is due to cost, both economic and in time, that mothers have to expend if they seek health care outside the household. When mothers do seek health care at the CSPS, communication between mothers and the health personnel is poor (Sauerborn, Nougara and Diesfeld 1989).

4.2.2 Research dissemination and communication

Results of the research conducted in Solenzo were disseminated in the form of reports and presentations to MoH officials and responsible physicians in the district through meetings. They were not disseminated to the target groups, that is, the groups who were intended to implement and directly benefit from the research. On the other hand, some local researchers were themselves decision-makers, either working at the provincial or district health levels.

Researchers saw themselves as advocates for the recommendations of their results. They actively sought the contact to the MoH and used different forms of communication.

4.3 Decision-makers' perceptions of the research

Decision-makers who had been involved in the research agenda for *shared care* commented that applied research *per se* was a generally new idea in the 1980's. For the MoH, research and its application only became priorities during the late 1980's, witnessed through the creation of a separate Health Research Unit. This unit was intended to closely review and monitor the progress of health and health systems research in the country. Even in the 1990's, however, some commented that although research projects should ideally influence health systems and policy-making, the lack of continuity in research teams and the high turnover among decision-makers often meant that: "*we are never able to finish what we start*".

Persons attending the interface meetings knew the content, conclusions and recommendations regarding *shared care*. However, there was general agreement that the issue of *shared care* had been put on the agenda by the researchers. One interviewee commented: "*We asked ourselves whether these ideas had been parachuted from Heidelberg*".

Decision-makers perceived the research results as an adequate description of the situation (mothers as primary caregivers, poor access to health system, etc). They did not question the validity of the results. However, the MoH-officials apparently did not perceive the researcher's material as something, which could have prompted an action from their side. Interviewees felt that a clearly defined strategy for how to proceed in the field was lacking. They also commented on the lack of mechanisms for the monitoring and evaluation of the intervention.

MoH officials also mentioned that some of the reports were not read. They appreciated therefore interface meetings, and regarded them as appropriate for information transfer. However, because of the high turnover in responsible positions, it was claimed that participants at the meetings were often not necessarily the ones to take the decisions later.

Strikingly absent was any sense of *institutional* ownership by the MoH of either the research underlying the *shared care* concept or the proposal for the intervention

study. Apparently this has not been changed much by the fact that some decision-makers of today had been involved in the research projects.

V THE DECISION-MAKING PROCESS: The context and the stakeholders

5.1 The context

5.1.1 Macro-level

In the 80s, following the Alma Ata declaration, in Burkina Faso as in most Southern countries worldwide, village health workers (VHW) formed an important arm of the PHC approach. In Burkina Faso, more than in other countries the central government acknowledged and assumed an extensive responsibility for the population's health care. The "commando" approach, as it is referred to, was visible, for example, in the immunisation campaigns as well as the widespread slogan "for every village, a primary health care post (PSP)".

The *shared care* strategy with its emphasis on the mothers as medical caregivers was perceived as countering these efforts as it apparently undermined the authority and the utilisation of the VHWs.

The end of the 1980's and the 90s have witnessed internationally a growing interest in health sector reform and health financing mechanisms. One of the prominent elements of sector reform has been decentralisation. To understand *shared care* as part of the decentralisation process could have been a possibility of embedding it into the context at the time.

5.1.2 Micro level

Mothers are the primary medical caregivers of their children. This could be shown for Burkina Faso (Sauerborn, Nougara and Diesfeld 1989) and it is true for many other countries. So apparently it was to expect that a strategy that builds on this fact should not encounter strong resistance. However, several questions have to be tackled, such as the additional burden for mothers, their confidence in recognizing signs &

symptoms and giving medication, their trust in other women to treat their children, and the position of the husbands.

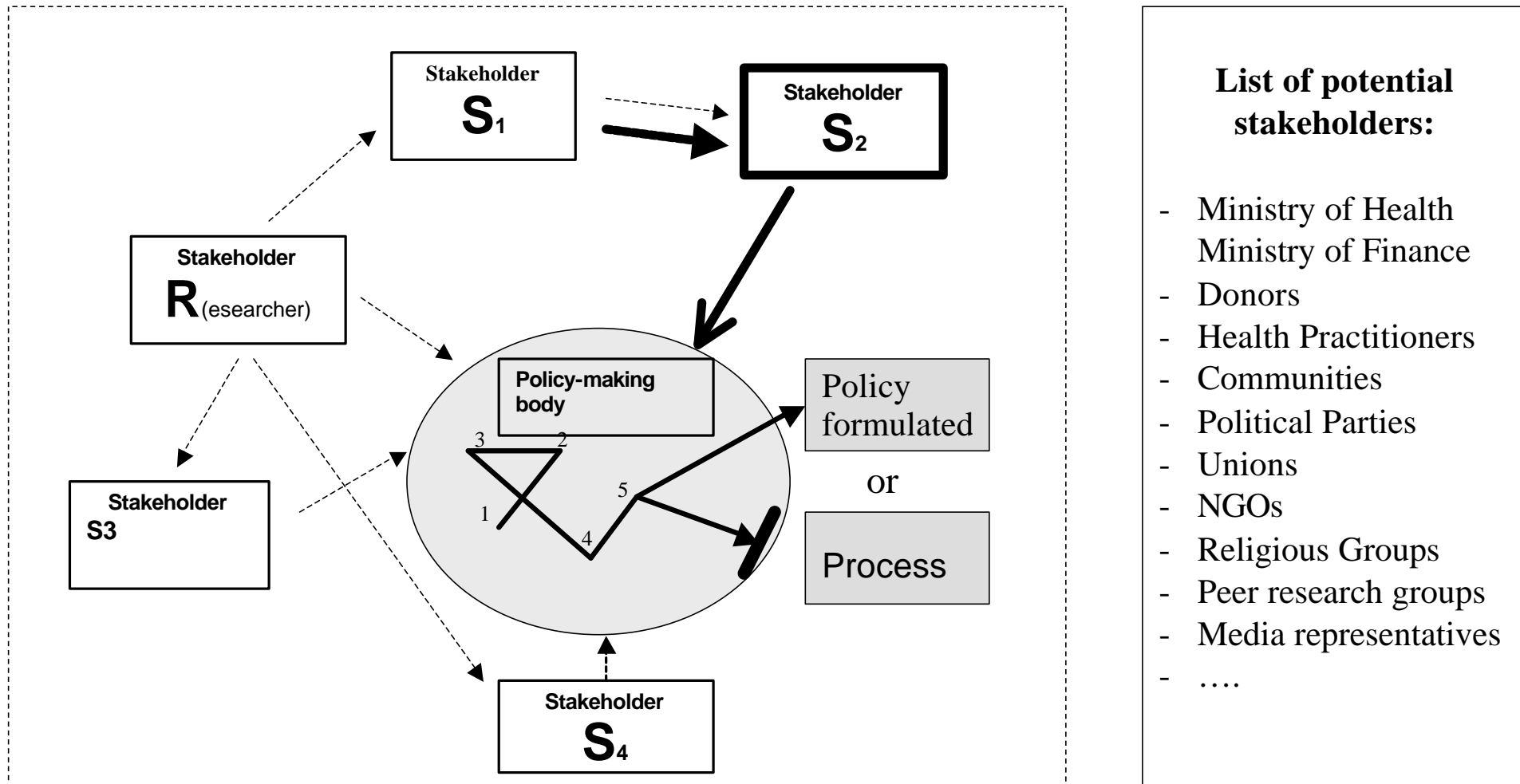
Focus group discussions with women groups and mothers revealed no contextual constraints in this sense (for details see below). However it has to be emphasized that in the perception of some of the stakeholders (MoH, health staff) these constraints were relevant and might have contributed to the reserved attitude towards *shared care*.

5.2 Stakeholders, their interest, influence, and involvement

For the description of the decision-making process, we used the stakeholder-oriented approach. A stakeholder, in a modified version of Freeman's definition is an individual who has an effect on, or is affected by a process (Freeman 1984). The advantage of this approach is that it is not limited to the active, visible players, but takes also into account the often invisible but not necessarily weaker influence of stakeholders who are not directly involved in the process of decision-making. Their power can be described as passive; they are not influencing the formulation of a policy actively but without their active support the concept can not be implemented successfully.

This concept is presented in Figure V-1.

Figure V-1: The stakeholder oriented model of decision-making (Sauerborn et al 1999)



Using the stakeholder-oriented framework of research use: The flow of **research results** is indicated by the **dashed arrows**. The **solid arrows** signify the direction and the level of **influence** which stakeholders S₁, S₂, S₃, and S₄ exert on the policy-making body on other stakeholders (the thick line indicating stronger influence). The stakeholders' relative power is reflected by the thickness of the frames. The non-linear character of the policy-making process is shown inside the shaded oval.

In this example it is assumed that the researcher (Stakeholder R) does not have access to the powerful stakeholder S₂. Knowing about the relationship between S₁ and S₂, he can still influence the policy-making body indirectly.

As mentioned above, *shared care* was first discussed at a workshop in 1988 organized jointly by the MoH and the University of Heidelberg. The researchers expected the MoH to execute the intervention while the researchers would monitor and collect data on the intervention.

For the **researchers from Heidelberg**, the concept of *shared care* was a logical consequence, following the results of the Solenzo studies, presented in Table IV-1. They used meetings with representatives of the MoH to promote it as a locally adequate mechanism to reduce childhood mortality and morbidity.

The **MoH-DEP** (Direction des Etudes et de la Planification) did not provide any active support for implementation of the concept. This becomes understandable if the context is considered (see above). In part *shared care* was competing with the recently VHW-approach. Apparently it did not fit into any of the major programs launched internationally.

It is important to note that the degree of involvement by the MoH-DEP was interpreted differently by the researchers and by the MoH-DEP. Researchers commented that the MoH-DEP has been included in all the discussions and that researchers had always pursued an active transfer of research results. In contrast, the DEP representatives attributed a different weight to their presence in those meetings. In interviews many of them had problems to remember more than rough structures of *shared care*. In addition they stated that the lack of staff at that time resulted in the participation of persons who were not necessarily the most relevant for the implementation of *shared care*.

The **provincial staff** was included in the discussions but did not play a major role in the decision-making process. More practical issues regarding the logistic organization were revealed during informal interviews carried out with the district health team (*équipe cadre du district*, ECD) and the health centre staff in the project area (Sanou 1998). While the idea of *shared care* was welcomed as a means to improve relations between health personnel and patients and to reduce health care costs, queries were raised regarding the choice of villages for piloting the strategy, the organisation of mothers, the incentives for health personnel and the lack of

working materials in health facilities. One of the interviewees stated that the location for the intervention has been changed after a meeting in which a different location had been agreed on. They expressed a general support for the idea of *shared care* and stated that if it were tried again now, the context would be more favourable than before.

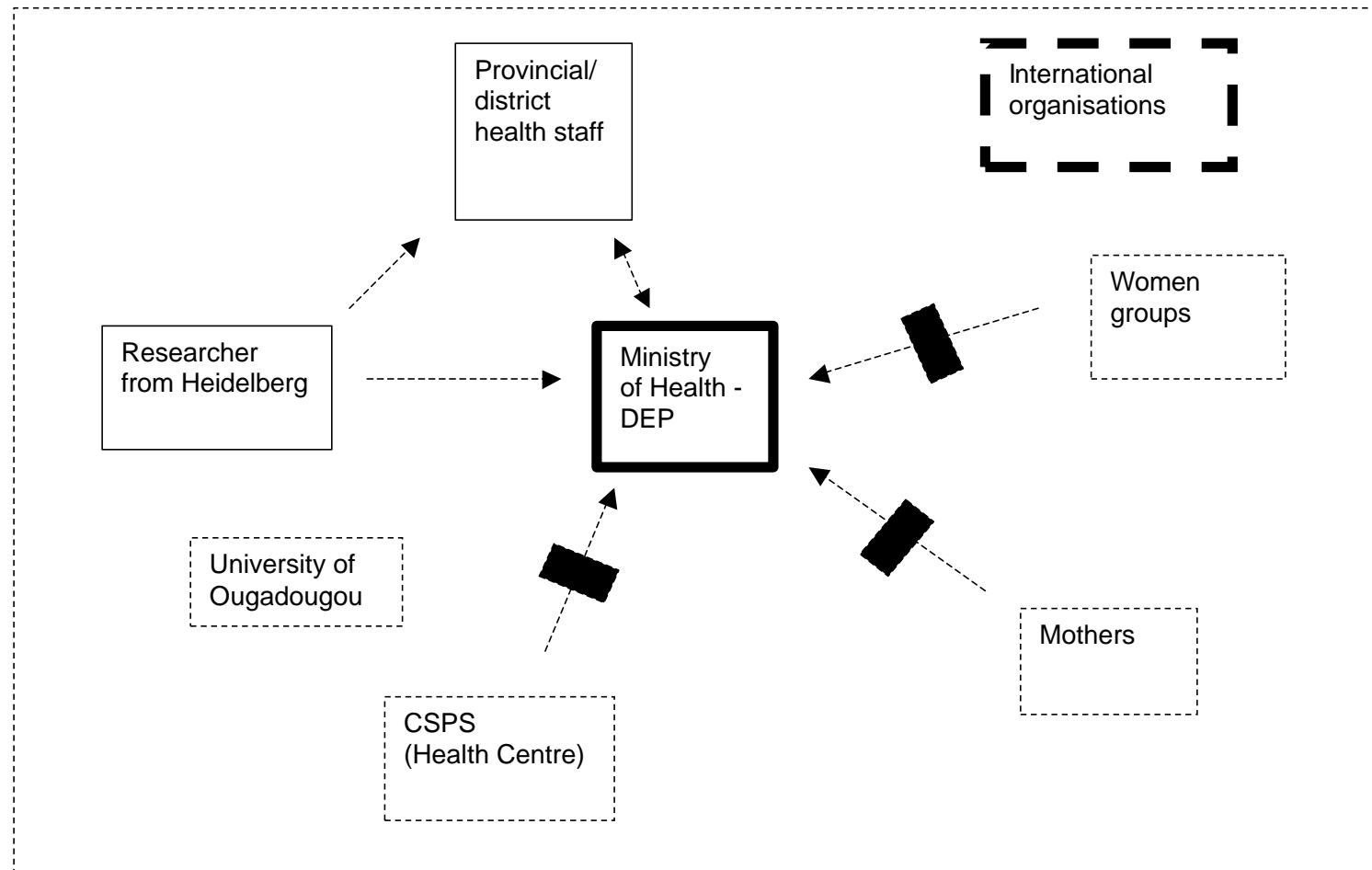
The **Health centre staff (CSPS)**, the women groups, and the mothers were not included in the decision-making process. This led to different assumptions about their ability and willingness to execute the program. Regarding the role of the CSPS, there was a striking contrast between the view of the researchers on the one hand and the MoH-DEP and the CSPS on the other hand. On the basis of their study (Sauerborn, Nougara and Diesfeld 1993), the researchers concluded that the CSPS staff would have the spare time needed to train and supervise women groups and mothers. In contrast one of the interviewed decision-makers mentioned that the CSPS staff was already overloaded with work. This coincided with the perspective of the CSPS staff when they were interviewed. In addition they suggested combining the implementation of the concept with a system of incentives for the health staff (Sanou 1998). It was also not clear if the health staff would accept mothers as partners at a professional level.

Women groups and mothers were assigned a key role in the concept. However they have not been involved in the design of the intervention study. Health staff and MoH-DEP questioned the ability of mothers to perform the tasks assigned to them.

In the focus group discussions women groups and mothers showed great interest in the concept of *shared care* as an adequate mechanism to improve childhood health at low cost. Mothers felt that they could perform this task technically if proper training and supervision will be provided. They acknowledged that it might imply an additional workload but thought it would be bearable. Other potential constraints were related to gender (will husbands agree to their wives performing medical tasks?) and cultural factors (will mothers accept that other women cure their children?). When explicitly asked, women groups and mothers acknowledged the problematic but stated that it could be resolved and would not jeopardise the implementation of *shared care*.

International organisations have not been actively involved in the promotion of *shared care*. A direct involvement was not even desirable. The idea of the intervention study was to perform it under “real-life” conditions, which implied to do it without external funding.

Figure V-2 gives an overview on the relationships between the various stakeholders. Table V-1 summarises the different interests, degrees of involvement, influences and activities of the stakeholders.

Figure V-2: The stakeholders involved in the decision-making of *shared care*

The flow of **research results** is indicated by the **dashed arrows**. The **solid arrows** signify the direction of **influence**. The **blocked arrows** signify that there is the potential to block an initiative, though no active influence was exercised. The stakeholders' relative power is reflected by the thickness of the frames. The dashed frames indicate that these stakeholders have not been involved in the process.

Table V-1: Stakeholder, their interest, degree of involvement and activities

Stakeholder	Degree of involvement / participation	Interest / Position towards S.C.	Influence / Power	Activity/Strategy	Comment
<p>Ministry of Health Department for Studies and Planning (DEP)</p>	<p>The participation of “decision-makers” in the agenda-setting process was referred to as “only nominal”; because of lack of staff at the DEP they “took turns in representing the DEP, without further involvement”. Active participation and support was solicited from the MoH for the implementation of shared care</p>	<p>In the 80s the favourite approach was the installation of Village Health Workers. S.C. was partly perceived as competing with this program.</p>	<p>+++</p>	<p>In the 90s the MoH was not explicitly against the concept, but stated that further research on more practical issues was needed (e.g. on willingness and ability of health professionals to co-operate with mothers, ability of mothers to manage potential drugs, etc.). It also questioned the transferability of results from one area (Solenzo) to the whole country.</p>	<p>High turnover of directors might have played an indirect role in the stalling of events. The current director claims that the MoH is already working on the ideas of shared care (through for example, the national diarrhoea and malaria control programs) and sees the role of PRAPASS research as a “closed chapter”.</p>
<p>Researchers from the University of Heidelberg.</p>	<p>Strongly involved at all stages</p>	<p>To promote the concept of S.C. as a valid, appropriate, and sustainable mechanism to reduce childhood mortality and morbidity</p>	<p>+</p>	<p>Promotion of the idea of S. C. through personal contacts and interface meetings with the DEP and health staff.</p>	
<p>University of Ouagadougou Faculty of Medicine</p>	<p>Initially involved but distanced itself later. The relationship is strained, although attempts have been made to establish links, though this time with the departments of sociology and anthropology.</p>	<p>Not defined</p>	<p>+</p>	<p>No active support No own research on the subject</p>	

Table V-1: Stakeholder, their interest, degree of involvement and activities

Stakeholder	Degree of involvement / participation	Interest / Position towards S.C.	Influence / Power	Activity/Strategy	Comment
Health Staff Provincial level District level	At the province level included in all discussions. At the district level only some persons were aware of all the discussions. Did not contribute / was not involved in development of the concept.	Neutral	+	Tried to some extent to work with women's groups in Nouna on health and sanitation matters. However, child health was not one of the areas in which training was provided.	
Primary health care personnel (CSPS)	Not involved	Would be willing to participate in this program, if they got logistic and financial support. In contrast to the researchers' conclusions they felt that they would need extra time and manpower.	+ Without their willingness and active participation, S. C. is unlikely to function	None	The CSPS has no active influence on the decision. However, as the implementing unit their active support is needed which gives them "passively" power on the decision.
Women groups in the villages	Not involved	Contribute to the reduction of childhood mortality and morbidity. Agree on the concept.	+ Active participation is key in the S.C. concept (care of at risk families)	None	Women groups and mothers need to accept the concept, otherwise its implementation will be jeopardized. "Passive power", similar to CSPS.
Mothers	Not involved	Genuine interest in the reduction of childhood mortality and morbidity. S.C. is a realistic approach for the poor. Expressed willingness to take over certain treatments if they were well advised, and the tasks could be integrated in their daily duties.	+	None	Women groups and mothers need to accept the concept, otherwise its implementation will be jeopardized. "Passive power", similar to CSPS.

Table V-1: Stakeholder, their interest, degree of involvement and activities

Stakeholder	Degree of involvement / participation	Interest / Position towards S.C.	Influence / Power	Activity/Strategy	Comment
International Organisations (IO)	Not involved	There was a lack of interest by IO in the concept of Shared Care.	+++	None	Especially when acting as donors, IO have a huge influence on the decision-making process. In contrast the absence of interest in S.C. by IO presents an obstacle for implementation.

VI. Conclusions and recommendations:

6.1 Factors relevant for research use and non-use

A number of factors, external as well as internal, are decisive for the success or failure of research use. As external factors we consider those that can not or only to a very small extent be influenced by the stakeholders. Internal factors are those which –to a certain extent- can be controlled by the stakeholders. As a guiding principle we follow the hypotheses formulated in chapter I.

6.1.1 External factors for research use

As described above, when launched, *shared care* was not compatible with the dominant approach at that time, the village health worker. In the 90s, a set of specific health reform issues became prominent on the national agenda. It is difficult to assess if it could have helped to make *shared care* part of this agenda, within the frame of decentralisation efforts. Also the increasing pressure for cost control in the health sector could have been supportive for the adaptation of *shared care*. However, there is no indication that the MoH-DEP perceived these external factors as an incentive to adopt *shared care*.

In general, the **status of research for decision-making** in Burkina Faso was described as rather limited at that time. Only in the last years a health research unit within the MoH has been created.

Contrary to our hypotheses, **the socio-cultural environment in the villages** seemed to be in favour of *shared care*. Women's groups and mothers revealed that they would accept the additional workload and did not expect their husbands to keep them from fulfilling their related tasks.

6.1.2 Internal factors for research use

The **stakeholder analysis** has been done extensively in chapter V. It revealed that the researchers achieved to inform the most powerful stakeholder, the MoH-DEP. However, the interrelationships between the MoH-DEP and other stakeholders might have been underestimated. To keep a good relationship with the health centre staff is vital for the MoH so that an initiative which might be received with hostility bears uncalculable risks for the MoH. Therefore it would have been necessary for the researchers to suggest a mechanism which considered the point of view of the staff.

A similar situation could be found regarding the women's groups and the mothers. Their attitude towards *shared care* was not systematically gathered. In this case the focus group discussions indicated that mothers might welcome the *shared care* concept. Researchers in order to support their argument could have used this knowledge. Although the political influence of these groups is rather low, without their active support *shared care* cannot be successfully implemented.

These findings confirm our first hypothesis, which assumed that the researchers did not pay sufficient attention to the stakeholders involved.

Ownership of the research agenda was perceived as being monopolized by the researchers associated with Heidelberg, although it appeared to be a joint project. MoH-DEP members described themselves as rather passive, receiving results and suggestions for future work. This led to the problem that especially questions related to the implementation did not receive sufficient attention. If they were treated, the researchers' perspective dominated. The most prominent example is the diverging perceptions of the workload of the health centre staff. Whereas researchers, referring to their studies, stated that the staff would have the spare time to do the training of the mothers, the staff itself and the MoH-DEP felt that additional personal and/or incentives would be needed in order to cope with this new task. Leaving this problem unsolved contributed to a sceptical attitude towards *shared care*.

The **validity** of the research results was only rarely questioned: Only one interviewee was sceptical about the possibility to transfer results from one region to another.

Rather stakeholders were sceptical if the research results were **adequate** to support the recommendations. E.g. decision-makers saw a gap between the research result “mothers are the primary (medical) caregivers of their children” and the proposed intervention “train mothers how to give medication to their children”. In this case the MOH-DEP questioned the ability of mothers to provide the correct dosage and would have liked to see more evidence before initiating the intervention study. As described above, decision-makers also missed evidence-based suggestions regarding the conditions under which the health centre staff will be in the position to perform the training for women’s groups and mothers.

Communication of research results has been effective to the MOH-DEP and partially to the provincial and district level. Most of these interviewees were aware of the *shared care* concept. However, knowledge seemed to be limited mainly to results and recommendations. Only those who had been personally involved in the research knew more than the most basic key-concepts. Apparently there were no independent discussions of the concept within the MoH-DEP.

It became clear that decision-makers did not have the time to read extensive reports. The joint workshops between researchers and decision-makers were a more successful strategy of transmitting information. However, as single events they **lacked sustainability**; after the workshops the process did not continue on the decision-makers side. Another disadvantage was the fact that it was not always possible for the most relevant decision-makers to attend the workshops.

None of the stakeholders mentioned that a **need for specific research** was expressed. It seemed to be a one-way process in which researchers communicated results without getting more than a general feedback.

In summary, it has become clear that researchers managed to transmit their results. Decision-makers were aware of them, thanks mainly to the joint workshops. However, the process of research for policy was halted at this stage: results and recommendations were not discussed and were not transformed to the proposed intervention study.

The case of *shared care* is an example for a research (and researcher) driven policy development. As in these cases the decision-makers have no interest *per se* in the adaptation of the policy (in contrast to a policy launched by the decision-makers themselves or even by the context) the possibilities for implementation are limited. Chances can be increased if the following recommendations are taken into account.

6.2 Recommendations

- 1) A stakeholder analysis should be done as early in the research process as possible. This enables the researcher to include the most important viewpoints and supports a design which is likely to produce results that are relevant to the stakeholders.
- 2) Ownership by the stakeholders should be encouraged. If they have been assigned an active part during the various stages of the research process, it will be more likely that they perceive the recommendations as theirs. Implementation will become easier.
- 3) Context plays an important role but usually it will not be possible to change the context significantly. A more viable alternative will be the embedding of the policy into the existing context. *Shared care* could be presented as an interesting approach within the frame of decentralisation, cost control, and and enhancement of the quality of care.
- 4) Communication has to be two-sided. Reserachers have to transmit their findings and stakeholders should express thir needs. Time constraints for the reception of information have to be taken into account, as well as the continuous change of key-personal on either side. The health research unit within the MoH should have the potential to enable a sustainable exchange of information, to become an institutional memory and a veritable “broker of information”.

References

- Freeman, R.F. (1984). *Strategic Management. A Stakeholder Approach*. Boston: Pitman.
- Nougara, A. (1996), Morbidité perçue et vécue par la population. *Bulletin d'épidémiologie et information socio-sanitaire*. Ministère de la Santé, de l'Action Sociale et de la Famille, Burkina Faso.
- Nougara, A., R. Sauerborn, C. Oepen and H-J Diesfeld. (1989) Assessment of MCH-services offered by professional and community health workers in Burkina Faso. *Journal of Tropical Pediatrics* 35 (1): 2-9.
- Pagnoni, F, N. Convelbo, J. Tiendrebeogo et al. (1997) A community-based programme to provide prompt and adequate treatment of presumptive malaria in children. *Transactions of the Royal Society of Hygiene and Public Health* 91: 512-517.
- PRAPASS (1997) Conclusions des résultats du projet PRAPASS pour la politique de santé Burkinabé – papier de discussion à l'intention des décideurs Burkinabé. No.2: Implication des mères aux “soins partagés”.
- Sanou, A. (1998) Memorandum sur les soins partagés. Internal report.
- Sauerborn, R. and A. Nougara (1992) Traditional medicine is practiced by mothers rather than by traditional healers-a study in Solenzo. *Curare* 15: 97
- Sauerborn, R., A. Nougara and H-J.Diesfeld (1993) Low utilization of community health workers – results from a household interview survey in Burkina Faso. *Social Science and Medicine* 29: 1163-66.
- Sauerborn, R., A.Nougara and E. Latimer (1994) The elasticity of demand for health care in Burkina Faso: difference across age and income groups. *Health Policy and Planning* 9 (2): 185-192.
- Sauerborn, R., A. Adams and M.Hien (1996) Household strategies to cope with the economic costs of illness. *Social Science and Medicine* 43(3): 291-301
- Sauerborn, R., A. Nougara, M. Hien and H-J. Diesfeld. (1996) Seasonal variations of household costs of illness in Burkina Faso. *Social Science and Medicine* 43 (3): 281-290.

Sauerborn, R., P. Berman and A. Nougara (1996) Age bias, but no gender bias in the intra-household resource allocation for health care in rural Burkina Faso. *Health Transition Review*.

Sauerborn R, S. Nitayarumphong S, A. Gerhardus (1999) Strategies to enhance the use of health systems research for health sector reform. *Tropical Medicine and International Health*, accepted for publication.

Reich, M.R. and D. M Cooper. (1996) PolicyMaker. Computer-Aided Political Analysis: Improving the Art of the Feasible. Brookline: Polimap

Annex

Annex 1.1

List of interviewees

Mme Azara Bamba	In-charge of reproductive health, WHO (used to be Minister of Health between 1983-1987)
Dr. Nignan Daouda	Ministère de la Santé, Department of Maintenance (formerly of the DEP).
Dr. Maurice Hien	Researcher; Acting medical officer in the research zone
Dr. Ibrango Manadji	Currently director of the DEP
Dr. Issaka Zongo	Currently researcher (used to be Directeur de Sante Provinciale during the mid 90's)
Dr. Arlette Sanou	Conseillère du Ministère de la Santé
Dr. Zina Yacouba	MoH-DEP
Prof. Abdulaye Traoré	Faculty of Medicine, University of Ouagadougou
Dr. Adrien Nougara	Independent researcher
Dr. Florent Somé	District medical officer at the time
Dr. Bocar Kouyaté	Permanent secretary of the MoH at the time
Prof. Hans Jochen Diesfeld	Researcher, PRAPASS-Heidelberg
Prof. Rainer Sauerborn	Researcher, PRAPASS-Heidelberg
Focus group discussions with health professionals in Bourasso and Toni	
Focus group discussions with women groups in Dara and Sobon	
Focus group discussions with mothers in Dara and Sobon	

Annex1.2

Analyse des parties prenantes dans le cas de « SOINS PARTAGES »

Guide d'entretien individuel

I. ID Information

Nom, Prénom _____

Position actuelle et institution d'affiliation _____

II. Introduction

Nous venons de l'Université de Heidelberg, Allemagne et du Centre de Recherche en Santé de Nouna. Nous menons présentement un projet qui interroge les liens entre recherche et politique de santé. Nous avons choisi un certain nombre de pays pour suivre cette question de près à savoir l'Afrique du Sud, la Tanzanie, le Burkina, le Brésil et l'Indonésie. Au Burkina, nous travaillons sur deux études de cas. Premièrement, la question de financement de soins de santé (vous aurez/avez eu l'occasion de rencontrer le équipe de Alain Zoubga et Célestin Traoré) et deuxièmement, la question de « soins partagés ». Comme vous le savez peut-être, dans le premier cas, les recherches ont contribué a un changement de politique de santé. Dans l'autre cas, celui que nous voulons discuter aujourd'hui, les recherches faites n'ont pas mené a une prise de décision politique.

III. Entretiens avec décideurs

1. Pourriez-vous nous dire ce que vous entendez par l'idée de « soins partagés »?

(Probe : IMMI – implications des mères, le « volet mères », les soins donnés à domicile pour les maladies infantiles comme la diarrhée, etc peuvent être partagés entre les mères et les agents de CSPPS)

2. Qu'est-ce qui était nouveau dans cette idée ?

3. Quels étaient les buts des « soins partagés »? *(Probes: améliorer la santé des enfants, améliorer la qualité des soins, soutenir le rôle des femmes dans la système de santé, donner plus de responsabilité aux mères)*

4. Quelle était l'approche prévue pour atteindre ces buts ? (*Par quels méthodes allait-on procéder ? Probes : former les mères, former le personnel de santé*)
5. Pourriez-vous me décrire votre rôle en ce qui concerne l'idée des soins partagés ? À quel point est-ce que vous étiez impliqué ? (*essayer de tirer un récit descriptif*)
6. Comment et par qui est-ce que vous avez été informé sur ce sujet ? (*Textes, media, niveau personnel*) Quelles étaient les sources les plus importantes d'information ?
7. Pour quelles raisons ces sources-là ont été choisies ? (*Probes: fiabilité ; pertinence ; accessibilité ; vitesse ; pas trop long, détaillé*)
8. Est-ce que vous avez essayé d'en savoir plus ? (**SI « OUI »** pourquoi et comment ?)
9. Quelle était votre attente par rapport à l'idée de « soins partagés » ?
10. Quels groupes soutenaient l'idée des soins partagés, quels groupes ne le soutenaient pas ?

Parlons maintenant de l'implantation de cette idée...

11. Est-ce que la question a été mise sur l'agenda de politique de soins de santé ?

SI « OUI » : Quand et par qui ? (*Qui étaient les promoteurs des soins partagés?*)

Quelles étaient les étapes successives de prise de décision ? (*Chronologie ? recherches, réunions, etc*) **SI «NON »** : Pourquoi n'ont-elles pas été mises sur l'agenda politique ?

12. Pensez-vous que les « soins partagés » - parmi autres stratégies - est une stratégie appropriée pour réaliser les buts que vous avez mentionnées ci-dessus (*les citer !*) ?

13. Quels obstacles est-ce que vous voyez à l'implantation de cette idée ? (*Probes : opposition d'agents de santé, capacité limitée des mères, aspects techniques et logistique, financement ?*)
14. Est-ce que vous pensez que l'implantation de ces idées sur terrain est réaliste, faisable ? sur quelles conditions ?
Vous savez peut-être qu'il y avait quelques recherches de base faites (l'étude de Solenzo). Nous voudrions savoir à quel point les résultats de ces recherches ont contribué à l'idée de « soins partagés » et si ils ont été incorporés dans la prise de décision...
15. Pourriez-vous nous dire ce que vous savez sur les recherches faites...
16. Est-ce que vous étiez directement en contact avec les chercheurs ?
17. Quelles ont été les conclusions importantes de la recherche qui pouvaient soutenir une politique de « soins partagés » ?
18. Est-ce que les résultats de recherches faites ont été utiles pour pouvoir prendre une décision politique sur les « soins partagés » ?
19. Est-ce que la présentation et la dissémination de résultats avaient-elles été bien faites? (*PROBES : trop tard ; pas d'importance, pas possible de transmettre les résultats à une autre région géographique*)
20. Qu'est que vous auriez aimé comme recherche pour pouvoir prendre une décision politique sur l'implantation de « soins partagés » ? Quelles questions restent ouvertes ?

Annex 1.3

Entretiens avec chercheurs

1. Quelles sont les recherches de base qui, selon vous, ont contribué à l'idée de « soins partagés » ?
2. Quel était, à l'époque, l'intérêt scientifique pour travailler sur ces questions ?
3. Avez-vous discuté de vos idées, objectifs, hypothèses de recherche avec les décideurs ? Quelles étaient leurs réactions ?
4. Quel était le rôle des décideurs ?
5. Est-ce que les résultats de recherches faites ont été utiles pour pouvoir prendre une décision politique sur les « soins partagés » ?
6. Quelles étaient les conclusions importantes des recherches qui pouvaient soutenir une politique de « soins partagés » ?
7. Qu'est que vous avez fait pour disséminer les résultats de recherche ?
8. Est-ce que c'est envisageable de mettre ces idées en pratique ? Quels obstacles voyez-vous ?
9. A quelles conditions pourrait-on mettre en place une politique de santé basée sur la stratégie des « soins partagés » ?

Annex 1.4

Annex 1.5

Interview avec les groupement féminins ou associations

Dénomination du groupe:

Identité du groupe:

Nombre de membres:

Année de création

Guide d'entretien

Présentation des problèmes de terrain

- 1- En saison de pluie les maladies comme le paludisme et les diarrhées sont les plus fréquentes.
- 2- Les formations sanitaires sont inaccessibles en saison pluvieuse.
- 3- La majeure partie des problèmes de santé est soignée au niveau des ménages.
- 4- C'est surtout les enfants qui sont soignés et ces soins sont le plus souvent administrés par les mères.

Que pensez-vous que l'Etat peut faire pour améliorer cette situation?

Avez-vous déjà mené des activités dans le domaine de la santé ou de l'assainissement dans votre village ou ailleurs?

Si oui

- Lesquelles?
- Combien de fois?

Présentation de l'approche soin partagée

Objectif

Démarche

Résultats attendus

Pensez-vous que cette approche est réalisable dans nos villages?

- Responsabilité
- Par rapport à vos activités habituelles (cuisine champs)
- Refus des hommes
- Capacité à le faire (est-ce trop difficile?)

Quelle peut être votre tâche dans cette approche en tant que groupement ou associations?

Si on vous disait de suivre une formation en tant que groupe et ensuite de former les mères et soigner les enfants dans le village.

- Est-ce possible?
- Quelles sont les problèmes que vous voyez?
- Quelles sont les conditions dans lesquelles vous pouvez travailler
 - matérielles
 - temps

Est-ce que toutes les mères peuvent accepter de vous laisser soigner leur enfant?

Pensez-vous que le groupe doit être pris dans son ensemble ou que seulement quelques membres devront être formés?

Annex1.6

Guide d'entretien

Focus group avec les mères

Présentation des problèmes de terrain

- (1) En saison pluvieuse les ménages disposent de peu de ressources pour subvenir à leur besoin pourtant c'est à cette période qu'ils ont besoin de plus force.
- (2) Les formations sanitaires sont inaccessibles en saison pluvieuse.
- (3) La majeure partie des problèmes de santé est soignée au niveau des ménages
- (4) C'est surtout les enfants qui sont soignés et ces soins sont le plus souvent administrés par les mères.

Que pensez-vous que l'Etat peut faire pour améliorer cette situation?

Présentation de l'approche soin partagée

Objectif

Démarche

Résultats attendus

Pensez-vous que cette approche est réalisable dans nos villages?

Quelle peut être votre tâche dans cette approche?

Qui est mieux indiqué pour former?

...et les infirmiers?

Comment cette activité peut-elle être organisée au niveau de votre village?

Quelles sont les difficultés qui peuvent survenir dans la mise en place de cette approche?

- Sont-elles surmontables

Si nous comparons toutes les solutions qui ont été données au début de notre discussion y compris celle qui a été proposée laquelle vous semble la meilleure?

Pourquoi?