Learning Brief

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The Use of Research for Decision-Making in the Health Sector - The Case of "Shared Care" in Burkina Faso

COHRED's Working Group on Research to Action and Policy tries to make a specific contribution to the global discussions on the research/policy nexus by commissioning studies that highlight country experiences in this regard. Case studies have been conducted in Brazil, Burkina Faso, Indonesia, South Africa and Uruguay. This learning brief examines the case study conducted in Burkina Faso.

Study context

In rural areas of Burkina Faso, child morbidity and mortality are extremely high. Both quality and utilisation of the existing health services are low, while treatment costs are out of reach - particularly for the most vulnerable groups. Following a series of studies on health services, care-giving at the household level, and inter-household distribution of disease, the concept of shared care was proposed by a group of researchers from Heidelberg University (Germany) in the late 1980s. The shared care approach was based on the idea that mothers and health workers could jointly assume responsibility for, and complement each other in the care-taking and treatment-seeking process for childhood illnesses. However convincing intuitively, the concept has not been implemented until now.

This learning brief presents the results of a study undertaken in 1999 to elucidate the factors constraining the implementation of the concept of *shared care*. The study focused on a stakeholder analysis which was undertaken to understand the different perceptions and level of involvement of the actors. Semi-structured interviews and focus group discussions were held with the main actors involved.

Stakeholder analysis

For the researchers from Heidelberg University, the concept of shared care was a logical consequence, following the results of the studies they conducted in the 1980s. They used meetings with representatives of the Ministry of Health (MoH) to promote the concept as a locally-adaptable mechanism to reduce childhood mortality and morbidity.

Policymakers from the MoH-DEP (Direction des Etudes et de la Planification) who attended the meetings organised by the researchers knew the content, conclusions and recommendations regarding shared care when they were interviewed in 1999. 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*". The MoH-officials apparently did not agree that the research results should have triggered an action from their side. The policymakers did therefore not provide any active support for implementation of the concept. This decision makes more sense when the context is considered: In part, *shared care* was competing with the recently-introduced Village Health Worker approach, and did not necessarily fit into any of the major programs launched internationally.

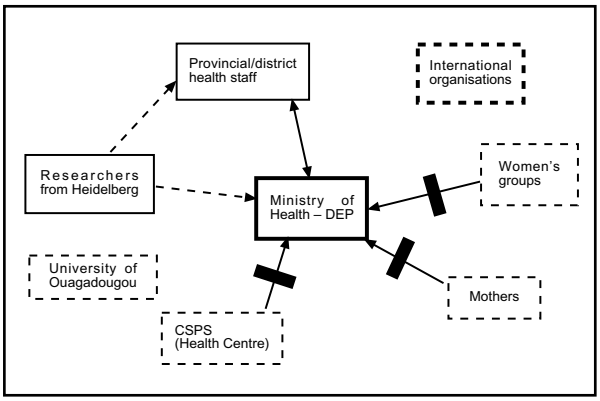
Neither health centre staff, women's groups, nor the mothers were included in the initial decision-making process. This led to different assumptions about the various groups' ability and willingness to execute the program. Regarding the role of the health centre staff, there was a striking contrast between the views of the researchers on the one hand, and the MoH-DEP and the health centre staff on the other. The health centre staff and the MoH felt they had no time to train and to meet regularly with the mothers. It was also not clear if the health staff would accept the mothers as partners at a professional level.

Ultimately, the women's groups and mothers were assigned a key role in the concept. However, they were not involved in the design stage of the intervention study, which led health staff and the MoH-DEP to question the ability of mothers to perform the tasks assigned to them. In the focus group discussions conducted in 1999, both the women's groups and the mothers showed great interest in the concept of shared care as an adequate mechanism to improve childhood health at low cost.

As to their technical capacity to file their role, mothers think it was no longer different from the real situation, prescribers are only giving advices and the real work is accomplished by the mother at the household level.

The figure below illustrates the stakeholder analysis which took place.

Stakeholders involved in the decision-making process for the introduction of the shared care concept



The flow of **research results** is indicated by the **dotted 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 dotted frames indicate that these stakeholders have not been involved in the process.

Lessons learned

1) A stakeholder analysis should be conducted as early in the research process as possible. This enables researchers 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 is more likely that the research will be relevant, leading to recommendations that can be operationalised and are perceived as a product of joint ownership, facilitating implementation.

3) Context plays an important role. However, it is rarely possible to modify the context significantly. A more viable alternative is 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 enhancement of the quality of care.

4) Communication has to be two-way. Researchers should communicate their findings, and stakeholders should express their needs. At the same time, communication has to be meaningful: It is not sufficient to simply transmit information to a "decision-maker". It must be ensured that the receiver is the appropriate person and is able to process the information. Therefore, time constraints for the reception of information have to be taken into account, as well as the fluctuation of key functions on either side. The health research unit within the MoH should have the potential to enable a sustainable exchange of information, to retain an institutional memory, and act as a veritable "broker of information".

Further Reading

➡ Gerhardus A, Kielmann K, Sanou A (2000) *The Use of Research for Decision-Making in the Health Sector - The Case of "Shared Care" in Burkina Faso.* Report for the COHRED Working Group on Research to Action and Policy.

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