

Development of a tool for planning and evaluating action research on health in Burkina Faso

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Analysis of the implementation of an action research project on health in Burkina Faso led to the development of a list of 19 best practices. This list serves as a useful planning, monitoring and evaluation tool when undertaking an action research project.

Introduction

Since 2008, the Sahel Regional Health Department and the NGO HELP have subsidized the payment of user fees for children under the age of five years in two districts, Dori and Sebba. They reimburse health centres (CSPs) on a monthly basis for the actual costs of products and services delivered free of charge to children under five. Since August 2011, with support from the University of Montreal, they have operated a pilot program in which episodes of illness are reimbursed at a fixed rate, as part of an action research (AR) project.

Using a quasi-experimental model, the aim of the AR project is to evaluate the feasibility of fixed-rate reimbursement (FRR) and its impacts on costs and administrative workload as compared to actual-cost reimbursement.

This research briefing summarizes the methodology, results, and products of our analysis of the implementation of this AR project.

Methodology

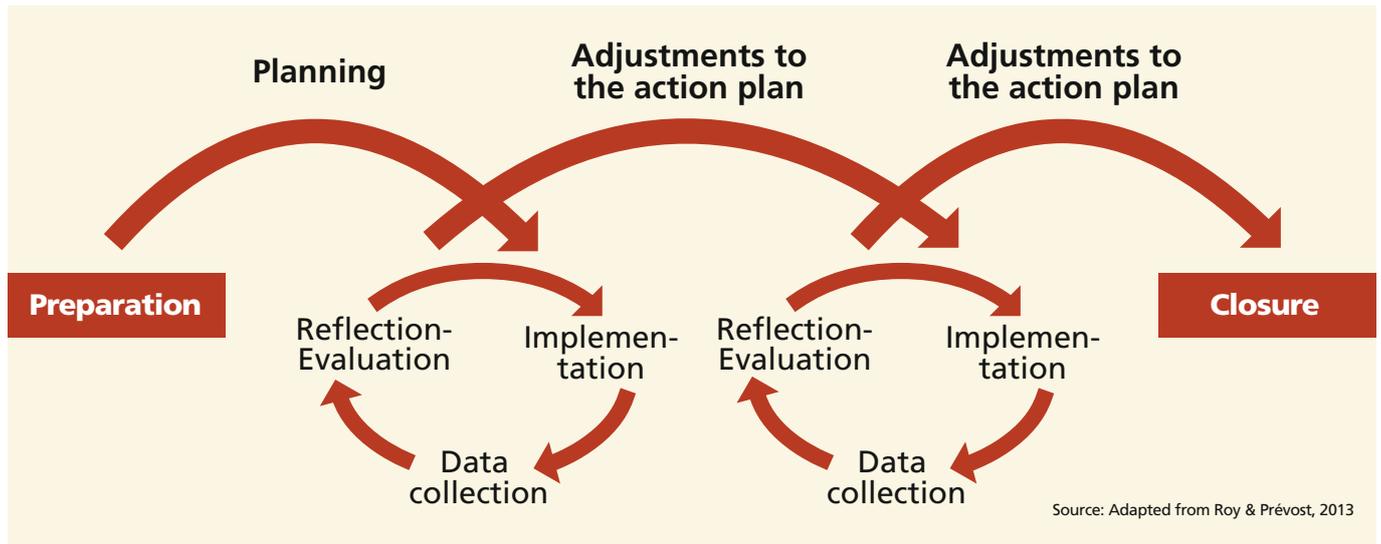
The study was carried out by the first author, external to the AR project, the research team and the chief medical officer of Sebba. It was conducted in three stages: i) knowledge synthesis on the AR approach and identification of best practices; ii) documentary analysis, observations, and individual interviews (n=22); and iii) reflexive analysis by stakeholders in the AR project through a group discussion (n=19), an individual questionnaire (n=17), and a discussion of the results of the preliminary analysis. This study was described in a published article focused on the methodology (Aka et al., 2014).

Results

Action research cycles

AR is an iterative process in which researchers and practitioners collaborate in a cycle of activities that include problem identification, planning, implementation, evaluation of solutions, and reflection (Avison et al. 1999). Roy and Prévost (2013) have represented the different experimental cycles of AR, adding both a preliminary and a final step to the original model developed by Lewin in the 1940s. The cycles end when the stakeholders have resolved all the problems identified. We have simplified the illustration of the AR cycles to facilitate understanding and use (see figure, page 2).

Figure. AR experimental cycles



Best practices for each AR cycle

According to Patton (2001), **best practices rely on principles to guide actions, whereas good practices are normative, specific, and difficult to apply in a variety of contexts.** Our analysis of the scientific literature identified best practices for each AR cycle. In our analysis of the AR implementation, we were able to test our original grid and to improve it (the definitive version is presented in the table, page 3).

Successful AR implementation

External analysis of the data collected through documentary analysis, observations and interviews showed mainly that:

- ➞ the situational analysis created an intention for action and research in the stakeholders;
- ➞ identifying and involving all the stakeholders from the outset legitimized the process and facilitated the AR project's implementation and chances of success;
- ➞ discussing the issues and signing agreements inspired stakeholder confidence and commitment;
- ➞ the implementation guide, data collection instruments, and field visits facilitated the AR project's implementation;
- ➞ organizing follow-up meetings that were regular, democratic, and guided by rules of functioning helped to stimulate reflection and the consensual evaluation of results;
- ➞ the solutions proposed during the AR project were flexible, progressive, innovative and appropriate.

The main weaknesses identified in the AR project's implementation had to do with the time involved in sharing documents among stakeholders, delays in starting up certain meetings, and the fact that no one from the Ministry of Health headquarters was involved.

The questionnaire administered to participants in the reflective workshop allowed the 17 respondents (76% CSPS medical personnel, 12% from the NGO HELP, and 12% from the AR team) to assess the degree to which best practices were applied. Results were positive. Regarding the application of best practices, the average score was 96% 'agree' to 'agree completely'. The lowest scores had to do with: the AR team's work sessions in the field [Implementation] (71%); the dispelling of fears regarding the AR project's feasibility [Planning] (77%); the innovations of the proposed solutions [Planning] (86%); the sturdiness of the innovations tried [Planning] (87%); and the reliability of data collected [Data collection] (88%). All other scores were above 90%, with a majority being 100%.



Table. Analysis grid with the 19 best practices for AR based on our studies

Preparation	Planning	Implementation	Data collection	Reflection & Evaluation
<p>1. Perform a situational analysis</p> <p>2. Identify stakeholders</p> <p>3. Set up an oversight body</p> <p>4. Formalize the stakeholders' reciprocal commitments</p> <p>5. Define the researchers' role</p>	<p>6. Define the AR objective</p> <p>7. Formulate the AR questions</p> <p>8. Analyze the issues related to the topic and to the AR implementation</p> <p>9. Propose appropriate and realistic solutions</p> <p>10. Plan the activities to be carried out</p>	<p>11. Develop a guide for implementing the activities</p> <p>12. Organize work sessions in the field</p>	<p>13. Develop the data collection methods</p> <p>14. Develop the data collection instruments</p> <p>15. Ensure the traceability and transmission of data by assigning responsibility to the various actors</p>	<p>16. Organize periodic follow-up meetings</p> <p>17. Validate the results collectively</p> <p>18. Do a summary report on each cycle of the process</p> <p>19. Formalize the knowledge produced</p>



In discussions of the interim results of the external analysis, the stakeholders said they appreciated their involvement in the AR processes, the comparative design, the agreements, and the ways in which the follow-up and evaluation were organized. On the other hand, the things they appreciated less were the inability to ensure the duration of the AR project¹, the delays in signing contracts, the loss of two data collection notebooks, and poor time management in the follow-up meeting.

Conclusion

The results obtained from the different methods used were convergent. The AR project's implementation was successful. The stakeholders appreciated all aspects while noting a few weaknesses, mostly of a practical nature, to be considered.

We consider a "best practice" to be a form of expertise, and we see our analysis grid [table] as a list of tasks that enable the different stages of an AR project to be carried out effectively. Putting our best practices list to the test showed that it was accessible and appropriate. As such, we believe it is a perfectly suitable instrument that anyone can use when undertaking an AR project, regardless of the issue, environment, or stakeholders.

This research briefing and other documents related to healthcare access and program evaluation are available on the website of NGO HELP (<http://www.help-ev.de/en/projects/burkinafaso/>) as well as on the website of the EQUITE research program (<http://www.equitesante.org>).

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(1) The AR project had to be organized in several phases depending on the project's various short-term funding sources, which fortunately were renewed to the project's end.

