

Improving the Local Responses to HIV/Aids in Africa:

Gaoua District, a Case Study of Burkina Faso

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SUMMARY

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ABSTRACT

This thesis reports on a process of developing a new approach called the “Local Responses to HIV/Aids” undertaken in Gaoua District, Burkina Faso, between 1997 and 2000. It focuses on how communities, and organisations from the public and other sectors (voluntary, non and for profit, Churches) can develop more effective responses to HIV/Aids in their settings.

The study described in this thesis aims: first, to improve the knowledge and gaps (under the form of research conclusions) of how to plan and implement HIV/Aids strategies in rural settings in Africa by testing an approach called the Local Responses; second, to document critically a three years process, including some early results.

The research objectives were fourfold:

- first, to develop a rapid appraisal method which can be a resource for district and communities to circumscribe their needs in relation to HIV/Aids,
- second, to carry out situation analyses at the community and district levels,
- third, to apply the findings to improve responses, and
- finally, to assess the results, including the lessons learnt from using this approach for national and international implications.

The method used is based on health systems research with a pre-experimental before and after prospective intervention study.

The study gives evidence of the importance of carrying out situation analyses for HIV/Aids (baseline, 1997) both at the community and district levels. Based on the findings of the analyses a consensus-building was reached on a common vision to address the epidemic with all key partners from the District, including community representatives. In complement to the existing prevention strategies, the much needed care and counselling and psycho-social support components were identified as neglected up to now, and future priority areas. Under UNAIDS guidance, the partners developed their activities using a strategic planning approach and as a consequence, were able to mobilise their own and external resources too. I document the development of a new organisational tool called the Rapid Organisational Review (ROR). Finally, despite the strengths of this approach, the applications and limitations are presented using the case of migrants as a specific vulnerable group.

Six months of implementation of the Local Responses (2nd semester 1999) are sufficient to document already substantial results:

- ♦The partnerships of non-health public sectors (i.e. Education, Agriculture etc.) and non-governmental partners (i.e. Churches, traditional authorities), and local Associations (Community-Based Organisations of different nature) have increased tremendously.
- ♦Some vulnerable groups (e.g. youth, prisoners) are now addressed specifically.
- ♦Geographic coverage has increased in the District, both in towns and rural areas.
- ♦A massive number of agents of change have been trained for some in HIV prevention from the different local Associations, and others in care and counselling (particularly in the health sector).
- ♦The District of Gaoua and Poni Province have now a locally owned Technical Committee and Provincial Committee who co-ordinate the process locally.

The study reports on some of the national and international positive direct benefits of the “Local Responses” as well.

The study concludes that despite its positive overall outcomes, and its potential in the decades ahead, many issues related to the development of Local Responses still need to be addressed in order for this approach to become more broadly known, credible, and sustainable. Those are related to the methods used for Local Responses, to the policies, and to the research.

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GLOSSARY

Aids	Acquired Immune Deficiency Syndrome
BMZ	Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung (Federal Ministry for Economic Cooperation and Development, F.R. Germany)
CBO	Community-Based Organisation
CDC	The Centers for Disease Control
CDD	Control of Diarrhoea Disease
DH(M)T	District Health (Management) Team
DRI	District expanded Response Initiative
EPI	Expanded Program on Immunisation
HAART	Highly Active Anti-Retroviral Therapy
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
FAO	Food and Agriculture Organization
GDP	Gross Development Product
GPA	WHO Global Programme on AIDS
GTZ	Gesellschaft für Technische Zusammenarbeit (German Agency for Technical Cooperation of the BMZ)
KfW	Kreditanstalt für Wiederaufbau (German Financial Cooperation of the BMZ)
L.R.	Local Responses
MoH	Ministry of Health
NACP	National AIDS Control Programme
NGO	Non-Governmental Organisation
PHC	Primary Health Care
PLWHA	People Living with HIV/Aids
PRA	Participatory Rural Appraisal
RRA	Rapid Rural Appraisal
ROR	Rapid Organisational Review
SMC	Social Marketing of Condoms
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TB	Tuberculosis
USAID	United States Agency for International Development
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization
ZOPP	Zielorientierte Projektplanung (Goal-Oriented Project Planning)

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Ulrich Vogel, Team Leader HIV/AIDS, GTZ Headquarters, and George Dorros, WHO, Department of Organization of Health Services Delivery, and Carol Larivée, Department of Policy, Strategy and Research, UNAIDS, and all their different teams were instrumental in discussing and stimulating some of the approaches and generic framework which inspired this work in early 1997.

In Burkina Faso, particular thanks are given to Ms. Pascaline Sebgo, Reproductive Health Training Co-ordinator, AIDS/IEC, GTZ, Burkina Faso who participated to the situation analyses, and to the entire GTZ Burkina Faso team who provided support for the field studies. For the community situation analysis, the local Non-Governmental Organisation, Population Santé Développement (PSD), Ouagadougou, were instrumental in carrying out the interviews in the local languages and preliminary community data analysis, and I am grateful for their commitment and perseverance in their work. As an on-going action research, the key local partners are too numerous to cite here but I am most grateful to all of them, from the communities to the District of Gaoua, and Poni Province. I am particularly grateful to Ms. Karidia Kyère, Director of Social Affairs, Gaoua, and member of the Gaoua Technical Committee on AIDS who provided me mid-2000 with the latest development of the Gaoua Local Responses in a Technical Meeting on “Measuring Progress of Local Responses to HIV/AIDS” (Mwanza, Tanzania, 5-7 June 2000).

The success story would not have been possible without the careful steering of Dr. Kékoura Kourouma, the national CPA, UNAIDS, Burkina Faso, and the inputs of Dr. Pierre M'Pelé, UNAIDS “country broker” for Gaoua who made the process to move into strategic planning and implementation from mid-1998 to late 1999. I owe them many thanks to all I have learned from them.

Finally, without the overall stimulation from Jean-Louis Lamboray, Local Responses team, the Department of Policy, Strategy and Research, UNAIDS, the Local Responses could not have become a reality for a whole continent, from a mere three years case-study carried out in Gaoua, Burkina Faso. I owe much thanks for his support and stimulus and to his team as well particularly in the last phase of the study.

Many thanks for the advice and constructive support in the last stages of this thesis, to Dr. J. Chabot and Dr. R. Kerkhoven. Particular thanks to Dr. Y.K. Baruani who gave me thorough insights by reading the thesis from the beginning to the end.

Particular thanks to Professor Alexander Krämer, and Professor Ulrich Laaser, and the participants of the International Journal Club, and the International Working Group, of Bielefeld School of Public Health, from various professional and academic background, and who stimulated discussions and encouragement throughout the different stages of this study.

Finally, I thank my wife, Tina, who suffered as much as I did along this ordeal, and supported me on the front line (most of the time) wholeheartedly throughout this long journey. She wishes wholeheartedly as well that I do not push my limits to the "Habilitation".

The situation analyses in 1997 were supported by a research grant from the Federal Ministry of Economic Co-operation and Development (BMZ) Bonn, Germany, via the German Technical Co-operation (GTZ) Regional AIDS Programme (RAP) Office, Abidjan, Côte d'Ivoire, as well as the early stages of consensus-building and planning workshop which took place in early 1998. The different stages described afterwards, the implementation and follow-up work from mid-1998 on were financed by UNAIDS. This includes the documentation compiled mid-2000 of the UNAIDS Best Practice Collection Case-Study on "Gaoua District Local Responses: The Burkina Faso approach" I am currently writing and summarised in the Results section"(Chapter IV).

We hope the present thesis provides a useful documentation of the innovative approach and an encouraging description of a three years process developed by the communities and district, in partnership with their international partners, to tackle the HIV/Aids epidemic in resources poor setting, efforts which are often either undocumented or part of the grey literature only.

Cyril Pervilhac

Bonn, July 2000

PREFACE

This research stems from a team of different actors from UNAIDS, WHO, and GTZ who in 1996 expressed the need to join hands to develop an innovative way to tackle the epidemics at a local level, starting as an entry point with the Districts. This explains the name of origins to this effort called the "District expanded Response Initiative" for the five case-studies in 1997 which were carried out in five different countries in the Africa region, including Burkina-Faso, described in this thesis.

Local Responses have been over the past three years moving along with different political agendas as reflected in its successive titles. It started as the "District expanded Response Initiative" in early 1997. Then it was called "Health Sector Reform and the Expanded Response" (to move away from the idea that the District was where the solution was lying instead of communities) in 1998. The new name became the "Local Response" (but it became clear that there could be multiple solutions or responses) in early 1999, and, finally, in late 1999 and 2000 it became officially the "Local Responses".

The author was involved for several years in the early to mid-eighties as a program manager in the Africa region in Primary Health Care programs, and so-called vertical programs, encompassing interventions related to communicable diseases which can be prevented by immunisation, Diarrhoea diseases, and Malaria control. He co-ordinated several courses in the late eighties to strengthen management at District level summarised in a recent publication (C. Pervilhac, W. Seidel eds. "Training for better District Health Management" Berlin 1996), with the German Foundation for International Development (DSE Berlin), and organised the European Tropical Epidemiology Course held in Berlin (1989). He was further stimulated in the early nineties to carry out health research (systems and bio-medical) in the Ifakara Research Centre, National Institute of Medical Research, as co-ordinator for research activities.

Upon his return, from his journey in Tanzania, the opportunity to embark in the present HIV/Aids research at the district and community levels was a new challenge to put into practice this experience.

Broadly, this research illustrates how new innovative approaches to tackle the HIV/Aids epidemic, under the umbrella of Local Responses, are feasible. They can create hope among communities, partners, and countries that this epidemic will be controlled in the coming decades in the Africa region, just like in North America and Europe.

CHAPTER ONE:

BACKGROUND AND INTRODUCTION

This chapter introduces first the present research (1.1) by reference to the programmatic context set up to respond to the epidemics of HIV reported for the past ten years, particularly since the late 1980s, in the sub-Saharan Africa Region. The recent developments, originating from UNAIDS and WHO in the late 1990s, to test with five country case studies the present innovative “Local Responses”¹ in the context of Health Sector Reform, are then outlined. Burkina Faso where the present research takes place is one of the case study with a process which took place over a three years period and has been documented separately, including the personal contribution (Appendix 1A Chronological Benchmarks of the Local Responses: General and Research Contributions). The chronology illustrates the nature of this study and its process that has been on-going over a three years period (May 1997- June 2000).

The literature review (1.2) provides details about background information to understand the context of the Local Responses. Namely, it reviews first, the Primary Health Care (PHC) approach, including the types of selective and comprehensive programs; second, the health sector reform context; third, the numerous existing HIV/Aids strategies and interventions. The framework of analysis used in the research and in the presentation of findings is then outlined (1.3). Finally, the thesis is outlined briefly (1.4).

1.1 Research background

The Responses to HIV/Aids in the eighties and early nineties

Ten years after the WHO Global Program on Aids was launched, the HIV/Aids multifaceted and devastating pandemic is still disproportionately impacting on the developing world, as reported in an updated situation of each region in the world (Proceedings of the XI International Conference on AIDS, Vancouver, 1996). This picture describes the situation in the year that preceded this research.

The global responses to AIDS through the WHO Global Program on AIDS, (GPA) in the mid-eighties, was described in more details elsewhere (PANOS Dossier 1988). GPA since then has now being disbanded, and in 1996 the Joint United Nations Program on HIV/Aids (UNAIDS) was created. GPA activities can now be contrasted to the recent UNAIDS 1996 “Expanded Response to HIV/Aids at local level” activities, (UNAIDS 1996), and summarised as follow:

- sensitising the Governments to Aids (GPA) vs. sensitising individuals and communities, (UNAIDS)
- developing national mid-term plans steered by the Ministries of Health vs. implementing planning and management of Aids at the district level across sectors,
- using a top-down approach, with a vertical program, using the health sector alone vs. using a bottom-up approach, with a horizontal program, using multisectoral approaches,
- a centralised vs. a decentralised decision-making process, in the context of sector reforms,
- adapting a short term view, individual centred responses with the hope that drugs and/ or vaccines will be soon available, vs. a long term view, permanent self-financed responses with prevention interventions, emphasising individual and community behaviours risk reduction measures.

¹ Often referred in the study as “Local Responses” or as originally labelled “District Responses Initiative” (DRI) because of the nature of the local responses at the District level

These rapid changes of policies and approaches are not fortuitous but driven by the National AIDS programs, and international agencies concern about the sustainability of HIV/Aids prevention and care programs.

The epidemiology, facilitators and impact of HIV/Aids

Reviewing briefly the epidemiology of HIV/Aids justifies why this study focuses in the Africa region, and west Africa sub-region in particular with the particularities of the epidemics in that region. A review of Aids in the developing world can be referred to elsewhere (Silva Saavedra M 1996).

The epidemiology of HIV infection and Aids is complex as described in a typical natural history of adult HIV infection, with the severity of infectivity and clinical manifestations that vary in severity over a decade. The epidemiology, combined with the different natures of transmission, and the poor prognosis for those infected, make the selection of the correct mix of both prevention and care/ support measures difficult to choose or to deliver effectively.

Despite over a decade of combating the HIV/Aids epidemic, the HIV epidemic continues to spread rapidly with limited effects of prevention measures. In addition, the needs for care, support, and impact have been growing dramatically, and are far from being addressed correctly either (Gilks, Floyd et al. 1998). The following epidemiological HIV/Aids data illustrate the extent and impact of the epidemic world wide and then focuses in Africa, and West Africa, and finally, in Burkina Faso where this study is located.

Based on the 1997 epidemiological data when the present study started, the global burden of HIV world wide is evident. At the end of the year, over 30 million people were living with HIV/Aids, about 40% of whom were women, and 10% children. In addition, more than 11 million people had died because of Aids since the beginning of the epidemic, leaving over 8 million Aids orphans² (UNAIDS 1997). The more recent report for 1999 estimates that 18.8 million people around the world have died of AIDS, 3.8 million of them children. Nearly twice that many -34.3 million- are now living with HIV, almost three fourths of those (71%) in sub-Saharan Africa. (UNAIDS 2000). These huge numbers are difficult to grasp in terms of their magnitude, but the 4.0 million of new infections in the Africa region during 1999 represents half a million more than the whole population of Berlin infected yearly, and little over the whole population of the former German Democratic Republic states wiped out in less than twenty years!

As pinpointed in this report, the increasing number of new infections every year provokes an acceleration effect of long-standing epidemics: „as the rate of HIV infection in the general population rises, the same patterns of sexual risk result in more new infections simply because the chances of encountering an infected partner become higher“ (op. cit. p. 8). The proportion is expected to continue to rise in these countries „where poverty, poor health systems and limited resources for prevention and care fuel the spread of the virus“ (MAP (Monitoring the AIDS Pandemic Network) 2000).

² defined as HIV-negative children who lost their mother or both parents to AIDS when they were under the age of 15

Specific major facilitators of the heterosexual HIV epidemic in sub-Saharan Africa have been identified as:

- ♦“Ignorance of the population,
- ♦Poverty including poor health care systems and facilities,
- ♦Low socio-economic status especially of women compared to men,
- ♦Social demographic and cultural conditions in communities with predominance of one sex such as in the military, migratory work such as in mines, fishing villages and among long distance truck drivers...,
- ♦Highly prevalent infections including sexually transmitted diseases and tuberculosis which facilitate HIV transmission and/ or increase replication of HIV...,
- ♦Biological necessity of heterosexual intercourse for procreation,
- ♦Mystification of sexuality and denial of existence of sexual life among youths and adolescents...” (Mhalu 2000).

The infection rates in young African women are far higher than those in young men. The victims are largely women and children. Women because the epidemiology of HIV/Aids in women, combined with socio-economic and political factors, increase their risk (Bererr and Ray 1993). Children as well with “Aids being foremost a disease of the young”, because the combination of poor nutrition, poor health services, and widespread infectious diseases make children particularly vulnerable (UNAIDS 1997). In 1997, it was estimated that 5.8 million people were newly infected, and 2.3 million had died with AIDS (UNAIDS 1997). In the year of the present study, the 1997 World AIDS Campaign aimed to “children living in a world of Aids.”

Projections into decades ahead further justify both immediate and future action. In 1990, HIV ranked twenty-eighth only among the disease burden measured in Disability-Adjusted Life Years (DALYs), but will move to rank tenth in 2020 (Murray and Lopez 1996). If HIV was still a minor cause of deaths from infectious diseases among adults in the developing world (8.6%) in 1990, it will account for over one third (37.1%) of the share in 2020 (The World Bank 1997).

The overwhelming majority of HIV-infected people -about 95%- live in the developing world, and most of these do not know that they are infected. The incidence of HIV infection in poorer countries (750 per 100,000 people) is more than ten times that of industrial countries. Sub-Saharan Africa is one of the region in the world with the poorest population as documented in the Human Poverty Index (HPI³) ranking for developing countries. Poverty offers a fertile breeding ground for the epidemic’s spread, which sets off in turn a cascade of economic and social disintegration and impoverishment (UNDP 1997).

In sub-Saharan Africa, the epidemic due mainly to heterosexual transmission has already reached in 1997 an unprecedented high level of 7.4% adult prevalence rate⁴. New infections are thought to be levelling off in that region as a whole, but military conflict epidemic and civil unrest may be spreading the epidemic further in some sub-regions (The World Bank 1997). Different or “interwoven” (Piot P. et al. 1990) epidemics take place in that region of the world which are spread unevenly with its own distinct characteristics that depend on geography, the specific populations affected (e.g. mobility, societal factors), the frequencies of risk behaviours and practices, and the temporal introduction of the virus. In addition, biological factors such as the presence of Sexually Transmitted Diseases (STDs), of Tuberculosis (TB), male circumcision, and the viral characteristics of both HIV-1 and

³ composite index of three essential dimensions of human life: longevity (vulnerability to death at a relatively early age), knowledge (illiteracy) and a decent standard of living (access to safe water, to health services, and moderately and severely underweight children under five).

⁴ the proportion of adults living with HIV/ AIDS in the adult population (15 to 49 years of age)

HIV-2⁵, may influence the spread of the epidemic by increasing or decreasing the susceptibility to the virus, altering the infectiousness of those with HIV, and hastening the progression of infection to disease and death (Cohen and Trussell 1996).

For the West Africa sub-region, the most recent UNAIDS report notes that while it is relatively less affected by the HIV infection than East or South Africa, the prevalence rates in some large countries such as Côte d'Ivoire, or Nigeria, are creeping up. In Burkina Faso, a relatively small country in comparison to those, the estimated HIV prevalence rate in young people (15-24) ranged for females between the low and high estimates of 4.07 to 7.51, and for males of 1.28 to 3.33 (UNAIDS 2000). Prevalence estimates in Gaoua District fall in the higher range.

Infant and child mortality is in turn increasing, and consequently reversing gains in infant and child survival gained over the past twenty years. By the year 2010, if the spread of HIV is not contained, Aids may increase infant mortality by as much as 75% and under-five mortality by more than 100% in worst-affected sub-Saharan regions (UNAIDS 1997). The devastating impact of Aids has been well documented elsewhere (Carael and Schwartlander 1998). The victims are predominantly the very poorest, particularly exposed because of the lack of education, information and access to social and health services (UNDP 1997).

Burkina Faso is one among four countries in West Africa (Côte d'Ivoire, Benin and Guinea-Bissau) with a generalised epidemic⁶ located mostly in eastern and southern Africa, and concerning approximately half of the countries in the Africa region. Another approximately half of the countries in sub-Saharan Africa suffer from a concentrated epidemic⁷, and half a dozen from a nascent epidemic⁸ (The World Bank 1997). Life expectancy at birth, a common indicator of the health and well-being of a population, has taken a major blow in many countries. In Burkina Faso, life expectancy is now a mere 46 years, or 11 years shorter than it would have been in the absence of Aids (The World Bank 1997). In 2010, the projections put life expectancy at 35 years (UNDP 1997).

Arguments for a research on Local Responses to HIV/Aids

Five key arguments justify a need for research such as the present Local Responses⁹ in Sub-Saharan Africa, as outlined next.

First, the unequal regional distribution of the pandemic in sub-Saharan Africa, or disproportionate epidemics, as just described, explains why prevention efforts are being concentrated in that region of the world. The testing of the Local Responses in Burkina Faso is one of the five case study countries¹⁰ selected for this research. The total financial support of global efforts is nevertheless dismal in comparison to the needs. In the third world where 90 percent of the HIV infected live, the countries receive less than 10 percent of finances for prevention and care; prevention programs must be considerably expanded to contain the spread of HIV (Mann and Tarantola 1998).

Second, besides these epidemiological arguments justifying immediate action in the sub-Saharan region, national prevention programs have been less successful than at first hoped, using traditional health education about HIV/Aids to induce widespread behaviour change (Cohen and Trussell 1996). Despite large increase of knowledge of the HIV infection and its causes, positive changes in sexual behaviours are still lagging behind.

A number of interrelated factors affects the final choices of people: their perception of how HIV infection would affect them personally and of how much their own behaviour is risky, the skills they have to negotiate safer behaviours with partners, and the social environment enabling or constraining behaviour (The World Bank 1997).

⁵ HIV-2 is primarily found in west Africa (with the likelihood of transmission of HIV-1 through heterosexual intercourse to be estimated to be about 3 times higher per exposure than for HIV-2, and significant lower perinatal transmission rates of HIV-2 (4%), in comparison to HIV-1 (25-35%) (AIDSCAP, The Francois Xavier Bagnoud Center for Health and Human Rights of the Harvard School of Public Health et al. 1996)

⁶ generalised epidemic: prevalence among women attending urban ante-natal clinics is 5% or more; HIV has spread far beyond the original sub-populations with high-risk behaviour, which are now heavily infected

⁷ prevalence among women attending urban ante-natal clinics is still less than 5%. HIV prevalence has surpassed 5% in one or more sub-populations presumed to practice high-risk behaviour

⁸ HIV prevalence is less than 5% in all known sub-populations presumed to practice high-risk behaviour for which information is available

⁹ the local responses carried out originally in 1997-98 in 5 countries in Africa was labelled the District expanded Responses Initiative (DRI) due to its administrative and geographical location, district-based

¹⁰ Zambia, Tanzania, Ghana, Uganda, and Burkina-Faso

Third, HIV/Aids is having a tremendous negative impact on the agricultural production among populations who are for the majority living of this essential sector (up to 90% in most of the countries). This affects the nutrition, survival, and means of earning an income for households in that region of the world. Experts in agriculture (Sayagues 1999) draw attention to the rain-fed, maize-based cropping systems of West and Southern Africa where Aids spells a disaster. If terminal sickness and burial coincide with certain tasks like weeding and harvesting, the crop is compromised. Some solutions to cope with the impact of Aids on rural situation is to introduce in small-holder agriculture farming techniques that require less labour, such as zero tillage, and less expensive inputs, including natural pest control (Mutangadura, Jackson et al. 1999). In addition, high direct costs for taking care of patients and high indirect costs on the loss of labour and impact on families are well-documented in recent studies of the agricultural sector in West Africa (Baier 1997; FAO 1997; FAO 1997), and case-studies in various countries of the Africa region (Topouzis and Guerny 1999). Estimates of the direct cost of the disease in Africa, or lifetime costs per patient for medical care, vary widely from US \$ 64 to US \$ 11,800. The indirect costs to families are huge with AIDS killing people in their most productive years, leaving behind multiple dependants (Cohen and Trussell 1996).

Fourth, following the original first decade and strong support of external agencies to give financial support and technical guidance to newly created national AIDS control program in Africa, the approach of the late nineties is changing to a bottom-up one. The present research is therefore grounded and directed from the communities and District levels to the national level. As documented in the present research, the countries and their international partners are still lagging behind in understanding and mastering tools to expand the Responses at the local level, a much more daunting and challenging task than to produce a sound national plan¹¹.

Fifth, the HIV/Aids epidemic is placing a heavy toll on health services that are already suffering from a lack of human or material resources. Health sector reforms, a key element to the Local Responses, are attempting not only to increase the efficiency use of resources and produce more effective health care (Gilks, Floyd et al. 1998), but to increase the effectiveness of preventive health as well.

Current global country and institution strategies and the responses

Official publications draw heavily as an example for the way forward to respond to the HIV/Aids pandemic upon the successes of the activities in Thailand and Uganda. In addition, Botswana and China have been given as examples of countries that have successfully begun to expand their responses beyond the health sector (Piot 1997). The political leadership, empowering communities, mobilising employers, and addressing socio-economic issues were, beyond the medical field, developmental approaches instrumental in decreasing the rates of infection by avoiding high-risk behaviours (Cohen and Trussell 1996). Unfortunately, the experience of Uganda in stabilising its epidemic trends is still documented in a piecemeal fashion and does not allow to identify the exact causes of this success. In contrast, Thailand benefits from a comprehensive set of unpublished (Tanbanjong, Piyanat et al. 1998) and recently published data (UNAIDS 1998) (UNAIDS 2000) which have already been used extensively¹² to document in a convincing way to different audiences the origins and justifications of the Local Responses. It was in particular used to introduce and stimulate the discussion about the Local Responses during the Pre-Planning and Consensus Workshop (Section 4.3.1) held in March 1998 (Appendix 1A).

¹¹ countries follow short- and medium-term plans to fight the epidemic

¹² J.L. Lambaray's presentations: Technical Workshop (Dar-es-Salaam, May 1998), Health Reform and HIV Workshop (Geneva, June 1998), Health Sector Reform and the Expanded Responses (Eschborn, January 1999)

“Expanding the global responses to HIV/Aids through focused action Reducing risk and vulnerability: definitions, rationale and pathways” (UNAIDS 1998) which was published following the first year of the present research constitutes the core philosophy and principles of the Local Responses. It was adapted and used to give the rationale and clarify the nature of the present study on several occasions¹³. This conceptual framework, used for the sake of our research as the general definition of the Local Responses suggests pathways to take action to combat the complex epidemic with a multi-dimensional and dynamic responses encompassing:

- ♦the improvement of the quality and scope of short and long-term risk reduction strategies, and addressing vulnerability factors
- ♦the expansion of the partnerships (public and private sectors, including communities) in the design, implementation and evaluation of HIV/Aids related policies and programmes
- ♦the increase in the population coverage geographically, and for the under-serviced communities both in urban and rural areas, women and men in most vulnerable age groups, marginalised populations, and mobile populations
- ♦the involvement of all relevant socio-economic development actors, integrating HIV/Aids prevention and care in other human development initiatives (poverty alleviation, Agriculture, Education sectors etc.)
- ♦the mobilisation of resources (human, institutional, financial) at all levels (local, national and international)
- ♦the enhancement of the sustainability of HIV/Aids programs by strengthening the local and national self-reliance in the design and implementation phases.

As a common denominator to expand the responses, the following three key principles are underlined: the analysis of risk and vulnerability factors for focused strategies, the expansion of the quality and scope of HIV/ AIDS strategies, the enhancement of the responses to include those strategies addressing vulnerability through short-and long-term measures (reaching vulnerable populations, complementing and reinforcing interventions and services, introducing evidence-based strategies).

The present approach recommended to combat HIV/Aids fits narrowly and overlaps the recent WHO Jakarta Declaration on health promotion which identified the need for:

“new responses” with “new and diverse networks to achieve inter-sectoral collaboration...” in order to “unlock the potential for health promotion inherent in many sectors of society, among local communities, and within families. There is a clear need to break through traditional boundaries within government sectors, between governmental and non-governmental organisations, and between the public and private sectors. Co-operation is essential. This requires the creation of partnerships for health on an equal footing, between the different sectors of governance in societies.” (WHO/ HRP/ HEP/41 CHP/BR/97.4)

¹³ C. Pervilhac’s presentations: Consensus and Planning Workshop (Gaoua, March 1998), and DRI Meeting, GTZ RAP (Accra, March 1998) and Health Reform and HIV Workshop (Geneva, June 1998)

The Local Responses within UNAIDS Department of Policy, Strategy and Research
The Local Responses to HIV/AIDS was defined recently by UNAIDS/PSR as:

“As people’s decisions in their private lives determine the final outcome of battle against AIDS, the response is primarily local. With local we mean involving people where they live — their homes, neighbourhoods and work places ... Since there are limits to what people can do their own, there is a need for local partnerships (between services providers, key social groups, and facilitators/ catalysts)... The local responses approach uses a four-pronged approach: the first is human resource and systems development ... the second is policy development ... the third is mobilisation of local and external resources ... the fourth is learning from action and interaction between stakeholders ...”

The “Local Responses to HIV/AIDS: The Global Agenda“ (Key Note June 2000), accompanied by the „Strategic approach towards an AIDS-competent society“ (Technical Note Number 1) were recently issued from the Local Responses team from UNAIDS Department of Policy, Strategy and Research (Appendix 1B). They summarise in more details successively the recent concept of Local Responses, and the nine steps recommended in order to implement the approach.

The Local Responses: a personal view

The present research, or the development of successful responses, needs to overcome the dual challenge best illustrated and compared with the following piece of modern art exhibited in a gallery: *The cough syrup transport system*¹⁴ (Fig. 1.1).

In order to deliver prevention and care strategies effectively (with the spoon), we are attempting here to develop the best mix of an ingredient, the “syrup,” which looks simple in its composition and balance but is not.



In addition, we need further to adapt or create a simple and appropriate technologies or tools for an expanded responses, the “transport system” or Local Responses, in order to improve our understanding of the environment and be able to deliver these strategies effectively. The “transport system” (tools and technologies) is still disproportionately complicated and awkward, or inefficient in the preliminary stages of this research process, in comparison to the ‘syrup’ (better known and tested strategies).

Fig. 1.1 Cough Syrup Transport System, 1998
Andreas Slominski, Deutsche Guggenheim Berlin

¹⁴ Andreas Slominski, 1998, Detail of the exhibit, at the Deutsche Guggenheim Berlin (20. Feb.-9. Mai 1999)

1.2 HIV/Aids Programme in the Field and Local Responses

To understand better the context in which the Local Responses are striving, it is important to have an understanding of the field in which those are taking place. A review of relevant literature aims to give the necessary background information to understand on what this approach is based and the difficulties of implementation.

First, the Primary Health Care (PHC) District Approach to Program Delivery clarifies the PHC philosophy and the importance of focusing on the local or district level. The issues of comprehensive and selective approaches are revisited, and explain in turn how much the local responses match the original comprehensive PHC approach.

Second, we explain in turn what is the Health Sector Reform and how it can benefit the local responses, and reciprocally how the local responses can benefit the implementation of a successful reform.

Third, in order to have the local responses succeed, strategies and interventions need to be pursued which are reviewed in this section, as well as the issue of focused interventions. In complement to these three points, throughout the review specific references are made about the present development of the Local Responses approach as well which supports the evidence of a field in full expansion¹⁵.

1.2.1 Primary Health Care District Approach and Local Responses

The World Health Organization conference held in Alma-Ata in 1978 has been the main governing force in the policies of countries related to delivering comprehensive health care, and was formulated originally as the following goal, with the eight components:

„the attainment by all people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care includes at least¹⁶: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition, an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs“ (WHO 1978).

Twenty years later, following the failures and lessons learnt from PHC, some of the original concerns brought up by experts in the field are still valid: more attention should be paid to the support of village health workers and their training and financial incentives instead of hasty, large, and non-sustainable coverage¹⁷ (Chabot 1984). The Local Responses and Health Sector Reform can be seen as a revisit or a second birth of the Primary Health Care (PHC) approach applied to HIV/Aids. This is reflected in a closer analysis of the PHC concept based on the following Primary Health Care (PHC) definition. The Local Responses approach overlaps and fits well into the PHC principles based on the concepts stated next of equity and services to more at risks or vulnerable groups, of community participation, of prevention and promotion aspects, of technology, and of poverty alleviation:

„... the PHC approach advocates the provision of front-line, first contact services within the framework of the five principles of:

- a) health services must be more equally accessible, not neglecting rural and isolated populations or peri-urban dwellers,*
- b) active participation by the community in their own health decisions is essential,*

¹⁵ At least half of the references of the literature review are dating from the year of the research, i.e. 1997, or more recent

¹⁶ Next, the 8 PHC components

¹⁷ the polemic on the strategies and approaches used to carry out PHC schemes should not be underestimated: WHO rejected the publication of this open critique of PHC implementation which was submitted and accepted in The Lancet (personal communication with the author, June 1999)

- c) preventive and promotive services rather than curative services should be the focus of health care,
- d) the methods and materials used in the health system should be acceptable and relevant, appropriate technology -not synonymous with primitive or poor technology,
- e) health must be seen as only part of total care -nutrition, education, water supplies and shelter are also all essential minimum requirements to well-being“(Walt and Vaughan 1981).

In the late eighties, these PHC principles and the rationale for comprehensiveness were reformulated and acknowledged (Grodos and Xavier de Bethune 1988) as an attempt for PHC to give a ‘global’ responses to health problems (beyond the strict medical aim to address the ambitious social aim as well), and address issues related to equity, participation, and cost effectiveness. The authors identified four levels that drove the PHC implementation which match in turn the local responses approach as well:

- ♦first, a level of care close to and accessible by the communities and the District level;
- ♦second, an action program for the eight PHC components¹⁸ based on the communities’ needs and demands, the populations at risks, and responses to those;
- ♦third, a strategy of organisation of services (hospitals, community participation...) with scientific literature pointing to the need for integrating family planning, STD, and Aids (Ching-Bunge 1995) (Stein 1996) , and of the need for intersectoral collaboration with challenges to overcome the numerous and complex constraints to work within the health sector between programs (Mayhew 1996). The “Ten steps towards an integrated district health system” (WHO 1996) support in details the pathways of the local responses described earlier (1.1) explaining in turn how the local responses for HIV/Aids can tackle the issues of integration of health care delivery. The discovery of the potential roles of other sectors in responses to HIV/Aids such as agriculture (FAO 1997) (Baier 1997) (Hemrich G. et al. 1997), and education (Oulai D. et al. 1993) are only recent developments. Consequently, the methods to analyse and involve these various sectors still need to be more elaborated upon.
- ♦fourth, a general philosophy of the health system (local responsibilities, other development priorities, equity, global health and socio-economic-cultural environment).

Why the District or local Level?

The operational level of responses and focus at the district level, rather than the regional or national level, on which the local responses is based, comes from its recognition as “*the key level for the management of primary health care (PHC)... It is the most peripheral unit of local government and administration that has comprehensive powers and responsibilities*“ (Vaughan and Morrow 1989). The local politicians and civil servants of the government sectors are co-ordinated and linked at the most peripheral administrative level in the District (Mills 1994). This justifies further the focus for the local responses at the District and community levels, the pillar of the PHC approach, in the present democratisation process and empowerment of the local authorities, and civil society. This explains the numerous efforts to work in the eighties and nineties to strengthen that level of the health systems, and to invest into district human resources training as well, despite the known limitations (Pervilhac and Seidel 1995) (Pervilhac 1998). HIV Prevention and AIDS care in Africa. A District Level Approach (Ng’weshemi, Boerma et al. 1997) documents practical issues and approaches for district managers related to organisation, monitoring, behavioural interventions, health interventions, and financing at that critical level of the health care system.

¹⁸ Ref. above PHC Alta-Ata proceedings

In addition, district health services have recently become the focus for initiating new ways of working and moving toward a “sector-wide approach...” At this level, the “dialogue between governments and donors shifts up a level, from the planning and management of projects, to the overall policy, institutional, and financial framework within which health care is provided” (Cassels A. et al. 1998).

Which specific approach to use to fulfil the PHC goal?

Two schools of thoughts, with opposite views on which approach to pursue, have fuelled an extensive debate and created clashes in the eighties, as documented in a comprehensive and provocative issue of Social Science and Medicine on “Selective or Comprehensive Primary Health Care?” (Rifkin and Walt 1988). The issue of comprehensive vs. vertical approaches for PHC has had repercussions on the origins, present approach, support, and future of large public health programs in the nineties, including the present local responses to combat HIV/Aids.

In 1985, in Antwerp, some leading scientists took a stand against selective care (Barker and Turshen 1986). The dispute originated largely from two different programmatic experiences and views: first, the failure of the Malaria Eradication program which triggered indirectly PHC and a comprehensive approach one hand (Newell 1988). Second, the success of the Smallpox eradication in 1977 combined with other factors (believes in effective and cost-efficient medical interventions, and scarce resources due to the economic crisis which accentuated in the early eighties) led, on the other hand, towards a selective approach to PHC which has been largely supported (Walsh and Warren 1979; Walsh 1988) (Warren 1988) (Warren 1988). It was justified on the following basis:

The PHC approach is too idealistic to be implemented by most governments. Instead it was more realistic to target scarce resources to control specific diseases which accounted for the highest mortality and morbidity; which had available low cost technologies for prevention and treatment; and which had techniques that were cost-effective. This approach was called the selective Primary Health Care“ (Rifkin and Walt 1988).

The latter selective approach was mainly driven by international agencies (the Rockefeller Foundation, the World Bank¹⁹, UNICEF²⁰, USAID, CDC²¹...), and critical reviews of methods and results have been largely documented elsewhere (Unger and Killingsworth 1986; Newell 1988) (Wisner 1988). The Burkina Faso “vaccination commandos” of the mid-eighties were used as a model of successful top-down approach only ten years ago²², and contrasts with the present local responses bottom-up approach. This may explain why at the community level some of the old “sages” (older key informants) in our study still pointed to and expected an outside intervention to tackle the Aids problem. Even within WHO, “Selected Primary Health Care Interventions” (WHO 1980) were discussed in the early eighties among different programs. Vertical programs are the epitome of selective programs; Yaws, Dracunculiasis, and Measles were considered nevertheless to become part of “the eradication in the context of Primary Health Care” in the mid-eighties already (Taylor 1987). D. A. Henderson, an internationally known public health figure, has led as a Director the WHO’s successful campaign to eradicate Smallpox; he is still up to today recognised for his work²³. This program has influenced up to the turn of the century in turn indirectly international policies, and continues to stimulate the eradication programs, for example Poliomyelitis by year 2000, or Dracunculiasis (or Guinea Worm), or Onchocerciasis.

The original program thrust to combat Aids from the mid-eighties to the mid-nineties was largely driven by the WHO Global I Program on AIDS (GPA) which was characterised by a selective approach, although never referred to as such. It aimed to respond to a much feared and unknown epidemic with large resources, world-wide and quickly. It was largely centrally-driven, vertical, top-down, health sector exclusive²⁴, and relied essentially on the reduction in risk-taking behaviour through tar-

19 Basic Package

20 GOBI-FFF focused on Growth chart, Oral rehydration, Breast-feeding, Immunization- Family planning, Food supplementation, Female status (promotion)

21 USAID/ CDC CCCD-ACSI focused on the Combating Childhood Communicable Diseases-African Child Survival Initiative with Immunisation, Diarrhoeal Diseases, and Malaria (the author launched this program as a Technical Officer for CDC Atlanta in Burundi in the mid-eighties)

22 the researcher was a guest of UNICEF Burkina Faso in the mid-eighties to learn from that model

23 the researcher attended D.A. Henderson’s lecture on “Bioterrorism: Myths and Realities” (current issue of the destruction of all Smallpox virus stocks or not) for the Frank A. Calderone Medal and Award which Henderson received at The Joseph L. Mailman School of Public Health Columbia University, New York, on April 5, 1999

24 the central National AIDS Programs (NAP) of the Ministries of Health were powerful, often independent sections from the MOH, with large financial and human resources. They were driven by Strategic or Medium Term Plans (MTP).

getting individuals and groups, as the single spearheading strategy. HIV/Aids interventions as vertical and top-down “selective” programs have shown their limitations over a decade after the inception of the Global Aids Strategy (UNAIDS 1998), as mentioned in more details previously (ref. Section 1.1).

The present UNAIDS mandate that started in 1996 states “*the need for a broader/based, expanded responses to the epidemic in sectors ranging from health to economic development... (because) AIDS is not simply a health crisis, but a social and economic crisis...*” (UNAIDS 1998) In contrast to the past GPA, the present local responses is locally-driven (district and communities), horizontal, bottom-up, multi-sectoral, and uses a mix of prevention and care and support strategies (ref. next para.) to combat HIV/Aids.

The local responses joins therefore the present trends of the majority of health care programs moving into horizontal and bottom-up “comprehensive” approaches, in the original spirit of PHC.

In addition, the interaction of the HIV infection with other diseases (e.g. STD and TB) necessitates integration at the operational levels, and not independent programs.

With the clearer picture in mind of the larger public health context in which the local responses is grounded and evolving, the forces playing for and against the local responses become more visible. Senior decision-makers and policy-makers have their positions and views that automatically bias their choices either in favour of the local responses or make them hesitant to join the new band. The younger generations of program managers operating in the field are often unaware of the obscure forces at work and do not master the full picture of that complex game.

In conclusion, the local responses approach, overlapping so closely with the PHC and comprehensive approaches, makes it an attractive and praiseworthy agenda. But it can quickly meet some of its limitations as well: too broad, too ambitious, too vague, insufficient tools, in danger of being “recuperated” by some of the failures (Taylor 1987) of PHC schemes (e.g. revamping the old PHC village health workers schemes), functioning beyond the mandate of the health sector therefore, out of control. As a consequence, the local responses may not be such an appealing approach for donors and agencies to control HIV/Aids, particularly after the present unachieved original goal formulated twenty years ago by WHO of “Health for All by the Year 2000.” In addition, the policy-makers and program managers who come from the selective approach thinking may by default avoid to become involved and be trapped into the local responses. They will prefer to concentrate instead on a few strategies, even if not perfect, particularly in the case of HIV and Aids which already suffer from having so many strategies and interventions (ref. Section 1.2.3), with clearer outputs.

1.2.2 Health Sector Reform and Local Responses

The “Local Responses and Health Sector Reform” was labelled originally in 1997 without even any mention of “Health Sector Reform.” The rationale for the approach, though, did mention “sector reforms” among different justifications for the Local Responses multi country case studies. The original generic framework encompassed the need to improve the understanding at the district level of existing structures, both governmental and civil society, and the current trends in public sector reform. Policy tools and approaches were recommended to be used in the situation analysis to that effect.

Health Sector Reform has gained more weight with time in playing a central role to the local responses process with the turning point being the “Health Reform and HIV Workshop: an Agenda for Health Reform and HIV” (Geneva, June 1998). The importance for the UNAIDS partners and cosponsors, particularly the World Bank with early discussion and an important agenda on Health

Sector Reform (The World Bank 1993), explains in part this recent emphasis. More central to this refocus, and towards contributing to a successful responses, may be the key importance of political leadership and local partnerships, combined with the effective organisation of health-care provision.

Although often health professionals do not like, in general, to mingle into policies and politics, Health Sector Reform needs, nevertheless, to be perceived by these actors as one of the important enabling structural factors to succeed in expanding the Responses to HIV/Aids. Additionally, one of the lessons learnt from Primary Health Care is that implementing program activities do not fall into a vacuum and that the institutional context in which those take place can either facilitate the success of plans, or constrain those.

We reviewed two essential background materials on "Health Sector Reform: Key Issues in Less Developed Countries" (Cassels 1995) and "Health Sector Reform" in a recent Occasional Paper (Gilks, Floyd et al. 1998). Those were instrumental to help us next to clarify the important questions related to the rationale of the Health Sector Reform, the content and benefits, the tools used, and limitations of the Health Sector Reform.

Why Health Sector Reform?

This has been summarised for and formulated to the various partners under the question: "*Do Health Reforms pass the HIV test?*"²⁵ In other words, is Health Sector Reform setting an environment which enables the development of effective HIV/ Aids strategies and consequent positive outputs, or not?

Institutional or structural changes of the Health Sector Reform address the necessary organisational structures and management systems improvements that allow strategies to be effective.

Recently, a call was made to have the "*advocates of health reforms... to consider carefully HIV/Aids especially in high-prevalence regions*"²⁶, (Gilks, Floyd et al. 1998), to resolve important pending issues, for example²⁷:

how to link HIV-prevention activities to care and support in ways that promote prevention?

- ♦ what is the role of the private sector?

- ♦ what are the health staff's attitudes towards HIV and how does it affect the efficiency of services?

- ♦ how can district health teams focus efforts on improving quality, efficiency and equity of services for HIV/Aids with scarce resources?

- ♦ what are the new needs due to the additional burden that HIV places upon health-service infrastructures (drugs, beds, well-trained and experienced staff for in- and outreach-services)?

The reasons why programs or interventions must go in hand with health sector reforms were crystallised recently in the current state of advances and challenges of HIV Prevention. The answer for success of HIV prevention be it in the richer countries of the North, or the „resource-poor environments of the South“ lies in „...*implementing the right combination of interventions and policy initiatives at the correct time*“ (Piot 1998) based on evidence from Uganda, Senegal, Tanzania and Thailand.

What is Health Sector Reform and what are the benefits?

“Health sector reform is concerned with defining priorities, refining policies and reforming the institutions through which those policies are implemented” (Janovsky 1996). The original definition of

²⁵ J. L. Lamboray's "Health Reform and HIV" presentations, Geneva, June 1998, and Eschborn, January 1999

²⁶ Gaoua District where the case study took place is of high prevalence

²⁷ adapted from Gilks et al.

health sector reform identified it as a „sustained process of fundamental change in policy and institutional arrangements, guided by government, designed to improve the functioning and performance of the health sector and ultimately the health status of the population“ (WHO 1995). This major change is often perceived as a threat to the main actors, and can in turn be a factor of resistance to the implementation of reform. We argue, as a possible other facet of the way policies are implemented as well (Walt 1994), that Health Sector Reform appears to be more of a gradual, or incremental or evolutionary process. This coincides with the etymology of “reform”²⁸, even if the final result of Health Sector Reform may be a fundamental change. The reforms take place over a long period of time through sustained processes instead of a one-off brutal and quick change. Despite the original definition of reforms guided by governments, those are often pushed from the outside, hence creating some scepticism and resistance on the part of the local providers.

“Health Sector Reform is a political process, and recent experience in Europe and North America give evidence that health reform is a highly political and fiercely contested process” (Cassels 1995). It will never be in everyone’s interest and cannot be advanced by technical analysis alone. Stakeholders either on the providers (those involved in service delivery) or purchasers (those concerned about using the service) of health care, all have different interests which need to be determined (Gilks, Floyd et al. 1998), and taken into consideration.

Cassels identifies the reforms of institutions in the health sector to be central to the process of health sector reform, based primarily on practical experiences rather than research. However, it is *“a means to an end, and it is necessary to keep sight of the policy objectives -improved efficiency, equity, more responsive services and, ultimately, better health outcomes, that institutional reforms is designed to achieve”* (Cassels 1995).

It aims to improve the functioning of public bureaucracies, and often in parallel with, and sometimes in responses to, other aspects of institutional reform, such as increasing the role of private providers and increasing the autonomy of provider institutions (Cassels 1995). Ultimately, health reforms aim *“to improve the quality and effectiveness of the services delivered”* (Gilks, Floyd et al. 1998).

The components of health sector reforms programs that are applicable for the local responses are the following²⁹:

- ♦improving the performance of the civil service (public sector)
- ♦decentralization
- ♦improving the functioning of the local ministries of health and their links with regional and national levels, including integrated planning and execution
- ♦introducing health financing schemes and broadening the options
- ♦improved partnership between the public and private sectors
- ♦comprehensive plan for HIV/Aids in responses to local needs which integrates the prevention and care services.

The present research was stronger in analysing the last two points issues than the others due to the priorities of the research which needed to focus on partnerships, and plans for action, combined with the fact that the other issues had in turn been studied already earlier in details (Foltz A.-M. et al. 1996). The focus in the present case study is more on the health care systems reform and not so much on health reform in the general sense.

²⁸ re- again + formare- to form: to form again, to restore to a better condition

²⁹ adapted from Cassels and Gilks et al.

Frenk identifies four levels of the health reform process: systemic with equity issues, programmatic with efficiency and cost-effective issues, organisational with productivity and quality issues, and instrumental with information for action (Frenk 1994).

In summary, the aim of Health Sector Reform is broad and complex, and can be interpreted quite differently depending of the people involved or institutions mandating the work. It needs time to bring about changes. The political nature of the process can make it a difficult venture to embark upon or succeed into. Finally, the scope of assessment and execution necessitate different background and expertise.

What are the tools for Health Sector Reform?

“The process of reform and difficulty of implementing policy and institutional change has been relatively neglected in comparison to the debate about the content of the reform.” (Walt and Gilson 1994)

The present status of development of tools for the health sector reform suffers from a number of caveats as identified by Cassels: *“The development of policy and institutional analysis in the health sector lags far behind epidemiological, demographic and economic research. There is no consistently-applied, universal package of measures that constitutes health sector reform” (Cassels 1995).*

“There is limited experience in monitoring institutional change as compared, say, to looking at health outcomes in categorical disease control programs.” For example projects seldom have any indicators related to health sector reforms in their planning by objectives frameworks, or any baseline related to this area. Medical planners or epidemiologists are ill-prepared for this task. In addition, *“there is a need for the development of methods which will enable planners to analyze the effects of different approaches to policy and institutional change, as well as to develop better systems and methods for monitoring policy implementation.”*

A closer look to the case of the “Decentralization and Health Systems Change: Burkina Faso Case Study” (Foltz A.-M. et al. 1996), based on an original framework to analyse decentralisation and health systems change (WHO 1995), illustrates the complexity of such an approach, far from being a tool which can be replicated by a non-policy specialist. The policy environment found in Burkina Faso is analysed separately (para. 4.2.3).

The various local responses case studies experienced the conceptual and methodological weaknesses with wide interpretations about how to go about assessing Health Sector Reform in each country studied, and with one of the best analysis coming from the most knowledgeable group in the subject³⁰. Donors and agencies, including program managers that are under pressure to show results and outputs are obviously hesitant to embark on such an agenda with the present incomplete and status of the tool development still in the experimental stages.

What are the barriers to and limitations of the Health Sector Reform?

Donor agencies express reluctance to support governments *“to address systemic as opposed to programmatic issues” (Cassels 1995)*. The reasons vary widely: by lack of clear objectives, because of the complexity of the issues, by lack of tools or expertise. In addition, other reasons are: the limited opportunities to implement changes due to weak stability of systems of governance, the limited political support for fundamental change, the preferred investment in safer private partners (Non-Governmental Organisations, community organisations...).

³⁰ Ghana DRI Case study, JSA Consultants Ltd.

In addition, Health Sector Reform is often equated to address a “*particular set of prescriptions*” (Cassels 1995) only based on the donors’ interests and priorities, or the biases of the expertise (such as user charges, reducing the size of the public sector, cost-effective packages of services and privatization).

The health sector is often isolated to the overall process of decentralisation, as identified recently (Gilks, Floyd et al. 1998) —one of the last bastion of decentralisation in the country administration—and lacks either the management capacity or political support to direct the process. In the short term, performance may well deteriorate because the capacity to manage, rather than simply administer health care is not widely available. *“There is not yet any clear direct evidence that health reforms lead to better health services. However, successful efforts to improve the quality and efficiency of services, especially those for HIV-related diseases, will benefit all users”* (Gilks, Floyd et al. 1998).

Some of the more pertinent issues in which health sector reforms still need to prove whether it can meet the challenge of HIV/Aids are related to (Gilks, Floyd et al. 1998): the integration of HIV/Aids and STI services into district health plans; the prioritisation and financing of HIV/Aids care and prevention activities relative to other pressing public health and treatment priorities in the district; where does the treatment of HIV/Aids fit within the framework for essential care packages; how do more vulnerable and poorer households can care for their infected and affected by HIV/ AIDS relatives; are there policy guidelines or action plans for additional staff turnover, ill health and death related to HIV/Aids?

The present case study experienced some of these limitations and barriers to various degrees.

In conclusion, the chance for the Health Sector in the nineties is that it is benefiting from, and in turn is influenced by reforms in the area of governance and the public sector in general. The final purpose of reform being to bring government and decision-making to the community level fits well the PHC ideals. Reforms are taking place concurrently in other sectors as well, such as in education and agriculture. Health Sector Reforms are indeed part of broader reform processes taking place in each country. The economic and political reforms in countries are improving the overall administrative and technical structures. For example, the democratization processes are a direct stimulus to the decentralization of activities by empowering more the communities to select their local political leaders, and to take decisions and manage their own revenues. The four different types of processes³¹ which constitute decentralization need to be assessed locally, and the limitations of local professional cadre in sub-Saharan Africa to support the process considered carefully (Moore 1996).

As a consequence, health actors need to be pro-active and constructive and not reactive or defensive to such new developments, despite the present above mentioned broad interpretations, and limitations of know-how on how to conduct the full process. The “Local Responses and Health Sector Reform” is a deliberate step to try to have the HIV/Aids strategies take advantage and benefit from the Health Sector Reform process, and the same time be a catalyst towards successful reforms.

The Local Responses and Health Sector Reform Approach

Ten years into the epidemic, studies pointed already to the importance of the societal context in influencing and conditioning personal behaviour (Mann, Tarantola et al. 1992).

A critical review of the lessons learned from prevention of sexual transmission of HIV in sub-Saharan Africa pointed to the recent discovery of the “structural³²” and “societal³³” factors in the likelihood that transmission will occur, in comparison to the better known “individual³⁴” and “infrastructure³⁵” factors

³¹ Deconcentration, delegation, devolution, transfer

³² factors related to laws, policies, and developmental issues

³³ factors related to societal norms that encourage high-risk sexual behavior

³⁴ factors that directly affect the individual and that the individual has some control of changing

³⁵ factors related to the health system that directly or indirectly facilitate the spread of HIV

(Lamprey P. et al. 1997). This explains why most programs until now still intervene almost exclusively at the individual level, for example, identifying and acting upon individual risk factors using epidemiological methods. Consequently very few intervention programs address the “*long-term, complex, and difficult issues*” (op. cit. p. S65) related to structural and societal aspects, and the identification of vulnerable factors related to those. The consequence of this acknowledged gap is leading to the reassessment necessary to work out the perfect ingredients and mix of the “cough syrup.” (ref. Fig. 1.1) The local responses has the ambition to reconcile all four levels and set “*comprehensive, integrated, and multisectoral programs,*” (op. cit. p. S63) as a necessary new approach identified to slow the HIV/Aids epidemic in Africa.

Due to the complexity of these different levels, the need to combine “epidemiological, cultural and economic studies... to illuminate a different part of level of the whole picture” (Carael, Buvé et al. 1997), and design appropriate interventions in specific context is recommended. It is the backbone of the Local Responses approach and explains the present case study design.

Taking into consideration these recent developments, the local responses launched by UNAIDS and WHO aims to provoke plans and responses more for a local- than for a national-driven responses³⁶, given local levels were up to now insufficiently reached by national plans. The local responses at the District level attempts to link the national level to the reality and needs of the local level. It is hoped that the cumulation of several local responses experiences in each country at the local levels will be instrumental to refine the national strategic plan in each country as well. This contrasts with the opposite top-down original approach in the late eighties and early nineties expecting trickling down effects at the local level and which proved to be a wrong assumption.

The present concern and priorities to work through local levels are also found in industrialised countries. Taking the example of the USA, one of the key approach to battle the HIV pandemic acknowledged recently is to “*achieve higher degrees of coordination across a broader scope of program activities, particularly at the local, implementation level*” (St. Louis M. et. al. 1997).

In 1996, an early UNAIDS’ definition of an expanded responses was leading to some major orientations already which clarifies the approach used and gives evidence of the overlaps with the PHC approach:

“An expanded responses calls for social change, including the integration of HIV/AIDS into national development policy, creation of supporting environments, strengthening of community action, developing individual skills and reorienting services towards providing prevention rather than curative interventions.”

Most responses to the pandemic are primarily driven by risk reduction measures.

In order to expand the responses we need to analyze individual and broad societal factors influencing the HIV pandemic. This analysis and its impact can be enhanced by broad participatory process of reviewing available information, sharing experiences and facilitating a common vision of responding to HIV/AIDS.

The expanding responses recognizes that the social environment and individual risk behavior are closely concerted. It enhances the value of individual decision-making while relating behavior and behavioral changes to some of their underlying causes.

Vulnerability reduction implies a long process of profound cultural, institutional and

³⁶ UNAIDS has published in 1998, three Guides to the strategic planning process for a national responses to HIV/ AIDS: situation analysis, responses analysis, strategic plan formulation

environmental change in most societies. The setting of short and long-term goals for action aimed at reducing vulnerability are required to create a manageable plan of action out of daunting, seemingly overwhelmingly challenges.

This expanding responses must be based on the prioritization of needs at the national and community level, and requires the mobilization of the appropriate human, material and financial resources. It also requires concerted action by individuals and communities, as well as governments and private agencies, both in the short term and over long periods” (UNAIDS 1996).

The present current understanding of the Local Responses and Health Sector Reform is summarised in a recent UNAIDS publication, “Expanding the global responses to HIV/AIDS through focused action” (UNAIDS 1998) discussed earlier (ref. Section 1.1).

In conclusion, based upon the literature review, and the practical field work and exchanges we had over the past two years, and to take a step further Lamboray’s original question on “do health reforms pass the HIV test?” we may in turn ask: “Is the Local Responses and Health Sector Reform for HIV/Aids passing the Primary Health Care test?”

The present literature review supports what the local responses originally advocates, and that the approach is based on sound concepts. Those are laid in the combination of using the principles of Primary Health Care approach, with the search for the best mix of practical strategies and interventions, finally with striving for the improvement of the overall systems in which HIV/Aids function through the Health Sector Reform. On the other hand, due to the nature and weaknesses found in this combination, international and national institutions, policy-makers, technicians, and managers may still be skeptical to fully support the local responses now and in the years to come. They are the senior decision-makers who are the Primary Health Care (PHC) skeptics, and will not embrace any more what may be perceived as one of a U.N. agency latest fad. They are the managers who consciously or not may be inclined to the vertical approaches to responding to HIV/Aids. Finally, they are those who will only be converted once results are documented with hard data show and positive results.

We shall argue and document next how with relatively little inputs and scientific stimulus we were able to make an important step to respond locally to HIV/Aids through the present initiative along the PHC approach. This occurred with the technical and financial support of the country national and international partners, and of UNAIDS and GTZ in particular. It is a way to address the UNAIDS Executive Director’s plea for the donor nations to invest more into Aids because of the single greatest threat it represents to global development today, instead of the present “minimal” contributions (Piot 1999).

1.2.3 HIV/Aids Strategies and Interventions and Local Responses

As pinpointed by P. Piot in the Preface of the most recent Report on the global HIV/AIDS epidemic: after 15 years of action against the epidemic, important insights into effective responses are many (UNAIDS 2000). Ironically. Effective responses need a „nationally driven agenda“, a „single and powerful national AIDS plan involving a wide range of actors“ (multisectoral response), „social openness increasing the visibility of the epidemic and countering stigma“, „social policies that address core vul-

nerabilities“, „the engagement of all sectors (not just health)“, „a recognition of the synergy between prevention and care“, „support to community participation and targeting interventions to those who are most vulnerable, including young people before they become sexually active“, „forward-looking strategies“ (op.cit. p 7). In addition, as pinpointed in the report, „two decades of experience show that behavioural prevention can make a serious dent in the rate of new infections and change the course of the epidemic“ as reported with the review of existing tools and skills (op. cit. p. 55-77). Community-based responses, or the Local Responses, is one among the different ingredients to have effective national responses (op. cit. pp. 108-115).

What is missing up to now for effective responses are effective local responses, hence the nature of the approach and of the study in Gaoua communities and district described in the present research study.

“Expanding the Global Responses to HIV/Aids through Focused Action” requires a two pronged expansion of the global responses with political commitment:

“- *First, there needs to be an improvement in the quality, scope and coverage of continuing prevention, support, care and impact alleviation.*

- *Second, there needs to be new action directed at the societal factors which enhance people’s vulnerability to HIV and AIDS”* (Piot 1998).

Piot further recommends that *“past efforts to reduce individual and person risk must now be combined with actions to reduce vulnerability through changes in law and policy, and through longer processes of cultural, structural and environmental change.”*

A recent conceptual framework with four determinants (macro factors, socio-economic environment, sexual behaviour, and biomedical) could be used for an improved understanding of the various determinants of the HIV epidemic looking and assessing more systematically those. (Barnett and Whiteside 1999)

The Local Responses and Health Sector Reform being an approach, rather than a clear cut strategy or intervention, it relies in the end upon existing HIV/Aids strategies and interventions to be implemented in order to reach and document changes and successes.

Following the local responses situation analysis of mid-1997 in Gaoua District, Burkina Faso, the Consensus and Planning Workshop took place several months later in early 1998, and clarified the context of the local responses (Appendix 1A). The partners from the public and private sectors, established how ill-equipped and -prepared the technical planning and the management teams were to design clear cut strategies and interventions with the local district partners in responses to the problems identified in the situation analysis. At the local level, while prevention strategies are evolving rapidly, those for care and support are even more recent and still at the experimental stages (Gilks, Floyd et al. 1998). As a consequence, the planning and implementation of strategies by local managers working in high prevalence areas, who need to combine and tackle the epidemic from both the preventive and curative angles, become a daunting challenge. In addition, the care and support strategies for Aids largely depend of activities to be implemented outside the walls of the hospital just like the bulk of the preventive activities are for HIV.

What is, in the late nineties, or little over ten years of experience only, the status of development of strategies and interventions available to combat HIV/Aids? What is the state-of-the art of those? Are they as straightforward for HIV prevention or mitigating (care and support) Aids purposes as the following illustration of the “One bug. One drug. One shot” slogan (advertised to treat uncomplicated gonorrhoea) may at first suggest?

Fig. 1.2



**HIV/Aids Strategies and Interventions—
recommended international standards for preventing HIV and mitigating Aids?**

Even if numerous strategies and interventions are available (next paragraph), the above question is still open, given the state-of-the art of development of HIV prevention and effectiveness to prevent sexually acquired HIV is only in the incipient stage of development in the public health field. For the patients who need special strategies, care and support because of Aids, the field is new too. We can draw a parallel with the present research to the development of a highly active anti-retroviral therapy, or of a safe and efficacious vaccine in the bio-medical field. We have the ambition to contribute with the present research to a so-called systemic (i.e. systems based) HIV prevention and mitigation vaccine development over the years to come (C. Pervilhac 1997). Yet, the slow and difficult status of development of HIV prevention is seldom recognised as such in the literature or in international conferences. To revisit the image of the best “coughing syrup” (1.1), the development of the local level responses is still being studied and the machinery needs to be simplified. In addition, in contrast to the bio-medical developments with “sensational reporting” (Piot 1998), public health advances and progresses are more often reported in the international news media as gloomy developments with limited impact on a growing epidemic.

Despite the promises shown in the development of the bio-medical field, prevention remains in the short and long term the most feasible global strategy for the control of HIV/Aids, justifying local responses-related research such as the present one.

Which strategies and interventions?

Based on WHO/GPA training manuals³⁷, a “strategy” is “a major means of achieving an objective which may include one or more interventions” and an “intervention” is more specifically “a set of activities through which a strategy is implemented” (WHO 1995). At present, surprisingly, no documents or articles exist which give a comprehensive view of existing HIV/Aids strategies and interventions, a sign of a rapidly evolving field of research still.

To fill in this gap, based on information and materials gathered at the 12th World AIDS Conference, we reviewed and categorised the types of strategies and interventions into prevention, care and support, and additional ones. We sub-divided the strategies into a “typology of intervention programs” (Cohen and Trussell 1996) according to the foundation on which they are based (Table 1.1).

The known relative easy access of populations to the institution-based programs are attractive to the various partners, potentially cost-effective in comparison to other programs. In addition, being mainly health-institution based, or medically driven, they are often largely favoured by the powerful medical lobbying groups in comparison to the public health ones, and they are the ones that have had the most experience over time. The community-based programs with the community participation component necessitates time, special techniques, logistics support, are less cost-effective and have been well-studied in the PHC literature, as well as in the context of Aids (UNAIDS 1997). The population-based programs are for the most part, relatively new programs and are still being experimented upon.

Such useful classifications are not used in planning exercises, and more complicated economic analysis appear to prevail in the current setting of priorities instead.

³⁷ The training manuals targeted to National AIDS Program Management” by WHO/ GPA have had limited distribution and applications due to the UNAIDS mid-nineties policy changes. These manuals were not known in Burkina-Faso in 1987 either at the national or local levels

Table 1.1 Summary Table of HIV/Aids Strategies

1. Nine major HIV Prevention Strategie	2. Six major Aids Care and Support Strategies	3. Eight additional Complementary Strategies
<i>Institution-based programs:</i>		
1.1. Promoting and distributing condoms (WHO-GPA 1995; D'Cruz-Grote 1997)	2.1. Clinical Management (drugs for opportunistic infections and STD, and ARV therapies...) (WHO-GPA 1995; WHO-GPA 1995; Gilks, Floyd et al. 1998; Girma and Schietinger 1998)	3.1. Tuberculosis treatment, control, and prevention (Gilks, Floyd et al. 1998)
1.2. STI treatment, control, and prevention (syndromic approach) (WHO-GPA 1995; Gilks, Floyd et al. 1998)	2.2. Nursing Care (Gilks, Floyd et al. 1998) (WHO-GPA 1995; Girma and Schietinger 1998)	3.2. Epidemiological and behavioural surveillance (WHO-GPA 1995; Gilks, Floyd et al. 1998)
1.3 Provision of safe blood for transfusion (WHO-GPA 1995; Gilks, Floyd et al. 1998)		3.3. Training of health care staff of volunteers in health and other sectors (Gilks, Floyd et al. 1998)
1.4. Prevention of perinatal transmission of HIV (WHO-GPA 1995; UNAIDS 1997)		3.4. Improving the systems for delivering care (WHO-GPA 1995)
<i>Community-based programs:</i>		
1.5. Promotion of safer sexual behaviour through education (Gilks, Floyd et al. 1998)	2.3. Voluntary testing and counselling (WHO-GPA 1995; Gilks, Floyd et al. 1998; Girma and Schietinger 1998)	
1.6. Reduction of the vulnerability of specific population groups (WHO-GPA 1995; WHO-GPA 1995; USAID 1998; Hunter and Williamson n.d.)	2.4. Home-Based Care (WHO-GPA 1995; Girma and Schietinger 1998)	
1.7. Prevention of unsafe drug use among injecting drug users (WHO-GPA 1995; Gilks, Floyd et al. 1998)	2.5. Social Support (WHO-GPA 1995; Gilks, Floyd et al. 1998; Girma and Schietinger 1998; Hunter and Williamson n.d.)	
<i>Population-based programs:</i>		
1.8. Provision of condoms through social marketing (Gilks, Floyd et al. 1998)	2.6. Promotion of Human Rights issues related to HIV (WHO-GPA 1995)	3.5. Eliminating barriers to providing HIV-related services to youth and women, to vulnerable groups, and to people living with HIV (WHO-GPA 1995)
1.9. Promotion of safer sexual behaviour through mass media (WHO-GPA 1995; Gilks, Floyd et al. 1998)		3.6. Increasing the capacity of non-governmental, community-based, and private sector organisations to respond to HIV (WHO-GPA 1995)
		3.7. Community and District mobilisation and sensitisation (D'Cruz-Grote 1997)
		3.8. Policy Support (The World Bank 1997) (WHO-GPA 1995)

Source: C. Pervilhac, based on a literature of the references on the availability of strategies and interventions in HIV and Aids of relevant materials from 12th World AIDS Conference.

The review is not exhaustive but merely aims to identify the numerous strategy options, over twenty, which are offered to district program managers to expand the responses. Taking as a conservative estimate an average of five interventions for each strategy, a huge spectrum of over one hundred options is available to managers. HIV/Aids planning, prioritising, and finding the best mix of the strategies (the “cough syrup” presented in the introduction) is complex and outcomes are difficult to measure. This contrasts with the straightforward vaccination preventable diseases, i.e. one vaccine and one shot with at the end a direct visible effect or positive and measurable outcomes. It goes far beyond the past clear cut “core set of prevention indicators” developed in the early nineties by the previous WHO/ GPA. Those were limited to the knowledge of prevention practices, the condom availability and use, the sexual behaviour change, the quality of STD case management and the HIV/ STD sero-prevalence (Mertens T. et al. 1993).

The above wide spectrum of complicated strategies contrasts with the much clearer set of policies and guidelines currently promoted for STD control (UNAIDS 1997) (UNAIDS 1997; UNAIDS 1998), or for Tuberculosis control (De Cock K. 1996; UNAIDS 1997). STD or TB program technicians or managers may consciously or not avoid to mingle into complicated “comprehensive” HIV/Aids programs, and find in turn more satisfaction in their own limited, nevertheless important, “selective” programs.

While the strategies mentioned above aim to expand the global responses by addressing the current acknowledged needs in prevention, support, and care, those addressing the “impact alleviation” and the “societal factors” which enhance people’s vulnerability to HIV and Aids still remain to be clarified. As of 1995, WHO/ GPA had already developed training modules for prevention, support, and care only. But then, no modules had yet been developed about the strategies “to promote action to reduce social and economic consequences”(WHO-GPA 1995), giving evidence of the difficulties to identify clear strategies. This is still true at the end of the nineties. The status of the latest developments of “Efficient and Equitable Strategies for Preventing HIV/Aids” (The World Bank 1997) is disappointing in this sense. In the “Research Report” (op. cit. pp. 123-132), improving strategies to influence individual choices seems to be mainly a concern of containing costs which reflects in turn among some Agencies their present priorities and concern in running programs, e.g. social marketing of condoms. In relation to the “impact alleviation” and “societal factors,” the current status seems to point more to problems than to spell out clear strategies or solutions, for example in the difficulties of:

- ♦ altering social norms, e.g. traditional polygyny, traditional custom of “levirat” (ref. findings of community level study, Section 4.1) marriage, marriage and childbearing, large families for a woman’s social status and economic well-being,
- ♦ improving the status of women with low social and economic status who cannot insist upon male sexual fidelity and the negotiation of safe sex,
- ♦ reducing poverty and the impact of poverty on the decisions people make about risky behaviours.

At present HIV/Aids strategies are more often run under the form of a patchwork of different vertical and independent programs, based on the Agencies’ interests and managers’ expertise, instead of a harmonious prevention-care continuum. The epitome of such a strategy is the HIV prevention through the social marketing of condoms which is run as a strict vertical program. It is found across Africa run by Population Services International (PSI/USA) funded by the Kreditanstalt für Wiederaufbau (KfW), with current reviews emphasising more the economic program efficiency than the above considerations, as per our recent experience in Rwanda (Pervilhac and Kielmann 1999).

Where to focus interventions?

The correct choice of strategies and interventions at a local level is further complicated as experienced in the 1998 Planning and Consensus workshop (ref. Section 4.3.1) as well, by the problematic of prioritisation of approaches either for a general population and/ or targeting vulnerable groups. Prioritising vulnerable groups at the local level with the best program managers available in the country, and additional support of outside expertise, proved to be a difficult exercise with simple prioritisation methods still lacking. It is indeed a much more difficult choice to identify vulnerable groups to combat HIV/Aids than to prioritise for the Expanded Program of Immunisation for example for which for example there are clear cut age groups suggested as standard policies to vaccinate children for specific antigens.

Almost twenty years into the epidemic, a recent review of targeted and general population interventions for HIV prevention in the USA, recommended both approaches to “*match the needs of an evolving epidemic*” (Sumartojo, Carey et al. 1997). The question is not so much to choose one or the other, but “*to determine how best to use and combine these intervention approaches*” (op. cit. p. 1206), a premise applicable in general to all countries.

In sub-Saharan Africa, the heterosexual mode of transmission combined with the determination and identification in the late eighties, early nineties, of more vulnerable groups, and the avoidance of stigmatisation, have justified general population interventions. Yet the traditional health education of the late 1980s, or such diffused interventions, have not induced the widespread behaviour change expected. More specific programs need to be designed preferably by “targeting interventions to specific target audiences” (Cohen and Trussell 1996). Vulnerable groups in the late 1990s are now better known and can be better targeted.

Despite the fact the strategies and interventions are available, numerous barriers exist to reach vulnerable groups. Taking the example of border migrants in the case study of Burkina Faso, we identified (ref. Section 5.1.7) at least five major categories related to population, paradigmatic and epidemiological, program conception and design, organisational and institutional, and political and economic issues.

The technical difficulties of tailoring interventions for each vulnerable group at a local level combined with the financial cost to support such interventions can explain the lack of support to embark into such efforts as well. In addition to be more convincing to donors and agencies, cost effectiveness studies on HIV prevention targeting, such as the one carried out in the USA and giving evidence of substantial benefit (Kahn 1996), still lack in sub-Saharan Africa.

Let us take the above mentioned example of Social Marketing of Condoms (SMC) strategy in a recent review of HIV/STD Prevention in Rwanda (Pervilhac and Kielmann 1999). That strategy is by nature better equipped and has the mandate to reach vulnerable groups, and yet, the following gaps were noticed. Many important vulnerable groups (STD patients, Persons Living with HIV/Aids, returnees and refugees) had not yet been adequately addressed, even if several groups (several women’s groups, urban youth, the military, and clients of non-traditional outlets) had already been reached by the program.

In conclusion, the review of HIV/Aids strategies and interventions documents a rapidly evolving field with a wealth of new experiences, combined with the danger of the emerging curative strategies and interventions taking much attention, energies and resources from the preventive aspects. Strategies and interventions targeted to vulnerable groups have not yet had the attention they merit in sub-Saharan Africa. Yet the knowledge gained over the recent years, and the future needs to respond to

the changing epidemic, will hopefully bring those in the forefront soon. Much remains to be done to simplify for local use the offer and correct choices of mix of strategies and interventions, of the development of clear country specific guidelines, and to develop prioritising schemes to select the vulnerable groups at a local level.

1.3 Systems Approach of the Research

To identify the social and behavioural sciences research priorities to prevent and mitigate Aids in Sub-Saharan Africa, a panel of experts in the mid-nineties confirmed the necessity to direct more research to “contextual interventions” or indirect interventions as a weapon against HIV. Efforts have been biased up to the mid-nineties towards “proximal interventions” that attempt to interrupt HIV transmission directly targeting individual perceptions and behaviours, and overlooking often the large context within which those perceptions and behaviours are shaped. The new approach attempts to change the environment in which the HIV/Aids epidemic and many other communicable and non-communicable diseases are deeply rooted (Cohen and Trussell 1996).

Recently, through consultative workshops which took place in different parts of the world between 1997 and 1999, leading researchers and practitioners from different parts of the world examined the global use of communications for HIV/AIDS prevention, care, and support, reported in „Communications Framework for HIV/AIDS“ (UNAIDS and PennState 1999). In the majority of non-western contexts, the family, group, and community play a greater role than individualism (as opposed to collectivism) in decision making. The group of experts identified five domains of context that are virtually universal factors in communication for HIV/AIDS preventive health behaviour: government policy, socio-economic status, culture, gender relations, and spirituality. Beyond the individual health behaviour approach driving up to now communications interventions in Western societies, these interrelated domains form the basis of a new framework suggested as a flexible guide to adapt in the developing world for HIV/AIDS communications interventions. The Local Responses is based on this emerging framework. It goes beyond the more traditional and well-know diffusion of innovation theory used to inform health promotion programs. The framework recognises that the individual is a product of the context, and for the HIV/AIDS Local Responses (beyond strict „communications“ consideration) strategy to have a meaningful effect, intervention programs should begin with one or a combination of these domains. The framework specifies that „effective approaches can only be developed and refined when the framework for each region, nation, and locality is locally derived“(op. cit. p. 22). This explains the nature of present research based on the recommended „community-based approach“ (op.cit. p. 52), introduced with the comprehensive situation analyses conducted at the community and district levels (Chapter 4).

At the same time, a comprehensive review of “Communications programming for HIV/Aids” (UNAIDS 1999) summarised the state-of-the art of publications on communications which cut across all programs. The review is encouraging in documenting how much has been done over the past ten years in adapting communications strategies to HIV and Aids.

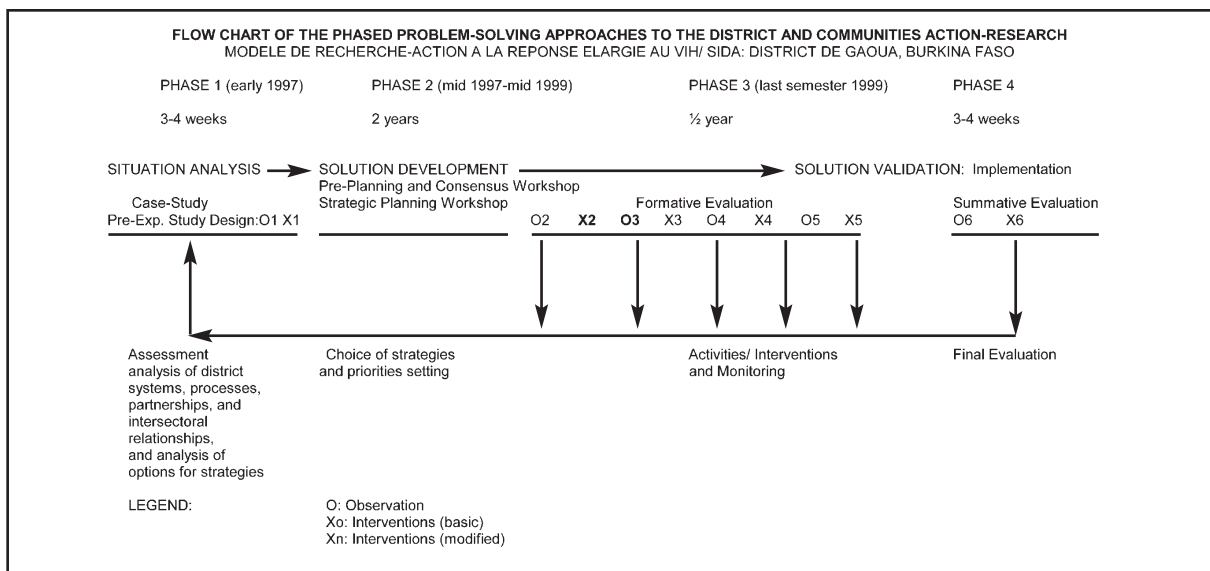
The social, cultural, policy, economic factors are a combination of structural factors that influence individual and group behaviours and need to be taken into account by the contextual interventions. More than a decade of work has indicated that proximal and contextual interventions are necessary to reduce the spread of HIV, as well as to mitigate its impact (Mann J. et al. 1992).

The generic “District Responses Initiative Protocol for Field Assessments and District Case studies” (UNAIDS January 1997) which has been adapted for the present research is therefore largely based

on contextual and country issues. The combination of developing and attempting to carry out a bi-dimensional research to understand, explain, and act upon both proximal and contextual interventions, is daunting but courageous from UNAIDS, and a much needed initiative. It also can explain some of the scepticism encountered in this early stage still of the development of Local Responses by Development Agencies, besides a few such as the German Technical Co-operation (GTZ), or the Co-operation for The Netherlands.

The same panel identified operations research as a high priority in order to improve the effectiveness, cost-effectiveness, and quality of institutional and community-based responses (op. cit. p. 196). The emphasis is not so much on individuals as the main units of analysis, but more on the understanding of contexts, e.g. communities, organisations, policies etc. This explains the choice of a problem-solving systems approach to the present research, along the method proposed in the original protocol. We adapted a phased approach to this action-research (Figure 1.3), drawing from experiences described in "Operations Research Methods," (Blumenfeld 1985) and clarified in the Methods section (Chapter 3).

Fig. 1.3

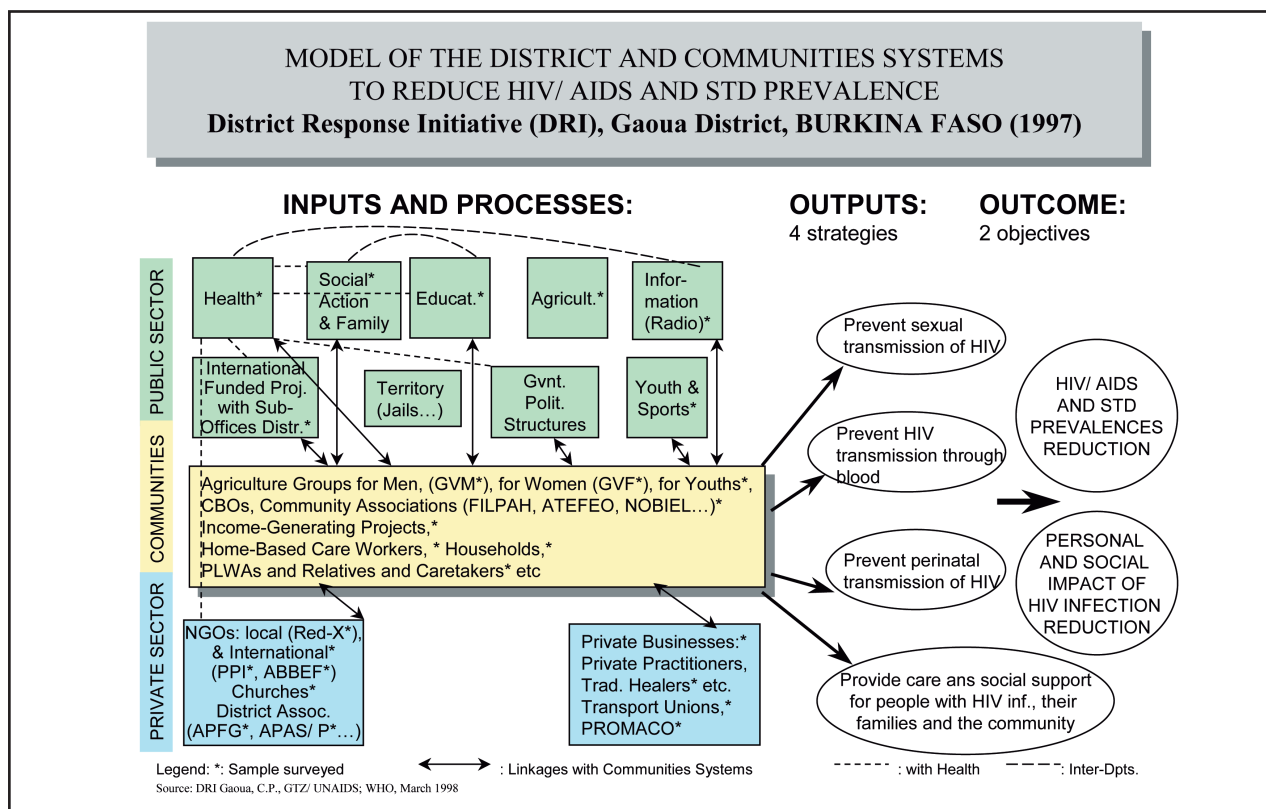


This Flow Chart (Fig. 1.3) illustrates Phase 1 of Problem Analysis, or the Situation Analysis at the Community level (4.1), complemented by the one at the District level (4.2), carried out in early 1997. A long process follows in Phase 2 of Solution Development (4.3), between mid 1997 to mid 1999. Finally, the outcomes of Phase 3 of Solution Validation or the implementation took place for the convenience of the study over a very limited time period of 6 months only (last semester 1999), and were complemented by Phase 4 of auditing the developments (early 2000). The results of these two Phases are documented jointly separately (4.4), as well as the national scaling-up and international dissemination (4.5).

The first phase focuses on an improved understanding of the communities and district systems, the second phase prioritises the interventions, the third phase implements and monitors interventions which will be multisectoral and community-based driven, and the fourth phase evaluates the whole study.

Systems analysis seeks to determine the components of the health and other systems interacting with health, how those interact with one another and with inputs into the systems. It also seeks to understand how the health system is influenced by the external environment (op. cit. p.7). In the context of the health sector reform, the health system has multi-dimensions which includes the vast spectrum of health policy, resources, organisational structure, management and support systems and service delivery. It becomes in turn the basis of the agenda for research in health policy and systems development (Cassels 1995; Janovsky 1996). This multi-dimensional aspect adapted from a systems model (Blumenfeld 1985), illustrates the additional complexity and ambition of the present research (Figure 1.4).

Fig. 1.4



The present model is designed for the action-research to concentrate on the inputs and processes, and particularly the interaction between the communities at the core of the model, and the public and private (voluntary and private) sectors. This focus, over a certain period of time on the up-stream of the system, is too often overlooked in the hasty design of interventions, and yet is essential to develop sound effective strategies (outputs) which in turn lead to impact (outcome).

The present research cycle can be illustrated based on a recent community-oriented health systems planning research (Rohrer 1996). The planning and interaction between the communities and the service providers start with a community needs assessment, followed by an organisational performance assessment. Both processes in turn can improve the overall systems design that is finally evaluated as well (communities and providers' responses).

The evaluation approaches described previously are a contribution to improve the program evaluation aspect of HIV prevention practices with among others the determination of the most informative mix of formative, process, outcome and impact evaluation (Swiss AIDS Federation 1998). They go far beyond the original mere concerns of and emphasis on paying mainly attention to outcome by monitoring the epidemic through sentinel sites.

To implement the Local Responses, UNAIDS launched the process in early 1997. The present research is based on two personal country visits to Burkina Faso in mid-1997, and in the first semester of 1998. It is part of broader general process of the Local Responses with other concurrent events between 1997 and 1999 documented separately (Appendix 1A), and a continuous relationship with the development of the activities over a three years period.

Five case study countries in sub-Saharan Africa with three districts in each were selected to allow to field test the Local Responses generic instrument proposed. An agreement between UNAIDS and WHO, and the German Technical Co-operation (GTZ), identified GTZ to be responsible to carry out the studies in one district of Burkina-Faso, and of Uganda in which the German Co-operation has projects.

The present research is grounded on a combination of empirical research directly based on a field case study, with a three years documentation of the full process. We hope that it will contribute to the success of the Local Responses approach into the XXI Century.

1.4 Outline of the thesis

Section 1 sets the context of the research, its rationale and theoretical background, including a review of the Primary Health Care Approach, Health Sector Reforms and current HIV/Aids Strategies and interventions (Chapter 1), and they justify altogether the aim and objectives of the study (Chapter 2). Finally, the study site, the research methodology and data collection and analysis are described (Chapter 3).

Section 2 of the thesis (Chapter 4) presents the overall results of the study. It is related successively to the four different Phases of the research illustrated earlier (Fig. 1.3 Flow Chart of the Phased Problem-Solving Approaches to the District and Communities Action-Research). The findings of the two situation analyses (Phase 1) at the community level encompassing community determinants and factors of vulnerability (4.1), and at the district level the responses of the public and voluntary sectors and the policy environment (4.2). These analyses set the stage for the Local Responses. Different facets (4.3) are then presented, related to the development of the solution with a consensus-building and pre-planning exercise of the local partners, followed by the strategic planning (Phase 2). Finally, following a brief implementation of the approach in the last semester of 1999 on a small scale (Phase 3), the last sections present the early outcomes (Phase 4) (4.4), and the national and international dissemination (4.5).

Finally, section 3 of the thesis (Chapter 5) discusses the former results sequentially (5.1 to 5.5). It includes a discussion on the development of a new tool called the Rapid Organisational Review (5.6), and a review of applications and limitations of the Local Responses approach taking the example of the migrants, as a specific vulnerable group (5.7). The limitations of the study follow (5.8), and, finally, the overall results in light of the original hypotheses (5.9). The key methodological (5.2.1), policy (5.2.2) and research (5.2.3) recommendations arising from the study are highlighted for conclusions, followed by the bibliography (Chapter 6).

We turn next (Chapter 2) to the aim, objectives and research hypotheses of the study.

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CHAPTER TWO: AIM AND OBJECTIVES

In light of the background and introduction to the present research (chap. 1), this chapter formulates the research study aims and objectives (2.1), and the study hypotheses of this operations research (2.2).

2.1 Aim and Objectives

The study described in this thesis aims: first, to improve the knowledge and gaps (under the form of research conclusions) of how to plan and implement HIV/Aids strategies in rural settings in Africa by testing an approach called the Local Responses; second, to document critically a three years process in Gaoua District, Burkina Faso, including some early results.

This research study had the following four objectives (C. Pervilhac Expanded Study Protocol for District and Communities Social and Health Systems, WHO/UNAIDS/GTZ, Apr. 1997, p. 3):

1. to develop a rapid appraisal method which can be a resource to assist district and communities in determining their options for approaches to meeting social and development challenges of the HIV/Aids epidemics at the District level
2. to carry out situation analysis with respect to:
 - 2.1 the community needs and priorities (vulnerability factors),
 - 2.2 the links and determinants of the public and private sector institutions in the district systems;
3. to apply the findings to improve the planning and management at the District level (identification of the key factors and priority interventions which can improve the responses);
4. to broaden the lessons learnt from the present research to international implications and applications (if outcomes are not yet possible to measure over the next three years time period of the present research, processes may be used as proxy indicators).

In the present study, we defined the “public sector” as the various Ministries, and the “private sector”, as the non-profit and for profit one, i.e. Non-Governmental Organisations (NGOs), Churches, voluntary sector, community-based organisations and businesses.

2.2 Study Hypotheses

The Operations Research can be, in turn, broken down into **three hypotheses** that will be tested through different Phases (ref. chap. 1, Fig. 1.3 Flow Chart of the Phased Problem-Solving Approaches to the District and Communities Action-Research):

- ♦ **First (phase 1), the feasibility of using a systems approach to analyse the situation at a local level (district and communities),**

- ♦ **Second (phase 2), the possibility, based on the findings of the situation analysis, to design and stimulate well tailored priority interventions,**

- ♦ **Third (phases 3 and 4), to give as a consequence evidence that a number of activities can be implemented successfully over a short period of time by taking stock of the existing and potential partners' inputs.**

We turn next to the methods (chap. 3) used for the study.

CHAPTER THREE:

METHODS

Burkina-Faso was the first of the five countries selected to carry out the Local Responses, and to pioneer the generic instrument in a district case study (May 1997). It was soon to be followed by Ghana, Uganda, and Zambia in the second half of 1997, and finally, Tanzania in early 1998. The Burkina-Faso case study methodological set-up presented next was discussed briefly in Geneva and in Accra before the country visit, and the study was followed by a number of technical and follow-up meetings related to the Local Responses between 1997 and 2000 (Appendix 1A).

The local responses case study is innovative in that it attempts to tackle some of the uncomfortable situation of systems research methodologies, joining Peter Piot's opening remarks at the Symposium on HIV Prevention in Geneva (1998). Evidence of prevention success needs to be documented not just using „*experimental studies, randomized controlled trials for example*“ but „*may come from comparative studies of intervention effectiveness,*“ as well as „*other valuable evidence derived from efforts to evaluate complex programs of intervention in the pursuit of predetermined objectives. While this approach may be methodologically 'messier,' it may be a more realistic way of proceeding since we know that complex and multi-levelled programs of intervention - not social 'magic bullets' - are most likely to work...*“ and not just the „*promise of technology.*“ The society for success is based on „*both individual persuasion and societal enablement*“ necessary to develop successful programs and interventions (Swiss AIDS Federation 1998).

This joins the Ottawa Charter for Health Promotion as one of the first internationally endorsed documents to recognise the importance of supportive environments for health. The local responses is further rooted on earlier claims formulated in an agenda for research of „Health policy and systems development“:

„... The challenge (lies in developing) methods for understanding context and process, and the need to take a holistic approach to analysis in contrast to the reductionist research tradition of the bio-medical sciences. There is a need to legitimate analytic research approaches that feature broad-based, often qualitative assessments, identify a range of policy options, indicate what specific conditions are associated with success (or failure) and under what circumstances, and provide some guidance on how to identify opportunities and implementing change“ (Janovsky 1996).

We first present next the study site and the rationale for the district selection (3.1). We then review successively in the research methodology (3.2) the following points, and when necessary bring up some of their current developments or limitations which explains the depth of this chapter: the methodology selected grounded on the original generic protocol; the action-based operations research type on which the present case study is based; the systems model, the „pre-experimental design“ before and after prospective intervention study concentrating more on the structural and systems factors; the qualitative methods; the sampling units based on systems and groups; the assessment of existing tools. Finally, we present the data collection used (3.3), followed by the data analysis (3.4).

3.1 Study site

The political and economic background of Burkina Faso explains the context in which the decentralisation (4.2.3) takes place (Foltz A.-M. et al. 1996). The country became independent in 1960 and had been accustomed to a highly centralised quasi-military rule. Traditional rulers who were allowed to maintain some influence in exercising customary law with an authoritarian slant. During the next twenty years the country experienced three republics with policies influenced by Marxist-Leninist regimes, and interspersed with coups and military regimes. Meanwhile, the economy, based mainly on agriculture, had severe setbacks during the Sahelian droughts of the 1970 and 1980s. The present President Blaise Compaoré took power in 1987 in a bloody coup, and a new Constitution was approved in 1991. In that period, and pursued until the mid-nineties, the Government began its structural adjustment program (curbing external current account deficit, reforming taxation and customs, combined with funds channelled into primary education, health, and financial administration) negotiated with the World Bank and the International Monetary Fund. By 1995, Burkina Faso had weathered the devaluation better than most countries in the Franc Zone; nevertheless, it had also experienced only a disappointing growth in GDP (1%), and its budget deficit stood at 9.5% of the GDP, the worst showing in the Franc Zone. The political stability makes Burkina Faso one of the countries benefiting from large external assistance, and is often taken as a model for the Sahelian region. Despite this, the Regime, even though recently democratically re-elected (Nov. 1998), and run through a National Assembly with almost no opposition, suffers from serious internal growing dissatisfaction becoming increasingly visible (Jaffre 1999).

Gaoua District, located in the south-west Poni region of Burkina Faso, shares more than a third of its borders with Côte d'Ivoire and Ghana. It is hilly, and benefits from some of the best rain falls in the country (tropical vegetation) which profits in turn the agro-pastoral activities such as farming corn, and millet, and in animal husbandry. The population of over 250,000 in 500 to 600 communities is largely rural; Gaoua District capital with 17,000 inhabitants is growing rapidly (10% annual growth rate). Among the seven different ethnic groups, the four main ones (Lobi, Dagara, Mossi, and Birifors) speak identical languages as the bordering communities of the Upper West Region of Ghana and of Côte d'Ivoire. Within the District, however, the cultural diversity and distinct traditional values of each ethnic group create important barriers in social communication between communities or villages. Gaoua is a well-known reservoir of migrant workers for the coastal plantations in Côte d'Ivoire and the gold fields in the Ashanti region of Ghana. The rural District is remote and relatively isolated from the capital Ouagadougou. Until recently, it has received relatively less attention than other Districts in the allocation of Government and international development resources. In Gaoua town, the HIV prevalence among pregnant women was reported at 12.5 percent in 1992, and 5.7% in 1994, in the routine HIV surveillance District/ Regional hospital-based. Although it is one of the best sources of information for estimating HIV prevalence, it underestimates the magnitude of HIV infections (Burton A. et al. 1998). The study revealed and confirmed that AIDS is experienced and recognised as a major health problem by the population of the District.

It is one of the four health Districts of the Regional Province of Gaoua (or Poni Region). The decentralization process started over two years ago is not yet fully operational. It benefits from one Regional Hospital (150 beds), and twenty health centres.

We selected Gaoua District out of ten Districts in which GTZ works with the Ministry of Health in Burkina Faso based on the following criteria classified by order of importance:

- ♦ First, the district suffers from a high prevalence of infection based on the most recent available HIV sero-prevalence surveillance data (5.7% in 1994) among pregnant women at the District/Regional Hospital of Gaoua. As such it is one among the ten Provinces considered as high risk zones in the World Bank Project (1995).
- ♦ Second, the district is weak in terms of systems: HIV/Aids programs and projects are young and not yet either well planned or implemented in the health and other sectors¹, and the district has been relatively neglected in the allocation of scarce resources (lack of personnel, drug shortages etc.).
- ♦ Third, the district is located in a border region with Côte d'Ivoire and Ghana, with highly mobile populations who are also known to be attached to their traditional values and difficult to access.
- ♦ Fourth, the District capital, Gaoua, is also the headquarters of the new Poni Regional Direction of Health, an important entity in the Health Sector Reform, and a good base to ground the work, gain political support, and extend later to other Regions and Districts.
- ♦ Fifth, due to some of the above constraining factors, the District does not benefit from any research-action projects like other Districts supported by GTZ, but does benefit from a GTZ supported Agriculture Project in thirteen villages close to Gaoua.

Ironically during our first visit, the national media was paying more attention to a new more visible epidemic related to the strange disappearance of male genitals, in comparison to the silent pandemic of HIV devastating communities across several Provinces of the country, such as the Poni region. The sex disappearance epidemic had just hit Ouagadougou, as illustrated (Fig. 3.1) in the headlines of the national newspaper "*Le Journal*" (Some 1997). It was raging across the capitals of West Africa, and had already made some victims in different countries among witch crafters originating from other countries.

¹Scepticism expressed at the national level in selecting this District was often expressed as "Why go to Gaoua? —Nothing is going on there."

sexes à Ouagadougou



Fig. 3.1

Source: Lierme Some, "Disparition de sexes à Ouagadougou Des victimes témoignent...", *Quotidien ouest-africain d'information Le Journal du soir*, 16 mai 1997, p. 1

3.2 Research Methodology

The UNAIDS/WHO District Initiative Project First Working Draft Protocol for Field Assessments and District Case Studies (UNAIDS/WHO 1997) proposed a "multi-stage approach" for the development of the Initiative. The development of the Local Responses in Burkina Faso followed the similar stages with a few modifications (indicated in the footnotes):

1. the development of the district responses concepts,
2. the development of protocols and tools for country visits and case studies,
3. country assessment visits by WHO/ UNAIDS joint missions working with national institutions and UN Theme Groups on HIV/Aids²,
4. a consultation in Geneva to review the protocols and tools³ in line with countries' systems and experiences from field visits,

² Both in Burkina Faso and Uganda the local responses case studies combined this stage with stage 5

³ A more detailed inventory and analysis of tools which could support the local responses was accomplished in early 1999 (ref. Section 5.1.5)

5. national case studies in 3 districts of each country⁴,
6. review and analysis of the country case studies for agenda for action,
7. national consultative meetings⁵ on the development of the local responses.

For the purpose of the local responses in Burkina Faso, we adapted an “expanded study protocol” described based on a review of the UNAIDS/ WHO generic “Protocol for field assessments and district case studies” (UNAIDS/ WHO January 1997).

Type of Research

Operations research is known as a powerful analytical and decision-making tool to resolve a problem-solving process and find practical solutions. It can be used to test new interventions and improve the cost-effectiveness of service delivery. The operations research methods used for the present health systems research design are based on operations research methods developed for Primary Health Care (Blumenfeld 1985). They have been tested and applied successfully in many projects world wide. Measuring the outcome of community-based preventive intervention programmes have been documented the need for more problem-orientated, inter-disciplinary and multi-sectoral approaches (the findings of the review of cardiovascular studies would certainly apply to those of HIV/Aids too) (Brannstrom and al. 1994).

Measuring intervention at community level has been the recent challenges borderline with epidemiological methods (Susser 1995; Fishbein and al. 1996; Lawson and al. 1996). Community forces that influence change need to be better understood because of the “complexity of community dynamics”, and a balance needs to be found for “risk targeting” between “public health (community) intervention model,” and the “medical (individual) intervention model” (Feinleib 1996).

The three years **action-based operations research** consists of four Phases which can be distinguished under the form of a Flow Chart of the Problem-Solving Approaches of the Action/ Operations Research for Districts and Communities (Fig. 1.3 Chap. 1):

- ♦ 1st Phase: 2 months (1 week preparatory period, 3 ½ weeks visit, 3 weeks data analysis). Supported by a consultation visit.

This phase forms the core part of the present thesis (next Chapter 4). It consists of a descriptive or information-building systems situation analysis to describe the roles of partners and links within and between systems and to determine the correct mix of strategies and interventions. Based on the Model of the District and Communities System (Chap. 1 Fig. 1.4), the situation analyses focuses on the Inputs and Processes of the various systems. In particular, they analyse the Communities Organisation System as the heart of the model, and its internal functioning and linkages with other systems, and the District Health System as well. The rapid assessment of problems of district systems, processes, partnerships, and interrelationships prepares for in the next Phase the consensus on objectives, and options of priorities for strategies and interventions.

How each system in turn can and will contribute to improve the responses to HIV/Aids outputs, and finally outcomes are further planned for in Phase 2, implemented in Phase 3, and reviewed in Phase 4.

⁴ In agreement with UNAIDS/ WHO, both in Burkina Faso and Uganda, the case studies supported by GTZ took place in one district only

⁵ National consultative meetings were held in each country through the UN Theme Group, and two international meetings took place in Dar-es-Salaam (May 1998), and Geneva (June 1998)

In addition to the above, Phase 1 allows:

- first, to identify the most appropriate questions to answer in order to facilitate the improved HIV/Aids responses,
- second, to identify and test the tools selected and their usefulness to collect the data, and whether they serve the purpose expected given the important questions to answer,
- finally, to set the correct stage for the next second Phase.

- ♦ 2nd Phase: 1 to 1 ½ year. Supported by two consultation visits: first, by the present researcher for a pre-planning and consensus workshop, second by the UNAIDS country “broker⁶” for a strategic planning workshop.

The solution development Phase 2 was much more complex and critical than the original one, originally planned as short and simple process driven by the local decision-makers and managers. It took place over a longer period of time (more than one year). This can be explained by the delays encountered in the feedback of the situation analysis (half a year), combined with the additional duration to analyse and act upon the data at the national and local level. In parallel to these unofficial solution developments at the national and local levels, “official” solution developments needed to take place. Two outside consultants supported this process: for the pre-planning and consensus workshop, and for the strategic planning process both described in this thesis (Sections 4.3.1 and 4.3.2 respectively).

The solution development, with the results of the situation analyses leading to a sound consensus and planning exercise locally, is therefore a critical long bridging period between the situation analysis and the solution validation. Whether the results of the situation analyses are shelved, like many studies end up to be, or acted upon, depend of the original involvement of local partners and understanding of the process, and of the dialogues at different levels. It also depends of the planning exercises which, as documented next (4.3), are more difficult to carry out than other classical planning program exercises.

- ♦ 3rd Phase: 2 years. Supported by periodical visits 3-4 times per year of the country broker.

This phase consists of the implementation of interventions (X1 to Xn as per Fig. 1.3 Chap. 1) by the local actors. The solution validation of the research is done under a number of on-going formative evaluations (O1 to On... as per Fig. 1.3 Chap. 1).

- ♦ 4th Phase: 3-4 weeks. Outside external review team.

The summative evaluation (Jan.-Feb. 2000) planned as a classical external mid-term review took place following the 3rd Phase. The present study documents the original outcomes (4.4), and the national and international dissemination of the experience (4.5), and discusses the lessons learned (5.1), and the overall results of the evaluation (5.1.9).

The local responses intervention and its successes may, like the control tobacco and smoking studies, be based on “mass change... followed by multiple, multilevel interventions which, in turn were founded on causal inference from observational studies only” (Susser 1996). The success may therefore “emerge only after two decades of research and action” (op. cit. p. 1715). Pioneer health systems researchers working in HIV/Aids also need to develop their own “systems responses,” over a longer period of time (10 to 20 years Phases 3 and 4). Hence, they can be compared to the virologists and immunologists who necessitate this time-period presently to discover a safe and effective HIV vaccine, or the pharmacologists to develop the anti-retroviral therapies.

⁶ the “country brokers” concept to have a permanent 3-4 months per year consultant facilitate the process in each country was introduced as an appropriate way to support the local responses in each country and accepted as such in the Health Reform and HIV Workshop (Geneva, June 1998)

Systems Design Research

Due to the nature of the research rooted in an improved understanding of systems, we designed a **systems model** illustrated in the “Model of the District and Communities Systems Aimed at Reducing HIV/Aids Prevalence and STD Prevalence” (Fig. 1.4 Chap 1).

The model has two entry points:

- ♦ from a research perspective, it illustrates the various systems operating at the district level, the institutions and individuals within those, and the main links between the “Communities Organisation System” and “District Health System” due to the importance of these two systems;
- ♦ from a managerial perspective, it illustrates the Inputs and Process originating from the various systems which lead in turn to improved Outputs, and finally will contribute to the ultimate Outcome of the intervention which is to reduce HIV/Aids prevalence and STD prevalence.

Partnerships are illustrated under the form of linkages first, with the Communities at the centre of the model, second between Public Sectors, and third between the voluntary for profit and non-profit, and public sectors.

Research Design

For the purpose of the present research, the study design is a “**pre-experimental design**” **before and after prospective intervention study** with a classical pretest-posttest design of the form:

O1 X O2

where “X” represents the combination of the situation analysis (Phase 1) and the plans (Phase 2), and O1 the baseline at the time of the situation analysis, and O2 the first formative evaluation.

The various systems (inputs and process) are considered as independent and intervening variables that in turn will affect the dependent variables, or contribute to the outputs and outcome. Instead of “variables,” the local responses research protocol (UNAIDS Apr. 1997) prefers to identify “factors” which can influence HIV transmission and are grouped into four levels, two of which are essential (indicated in bold) to the present research:

- ♦ super-structural factors: (extraneous variables) background or environmental factors which neither individuals nor governments can change in the short or medium term (ex. unstable politic system, economic inequities, rapid urbanisation, presence of refugees in border regions),
- ♦ **structural factors**: not controlled by individuals but can be addressed by Governments (ex. laws, customs),
- ♦ **systems factors** in Health, Communities, Agriculture, Education⁷: controlled by Ministries or influenced by the private sector (ex. quality and accessibility of services),
- ♦ individual factors: directly influenced by intervention programs (ex. behavioural changes).

The local responses case study in Burkina Faso (as well as the one in Uganda) focused on critical information related to poorly understood structural and systems factors of relevance to HIV/Aids which can be influenced.

Less emphasis was placed on data related to the larger super-structural factors which cannot be influenced but which nevertheless need to be identified and known, and on the individual factors

⁷ our definition is broader than the UNAIDS one restricted to “health services” alone and is “systems” based

which are better known because of the strong Information Education Communication (IEC)/ health promotion programs. Such key methodological choices influencing the Local Responses case studies would merit further discussion⁸, and yet were never revisited during the various technical meetings over the past two years.

The original classics of “Experimental and Quasi-Experimental Designs for Research” ADDIN ENRf8 (Campbell and al 1963) analyses the pros and cons of different types of design. The present pre-experimental design cannot control for many confounded extraneous variables that can jeopardise the internal validity of the results. For example in the case of the Local Responses such factors as the “history” or changes in events over time, or the “maturation” or changes over time in biological processes of the communities may have affected the changes despite the Local Responses process.

The study design limited by time and budget constraints did not allow the use of a control, non-experimental site. If the Local Responses were to be truly experimented and validated it would need to compare the progress with another control, non-experimental neighbouring district. The ideal “true experimental design,” under the form of a pretest-posttest control group design, would then be:

District of the Local Responses:	O1	X	O2
Other district:	O3		O4

For the purpose of the Local Responses formative and on-going evaluation taking place, we recommend at least an improved “quasi-experimental design” such as the time series design of the form which necessitate periodic (for example twice yearly) careful review (using the same evaluation instrument):

O1 X O2 X O3 X O4 etc.

The limitations of this study design are discussed in more details separately (5.1.8).

Research methods

The local responses first Phase consists of a rapid assessment situation analysis and inventory taking of the key partners from the communities, and public and voluntary for profit and not for profit sectors based on **qualitative methods**, as recommended in the original generic framework protocol (UNAIDS/ WHO 1997).

The Local Responses benefits therefore of the recent developments and recognition in the nineties of rapid assessment and qualitative methods as sound and much needed scientific methods, which have been neglected up to now in comparison to the quantitative methods. In the mid-eighties, social scientists pointed to the validity of and need for qualitative research methods (Borman and al. 1986; Krenz and al. 1986). It includes more recently the development of software for analysis (Tesch 1990), and methods described in a recent comprehensive masterpiece in the field of qualitative research (Denzin 1994). Developments of Rapid Rural Appraisal (RRA) methods originate from the field of agriculture with the early work of Chambers (Chambers 1981; Chambers 1992) and some RRA were reviewed comprehensively in “qualitative research methods” (Jefremovas 1995). The relevance of such applications in the field of health research and interventions has been recently acknowledged (Vlassof and al 1992). As a result, numerous manuals have been developed for public health purposes in the nineties to clarify either the methodologies of rapid appraisal (Rifkin and al 1991; WHO 1991; WHO 1991), or the specific qualitative methods (Maier and al. 1994; WHO 1994).

⁸ we differ here from the UNAIDS study protocol (Apr. 1997 draft) which recommended emphasis on super-structural and structural factors

The present research is based in particular on the qualitative research methods⁹ and definitions that were used in the field during a workshop (Kikwawila Study Group 1994), with the results, in turn, documented separately (Kikwawila Study Group 1995).

The community level study surveyed ten to twelve **key informants**¹⁰ per community which encompassed a balanced mix of males, females and youth, based on the pre-selection of the best types out of a list of thirty potential ones the experienced surveyors identified (Appendix 3A).

In addition, **two focus** groups of youth males and females, between 16 and 25 years, were completed.

In parallel, the district level study surveyed a dozen of **key informants** or **group discussions** of representatives from the public and private institutions. In addition, this was accompanied by a **review of documents**, if available.

Sampling Units

In order to step beyond the classical individual level of organisation used in the population sciences (e.g. individual behavioural studies), Susser's "eco-epidemiology" (Susser 1996) paradigm appears to be the most appropriate model for the systems design research needed. It emphasises how beyond the individual level analysis, complex contexts such as groupings, communities, cultures, and legal systems and their effects need to be understood. As recommended by Susser, groups can be used as units of study, as long as the different levels of organisation and "study units" are recognised. This is justified because "variables special to groups are present wherever groups are constituted and at all levels of the organisational hierarchy..." and "we are clearly dealing with dynamic systems rather than static situations" (op. cit., p. 1714).

The original District Responses Initiative Protocol for Field Assessments and District Case Studies (UNAIDS/ WHO January 1997) stated as general objectives that the local responses "working with countries, will undertake assessments of the responses situation within each selected country as well as specific district systems." We designed the "Model of the District and Communities Systems" (Fig. 1.4 Chap. 1) on which we drew the "Units of Analysis and Sample Checklist of Specific Problems related to District Systems" (Appendix 3B) to analyse these specific District systems. This was based on the above recommended new "study units" for "complex contexts." We further outlined the Types of Studies and Tools that could be used for the study (Appendix 3C).

The community level study concentrates on the heart of the model, or the communities organisation system who are the clients, but can also be the providers of services through their associations, or trained health workers. The district level study reviews the various other systems from the public and private sectors found at the district level (ref. next section 3.3).

For the community level study (Community Organisation Systems Sampling), four communities were selected by convenience sampling to represent the communities organisation system. They were surveyed within the time constraints of the study (two days per village): two rural (remote villages), and two semi-rural (one district capital neighbourhood and one small border town neighbourhood). All communities could be accessed within an hour drive from the District capital even under heavy rains. Each rural community represented the main ethnic groups found in the District.

For the District level study (Systems Sampling), we sampled all public institutions (N=14), and an approximate equivalent number of various private ones (N=15). The private ones included the largest international and national NGOs, then the most important Community-Based Organisations of different types already active. At least one representative or a group of representatives from each

⁹ the researcher attended this workshop, and facilitated a module on qualitative methods introduced for the first time in the European Course in Tropical Epidemiology (13th Course, Barcelona, Sept. 1994)

¹⁰ among the choices were the following: chief of village, administrative chief, responsible of associations, (1 male and 1 female) teacher, agriculture technical delegate, traditional healer, artistic traditional chief, (1 male and 1 female), responsible for cooperatives, (1 female and 1 youth) traditional birth attendants, president of the Parents Pupils' Association

system (public and private) was sampled. Each system can be divided in turn into a number of sub-systems or units of analysis. For example, the health system which is studied in more details comprises the following sub-systems:

- ♦ infrastructures (district hospital, peripheral health units),
- ♦ managerial (different committees and district health management team),
- ♦ programmatic (various programs¹¹ and their support services¹²),
- ♦ community (local committees, local associations, groups, and primary health care workers, i.e. village health workers, traditional birth attendants, traditional healers...).

Assessment of existing tools

One of the hypotheses testing of this action-research is that first, a systems approach is feasible with existing tools, and second, local capacities can apply those.

In sub-Saharan Africa, like in the United States, the challenges lie in turning fragmented local delivery systems into co-ordinated primary care systems (Rohrer 1996). Older epidemiological, or population-based perspectives adapted from older health systems models (Donabedian 1973) may still be insufficient to reach this aim, or to develop the HIV/Aids improved responses at a district level. This explains the combination of different approaches and tools used.

Originally, we aimed among different hypotheses to test the feasibility and use of different but complementary approaches, using the lenses and applying various existing tools with a set of questions from the different following disciplines: epidemiology, anthropology, policy, sociology, and economics.

The study attempts in light of the aforementioned objectives to answer several general questions (Appendix 3C) based on a list of issues which needs to be addressed in each country for each unit of analysis in each system:

- How well each system in the district performs?
- What are the different district systems leaders' roles through a self-analysis?
- What are the stakes of each organisation or individual?
- What are the types of organisations running each system?
- What is the community managed responses to HIV/Aids?

¹¹ example: HIV/ AIDS, immunization, diarrheal diseases, malaria control, respiratory infections

¹² example: training, health management information system, logistics, health promotion

The approaches and purposes of each tool are the following, with additional references for those in the previous Chapter 1 (1.1 to 1.3):

- 1) *The epidemiology approach*: Assessment of the present performance of each system, using epidemiological existing indicators (WHO 1996).

Purpose: to assess each performance systems based on documents, available information, and external reviews of reports; monitoring behavioural changes and evaluation of existing services capacity.

- 2) *The anthropology approach*: assessment of the community managed responses. The approach is based on community participation assessment (Bjaras 1991; Schmidt D. et al. 1996), and qualitative methods of research to assess community participation (Kikwawila Study Group 1994; Nakamura Y. et al. 1996).

Purpose: to assess the communities' roles in responses to HIV/Aids and their perceptions of other systems' roles, support, including the estimation of the degree of the community participation.

- 3) *The policy approach*: Self-analysis of roles and other systems roles from different district systems' leaders (e.g. Position Map). It is based on political mapping approaches, and exists under the form of a software for political analysis and policy advocacy tool (Reich 1994), with a stakeholder analysis for an improved responses, policy networking map, and transition assessment.

Purpose of the Stakeholder Analysis: to describe the consequences, actors, resources, and networks involved in a particular decision, and explain how and why the decision process was taken (improve the communication process among organisations), and finally to assist decision-makers in choosing strategies to influence the politics of formulating or implementing a decision.

Purpose of the Policy Network Mapping: to understand how different organisations related to each other in practice (key decision-makers, access to influential individuals, direction of influence and degree of conflict among organisations, potential flow of interests and conflicts...), as opposed to the connections shown in official agreements or organisational charts.

Purpose of the Transitions in Progress: to understand the dynamic environment in which the public policy occur, particularly in light of the current sector reforms.

- 4) *The sociological approach*: categorisation of the type of organisations running each system. There exists no experience, and no specific succinct guidelines in the context of district level¹³ to apply some analysis techniques of organisational theories (Mintzberg 1982). Those encompass power, environment, technical systems, age and size of organisations. An attempt is made to understand some of the more "innovative organisations" or "operating adhocracy" (projects) from the private sector vs. the "machine organisations" (centralized government bureaucracies) from the public sector, and their interactions (Mintzberg 1989).

Purpose: First, to improve in each system the understanding for each institution of its type of organisation, and forms of politics and games that can influence the strategies of HIV/Aids responses and improve the efficiency of their implementation. Second, to analyse the past, present, and future roles of each organisation or individual and their main enabling and constraining factors; to assess the organisation's position vis-à-vis the proposed decision or policy related to the improved HIV/Aids responses.

¹³ personal communication with H. Mintzberg, March 3 1997

- 5) *The economic approach: costing analysis assessment and capabilities* (Creese and Parker 1994).

Purpose: to be able to select the most cost-effective combinations of interventions.

Our experience during the study did not support the original hypothesis that existing tools of different disciplines are already sufficiently developed to be applied to the local responses. As a consequence the state-of-the art of the development of the existing tools cannot be used easily with local capacities at the district level. Due to our own limited expertise, time and resources constraints, we confined our original large ambitions to concentrate instead to the testing of approaches and tools essentially to anthropological methods for the community level study, and epidemiological and sociological methods for the district level study. We pointed to the importance of understanding more the cost of interventions and activities at a district level in order to be better able to take this dimension into consideration in the final weighing of priorities.

In conclusion, based on the wide interpretation by each Local Responses study team for the five different country case studies of which tools to use and questions to ask, it was not possible in the follow-up Technical Workshop (Dar-es-Salaam, May 1998) to draw any conclusions about their strengths and weaknesses. Suffice it to say that different country team leaders concentrated on different approaches and tools with a fair amount of success to analyse the situation in the different districts. The aggregated amount of experiences cumulated, and a special exchange concentrating on each approach used, would allow to enrich substantially the state-of-the art of the local responses methods. The testing of the different approaches by a multi-disciplinary team as originally planned is pending some of the financial and design constraints mentioned previously (Research Design).

Following the Local Responses study, a detailed inventory of tools accomplished in early 1999 which could be used and adapted for the local responses shows the gap which still lies ahead to disseminate and promote the local responses approach (Section 5.1.5). A package for the local responses such as the rapid assessment of district health system ADDIN ENRf8 (Nordberg 1995) still remains to be fully tested and validated.

3.3 Data Collection

For the situation analysis (Phase 1), a couple of days were necessary at the national level, before and after the study for technical briefing and debriefing visits to various authorities. Two different teams collected the data in parallel over a two weeks period, with an additional three to four days necessary before data collection in order to pre-test and finalise the protocols:

- The community level study: headed by a country national sociologist, with applied knowledge of use of qualitative methods, with two teams of two or three people (depending if a local translator was needed or not);

- The district level study: headed by the international principal investigator (present researcher) as public health specialist with a sociology background, accompanied by a country national specialised in Information-Education-Communication (IEC) in HIV/Aids. When necessary, the support of a local district health staff was sought to co-ordinate the visits, and to facilitate the access to the communities.

The two team leaders of each study team were responsible for the adaptation of the questions, testing, implementation of the study and data collection quality, and preliminary analysis of findings.

The original local responses generic framework (UNAIDS 1997) recommended the studied be carried by “multi-disciplinary HIV/Aids local (or country) team.” The qualifications sought reflect well the diversity and complexity of the nature of the present study. Unfortunately, they are almost impossible to find all at once: “broad social sciences and health systems research and analysis experience and capacity... multi-disciplinary... previous links with institutions from national and district levels... sustained presence in the country...involvement in health and health sector reform... acceptance by UN Theme Group and Ministry of Health.”

In country, we could not gather that ideal “multi-disciplinary HIV/Aids team” (of 10 to 12 members) coming from different systems to develop, test, and carry out the different types of studies, because of the non-availability of the expertise on a short notice. We were additionally limited by funds to hire a large team. We overcame the difficulty by concentrating on using at least the local expertise (a local Non-Governmental Organisation) to carry out the community level part of the study.

The participatory nature of the exercise, and its ownership at the local level, were stronger in Phase 2, the solution development, and Phase 3, the solution validation or implementation, than Phase 1, the situation analyses. The GTZ project staff and UNAIDS and WHO were encouraged to play more the roles of co-ordinator and facilitator, and to be only another mere stakeholder in this initiative rather than to be the main engine or driving forces.

3.4 Data Analysis

Preliminary data analysis for Phase 1 was done daily on the spot for the two studies.

A rough outline of impressions of the findings of the studies was done immediately following the full field work. Two levels were involved: the District level to the District Health Management Team, and the national level with the Directorate General of the Ministry of Health, and the U.N. Theme Group.

After the survey, two weeks of data analysis for each study by each team were necessary.

Finally, all the data were then reviewed and compiled by the principal investigator in a country case study report for GTZ, and UNAIDS/WHO.

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Despite these constraints, the GTZ Head Office, Eschborn, has kept a strong interest in the Initiative and been able to keep the networking going, particularly through its Regional Aids Support (RAP) office located in Accra, Ghana. In addition, a number of international and national meetings and conferences (Appendix 1A), took place in 1998, and have allowed to gain local and international recognition and to facilitate the exchange of experiences.

In conclusion, we structured the local responses under the form of an action systems research. It is based on the best methodological set-up presently possible under several constraints: first, the limited state-of-the-art of developments of community-level interventions and of tools development; second, limited financial resources to monitor the case study development closely. The next chapter documents the findings of the situation analysis at the community level (4.1), and at the District level (4.2), with the original planning stages (4.3).

We advocate here for the development of the Local Responses approach on a large scale, to apply more rigorous quasi-experimental design and systems approach identified in this section. This in turn will allow to document and to validate scientifically the processes and outcomes over time.

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¹⁴ the present researcher is not UNAIDS "country broker" allowing the present analysis of process, outcome and outputs to be analyzed even more objectively as an independent researcher

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CHAPTER FOUR:

RESULTS

This chapter is the core of the study presenting the results of the work carried out in Gaoua District, Burkina Faso. The results represent the different Phases described in the Flow Chart (Fig. 1.3).

The findings of the situation analyses (Phase 1) have been compiled in details in the original Report submitted to the German Technical Co-operation (GTZ) (Pervilhac, Kipp et al. 1997), and in a summary of the findings presented at the Pre-Planning and Consensus Workshop (Pervilhac C. et al. 1998). An overall review of the study was presented at two poster sessions at the 12th World AIDS Conference (Salla, Sebgo, Pervilhac et al. 1998), and the 13th World AIDS Conference (M'Pele, Pervilhac et al. 2000).

We present first the situation analysis at the community level: first, the findings of the six community participation determinants (4.1.1) to measure the present and potential responses of the communities with key strategic priorities for each; second, the findings of the three main categories of factors of vulnerability (4.1.2) to measure risk reduction potentials among the “window of hope,” the youth, are discussed, with the strategic consequences as well.

We then present the situation analysis at the district level with the Responses of the Public (4.2.1) and Private¹ (4.2.2) Sectors and illustrate this under the form of an institutional landscape. Then we present the policy environment in which the present study takes place in light of the Health Sector Reforms (4.2.3).

Following the situation analyses, the planning stage (Phase 2) is described with an early phase of consensus-building and pre-planning (4.3.1), followed by a strategic planning exercise (4.3.2).

The outcomes (4.4), representing the early efforts of implementation (Phases 3 and 4) are reported next, and the consequences on the national scaling-up and international dissemination (4.5).

4.1 Situation Analysis at the Community Level

The findings related to the community system presented in this section were collected mostly through the community level study, and partly through the district level study.

The present analysis takes one step further the former findings of the original situation analysis approach, by using next a more direct, concise, and applied analytical framework. It is hoped therefore that this framework can be used in future local responses baseline analyses and can maximise for planning purposes the profit combining at the same time the analysis with data presentation oriented for an improved applications of the findings.

¹ we call here “private” any non-public sector, i.e. voluntary for or not for profit, Churches, and the communities

4.1.1 The Essential Community Determinants

The assessment aimed to gain knowledge of the social milieu of communities, an essential component of public health prevention programs (Keeley 1999) in order to understand and improve the responses towards HIV/Aids at the community level. First the social characteristics, more difficult to change, but important to understand and consider in the process of community participation are reviewed, followed by five essential determinants of community participation: perceived community needs, health sector, perception of Aids, community organisations, and external partnerships (Table 4.1). The selection of the five essential determinants (determinants 2 to 6) which can strongly influence the community participation process is based on the adaptation of existing community participation assessment frameworks to the particular case of HIV prevention (Bjaras 1991) (Schmidt D. et al. 1996). The detailed questionnaire to the Key Informants at the Community Level is attached separately (Appendix 4A).

Table 4.1 Community characteristics (1) and critical determinants (2 to 6) with related questions to measure community participation for the Gaoua Local Responses Initiative

1. Characteristics

- a. What are the formal and informal community structures?
- b. What are the essential characteristics of these structures?
- c. Are there more immediately visible vulnerable groups to HIV?

2. Perception of Aids

- a. Is Aids a serious problem?
- b. What is the impact?
- c. On whom?

3. Perceived Needs

- a. What are the most important health problems?
- b. What are the most important needs?
- c. How does HIV prevention rank among those?

4. Health Sector

- a. What is the status of the old Primary Health Care network?
- b. Are there communication agents from the village and functional?
- c. What role does the closest Health Centre play in relation to HIV/Aids activities?

5. Organization against Aids

- a. Are there structures organized to respond to some of the health problems?
- b. For the problem of HIV and Aids is there any structure(s)?
- c. Leadership and influential peoples' roles in relation to the above structures, and management?

6. External Partnerships

- a. Who are the external partners?
 - b. What is their role(s), and in relation to health, and to HIV/Aids in particular?
 - c. Is the partnership an outside intervention or a true partnership?
-

The following summarised key findings of the situation analysis is based on information collected through various key informants (Research Methodology, chap. 3, 3.2) at the community level. They are recapitulated in a comprehensive table summarising the obstacles, opportunities, and based on those, the strategic priorities are suggested as well (Table 4.2). The data are aggregated for all four communities. For the purpose of specific interventions, e.g. rural vs. urban, or for specific ethnic groups etc., it would also be possible to analyse the data with the original transcripts separately to tailor specific strategies as well.

1) Community Characteristics

The characteristics of the urban communities are dominated by more formal (registered) and structured Associations, whereas the ones from the rural areas are more informal and less structured grassroots community organisations. The community characteristics are complex to understand due to the large diversity of ethnic populations who live in the villages or in town. Each community has its own characteristics and mix of populations, confirming the non-homogenous communities' composition. A core autochthonous group constitutes often the majority of a village (in Banlo, for example the Lobi), with the minorities from different origins (in Banlo, the Mossi and Peulhs). In general, each ethnic group has its own grouping, or associations by occupational activities, and leaders under the traditional village chief. The more visible and easiest groupings and associations found are the ones for males, but women have theirs as well, and the youth much less formal and visible ones (tea, sports...).

Some communities have large migrant populations, particularly among youth, and constitute therefore an important vulnerable group to concentrate upon, although targeting migrants call for many barriers of various nature to be overcome (ref. section 5.1.7).

In both rural and urban areas, influential people, or gatekeepers, (land chiefs, religious leaders, teachers, administrative delegates, health workers, traditional birth attendants, traditional healers...) are essentially male-dominated. They play different roles (social, cultural, economic...) on different population segments. Decisions are taken in group meetings which these influential people call. In addition, they have their own agents of diffusion of information in the communities. Such networks should be favoured over the more visible and favourite "project" entry points of administrative structures. The latter are too often more coercive, hence less participatory, or picking up individuals for training in isolation from their community organisations of support. Multiple segments of the communities possess different types of social networks each with their own popular opinion leaders. An improved partnership with these various support community networks should allow to tailor and deliver improved and more sustained community-level HIV prevention interventions to those at greater risk, overcoming the challenges of community-level interventions described elsewhere (Keeley 1999).

Based on these findings the key strategic priorities identified are:

- ♦ to use Rapid Rural Appraisal (RRA²) to identify by ethnic background the important groups and associations to work with and their leaders,
- ♦ to reinforce and work through the hidden or less visible but existent women and youth community organisations instead of individuals,
- ♦ to stimulate the responses to HIV/Aids through the dozen of different groups/ associations in each village (feasibility and sustainability to be tested), and/ or through the gatekeepers, with particular attention to those directed towards women and youth,
- ♦ to identify communities with migrant populations and tailor special strategies in town through the Associations (more formal), and in villages the groupings (more traditional).

² Local Responses recommend particularly the use of Participatory Rural Appraisal (PRA) methods, such as mapping techniques, to stimulate the ownership of the process from the beginning (ref. UNAIDS Technical Note no. 3, in press)

2) Perception of Aids at the Community Level

Aids is perceived as a serious problem in both rural and urban communities because it cannot be cured. It has already caused a dramatic increase in the populations of widows and orphans, and has had serious socio-economic consequences, including “contaminating mostly the youth, the engine of development” (ref. section 4.1.2). Voluntary support networks exist to support Aids patients through the direct relatives, friends, or religious groups, for example by bringing financial support or food. Care and support activities related to Aids patients are perceived to be more urgently needed than HIV preventive activities, as can be expected from an area experiencing a micro-epidemic of HIV over the past few years, and the fact that strategy has been largely neglected by existing programs.

Some of the youth groups are able to identify themselves as the most vulnerable groups among their communities based on their approximate estimation of the number of men and women who have already died from Aids.

Based on these findings the key strategic priorities identified are:

- ♦ to develop the care and support³ of Aids patients among the communities requesting those,
- ♦ to focus efforts among youth groups who perceive themselves as the most HIV vulnerable groups.

3) Perceived Community Needs

In addition to the perception of Aids mentioned above, other serious health problems identified by the communities are Meningitis, Measles, Malaria, Yellow Fever, and Tetanus.

Despite this, perceived community needs and priorities are often different than public health ones, and concur to the ones found in earlier Primary Health Care (PHC) needs assessment of the seventies and eighties. Priorities ranking indicates needs for infrastructures (health posts, mills for cereals, water pump or well, schools, teachers' residences, agricultural materials...) or systems development (small commerce, pharmaceutical depot...), in comparison to less immediately tangible public health preventive strategies, such as HIV prevention.

Based on these findings the key strategic priorities identified are:

- ♦ to respond to one of the community perceived needs through micro-development income-generating projects first, or in parallel, to HIV prevention,
- ♦ to introduce feasible and cost-effective immediate complementary public health measures (e.g. Measles and Tetanus Toxoïd vaccinations, or Malaria prophylaxis with impregnated mosquito bed nets and early presumptive treatments...).

4) Health Sector at the Community Level

Most of the old village primary health care (PHC) workers are not functional any more. In addition, either the few still functional PHC workers or special communication agents, too often in isolation from their communities, have been trained by the national NGO (ABBEF) to sensitise the population and do demonstrations on the use of condoms to prevent HIV. In some of the communities where these workers are functional and where they are answerable and accountable to a larger community organisation they belong to, they can be tapped to for HIV/Aids strategies. The youth favoured the health personnel from the closest Health Centre to receive information related to HIV prevention, instead of the local less anonymous resource. As a consequence easy accessibility to information is a problem. Youth were identified as more open, receptive, capable of interpretation, eager to forward

³ Care and support, or in French, “la prise en charge,” is the common terminology used in Burkina Faso despite the fact the term is rather ambiguous and entails the additional financial support discouraging the local NGOs and Associations to commit themselves fully to this strategy

information and use those, and appeared therefore to be an ideal group to support their own volunteer peer advocates who are for the time being not tapped to.

Based on these findings the key strategic priorities identified are:

- ♦ at the community level, to benefit from the existing functional or ABBEF trained agents as dissemination agents of HIV preventive activities with the support of their community organisations, while avoiding at the same time revamping a full scale PHC workers' network,
- ♦ in the health centres, introduce an adolescents' reproductive health program,
- ♦ to introduce other less informal communication channels with the community, e.g. from the gatekeepers, and local Groups and Associations such as youth groups and their own peer educators (ref. section 1 above).

5) Community Organisation against Aids

Essential to the process of stimulating community participation is the assessment of the present and future potential of community organisations to Aids activities, and the improved understanding of their constitutions, decision-making, concrete contributions and spheres of influence.

In general, both rural and semi-rural⁴ communities do not have any special structures organised to respond to Aids because they expect solutions (e.g. "magic bullet" such as a vaccine for example⁵), or support (e.g. information from NGOs) from the outside. For example in Kampti town, the youth mentioned four types of sources of information (market stands, theatre, informants from Ouagadougou, and national Aids Day), and deplored the majority of those (besides national Aids Day) did not take place anymore.

Influential people who are gatekeepers over different segments of communities or groups (religious, ethnic divisions, different types of crops, youth, administrative delegates, chiefs of land, tailors, traditional healers etc.) do not play any major role presently in the responses to Aids. Such popular-opinion leaders, yet, have been capable in each community to mobilise those and the resources necessary to participate in activities beneficial for the whole villages or neighbourhoods. Examples are numerous: purchase of a mill, training women for a small income-generating soap factory, building a school, installing water pumps, drilling for water, planting trees, building a health post, lodging facilities for teachers, working in collective fields, fabricating butter, building a market, improving the hygiene.

A number of activities in each community exists which are collective income-generating initiatives benefiting to different segments of population (e.g. women), to the benefits of specific community groups (shared incomes), or individuals (salaries), or both, such as collective fields, fabricating butter or oil or palm-wine. Large local active support networks of families, relatives, clans, religious groups, take place in case of serious problems (diseases, deaths...) to assist persons or families under various forms (food, physical, presents or materials, financial...). Several groups from different Churches have a support network for People Living With Aids (PLWAs) (hospital, home-visits in Gaoua). The potential of empowering those into self-help groups of people with HIV/Aids can be pursued. The creation of new Associations are sweeping west Africa, particularly among women and the youths due to the emergence of the civil society to face the shortages of their Governments (Hoth-Guechot 1996). Working with these Associations may be the new societies of hope for energetic responses originating from the local population, and still remain to be fully exploited.

⁴ we prefer the use of "semi-rural", instead of "semi-urban" for the urban communities, either District capital, or Chefs Lieux d'Arrondissements, due to the original nature of the rural communities still largely dependent of agriculture for income

⁵ the false expectations of overcoming the epidemic of HIV at the community level with the present vaccine development originated from radio sources in isolated communities

Resource people (informants, youth groups) in each community are capable to identify and prioritise some of the needs and potential responses (prevention messages promoted through well respected channels such as youth groups, agricultural agent, church leaders, teachers...) to Aids at the community level. In addition, influential people can be instrumental in stimulating and operationalising those. The willingness to contribute to the local responses to Aids by being Aids prevention advocates exists.

Based on these findings the key strategic priorities identified are:

- ♦ to inform the numerous existing structures and organisations at the community level that their contributions are essential, and that no ("magic") solutions can be expected from the outside in the near future,
- ♦ to stimulate sustainable or on-going community prevention activities through the existing local groups and Associations, e.g. youth-driven peer education, instead of outside interventions with ad-hoc information,
- ♦ to involve the influential people or gatekeepers of each community and develop preventive education materials tailored to their specific segments of populations or sphere of influence, and offer them a range of activities which can address the care and support activities,
- ♦ to investigate how part of local existing income-generating resources can benefit in turn some of the needs to stimulate local HIV responses,
- ♦ to stimulate and support local active support networks (e.g. Church groups) to assist People Living With Aids, and their families,
- ♦ to use resource people to identify and prioritise needs and potentials responses, and influential people to have communities act upon those.

6) External Partnerships of Communities

Numerous external partners build up fruitful collaboration with the communities through different sectoral activities others than health (agriculture, education, social affairs...), and are willing to contribute to HIV/Aids activities. Communities perceive themselves as recipients of an intervention of external partners, instead of being themselves partners in the interventions' deliveries.

External partners are little involved in HIV/Aids activities in general with the exception of one international NGO (Plan International Burkinabé). The latter operates in a few communities where other interventions are already taking place. In addition, GTZ provides some ad-hoc information activities (video films, market...) in the towns of Gaoua and Kampti, and the Ministry of Social Affairs has a few schools education activities in Gaoua town as well.

HIV prevention activities are limited geographically to very few among the most accessible communities (estimated 10%). They are ad-hoc, implemented and driven directly from the outside without the participation of influential individuals. They are largely general population interventions, ignoring more vulnerable groups (e.g. youth, migrants...).

Based on these findings the key strategic priorities identified are:

- ♦ the involvement of new external multi-sectoral partnerships in HIV prevention and Aids care and support activities,
- ♦ the development of HIV prevention and Aids care and support activities in larger geographical areas, covering less accessible communities, more sustainable, using local support organisations, and targeting some of the more vulnerable populations,
- ♦ the change of interventions and approach from externally-driven partners with their own of communities being passive recipients to communities as partners in interventions' deliveries.

The following Table (4.2) summarises the key findings of the situation analysis related to the determinants of community participation. The latter needs to be brought to the attention of program managers of the public and private sectors, and is necessary to build up community-oriented and participatory responses to HIV and Aids.

Table 4.2 Key summary findings of the situation analysis at the community level

Determinants	Obstacles	Opportunities	Strategic Priorities
1) Characteristics	Complexity (need special studies) based on ethnic origins, age groups, and sex More visible male dominated assoc., but existing women assoc., informal youth groups Large migrant populations, different characteristics between urban and rural settings	Numerous occupational (farming, palm wine...) groupings/ associations exist by sex and for youth Possibilities to stimulate women and youth groups To focus on a vulnerable group (migrant populations), and to use different entry points for urban and rural settings	- Use of RRA methods to identify by ethnic background the important groups and associations to work with and leaders - Reinforce and work through the hidden but existent women and youth groups - The responses to HIV/Aids can be stimulated through the dozen of different groups/ associations in each village (feasibility and sustainability to be tested), and/ or through the gatekeepers (key informants) - Identify communities with migrant populations and tailor special strategies - Use in town, the Associations (more formal), and in villages the Groupings (more traditional)
2) Perception of Aids	Cannot be cured Negative socio-economic impact Preventive not a priority	Perceived as serious problem Dynamic youth population Care and support activities are a priority, and existing voluntary support networks	- to develop the care and support of Aids patients among the communities requesting those - to focus among the youth groups where those perceive themselves as the most HIV vulnerable groups

3) Perceived Needs	<p>In infrastructures and systems development</p> <p>Aids one among other public health problems</p> <p>Prevention of HIV: low priority in comparison to care and support of Aids</p>	support networks	<p>For small scale micro-projects development</p> <p>Aids is recognised as a serious problem</p> <p>Need to introduce care and support, and further introduction with justification of preventive activities</p> <p>Some communities have benefited from PHC support</p> <p>National NGOs have been active for HIV prevention with some agents</p> <p>Health centres well appreciated by youth</p>	<p>- to develop micro-development income-generating projects</p> <p>- to develop the care and support of Aids patients in communities requesting</p>
4) Health Sector	<p>Functional PHC network minimal</p> <p>ABBEF agents not motivated anymore but trained</p> <p>Health centres are not so accessible by all communities</p>		<p>- to introduce other cost-efficient public health measures (vaccination)</p> <p>- to introduce HIV preventive activities with a strong rational or information component, justifying those</p> <p>- to benefit from the existing functional or ABBEF trained agents for agent of dissemination of HIV preventive activities</p> <p>- in the health centres, to introduce an adolescents' reproductive health program</p> <p>- to introduce other community health sector less informal communication channels, e.g. ref. 1 gatekeepers or local Groups and Associations</p> <p>- Target communities where youth do not recognise condom use as an important protection measure</p>	

<p>5) Community Organisation</p>	<ul style="list-style-type: none"> - Miracle solutions expected, and coming from the outside - No involvement of gatekeepers or leaders - No use of present local income-generating activities to respond to HIV/Aids 	<ul style="list-style-type: none"> - Recognise importance and interested in preventive activities - Gatekeepers and leaders willing to contribute and important capacity to mobilise - Solidarity networks function for sick people and their families, as well as income-generating activities 	<ul style="list-style-type: none"> - to stimulate sustainable or on-going prevention activities through existing local groups or Associations - to tap to local existing income-generating resources activities - to involve the local influential people or gatekeepers and develop materials tailored to their needs - to assist PLWAs and families with local active support networks - to use resource and influential people to prioritise and act
<p>6) External Partnerships</p>	<ul style="list-style-type: none"> - Minimal involvement of external partners in HIV/Aids activities - HIV prevention activities are geographically very limited, punctual, driven from the outside, not targeted to the more vulnerable groups (e.g. youth, communities with migrants) - Existing intersectoral partners untapped 	<ul style="list-style-type: none"> - Some fruitful external partnerships exist in some domains - Some HIV prevention activities take place through external partners (NGO, GTZ, Social Affairs) - Intersectoral partners willing to participate (Agriculture, Development, Youth...) 	<ul style="list-style-type: none"> - to involve new external multi-sectoral partnerships - to develop activities extending the geographical coverage, the less accessible communities, the sustainability, the use of existing local organisations, the targeting of more vulnerable populations (youth, migrants) - to have external partners promote communities' participation as partners instead of recipients

In summary, the findings point to the feasibility and value of identifying the characteristics of each community to build up a sensible partnership. Due to the advanced stage of the epidemics, communities are eager to enter into care and support activities, but they need to be guided through their own already existing community networks. Some more visible public health interventions, (vaccinations, malaria control) or micro-projects, may need to be introduced first to some communities to respond to their priorities before any HIV/Aids activities are accepted. This is an additional argument justifying the integration of HIV/Aids activities with other PHC and broader development activities. It also justifies the use of participatory methods for communities to recognise and act upon the disease. Aids prevention advocates need to be carefully selected among supportive groups and linked to the closest health centres, in addition to the district teams. Health Centres should offer in turn the broader Reproductive Health activities and support the community advocates. Existing active community organisations and their leaders should be the cornerstones of HIV prevention efforts and be active and supportive gatekeepers as their catalysts.

In turn, community participation was ranked based on six indicators (Table 4.3). A hectogram (spider web or spoke configuration) documents visually next (Fig. 4.1) the present situation of community participation using the above mentioned aggregated data based on the adoption of recent community participation assessment tools (Bjaras 1991) (Schmidt D. et al. 1996). It may be further exploited to observe the expected changes over the two or three year period during which the intervention takes place.

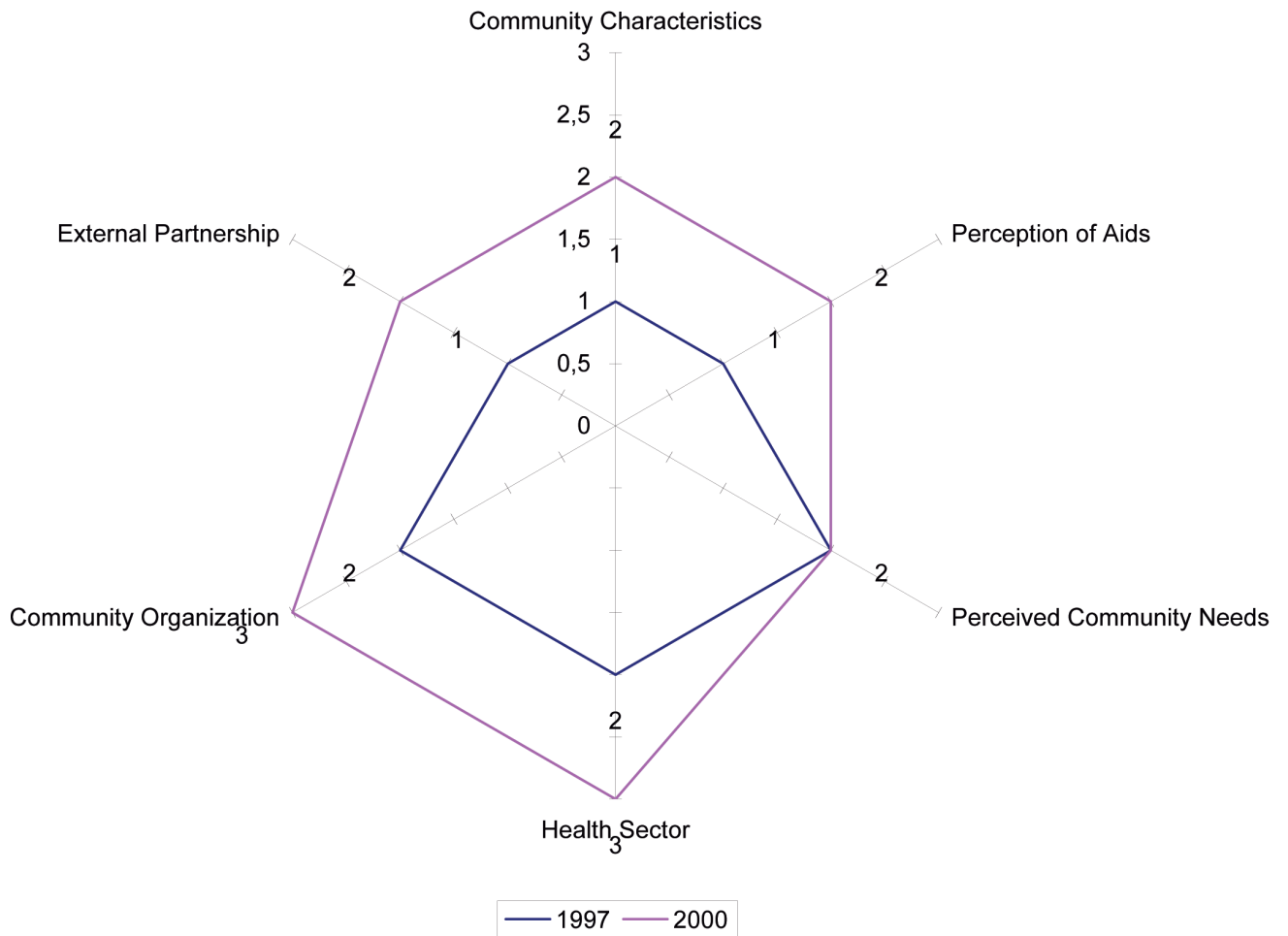
Table 4.3 Ranking scale for process indicators of community participation

Degree of participation			
Indicators	Narrow	Medium	Wide
1. Community Characteristics	<i>Not considered or unknown</i>	Considered and known but not used correctly	Networks fully exploited
2. Perception of Aids	<i>Helplessness</i>	In between	A disease which can be overcome by the community
3. Perceived Community Needs	Others than health	<i>Development and Health related</i>	HIV prevention as a central need
4. Health Sector	Passive local health network	<i>In between</i>	Functional local health networks
5. Community Organisation	Not involved in public health activities	<i>Involved in public health but not in HIV/ Aids</i>	Involvement in HIV and Aids activities
6. External Partnerships	<i>None or almost none in health and externally-driven</i>	Some external involvement in health but still externally driven	Communities true partners in HIV/Aids activities

Legend: present estimates indicated "in italic"

Fig. 4.1 Hectogram Visualization of Community Participation to the DRI Gaoua District:

1997 and Planned Changes by Year 2000



Based on the data collected as a baseline and their visualisation, besides a different forms of organised responses observed through the Health Sector and the Community Organisation⁶, other components rate low still in the participatory process. By the year 2000, the local responses intervention should intensify and build-up on these two essential components of Health Sector, and Community Organisation. At least three others should be instrumental in making good head-ways into the local responses as well: taking into consideration the various Community Characteristics when working with the communities, changing the Perception of Aids, and building up on the External Partnership. Finally, little changes may be expected in the short run for the Perceived Community Needs.

⁶ unfortunately, the qualitative method used in early 2000 in Gaoua does not allow to compare the development of community participation with the baseline (other questions and communities)

4.1.2. The Factors of Vulnerability

In parallel to the analysis of community determinants, we collected and organised data into three broad categories (Table 4.4). They may allow to focus efforts to reduce the vulnerability of individuals and communities to HIV and Aids based on the known interaction of key factors: (i) personal factors, (ii) factors pertaining to the quality and coverage of services and programs aimed at prevention, care, social support, and (iii) socio-economic factors, such as norms, laws, social forces and impact alleviation (UNAIDS 1998). The literature and experiences abound in interventions related to the first two categories of factors, whereas the last one is less known. Influencing the environment to support personal behaviour change efforts, with additional elements such as social norms, relationships, environment and public health policies, is essential to complement the individual traditional approaches with risk reduction strategies (Keeley 1999).

The Focus Group Questionnaire for the Youth at the Community Level are attached separately (Appendix 4B).

Table 4.4 Critical factors and related questions to measure vulnerability and vulnerability reduction for the Gaoua Local Responses

1. Personal

- a. Is Aids a problem among the youth?
- b. What can be done to avoid Aids? Problems or difficulties with the use of condoms?
- c. Changes in behaviours since Aids are known? More a problem of men or women? Due more to men or women (to identify any gender bias)?

2. Services and Programs

- a. Are condoms available? Problems encountered to have access or buy condoms?
- b. Availability of HIV testing and counselling services?
- c. Availability of information about Aids, STD, Family Planning?

3. Socio-Economic

- a. What is the impact of Aids among the youth? Among the community?
 - b. Is Aids feared among the youth? Why?
 - c. What can be done to avoid Aids among the youth? Among the community?
-

The following summarised key findings of the vulnerability factors are based on information collected through two focus group discussions in each community among 16 to 25 years old youth, males and females separately (Research methods, chap. 3). The full tables (Appendix 4C Vulnerability Factors: Original Findings) compiled in the original report (Pervilhac, Kipp et al. 1997) are recapitulated here under the form of a comprehensive table summarising the obstacles and opportunities. Based on those, the strategic programmatic priorities are suggested as well (Table 4.5). The data are aggregated next for all four communities. As per previous analysis of determinants, to tailor specific strategies for interventions, e.g. rural vs. urban or by gender, it is possible to analyse the data with the original transcripts separately.

Our findings concur with some of the earlier studies (Cros 1994; Cros 1995; Cros, Msellati et al. 1997) from ORSTOM accomplished in the region to document some of the local perceptions and descriptions of Aids which unfortunately did not have any applied programmatic consequences in the District⁷.

1) *Personal Factors*

In general youth possess a good knowledge of the main means of prevention (fidelity, condoms use, abstinence...), with evidence of individuals that are personally convinced and could in turn be convincing elements as part of a volunteer peer educators' network. In each group there is always a minority who does not know the exact causes of means of transmission. This leads in turn to false believes (e.g. sharing food with PLWAs, or stepping over their urine, or eating pork who ate the faeces of PLWAs, being close to PLWAs, etc.) which perpetuates stigmatisation. These findings were confirmed in the above mentioned ORSTOM studies. In addition, correct use may be a problem among a minority as well. Strategic priorities point to the need:

- to combat stigmatisation by overcoming local negative believes and behaviours on the transmission of HIV,
- to take stock of some of the youth males' and females' reservoirs of peer advocates,
- to carry out visual and practical demonstrations of the correct use of condoms (the "wooden penis" demonstration), and discuss problems (solidity, permeability, storage of condoms...) and negative believes ("condoms originating from America and disseminating Aids ...").

The youth assert that some positive changes of behaviours (more abstinence, wearing condoms) are already occurring in their communities, but confirm some passivity to seek information and education about HIV prevention which are often too late, or do not care.

Strategic priority points to:

- to the need to promote group discussion for peer education to discuss delicate subjects and convince groups as a useful technique to approach the youth, and make information and education more accessible and timely (primary prevention), and convincing.

If a few males and females identify equal responsibilities of infections among both sexes, an important proportion of males blame females for being more responsible for the propagation of the disease. Strategic priority points to:

- the need to address gender issues by targeting male youth groups.

Several females gave evidence that successful negotiation with males for wearing condoms.

Strategic priority identifies:

- the need to understand better the factors and means for the females successful negotiations of condoms among males.

In conclusion, we have documented in the analysis of personal vulnerability factors evidence of education and information that have been able to reach part of the youth already successfully. Several strategies and methods can catalyse further some of the present specific needs of the youth needs among both males and females.

⁷ recent policies of the French government in 1998 and 1999 are attempting to have their research institutes (CNRS, ORSTOM) move into more applied research for the national authorities' benefits

2) Services and Programs Factors

Youth complained about the barriers to easy condom access, or to quality issues, more often in relation to the Social Marketing of Condoms (SMC) program. The public services played a minor role in the distribution of condoms. Strategic priorities address the need to:

- improve accessibility and quality of condoms distribution both through the SMC and public health services,
- train women sales force at the community level,
- increase accessibility of condoms for the youth through more anonymous distributors (e.g. peers) than the present ones (village shopkeepers who are relatives or lack discretion),
- study the feasibility of selling condoms by the unit instead of the present packaging of four condoms, in order to increase its financial accessibility for the youth.

Sources of information on HIV prevention need to be known and if possible, if not available within the communities, need at least to reach those. Existing media materials need to be distributed again or used in communities. Strategic priorities are to:

- let the youth, women, men know where they can find the closest information about HIV prevention,
- use, and disseminate existing materials to the groups (if too costly, at least to some of the gatekeepers and Aids prevention advocates).

Youth feel better informed about HIV than other areas of concerns as well, such as STD...). This finding is also congruent to the earlier⁸ ones from the ORSTOM studies mentioned earlier.

The strategic priority is:

- Health Centres need to offer the full Reproductive Health Services package (e.g. STDs, reference to testing and counselling...).

Care and support are perceived as a service to be received from the health infrastructures, and often not affordable. Strategic priority:

- address the accessibility issue of health services, and develop the care and support at the community level.

One young male commented on the importance of condoms and even suggested that a female condom would even be better. Female condom is "currently... the only safe, effective, female-controlled barrier method choice for preventing pregnancy and STDs, including HIV/Aids" (Gilbert 1999). It is currently available in seven countries in Africa, but not in Burkina Faso. This slow development of female condom experimentation contrasts with the better known and larger efforts invested in the multi-drug therapies trials. Strategic priority:

- study the feasibility of female condoms distribution in more vulnerable groups.

3) Socio-Economic Factors

The known impact of Aids among some communities and much feared disease may activate the collaboration of the hardest hit communities with more mobile populations to participate to HIV prevention activities (ref. section 5.1). Strategic priority:

- identify with rapid assessment methods the communities hardest hit by the epidemic and/ or with a more mobile, mostly young, population without stigmatising those.

⁸ this finding appears to be a worldwide pattern based on similar findings of the 1998 Durex Global Sex Survey in 14 different countries with a sample of over 10,000 respondents and where the youth said they knew less about Sexually Transmitted Infections (e.g. 32% had never heard of Chlamydia) others than HIV (ref. C. Weilandt and C. Pervilhac et al., HIV Prevention Policy in Europe, WIAD/SPI, March 2000)

Despite their remoteness, communities are aware of the existence or developments of multi-treatment drug therapies or vaccine that may negatively influence their support for HIV prevention activities. Strategic priority:

- inform on the importance and feasibility of introducing HIV preventive activities to protect the communities.

Condoms have a negative and shameful image. Strategic priority:

- Make condoms use a common and sensible feature of protection.⁹

Deeply ingrained barriers involving cultural norms and values that may be contributing negative factors to the spread of HIV. e.g. ritual cleansing involving sexual intercourse after a woman is widowed, "levirat"¹⁰.

Strategic priority:

- Overcome some of the negative cultural habits with feasible and acceptable alternatives

Negative impact on households with the young dying having as a consequence the loss of resources to cultivate field and to develop the village. Strategic priority:

- Extend existing small holder farming techniques (existence of a GTZ Agriculture project in the same area) tapping to the village Agricultural Co-operatives (males and females), and to the employees of the Ministry of Agriculture equipped with motor-bike to cover their communities.

The following Table (4.5) summarises the key findings related to the factors of vulnerability to allow program managers to tailor more effective strategies and interventions for the HIV and Aids programs.

⁹ "banaliser l'utilisation des condoms"

¹⁰ tradition recommending or obligating the widow to marry one of her husbands' relatives

Table 4.5 Key summary findings of the vulnerability factors at the community level

Vulnerability Factors	Obstacles	Opportunities	Strategic Priorities
1. Personal	<p>Exact causes of means of transmission still unknown with false believes inducing stigmatisation of PLWAs</p> <p>Information and education seeking are passive</p> <p>Some males blame females of importing, or transmitting, or being negligent (prostitutes, not serious...)</p> <p>Many false rumours and believes still impinge upon the use of condoms among the youth</p> <p>Youth making bad experiences have no chances to discuss their problems with condoms and find alternatives</p>	<p>Good knowledge of the main means of prevention (fidelity, condoms use, abstinence...)</p> <p>Some positive changes of behaviours (more abstinence, wearing of condoms) acknowledged in some communities</p> <p>In general an agreement that both sexes are responsible due to bad behaviours and being negligent</p> <p>Some females are capable of negotiating successfully their partner(s) to wear condoms</p> <p>Condoms recognised and accepted as a good mean of prevention in almost all communities</p> <p>Openness to discuss difficulties and interests</p>	<p>Combat stigmatisation by overcoming local negative believes and behaviours on the means of transmission of HIV</p> <p>Use group discussion for peer education (more difficult among females) to discuss delicate subjects</p> <p>Promote the use of condoms by addressing the bad experiences made by some youth, and reinforcing other positive experiences</p> <p>Address the males' blame on females in the youth education</p> <p>Exploit the successful negotiations of some females with their partners and study further the techniques involved</p>

Vulnerability Factors	Obstacles	Opportunities	Strategic Priorities
2. Services and Programs	<p>Logistics: poor storage, stock breakdowns, Health Centres play negligible role in condoms distribution</p> <p>Information on HIV prevention unavailable (except printed "STOP-AIDS" brochure in Kampti) or the sources of information unknown for youth or for women at the village level</p> <p>Less information on STD than on HIV in the Health Centres</p> <p>Lack of accessibility to testing and danger believes in mandatory testing for all travellers</p>	<p>Improve quality logistics and bridge the gap between the social marketing condom (SMC) program and the public services and determine responsibilities</p> <p>Target HIV prevention to youth and women and clarify sources of information and disseminate some of the appreciated written existing brochures or former appreciated communication methods (videos, theatres...)</p> <p>Offer STD and Reproductive Health Services in Health Centres. Health personnel often well considered and appreciated for their expertise</p> <p>Improve testing and counselling services and informing on best policy</p>	<p>Social marketing program needs to investigate and reassure</p> <p>Health Ctrs. Need to be active promoters of condoms</p> <p>Use youth or women groups from the villages or neighbourhoods to pass information. Specify sources of information, and use existing appreciated written materials. In Kampti the health centre needs to fulfil this role as well like in Gaoua</p> <p>Need to promote availability and accessibility by and for women groups</p> <p>Further investigate the pricing issue and sales strategy</p> <p>Improve STD and Reproductive Health Services in Health Centres</p> <p>Offering quality testing and counselling services</p> <p>Develop the care and support aspects in communities as well</p> <p>Focus SMC in remote villages, and train women sales force at the village level. Study options for condoms sold by the unit at the village level.</p> <p>Explore feasibility of female condoms among more vulnerable groups.</p>

Vulnerability Factors	Obstacles	Opportunities	Strategic Priorities
	<p>Poverty does not allow to receive care in health services</p> <p>Condoms seem less accessible for females than males (uncomfortable with the local known salesmen). Prices can be an issue for some individuals, males or females. Female condoms as perceived need.</p>	<p>Develop much neglected care and support component of Aids</p> <p>Improve accessibility of condoms through improved SMC in remote communities and promoting female sales force. Reconsider sales by unit locally. Promotion of female condoms.</p>	

Vulnerability Factors	Obstacles	Opportunities	Strategic Priorities
3. Socio-economic	<p>Aids cases cannot be detected and reported precisely at the community level</p> <p>Difficulty to assess exactly the financial impact of Aids</p> <p>Some community members knew and thought that multi-treatment drug therapies may be available soon, as well as a vaccine</p> <p>Aids as a disease coming from another country</p> <p>Shame of the users of condoms</p> <p>Stigmatisation of Aids patients</p> <p>Negative cultural habits</p> <p>Negative impact on the village development and household income</p>	<p>Known impact of Aids among the youth in the communities (approx. Aids cases known by youth), and psychological impact of surrounding deaths</p> <p>Known financial impact of Aids deaths among the youth and their communities (costs attached to care and support, or to lack of work force, or lack of future labour because the youth die and cannot have children)</p> <p>Aids is a disease much feared by the youth due because it is a source of pains, cannot be detected easily, cannot be cured</p> <p>Prevent HIV infection in the communities by targeting communities with more mobile populations</p> <p>Condoms accepted among most of the youth</p> <p>Aids spread among the population at large</p> <p>Changing believes among the youth</p> <p>Introduce small-holder agriculture farming techniques that require less labour, such as zero tillage, and less expensive inputs, including natural pest control.</p>	<ul style="list-style-type: none"> - Benefit from the youth groups' capacities to identify the communities most struck by Aids with a rapid assessment of the approximate numbers of Aids - Reinforce the importance of preventing new infections with community-level interventions instead of hoping for treatments and vaccine in the near future - Target more mobile communities and groups within those without stigmatising - Make condom use a common and sensible feature of protection - Use local NGOs and Associations to combat negative cultural believes - Tap to males and females cooperative groupings, and 32 employees Min. of Agriculture

A closer look at the various categories of vulnerability factors allows program managers to go beyond the first reaction commonly heard among national program managers of “d  j   vu”. As documented in the above Table, obstacles factors particular to the local situation to overcome can be identified, and in particular more opportunity factors as well. Those in turn lead to different strategic priorities which can be instrumental for the managers who can make, in consequence, an informed choice originating from the bottom-up to select the most appropriate strategy among the wide spectrum available (ref. chapter 1, Table 1.1).

In conclusion, the Community level study has brought a new community-oriented dimension to the planning and interventions approaches which was still missing up to now despite ten years of technical co-operation in this District of Burkina Faso. In addition to an improved understanding of the key vulnerability factors, some essential components of community participation to HIV/Aids are clarified. The present data can be used as baseline data for community interventions and progresses monitored over the next decade.

4.2. Situation Analysis at the District Level

The findings related to the district system presented in this section were collected mostly through the district level study, and partly confirmed with data from the community level study. The present data were analysed and documented in more details already elsewhere (Pervilhac, Kipp et al. 1997), similarly to the previous Situation Analysis at the Community level.

Program managers need to understand and master their environments at the District as much as at the Community levels. Current reviews addressing the present weakness of the HIV/Aids prevention programs point to the recent focus of efforts shifting from models aimed at changes in individual risk behaviour to models aimed at community mobilisation, with information-based campaigns displaced by intervention programs aiming at enabling and empowerment (Luger 1998). As a consequence, the local responses, in addition to the previous community level study (chap. 4), encompasses by nature an improved understanding of the intra-collaboration (e.g. within the Ministry of Health), and of the inter-sectoral collaborations (e.g. between different Ministries and between the Ministries and the partners from the private sector including the communities). This explains in turn the need to understand thoroughly who is doing what presently, who is not active among the potential partners and why, what is a common vision and the needs for the communities in the District, and how to improve policies and co-ordination in the District. Such an analysis aims to comprehend better the existing structures to support people instead of jumping directly and prematurely into implementing strategies, particularly in light of Health Sector Reforms (ref. section 1.2.2) which stimulated a District level responses. The failure of taking such a step leads, in turn, to responses to HIV/Aids that are limited, fragmented, inefficient, non-sustainable, not community-oriented, with insufficient resources, and often driven by the Ministry of Health without the support of other partners.

In light of this, the present analysis reviews first, the responses of the public sector, and, second, the one from the private sector. We have summarised and visualised the findings of the public and private sectors following these sections in an Institutional Landscape. Third, it takes the original findings of the situation analysis one step further in adding the review of the policy environment which were not covered during the study (ref. chap. 3 Methods), including aspects related to the intra- and inter-sectoral issues. Finally, we review the methodology and analytical framework we have used for the replication of the Local Responses.

The present analytical framework matches closely the “Managing AIDS project”, a WHO Collaborative Study and the European Council of Aids Service Organisations between 1992 and

1995 (Kenis and Marin 1997). In the context of Africa, we do not know as of today of any other research approach than the present study. The degree of the organisational responses (being the dependent variable in the study) is defined as the degree to which an organisation or group of organisations responds to HIV/Aids. The responses correspond to the development of specific activities to deal with the problems of HIV transmissions and/or to reduce the negative personal and social consequences of HIV/Aids. Any organisation having at least one activity in the area of HIV/Aids in the study is considered as having organisational responses.

Three essential dimensions are assessed for each organisation:

- first, the types of activities (strategies, interventions, activities often summarised in objectives),
- second, the types of organisations (public or private, types of Non-Governmental Organisations such as Community-Based Organisations (CBOs), civil society organisations etc.),
- third, the distribution of the organisational across social groups (communities, vulnerable groups) and geographical areas (urban vs. rural, border areas vs. others more accessible). The degree of the responses can be analysed on different levels (region, district, communities, households).

Our findings contrasted with the various original national experts' views that little or nothing was happening, i.e. little involvement of any institutions in the District of Gaoua, and that the situation was desperate with the consequence that other more active Districts than Gaoua should be approached for Local Responses. We observed among over half a dozen institutions surveyed in each of the public and private sector, that several partners in both sectors were already involved in some HIV/Aids activities. The profile is low and responses weak as we shall see next, with an institutional landscape not as crowded as Districts of higher profile and prevalence, for example in a similar Local Responses study carried out in Kabarole District, Uganda (Pervilhac, Kipp et al. 1997). The potential partners are numerous, and those could be involved at little additional costs in the Local Responses. Developing a common vision to the Responses and an improved share of roles and tasks between partners, under the leadership of one partner should be possible as well.

We developed an analytical framework (Table 4.6) to assess the degree of the organisational responses in the district and structured the detailed questionnaire (Appendix 4D) around these key areas. The framework has been adapted to be user friendly for program managers at the district level by categorising the questions and variables into the current categories of indicators (inputs, process, and outputs) they are familiar with. Those are currently used in public health development programs either by bi-lateral organisations such as GTZ (GTZ and ITHOG 1989), or WHO (WHO 1996), or more recently specific HIV prevention and Aids care programs (Ng'weshemi, Boerma et al. 1997).

The three categories fall into:

- ♦ Inputs or structural fix or independent variables, those which cannot be changed,
- ♦ Process or structural changeable variables, in turn those which can be either modified or influenced in the planning or implementation stages,
- ♦ Output or structural dependent variable, the result, or improving the degree of responses of each organisation from no, to at least one activity for the potential partners, and from weak or low to medium responses, or from medium to strong responses.

By including the degree of responses as an output indicator, the present model has the advantage to stimulate program managers to pay attention and enable the various organisations to play more efficient roles than they presently do, and monitor the changes over time as an organisational surveillance tool. After all, if individual behaviours can be influenced and change over times, organisational behaviours in relation to their responses and contribution to HIV/Aids can and should be influenced, and improve over time as well. To make an inventory from the beginning of the strength and weaknesses of these partners (inputs), and to analyse the factors which can or need to change over time (process) makes it a more powerful analytical and managerial framework in order to reach more effective responses.

Table 4.6 Analytical framework of the Organisational Responses with related questions to measure the degree of the organisational responses for the Gaoua Local Responses

1. Inputs (structural fix variables)

- a. Is the organisation a public or a private one?
- b. Is the organisation an active one or not in HIV/Aids? (at least one activity)
- c. What is the experience of the organisation? (age, maturity...)
- d. Is the organisation working on gender issues? (directed by women, targeting women and/ or women's issues...)
- e. What is the organisation future development plan?

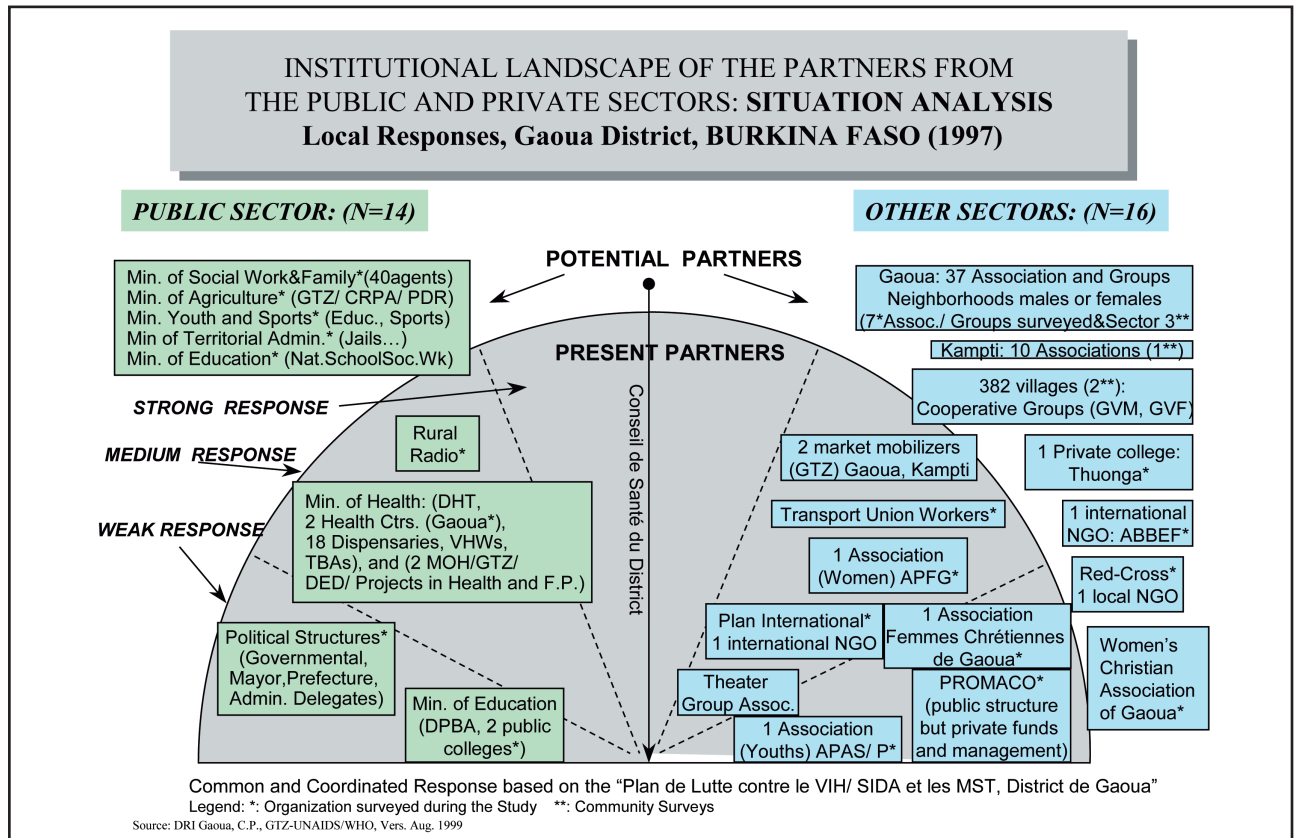
2. Process (structural changeable variables)

- a. What strategies and types of programs is the organisation involved in, or plans?
 - b. What strategies and types of programs is the organisation planning to get involved in, or plans? (future role, willingness...)
 - c. In Reproductive Health, which activities other than HIV/Aids (e.g. STD, family planning, TB) is the organisation involved in, or plans?
 - d. Which geographical areas of intervention (semi-rural or rural), or plans?
 - e. Which vulnerable groups are the organisation involved with, or plans?
 - f. How much is the planning for the types of programs based on communities needs, or plans?
 - g. What are the human resource capabilities (volunteers, motivation, expertise...), present general expertise, and main constraints for the organisation contribution to a future expanded Responses
 - h. What are the stakeholders' relationships of the organisation with other partners from the public or private sectors (threat, competition, stimulation...)
 - i. Who should take the leadership role of an expanded Responses in the district and why?
-

The Institutional Landscape (next Fig. 4.2) illustrates some of the key indicators of the inventory taking at the district level. It identifies the organisations active (present partners) or not (potential part-

ners), estimates the degree of responses of the active ones, visualises the co-ordinating and common vision development (reflected by the central arrow directed towards the centre with the identification of the co-ordinating body and Plan). It does not illustrate the strategies and types of programs that can be illustrated in another landscape (ref. 5.5).

Fig. 4.2



The results of the situation analysis described next is a step to identify the actors, and their present competencies and limitations, which in turn can improve the share of responsibilities and tasks (ref. section 4.3.1).

4.2.1 The Responses of the Public Sector

1) *The Ministry of Health*

The study used different proxy outcome indicators of health services provision (e.g. immunisation coverage and contraceptive prevalence) to assess services provision. It confirmed the present state of disarray of public health services, in comparison to former achievements, e.g. the high vaccination coverage reached in the eighties.

The Ministry of Health (MoH) new annual District Health Plan encompassed HIV/Aids activities in which the District Health Team and various levels of the health care systems with the twenty health infrastructures and the hospital operating in the District already involved. The Plan covers training, supervision, improvement of services, delivering of equipment including sterilisation, and setting up community patients' care. It fails to clarify either the strategies to reach the objectives or to specify who are the partners involved others than MOH or international bi-lateral agencies. Few Village Health Workers from the PHC days are still functional, and the large drop-outs may have exacerbated a lack of trust in the partnership between the MoH and the communities for community-based health activities. The MoH of Gaoua District is assisted by the German Technical Co-operation (GTZ) and German Development Service (DED) for Health Services in Rural Setting and Human Reproductive Health Project with three types of activities. First, the epidemiological surveillance which has problems of data completeness and of capacity for doing local testing. Second, the counselling and the patients' care which is quasi non-existent. Third, the Information and Education and Communication (IEC) which is functional for mass media (e.g. radio Gaoua), but with little or no activities for Communities and Households.

In addition, the District Health Team is very small, and HIV/Aids activities are in competition with other strong and priority national programs, such as the Guinea Worm Eradication, and Onchocerciasis¹¹. The integration of activities has led to a one man show, or having a single program manager for all Communicable Diseases at the District level. Yet, for accountability and daily management purposes, it now becomes difficult to know "who is really in charge?" in contrast to earlier large vertical programs (e.g. EPI, CDD...) of the eighties¹².

The communities and the organisations in the District perceived the MoH as the present leader in the public sector in the combat against HIV/Aids in the District. The MoH was identified as such because of its public health mandate, and its past and present activities. Based on the number of activities the MoH is presently involved in at the District level, even if insufficient in number and quality, we graded its present responses as "medium" in comparison to other public agencies. Hence, we used arbitrarily that structure as yardstick to assess the degrees of responses of the public structure.

2) *Other Ministries*

The rural radio ("Radio Gaoua") with the Director and managers have a long history of contribution, since 1996 at least, to information campaigns well adapted to and pre-tested among the local culture. Those have been financed by NGOs (Plan International and ABBEF), and by GTZ (Reproductive Health Project). The limitations of mass media campaigns to change behaviours are known to the technicians. The Radio was consequently rated medium on an equal footing to the MoH.

Two non-negligible but lower profile active structures were rated as weak responses: the Political Government Structures, and the Ministry of Education. The former, through the Mayor and the Préfet, and less so through the Administrative Delegates, are informing the public opinion about the danger of Aids and the importance of protection using condoms, even if not done systematically and efficiently enough. The latter, Ministry of Education, supervises all secondary schools in the Region

¹¹ During our visit and study, experts from both programs were present and competing for the scarce time and resources of the District Health Team

¹² personal communication with Harry Godfrey, Consultant for the Guinea Worm Eradication, Carter Centre, Atlanta, USA (Gaoua, June 1997)

and has recently in 1997 involved the teachers in a training program to educate school children; two public colleges are already active with sexual health and HIV/Aids education. We pointed to a few major constraints the school education program should overcome to have an impact on the youth. The program targets children between 13-15 years and may be more effective by targeting the 9-10 year children already to avoid early pregnancies, and to reach the young girls who drop out heavily from schools later. The teaching about Aids may be too academic and not practical enough (e.g. bio-medical and lacking simple messages on de-stigmatising the disease a topic much in need of discussion in the whole district). Finally, didactic materials need updating (e.g. dissemination and use of the excellent flip charts of Plan International).

3) *Potential Partners*

The **potential partners of the public sector** are numerous and their contributions to improved responses important. By order of priority based on their present or future roles in relation to their capacities, coverage, and the present needs determined by the communities:

- The **Ministry of Social Work and Family**, with a small team of nine employees in Gaoua town and forty trained Agents could play the much needed role in the key strategy missing of home visits and psychological support through its "Service of Social Insertion." A recent restructure of the MoH which has left that Ministry on its own with little resources and a new role to be defined may have created hard feelings to collaborate together.
- The **Ministry of Agriculture**, in charge of the popularisation and efficiency of the agricultural sector in the whole Province has thirty-two employees who are in permanent contact and speak the communities' vernacular languages. They also have the advantage of benefiting from their own transport (motor bikes). Some Agents are participating presently to the Guinea Worm Eradication program giving evidence of the feasibility of the inter-sectoral collaboration with the MoH. This could be an excellent entry point for training and supervising peer educators in the Agricultural Co-operatives Groupings.
- The **Ministry of Youth and Sports** (Education, Sports...) can reach several hundreds of youths through its Continuing Education program, and organises small well attended regional football events for the youth. An "Anti-Aids Cup" was an idea welcome and financially feasible, under the potential sponsorship of the Social Marketing of Condoms Project (PROMACO).
- The **National School of Social Work/ Ministry of Education** is responsible for the output of approximately thirty to forty social workers per year for the country. Despite twelve teachers trained for a month in 1996 on Aids/IEC, the social workers' curriculum and roles, particularly in relation to the care and support components, are still quite limited and cannot meet the new needs described above of the Ministry of Social Work and Family. A narrow partnership between the School interns and the Ministry operating in Gaoua could spearhead the efforts in that direction, and encourage the School staff to integrate such topics and applications in their curricula.
- The **Ministry of Territorial Administration** (jails...) welcomed the fact of introducing HIV/Aids prevention, at least information and education, among the prisoners of the jail located in town, particularly due to the high turnover of a large part of that population.

4.2.2 The Responses of the Private Sector

The programs from the private sector are largely community-based. Several actors in the private sector, particularly NGOs, could use other more cost-effective types of programs (institutional or media-based).

1) *The Non-Governmental Organisations*

We identified two key international NGOs active in the District, and by-and-large in the Poni region: Plan International, a branch from the United Kingdom, and the Social Marketing of Condoms Project (PROMACO)¹³, a branch from Population Services International (PSI), USA.

Plan International covers 56 villages out of over 500 that the District encompasses with an “integrated development” project, but only 18 villages comprise an HIV/Aids prevention component under the form of community education and communication strategy. The villages have been selected by geographical priority: at least half a dozen around the high prevalence Kampti area, and half a dozen at busy road -crossings. In addition a second component of HIV/Aids prevention relates to school health programs.

The health education materials used (flip charts, T-shirts) and messages are well designed, of high priority (e.g. on de-stigmatisation) and culturally well adapted.

Potential remains in several domains: first, to improve the geographical coverage; second, to share and promote materials with other partners of the public and private sectors; third, to contribute with lessons learnt from the program to skills-building and diffusion of experiences to the other numerous present or potential district private and public sectors’ partners; fourth, to play a pro-active role in leading the expanded responses in the District, instead of confining itself and be satisfied with limited direct interventions in a few villages.

In parallel to the above mentioned selection of the MoH as the yardstick for the public sector, the partners identified Plan International as the most visible and efficient private organisation working in HIV/Aids selected consequently as the yardstick for the private sector. With a large potential to improve performance still, it was rated as medium responses to HIV/Aids in the District.

The **social marketing** of the “Prudence” **condoms** by **PROMACO**¹⁴ benefits from over 250 outlets in the District, with approximately 20 located in Gaoua and Kampti towns. Yet the qualitative studies, carried out at the community level, confirmed among the youth the lack of accessibility still to those, either geographic (particularly rural areas) or economic (high cost of packet vs. unit for youth), or social (among youth, fear of vendors’ lack of confidentiality in small communities). In addition, storage breakdowns are frequent, and clients’ complaints point to the deficiencies of the distribution systems either in the public (despite large stocks available permanently in the district capital) or in the private sectors. Besides the two direct and well appreciated “bals populaires Prudence” (Prudence dancing balls) sponsored in Gaoua town, PROMACO, through its local representative, is not participating as much as expected to local events and is oblivious of the public sector representatives and their activities and problems. The strategy used is not much different than any salesmen functioning in the area (Coca-Cola, Marlboro¹⁵...), whereas the “social” in the marketing should make a difference, instead of the mere sales of condoms, as cigarettes, for example. In conclusion, we rated PROMACO as weak responses in comparison to the large untapped potential of being a more active partner.

¹³ financed largely by KfW

¹⁴ classified despite its attachment to the MOH as a private structure because of its private sources of financing and independent management structure from the MOH

¹⁵ as we observed incidentally during our visit the PROMACO and Marlboro sales agents’ presence and activities during our visit in the Gaoua town

2) *The Associations*

Among large local formal community organisations (registered or well-structured), belonging to a type of civil society organisations, we identified one outstanding organisation, the “**Association of the Women of Gaoua**” (**APFG**). It focuses on women on socio-economic and cultural activities which can change women’s conditions (family planning, circumcision, Aids and STD, hygiene and health, girls’ schooling, persons and family rights such as women’s violence or access to land). Local conferences are sponsored on such delicate topics. In a few villages around the district capital, the APFG carries out similar education and sensitisation about HIV/Aids transmission and prevention as Plan International. It also produces its own self-sustaining income generating projects (soap, plantation). It is the only organisation that can document an active role, and shows concern, in the development of Community-Based Organisations (CBOs) or self-help groups capacities (training, demonstration, supervision...). As such the APFG was rated as having medium responses. It was identified as being the main partner capable to lead the needed co-ordination of the private sector’s responses in the district.

A smaller and more recent local Association created a few months before the visit, the “**Anti-Aids Promotion and Family Planning Association**” (APAS/P) was created specifically to respond to the problems attached to HIV and Aids. With its limited resources, it concentrated in Gaoua town on de-stigmatising the disease but lacks trained health promoters, and cannot really have their People Living With Aids (PLWAs) come out. They also visit Aids patients and their families and support them (washing, presents...). The few activities documented allowed to place already this organisation as an active partner with still weak responses.

Three smaller Associations have been capable to contribute to “medium” responses in the District given their relatively small capacities in comparison to other larger organisations. The “**Theater Group Association**” based on the findings of the community level study has been doing extensive and successful work in the promotion of HIV/Aids campaigns among communities in the District. Due to financial difficulties, this Association presently had a lower profile. The “**Transport Union Workers**”, a civil society organisation, benefited recently locally from one information session on HIV/Aids dangers and prevention methods by an outside team from Bobo-Dioulasso and had mobilised its workers to benefit from the information. It is well organised, with branches throughout the Region. A recent evaluation of the national Program with an increase of 65 to 79% in a two years intervention program on the use of condoms among truck workers documents quite a positive outcome; despite the authors’ formulation of a different opinion, saying the condom use increased little (Testa J. et al. 1996). Two GTZ-financed individuals identified as the “**Market Mobilisers**”, a special project, have played similar roles of information as the two organisations just mentioned previously by holding regular sessions on market days.

One self-help group, the “**Christian Association of the Women in Gaoua**” with 130 women voluntary members functions in Gaoua town and the immediate surroundings. It plays already the role, informally and as a self-sufficient group, of supporting the PLWAs. Some members have been trained in management and family planning. The Association lacks financial means to extend their work (gasoline for mopeds...), and would like to become more involved and have more capacities towards the needed role of psycho-social care and support of PLWAs.

3) Potential Partners

In turn, the **potential partners of the private sector** are huge, and as such, their contributions to expanded responses remain to be tapped to. We have classified next by order of priorities (town first, less costs and a highly mobile population and probably more highly infected than rural) and feasibility of success these organisations:

- ♦ In Gaoua, 37 males or females **Associations and Groups by neighbourhoods and for the youth** as well, and in Kampti, 10 of those, are true self-help groups self-sustained or informal grassroots community organisations that could be at the heart of peers educators' support, local activities development.
- ♦ approximately **500 villages in the rural District with existing distinct males and females Co-operatives Groupings**, are Community-Based-Organisations (CBOs) similar to the ones mentioned for Gaoua above, but may need more nurturing, support and supervision than those.
- ♦ the **Red-Cross**, a local NGO, dynamic, with over 30 volunteers, one third females, with many qualified first aid workers. Would have much potential to support the psycho-social and care support component in urban areas (Gaoua, Kampti, and capitals of Departments, and jail), if they were provided minimum resources.
- ♦ one **private College** (Thuonga) in Gaoua, can add an HIV prevention information and education activity like among the public colleges mentioned previously.
- ♦ the "**Association for the Good Condition of the Family**" (Association pour le Bien-Etre Familial/ ABBEF"), international NGO, is dormant in Gaoua, but would have the potential to focus as well on the same component as the Red-Cross, but in rural areas.

In conclusion, we found the Associations to be a large untapped potential of existing resources of structures, people centred, to expand the Responses at the roots among the more vulnerable groups of women and youth.

Among civil society organisations, different Associations have different talents and a large potential to contribute to some of the needed strategies. To cite a few examples:

- ♦ the "Association of the education and training of orphan children" (ATEFEO);
- ♦ the "Association Souotaba" combining working professional and their talents from the health field (Medical Centre and Hospital) and Agriculture (CRPA, PDR/GTZ) which could instigate an intersectoral project with the Agriculture sector, or improve the quality of care in health infrastructures;
- ♦ the "Association of new ideas" (FILPAH) who has several community micro-projects particularly in literacy programs for school drop-outs;
- ♦ the "Association of the promotion of young girls and the prevention of Aids in urban area" for young girls from rural areas who need lodging in town to continue their education.

NGOs and Associations have increased by three folds over a three-year period from in the capital Ougadougou between 1994 and 1997 to reach almost one hundred (Desconnets and Taverne 1997). This rapid expansion translates the growing interest and willingness of the communities, and by and large the society, to organise itself to respond to HIV and Aids. Inventories have not been taken yet at the District level. It is encouraging though to find out in our study, in 1997, that the rural communities had organised themselves as well with a substantial number of formal and informal groups already committed or ready to contribute to the HIV/Aids activities.

4.2.3 Policy Environment for the Local Responses

This analysis is based on the situation analyses combined with a literature review of existing studies. It is not a focus of the present research and therefore will not be discussed any further (chap. 5).

The present micro-policy environment is little conducive or even counter-productive to expanded Responses towards efficient activities encouraged and shared between the present or potential public and private partners.

In the public sector, the Ministry of Health (MoH) is keeping its old prerogative of dominating and running the HIV/Aids activities in the District with a few privileged partners. Among those, activities with GTZ encompass the support of a few HIV/Aids activities related to the Market Mobilisers and IEC among the communities, the problematic HIV testing and counselling in the hospital, and the supervision of health personnel in the district. Neither the MoH, nor GTZ, are playing a leading force of empowering and delegating tasks within the presently active public institutions, nor are they encouraging some of the key public institutions to join forces in expanding the Responses. In addition, the MoH is competing with some of the private institutions for some activities, for example school education activities, condom distribution, community sensitisation. Only the Rural Radio has been quite active as another public institution. Its mass media information in the Region, for example improving the knowledge of the danger of HIV and routes of transmission, has been successful. Still, its impact in de-stigmatising the disease among the communities has been quite insufficient, and therefore negligible. No policies or plans, up to this study, have addressed this major negative barrier which still urgently needs to be overcome.

In the private sector, the Plan International is dominating the activities but in isolation, within a limited geographical area, with little benefits for other private or public partners either to learn or strengthen their capacities. Private partners are competing, when not with the MoH, between one another for scarce resources. An atmosphere of conspiracy is even dominating between organisations with the fear of having its proposal “pirated¹⁶”. Existing powerful and effective small Associations who could be the best multipliers either for sustainable community mobilisation, or for peer education, are overlooked.

No consensus exists among partners on priority areas, either by strategies or geographical or vulnerable groups, and the Responses are piecemeal with no overall orientation. All present partners in the institutional landscape look in a dynamic environment as isolated actors functioning under centrifugal or dispersing forces.

At a national level, co-ordination offices for NGOs, which should play a facilitating role between private partners and the public sector, are numerous and sponsored by international organisations. Those are, for example: the “Bureau de Suivi des

Organisations Non Gouvernementales” (BSONG), the “Secrétariat Permanent des Organisations Non Gouvernementales” (SPONG), the “Bureau de Liaison des ONG et Associations Nationales” (BLONGA). Their impact and usefulness to facilitate HIV/Aids activities at the District level appear to be negligible based on our observations.

The Local Responses approach attempts to remedy to the present weaknesses by creating a policy environment conducive to the expansion of more efficient responses. All actors work towards a common vision, as partners, of how the HIV/Aids responses should be organised in the District. Each partner contributes to this common goal by taking into consideration the institutions’ own strengths and limitations. The partners will function therefore under centrifugal or unifying forces co-ordinated

¹⁶ term commonly used by NGOs and Associations’ representatives during the survey

by a District Health Committee (as illustrated by the arrow of the Institutional Landscape) in which the MoH becomes a leading and co-ordinating force. District Health Offices of the MoH have been requested recently to produce a five years "Development and Action Plan of the District Health" in the context of the Health Sector Reform. A common consensus exists that the public sector through the MoH should be more a steering and leading force in expanding the Responses, instead of carrying out activities itself, with roles focusing more on planning and evaluation of programs, and on training, i.e. steering more the boat instead of rowing.

A macro-policy review of the "Decentralisation and Health Systems Change: Burkina Faso Case Study" (Foltz A.-M. et al. 1996) gives evidence that the recent development of the Health Sector Reform creates an enabling context to the implementation of the Local Responses.

Foltz et al. documents that administratively it was only recently, after 1991, that decentralisation became a major explicit policy goal of the administration. Until the reforms, none of the administrative units of the country, whether Provinces, or Departments, or Communes, or villages, enjoyed actual functional autonomy of any sort in a country where political and administrative rule was conjoined in the one-party state. Budgets, personnel, and infrastructures were strictly controlled from the centre. This control extended to the Ministries themselves. The territorial decentralisation encompassed in the 1991 Constitution, and encoded in a series of laws passed in 1993, divided the country into decentralised collectivities in order to provide a framework for local democracy, and to assure local economic and social development.

The Health Sector in turn, under a condition to a World Bank Project financing in 1993, imposed the creation of the districts. The latter still had no juridical status as of 1995. This choice, not perceived as an indigenous policy preference and not accompanied by the necessary staff, funds, vehicles, equipment, infrastructures allocations, has led in turn to difficulties in making the District system a functional unit. In addition, confusion, when not conflicts, were rampant between the Provincial health directorates and the new District directors. Finally, to complete a process of a district health policy going nowhere, the health sector has in turn reached recently a consensus in 1995 to eliminate entirely the Provincial Departments of Health. The latter had no more autonomy than in 1983 when first established, and it was decided to move towards 11 Health Regions, each with its own hospital. As of 1995, none of the Regional hospitals was authorised to manage its own staff, finances, equipment or infrastructure, still making it an independent centrally run Unit from Ouagadougou, and downplaying its role as Districts and Regional referral centre. Hospitalisation for Aids, TB, Leprosy and Trypanosomiasis is free of charge for third to fifth categories of room in public hospitals by Presidential decree (May 1991). But the application of this decree is low because the hospitals suffer budgetary constraints, and the Aids patients are not identified correctly by lack of HIV test or mis-diagnosis¹⁷. The 53 Health Districts, created on paper by the Ministry, had no juridical status as of 1995, as well as no counterpart in the larger territorial administrative structure, and no resources allocated by the Ministry.

One of the main conclusions of the 1995 policy analysis is still very present in the positive, but still incomplete, present policy process developments that were taking place at the time of the local responses study:

"The multiplicity of levels involved, the multiplicity of institutions involved, and the contradictions among the different streams which arose from different objectives or from different advocates and supporters, created uncertainty about what decentralisation processes were actually underway. For example... autonomy of the provinces, as part of territorial decentralisation, could lead to provinces as the dominant decentralised unit in the health system." (p. 16)

¹⁷ K. Ouedraogo, Key Correspondent (Burkina Faso), Fondation du Présent. "Services Under Strain –Burkina Faso, XI Pre-ICASA internet communication, 13.8.1999

In 1997, we observed still the dominant role played by the Health Region in comparison to a power and resource-less District. The complexity to implement decentralisation —a mix of political, administrative, and technical choices— is known for the health sector as a whole. The Health District and its District Health Team (DHT), as a consequence, will face difficulties to take a leadership role in the Local Responses to HIV/Aids in Gaoua District. Fortunately, the identical location of both the Region and the District authorities may confound and resolve the issue where the personalities' relationships and good will can overcome locally and temporarily, structural barriers. Still, this threatens the replicability of the Local Responses approach on a larger scale in other districts, even in the Poni Region.

A very big and real danger of „decentralisation” has been well described recently in the recent World Bank strategic planning document for Africa:

„Through health sector reform, HIV/Aids programs are being decentralised to districts without much-needed strong central guidance and sufficient resources.“
(The World Bank 1999)

In 1999, an inter-country workshop on Health Reform and HIV (Reeler 1999) located in Gaoua District, with participants from the West Africa Region (Burkina Faso, Ghana, and Mali) and Thailand, identified the following main constraints related to the health system of the District:

- ♦ first, the insufficient accessibility to health care, either geographical or financial;
- ♦ second, the weaknesses in the performance of the health system due to the insufficient quality and quantity of health personnel and their high mobility, and specifically for HIV/Aids, the insufficiency of counselling for testing for HIV and lack of availability of testing facilities, and inadequate blood screening and safety;
- ♦ third, the underreporting of STD/Aids cases.

In conclusion, the Local Responses may facilitate the policy-making process to advance some of the key national policy areas and questions relating, to resolve, for example, the following issues raised through this study:

- ♦ How can the Regional Hospital still heavily linked to the central level of Ouagadougou play, at the tertiary level of care, a more active role at the District(s) level in the Poni Health Region (e.g. activities related to the HIV testing and surveillance, and counselling, to blood screening and safety)?
- ♦ How can the secondary level of care in the District (Health Centres) be functional as “community-managed health centres” through the introduction of the user fees? How can the Health Centres offer sufficient quality of care (drugs/ condom availability, and services for example in Reproductive Health, counselling in HIV/ Aids...) and improve the referral link between the communities and the hospital?
- ♦ How can the District Health Team, with reduced personnel and limited skills in HIV/ Aids, be empowered to play the role expected in the Local Responses with a supportive role from the Region Health Team?
- ♦ How can the political structure in the Region and in the Departments contribute to these different elements?
- ♦ How can the Co-ordination Offices for Non-Governmental Organisations located at the national level address the urgent problems of co-ordination at the District level, ironing out the competi-

tion between large international NGOs or between small Associations, while maximising their inputs to the Local Responses, and facilitating the financial mechanisms of the activities?

4.3. Planning

Following the Situation Analyses at the Community and the District levels (4.1 and 4.2), I initiated the Solution Development, or the planning process, through a “Consensus-Building and Pre-Planning” in country workshop. It had been originally planned at the beginning of the Action-Research, as a logical step following the “Situation Analysis” (chap. 1, Fig. 1.3). Observations follow to improve this step (4.3.1). The process was further catalysed and accelerated between mid-1998 to mid-1999 by the UNAIDS Country Broker into a full “Strategic Planning” process and document (4.3.2). These two steps show the long and critical period needed for “Solution Development” Phase, following the situation analyses to anchor ownership locally.

The different case-country studies and the new Local Responses approach were carried out in 1997 and 1998 with the first results collected already in 1999, such as the ones reported here for Burkina Faso (4.4). UNAIDS and some of the co-sponsoring Agencies, e.g. the World Bank or UNDP, needed to know what is the state-of-the art of the different tools which can be used to sustain and scale-up such an approach in other countries. After two years of the planning and first stage of implementation of the Local Responses process, the present researcher was mandated by UNAIDS to make an inventory and analysis of existing tools (5.1.5). The Local Responses will necessitate the adaptation of existing tools, or the development of new ones. We illustrated our experience in Burkina Faso limited to one facet of assessment: the “development of a new organisational tool”, called the “Rapid Organisational Review” (ROR), based on the sociology of organisations (5.1.6). It aims to give insights into the public and voluntary structures functioning at the district level, and is illustrated under the form of institutional landscapes. If the solutions appear to be evident and easy on the paper, and despite the existence of some tools, we identified several barriers and constraints which need to be addressed in order to have more vulnerable groups participate and respond to HIV/Aids, taking the example of border migrants (5.1.7).

4.3.1 Consensus Building and Pre-Planning

The workshop aimed to plan and reach a consensus among the various partners on how to expand the responses in the District. To catalyse the transition from translating research case study findings into action, the workshop brought together all key partners from all Sectors, as well as the community representatives from the four communities where the study had taken place (chap. 1, Fig. 1.4). Consequently, representatives from each health system (communities, public, and voluntary for and not for profit) were invited in equal proportion (approximately 10 of each, or a total of 30).

The present researcher conceptualised and co-ordinated the Consensus-Building and Pre-Planning Workshop with the support of various international and local partners¹⁸.

The present findings were part of a formal Report addressed to GTZ (Pervilhac C. et al. 1998) with full detailed findings of the Workshop available in a separate Report (Nana and Sanogo 1998).

The workshop succeeded in accomplishing the following objectives:

- ♦ first, the institutional baseline data collected during the situation analyses were confirmed, or validated, during the workshop. All the partners outlined the various objectives and

¹⁸ GTZ Burkina Faso country team, the GTZ HQs Office, Eschborn, FRG., and GTZ RAP Office, Accra, Ghana, and national resource technicians (UNAIDS, WHO, National AIDS Control Program)

strategies in which they were presently engaged. The provision of care and social support for people, and socio-economic impact reduction were pointed as important strategies overlooked by all partners both from all sectors.

- ♦ second, several feasible Information Education and Communication (IEC) activities targeted to youth, women and migrants were identified by the four different communities (including resource and influential people, internal and external resources). Ten vulnerable groups were prioritised (youths, women of childbearing age, STD patients, international migrants, orphans as the first five of those) (para. 5.1.7 Migrants). A more detailed planning matrix, describing the youth and the women of childbearing age as vulnerable populations, was tested successfully by a group of technicians (Appendix 5A Matrix to Describe Vulnerable Populations). The matrix allows to assess for each vulnerable group dimensions related to: size of the population, risk behaviours, factors influencing infection, levels of possibilities of being infected or infecting others, relative importance, present interventions, future interventions). Geographical areas of interventions could not be determined by lack of time.
- ♦ third, all the participants agreed as a common vision for 1998-2000/2002 to have the following five objectives to expand the Responses to HIV/Aids, accompanied by twenty one interventions (Appendix 5B Synthesis Table) identified to complete those:

- | | |
|---|--|
| 1 | The prevention of HIV/Aids infection to the target groups is secured |
| 2 | The multisectorial and community participation are secured |
| 3 | The care and counselling for Aids/STDs are secured by the health infrastructures and the communities |
| 4 | Aids is felt as a priority among target groups (importance, seriousness, risk behaviours) |
| 5 | The socio-economic impact of Aids and STDs is reduced in the district |

- ♦ fourth, the key partners of the public and private Sectors in the District positioned themselves in relation to these interventions and clarified their inputs/ expertise, and limitations, in light of their experiences, human resources competencies, didactic materials, financial resources, existing interventions, population mobilisation. This represented a substantial improvement in comparison to the original (Ministry of Health) MoH 1997 HIV/ Aids Plan for Gaoua District found during the situation analyses. The MoH Plan was originally limited to six activities, MoH centered, had only a few other partners mentioned (GTZ and the NGO, Plan International Burkinabé), and the budget line items did not refer to the sources of financing.
- ♦ fifth, an informal co-ordination body for the private sector under the leadership of a local Non-Governmental Organisation (NGO), and an informal public sector co-ordination body with the existing District Health Team extended to a few other public sector partners, was identified to lead the Responses for each sector. The global co-ordination in the District falls as well under the mandate of an extended District Health Team structure encompassing representatives from all sectors. For the next six months following the Workshop, follow-up steps and dates were outlined with the institutions responsible and concerned.

In conclusion, the **2 main positive outcomes** of the Gaoua Workshop in the planning/ priorities setting process for the Local Responses were:

- ♦ the creation of an enabling positive micro policy environment with a consensus in planning and priority setting with an initiative based on the views of all three main partners of all sectors, and the communities' representatives together (in contrast with last year's MoH single and limited in scope planning exercise)
- ♦ the formulation of a five years common vision planning framework which fits well into the Five Years Plan of the Health Sector Reform, and which relates to five main objectives of HIV/Aids. Each main partner is positioned for specific intervention(s) in which the partner believes its institution large or small is most qualified and committed to.

4.3.2 Strategic Planning

Strategic Planning for the Local Responses Gaoua District

Mid-1999, or two years after the Case study took place, Gaoua District had elaborated with heavy inputs and guidance of UNAIDS a final comprehensive "Strategic Planning" document (Lamboray and M'Pele 1999).

We produced originally two documents of the Case study for Situation Analyses at the Community and at the District Levels (chap. 4), and for the Consensus-Building and Pre-Planning Workshop (4.3.1).

The mid-99 "Strategic Planning" document was based in addition on a series of the following eight other inputs and documents, produced over a one year period (between mid-1998 and mid-1999) by the country broker, with the last one on Health Sector Reform and HIV moderated by another consultant:

- ♦ "Analyse de la Situation et de la Réponse de la Prise en Charge du VIH/SIDA" (draft for the consensus workshop, third quarter of 1998): is a specific situation analysis of the much needed interventions in psycho-social support and care quasi-inexistent up to now.
- ♦ "Analyse de la Situation et de la Réponse de la Prise en Charge du VIH/SIDA" (Report of the workshop, end of 1998), and "Formulation du Plan Stratégique et Planification des Activités de Prise en Charge du VIH/SIDA" (Working document for the Planning Workshop, end of 1998): the situation analysis is finalized, and an original accompanying strategic planning document is drafted, addressing the psycho-social support and care only.
- ♦ "Guide d'Opération pour le Processus de Planification Stratégique dans le Domain Spécifique de la Prise en Charge du VIH/SIDA. Analyse de Situation et de la Réponse. Formulation d'un Plan Stratégique" (Jan. 1999), and "Etude de Cas Burkina Faso Processus de Planification Stratégique de la Réponse Nationale contre le VIH/SIDA dans le Domain Spécifique de la Prise en Charge des Personnes vivant avec le VIH/SIDA dans un District Sanitaire" (January 99): both documents addressing specifically as well the psycho-social support and care.
- ♦ "Plan de Lutte contre le VIH/SIDA et les MST dans le District Sanitaire de Gaoua" (Draft, January 99): is a the first comprehensive plan under the form of a draft, less than two years into the process of planning.
- ♦ "Health Reform and HIV Report of a workshop in Gaoua, Burkina Faso 15 to 19 March 1999": documents how the Local Responses into the health reform country process.

The Solution Development process (Phase 2) is presently cumbersome, time-consuming, costly, and hardly replicable if the tools and methods used are not more efficient, and simplified. This lengthy process gives evidence that the strategic planning approach recommended to implement the Local Responses is still in its initial testing stages, and merits further refinement. This is true despite the existence of the following modules, used throughout the process by the country broker: "Guides to the strategic planning process for a national responses to HIV/Aids" (Module 1, Situation analysis)(UNAIDS 1998), (Module 2, Responses analysis) (UNAIDS 1998), (Module 3, Strategic plan formulation) (UNAIDS 1998).

I pointed early on¹⁹ to one of the major deficiency in the first (draft January 99) Planning document related to the huge number (27 strategies) which were to be executed by a limited District Health Team and their partners. Those were quite complex shared between Prevention (12 strategies), psycho-social and care (8), socio-economic support of PLWA (4), co-ordination and partnership (3).

Corrective action was taken through the elaboration of a quite well-balanced and feasible "Operational priority Plan 1999" in the final "Strategic Plan" limited to a few essential activities only:

- ♦ Health care/counselling: a large training component (traditional practitioners, social agents, association leaders, health care staff), provision of essential drugs and laboratory reagents, home visits and care in 8 sectors to support PLWHAs,
- ♦ Prevention: also a large training component of various essential collaborators (leaders from Associations, animators), social marketing of condoms, sensitisation and media coverage,
- ♦ Co-ordination: mechanisms set up, follow-up of implementation and supervision, Financing (one fourth of the 3 years budget for the 2nd semester plan).

4.4 Implementation and Outcomes

Three years after our original situation analyses (4.1 and 4.2) we present next some of the early outcomes of implementation of activities in Gaoua District²⁰.

In the context of the present research, bounded by time limits, in the implementation phase (Phase 3), despite a very limited time span (second semester 1999), several outcomes were already visible, based on a recent formative evaluation (Phase 4).

The three-prone **prevention strategies** have allowed:

- ♦ First, the training of agents of changes (design of new training modules by the Technical Committee members with the NACP) to build up the skills and work with some of the vulnerable groups in the District:
 - 25 traditional practitioners of the District of Gaoua, 9 social workers, and 17 leaders (5 youth associations, 10 women associations, 2 military and police) participated in three different seminars to a five days sensitisation training with special training modules designed locally on the importance and means of prevention,
 - 28 animators or facilitators for HIV/Aids/STDs information and training activities of groups (5 radio Gaoua, 14 public services, 9 teachers of primary school, 1 each of agriculture, poultry, environment, primary inspection, militaries), and 9 Associations (Red-Cross, Catholic Women Association...), 14 public service employees (9 primary school teachers, 1 of each among livestock, agriculture, environment, primary inspection, military) to improve the effectiveness of local communication adapted to the different audiences,
 - and 5 communicators for radio information and education broadcasts.

¹⁹ memo. of 18.3.1999 to UNAIDS Burkina Faso and Geneva of "Feedback on the Plan of Jan. 1999"

²⁰ The results presented here will be part of a UNAIDS Best Practice Collection, "UNAIDS Case study Gaoua District Local Responses: The Burkina Faso approach" planned to be completed in August 2000 during a visit in Gaoua District (expected publication, late 2000)

- ♦ Second, for condom distribution, the social marketing of preservatives has launched additional community-based sales efforts. 10 condom sales males and females were trained, and equipped with bicycles, and supplies (cartons of condoms and promotion materials). They operate in a fifteen kilometre radius of Gaoua town (3520 condoms sold in December). In addition 14000 condoms were sold in new outlets. Over 10000 condoms were distributed freely through the public outlets in 1999.
- ♦ Third, a number of different health promotion, or Information and Education and Communication (IEC) activities using different channels have taken place:
 - the radio has developed messages in local languages with 180 broadcasts of sketches in French and Mooré, and have provided media coverage of activities for the promotion of HIV/Aids/STD coverage in the Region,
 - 9 local language stage performances by peers reached out-of-school youth in Gaoua town,
 - 5 inter-community contests on Aids control took place in 5 rural villages with 6 theatrical performances and 6 songs,
 - several sensitisation of communities took place among protestants and muslims, military men's spouses, associations of the disabled, teaching mothers; a local Association for women (APFG) have provided educational talks by peers on HIV/Aids/STDs in the local languages,
 - 2 educational talks by the Gaoua training centre (CRESA) reached approximately a total of 150 soldiers, and one educational talk a total of 150 prisoners in Gaoua jail,
 - finally, World AIDS Day in Gaoua carried out a number of substantial activities in Gaoua town (T-shirts on the theme related to youth), animation and theatrical performances and sketches and plays on Aids, football tournament, run, radio messages, evening show, drawing and poetry contest, training of traditional beer brewers, visit and provision of disinfectants to the Gaoua regional hospital patients, official ceremony by the High Commissioner, and over 4000 distributed free as promotion.

The newly launched **care and counselling strategies** started with massive training too:

- ♦42 health workers from the Gaoua regional Hospital and Kampti and Gaoua Medical Centres have been trained in care, pre and post tests counselling, screening, information, psycho-social support, and improved blood transfusion and safety measures,
- ♦7 additional health and social workers from the Gaoua hospital received complementary practical training for the medical care of People Living With HIV/Aids, and home visits in Bobo-Dioulasso at the regional hospital there, and at the voluntary screening centre (*Centre de Dépistage Volontaire*) and at the network of volunteers of PLWH+ (*Réseau des Volontaires+*).

In addition, it addresses also the following areas with a mix success due to their innovative aspects, but with encouraging signs that the population is becoming conscious of the availability of facilities and personnel equipped to support the communities:

- ♦ in the regional hospital:
 - 61 screening tests were done to volunteers in the hospital, 72 people were counselled, 6 People living with HIV/Aids were attended for care and counselling in the hospital, and 14 sick suffering from opportunistic infections were taken care of,
 - 7 health workers trained supported People Living With HIV/Aids on the spot but did not make any home visits, and social workers made 40 visits at the hospital,

- ♦ home visits and care (600 per semester) were planned in 8 sectors of Gaoua town with a minimum package of activities, but could not be implemented immediately. However, minimum home care is now feasible: the members of the Catholic Women Association supported 14 People living with HIV/Aids at home, with 728 home visits, and 10 visits by social workers,
- ♦ an Association of PLWH has been created but still has a low profile,
- ♦ drugs were ordered at the national level, as well as laboratory reagents for HIV/Aids, Syphilis, and Hepatitis B tests and delivered early 2000; they are planned for the Gaoua regional hospital and the urban Medical Centre of Gaoua town for patients, blood donors, pregnant women and those who volunteer for counselling.

The **socio-economic support** component could not yet take place by lack of funds, but the Catholic mission has completed an action plan for 2000.

Finally, several **co-ordination** activities allowed the smooth implementation of the above mentioned strategies:

- ♦ Functional and effective committees, with the meetings (10) held by the Technical Committee , and (2) by the Provincial Committee,
- ♦ The Technical Committee accomplished more than 30 supervisions, and received 1 visit from the NACP,
- ♦ The six-monthly plan was reviewed by UNAIDS, and the Committee members and progress reported in a semester "Assessment of 1999 activities", including an opinion survey of different partners, including community leaders and associations, of different dimensions of their perceptions of Aids,
- ♦ The design of an Action Plan for the year 2000.

Some of the early problems encountered in setting the Local Responses were:

- ♦ The mobility and insufficient number of health workers,
- ♦ The weak capacity in health and HIV/Aids of the various local partners, particularly non-health,
- ♦ Divergent, donor-driven disbursements and complex fund management procedures, accompanied by low coverage, reaching insufficiently the rural communities,
- ♦ Committees too large for effective management,
- ♦ The stigmatisation of the disease, and taboos surrounding it, still largely existing in the communities,
- ♦ VCT still under used,
- ♦ Strategies to reach PLWHAs and their families proven more difficult than expected.

4.5 National Scaling-up and international dissemination of the Gaoua Local Responses

Several indirect effects or results of the Local Responses in Gaoua District have spilled over at the national and international levels.

Burkina Faso National Response and International Contributions

Since 1987, the country has set up large-scale HIV prevention activities. The country is exploring, since 1998, different new approaches to become more effective in responding to HIV/Aids. Those are currently being formulated in the 2001-2003 National Strategic Plan which is in the process of being developed, and finalised by the year 2000. It involves the Health Sector and non-health public Sectors, as well as the voluntary and private for profit Sectors, who take the necessary time and attempt to define the best solutions to the problems and realities of the country, in contrast to quick fix solutions imposed from the outside. Several Ministries, in addition to the MoH, are presently directly involved in the planning of activities: Economy and Finances, Social Action and Family, Secondary Education, Higher Education and Scientific Research, and Communication and Culture.

The plan becomes a mean to articulate and agree upon a collective understanding of all key partners to respond to the epidemic. A United Nations (U.N.) Theme Group co-ordinates the national response and is comprised of the Government representatives with a dozen different representatives from key international U.N. and non-U.N. agencies (e.g. World Bank, FAO), expanded recently to involve other important stakeholders (bilateral agencies, the European Union, international NGOs, businesses), and representatives from the civil society (CBOs, social organisations). The national process and structures are strikingly similar to, and inspired by the ones described next for the Local Responses in Gaoua District.

Despite the fact the population is well informed and aware of the existence and modes of transmission of HIV, Aids is still considered to be a taboo. This taboo is recognised as a major barrier to prevention. This has direct operational implications on the need to tailor better Information Education and Communication messages, as well as other strategies (e.g. People Living With HIV/Aids organisations direct involvement), to overcome these barriers. Some vulnerable groups (youth, migrants, prisoners, soldiers) have not been sufficiently addressed, and some strategies (Voluntary Counselling and Testing or Care) are just nascent.

The civil society has been largely and increasingly involved in the responses to HIV/Aids based on the rapid increase in the numbers of registered NGOs and Associations. In 1997, approximately one hundred local NGOs and Associations were involved in HIV/Aids in the urban areas of Ouagadougou and Bobo-Dioulasso in an inventory accomplished then (Desconnets and Taverne 1997). Their numbers had tripled in three years. In Gaoua District, an institutional review, documents the same year dozens of them in a rural district, giving further evidence that the rural communities in the country are quite active as well. Still this essential reservoir of resources remains largely under-used, or untapped by programs. Yet, in 1997, it was felt that the social mobilisation is still weak in comparison to the severity of the Aids situation, perceived as largely the MoH's responsibility.

The President has declared recently Aids as a national disaster, rendering it a national priority. This political will to combat the epidemic has been translated into the creation of a National Solidarity Fund (January 99) for which funds still needed to be allocated by early 2000.

In 1999, the International Partnership against AIDS in Africa (IPAA) was launched bringing together a coalition of actors to work together to achieve a shared vision and common goals and objectives, based on a set of mutually agreed principles and key milestones to mount an “extraordinary” response. In this context, Burkina Faso was one of the six countries to conduct initial activities, with the agreement to develop a National Strategic Plan, and to mobilise resources, e.g. a special fund has been created for HIV/Aids.

Presently the intensification of the national response lies in four domains:

- ♦ institutional strengthening (still heavily centralised health system and limited managerial capacity of NACP),
- ♦ financial sustainability (increase the financial support for new strategies and the national and district levels, and finding mechanisms for effective transfer of funds to Districts),
- ♦ HIV drugs procurement policies and strategies and kits and materials for safe blood transmission,
- ♦ Necessary changes in law (for example in more effective channelling of funds).

In the international context, in May 2000, sixteen representatives from Ministries of Health members of the Organization for African Unity (OAU), met in Ouagadougou to prepare their health systems for both HIV prevention and care on an increased scale, and evaluating the Health Sector HIV/Aids control activities within the framework of the new International Partnership.

“... we need more information about the situation within the Burkina Faso itself, as well as coordinated efforts and a broad and transparent commitment to rolling back the epidemic.”

(Christian Lemaire, UNDP, coordination of the UN system’s response to HIV/AIDS in Burkina Faso)
Source: OAU Meeting of Ministers of Health of the OAU, Ouagadougou, May 2000

National Scaling-up

Gaoua District has set up a model of decentralised HIV/Aids planning, with HIV/Aids activities that are integrated and multisectoral, and which reinforce the national policies of decentralisation. This model has been able to influence the making of national HIV/Aids and reforms policies through different means as outlined next.

Faced by the urgency to respond to the epidemic, the Government has not been satisfied with keeping Gaoua District as a “*pilot*” project but has been encouraging that the lessons learnt and the “*learning by doing*” approach used there are replicated as quickly as possible to other districts and regions. As early as 1998, following the original successful early steps of Local Responses in Gaoua, the Government involved local consultants to disseminate and be directly inspired by the experience of Gaoua District (Diébougou and Banfora), and others indirectly (Kaya, Fada N’gourma). As an example, the District Health Team of Diébougou District articulated to the national level in late 1998 the need to offer individual and community counselling services, based on the experiences of Gaoua.

Some of the national legislation stimulated in turn local activities, for example, the new 1998 policy of the MoH to provide HIV-positive patients with free medication for the treatment of opportunistic infections, with drugs newly available in the District.

In 1999, two major national events triggered the advocacy of the local responses to HIV/Aids at the provincial and community levels with the sharing of the Gaoua experience on the implementation of an expanded response by the Gaoua Committees' members:

- ♦ the meeting of 45 High Commissioners of Burkina Faso (July 1999),
- ♦ the meeting of 44 Mayors of Burkina Faso (August 1999).

"In 1999 we had a meeting of all the Burkina High Commissioners, and we presented our work in Gaoua; and we expect that all will follow our lead. And we did the same at a meeting of Mayors. These meetings went very well, and we hope that this year and in the years to come all the big towns will begin multisectorial plans like ours against AIDS. And in all the Provinces, they are going to create provincial committees like ours in Poni, tuned to their own particular problems, but working from the community."

(President of the Comité Technique de la Lutte Contre le SIDA of Poni Province)

Source: Robert Walgate, Open Solutions, Interviews in Gaoua District, February 2000

In addition, in that meeting, the High Commissioner of the Poni Region expressed the wish to expand the Response to encompass the three other Districts of the Poni Region as well. Following these meetings, several Districts expressed their interests and willingness to develop a similar approach.

The MoH decided to extend support to Local Responses to HIV/Aids in 11 Districts (one per Region) by the year 2000 in order to scale-up the national response. The different criteria to scale up the responses in Burkina Faso suggested are the following:

- ♦ Districts sufficiently large (i.e. approximately 250.000 inhabitants)
- ♦ A mix of urban and rural districts (rural areas are lagging behind in the responses)
- ♦ Evidence of effectiveness in Aids, and district participating to the Health Reforms

The steps suggested are to start the multisectoral and involvement of all partners on a small scale (one administrative "Département", District and Regional capital) and if the experience is positive to scale-up to the whole District, then the Region, to identify the mechanisms to give the responsibility to the local political administrative authorities including the support structures, to empower the local district team to implement the response with the partners and identify the necessary technical, financial and logistics support.

A national Non-Governmental Organisation is foreseen to support the learning from Local Responses implementation throughout the country.

The planning framework and approaches used in Gaoua District have been adapted for the national strategic and multisectorial 2001-2003 plan of combat against HIV/AIDS/STI of Burkina Faso.

Finally, in year 2000, at the national level, in the public sector, many different Ministries, besides those mentioned in the planning process already, have been identified as potential stakeholders to HIV/Aids strategies and are presently carrying out their own strategic planning exercises. Those

include: Water and Environment, Energy and Mines, Agriculture and Animal Resources, and the Army. Seven additional Ministry Departments, as well as large public and private enterprises plan a similar exercise. These developments give evidence that there exists a multi-sectorial involvement at the national level similar to the local level involvement of various stakeholders in Gaoua Region and District.

With a maximum of less than half a million \$ U.S. for two years (\$ 170.000 Gaoua District or \$ 400.000 approximately for the Poni Region), the country can implement for approximately a mere 5 million \$ U.S. Local Responses on a national scale in 11 Health Regions. It would in turn become a full-fledged national strategy like others that are presently foreseen (IEC, condom distribution...). This would represent a relatively small amount in comparison to the current budgets available in the country for population programs which range above 20 million \$ U.S. for a five years period.

“The experience... of Gaoua is from that angle an example because it associates the higher administrative and political authorities with the various technical sectors and the Associations originating from the civil society and the private sector. This process needs an on-going and strong support from the central level and the necessary financial resources.”

Source: Ministère de l’Economie et des Finances. Revue des dépenses publiques du secteur santé, Janvier 2000.

International dissemination

Catalysing the stakeholders’ synergies to the benefits of HIV/Aids control activities is possible in any country, granted the understanding of their own cultural and socio-economic situations, and political will and commitment.

The “inter-country HIV and Reforms for Health workshop” (March 1999) with participants from national and district levels from Burkina Faso, Côte d’Ivoire, Ghana, and Thailand resulted in practical suggestions on how to make health system more effective in dealing with HIV/Aids, and to support communities to become “*AIDS competent*”.

Technical meetings of the Local Responses network allowed to present some of the Gaoua findings (Tanzania 1998 and 2000, Zimbabwe 1999), and to compare those with the experiences collected from other countries, in relation to the different steps involved for implementation (Appendix B, Technical Note 1), and the measurement (Technical Note 3, to be issued in September 2000).

The Gaoua experience has stimulated a large debate internationally among major stakeholders from international agencies, including UNAIDS/PSR, and contributed directly to a global vision of how to stimulate locally “*AIDS competent societies*”. The approach is gaining momentum and being disseminated in the West Africa Region rapidly (e.g. Ghana, Mali, Guinea). In addition, this experience has and is being shared and disseminated through a number of large international Conferences and Meetings over the past three years: the International AIDS Conference (Geneva, 1998 and Durban, 2000), International AIDS Conference for the Africa Region (Dakar, 1999), OAU Meeting of Ministers of Health from the Africa Region (Ouagadougou, 2000), American Public Health Association annual meeting (Boston, 2000).

Finally, in 2001, Burkina Faso will be hosting the International Conference on AIDS and STDs in Africa.

These different milestones indicate that Burkina Faso is deeply involved at the national level to overcome some of the major barriers to an effective national country program and to an acceleration of Local Responses. Burkina Faso is an important stakeholder in the Africa region and the different international discussions taking place on Local Responses.

Over a relatively short period of time between 1997 and 2000, the Local Responses of Gaoua District could plan using situation analyses and different planning methods, and implement HIV/Aids strategies in a rural setting. In addition, we could document the full process with visible outcomes of a few months of implementation only, and already national and international effects and benefits.

We hope the above framework (documented in this chapter) focusing on an organisational analysis for the Local Responses provides a useful analytical tool to the Local Responses. As a consequence we hope this process, with the development of the Rapid Organisational Review (5.1.6), contributes as well to the advancement of the sociology of organisations in the field of public health.

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CHAPTER FIVE

DISCUSSION AND CONCLUSIONS

As illustrated in our present research work, the HIV/Aids is a complex issue (chap. 1 illustration, in fact with “several bugs, necessitating several drugs, and several shots”) which as a consequence needs complex solutions, or responses. The constant search for the best patterns of responses in a country can be understood under the form of the following illustration. The managers and researchers are faced with a vast choice of strategies and interventions (illustrated here by the various coloured barrels) and are in constant search of the best mix of those, confronted with the various specific but also changing determinants of the epidemic. Yet, no definite pattern can emerge, as the responses are either community, or district, or country specific.

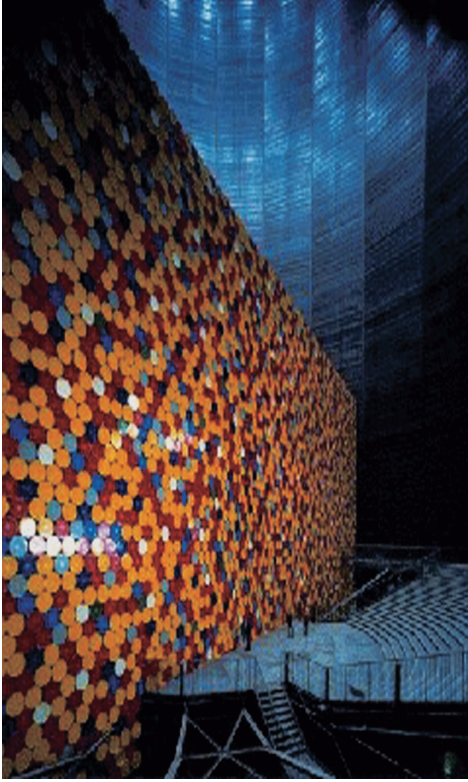


Fig. 5.1 *The Wall*, Installation in the Gasometer, 13.000 Oil Barrels, 1998-99, Christo and Jeanne-Claude, Oberhausen, Germany

At best, the overall approach and its different steps through the Local Responses may be distinguished, improved, and adapted for replication.

We first draw the main lessons (5.1) from the previous results (chap. 4). Then we discuss each specific result and step described previously (in chap. 4), to identify how the study methodology and the analytical framework for the diffusion of Local Responses can be improved: for the situation analysis at the community level (5.1.1), and at the district level (5.1.2), then for the consensus-building and pre-planning (5.1.3), and for the strategic planning (5.1.4) successively.

status of development of tools (5.1.5), the development of a new tool called the Rapid Organizational Review (5.1.6), and the applications and limitations of Local Responses looking at migrants as a specific vulnerable group (5.1.7).

We then turn to three examples of the potentials but also limitations of what is known or can be discovered in relation to disseminating and applying Local Responses: with the current

Finally, we review the main limitations of the present study (5.1.8), and the overall results in light of the original study hypotheses (5.1.9).

In conclusions, based on this research study, we identify the methodological (5.2.1) and international policy (5.2.2) issues, and research priorities for the future (5.2.3).

5.1 Introduction to the Discussion: Lessons Learned

Although past programs have focused on interventions and strategies, or the “magic bullet approach”, the Local Responses approach places equal importance and emphasis on the environment in which those are implemented, hence the results for mobilising resources, structures and advocacy, and partnerships, presented next, before those for strategies.

Monitoring the Local Responses

It is too early to assess the impact (prevalence reduction) of the Local Responses in Gaoua District. Yet, the results, process and outputs data summarised next (M'Pele, Pervilhac et al. 2000), give strong evidence that the epidemic and its consequences are being addressed fully by the local actors with the potential to reverse the epidemic in the years to come. This situation contrasts to one described above and found in the earlier years, described in the 1997 baseline situation analyses (chap. 4).

The Local Responses uses a light combined system of bi-yearly monitoring and on-going evaluation. The monitoring matrix, or a progress report, is based on the review of activities planned, the period when those took place, the actors, the results and additional remarks which refer often to some of the main constraints encountered. The facilitator, with the Technical Committee members' support, reviews the activities together. The results are presented to and discussed with the members of the Technical and Provincial Committees. They are used for corrective or follow-up actions, and in addition, for the design of the new plan of year 2000.

⇒ **Lessons learned:** *a light monitoring system with on-going review becomes a useful management tool for the local planning and implementing partners*

Mobilising resources

The situation analysis at the district level carried out in 1997 was unable to determine either the allocation of funds for the different activities, or the total amount of funds allocated to HIV/Aids activities in the District with the exception of the Ministry of Health (MoH). At best the analysis identified that the MoH had earmarked \$ 15,000 U.S. (5%) of its total 1997 health budget of \$ 300,000 U.S. for HIV/Aids activities. Those were roughly shared for half to Information, Education and Communication (IEC) activities in the communities ("District Sanitaire de Gaoua, Plan d'Action 1997"), one fourth to care in the communities, and one fourth to health services. No funds were allocated to socio-economic, or coordination and advisory support.

In early 1999, the planning team established transparency by budgeting over a two years period (1999-2000): a total of \$ 200,000 U.S. for all partners in the District for the whole District, or in comparison to the original 1997 MoH budget, five times more funds for a one year period. Although this budget seems to be large (half of the total 1997 MoH budget for the whole District), it represents a mere \$ 1 U.S. per inhabitant.

In addition, the activities budgeted for by the different local actors reflected the new priorities in the District: over half were earmarked to both care and counselling (40%), approximately one third (35%) was earmarked to the former main and almost unique strategy of IEC for the prevention of HIV and STDs, socio-economic support (16%), and finally, a small but sufficient amount (9%) to co-ordination and advisory support.

Each partner in the District knew now the priorities (4.3.1). Consequently, international partners involved already locally (e.g. PBI, GTZ) could then mobilise their own resources to contribute to the Local Responses.

"Before this exercise, AIDS was the business of the health service alone. The new approach takes advantage of all local powers and potential - such as women's associations, youth associations, collaborations with other administrative sectors, the army, the truck drivers - all the different workers' groups. They came together to create a common plan, with common objectives, each one mobilising its own resources, and all with the support of Gaoua authorities. This gave us a much greater chance of success against the disease - and much greater credibility with outside donors..."

(GTZ Gaoua technical advisor)

Source: Robert Walgate, Open Solutions, Interviews in Gaoua District, February 2000

However, local resources were insufficient. Finally, knowing the budget and its allocation, the time was ripe to mobilise external resources for the District. A one-day meeting (June 1999) took place for that purpose in Ouagadougou with the various donors. In parallel, most importantly, the process was accompanied by the decentralisation of funds to the local Provincial Committee, giving it a special status along the current public reforms national policies.

“The funds are concentrated in Ouagadougou. It is essential to decentralise the resources, to liberate - completely - the Provincial Committee and the Comité Technique... After the preparation of a multisectoral plan of action, in collaboration with UNAIDS and the national programme, we held a meeting with international donors in Ouagadougou. They studied our plans, recognised its significance, and were convinced they should give them direct support at provincial level - that's to say their funds would and are coming directly to the provincial Comité Technique, in contrast to the usual method where funds go to the Ministry of Health before being distributed to provincial level. So that gave our work a completely original status.”

(High Commissioner Poni Province)

Source: Robert Walgate, Open Solutions, Interviews in Gaoua District, February 2000

„The High Commissioner, having recognised the importance of the AIDS epidemic in his Province, emphasised the initiative taken by the Gaoua Health District to organise an extended and better structured response to the epidemic. He acknowledged the strong mobilisation of all the social strata on AIDS issue and reiterated the commitment of all the provincial leaders to untiringly work towards the success of the Provincial AIDS Control Plan. He announced a 5% contribution by Gaoua District to the cost plan and stated that henceforth a special budget line would be provided for HIV/AIDS control. He committed himself to implement the whole Plan together with the Poni population and welcomed the presence of international partners and the support that they would give to his Province under the AIDS Control Plan.“

(from High Commissioner Poni Province' opening speech)

Source: HIV/AIDS and STD Control partners Meeting, Ouagadougou, 25th June 1999

As the groundwork had been completed over the past several months, several international partners found the Local Responses plan and suggestions credible and worth the investment, along the lines of their own policies, and consequently committed their institutions with different amounts (the World Bank 60%, UNAIDS 18%, UNFPA 8%, Plan International 6,25%, WHO 4,5%, and GTZ 3.25%), and the African Development Bank financing the working action plan for 2000. The total funding was shared between new international (75%), local former partners such as GTZ and PBI (25%), and the district and communities (5%).

Resources mobilisation gave confidence to the local partners about the credibility of their Plan and efforts. How the funds are disbursed successfully and used effectively among the myriad of local partners remains to be fully assessed. Preliminary findings¹ though show that despite the structures in place, one of the main bottleneck caused by so many different sources of financing is the slow disbursement procedure from the external partners, and that the funds are reaching very partially the rural communities for the activities.

¹ H. Binswanger, the World Bank, report of a visit to Gaoua District (June 2000) in “Scaling-up HIV/AIDS Programs to National Coverage” in the Local Responses satellite meeting on “Local Responses to HIV/AIDS: Going to Scale with Local Partnerships”, 9th July 2000, Durban, XIII International AIDS Conference

⇒**Lessons learned:** *expanding the resources means mobilising rapidly a minimal amount of external resources for the partners involved to start the process and building up the confidence of all local stakeholders, including the communities, but financial flow and disbursements locally with multiple sources are a major constraint to be overcome*

Structures and advocacy

The early steps of the Local Responses allowed the HIV/Aids program from being originally essentially a MoH's single vertical and unique concern to become a local program cross-cutting different sectors. It was concerned to establish partnerships not just by operational means (e.g. strategies, services) but to complement those with other means as well (e.g. institutional and structures, policies).

Early on, the Local Responses took stock of the local Government's deep concern and interests in tackling the epidemic locally.

One early visible and useful contribution was to implement in the Region a favourable policy climate, instead of waiting for national initiatives. For example, in December 1998, the High Commissioner of the Poni Region passed an official legal decree ("Arrêté") to create the Provincial Committee for the Control of HIV/AIDS and STD, and the Technical Committee, specifying their mandates. In addition, the High Commissioner signed an official declaration ("*Principes Directeurs de Lutte contre le VIH/SIDA et les MST dans la Province du Poni, District Sanitaire de Gaoua*") which stipulated the six principles guiding the efforts and agreed upon by the different partners in an earlier workshop (ref. "*Determining the District objectives, activities, and priorities*"). Those became in turn an official and widely supported vision and ideals that the larger local society and local partners advocated and endorsed.

The committees and their different members are now active in sharing different tasks such as planning and supervising, making it a program locally owned and managed with powerful advocates of the Local Responses, in addition, supporting the fund raising for the Provincial Committee.

“We (the Technical Committee) coordinate and apply the programme of the Provincial Committee... For example, a youth association could decide on a certain activity according to the programme; they would work out their budget, supervised by the Comité Technique; and then the Provincial Committee would find the necessary resources from international partners.”

(President of the Comité Technique, Gaoua, Army Officer)

Source: Robert Walgate, Open Solutions, Interviews in Gaoua District, February 2000

As an example of technical inputs locally, in 1998 the local IEC regional team had planned a Campaign on Reproductive Health targeted to the youth, with the support of the National AIDS Control Program (NACP) technicians. The national level plays now an important role in supporting locally technical inputs, and at the same time is passing along and strengthening the technical know-how. In comparison to the situation described in 1997, the local team and partners have increased substantially their knowledge on the design of Local Responses, as well as the organisation and management of the Responses.

Health Sector Reforms are gaining impetus and facilitating the implementation of the Local Responses agenda in turn. In 1998, the Gaoua District Health Team was looking forward to the creation of the District Health Board as part of the nation-wide decentralisation of the Government. The decisions for district level activities is gradually moving to the local board, instead of going through previously via the central Ministry of Health in Ouagadougou.

The specific situation of HIV/Aids is now well known, as well as the priorities, as mentioned previously. The share of responsibilities between the different Sectors are well articulated by the main actors themselves, complementing and reinforcing the Health Sector.

“There are real difficulties at three levels: at the level of the person who is sick, there is no preparation so he or she can accept his or her seropositivity (HIV infection)... at the level of the family, they find it difficult to accept that a member of their family is affected by AIDS... What is going to happen to the sick person... to the family... misperceptions both of the disease and of the sick person... At the level of the health staff, are there any laws which can protect them when they announce the diagnosis? Can they be protected if they announce a person’s seropositivity to another, without his or her agreement? I am talking about protection from aggression.”

(Madame Kyéré, Directrice des Actions Sociales, District Gaoua)

Source: Robert Walgate, Open Solutions, Interviews in Gaoua District, February 2000

“Above all to improve the respect for AIDS victims in the community. If People Living With HIV/AIDS could be accepted in the society, that would already be a great victory. After that, there’s a big programme: to intensify prevention measures; then to be able to provide medicines at the lowest possible cost for opportunistic infections to all those who are diagnosed HIV positive, to improve and hopefully prolong their lives. And then to work directly in the community. To support families affected. To support the sick person in the community. We are working on all these ways of taking care of those who are suffering from HIV and AIDS.”

(President of the Comité Technique, Gaoua, Army Officer)

Source: Robert Walgate, Open Solutions, Interviews in Gaoua District, February 2000

The population is increasingly aware of the need for case-finding, i.e. to use the Voluntary and Counselling and Testing (VCT) services, but the persons who agree to be tested are still very few due to fear still. A situation which may change in the near future under the present strategies.

“... On... the community side, it’s extremely important that people show to the AIDS patient that it is simply a disease, like any other, and that they don’t abandon him or her. If a patient knows he won’t be abandoned by his friends, by his work mates, then he could announce his state. But now, as soon as a person says he or she has HIV, everyone runs away.”

(The doctor, at the hospital, Gaoua town)

Source: Robert Walgate, Open Solutions, Interviews in Gaoua District, February 2000

⇒ **Lessons learned:** *The Technical Committee was not fully effective the first two years because of its large number of members, the poor distribution of tasks and lack of job descriptions, the poor dissemination of information among all local actors and partners, and the Committee’s overall ill-defined role still. It wishes to become a body with more responsibility to co-ordinate and support the implementation. Remedial action has been taken locally in early 2000 to address these problems.*

Partnerships

A higher commitment and mobilisation of the different partners, public, voluntary and private, and communities, are visible based on their present involvement in HIV/Aids activities.

The local partners’ guiding principle falls under the motto “learning by doing”. All partners learn from past errors, and take corrective actions to build upon those.

A new institutional landscape in year 2000 would indicate, based on the organisational markers (5.1.6), an increased number of active partners in comparison to 1997 (4.1 and 4.2), both in the public and voluntary sectors (NGOs, Associations and CBOs, Churches).

In 2000, 27 Associations, and 382 agriculture co-operatives were involved in HIV/Aids activities.

Activities covered mainly Gaoua town, and a few communities in the District, placing emphasis on the key social groups. Those were either some vulnerable groups (i.e. youth, women), or gatekeepers (religious leaders and communities, opinion leaders, and tradi-practitioners), and Community Associations. For the general population, the local Gaoua radio coverage in the District placed emphasis on messages in the local languages focusing on de-stigmatising the disease. Many Associations address some of the more vulnerable groups, e.g. women, youth, and promote effective strategies (Social Marketing of Condoms that are community-based, theatre) which was missing up to now.

"I think what's needed is education and information -so people can understand the disease... Yes (what is being done in Gaoua is effective) with the associations that are mobilising people, the young are now aware of this disease. They think they now want to save their lives... I think in Gaoua (town), people now take care. But perhaps people who come here from outside do not. If the education continues, I think we will beat the disease."

A young man with a baby at the Gaoua market

Source: Robert Walgate, Open Solutions, Interviews in Gaoua District, February 2000

"Well after training, we've covered eight small villages around Gaoua, and contacted 572 women, 140 men and 227 young people -nearly 1000 people so far- to make them aware of HIV and AIDS. We've used several methods, but the villages people seem to like our women's theatre best. Also young women in our associations are given bicycles and trained to explain and sell condoms -"social marketing" - in the village markets..."

(Association pour la Promotion Féminine Gaoua, President)

Source: Robert Walgate, Open Solutions, Interviews in Gaoua District, February 2000

The Voluntary Sector has been tapped to with different activities. For example, religious associations address groups who are more vulnerable, and pick up strategies such as care and counselling that were largely neglected up to now.

"We're working on two issues: first, the young men, who go to Côte d'Ivoire to make money, and come back with AIDS. And secondly, the young girls, who also leave for money to serve in bars in Ouagadougou and Bobo Dioulasso, they also often return ill, and die in their villages. And they leave behind orphans, and we try to take care in the Mission... We try to help women sick with AIDS, visiting them, alone and in the community. We try to support them at home, in the villages, with our prayer; and with some activities such as soap-making, and with information and education about HIV/AIDS..."

(President of the Association of Catholic Women)

Source: Robert Walgate, Open Solutions, Interviews in Gaoua District, February 2000

NGOs are strengthening or creating new income-generating projects.

"The difficulties identified here are rural poverty; young people leaving the land, which is perhaps the greatest problem; and the proximity of Côte d'Ivoire and Ghana (where farming is easier): people migrate to improve their way of life. These are facts we work with. So we try to find ways of keeping people on land... (by) rural credit. For cattle rearing, for example. And anything that will bring them revenue."

(The Burkina Faso South-West Development Project Director)
Source: Robert Walgate, Open Solutions, Interviews in Gaoua District, February 2000

In addition, the Defence and Security Ministry have joined in with information sessions among the prisoners, police force, soldiers, soldiers' wives. New recruits, e.g. the newly appointed military medical doctor, support these measures.

"...my role is as one of the doctors on this multisectoral group, for the expanded approach to AIDS. And as a soldier, I can say AIDS is a reality which affects us too. There's no real difference in the approach we must take to AIDS in the army from that in civil society. Our ages are from 20 to 50 years old; and most are unmarried. So all the STDs, including AIDS, are here... I intend to hold small meetings to explain how HIV can be contracted, and about the whole story of AIDS -and the other STDs. And to explain that for the moment our only means of attack on this disease is prevention, and convince them that AIDS is a reality in this region."

(New military Medical Doctor of the Gaoua regiment, Gaoua town)
Source: Robert Walgate, Open Solutions, Interviews in Gaoua District, February 2000

New sectorial plans, designed with the World Bank support under recently strategies (The World Bank 1999), involve the Agriculture and Education Sectors (ref. Health Systems Reform workshop, Gaoua, March 1999). These Ministries fill up presently some of the gaps identified in the situation analyses to address better the youth, and the migrants, and develop poverty alleviation measures. These new plans encompass: strengthening HIV prevention among the youth, the workers and the agricultural communities; creating jobs and settling the young populations; initiating income generating activities; improving the standard of living in the migrant communities.

"...AIDS is not the property of the health system. You know that we local authorities, as well as having a role to advise in general matters of development, must also be promoters. The High Commissioner, the Prefects, the radio broadcasters, the journalists, the bar girls, the beer brewers, the religious leaders, the stall-holders in the market, the shop keepers, the clothes-makers - everyone is involved in the struggle against AIDS. The strategy must be "de-medicalized... It's not only for the men and women of the health sector, but for everyone who can be useful... Because if we confine the effort just to the health people, we will just look at them from afar and think we can let them get on with it. But it is we ourselves who must act."

(High Commissioner Poni Province)
Source: Robert Walgate, Open Solutions, Interviews in Gaoua District, February 2000

The Health Sector has changed its role from being a mere implementation agency of a few activities to become an important local and recognised stakeholder. It has now major inputs into having the public and voluntary sectors share a common vision, designing a plan based on local needs, and finally, stimulating the contribution of the various local partners.

In order to be effective in developing local responses, the situation analyses determined the need to accelerate and facilitate some of the health system reforms in particular *“to pass the HIV test”*. This contrasts with the past situation of the majority of local actors being oblivious about policies and reforms. The four priorities identified fell into the need to strengthen the Health Information System, the Decentralisation, the STD and HIV/Aids care system (many service providers requesting more training and health education to play the information providers' role), and the partnerships in action.

“Reforms in different sectors must take place before any community can become ‘AIDS competent...Health sector needs capacity building for health personnel in order to obtain better interaction with community members, to gain their trust and to know how their needs and how to respond to community needs.”

(Abstract from conclusions, Gaoua District)

Source: Summary of inter-country Workshop on HIV and Reforms for Health, April 1999

The Health Information System benefits now of a continuous and improved surveillance of HIV/Aids in the hospital (number of Aids patients, sero-prevalence among blood givers and among pregnant women), although behavioural surveillance is still lacking. Those data are reported under the epidemiological situation in the semester assessment of activities. Decentralisation has been stimulated by the Local Responses (e.g. local legislation, committees, planning, reviews). The 1999-2001 Work Plan emphasises purposely, early on, the training of health care providers to strengthen the STD and HIV/Aids care system, a process that started already in 1999. Finally, the local partners are stimulated to take stock of their competencies and desires as documented here. The Local Responses is not functioning in a vacuum but taking advantage and at the same time stimulating the reforms. This in turn makes it an enabling environment for the Local Responses to grow.

The communities are receiving well the messages and are active partners in the activities.

„Because what we can show in Gaoua is the real enthusiasm of the community, who have been committed from the very beginning of our plan. A real enthusiasm.”

(President of the Comité Technique de la Lutte Contre le SIDA of Poni Province)

Source: Robert Walgate, Open Solutions, Interviews in Gaoua District, February 2000

Finally, the needs to create an ethical, legal and social environment for taking care of the People living with HIV/Aids and affected by HIV/Aids, and ensure the greater involvement of People living with HIV/Aids was addressed as well. A project involving in Gaoua a national UNDP- United Nations Volunteers was drafted for this purpose.

“...I think to have associations prepare the family and the sick people is one thing; but the most appropriate would be to have an association of People living with HIV/AIDS ... an association of people who are seropositive, who are sick; this would be the right environment...”

(Association Pour les Femmes de Gaoua, President)

Source: Robert Walgate, Open Solutions, Interviews in Gaoua District, February 2000

For the first time in Gaoua District, a branch of the national NGO, Initiative Privée Communautaire (IPC), Ouagadougou, for People Living With HIV/AIDS (REVS+/IPC), has opened in Gaoua town and participated to the technical meeting of the District (first trimester 2000).

⇒**Lessons learned:** Despite a positive partnership environment, setting up a local organisation of PLWHAs needs time to become accepted in the society and fully operational

Strategies

Although it may be too early in the process to measure any specific impact, the second semester 1999 activities (Phase 3 in Fig. 1.3) document a substantial number of activities and processes that are already addressing the issues identified in the earlier situation analyses.

The biennial Work Plan July 1999- June 2001 finalised in July 1999 (Phase 2 in Fig. 1.3), preceded since early 1997 by the steps described elsewhere (chap. 4), and setting the ground for implementation, is the milestone of the beginning of the implementation of Local Level responses.

By late 1999, the activities covered geographically the two larger towns of Gaoua and Kampti, and the small town of Broum-Broum, in addition to one hundred fifty villages² in other Departments Gaoua District.

The present HIV/Aids and STDs activities listed next are locally executed and owned by the local health structures and partners, and the communities. Along the present Health Sector and other Sector Reforms, the present strategies are decentralised and better integrated into the existing health services.

⇒**Lessons learned:** *The outcomes and impact of existing strategies still need to be assessed on the long term in the district, as well as their sustainability*

5.1.1 On the Situation Analysis at the Community Level

The main aim of this analysis (4.1) was to assess rapidly the situation at the local community level, the heart of the present systems analysis, in order to articulate a Local Responses responding to the local needs, with more effective strategies tailored to the existing communities. This study's particular methodological strength includes the use of existing participatory methods adapted successfully by a local national Non-Governmental Organisation (Population Santé Développement) to collect the data.

Applying participatory methods such as Rapid Rural Appraisals (RRA), even Participatory Rural Appraisals (PRA), are not the ultimate panacea of community participation and, although becoming fashionable in program design, have their own pitfalls (Kahrmann 1997). The author points to the difficulties in practising methods to design and implement projects in the Sahel taking the example of a farming project where the women are looking for pragmatic solutions for their own „daily battle of survival“ and not so much for long-term solutions. Technocrats and local experts from the city are interested to resolve „how can the target group be made participatory?“ from the above instead of getting involved with the problems of the rural population. We have faced a similar situation in the case of the RRA of Gaoua. The team was stronger at collecting the data, but weaker in presenting those in a useful and applicable way for program managers in a participatory fashion³. From the outset a difficulty lies in the RRA team's origins. Although Burkina Faso, the team came from the capital

² the exact number of rural communities (contrasting with the 30 reported recently by H. Binswanger during his recent visit) really active and on what basis needs to be verified

³ the reader may refer in the future to the mapping techniques (biblio. Ref. Nyonyo V., D. Mayunga, C. Pervilhac, et al., TANESA, Tanzania), and Technical Note no. 3 (in press)

city and had no direct obligations either over the consequences of the District findings or over the process of ownership by the communities. In addition, the problem was compounded by having no future local actors from the District Health team involved in the RRA. This was due to district personnel shortages at the time the study⁴. As a consequence, the above findings were in turn difficult to exploit for its original purpose of setting priorities in a planning situation at the District level (4.3.1). Finally, it remains still to be fully assessed how much participatory methods are stirring up more bottom-up participation during the intervention phase through the communities, committees, and private and public sectors supporting institutions.

We selected six dimensions or variables to measure the community participation's responses to HIV/Aids. The hectogram can be a useful and stimulating visualisation of a soft process such as community participation (4.1.1), and can encourage the monitoring of further progresses over time. Such methods were not yet known during the Primary Health Care (PHC) vogue of the seventies and eighties, and were only more widely publicised in the nineties. The method applied to community participation for the local responses merits refinement. Further studies may identify what are the most robust indicators (valid⁵, specific⁶, sensitive⁷ and reliable⁸) and most useful to be acted upon, for example management, or leadership, as markers of the local responses progress, following the standards for selection of indicators in the field of Reproductive Health. In addition, the accuracy and standardisation of measurements (scale) of community participation to HIV/Aids need to be further developed. Finally, each community may have its own different baseline or web, and the aggregate of the four separate communities may be more representative of the communities in the District than the general aggregated estimates we have based our scores upon.

We used the essential categories of classifications proposed by UNAIDS, and found that those can be instrumental to complement the broad spectrum of risk reduction strategies which were wrongly in general limited more up to recently to individual risk factors. Further studies merit to address whether information collected by focus groups among men and women adults would be an added value or not to the identification of vulnerable factors, in comparison to the present study limited to the youth.

The present study findings are based on aggregated data collected between key informants and focus groups. Further studies may also consider three additional types of analysis of the raw data for interventions purposes: by genders, by locations (rural vs semi-rural), and by ethnic groups. The major limitation of the study, due to time and financial constraints, was not to include the household responses. The importance of the latter was just thoroughly analysed recently on a literature review (UNAIDS 1999). An improved design of the present community level study encompassing household data could at the same time allow to make the link, expressed in a recent regional conference (UNAIDS 1998), between the HIV sero-surveillance, answering the "how much," and the behavioural surveillance, answering the "why."

Finally, the challenge of the community level study may lie more in the use and application of the findings than in the collection of data itself. Some vulnerability factors are much more complex and difficult to address than the mere identification of problems through a PRA or a RRA and can be the subject of controversies, or still pending solutions, for which no quick fix exists. For example, in relation to social norms and cultural barriers, a medical anthropologist from a well-known international research organisation has recently challenged the numerous organisations which combat the "levirat" as a traditional practice facilitating the spread of the epidemic, to reconsider their positions based on two observations (Taverne 1996). First, from an epidemiological angle, the "levirat" is containing the spread of the virus at least among family members only, whereas, if not, widows would have broader sexual networks among the general population. Although such statement would merit further documentation for example through more research in sexual networks (UNAIDS 1998), the

⁴ we did not encounter this difficulty in late 1997 in the Kabarole local responses study, Uganda, with members of the District Health Team participating in the studies as observers

⁵ valid: measures the factor it is supposed to measure

⁶ specific: reflects only changes in the factor under consideration

⁷ sensitive: reveals changes in the issue of interest

⁸ reliable: gives the same value if its measurement is repeated in the same way on the same population and at almost the same time

argument is plausible. Second, from a social perspective, it represents presently the only efficacious social protection offered to widows. As an example of the cleansing involving sexual intercourse after a woman is widowed, it remains to be determined in Burkina Faso the extent of that practice still. No original local alternatives have yet been identified that we know of, in comparison to Zambia for example, such as the beaded ring around the waist of the widow (UNAIDS 1999). Identifying locally acceptable and positive cultural alternatives to reduce the risks of infection to HIV due to commonly and deeply rooted dangerous practices remain important under-developed more applied “projects” for anthropologists or ethnologists.

Under the Services and Programs, we could not investigate the closest formal supportive health structures, or Health Centres, to the communities. This was due to the nature of the team collecting data at the community level not qualified for such an assessment, and of the investigating team at the District level limited in number⁹. As a consequence, some technicians of international agencies (e.g. GTZ) may not have picked up so quickly on using some of the findings of the present study. Indeed intervention efforts prior to the study had been more invested and limited to that more formal level of care for the communities, and co-operation technicians were particularly interested to review these activities, and disappointed if not carefully assessed. Several observations of the formal Health System are nevertheless articulated in the District level findings (4.2).

The Community level study (4.1) has documented the feasibility of using RRA methods such as focus groups and key informants interviews, over a two weeks period, to comprehend the community participation at a District level, and their vulnerability factors. The RRA was not enough geared to participatory methods (i.e. using PRA). If the general impressions about the data are that the information is known already, a closer look to the above Tables (4.1 to 4.3 and 4.4 to 4.6) confirms their usefulness for local planning and interventions purposes, particularly identifying the local opportunities or strategic priorities. The challenge and success of community participation may not so much lie in mastering the tools of data collection than the use of the findings for prioritisation purposes in planning, and the design of programs. We would further recommend that such methods be not just limited to HIV/Aids program but more broadly based in the field of Reproductive Health encompassing at a minimum STDs, Tuberculosis, Family Planning. The local responses for HIV/Aids is now using planning tools which were still being tested or unheard of in the Primary Health Care (PHC) endeavour a few years ago.

The essentials to plan and design sound community-based programs in Gaoua District are now documented. This rapidly evolving field of research (UNAIDS 1999) is just starting to document current experiences with the top league models of African countries (Uganda, Tanzania, Zimbabwe, Kenya, Zambia...), all English-speaking countries. Little or no documentation of the French-speaking countries exists (besides Sénégal), leaving out a large majority of the poverty struck Sahelian countries. The present case study can be further used to stimulate community planning in other Districts, and in turn be used for the national strategic planning exercises. Although a young player in public health programs, HIV/Aids programs will benefit from such initiatives and approaches and become better equipped as a program to become part among other important old players to contribute actively to the comprehensive approach to Primary Health Care.

5.1.2 On the Situation Analysis at the District Level

The main aim of this analysis (4.2) was to assess rapidly at the district level the various systems, and their organisations as units of analysis. This in turn leads to an improved understanding of the organisations which have inputs into the community system, be it in the public or the private sectors (ref. chap. 1, Fig. 1.4), in order to expand the responses to HIV/Aids in the district.

⁹ in contrast we could carry out this analysis for the local responses case study in Kabarole, Uganda, late 1997

The study design, similarly to an earlier WHO Collaborative Study and the European Council of Aids Service Organisations (Kenis and Marin 1997), focuses attention on the meso-level of organisations, here the district, by the nature of the Local Responses study. The district is the level at which organisations are located, instead of the more frequent traditional studies referring to the micro-level of individual behaviour, or the macro- (or national) level. The study extends to the community level as well to articulate further the bottom-up approach (4.1).

The institutional landscape, the dimensions contained and their measurements, has proven to be a more powerful management and surveillance tool of the Local Responses than the mere “inventory” of organisation suggested in the original UNAIDS/ WHO proposal (UNAIDS 1996).

The present limitation of the institutional landscape is that it does not illustrate the strategies or types of programs covered or not in the District. One of the original landscapes we developed contained the additional dimension of strategies, but was dropped after some technical feedback because the landscape became too complex to comprehend. A landscape for the strategies¹⁰ could be easily adapted though, by substituting to the measurement of the degree of responses that dimension (ref. section 5.1.6).

A further limitation is that people may not be used to visualise activities in a landscape form. In the presence of public health experts, often with a medical and/ or epidemiological background, data presentations are better understood in the form of numbers, rates, ratios and regular two by two, or other statistical tables. We observed on a couple of occasions, difficulties for non-social scientists to comprehend the landscape. It needs therefore clarifications or some education first¹¹, before overwhelming or losing the audience.

We assessed the degree of the responses of each organisation by reviewing its global activities based on the above inputs and process indicators for each organisation and given its present status and capacities. The method was criticised later for being too subjective¹².

To improve the method, we used and validated a triangulation approach in the second Local Responses study carried out in Uganda at the end of 1997 (Pervilhac, Kipp et al. 1997). We developed a numeric scale to assess the depth of each organisational responses which based on scores fell into strong, medium, or weak responses. We were able to validate our observations and opinions by cross-checking the rating of the degree of each institution's responses based on our own observations and impressions, with the independent rating based on their own impressions only of each organisation between and by themselves. The second Case study in Uganda also demonstrates that methods can be improved and refined over time when repeating and replicating the tools in other national contexts.

Finally, the challenge of this tool lies also more in the use and application of the findings, like the community tools (4.1.1) than in the collection of data:

- Which institutions of which sector, within their limits, can improve their roles given the types of programs best tailored to respond to the communities' needs?
- What are the most cost-effective strategies to concentrate upon? Priority? Feasibility? Sustainability?
- How to bring in new partners into the picture (landscape), with the considerations just mentioned?

¹⁰ strategies were classified into community-based, institutional-based, and media-based and social marketing

¹¹ we used a blank landscape first for people to comprehend its dimensions

¹² personal communications with a couple of UNAIDS-WHO experts following the presentation of the Burkina Faso findings at the UNAIDS Technical Meeting, Geneva, September 1997

The Local Responses success is narrowly limited as well to an uncertain policy environment unveiled through the Health Sector Reform that we have just described. The latter can be an important confounding factor difficult to control for in the present methodological case study set up.

We have moved purposely the measurement of the organisational responses as an output indicator so that programme managers do not overlook this essential component of the program in their plans and reviews. However, the ultimate aim or outcome of the Local Responses should not be lost of sight in the process, and that is to reduce the HIV/Aids and STD prevalence, and to reduce the personal and social impact of HIV infection (ref. chap. 1, Fig. 1.4).

5.1.3. On the Consensus Building and Pre-Planning

For the findings of the Consensus-Building and Pre-Planning (4.3.1), the three days workshop is a good method to catalyse the forces and reach a consensus quickly for all stakeholders/ partners together, and to move from a study into implementation in an organised and systematic fashion. The workshop contributed to have the partners share a common vision and their parameters (objectives, strategies) given their strengths and limitations. It answered the question on “*What*” can be accomplished for Expanded Responses? However, the workshop was not sufficient to answer the “*How*” can the Expanded Responses be accomplished, or what are the exact activities of each partner, what are the priorities, what is the Plan/ calendar? This next step was further addressed by the UNAIDS Country Broker nominated mid-1998 who carried out for this purpose a “Strategic Planning” workshop.

We concluded, to follow-up the workshop, that additional financing does not appear as a condition sine qua non to Expanded Responses. Based on a recent inter-country meeting which had just taken place in Dar-es-Salaam (May 1998), it was determined necessary to prioritise activities which can put the local actors (communities and various partners) into confidence, and which can have a rapid and visible success on the short term. The activities should be feasible with the limited existing resources. The workshop results were a step in this direction. We further recommended that interventions/ activities taking place on a quarterly basis be monitored carefully, and corrective actions be taken as on-going process over a one year period through a special technical support (identified mid-1998 as the “Country Broker”). The original thinking that existing resources to expand the Responses is sufficient was proven to be naïve but was based on the original thinking that a wealth of human and local resources exist already but are not tapped to. It overlooked the necessity to increase resources mobilised in support of HIV/Aids prevention and care activities.

This condition is stated in the original *Best Practice* on Expanding the Responses, as one among the six pre-conditions to fulfil equally (UNAIDS 1998) in order to increase the chances of succeeding in implementing a Local Responses.

In conclusion, the results were instrumental to consolidate and catalyse the various pathways to Expanded Responses with ambitious objectives fixed by the various local partners (Public and Private Sectors and Communities) in an original effort to increase the local ownership of the process.

The following main observations summarised in eight issues may allow to improve a future Phase 1 of Situation Analysis, and Phase 2 of Solution Development/ Priorities Setting, in other Districts of Burkina Faso, or other countries. Those may be instrumental to improve its in-country or other countries replication, should it be used to catalyse Responses. These issues show also that there is still much work to be done in improving the steps of Local Responses within the country.

1. Need to adapt the international terminology for interventions to the country national/ district one: the use of categories of objectives, strategies, and interventions based on the “Interventions and Policies” (National AIDS Program Management A Training Course, GPA/ WHO, 1995) to orient the workshop participants to a common vision was appropriate. The identification and language of “interventions” need to match the local realities and be more comprehensive particularly for care and counselling and social and economic impact reduction. The National AIDS Control Program (NACP) and the program managers at the local level would need in the future to design this framework of reference before such a workshop. It can in turn be used for the various Districts in the country.

2. Lack of benefits from the use of the Local Responses situation analysis findings for solution development: the study questions and approaches to encompass programmatic questions or aspects lacking for District and other program managers, targeted population interventions approach vs. the by and large “community approach”.

3. Three key partners groups and the preparation and implementation of the workshop: community participants could not function well into a more academic room environment and needed more time and participatory methods as what they were offered in their own language. Group work exercises need to flow better into the general process for the various types of participants: either the exercises have to be tailored for each group of participants, from community representatives to public officials (different interests and aptitudes), or groups need to be involved in different workshops.

4. Consensus building was reached through plenary and pin-boards: the tight agenda and group works did not allow the original planned dialogue for exchanges of experiences, disagreements and controversies between the major stakeholders of different sectors. Group works which allow this fruitful and necessary exchanges, followed by debates in plenary would allow to overcome this problem, particularly on (re-) defining the major roles of some of the key actors (Ministries, NGOs, Associations).

5. Clarifications from external partners to District actors: local partners requested a number of clarifications from external participants (agencies, donors...). A better atmosphere can be created if all agencies can clarify their roles and potential inputs. As examples of issues raised are:

- directed to the MOH: the role and collaboration between the social private marketing actor, PROMACO¹³ with 265 outlets selling condoms in the District, and the MOH with a limited impact of its 20 Government health facilities which have a restricted geographical coverage, suffer from condom supplies shortages, and distribute a very limited number of condoms per month.
- by local NGOs/ Associations: the role of the PNLs (World Bank credit) to stimulate local NGOs/ Associations via the new Plan International Burkinabé (PIB) acting as a local relay (“ONG relais”) for those in the District,
- by some public Ministries and local Associations: the role of ABBEF in stimulating for example much needed interventions, e.g. care and counselling, and local fund raising (for ex. via PI) or including those in the new “Plan Stratégie 1998-2002” at the national level¹⁴.

6. Technical preparation of prioritisation of target groups, geographical areas before the workshop by technicians: a technical working group managed with great difficulty the prioritisation of target groups in the District, a concept that was non-existent in the previous plans and interventions. The adaptation from GPA/WHO 1995 Module 2 “Description of the Target Populations” and 4 of the “Determination of Priority Interventions” was well received by the technical group. However, also due to time constraints, the group could only describe a couple of priorities. The rationale for classifica-

¹³ the Social Marketing of Condoms project is a KfW funded effort but we noticed little communication and coordination between GTZ and KfW to implement this prevention strategie effectively at a local level

¹⁴ Source: the national plan is budgeted for over 5.600.000.000 FCFA. ABBEF, IPPF “Su noog Zaka” no. 11 1^{er} semester 1997, pp.10-12

tion would merit further discussion and attention by local planners and managers (ex. prostitutes classified last despite the fact that Burkina Faso rated 6th with 60% infection among 20 countries in terms of HIV prevalence infection in urban sex workers in Sub-Saharan Africa¹⁵). This low prioritisation may reflect the fear of embarking on difficult interventions, combined with the lack of understanding of potential entry points and local cultural unacceptability to consider prostitution issues. The important planning of priorities of geographical interventions with eight various locations to classify to provide guidance for the planning and interventions either for the public or the private Sectors was not carried out by lack of time. Mapping exercises as part of a situation analyses would resolve this difficulty.

7. Lack of planning of other program components related/ integrated to HIV/Aids: STDs, Family Planning, TB components were not discussed or considered. This should be addressed in the future to have HIV/Aids be part of the broader Reproductive Health package and agenda. The main reasons of this issue were:

- the situation analyses did not analyse these other components,
- the workshop was geared to a strict HIV/Aids expanded responses from the in-country users' (GTZ, MoH...) point of view,
- the workshop had to limit itself in its goals and objectives due to its experimental nature, and time constraints.

8. Monitoring and Evaluation Process: five categories of progress for Local Responses may be monitored over the next few months were discussed during the workshop:

- Documentation of the various stages defined in the workshop and their status completion, and solutions to constraints
- Detailed District Action Plan (yearly) by the MoH incorporating the findings of the Workshop and detailed Plans for each main Actor
- Documentation of activities (brief Quarterly Progress Reports with on-going internal evaluation) by each main actor , and comparing the new interventions 1 year later with the baseline of interventions collected in the Gaoua 1998 workshop
- Determination of the terms of partnerships between various actors (between public, but particularly between public and private) clarified for each intervention where the partnership is necessary
- Measurement: Inputs indicators encompassing institutional indicators. Process indicators encompassing personnel, activities, management, co-ordination, logistics indicators, and HIV/Aids services (integration, quality of health services), and outputs indicators measuring the degree of responses.

5.1.4 On the Strategic Planning

The UNAIDS Strategic Planning

For the results of the Strategic Planning (4.3.2), as clarified in the recent UNAIDS Guides to the strategic planning (UNAIDS 1998; UNAIDS 1998), the traditional normative planning exercise is planned according to universal norms (e.g. a standardised treatment, vaccination, etc.). It applies to all beneficiaries, irrespective of their conditions or situations, and will produce its effects to the extent

¹⁵ Source: A World Bank Policy Research Report, Confronting AIDS Public Priorities in a Global Epidemic, p.89

that it is reproduced accurately. Strategic planning contrasts with normative planning by adapting the norms to a given or changing situation, or taking into consideration a dynamic and flexible environment. It takes underlying determinants into account. Those vary according to the persons concerned (e.g. social class, religion, culture, gender specificity etc.) and according to situations that may alter rapidly over time.

Strategic Planning in the Private Sector

In the private sector, strategic planning has mesmerised many organisations since 1965. The massive use of strategic planning by the industry has been explained because „as firms grew and became more complex... *they needed a systematic approach to setting strategy. Strategic planning emerged as the answer*“ (Porter 1987).

Recently, Mintzberg, a sociologist, world wide known expert in organisations (Mintzberg 1982), and management (Mintzberg 1989), argued in a milestone on the review of planning that „strategic planning“ is far from being the ultimate panacea because of several fundamental fallacies (Mintzberg 1994). First, the difficulties of forecasting (particularly true in relation to the development of the HIV epidemic) are a major difficulty. Second, the detachment of planners and managers to strategy making is evident for different reasons. Among others: hard information are often limited in scope, not encompassing important ... non-quantitative factors (true in HIV/Aids with the lack of behavioural data), information are often too aggregated for effective use in strategy making, or arriving too late, and finally, there exists a surprising amount of unreliable hard information. Third, the failure to formalise gives evidence that innovation cannot be institutionalised.

In addition to the limitations of strategic planning, the author points to the real pitfalls of the original traditional planning too. Those are related to the lack of commitment of planning (with the exception of the “*Top*”), the inflexibility of plans, the biases of objectivity in light of the politics and policies, the obsession with control.

Finally, the author concludes:

„We have no evidence that any of the strategic planning systems -no matter how elaborate, or how famous-succeeded in capturing (let along improving on) the messy informal processes in which strategies really do get developed.“ (p. 296-7)

A closer look to Mintzberg's position in light of the application of strategic planning for the Local Responses, one would not recommend to HIV/Aids program managers to use strategic planning to come up with the best strategies and interventions in the District. The industrial sector has become more critical of strategic planning after thirty years of experience, and may be moving away from it in the nineties. Ironically, the health sector, late to catch up on the industry approaches, is attempting presently those with various degrees of success.

Strategic planning tools are used in development co-operation (e.g. logical framework) with well-trained experts, combined with additional outside expertise. We based our brief analysis on a recent review of the “logical framework”(Wiggins and Shields 1995). The logical framework usually consists of a four-by-four matrix which summarises the project, records the assumptions which underpin the strategy adopted, and outlines how the project may be monitored, all arrayed according to a hierarchy of objectives or an ends-means continuum. “(op. cit. p. 2) As a management tool, the framework emphasises objectives.” Yet it is also acknowledged that „the logical framework is not by itself, however, a comprehensive tool for either planning or management“ (op. cit. p. 4).

Germany's GTZ goal -orientated project planning and programming (ZOPP¹⁶), as a key part of its integrated project planning and management system, is perhaps one of the clearest and most detailed application of performance management to development programs. The authors point and refute some of the criticisms of the use of the logical framework such as a „rigid blueprint“ which can lead to reduced flexible implementation and „learning process“ (op. cit. p. 11). They counteract the criticism by documenting that the GTZ manual mention how the project matrix is expected to be revised at least four to five times during the project cycle (2-5 years), particularly as part of annual review and programming meetings.

We think that the criticisms are quite valid and are sufficient not to recommend the standard use of the logical framework to plan Local Responses (particularly out of „project context „, e.g. GTZ or USAID-financed). The Local Responses process we describe in this research must overcome the constraints of a limited „project cycle“ and cannot afford the administrative time-consuming and technical dimensions bi-lateral funded projects entail.

It is still too early to know if the strategic planning approach is the best way to implement the Local Responses, and further replication, and research will answer this in five to ten years down the line. Our present review of the origins of strategic planning suggests that it is a planning tool better tailored to meet the needs of large businesses ran by well-trained north-American business managers. In the case of the various original UNAIDS Guides to the strategic planning process for a **national**¹⁷ responses to HIV/Aids, those have been originally planned for the national level and better trained and supported program managers. In addition, even countries in Europe are moving away from Strategic Planning: “It is not envisaged that the forthcoming national HIV/Aids strategy will be in the form of a ‘strategic plan.’ It is likely that it will follow the format of ‘An Evolving Strategy’”(U.K. Country Report 1999¹⁸). We remain sceptical whether its present form can meet the needs and capacities of planning for the Local Responses in the context of improving the **local** or **district** responses.

Despite the limitations of the present strategic planning process, the end product is satisfactory and much more powerful than what existed two years ago, thanks to the country broker's persistence, qualities, and flexibility. The process of taking the various partners through the various planning stages led early on to have a common vision on some of the priorities in the District and agreement on the tasks to be shared between numerous essential partners. As an alternative, the identification of an effective planning tool for HIV/Aids at the local (in contrast to the national) level merits further discussion and research.

Strategic Planning and Health Sector Reform

One important aspect of the Strategic Planning process is the component related to the Health Sector Reform due to the nature of the Local Responses. The HIV/Aids epidemic has put forward the weaknesses of the health systems in many countries which do not “pass the HIV test”, and can be better understood quoting the findings of the inter-countries (Burkina-Faso, Ghana, and Thailand representatives) Health Reform and HIV workshop which took place in Gaoua:

“Reforms, whether related to health or related to other public sectors, provide an opportunity to influence the way systems respond to their clients’ needs. The HIV epidemic illustrates better than anything else the extent to which the responses is adequate or not.” (Reeler 1999)

¹⁶ ZOPP (in German), or the GTZ “Ziel Orientierte Projektplanung”

¹⁷ “bold” is our emphasis

¹⁸ the researcher was involved in 1999 in a EU funded for the Review of HIV Prevention Policies in 28 Countries in Europe

The objectives of the reforms of the Health Sector in the new strategic plan of Gaoua District outlined the following:

1. an “individual/ client” (or community or district) centred action (vs. an original fix on combating the virus),
2. a common vision among all partners,
3. a consensus among all partners to prioritise and implement the program,
4. a capacity-building of communities, health systems and other sectors to respond to HIV/Aids,
5. bridging the gap between the politics and practice,
6. stimulating and supporting new partners,
7. setting up a Health System Reform of HIV/Aids.

To implement those, in relation to the Health Sector Reform, four priority areas were identified:

- ♦ Health Information System strengthening
- ♦ Decentralisation
- ♦ Strengthening of the Health System
- ♦ Partnerships in action.

Analysing the Health Sector Reform dimension is beyond the scope of this research, as mentioned earlier (4.2.3). Suffice it to say that for the program managers at the district level, the combination of tackling the above mentioned activities described in the Operational priority Plan 1999 with those of the Health Sector Reform can be daunting.

The combination of tackling the Health Sector Reform, combined with the strategic planning approach promoted presently, are part of the complicated and awkward tools and technologies illustrated in *The cough syrup transport system* (Fig. 1.1). Those will need improvements in the next few years to become a lighter system with a more feasible and replicable approach to the Local Responses.

Half a year into the implementation of the Local Responses, the process and outcomes were assessed through a Formative Evaluation described separately (4.4).

5.1.5 On the Development of Tools for the Local Responses

The World Bank’s new strategic plan (The World Bank 1999) to combat the epidemic with African governments and partnership with UNAIDS stands on four pillars:

- ♦ „Advocacy to position HIV/Aids as a central development issue and to increase and sustain an intensified responses,
- ♦ Increased resources and technical support for African partners and Bank country teams to mainstream HIV/Aids activities in all sectors,
- ♦ Prevention efforts targeted to both general and specific audiences, and activities to enhance HIV/Aids treatment and care,

- ♦ Expanded knowledge to help countries design and manage prevention, care, and treatment programs based on epidemic trends, impact forecasts, and identified best practices.“

The Plan is particularly useful in providing the basis of and rationale for the Local Responses approach described in the present research with the provision to „Build Local Capacity in National and Local Government, Civil Society, and the Private Sector to Lead and Implement Effective Programs“ (p. 28). The Bank is setting up a special Unit called the „multisectoral AIDS Campaign Team for Africa“ (ACTafrica), based in the Office of the Regional Vice Presidents which will, among other tasks, in collaboration with UNAIDS prepare tools for project development and evaluation.

To respond to this need, before the set up of ACTafrica, I was already requested by UNAIDS Department of Policy, Strategy and Research (PSR) Department, in early 1999:

- ♦ first, to develop a framework which summarised the various dimensions of each tool in a one to two pages “Explanatory Fact Sheet” (Appendix 5C)
- ♦ second, to make an inventory of the Tools used of the implementation of the Health Sector Reform and HIV Agenda in various national settings. The output of forty-five tools identified is attached in the “Summary Tables of Six Categories of Key Tools for the Implementation of the Health Reform and HIV Agenda in various National Settings” (Appendix 5D). Those are categorised into the logical key categories discussed next which are found in assessing and developing an expanded responses at the district level
- ♦ third, to review at least three or four of each using the Fact Sheet, the aim being of having some of the key ones reviewed as models. Twenty of those were reviewed in more details (Appendix 5E Sample of Seven Tools Reviewed). They are to be disseminated in late 2000 for countries on the recently available UNAIDS electronic “Local Response” network site¹⁹.

The World Bank Strategic Plan refers several times throughout its document to the fact Governments only need the tools, that those are being presently developed, and finally, that they need to be accessible to countries (p. 35) in order for them to respond more effectively to HIV prevention. This appears to be also the current thinking at UNAIDS. Our experience in the review of the tools, combined with the field level findings of the Local Responses case study of Burkina Faso, brings a caveat to this thinking though. We still have a long way to go to be able to offer simple and effective tools to country partners: the tools still need to be either further developed, or adapted and simplified, or tested, or a combination of those. We give an example next of a tool (section 5.1.6) we have newly developed to assess organisational aspects in relation to the Local Responses which is grounded on the sociology of organisations.

Specific limitations to each tool were reviewed and documented separately (Appendix 5E). We have found the following general limitations to some of the tools used as reviewed next for each category of tools. Those may in turn merit further research to develop standardised tools:

- 1) *For the Situation Analysis*: the existing UNAIDS Modules (Module 1 and 3) are more tailored to the national level, than to the district level, and the testing in Burkina Faso gave evidence that even with a country broker expertise the steps of the Guidelines were difficult to follow. A gap still exists between circumscribing the determinants of HIV and the specific factors of vulnerability and prioritising strategies and interventions.

Furthermore, the situation analysis does not allow yet to clearly prioritise vulnerable groups, and consequently the strategies and interventions used. The UNAIDS “Strategic Plan Formulation”

¹⁹ “Local response to HIV/AIDS” available under “What’s new” at www.unaids.org since July 2000

(Module 3) does not address the last key step of the planning process, or how to develop targets and indicators and work plans.

- 2) *For the Institutions' and Sector's Capacity Assessment:* based on the angle and emphasis placed for this assessment, different tools need to be tailored and experimented upon still. For example, we developed the "Rapid Organisational Review" (ROR) tool based on the sociology of organisation theories and practice and tailored for the Local Responses (ref. next section 5.1.6). In Malawi, an emphasis on the problem of drug shortages led to an instrument tailored to the "Rapid Assessment of Access to Care and HIV/Aids-Related Drugs in Communities and the Health System" (Reeler 1999). In Tanzania, the struggle of various interests groups in the public sector led to an emphasis on "power relationships flows" with the "Mapping of Institutional Relationships and Decision-Making in Public Sector." That tool is based on an adaptation of M. Reich's "Policy Maker" and political mapping tool adapted for an institution and sector capacity assessment, and needs further testing too. It would also gain to be further developed for the mapping of power relationships at the District level. The UNAIDS "Responses Analysis" is limited to a few interventions only in comparison to the broad spectrum existing.
- 3) *For the Assessment of Existing Policies vs. needs and realities:* the original framework of analysis on "Decentralization and Health Systems Change" was developed and used by WHO was made for policy analysts. It still needs to be adapted and simplified (e.g. 27 "facets" of the framework) for lay people to be able to use for the Local Responses. The same for the "Health Financing Reform" tool. The numerous Guidelines for Human Rights assessment need in contrast to be developed into simple tools with the right questions to be asked to the right people at the district level.
- 4) *For the Calculation of Intervention Costs:* there is evidence that these calculations are feasible based on various documentation and studies done by experts. Clarifications on „what does an ideal program look like and how much does it cost?“ (The World Bank 1999) exist at a national level, but those need to be tailored and simplified for planning purposes at the district level. The experience of the calculation of intervention costs are limited on a micro-level to projects (Ng'weshemi, Boerma et al. 1997), and remain in general an isolated effort with no benefits to other District planning exercises, or still belong to the grey (non-published) area. In addition documenting costs of interventions are favoured over the development of simple costing manuals such as the one recently developed in Primary Health Care (Creese and Parker 1994). If the latter took more than fifteen years after the Alma-Ata Declaration to address PHC issues, we may expect simple costing manual for the Local Responses to be available by the year 2015! Critical to the Local Responses planning process for managers, we have still not answered their questions on how to use economic data for district planning purposes.
- 5) *For Resource mobilisation:* this is a fairly new concept in the Local Responses to HIV/Aids and as such very little exists on the subject. Besides merely mobilising resources, the advantage of advocating such tools is that they allow a degree of transparency that plays to the benefit of the clients (communities and District), and their partners (public and private). The mobilisation of financial resources has been successful and is described separately (4.4 Outcomes).
- 6) *For the Program monitoring and evaluation:* experiences have been collected and documented in different countries more frequently by categorical areas (counselling, care...) than comprehensively, with the exception of Thailand. The complexity of the Local Responses and dimensions necessitates a multi-disciplinary team, and a mix bag of indicators. This is docu-

mented by the indicators for Formative Evaluation (ref. Section 4.4) which we developed, and were tested in Gaoua District in the last Phase 4 of the Action-Research (Flow Chart, Fig. 1.3, chap. 1).

In less than two weeks, we were able to identify almost fifty different tools that can be used for the Local Responses. Each and every expert at UNAIDS, or WHO, or any institution may come up with his/ her tool based on the individual interests and focus. A large number and spectrum of tools exist already, a couple of hundreds maybe.

The feedback I received in a presentation of the present status of the tool kit during the “UNAIDS Technical Meeting on the Facilitation of Local Responses: Training and Methodology Development” (Bulawayo, Zimbabwe, 22-25 Nov. 1999) pointed to the following limitations and potentials. The tools needed are those that share one’s own paradigm, e.g. looking at communities, or understanding local institutions etc., or a combination of those. The tools may consist in a list of updated questions which one can select from, and that can match best the local situation and needs, avoiding a top-down approach. The challenge lies more in the correct selection of the most important tool(s) for a particular situation, and in asking the most important questions, and using the findings, or in a nutshell, how to make the best use of which tool at which moment? At the present time, most of the existing tools can only be used by the person who developed them, or experts in the subject, which limits as a consequence their applications and replicability.

Going back to the original image of “*The cough syrup transport system*” (Fig. 1.1), the syrup, i.e. the strategies exist, are known, and appear quite straightforward and simple (a mere syrup), as well as the apparent simple mean to deliver those (with a simple spoon). But the selection of the best mix of those, or the exact ingredients of the syrup, remains a challenge for program managers. In addition, the supportive machinery for the syrup to be delivered with a simple spoon, i.e. the various tools existing to do a situation analysis and plan the responses, is still complex under the present Local Responses, as illustrated by the cumbersome and awesome transport system. The latter can become even more complicated when efforts to develop multisectoral collaboration are pursued. Many tools still need to be adapted or refined. In addition, the best mix of tools as well needs to be selected carefully, given the frequent unique environment.

There is a need to develop and tailor simplified tools, to select the correct mix of those too, and finally be effective in delivering the “*syrup*”. For this purpose, we advocate first, in the original stages that experts in different areas further develop and adapt their tools for the Local Responses in the different countries. Second, the tools can be tested and simplified in several Districts and adapted for the needs of each country. Finally, in the last stage, those can be scaled-up for use by the different countries on their own in the priority regions of each country.

In conclusion, there is no quick fix solution to the Local Responses. The state-of-the-art of the development of the existing tools and the supportive machinery to deliver those effectively, are both still limited, as well as the exact knowledge of the best mix of use of any of those. What is needed is a major financial and technical investment of different scientists from different disciplines. They should work both on the selection of the best strategies and the refinement of prevention tools to consolidate the Local Responses into commonly accepted, feasible, and successful HIV prevention strategies over the next five to ten years (5.2). This effort can be pursued as diligently as the immunologists and virologists presently are for the development of the vaccines against the HIV strains.

5.1.6 On the Development of a new Organisational Tool: the Rapid Organisational Review (ROR)

Rationale for the ROR

The Local Responses is taking place within the favourable emergence of Reforms in the Health and other Sectors as well, and accompanying structural adjustments to strengthen human and institutional capacities (ref. section 4.3.2). In the Health Sector, reforms like decentralisation or local budgeting and financing are encouraging the public sector to work hands-in-hands with the partners from the private sectors and the communities. The focus is changing to local capacity building taking stock of the wealth of experiences available locally.

In this broader context, health managers at the district or local level are increasingly responsible to plan and manage their own complex environments, including to operate with the numerous organisations, active in HIV/Aids activities or stimulate the contribution of potential ones. Two dimensions are seen as essential to tackle the various vulnerability factors of communities and larger societies to HIV/Aids. First, the improvement of the intra-sectoral collaboration in the health sector, e.g. between Departments and/ or programs (e.g. Family Planning, STD, Family Planning...). Second, the building-up of inter-sectoral partnerships between different sectors, e.g. Education, Agriculture, Interior etc. and Health, and between actors of the public and the private sectors.

The multidisciplinary approach to public health planning and programming remains largely conceptual due to the limited or lack of policy or sociological approaches available for that purpose, with rare exceptions (Soucat 1998). "Expanding partnerships in the design, implementation and evaluation of HIV/Aids-related policies and programs"(UNAIDS 1998), or as a corollary the support of the necessary tools to support such a strategy, is one of the recommended pathways to improve the responses to HIV/Aids. Bilateral agencies encompass as an approach to preventing HIV/Aids and mitigating its impact, the need to increase the capacity of non-governmental, community-based, and private sector organisations to respond to HI/Aids, such as USAID (USAID 1998) or GTZ (Hemrich G. et al. 1997) (D'Cruz-Grote 1997).

At best, projects and programs identify in their plans for activities related to HIV/ Aids most often all local private partners as Non-Governmental Organisations (NGOs), and often, group those as such. The partners' strengths and limitations, and their various roles and opinions, are often in a situation analysis either taken for granted, or not accounted for. Yet the importance and roles of institutions, systems and structures of health promotion and prevention are known (Brösskamp-Stone et al. 1998). These include the various types of NGOs (e.g. client affinity groups, social service clubs, non-profit firms, private charities), and the Community-Based Organisations (CBOs), (e.g. local associations). This renders the task of the public sector to build stock on what exists either inefficient or impossible.

Understanding those different systems and their organisations is a difficult challenge for district or local health managers. They are already burdened with numerous tasks and expectations, and usually are not from social sciences, but from medical or public health backgrounds.

In order to respond to this need, the Rapid Organisational Review (ROR) tool we developed, and presented next, aims to contribute to an improved understanding and operationalisation of the organisations functioning at the district level. It can be used as an organisational baseline as well. This allows in turn to document and understand the processes leading to improved HIV/Aids outcomes, via fostering partnerships and consensus-building.

The ROR encompasses the following three steps (situation analysis, strategies, action plan) approach illustrated in the chart "Rapid Organisational Review (ROR): Building the Organisational

Plan. A Tool for Partnerships and Consensus-Building at the Local Level” (Appendix 5F). The ROR is accompanied by an “Introduction Sheet for the Users” (Appendix 5G). Finally, the next steps are detailed separately in a “Users’ Guide to the ROR” (Appendix 5H).

Step 1. Situation Analysis

Illustration: **Model of the District and Communities Systems**

The Situation Analysis answers the question: “where are we?” The study uses a systems approach and is based on sociological and public health thinking and approaches. The units of analysis are institutions, organisations, societies, operating at the present time (or the organisational network), rather than individuals (ref. 3.2). First, systems and sub-systems are categorised and illustrated as inputs and processes in the program cycle. The inventory of the partners (sub-systems) at the local level is made for each of the three key systems illustrated in our original model (Fig. 1.4 chap. 1): the communities are placed at the centre of the model, then the public and the private sectors are reviewed. The relationships between these various partners, or the individual inter-sectoral linkages, are explored and illustrated as well at this stage. This inventory, as comprehensive as possible, allows to draw the sample of the partners involved for the review. The study uses first existing sources of data, then complements these data and identifies through questionnaires the present focus areas (strategies, interventions) for each partner reviewed, and the internal obstacles and opportunities to accomplish the present activities. Finally, as an option, in addition to the individual inter-linkages, the global co-ordinating mechanisms, needed between the three systems necessary to strengthen the partnerships, are analysed.

Step 2: Strategies

Illustration (next illustrations, and details in 4.2): **Institutional Landscape of the Partners from the Public and Private Sectors (present situation or organisational baseline)**. Originally, the team wants to know “Where are we?” (4.2). Then, the Strategies will answer the question: “Where do we want to be?” First, the review team identifies the various partners’ common or diverging vision of HIV/Aids responses at a local level. Then, the team collects and discusses the partners’ views to strengthen their responses in the focus areas they are presently involved in and how much (baseline), and the same in other new areas of need. Internal and external obstacles and opportunities for the future are analysed. Assumptions about the future are identified. As an option, the necessary strengthening of inter-linkages and mechanisms to facilitate the support of the future strategies are identified as well.

Step 3: Action Plan

Illustrations: **Institutional Landscape of the Partners from the Public and Private Sectors (future situation)**

We described the Situation Analysis in 1997, and the one predicted using the Strategic Planning of 1999, and projected institutional responses in a hypothetical planned scenario in 2000-2001. In addition, we distinguished the institutions involved in Preventive Strategies and those involved in Care and Support. The various scenarios were presented and discussed²⁰ in an overhead presentation (Appendix 5I), and are illustrated next²¹.

Planning and Consensus Synthesis Matrix by Objectives and Inputs

The Action Plan answers the question: “how do we get there?” In a follow-up workshop, for example, the partners develop a common global vision of the HIV/Aids activities in terms of the vulnerable groups to target and their needs. The main objectives to support that vision need to be outlined. Detailed strategies for each objective are spelt out. The partners’ roles in relation to each of the strategies are defined based on their strengths and limitations. The action plan with priorities and calendar of implementation can be either developed immediately in the workshop, if time allows, or following the workshop with a special working group representing the various partners.

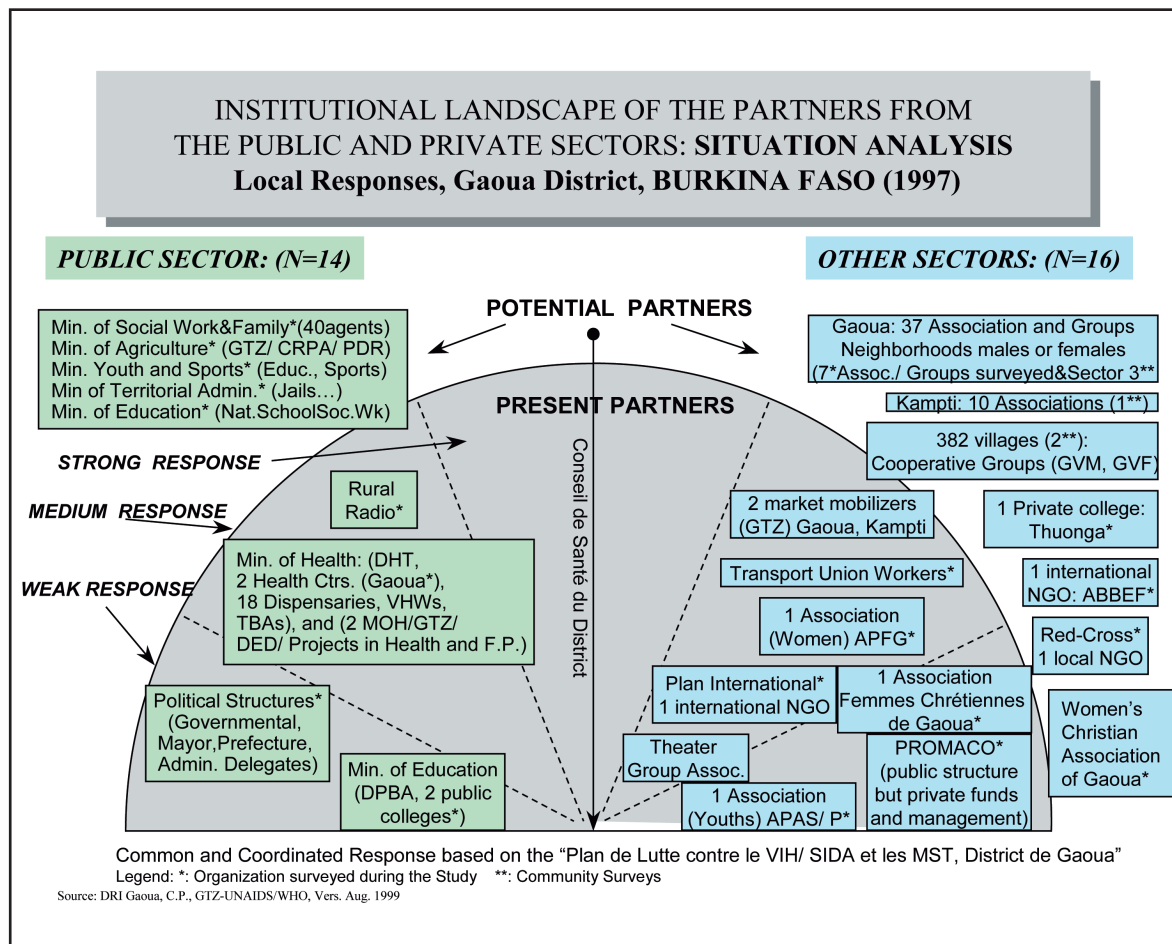
²⁰UNAIDS Country Team Workshop, Gaoua, Burkina Faso, March 1999: the present researcher prepared the slide presentation. The presentation was made by the Country Broker who was present at the workshop

²¹“Public Sector” is the ministries, and the “Private Sector” encompass all other sectors, voluntary, for profit and not for profit, including NGOs, churches, CBOs

As an option again, the various parties may use the opportunity of the workshop to decide in consensus on means to strengthen the inter-linkages between partners, and mechanisms between the three key systems, i.e. communities and the private and the public sectors.

As described in details previously (chap. 4), in 1997, the general Situation Analysis (Fig. 5.2) documented in the Public Sector the involvement of the MOH and the Radio/ Communication Department, with some involvement of the political structures and the Ministry of Education, and 5 Ministries are potential actors. In the voluntary sector, 5 partners quite active, and 2 less active (PROMACO/SMC & Youth Associations). Large untapped sources remained among the private organisations (communities, Churches, NGOs).

Fig. 5.2



As illustrated next, another useful dimension and analysis of the landscape allow to detect that the bulk of organisations active intervened in prevention strategies (Fig. 5.3) . In contrast, for the care and support strategies (Fig. 5.4), those were largely left out with the MOH active only, and one large NGO (Plan International Burkinabé), but in a limited geographical area (ref. chap. 4).

Fig. 5.3

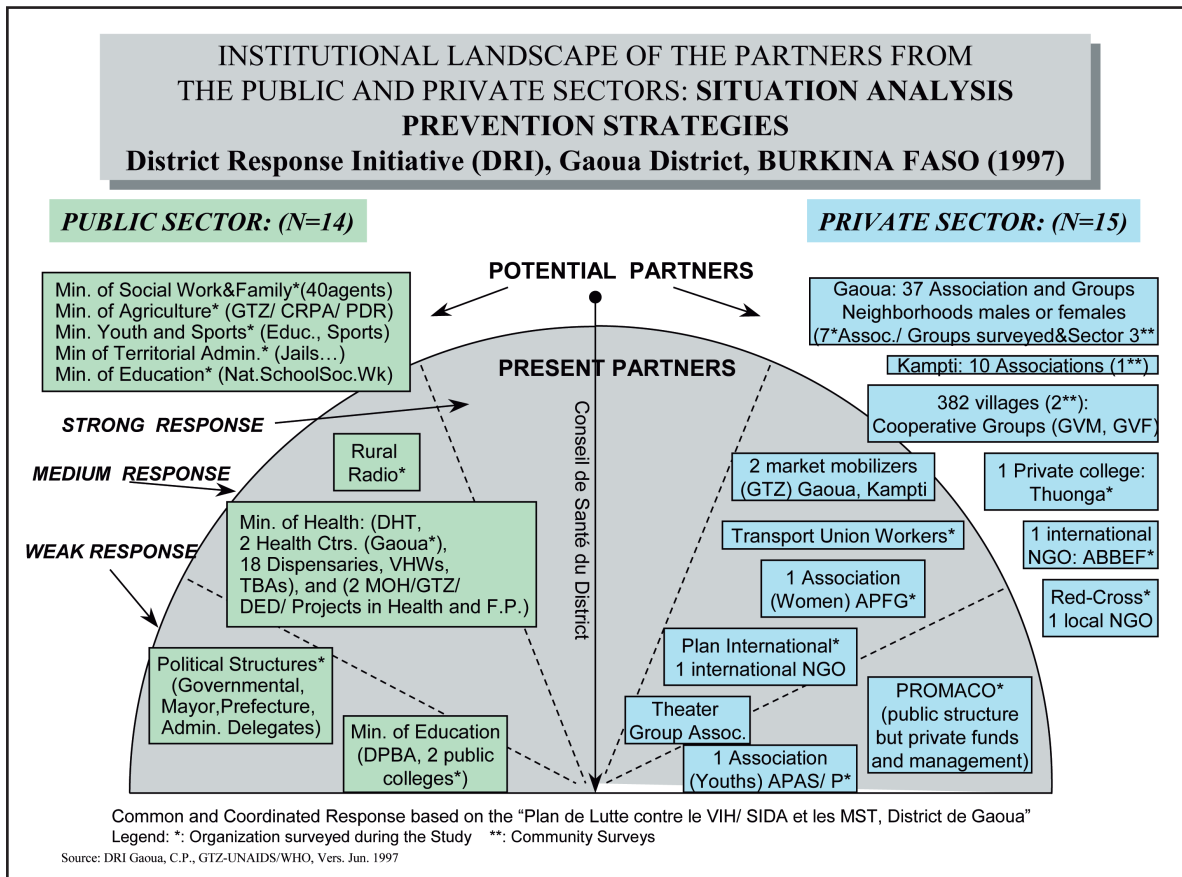
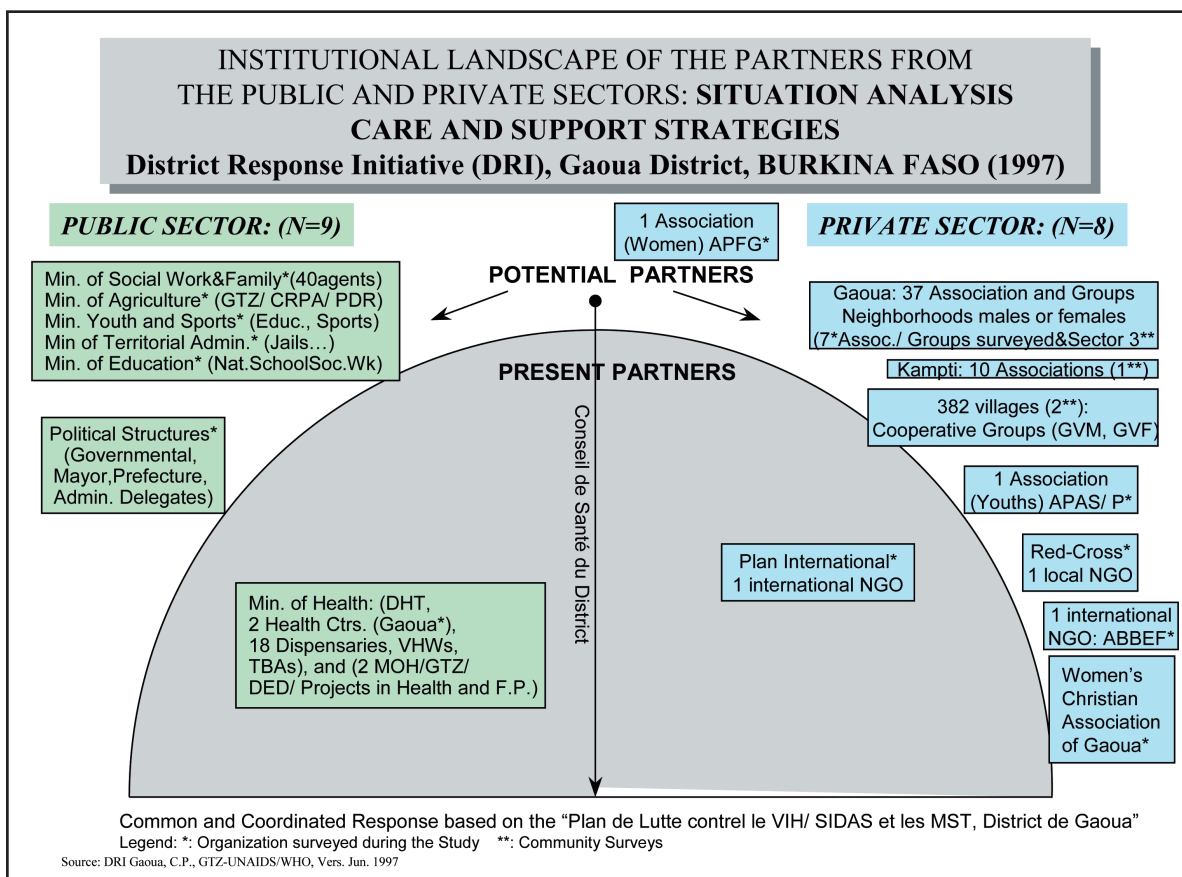
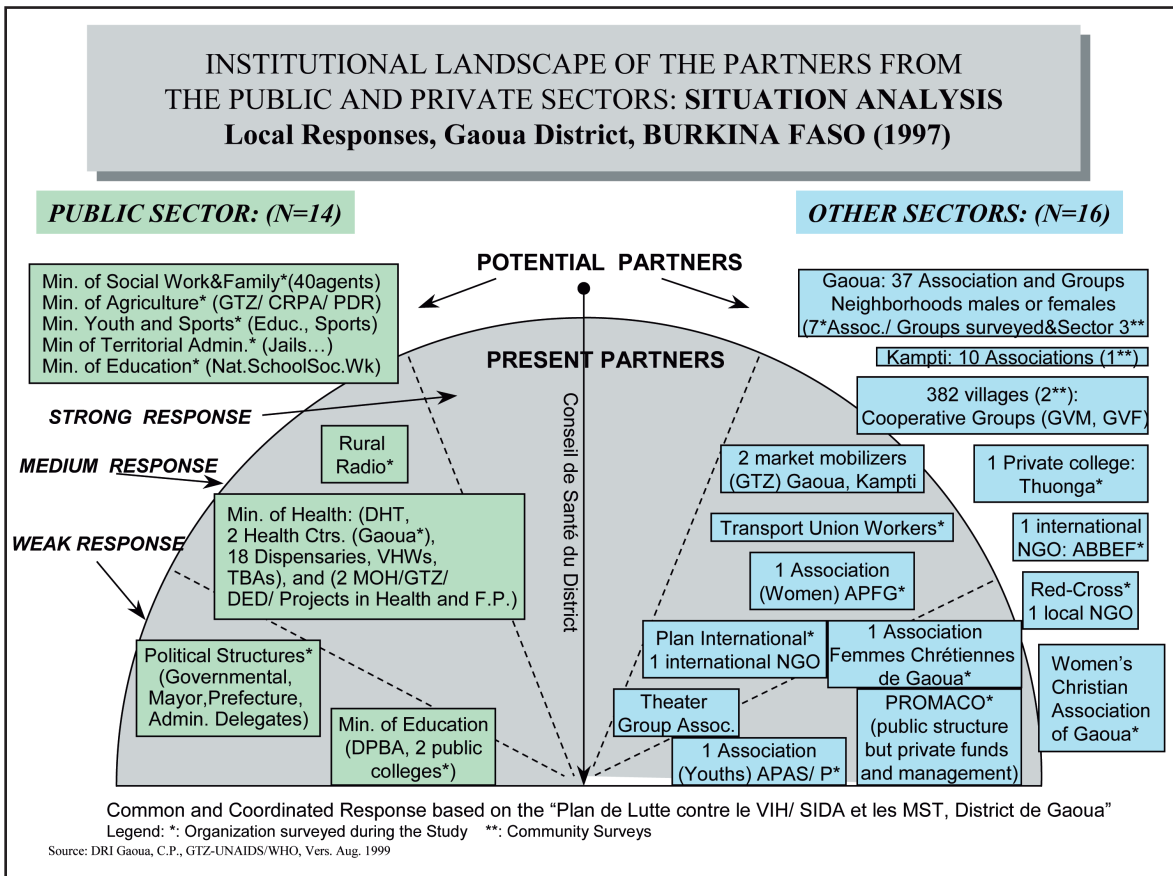


Fig. 5.4



Two years later, in 1999, the Strategic Planning (Fig. 5.5) aimed to have in the Public Sector all new partners or 5 new partners involved, and in the Private Sector 4 new partners plus numerous Associations in Gaoua and Kampti towns.

Fig. 5.5



As illustrated next, a substantial improvement is now visible with 4 new partners involved in preventive strategies (Fig. 5.6), and 11 new partners in care and support strategies (Fig. 5.7), some involved in both strategies.

In 1999, the Strategic Planning aims to have in the Public Sector 7 new partners involved (4 in preventive strategies, and 3 in care and support). In the Private Sector, 8 new partners are involved, including Associations (18 in preventive strategies, and 16 in care and support strategies, some of them involved in both strategies).

Fig. 5.6

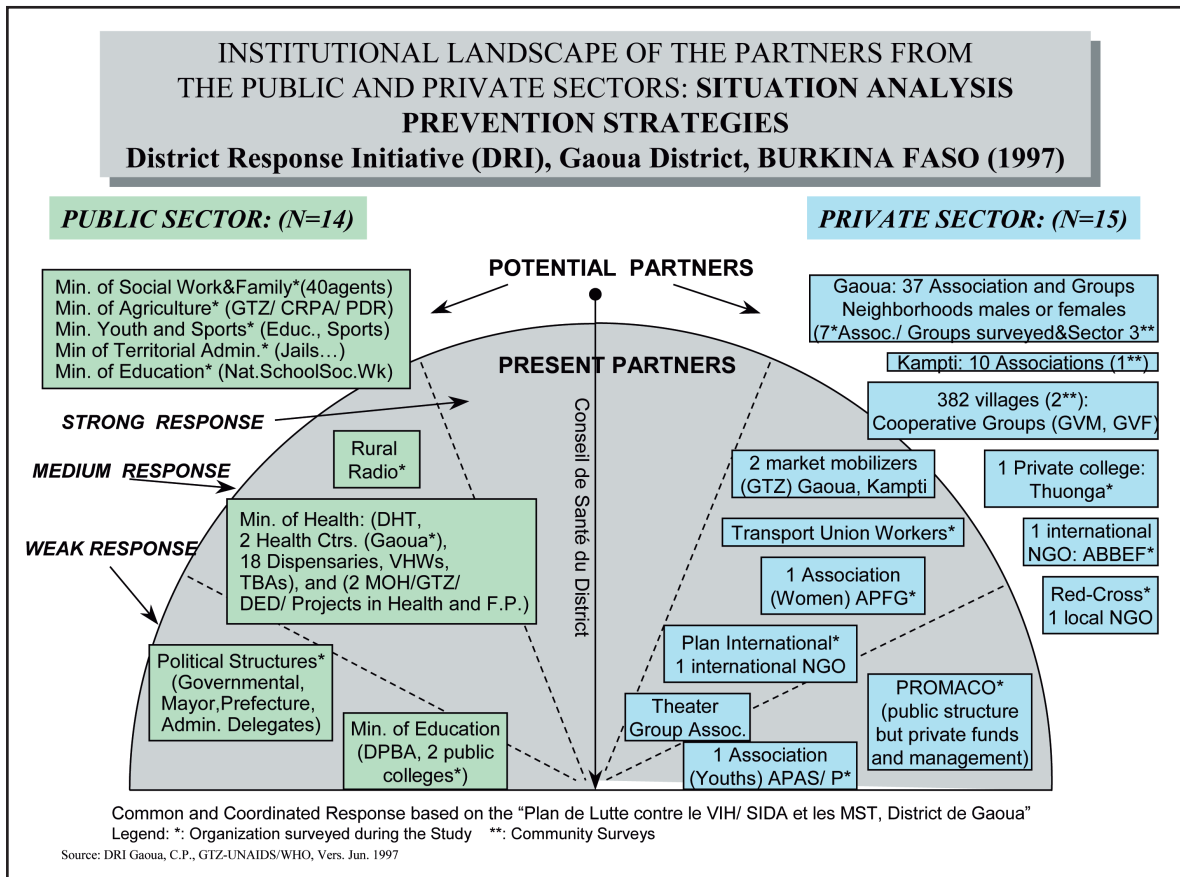
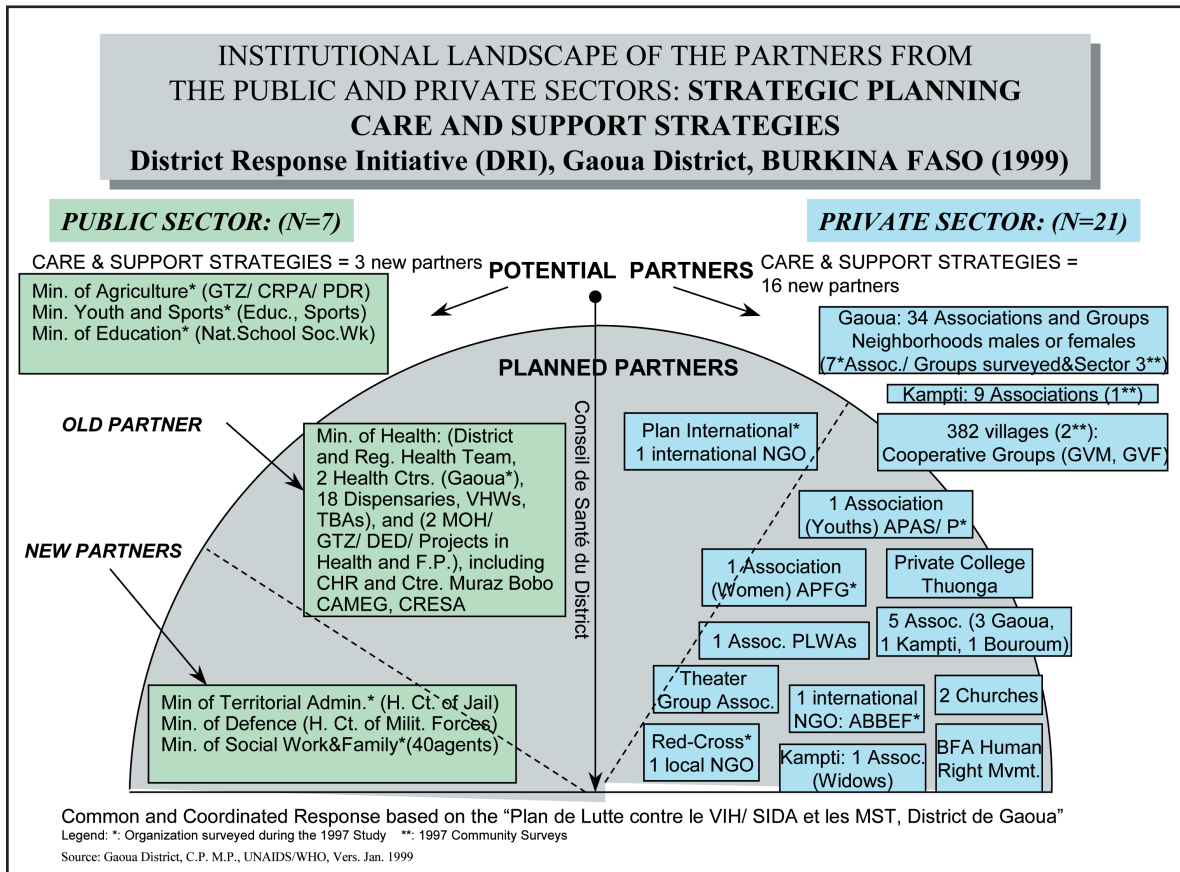
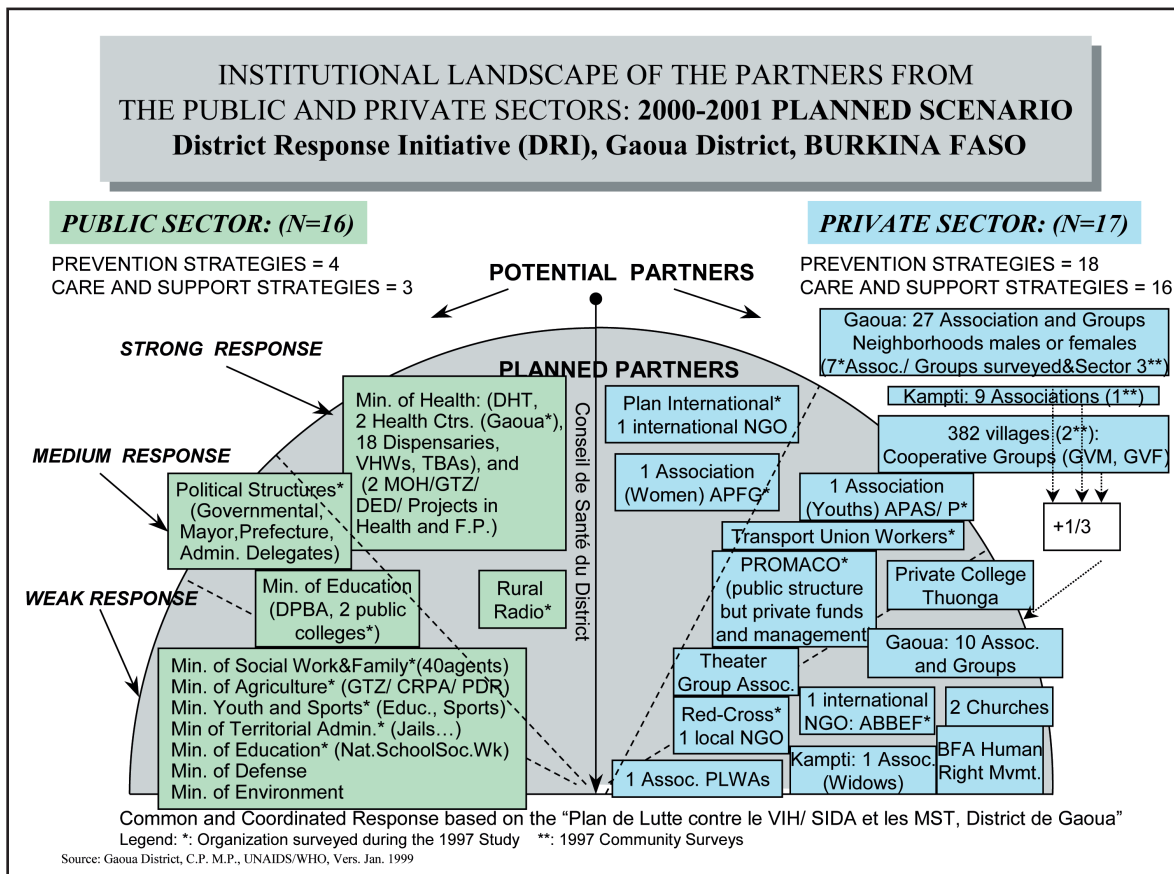


Fig. 5.7



Ultimately, the planned scenario for Years 2000-2001 (Fig. 5.8) in a situation of Monitoring and Evaluation may document that among the old partners, those are responding with a strong or a medium responses given their means. In turn, the new partners are responding, at least, with weak responses (are at least active). Finally, there is now within five years of the original baseline, a new balance between preventive and care and support strategies, meeting the original needs collected in the Situation Analysis at the community level (chap. 4).

Fig. 5.8



The present institutional landscapes have been incorporated in the latest Strategic Planning documents in Gaoua District ADDIN ENRf8 (Lamboray and M'Pele 1999). We recommend using new units of analysis, i.e. organisations and institutions as markers of the HIV/Aids Responses, and incorporating those as standard output indicators of HIV/Aids programs.

5.1.7 On the Applications and Limitations: the Case of Migrants as a Specific Vulnerable Group

Despite the above mentioned existing tools, and their developments, the application and limitation of those can be better comprehended looking at the case of migrants as a specific vulnerable group addressed by the Local Responses (Pervilhac and Kielmann 1999)²².

HIV and Migration in West Africa

The origins of migration in West Africa can be traced back to medieval times when an extensive network of trade routes connected the region to the Mediterranean and Middle East (Davidson 1968). The slave trade and the conquest of the region by the Felani empire from the north and the

²²This section is based on the draft of an article written with Joseph Decosas to be submitted for publication

European colonial armies from the south were the major determinants of population migration in the 18th and 19th century. In the early 20th Century, the European colonialists established their cocoa and sugar plantations on the coast of the Gulf of Guinea with forced labour from the Sahel, thereby laying the foundations for a migration pattern that persists until today.

Despite the many international borders established through European colonial geo-politics of the early 20th century, West Africa remains an economic and social unit in which people circulate freely while maintaining their ties to the region of origin for social or religious reasons (Lalou and Piché 1994). Almost all West African borders divide ethnic and linguistic groups, and residents of border regions move easily between countries. New social situations created through rapid urbanisation or migration are known to increase the vulnerability to HIV (Gilks, Floyd et al. 1998), and the association of migration with the spread of Aids in East, Central, and Southern Africa (the "Aids Belt") is well known (Brockerhoff and Biddlecom 1998).

Several studies (Brockerhoff 1995; Caldwell, Anarfi et al. 1997), including studies in agriculture (FAO 1997) (FAO 1997) (Baier 1997) have linked labour mobility to the spread of HIV in Africa due to new social environments inducing high risk sexual behaviors, and new sexual networks, with more recent similar findings in the West Africa sub-Region (Anarfi 1992) (Decosas, Kane et al. 1995) (French 1996) (Equipe du Burkina Faso 1998). The observed profile of the HIV epidemic in West Africa can to a large degree be explained by the pattern of circular migration between the cities and plantations along the Gulf of Guinea and the rural areas of the Sahel (Decosas 1998).

Côte d'Ivoire is one the main poles of attraction for labour migrants in West Africa. The 1988 national census reported that 25 percent of the Ivoirian population was of foreign origin (FAO 1997), about half of them from Burkina Faso (Decosas 1998). About sixty percent of men from the arid Mossi Plateau west of Ouagadougou travel abroad to find work at least once in their life (Traore and Ouango 1994). Migrant workers in Côte d'Ivoire are predominantly male and come from rural areas. However, the proportion of women migrants is reported to be increasing steadily. At the origins of the migration behaviour is the short farming season and insufficient agricultural yield in the Sahel. The Sahelian farmers are thus forced to complement their incomes with additional revenues earned in the off-seasons in plantations, factories, or service jobs on the coast (FAO 1997). A pattern of long term migration taking place over several years is becoming increasingly more important, although the main pattern continues to be seasonal migration.

Thomas Painter recently evaluated twenty-one United States supported projects for Aids prevention among mobile populations in Sub-Saharan Africa (Painter 1998). The projects focused on the large and heterogeneous group of migrants represented by labor migrants, itinerant traders, migrant sex workers, mine workers, soldiers, long distance truckers, bus and boat conductors and crews, pastoralists, and refugees. The majority of the interventions targeted female sex workers and long-distance truck drivers. The vulnerability to HIV of these groups is well known and the groups are easy to identify. Only three interventions were conceived in a multi-country framework, and only one intervention targeted residents of border communities. This latter group deserves special attention because it represents a large proportion of the total migrant population, and it is relatively invisible, yet often socio-economically disadvantaged. International mobility among border populations is high, presumably translating into high vulnerability to HIV.

Despite the fact that Burkina Faso is one of the countries most severely affected by the HIV epidemic in West Africa, it receives relatively little international attention. At the 12th World AIDS Congress in Geneva in 1998, for example, 242 presentations documented different research projects and interventions in Uganda, whereas only 18 presentations documented those in Burkina Faso, none addressing the issue of migration.

HIV and AIDS related to Migration in Gaoua District

The importance of the migration factor is illustrated by the village of Banlo, one of the four communities.

Banlo has a population of about 1,000 of whom 200, particularly the youth, were working in Côte d'Ivoire at the time of the study. The push factors which determine the out-migration of young men from Banlo include poor harvests, poor soils, insufficient or irregular rainfalls, insufficient agricultural equipment, lack of storage and milling facilities for crops, lack of potable water, poor conditions of schools, lack of access to health care, and the need to raise money for the payment of dowry (Sanon 1997). We estimated that about one fourth of the population of Gaoua District, or 50,000 or more people experience a similar migration pattern as found in Banlo. The survival of these communities depends on seasonal or long-term migration of young people to Côte d'Ivoire and Ghana. The pull factors are the long term, more permanent, economic benefits and opportunities offered by the countries of destination. They have been described in detail in a recent economic theory of African rural-urban migration (Todaro 1997).

Through key informant interviews and group discussions, we ascertained the following determinants of vulnerability to HIV in these communities (4.1.2). The factors documented next are more related to the issue of migration and are grouped in three categories: behaviours and beliefs, weakness of services and programs, and social organisation and the societal impact of Aids.

Factors of vulnerability to HIV related to behaviours and beliefs reflect the fear of Aids and a lack of accurate information.

"AIDS is caused by men because there are some who come from Côte d'Ivoire with AIDS and negotiate with the girl once in the room, and refuse to use the condom."
(a young woman from Kampti)

Vulnerability factors related to *weaknesses of services* and programs in the study communities include poor access to and poor quality of condoms. Shopkeepers do not store condoms under appropriate conditions, and supplies break down. At the village level condoms are not available and the cost is too high for some youths, particularly when condoms are sold in packets of three rather than as a single unit. Services for information and treatment of STD are lacking but highly desired, and sources of information about Aids are not available in the villages. Previously, Aids information activities (theatre, market stalls, local conferences, and video showings) were conducted in Kampti and were highly appreciated but the program has been discontinued.

"We are at the border and many of our brothers are in Côte d'Ivoire, the country most hit in the region, and the bus comes every Friday from Abidjan. We need to have people do the test and help the sick people." (a young man from Kampti)

The ascertained vulnerability factors related to *social organisation and the societal impact of HIV* include high mortality among the youth clustered in some neighbourhoods or villages and associated with return migration. The financial and labour costs of caring for Aids patients weigh heavily on their families, while the reduction of remittances by migrant workers and the loss of productivity by young people at home is showing an overall negative development impact on the villages. Social security for the elderly which was once assured through the labour of young people is failing; widows and young girls can no longer depend on the male migrants' remittances and have started to migrate to Côte d'Ivoire to find jobs; and the stigmatisation of returned migrants with Aids or suspected to be infected with HIV is tearing down the fabric of traditional village solidarity.

“Today girls are not serious. They can go to Gaoua to get their identity cards and leave to Côte d’Ivoire where they can get AIDS before coming back to get a spouse in their village.”

(a young man from Banlo)

“It is particularly due to the girls. They think they are aware, do not listen to their parents and go to Côte d’Ivoire. As they are taken care of by men who have AIDS...”

(a young men from Banlo)

Based upon the study findings, and the participants’ knowledge of the local situation and priority needs, a consensus was reached on where to target interventions based on the identification and ranking of vulnerable groups. International migrants were ranked second as a specific vulnerable group after STD patients and followed by orphans, soldiers, truckers, prisoners, people living with Aids and sex workers. The issue of border migration emerged as one of the most important social factor of vulnerability to HIV, despite the fact it had not received much attention previously. The process of the study combined with the workshop was recognised as an important means to focus attention on programs targeting these border migrants.

Opportunities for the Responses to HIV and AIDS among Migrants

Border communities, especially out-migrating communities, like the villages and towns of Gaoua District are receiving relatively little attention in the national and international responses to Aids for a number of reasons related to: population issues, paradigmatic and epidemiological reasons, program conception and design, organisational and institutional issues, political and economic issues. These reasons and the opportunities they offer are detailed next.

Population issues

The international migration of border communities, particularly across the divisive borders of the post-colonial African states, follows historically established patterns of population movement. It may gradually increase in volume due to population pressures, drought, or unequal economic development, but in comparison to the dramatically visible movement of refugees it remains a largely silent phenomenon. The mobility of border migrants appears relatively organised and is of little concern to the countries of origin since these populations are not economically active at home; nor is it a priority in the countries of destination, because the individuals concerned are not country nationals. Border migrants thus tend to fall through the social safety nets in both their country of origin, and the one of destination.

Paradigmatic and epidemiological reasons

The understanding of HIV epidemics is largely based on epidemiological data derived from sentinel serological surveys. In many countries, the rather loose networks of national sentinel survey sites miss the important local epidemics in remote areas where most of the border migrants are found. Furthermore, the focus on numbers and rates precludes efforts to understand determinant factors of vulnerability to HIV which require information of a more qualitative nature. It is precisely this qualitative information which is needed to stimulate and design appropriate strategies for the reduction of vulnerability.

District strategies for the responses to Aids are largely based on the presumption that rural districts are inhabited by the “general” or a homogenous population. Interventions are therefore conceived within the very broad framework of „general population interventions” ADDIN ENRf8 (Sumartojo, Carey et al. 1997) with little attention to specificity and targeting. Border districts such as Gaoua, however, are part of a system of circulatory migration. They have specific needs related to the migration behaviour of their young population such as an increased need for young women to be able to negotiate safe sexual practices, or an increased focus on the promotion of condom use for extramarital sexual relationships. They would, in addition, benefit from targeted program support.

Prioritisation techniques that exist for the control of outbreaks such as Cholera and Meningitis are not applied for HIV programming, and mapping techniques ADDIN ENRf8 (Long 1998) to identify and collect detailed information about communities and social networks are just being developed.

Program conception and design

Because targeted interventions may stigmatise some groups, national policies have tended to pursue general population interventions (Taverne 1996). Targeted interventions on a restricted scale (Sumartojo, Carey et al. 1997), on the other hand, have been a mainstay of HIV prevention for many years. Education materials, strategy manuals, and other tools have been developed for many different groups. Yet, very little has been developed specifically for migrants despite the fact that migrants have specific needs related to their cultural identity and level of literacy (Lalou and Piché 1994). Furthermore, wherever these materials exist, they are almost exclusively designed for migrants at their destination points. The important role of the communities of origin has not yet been explored from a programmatic perspective, and the necessary partnership with these communities is not yet part of the standard responses to Aids.

The communities themselves have many urgent and essential needs for survival which are at the basis of their dependence on out-migration. Lessons which were learned by the Primary Health Care movement on prioritisation through community participation have not yet been fully appreciated by the National AIDS Programs and their international supporters who tend to determine priorities at the international or national levels, and not at the community level. The challenge lies in establishing the relative priority of the responses to Aids in border communities such as those found in Gaoua District. The communities need to have ownership of the prioritisation process in order to establish a functional hierarchy of priorities.

Organisational and institutional issues

The fundamental and multi-faceted structural problems of poor and remote border communities and their chronic and largely silent adaptive responses of seasonal migration preclude short-term project aid as a viable support strategy. Sustainable assistance needs to be planned with a long horizon and a broad focus. This is generally very difficult for international aid agencies. Furthermore, the migration pattern itself, together with the high mortality from Aids (M'Boa, N'Dah et al. 1998), weakens local community organisations who could serve as partners for an intervention. Finally neither national governments nor international organisations working primarily in partnership with governments are well organised to address migrant communities on both sides of a border, at the origin and the destination of their migration. This, however, is one of the key requirements of an appropriate and effective program (Long 1998). International Non-Governmental Organisations generally have greater flexibility in this area.

Political and economic issues

The first and still the most prevalent responses to the issue of HIV and migration is deportation and the closure of borders (Decosas, Kane et al. 1995). The prevailing image is that of the migrant as a vector carrying disease. This charges the issue of HIV and migration with political explosives used by many different sources for their own means. The main public health discourse, the discussion of the factors that link the social phenomenon of migration to greater vulnerability to HIV, is often lost. There is an understandable hesitation by public health professionals to develop and expose the theme of migration through targeted programming, in order to avoid that it be captured and instrumentalised by political forces promoting xenophobia and racism.

The fora where inter-country health issues such as the issue of HIV and migration are discussed usually in international scientific meetings or regional consultative bodies without an executive capacity or role. Consensus on issues may be reached such as the inter-country meeting of

Ministries (June 1997) on creating new cross-borders “solidarity” in West Africa to combat emerging diseases such as Meningitis, Cholera, and Aids. Agreements on program approaches may even be signed, but they rarely trickle down to the implementation level. Occasionally a functional executive inter-country program for a specific disease is established (e.g. Onchocerciasis), but in most cases the regional institutions are consultative and advisory and have little impact on actual program delivery.

African Governments are under enormous internal and international pressure to reform their health and social systems, and to increase the quality of social services while controlling costs. Cost versus benefit analysis rules the public social services. There is no issue which raises the question of „whose cost and whose benefit?“ more blatantly than health and social programs for circulatory migrants. It can be argued that decreasing the vulnerability in the migrants’ environment has benefits for all, but this argument is complex and politically inexpedient. Investing scarce public resources in services for a foreign population temporarily working in the country is difficult to defend politically, as would be the investment of resources in another country to provide services to their expatriate workers. International agencies are subjected to the same pressures because most donor agencies negotiate the use of their resources with the national Governments.

Burkina Faso has recently developed a new strategic plan (Lamboray and M’Pele 1999) using the UNAIDS planning tool (UNAIDS 1998) which includes a specific strategy to target programs for truckers as a vulnerable group. Future interventions may address interventions for the border migrants but the opportunities analysed previously need to be further exploited. Striving towards resolving the issues raised will contribute to prioritising strategies addressing the vulnerability of border migrants in Burkina Faso, and in sub-Saharan Africa. Effective and feasible interventions would already be possible in Gaoua District by concentrating efforts in and close to the communities with international migrants, such as: health promotion to youth before departing their communities through peer education, making condoms accessible and accepted, availability of outreach services and mobile counsellors, strengthening health services with quality STD services, facilitating HIV voluntary testing and counselling for returnees and their families. Further work is required locally to develop a more precise social profile of migrating communities. Internationally, the issue of border migration requires more attention by organisations capable of developing and implementing programs that span beyond and across borders. There is a need for institutional structures to address migrant workers’ needs through interventions in their communities of origins, along the migration pathways, and at their destinations.

In conclusion to this section on the development of tools and their applications (5.1.5 to 5.1.7), we have documented the large potential but also the limitations of existing tools that can be used for the Local Responses. New ones, such as the Rapid Organisational Review (ROR), can be developed, or refined and further tested, for the Local Responses specific use at little additional cost. The large spectrum of issues and barriers documented for the case of border migrants as a vulnerable group show that the ultimate success of implementing an expanded responses may also lie in overcoming other barriers or constraints as well. This brings another dimension of complexity to succeed in the Local Responses approach in addition to the mere development of the ideal tool kit that we are presently striving for.

5.1.8 On the limitations of the study

The study has several overall limitations due to the nature of the study design, the limited implementation time and low coverage, the lack of epidemiological and behavioural evidence, an incomplete systems analysis, and the lack of a multi-country evidenced-based prevention study.

Study design

The present set-up of the study design of the local responses which follows the “pre-experimental design” before and after prospective intervention study described earlier is poor in comparison to the last two more valid and forceful potential designs of a true experimental design or a quasi-experimental design (3.2). In addition the “X” or interventions (Fig. 1.1) are not carefully singled out and their direct effects cannot be monitored. The Local Responses in general has not yet received the attention it merits in terms of a careful and sound systems research design. It cannot compete with, and is little convincing to the scientific community, in comparison to the well-financed and better-designed research of the bio-medical field. For example, the well-designed study of the vaccine development field trials of the synthetic malaria vaccine SPf66 (Alonso and al. 1994; Alonso P. et al. 1994) in Tanzania²³, a practical similar field-testing of vaccine. It contrasts to the present almost improvised form of field-testing of the HIV/Aids prevention in Burkina Faso (ref. last para. On “*Lack of multi-country evidenced-based prevention study*”).

There are current debates raised on “how to promote multidisciplinary research without ‘biomedicalizing’ prevention,” acknowledging the value of “quasi-experimental, ethnographic, and other kinds of behavioural information and social research” (Auerbach 1998) to test highly active anti-retroviral therapy (HAART). Such discussion has not yet trickled over to the domain of systems research in HIV/Aids prevention such as the present Local Responses experiment.

In a nutshell, the findings of the present Local Responses country case studies in general cannot yet either document carefully the impact of the interventions and their causal factors, or receive the attention they deserve in the scientific audiences (ref. poster session in Durban (M’Pele, Pervilhac et al. 2000)). As a consequence those, largely anecdotal for a strict scientist and conservative audience, can only and unfortunately for the time being be more taken at face value.

Limited implementation time, low coverage

The implementation time (half a year for Phase 3) was too short, with as a consequence a review too much based on processes, and insufficient time to evaluate outputs and outcomes, and to measure the sustainability of the approach.

The coverage was low (Gaoua and Kampti towns and approximately twenty communities) making essential recommendations for scaling-up still missing.

Lack of epidemiological and behavioural evidence

2nd generation surveillance for HIV combining behavioural data to validate the biological data collected (MAP (Monitoring the AIDS Pandemic Network) 2000) have not yet reached Gaoua District. Behavioural surveillance was never set up, and the impact of the Local Responses on a reduction of HIV prevalence, based on the sero-prevalence surveillance, may only be visible in five to ten years from now.

Research priorities for the Future (5.2.3) need to address those in order to validate further this study, and replicate such a model for other Local Responses study trials.

²³the researcher coordinated the Ifakara research Centre in Tanzania where this biomedical trial took place at the time the trial

Incomplete systems analysis

For the sake of the present study constrained by time, money and technical inputs, the present research was limited to HIV/AIDS in Reproductive Health, excluding other Sexually Transmitted Infections (STI), or family planning components. In addition, the original “systems analysis” designed originally (1.3 and Fig. 1.3) could not be fully comprehended and answer the essential question: which part(s) of the system is or are essential in influencing the outputs and having an impact on the outcome?

Lack of a multi-country evidenced-based prevention study

Although the Local Responses, or District expanded Response Initiative, was originally designed to encompass three districts in each of the five countries, the countries met and discussed only once in the preliminary stages of the study for the original situation analyses (Appendix 1 A, May 1998: Technical Workshop, UNAIDS/WHO the multi-country study teams). No lessons were learned systematically based on the compared experiences of how to move into the planning at the local level, nor to prioritise, nor to implement on a small and large scale within a District, or within a country. Is the approach similar in high and low prevalence areas? We are still hard press to prove scientifically that Local Responses are part of a larger valid way to go to implement effective local responses. The positive results of the Gaoua case study may originate from its unique experience, and cannot unfortunately be substantiated by any other several multi-country evidence-based prevention studies.

5.1.9 On the Overall Results and Hypotheses

The present research documents the early stages of an innovative approach called the *Local Responses to HIV/Aids* to stimulate HIV/Aids activities in a rural district of Africa with a high epidemic of HIV/Aids, and measure its early outcomes (4.4).

Based on the above four objectives, the present operations research was broken down into **three hypotheses** (ref. chap. 1) which were tested in different Phases (chap. 1, Fig. 1.3). We highlight the essential findings and limitations for each, for the purpose of replicating the approach in other contexts. Further research priorities are highlighted separately in the Conclusions (next section 5.2).

● First (phase 1), the feasibility of using a systems approach to analyse the situation at a local level (district and communities)

We documented in the situation analyses carried out at the community level the essential determinants of the epidemic at the community level (4.1), and at the district level (4.2), and the different existing partners' inputs, and potential ones, from the public and voluntary sectors. A rapid appraisal method has been developed and applied to assist district and communities in determining their options for approaches to meeting social and development challenges of the HIV/Aids epidemics at the District level, giving evidence that tools and techniques are available.

However, the earlier tool used was largely focused on prevention aspects. One year later a complementary study of three weeks (supported by UNAIDS) highlighted other aspects related to care and counselling. The fact the epidemic is already high may have facilitated the mobilisation of partners. The development of a simple comprehensive rapid assessment participatory method to capture the full spectrum of prevention to care and counselling, and policies, and which can be used by the local partners in the district, merits further development and research. In addition, the approach needs still to be tested in other settings with a lower prevalence of HIV.

- **Second (phase 2), the possibility, based on the findings of the situation analysis, to design and stimulate well tailored priority interventions**

Based on the aforementioned situation analyses, essential strategies and priority activities to respond to the HIV/Aids epidemics could be designed and stimulated in a planning process (4.3).

The strategic planning approach used by UNAIDS has shown its limitations in terms the complexity and length of the approach, the need for an outside expert to carefully drive the local team through the process (5.1.4). The further development of a simple planning framework for local applications may also be a future challenge and merits further development and research too.

- **Third (phase 3), to give evidence that as a consequence, a number of activities can be implemented successfully over a short period of time by taking stock of the existing and potential partners**

Following the planning exercise, within less than one year, several priority activities have already taken place to set the ground of Local Responses (4.4), even if it is too early to detect any direct impact such as a decrease in the incidence or prevalence of HIV.

“Changing organizational behavior is a harder, more time-consuming, and slower process and requires more scarcely available skills than changing individual attitudes, even among group of individuals” (Vladeck 1993).

Despite the known difficulties, and using these activities as proxy indicators of organisational changes, the findings of the Local Responses give strong evidence that local organisations can be within a short time period mobilised and involved in HIV/Aids.

Yet, the process was largely supported by the external country broker’s inputs and the original enthusiasm of a new project bringing in extra funding. In addition, it remains to be seen what will be the more specific outcomes and impact of the different interventions in the communities in general, as well as on specific groups (e.g. the many barriers to overcome in order for migrants to respond to HIV/Aids). The nature and long term results of a locally owned and sustainable process cannot yet be assessed. A three to five year follow-up will allow to evaluate these essential questions to validate further the added-value of the Local Responses approach.

In conclusion, in addition to taking into consideration the limitations of the study which still need to be overcome (5.1.8), much research is still needed to ground further the Local Responses (next section 5.2). Yet, the recent UNAIDS Press Release (ref. following abstract) of the International AIDS Conference (Durban, July 2000), is a solid convincing argument validating the present approach used to stimulate the HIV/Aids with three different country examples, including Gaoua District, Burkina Faso. It summarises in a nutshell the concepts and achievements of the Local Responses agenda which has improved tremendously and become more focused over the past two years.

“People, not technology, drive AIDS responses

Local partnerships on ideas for dealing with HIV/AIDS, practices and sharing effective approaches may be the key to scaling-up what we know works to slow down the spread of HIV and minimise the impact of the pandemic.

During the opening day of the conference several countries shared their experiences and agreed on these conclusions:

It is people who drive the response to AIDS. Technology and information facilitate, but do not substitute for people-driven responses.

In an increasing number of countries, real progress is being made because communities acknowledge that HIV/AIDS is affecting everyone.

As a result, they are developing local partnerships that enable them to effectively deal with the pandemic and its consequences.

United in local partnerships, people are gradually building societies that live positively with AIDS.

Improvements in quality of life, the acceptance of People Living with AIDS (PLWA) in communities and the participation of groups of PLWA in activities can all be seen as indicators of the success of local responses.

To achieve this the AIDS community needs to change its mindset. We need to put ourselves in a learning, rather than a teaching mode.

Local responses can spread quickly to countries if those who support them build on local or ‘collective’ wisdom.

Also, radical new thinking is needed to ‘break the hardened arteries in our bureaucracies’. People are not the objects of interventions but the subjects of their own destinies.” – Key Correspondent

Source: UNAIDS/ PSR, Press Release for the Local Responses, Satellite Meeting, 9th July 2000, 13th. International AIDS Conference, Durban, South Africa, Durban Daily News, 13 July 2000

The Local Responses may become in the near future the basis of a well-known approach for a successful control of the HIV/Aids epidemic in the Africa region in the XXI century.

5.2 Conclusions

This three years action-research study (1.1) leads to many more questions than answers. To move the Local Responses approach beyond a mere fad, into a visible, credible, feasible, replicable and sustainable program, much research remains to be done addressing methodological (5.2.1) and policy (5.2.2) issues, and research priorities (5.2.3) as well, which we review next as conclusions.

5.2.1 Methodology Conclusions

Based on a recent “**UNAIDS Technical Meeting on the Facilitation of Local Responses: Training and Methodology Development**” (Bulawayo, Zimbabwe, Nov. 22-25 1999, in C. Pervilhac, 3.12.1999) several practical answers for a phased-approach to the Local Responses were formulated. This meeting can be seen an important technical benchmark of the Local Responses initiative which started three years ago, and described in the present research work in more details for the case study of Burkina Faso from early 1997 to mid-2000 (Appendix 1 A Chronological Benchmarks).

The findings of this meeting can be summarised in the following five key points. Those highlight the overall status of development of the Local Responses and the limitations of the approach still.

First, in less than three years the Local Responses have expanded geographically as documented with the ten countries presently involved, and several countries which are already replicating the approach in different districts. There is strong evidence that the Local Responses process which started in different countries, has in turn stimulated many districts to be proactive in Aids, whereas originally they were barely addressing HIV/Aids as an issue, as documented in the present case study of Gaoua (4.5). In addition, the launching of the ‘International Partnership against AIDS in Africa is setting a positive environment for such initiative with a vision that within five years, African nations will be implementing large scale, sustained and effective national responses to HIV and Aids. The partnership aims to mobilise vastly more resources with and for the African countries together with seven UNAIDS cosponsors and secretariat, bilateral development agencies (including GTZ), Non-Governmental Organisations (NGOs), and the private sector. A larger mobilisation of the public, and voluntary and private sectors, is at the heart of the Local Responses as documented in this research (chap. 4).

Second, within the same limited time span, both the concepts and values of the Local Responses, and mechanisms to implement the scheme have been clarified. One of the key concept to stimulate and have an Aids competent society is to listen and involve all stakeholders, from individuals to Ministries, via different sectors, to make them competent to participate to the responses. The agreed denomination of the “Local Responses” supports the nature of the responses at a “local level”, i.e. sub-district (vs. the “District responses”), and not of an administrative nature (vs. the “Government responses”). A number of basic steps, recently documented under the form of a Technical Note (Appendix 1 B), have been identified to facilitate the process which can be implemented sequentially or in parallel, and in different order than listed next:

- ◆ Appointment of a national facilitator of local learning (“the country broker”)
- ◆ Establishment of Local Responses support teams of local learning
- ◆ Situation/ responses analysis
- ◆ Identification of key social groups
- ◆ Common vision of all partners
- ◆ Definition of institutional relationships and determining the Local Responses structures
- ◆ Planning
- ◆ Development of local partnerships
- ◆ Mobilisation of resources and implementation
- ◆ Monitoring and evaluation
- ◆ Learning from action.

Third, the Local Responses need to grow from a mere approach to become a more marketable approach, or a full-fledged strategy, but the nature of the process often precludes clear goals and hard objectives (e.g. how to measure health reforms? How to measure changes in community participation to HIV/Aids?). Such limitations need to be quickly addressed for international partners to buy the product.

Fourth, at this stage, we are at the cross-road of the development of the Local Responses with a number of questions which remain to be answered. Following this research, in my opinion, the answers to those may be the following:

- Should we move the Local Responses along with more control or with the facilitation of the process only? – Yes, Local Responses need to be further nurtured with more control. This can be explained because one cannot hope the communities can act and react on their own initiatives, particularly in the case of heterosexual transmission in Africa, in comparison to the some of the original vulnerable groups found in Europe, e.g. homosexuals or Intra-Venous Drug Users (IVDUs). In addition, in the African context, other scourges and priorities, combined with scarce resources, generally do not allow local communities to organise themselves on their own against HIV/Aids, or to perceive the epidemic as a priority.
- Is it a movement or a program? – It is both a movement and a program. It is a movement, or an approach, because by nature as we explained earlier (section 1.2.1) we found the Local Responses is the forgotten PHC concept adapted to the reality of HIV/Aids. In complement, it is a program because its final goals are the reduction of HIV/Aids prevalence both among the general population and some vulnerable groups, with objectives and priorities going beyond the mere statements of classical indicators of interventions. The program avoids to be caught up in a constraining “project” cycle and allows with the existing flexibility to have any partner or communities join into the effort any time.
- How should the country/ district selection or participation process be dealt with? The original generic „District Responses Initiative Protocol for Field Assessments and District Case studies“ (UNAIDS January 1997) proposed approaches focusing more on generalised epidemic approaches, and selecting three districts per country. Based on the past three years, districts at any stage of the epidemic, generalised, concentrated, or nascent may join the Local Responses with different strategies tailored for the circumstance. It is well known that locations with a nascent epidemic need to promote early on already prevention strategies. Furthermore, the Local Responses wishes not to embark on similar negative past experiences of investing in expensive pilot studies that have no chance of being sustained, replicated, or expanded. It is foreseen that the urgency of setting Local Responses, at any stage of the epidemic and anywhere, leaves a chance to any partner to join in the effort.
- What are the teaching or learning processes involved? The experiences documented up to now show that thanks to the national Aids theme groups that the Local Responses experiences are known and being shared within countries. The whole process is now challenged on how to institutionalise the teaching and learning process both nationally and internationally (next para.).

Fifth, the technical meeting identified a number of solutions to formalise the Local Responses, and legitimise the approach:

- involving and supporting more sub-regional experiences (UNAIDS regional offices, SADEC...),
- documenting case studies, diffusing information via videos, and sharing the state-of-the-art and papers related to different steps of the process, and spreading best practices,

- facilitating the sharing of successful experiences between countries, and learning from others in countries and through site tours, and involve training organisations, particularly with open walls,
- mobilising resources,
- monitoring the process²⁴,
- spreading information through Conferences (Satellite meeting of the 13th World AIDS Conference in Durban on the subject).

1) Research design and documentation of the process

Carefully designed action research (ref. chap. 3) has not yet permeated systems research, at least for the Local Responses to HIV/Aids, in comparison to any bio-medical research, e.g. AIDS vaccine trials. The crossover design already documented in a recent quasi-experimental design of an education program would have the advantage of intervening in an index site, and later, given the ethical aspects, a replication (control) site (expanding the response) receives the intervention at a latter stage (Skinner, Arfken et al. 2000). The findings of the Bulawayo technical meeting, just mentioned, overlooked this aspect. As a consequence, the present research design and presentation of findings for Burkina Faso, building on carefully designed systems research, remain an exception rather than a rule, despite the intention in the original protocol to do so (UNAIDS 1996). As a consequence, three years into the process, the findings are still soft, too anecdotal, and not sufficiently convincing to the broader scientific community. At least, efforts are being made in year 2000-on to have the processes documented carefully. Our study shows the added value to ground the Local Responses findings on a scientific quasi-experimental research design, even if it is not the most powerful one. Well-designed community studies, such as a cross-sectional design with repeated sampling over time in matched intervention and comparison communities, seem to be the luxury of industrial countries, and have been recently carried out for HIV/Aids (The CDC AIDS Community Demonstration Projects Research Group 1999) (Lauby, Smith et al. 2000). More financial resources for Local Responses may allow such developments in the near future, or pairing up with projects funded for this purpose (e.g. USAID funded "Measure" project).

2) Situation analysis at the community level

A thorough understanding of the community is at the heart of any situation analysis for the Local Responses as documented in the original systems Model (chap. 1, Fig. 1.4), and to plan and build the bottom-up approach through an improved understanding of their determinants and their structures. The study at the community level (chap. 4) using some of the latest qualitative methods brings forth data that could not have been collected ten years ago. Post-facto, we think that the present gap of interventions addressing vulnerable groups (5.1.7) can and should be overcome by focusing on those identified in the original situation analysis as well (e.g. migrants, truck drivers).

3) Situation analysis at the district level and the Rapid Organisational Review (R.O.R.)

The study revealed the wealth of existing and potential partners existing at a local level, namely at the district level and their communities, using an innovative sociological method, the Rapid Organisational Review (ROR) tool we designed for the circumstance. Organisations are often synonymous to bureaucracies, in the narrow definition of the theories of Max Weber. We adapted a broad definition of organisations as both formal and informal organised structures or groups, e.g. community-based organisations to Non-Governmental Organisations (NGOs). Much attention has been paid over the years to the individual responses. Yet, an understanding of the institutional or organisational responses lacks using those as a unit of analysis (ref. Susser's „eco-epidemiology“ in 3.2), and working with directly with organisations, without understanding them fully, is often the standard way to operate. As a consequence, the institutions at a local level have been largely left out of the process and can explain as a major contributing factor inefficient responses as we documented

²⁴UNAIDS Technical Meeting on Measuring Progress of Local Responses, Mwanza, Tanzania, 5-7 June 2000, and „How do communities measure progress on Local Responses to HIV/AIDS“ (Technical Note 3, Aug. 2000)

in the situation analyses at the community and district levels (chap. 4). The present inventory and task sharing of the partners from the public and voluntary sectors, combined with the improved understanding and agreement of their roles towards a common vision, foster more effective Local Responses (4.4 and 4.5) which we hope will be sustainable too.

4) Combination of different approaches

The complex problem calling for different solutions explains why different approaches are necessary to understand and respond to the HIV/Aids epidemic at the local level. The present research had too high ambitions with limited means and time (chap. 3), and focused in the end on anthropological and sociological approaches only. Yet, epidemiological, policy, and economics approaches are necessary to have a full picture of the environment in which the virus proliferates. The Local Responses would benefit from the expertise of different specialists working in the same geographical location together to tackle the responses from different angles. This in turn would help contribute to the design of responses that may be better replicated or adapted in different geographical areas of a national context.

5.2.2 International Policy Conclusions

HIV/Aids Local Responses as the HIV prevention and Aids mitigation vaccine

HIV/Aids Local Responses approach outlined in the present research must be accepted by all institutions in a united front. Presently, not all agencies, including within UNAIDS, are behind the approach, mainly because of the lack of documented success still.

Considering the aforementioned epidemiology and impact of HIV/Aids in the communities (chap. 1), and the search for more effective interventions, the Local Responses ought to be recognised as an innovative and leading strategy to prevent HIV and mitigate Aids. To this effect, it requires well funded and designed cross-country trials, just as vaccine trials or multi-drug therapies benefit from. The present development of the multi-preventive and mitigation responses in public health to combat HIV and Aids is part of the development of a systemic prevention vaccine (C. Pervilhac 1997). It needs to be considered as an important approach in public health, as the development of the vaccine to prevent Aids, or the multi-drug therapy to combat Aids, are in the bio-medical sciences. Despite this, it is not yet recognised as such but three years is still a short time to gain credibility in the public health field.

2) Focus at the local level

The focus at the local level is an essential and feasible ingredient of the responses to HIV/Aids. Burkina Faso illustrates the value of bottom-up approaches vs. other former top-down, or national to district, blueprint approaches. National strategic plans should be based on aggregated findings from district plans, and not the opposite. The situation analyses need to combine a balanced improved understanding of the determinants of HIV/Aids among the various communities, the different vulnerable groups, and the institutional partners from the public and voluntary sectors.

3) National and international support mechanisms and procedures

Efforts at the local level are sustainable and can be replicated only if the national level supports the Local Responses through support mechanisms and procedures. The experience of Burkina Faso has allowed such developments through an early and on-going information and participation of decision-makers from the national level to the local processes, either through the National AIDS Commission, or field visits and meetings. National policy can set guidelines for the country-specific Local Responses approach, but specific key national policy questions (ref. conclusion to 4.2.3) need to be addressed. We have illustrated with the "Cough Syrup Transport System" (1.1), the necessity

to simplify the support mechanisms and procedures for what should be in a reality a relatively simple operation (the mere delivery of the syrup with the spoon).

The role of international agencies to support the local level mechanisms and procedures, for example through the important concept development and refinement, needs in turn to be defined taking the example of the recent UNAIDS inputs through the country broker in Burkina Faso and the Local Responses team in Geneva.

4) Country specific approaches

The recent findings of an inventory and review of HIV Prevention Policies in Europe (Weilandt, Pervilhac et al. 2000) document how European countries have either developed or adapted for their own country the HIV prevention strategies and interventions with the supportive policies. In Europe, some of the core strategies (e.g. condom distribution and use, clean and free syringes for IVDUs) are the same in appearance. The key to their success may lie in what is the best constellation or mix of those, and how have they been adapted to the different country cultures or sub-cultures. Similarly, for the countries in Africa, the Local Responses may need a core set of strategies, accompanied by similar individual flexibility for each country, with local managers confronted with the large set of choices illustrated by the coloured barrels presented earlier (Fig. 5.1). The combination of the ingredients to success is learning by doing, recognising and correcting errors, and exchanging within and between countries.

5.2.3 Research Priorities for the Future

The present research priorities have two main aims: first, to support the development of the methodologies necessary to strengthen (5.1.8 and 5.2.1 and 5.2.2), document and disseminate (para. 4.5) the Local Responses, and second, to combat the present scepticism that may deter organisations to join the approach. Some countries have already shown successful results in handling the epidemic (e.g. in Uganda the prevalence of HIV has decreased among the youth) but these trends were visible before the setting of the Local Responses. Nevertheless, in Uganda, like in Thailand, all the ingredients of the Local Responses could be found already before the present initiative that takes stock of past experiences.

At the recent XIII International AIDS Conference, P. Piot, Executive Director at UNAIDS, suggested two paths of research which can form the two prone research strategy for the Local Responses:

- *“Applied research: what works best in various contexts?”*
- *“Basic research: what are the most effective tools and interventions?”* (Piot 2000)

1) Local Responses with improved study design and methodology

Despite the present study design, the Burkina Faso results based on the local partners' contribution may have been confounded by heavy technical inputs and additional financial support received (4.3.2). The necessity to address improved study design and the methodology of the Local Responses is compelling (5.2.1). In addition to processes and outputs, outcomes must be measured in addition (reduction in HIV prevalence accompanied by changes in behaviours). To validate the Local Responses biological markers need to go in pair with sexual behaviour markers and measure the outcomes. For this purpose, for example, a similar design than the recent findings of the “Triangulation of biological markers and quantitative and qualitative responses in sexual behaviour research with adolescents in rural Tanzania” (Plummer, Todd et al. 2000) could be adapted and tested widely using different tools and interventions. Standards need to be set as high for the development of this prevention vaccine as high as the ones in the bio-medical field.

Inter-country comparative Local Responses studies, funded by the E.U. or other international agencies, similar to the ones we carried out in Europe on HIV Prevention Policies (Weilandt, Pervilhac et al. 2000) could stimulate research specific areas. The support of country collaborators who know the country and have access to information is fairly simple and effective to document the work.

There is a need for an improved understanding of how to take the best advantage of the local capacities to support the process, and to determine the gaps. This will allow to identify what outside support is necessary for local ownership, sustainability and replicability purposes.

2) Cost-effectiveness

Apart from the overall worthiness of the approach, agencies do want to know how much the Local Responses costs, and whether it is cost effective in comparison to other approaches, for example more vertical approaches to HIV/Aids services delivery. Simple cost analysis methods can be set up to plan and monitor costs. Further research might focus on the cost effectiveness of the Local Responses in other districts than Gaoua in comparison to other more traditional classical strategies.

3) Links and effects between the Local Responses and the Health Sector Reform

The Local Responses takes advantage and at the same time stimulates the Health Sector Reform. Yet, the links between the two processes merit further study to understand how the Local Responses stimulates the Health Sector Reform, and in turn how much the Health Sector Reform facilitates the implementation of the Local Responses. In Burkina Faso, on one hand, the Local Responses has allowed the local Governments (Region and Districts) to play fully their roles in setting up the coordinating structures and participating to those, or in earmarking locally a budget line to HIV/Aids, for example. The Health Sector Reform, on the other hand, has permitted the local level to take full responsibility of the new HIV/Aids plans and activities, and to get the necessary support from national and international partners.

4) Refining the tool kit for the Local Responses

The Local Responses is no quick fix but a set of tools that can be used and applied depending of the local needs. Presently, there exists a mere incomplete inventory of those with applications on a small scale or experimental basis (5.1.5). Carefully documented research needs to test, document, and illustrate the experiences of the different tools used in each setting, coming from different sciences, and applications on a national scale. As an example to a local application, we described for Burkina Faso the situation analyses (chap. 4) at the community level of an anthropological nature, and district level of a sociological nature with for the latter the development of the Rapid Organisational Review (ROR) tool (5.1.6). New tools, such as risk behaviour mapping (Nyonyo, Mayunga et al. 2000), are being now being shared to wider audiences.

5) Planning: determining and using the vulnerability determinants to identify priorities and selecting and improving responses

The rationale for planning is the selection of the best mix of strategies, or as illustrated earlier in the "Cough Transport System" (chap. 1), or what is the best syrup? The tools used are powerful enough to identify the different vulnerability determinants. Research needs to focus more, based on the vulnerability determinants, how to identify local priorities, or how to address and overcome negative factors, and how to take advantage of the positive ones, in order to select and design improved interventions.

In addition as part of priority setting, the mix share between interventions for general and vulnerable population needs to be determined which is another necessary area of research. In Burkina Faso, we noticed the difficulty to identify, and as a consequence to work with the vulnerable groups in the local environment when they are still stigmatised (ref. 5.1.7 with migrants). Countries of western and

southern Europe, ironically, are struggling presently as well to find better paths to respond to the mobile populations' needs. In addition with stigmatisation, there is a parallel between Africa and the situation in Europe ten to fifteen years ago. In Africa, there is a wide and diffuse vision of how to go about responding to HIV/Aids linked to the nature of the problem due to the large heterosexual transmission of the virus. This may render the task of overcoming stigmatisation even more difficult than in Europe which has an epidemic largely concentrated in vulnerable groups transmission (e.g. homosexual, IVDUs).

Finally, if we discourage the use of strategic planning as a method to plan the Local Responses (5.1.4), research needs to test and select better options still.

6) Simplifying the supportive machinery for the Local Responses

As simple as the medication can be, i.e. the syrup in our original illustration of the "Cough Transport System" (chap. 1), the Local Responses carried out in Burkina Faso, and which we described in more details for the four different successive phases, is cumbersome and heavy. The supportive machinery for the Local Responses needs to be simplified in order to be more appealing to the local and international partners. Research needs to focus on how to simplify the process. A distinction should be drawn between the original efforts and trials in individual countries that are automatically more complex (time-consuming, costly, difficult) in the original Local Responses, and the next stages of dissemination which should be more straightforward.

7) Monitoring and selection of the best indicators

The Local Responses necessitates the monitoring of the process to take on-going corrective actions. In addition, to measure the effect of the Local Responses a set of best indicators needs to be identified. Different Local Responses efforts need to join efforts to select the best indicators to measure the Local Responses along the indicators classification (inputs, process, outputs, and outcome). In Burkina Faso, the recent review (4.4) and use of indicators to measure progress is a first attempt to do so. The last UNAIDS technical meeting (Mwanza, Tanzania, June 2000) on the subject shows the urgency to exchange the experiences on the measurement of the Local Responses and improving the monitoring of those²⁵.

In conclusion, following these early stages of development over the past three years of what we identified as the HIV prevention and Aids mitigation vaccine development, the various research areas identified above show that much work remains to be accomplished for an international recognition and application of the Local Responses to HIV/Aids. Based on the recent rapid and positive developments of the approach reported and described in this study, I foresee a breakthrough of the Local Responses in the next five to ten years as a standard and effective approach to respond to the HIV/Aids epidemic and implement HIV/Aids activities in different parts of the world.

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²⁵the present researcher is presently producing a Technical Note no. 3 on the subject (expected publication in Aug. 2000)

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CHAPTER SIX:

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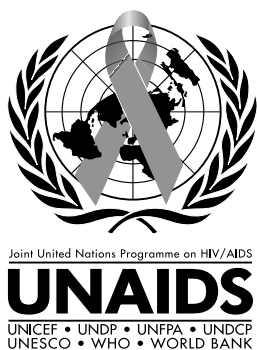
APPENDIX 1A

CHRONOLOGICAL BENCHMARKS OF THE DEVELOPMENT OF THE HEALTH SECTOR REFORM AND LOCAL RESPONSE: GENERAL EVENTS AND PERSONAL CONTRIBUTIONS (Jan. 1997- Aug. 2000)

DATE:	GENERAL EVENTS:	PERSONAL CONTRIBUTIONS:
January 1997	District Response Initiative (DRI) First Working Draft Protocol for Field Assessments and District Case Studies (UNAIDS/ WHO, Jan. 97)	
March 1997	UNAIDS, WHO, and GTZ representatives meeting on the GTZ's involvement and contribution in Uganda and Burkina-Faso (BFA)	Participated, GTZ, Eschborn (1 day)
April 1997		Adaptation of the study protocol for the District Expanded Response Initiative Case-Studies in Uganda and Burkina-Faso
May 1997		Visits to UNAIDS Geneva, and to the GTZ/ RAP Office, Accra, Ghana
May- June 1997		Original situation analyses Case-Study in Gaoua, 14 May- 6 June
June 1997	UNDP Human Development Against Poverty (launching) with special section on AIDS and the links to Poverty	Participated, Bonn, 12-13 June
Sept. 1997	UNAIDS Technical Meeting	Presentation of the BFA findings and Uganda study protocol; UNAIDS, Geneva (1 day)
Sept.- October 1997		District Expanded Response Initiative Case-Study in Uganda, 17 Sept. to 8 October
March 1998	DRI Meeting, GTZ Regional AIDS Programme for W. and C. Africa: Ghana and BFA Experiences	Pre-Planning and Consensus Workshop in Gaoua, 1-12 March Participated, Accra, 16-17 March
May 1998	Technical Workshop, UNAIDS/ WHO of the multi-country study teams	Participated, Dar-es-Salaam, 6-8 May
June 1998	Health Reform and HIV Workshop: an Agenda for Health Reform and HIV, UNAIDS/ WHO and co-sponsors 2 nd Symposium on HIV Prevention (Satellite Meeting of the 12 th World AIDS Conference), Geneva, 27-28 th June	Participated, Geneva, 24-26 June
July 1998	12 th World AIDS Conference, "Bridging the Gap," Geneva	2 posters presentations: (1 July) - DRI: Fostering Partnership in HIV/ AIDS Control. Situation Analysis in Burkina Faso. - The DRI: Missing Link in HIV/ AIDS Control. A Situation Analysis in Uganda
July-Aug. 1998	Situation Analysis and Response focusing on Care and Counseling, Gaoua, UNAIDS Consultant "Country Broker", Burkina Faso (27 days)	

DATE:	GENERAL:	PERSONAL CONTRIBUTION:
Sept. 1998	VII Entwicklungsmedizinischen Forum, "Migration innerhalb und aus Entwicklungsländern", Bonn	Paper presentation "HIV/ AIDS for Border Migrants in West Africa: Hidden Problems and New Perspectives from the Gaoua District Case-Study, Burkina Faso"
Sept. 1998	Local synthesis of results of the previous situation analysis and response, Gaoua, UNAIDS Consultant "Country Broker", Burkina Faso (7 days)	
Nov. 1998	Workshop of feedback and consensus on priority areas and objectives with 57 participants (4 days)	
Dec. 1998	Strategic planning writing with local participants (9 days, including 77 participants for a 4 day workshop)	
January 1999	Strategic Planning Gaoua (finalisation of Plan and budgeting) and UNAIDS Consultant "Country Broker", Burkina Faso, 2 days GTZ-UNAIDS Meeting: Health Sector Reform and the Expanded Response	Participated, GTZ, Eschborn, 8 January
February 1999		Identification and simplification of key tools to be used in facilitating the Health Reform and HIV Agenda in various national settings, UNAIDS, Geneva, 4-19 Feb.
March 1999	The Health Reform and HIV Country Team Workshop for the West Africa Region, Gaoua, BFA, 15-19 March 1999	Prepared Overhead Presentation of Landscapes (1997, 1999, 2000-2001) for UNAIDS Workshop
May 1999	Operational Priority Gaoua Plan for June to Dec. 1999 (4 days) UNAIDS Consultant "Country Broker", Burkina Faso	
June 1999	Implementation of the priority plan (2 nd semester 1999) by the local actors	Development of a Formative Evaluation Framework (submission of proposed draft to UNAIDS country office and broker): Measurement of progresses using Inputs, Process, Outcomes and indirect benefits Indicators
June-July 1999	Elaboration of Plan of Activities for Gaoua/ Strategic Planning Process and Results documentation, and International Partner Meeting in Ouagadougou (Jun.25 th) for financial commitments, UNAIDS Consultant "Country Broker", Burkina Faso	Institutional Landscapes incorporated as baseline and benchmarks
July 1999	Setting of local coordinating structures for the follow-up of the implementation of the Plan and Meeting of the Provincial Administrative Heads (45) for whole of Burkina Faso, UNAIDS Consultant "Country Broker", Burkina Faso	

DATE:	GENERAL:	PERSONAL CONTRIBUTION:
Aug. 1999	Contact with Muraz Center in Bobo-Dioulasso, and Meetings of the Mayors of Burkina Faso, UNAIDS Consultant "Country Broker", Burkina Faso. Implementation of the Strategic Plan.	
Nov. 1999	UNAIDS Technical Meeting on the Facilitation of Local Responses: Training and Methodology Development, Bulawayo, Zimbabwe, 22 to 25 Nov. 1999	- Participated: Presentation of the Gaoua District, Burkina Faso Local Level Response, by P. M'Pele, country facilitator - Presentation of the status of the tool kit for the local level response (ref. Feb. 1999) by C. Pervilhac, and of the preliminary findings of the E.U. funded research on HIV Prevention Policies in Europe
Jan. 2000	1st Formative Evaluation (O3) by external review team	Measurement of progresses using Inputs, Process, Outcomes and indirect benefits Indicators
April 2000	Setting-up of the Local Responses library, UNAIDS, Geneva	Comprehensive review of fifty documents related to the Local Responses
May 2000	"Local Responses to HIV/AIDS in Burkina The Gaoua Experience, a Health District in the Poni Province": presentation at the OAU Ministers of Health of the Africa Region Conference, Ougadougou	
June 2000	Measuring Progress of Local Responses to HIV/AIDS, Mwanza, UNAIDS Technical Meeting, 5-7 Jun. 2000 Ms. Karidia Kyere, Director of Social Affairs, Gaoua Province, presents the " Progress of Local Responses 1997-2000 and their Indicators in Gaoua District, Burkina Faso " (among a dozen other country presentations)	Editing of the new Technical Note 3 on the subject. Designing and editing the TANESA tool on a "Step Approach Guide to HIV/AIDS risk behaviour mapping: Magu District experience (TANESA), Tanzania
July 2000	13 th International AIDS Conference, Durban	- Design of an improved "Progress Report on activities in the field" of Local Responses to HIV/AIDS in 8 countries and collection of information. - Participation to the Satellite meeting on "Local Responses" organized by UNAIDS Local Responses team, and to a poster presentation on " The impact of a local response to HIV/AIDS in a rural district of Burkina Faso " by P. M'Pelé, C. Pervilhac, J.L. Lamboray et al.
Aug. 2000	Gaoua District: Lessons learned from the Local Responses over the past 3 years with P. M'Pelé, ex-country broker, UNAIDS Abidjan Office. (1 week visit)	Final compilation of the lessons learned from Gaoua District to be published in the UNAIDS Best Practice Collection . " UNAIDS Case-Study Gaoua District Local Responses: The Burkina Faso approach "



June 2000

KEY NOTE

LOCAL RESPONSES TO HIV/AIDS: THE GLOBAL AGENDA

Key Note

The Local Responses team at UNAIDS monitors and analyses instances of local responses to AIDS from around the world, and extracts and disseminates the principal lessons from these experiences. This Key Note document, updated by the team each year, sets out the current level of understanding about local responses and how they may be best dealt with under varying circumstances, given that there is no single approach that can be universally prescribed.

What is a “local response” to AIDS?

“People are the subjects of the response to AIDS, not the objects of our interventions”
(Lesson from Phayao province, Thailand)

A local response to AIDS means the involvement of people where they live – in their homes, their neighbourhoods and their work places.

Why encourage a local response to AIDS?

What individuals decide to do and how they behave are of prime importance in the battle against the epidemic. It therefore makes abundant sense that responses should, in the first instance, be local.

What are the objectives of pursuing local responses to AIDS?

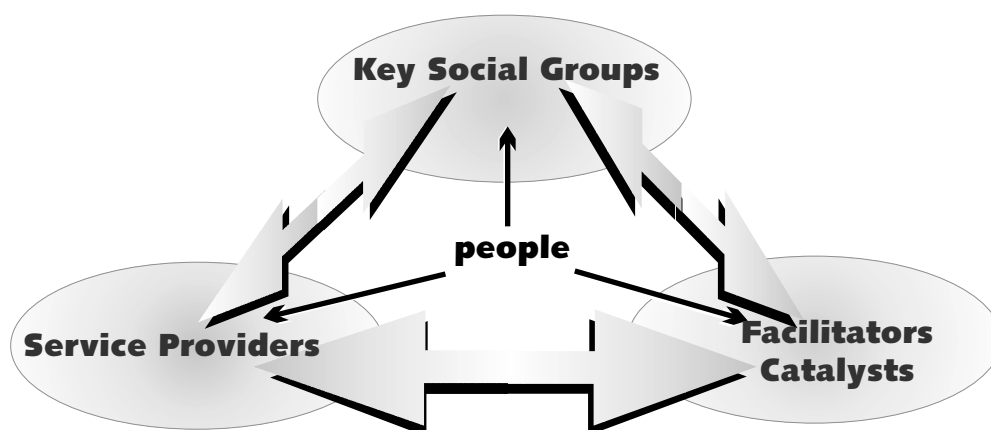
The ultimate goal of pursuing local responses is to enable local communities to acquire what may be termed “AIDS competence”. This means that people should become skilled in dealing with AIDS and, in particular, they should:

- be properly informed about the epidemic;
- be able to assess accurately the factors that may put them personally, or their communities, at risk of infection;
- act so as to reduce those risks.

The end goal of the process is to reduce HIV transmission, and enable those living with AIDS, as well as those affected, to enjoy an improved quality of life.

Local partnerships on AIDS

Since there are limits to what people can do on their own, local partnerships can help improve the effectiveness of local responses. Such partnerships bring together key social groups, service providers and facilitators.



Key social groups are those whose members have a particularly important role to play in HIV prevention and care activities. This may be because they are especially at risk of infection, or have been more strongly affected than others, or it may be for other reasons. The experiences of these groups are critical to the working of local partnerships. Individuals may be members of several overlapping key social groups. Examples of such groups are: young people (particularly those who are out of school or unemployed), women, men, people living with HIV/AIDS (PLHA), migrants, and members of specific occupational groups, such as sex workers, soldiers, miners, and fishermen on long-distance trawlers.

Service providers may be government bodies (including those of local government), nongovernmental organizations (NGOs), community-based groups or religious groups. They play a role by providing information, resources and services.

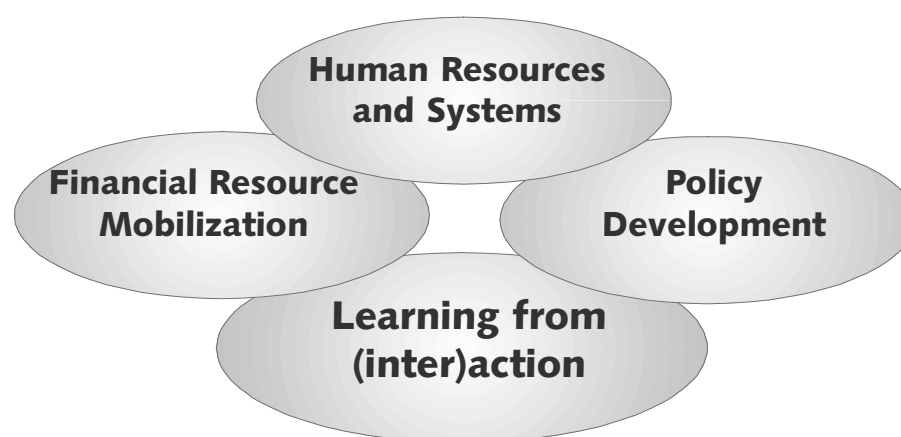
Facilitators enable and make easier the interaction between the various partners in the local response, helping them become more competent and attract greater resources. They also help people better to articulate their views. Some of the specific tasks of facilitators are:

- assisting individuals and communities to mobilize resources, both technical and financial;
- helping to devise ways of carrying out projects to combat AIDS;
- analysing the processes and results of projects;
- helping people and communities to document their experiences.

What type of approach is appropriate in local responses to AIDS?

Typically, a strategy for local responses to AIDS has four components:

- developing human resources and systems for AIDS competence - putting in place inputs, structures and processes necessary for effective local partnerships;
- developing policies, and creating an environment that enables AIDS competence;
- mobilizing local and external resources;
- learning from the process and from the interaction between the various groups involved.



Learning: the key element for scaling up

Complementary actions and learning at all levels of a country are the key elements for scaling up local responses.

Key social groups engaged in local partnerships can create the self-confidence necessary for progress to be achieved, sharing that confidence and their experiences with other groups and communities.

District bureaucracies, the first level of sector management, link local with national activities. They assess the HIV situation and help identify key social groups in the local response to AIDS, providing support to such groups. The bureaucracies analyse, document and disseminate what they learn from the local responses. They can then press for and negotiate with the national authorities the reforms needed in key sectors to sustain local responses.

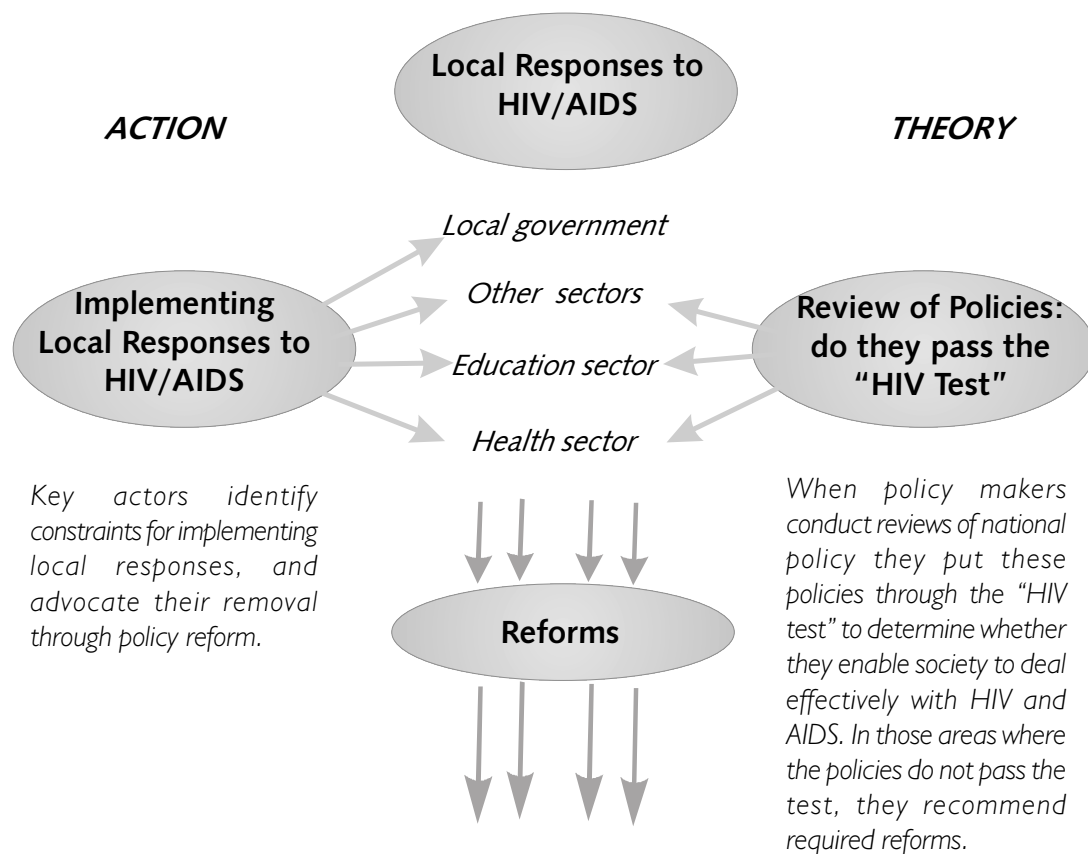
Government ministries, NGOs and the private sector should scale up local responses to the national level by incorporating local lessons into their strategic planning and reform processes. Governments, for example, should scale up by adopting policy reforms that have “passed the test” at the local level. Such reforms should enable effective and sustained local responses throughout the country.

Country facilitators act as intermediaries between local and global learning. They help people document and exchange experiences. Lessons learned are presented in Key Notes, Technical Notes and case-studies.

International organizations – A UNAIDS cosponsor or a donor agency should be responsible for enabling local response initiatives to take place and be effective in a particular country. The organization takes the responsibility for the financial and administrative support required to implement the agenda.

The international *Technical Resource Network* on local responses, consisting of country-facilitators and other key actors in local responses, exchange experiences all over the world. Communication takes place through an electronic platform (localresponse@unaids.org). Members of the network meet face-to-face twice a year during technical meetings where they seek consensus on global learning on local responses.

The Geneva-based *local response team* has a specific task in facilitating and stimulating learning on local responses. It incorporates the local experiences in the global agenda and advocates policy and strategy changes according to new lessons.



AIDS COMPETENT SOCIETY

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Number 1

TECHNICAL NOTE

LOCAL RESPONSES TO HIV/AIDS

A strategic approach towards an AIDS-competent society

From the experiences of local responses to AIDS that have been documented in a range of countries, it emerges that those strategies that have been successful have all employed a combination of at least some of the steps described in this Technical Note. The sequence in which they are performed is not critical, and – depending on local circumstances – any of the steps can be the starting point. The recommended steps are the following.

Step 1 Creating AIDS competence

In order to develop “AIDS competence” – whereby people are able to assess accurately the factors that may put them or their communities at risk of infection, and act so as to reduce those risks – a conducive political environment is essential, as are the availability of and accessibility to a range of services.

For a society to be AIDS-competent, every sector and its institutions must also be AIDS-competent. To achieve this, sectors need to assess the impact that AIDS has – or is likely to have – on their activities, resources and organization, and adapt to the new situation. Competence is not a single act, but needs rather to be continuously refined and redefined through the experiences that are learnt.

Step 2 The development, by consensus, of a national strategy on AIDS, based on local responses

The key elements in developing a national strategy based on local responses are:

■ *Decentralization*

The most appropriate decentralized planning unit, close to the communities, should be chosen to implement interventions. A basic package of interventions – cutting across all sectors – should be formulated, which is flexible and can respond dynamically to changing conditions. An initial evaluation of the various communities should be undertaken to help determine how best to reach decentralized groups. Communities should always be regarded as both partners and important actors in interventions.

■ *A multisectoral approach*

The approach adopted should be both multisectoral and participatory. Responses will be greatly enhanced if highly-placed officials in a given sector commit their support. All interventions in a particular community should take into account the social, cultural and legal aspects of that community.

■ *Partnerships*

Partners – from a range of social, cultural and religious groups – should be involved in programmes at the local level and in analysing the results of interventions. The ideal is a common goal and a plan of action with clearly defined tasks between the various partners.

Step 3 Appointing a national facilitator for local responses to AIDS

The main task of a facilitator is to encourage feedback from lessons stemming from activities at the local level and to set up ways to exchange experiences between communities, sectors and policy makers. The facilitator will also be responsible for helping to implement the remaining steps of the strategy listed below.

Step 4 Establishing a local responses support team at district level

A local responses support team should be set up at the decentralized level, whether urban or rural, with support from the facilitator. The team should be technically well-equipped and have the moral support of local communities. A team may develop out of existing structures, or may be created by the communities themselves. Its members may include people such as district officials, religious and traditional leaders, representatives of NGOs, community-based organizations and the private sector, and people living with HIV/AIDS. A team needs to be self-confident, with the ability to define priorities, develop a plan of action and implement the plan.

A team's working style should be participatory, interactive and based on consensus. It will take on situation analyses and analyse the outcome of interventions, and it will identify and set priorities, determine strategies, and plan, coordinate and monitor activities.

A team will seek to expand local partnerships against AIDS and enhance the resources of local communities.

Documenting and building on the experiences of community projects are core functions for every team.

Step 5 Understanding the epidemic and identifying key social groups

An early task of the local responses support team will be to identify key social groups. These are groups of people who – because of their occupation or life style – may be particularly at risk of HIV infection. For their own sakes and the sake of the local society as a whole, it is vitally important that these groups are AIDS-competent and that their vulnerability to HIV infection is sharply reduced. Key social groups might, for instance, involve groups of men – in particular, vulnerable groups such as truck drivers, fishermen on long-distance trawlers, and miners – women, and out of school or unemployed young people. The social groups themselves should participate in the exercise of mapping risk and vulnerability across the local society. Through such participation, they will become aware of the range of factors that create added risk.

Some of the techniques that can be used in this step include:

- local strategic planning
- mapping individual and group vulnerability
- selecting key groups and individuals for partnerships
- analysing the basic needs of the local society
- assessing the role of gender in the local society
- reviewing sectoral policies to check they pass the “HIV test” – enabling society to deal effectively with AIDS – and if they do not, then recommending reforms.

Step 6 Developing local partnerships

An important task of the local responses support team is to facilitate the development of local partnerships, with a view to attaining a high level of AIDS competence. These partnerships will include members of the key social groups and front-line workers from the different sectors at the sub-district level, and they should be supported in their work by a facilitator. Using a common starting definition of AIDS competence, the partners should develop an action plan for achieving it – working out their specific contributions to the process and the means of evaluating the results. They should also document and exchange experiences from the very beginning.

Step 7 Learning from action

The feedback process of learning from direct action will help local partners adjust the criteria for what determines AIDS competence, and the means by which it can be achieved. At the same time, the local response support team should collect the various lessons from around the district and, using these, refine the definition of AIDS competence and the means of attaining it.

As an example, in November 1999, the Provincial Multisectoral AIDS Committee of Gaoua, Burkina Faso, reached a definition of AIDS competence that included the following criteria:

- a change in individual sexual behaviour
- a reduction in the stigmatization of HIV-positive individuals
- a spontaneous willingness to come forward to be tested for HIV
- improvement in the quality of hospital care
- increased mobilization of people against AIDS
- a reduction or stability in HIV prevalence.

Step 8 Sector reforms to enhance sectoral AIDS competence

The formulation of criteria for AIDS competence at local and district levels and efforts to attain it will help groups in the field identify constraints and opportunities. This, in turn, will help the various sectors to develop their own AIDS competence. In each sector, units should review – with regard to AIDS – the amount and quality of the services they are providing, their internal organizational structures, their interaction with others, and the planning and development of their human resources. The implementation of sectoral reforms is intended to create a suitable environment in which AIDS competence can flourish.

A checklist on sectoral AIDS competence

Have we taken into account how AIDS affects:

- the quality and quantity of our services
- our ability to supply the required services
- the organisation of our sector
- the role of our service providers
- our human resource policy and management practices
- the planning and management of our sector resources
- the availability of public and private resources for our sector
- donor support to our sector?

(adapted from Kelly MJ, *The impact of HIV/AIDS on schooling in Zambia*. ICASA, September 1999)

Step 9 Encouraging the proliferation of AIDS competence

Communities should share their experiences with other communities, knowing that success is possible and that the threat of AIDS can be controlled. Front-line workers should share their experiences with their peers, who face similar problems under different conditions. The local response support teams should encourage these exchanges, structuring the process so that political decision-makers also have access to the documented experiences. This should lead to greater political commitment and a more vigorous and coherent national response.

From these interactions at local, district and national levels, some universal lessons will be derived, which in turn can be shared on a global level with those working to develop AIDS competence in other societies.

APPENDIX 1C

1 LOCAL LEVEL/ DISTRICT EXPANDED RESPONSE INITIATIVE TO HIV/ AIDS: **THE GROWING GAP & NEEDS**

OVER 10 YEARS AFTER GLOBAL AIDS STRATEGY, 2 GAPS STILL TO FACE THE RAPID SPREAD AND GROWING HIV EPIDEMIC:

- 1) LIMITED PREVENTION EFFORTS AND EFFECTS
- 2) INCREASING NEEDS FOR CARE, SUPPORT, AND IMPACT ALLEVIATION WITH INSUFFICIENT RESPONSE

(C.P., March 1998, Source: adapted from UNAIDS 97)

2 LOCAL LEVEL/ DISTRICT EXPANDED RESPONSE INITIATIVE TO HIV/ AIDS: **THE SOLUTIONS**

- ◆ Highly effective vaccine
- ◆ Combination therapies (Uganda, Ivory Coast, Vietnam, and Chile)
- ◆ Risk Reduction strategies (individual risk factors)
- ◆ Vulnerability Reduction strategies (environmental and socio-economic)
- ◆ Expanding the Response strategy (community, comprehensive, and multisectoral)

(C.P., March 1998, Source: adapted from UNAIDS 97)

3 LOCAL LEVEL/ DISTRICT EXPANDED RESPONSE INITIATIVE TO HIV/ AIDS: **ENABLING FACTORS**

- ◆ LESSONS LEARNT FROM PHC
- ◆ DECENTRALIZATION PROCESS FROM THE MINISTRIES
- ◆ EMERGING CIVIL SOCIETY
- ◆ NEW INVOLVEMENT OF THE PRIVATE SECTOR (NGOs, ASSOCIATIONS...)
- ◆ MORE EXPERTISE, QUALITY, ACCOUNTABILITY FROM THE PUBLIC SECTOR
- ◆ ORGANIZATION & INSTITUT. IMPROVED UNDERSTANDING

(C.P., BFA, Ghana, GTZ, March 1998)

4 LOCAL LEVEL/ DISTRICT EXPANDED RESPONSE INITIATIVE TO HIV/ AIDS: **JAKARTA DECLARATION**

“NEW PLAYERS FOR A NEW ERA:
LEADING **HEALTH PROMOTION**
INTO THE 21st. CENTURY” (1997):
NEED FOR “NEW RESPONSE”
WITH “NEW AND DIVERSE
NETWORKS TO ACHIEVE
INTERSECTORAL
COLLABORATION...”

(C.P., March 1998, Source: WHO)

5 LOCAL LEVEL/ DISTRICT EXPANDED RESPONSE INITIATIVE TO HIV/ AIDS:
PATHWAYS TO AN EXPANSION

- ◆ the quality and scope of HIV/ AIDS strategies
- ◆ the partnerships and its efficiency
- ◆ the population coverage
- ◆ the involvement of the Development sectors
- ◆ the resources mobilized in support of HIV/ AIDS prevention and care
- ◆ the sustainability of HIV/ AIDS programmes over time

(C.P., March 1998, Source: adapted from UNAIDS 97)

APPENDIX 3A

COMPILATION OF POTENTIAL KEY INFORMANTS AT THE COMMUNITY LEVEL IN BURKINA FASO

LISTE DES INFORMANTS-CLES RECENSES

PRIORITAIRES HOMMES:

1. Chef du Village
2. Délégué Administratif (village) ou Chef de Quartier ou Concessions (ville)
3. Responsables d'Associations de Cultures (Groupements, Associations Coopératives...)
4. Enseignant (instituteur) de l'Ecole
5. Encadreur d'Agriculture de Zone (élevage, développement rural) (village) ou animateurs "GRAP" SIDA/ P.P.I. (ville)
6. Tradipraticiens

Autres hommes:

- Chefs religieux (marabouts, imams, catéchistes...)
- Agents de Santé Villageois
- Commerçants
- Agent de Santé de la Formation Sanitaire la plus proche

PRIORITAIRES FEMMES:

7. Responsables de Groupements ou Associations Féminines (tontines...)
8. Commerçantes ("Dolo"...) (village) ou Animatrices "GRAP" SIDA/ P.P.I. (ville)
9. Responsables de Groupements Coopératives (coton, arachides...) (village), action sociale/ promotion féminine (ville)
10. Accoucheuse Traditionnelle

Autres femmes:

- Responsables de groupements religieux
- Groupes artistiques traditionnels (des 2 sexes)
- Enseignantes (rares)
- Accoucheuse villageoise formée
- Exciseuse

PRIORITAIRES JEUNES:

11. Groupes Coopératifs "Associations de Cultures" (jeunes hommes)
12. Président de l'Association des Parents d'Elèves

Autres jeunes hommes:

- Groupe Danse musique (mixte)
- Groupes de thé
- Associations de sports
- Club musique (mixte)
- "Leaders naturels"
- Vacanciers

Autres jeunes femmes:

- Equipe de Football (villes)
- Vendeuses
- Club musique (mixte)
- Tontines
- Groupes professionnels
- Vacancières

APPENDIX 3B

Units of Analysis and Sample Checklist of Specific Problems related to District Systems

* required component for each district analysis

District Health System

Units of analysis	Specific Questions
Health Committees or equivalent*	<ol style="list-style-type: none">1. Poor representation (women, powerful leaders etc.)2. Role of committee too passive (say always yes)3. No quorum reached
DHMT*	<ol style="list-style-type: none">1. Leadership of in charges (DMO, program managers etc.)2. Delegation of responsibility, if yes to which degree? Team spirit? Satisfaction of work3. Financial accountability
Projects/donor support*	<ol style="list-style-type: none">1. Does donor know government (district policy)?2. Does donor execute activities agreed upon in coordinating meetings?3. Planning not integrated in DH plan
Different programs	
• HIV/AIDS*	<ol style="list-style-type: none">1. Planning process weak (planning national level)2. Critical limit of manpower, new types of workers not available (counselors etc.)3. Multisectoral approach difficult ("others" do not see AIDS as a problem)4. No clear policy (e.g. condom use etc.)
• MCH*	<ol style="list-style-type: none">1. Non national plan or guidelines existing2. Often too vertical, no interest in AIDS3. See activities not as their duties (taking blood for HIV testing etc.)
• FP*	<ol style="list-style-type: none">1. No joint program planning between FP and AIDS2. Different messages for public (e.g. condom promotion)3. Offices in different locations.
• TB*	<ol style="list-style-type: none">1. Very vertical program2. Limited interest in AIDS control3. TB coordinator not part of DHT (physically office, mentally)
• EPI	<ol style="list-style-type: none">1. Little interest in AIDS problems2. Managed as national program (limited cooperation)3. Limited knowledge of staff about HIV
• other Comm. Diseases (malaria, CDD, ARI etc.)	
• others as relevant	

Support services

- Finance*
 1. Old-fashioned system of accounting
 2. Limited supervision and control by higher authorities
 3. Misuse of public funds was considered as normal
- Personnel*
 1. Extreme shortage of staff
 2. No personnel plan existing
 3. Remuneration low, staff can put in less hours (40-60%)
- Training*
 1. Training not tailored towards real training needs of staff
 2. Training not integrated
 3. Training results not evaluated at later stages (1 month, 1 year etc.)
- HIMS*
 1. Data not fed back to communities
 2. Data not fully used for planning
 3. Feed back of data to health units existed, but data not explained by supervisor
- Logistics*
(supply, transport, storage, maintenance etc.)
 1. No demand oriented supply system
 2. Supervision visits to health units not fully used for supplying
 3. No updates of inventories, no yearly inventory done
- Health education/ IEC*
 1. Done in old fashioned and negative way (example condoms)
 2. Department, other health workers felt not responsible for it
 3. Traditional communication not fully utilized

Health infrastructures/ personnel

- district hospital
 1. Role between MS and DMO not clear
 2. Hospital did not participate enough in field work and supervision of health units
 3. No community oriented spirit, not client focused
- peripheral health units*
 1. Shortage of qualified staff
 2. Little attractive of remote corners in the district
 3. In charges often weak, no supervision of subordinate staff

PHC workers

- VHWS*
 1. Overrepresentation of males, selection
 2. Few efforts to create small scale income for them, other wise drop out high
 3. Concept of VHW not understood by health workers, VHW and communities
- TBAs*
 1. Willingness to learn new things limited (age)
 2. Resistance to participate in FP/HIV
 - 3.
- Trad. healers*
 1. Differentiation between "true" TH and quacks sometimes difficult

2. Promote unsafe practices and make dangerous promises (AIDS is curable)
3. Not open about their work

Community Organization System

Units of analysis	Specific Problems
Local village committees/ groups	
<ul style="list-style-type: none"> • political* 	<ol style="list-style-type: none"> 1. Health/AIDS was not priority 2. Personality problems blocked decisions for a long time 3. Weak in manpower decisions 4. Health worker did not understand importance of getting political support
<ul style="list-style-type: none"> • health* 	<ol style="list-style-type: none"> 1. Good leadership missing (however existing) 2. Do not understand their role 3. Not enough technical basic background
<ul style="list-style-type: none"> • gen. development 	Did not exist
<ul style="list-style-type: none"> • agriculture* 	No information (health worker do not know about it). If they exist, no links with HW or VHC
<ul style="list-style-type: none"> • women groups* 	<ol style="list-style-type: none"> 1. Poor skills for designing realistic income generating schemes, poor proposal writing, what makes sense 2. Poor accounting of funds 3. Links to other groups weak or not existing
<ul style="list-style-type: none"> • youth groups* • others 	<ol style="list-style-type: none"> 1. Only few existed (boy scouts), more on paper, not active 2. Many youth did not grasp concept of peer education 3. Leadership within groups almost absent
AIDS patients* (if possible)	<ol style="list-style-type: none"> 1. Accessibility to care difficult 2. Stigmatization (family breaks apart) 3. Widows have no right on property
Caretakers	
<ul style="list-style-type: none"> • relatives* 	<ol style="list-style-type: none"> 1. Often refuse to care for relatives with AIDS 2. Can be overburdened with orphans 3. AIDS patient in family seems to increase stigmatization and prejudice
<ul style="list-style-type: none"> • friends neighbors 	<ol style="list-style-type: none"> 1. Are sometimes main caregiver 2. Tend to be not included in care plan by staff (home based care staff), if caregiver 3. Neighbor support traditional?
<ul style="list-style-type: none"> • professionals* 	<ol style="list-style-type: none"> 1. Fear of HIV infection 2. Lack of compassion (moral aspects) 3. Lack of confidentiality
Support groups for HIV infected persons*	<ol style="list-style-type: none"> 1. Still too much in secrecy 2. Fear of publicity 3. Some skills (counseling) within groups missing, understanding of role of group in individuals weak
Persons at high risk of HIV infection*	

(if possible)
Local church
groups* (care,
counseling etc.)

1. Refused to participate in condom promotion
2. FP and sexual health not welcomed topics for discussions
3. Information and coordination with PH department insufficient

NGO support
groups (care,
counseling etc.)*

1. Own agenda, planning outside district plan
2. Activities can be counterproductive to PH government
3. Budgets not open to government officials

Private Health Systems

Units of analysis	Specific Problems
NGO groups*	see above
Church groups*	see above
Social marketing condoms/ contraceptives	
<ul style="list-style-type: none"> • institution in charge (DHT)* 	<ol style="list-style-type: none"> 1. Little involvement of private enterprise 2. Initially reluctant to include private providers in training 3. sometime arrogant attitude
<ul style="list-style-type: none"> • pharmacies* 	<ol style="list-style-type: none"> 1. Poor network 2. Potential for IEC of pharmacists not recognized by DHT 3. Offer products without any quality control
<ul style="list-style-type: none"> • shopowners* 	<ol style="list-style-type: none"> 1. Thought selling condoms would negatively affect their business 2. Participate only if profits are made 3. Not clear which information they give to customers
<ul style="list-style-type: none"> • other distributors* 	
Private praxis	
<ul style="list-style-type: none"> • clinics* 	<ol style="list-style-type: none"> 1. Quality can be poor, no quality control, sometimes not licensed 2. Reluctant to give information to DHT 3. do not want to be supervised by DMO
<ul style="list-style-type: none"> • home based* 	<ol style="list-style-type: none"> 1. Very difficult to supervise, QA control 2. Sometimes exploit patients (easy for AIDS patients) 3. Poor training, no upgrading, low knowledge and skills
Pharmacies*	<ol style="list-style-type: none"> 1. Rather laymen, few have trained pharmacist 2. Sell products without QA control, some drugs may be only placebo 3. Sell antibiotics without prescription

Local Government System

Units of analysis	Specific Problems
District development committee*	<ol style="list-style-type: none">1. Under representation of women2. Focus on budgetary issues rather than technical or policy issues3. Role as supervisory board not fully understood, few actions taken
PHC committee health specific committees)*	see above
Other committees	
• education*	<ol style="list-style-type: none">1. Did it exist?2. No information available
• agriculture*	<ol style="list-style-type: none">1. Did it exist?2. No information available
• community development etc.*	<ol style="list-style-type: none">1. Did not exist
District officials*	<ol style="list-style-type: none">1. Accountability of funds was not enforced2. AIDS was seen as problem for DHT3. Limited outreach (transport, per diems, too lazy)
Political parties/ officials*	<ol style="list-style-type: none">1. Do not have awareness of full impact of AIDS2. Weak support in controversial public discussions for DHT (e.g. condom issue, HE on sex in schools)3. Decentralization in party different from administration, party too much dependent on national groups)

Education System

Units of analysis	Specific Problems
District education team (Min. of education)*	<ol style="list-style-type: none"> 1. No real team existing (team spirit) 2. Reluctant to include sexual health education in school health curricula 3. Very limited resources for program development and outreach (staff, budget, transport) 4. Do not use modern methods for communication 5. External technical support limited
Health education/ school health (Min. of Health)*	<ol style="list-style-type: none"> 1. Negative approach to design of messages 2. Coordination with health messages from DET weak or not existing (different messages-big problem- community confused) 3. Professional competence of DHE (DHT) weak
Parents association	<ol style="list-style-type: none"> 1. Main task to collect money 2. Not involved in curriculum development or other technical issues 3. No official role in AIDS control activities
Teachers association	<ol style="list-style-type: none"> 1. Only certain teachers were part of it 2. Teachers did not like it (how many?) 3. Very "invisible"
Church/private schools	<ol style="list-style-type: none"> 1. Concentrate on abstinence, no info on safe sex practices 2. Limited authority of government to enforce curriculum 3. DEO did not supervise church schools
School children male	<ol style="list-style-type: none"> 1. No information about sex from parents 2. Early start of sexual activities 3. No legal framework for sexual abuse of children existing? If existing, is it enforced
School children female*	<ol style="list-style-type: none"> 1. Cultural difficult to say no to sexual offers 2. Accessibility to counseling services-FP services of young girls (pregnant or non pregnant difficult (geographically, provider bias) 3. Limited information about prevention of STDs
Out of school youths*	<ol style="list-style-type: none"> 1. Difficult to reach 2. More prone to unsafe sex and sexual abuse due to lower educational status? 3. Less likely to be part of youth organizations
Media coverage	
• radio*	<ol style="list-style-type: none"> 1. Coverage still low 2. Radio listeners are more adults than adolescents 3. Limited coverage due to language problems
• TV	<ol style="list-style-type: none"> 1. No coverage in rural areas, can be replaced by video presentations with projector 2. Most available videos in English 3. TV and rural populations-evaluation of effects, cost effective

Traditional communication

- theater
 1. Not always appropriate messages
 2. Costs-can groups be organized in a sustainable way (commercial performances etc.)?
 3. Technical advice and supervision of groups not easily available

- puppet shows
 1. HIV presented as monster
 2. Technology for building puppets not easily available and costly
 3. Presentation not adopted enough to the understanding of young people (adult presentations)
 4. No systematic evaluation done (valid for all traditional ways of IEC)

- oral traditions*
 1. Little efforts by HE and other DHT members/officials/health workers to include them into IEC
 2. Some are lost during cultural shifts
 3. Limited interest of young people

Agriculture System

Units of analysis	Specific Problems
Agriculture district team*	<ol style="list-style-type: none"> 1. No team spirit, weak DAO 2. No coordination, no meetings within head of departments 3. Lack of technical competence
Agriculture extension programs*	<ol style="list-style-type: none"> 1. No systematic planning, no plans available (monthly, yearly) 2. Coverage of activities not district wide 3. Advice not tailored towards needs of farmers 4. No special program for AIDS affected families
Extension workers*	<ol style="list-style-type: none"> 1. Not familiar with modern methods due to lack of training (not upgraded for years) 2. Not accepted by many farmers 3. Redundancy created lack of motivation 4. Promotion of dangerous pesticides
Farmers' groups* Women groups*	<ol style="list-style-type: none"> 1. Emphasis on handicrafts 2. Agricultural "needs" of AIDS affected families not recognized 3. Resistant to new ideas
Cooperatives Small scale farmers	<ol style="list-style-type: none"> 1. Exist. Some supported by Ag. Sector 1. Unknown

APPENDIX 3C

Descriptive Table of the various Types of Studies (Purposes) and Tools

APPROACHES:	TASKS/ STUDIES:	REFERENCE TOOLS: (see Biblio. Ref. and Attachments in Appdx.)	UNITS OF ANALYSIS:	METHOD USED:
1. Epidemiology, Economics	1. Assessment of the present performance of each system	- classical evaluation tools (from GTZ Pfk etc.) (if exists, open to any specific suggestion ex.: for 1.5. "Health Information Sub-System Issue Framework" in WHO, SCHIU/ DHSTA, "Guidelines for The Assessment of National Health Information Systems", 1996)	- programme managers	- key informant interviews
2. Anthropology, Policy	2. Self-analysis of roles from different District System Leaders (in complement with Specific Problems (Appdx. C)	- Position Mapping (Reich's "Position Map" from "Political Mapping") combined with qualitative research methods (WHO/ TDR "Key informant interviews")	- opinion leaders - programme managers	- group discussion
3. Policy	3. Stakeholder Analysis for an improved response	- Stakeholder Analysis and Policy Network Map and Transitions Assessment (Reich's "Stakeholder Analysis" from "Political Mapping")	- opinion leaders - programme managers (different systems organizations or individuals)	- group discussion
4. Sociology	4. Categorization of the types of organizations running each system	- Organizational Analysis (Mintzberg's classification from "Mintzberg on Management")	- opinion leaders - programme managers (different systems organizations or individuals)	- combined observations from 1 to 3
5. Anthropology	5. Assessment of the community managed response	- Qualitative Research Methods from WHO/ TDR "Workshop on Qualitative Research Methods" - S. Rifkin's and et al. "Community Participation Assessment"	- males, females adults - children	- key informants (political, health, agriculture, education...) - focus groups

APPENDIX 4A

KEY INFORMANTS QUESTIONNAIRE AT THE COMMUNITY LEVEL

CADRE D'ANALYSE NIVEAU DU DISTRICT (GRILLE D'ENQUETE)

QUESTIONNAIRES NIVEAU DES COMMUNAUTES

(\comburkq)

1. QUESTIONNAIRE GENERAL D'INFORMANTS-CLES

(Vers. 25.05.97)

VILLAGE OU VILLE (QUARTIER):

INFORMANT-CLE:

TITRE (respecter l'anonymat):

SYSTEME (ne pas remplir):

1.1. Quelles structures (formelles ou organisées de l'extérieures, i.e. Gouvernements, Projets... et communautaires ou organisations propres aux villageois) existent à présent pour réaliser au village des activités de développement dans des domaines tels que agriculture (agents), éducation (écoles), santé (Postes de Santé Primaires, agents de santé si ils existent...), autres?

Préciser la ou les activités pour chaque structure identifiée.

1.2. Il y a 10 ou 15 ans, est-ce que ce village s'est organisé pour mettre en place les Postes de Santé Primaires ("Opération 1 Village: 1 Poste de Santé Primaire"), c'est-à-dire formations de comités de santé, agents de santé communautaires, accoucheuses traditionnelles formées, caisses de médicaments etc.?

Si oui, comment est-ce que ce village s'est organisé (est-ce que cela a fonctionné longtemps ou non, est-ce que ça marche encor ou non etc.)? Préciser bienfaits pour la communauté et réussites ou échecs?

1.3. Est-ce que le SIDA est considéré comme un problème au village? Si oui: grave ou non? Pourquoi "grave"? (pas seulement les aspects médicaux)

1.4. A présent concernant le SIDA, est-ce que le village a pris des initiatives à partir de ses propres structures communautaires et/ ou a été associé par des structures de l'extérieur (contribution) ou a vu faire (observation seulement) des mesures particulières? Lesquelles (discussion, activités, organisation...)? Comment? Depuis combien de temps ces mesures ont été prises? Progrès et réussites? Echecs et leurs causes?

1.5. Lesquelles parmi ces structures communautaires et/ ou de l'extérieure pourraient être utiles dans le actions futures de lutte contre le SIDA? Préciser la ou les activités pour chaque structure identifiée.

2. QUESTIONNAIRE DETAILLE D'INFORMANTS-CLES

(Vers. 25.05.97)

VILLAGE OU VILLE (QUARTIER):

INFORMANT-CLE:

TITRE (respecter l'anonymat):

SYSTEME (ne pas remplir):

EVALUATION DES BESOINS:

2.1. Y-a-t-il eu des besoins identifiés ou évalués sur un aspect quelconque de développement (agriculture, éducation, santé...) au niveau du village par des structures intérieures ou par des structures externes?

2.2. En fonction de ces différents besoins qui a conçu les activités à mener: de structures intérieures ou communautaires ou de l'extérieur? Pourquoi?

2.3. Y-a-t-il eu des besoins identifiés ou évalués concernant le problème du VIH/ SIDA au niveau du village?

APPRECIATION GENERALE:

BON

OK

FAIBLE

PERSONNES INFLUENTES:

2.4. Quelles sont les personnes influentes dans le village? (noter hommes et femmes)

2.5. Ces personnes ont-elles de l'influence sur quels groupes? (très réduits, larges... préciser du groupe normal d'influence, en dehors du groupe direct de l'informant-clé)

2.6. Est-ce que les décisions des personnes influentes au village ou dans les quartiers sont prises en général en groupes ou bien autrement? Préciser comment avec 2 ou 3 exemples.

2.7. Comment (ou moyens utilisés?) les personnes influentes mobilisent-t-elles la communauté pour entreprendre des actions dans le village?

2.8. Est-ce que les personnes influentes ont fait mener des actions? Si oui, Lesquelles? Est-ce que certains groupes ont été lésés? Dans quels sens (pourquoi)?

2.9. Est-ce que d'après vous, les personnes influentes du village jouent-elles un rôle contre le problème du SIDA au village? Lequel?

2.10. Qui pourrait-être d'après vous la personne la plus influente pour trouver des solutions aux problèmes du SIDA au village et suivre les activités? Pourquoi cette personne?

APPRECIATION GENERALE:

BON

OK

FAIBLE

ORGANISATION: (Comment les buts sont-ils achevés?)
(Vers. 25.05.97)

2.11. Est-ce qu'il a une organisation communautaire qui existe ou se met en place quand il y a des problèmes graves de santé au village?

2.12. Pour le problème du SIDA, est-ce que le village a une organisation communautaire spécifique? Et en dehors du village, avec quelles structures externes travaillent les villageois?

Comment la structure communautaire a-t-elle vu le jour?

2.13. Comment la ou les organisation(s) présente(s) est ou sont-elle(s) financée(s)?

2.14. Quels groupes (par sexes, par tranches d'ages, par religions...) de la communauté sont impliqués dans cette organisation? Les membres du groupe sont-ils payés?

2.15. A-t-on besoin d'une structure (comité, agents, autres...) spéciale pour le SIDA au niveau du village? Si oui, préciser pourquoi?

APPRECIATION GENERALE:

BON

OK

FAIBLE

GESTION: (Comment est-ce que l'organisation communautaire réalise son but?)

2.16. Quelles sont les principales activités que votre communauté a accompli concernant le VIH/ SIDA et principaux obstacles?

2.17. Comment est-ce que celles-ci ont été accomplies: initiative propre, associé à d'autres de l'extérieur, imposées de l'extérieur, etc.?

2.18. Comment est-ce que l'on décide de l'allocation de ressources internes ou externes pour les activités du SIDA (par les personnes influentes, par des groupes, par des comités etc.)?

2.19. Est-ce que les agents communautaires (Agents de Santé Communautaires, animateurs/ trices Action Sociale, animateurs Villages...) participent à ces activités de lutte contre le SIDA? Si oui, comment?

2.20. Y-a-t-il des agents communautaires formés en VIH/ SIDA? Si oui, qu'est-ce qu'ils/ elles font?

APPRECIATION GENERALE:

BON

OK

FAIBLE

MOBILISER DES RESSOURCES:

2.21. Est-ce qu'il existe un moyen dans le village pour générer des ressources par les villageois pour leurs propres bénéfices (puits, eau, route, école, poste de santé etc.)?

Donner des exemples et quand (approximatif: année)?

2.22. Est-ce que les réalisations découlant de ces ressources profitent à tout le monde? (inégalités, de malentendus...)

2.23. Y-a-t-il des activités communautaires génératrices de ressources spécifiques à certains groupes du village? Quels groupes? Quelles activités?

2.24. Y-a-t-il un système pour aider les indigents (10% de collecte par exemple)?

2.25. En cas d'un problème grave au village (maladies, décès...) et de manque de moyens par la personne frappée, quelles ressources sont mises en jeu? (chercher type de solidarité existante: famille, proches, amis, écoles, religion, clans, aucun i.e. juste famille etc.)

2.26. Un père vient de mourir de SIDA. Sa femme élève actuellement toute seule ses 4 enfants, et elle a besoin d'aide pour plusieurs mois pour s'en sortir (culture de son champ, se rendre à l'hôpital, acheter des médicaments acheter des livres pour l'école...). Est-ce que la communauté va l'aider? Si oui, comment? Si non, pourquoi pas?

APPRECIATION GENERALE:

BON

OK

FAIBLE

APPENDIX 4B

**FOCUS GROUPS QUESTIONNAIRE FOR THE YOUTH
AT THE COMMUNITY LEVEL**

**QUESTIONNAIRE D'EVALUATION DES COMPORTEMENTS
PAR DISCUSSION DE GROUPES DIRIGEE:**

(Vers. 25.05.97)

POUR LES JEUNES GARÇONS (16 A 25 ANS) ET JEUNES FILLES (16 A 25 ANS):

3.1. Quels sont les principaux problèmes de santé que vous rencontrez dans le village?

3.2. Classez les par ordre de priorité (ou "il faut faire quelque chose tout de suite") d'après vous.

3.3. Est-ce que dans le village, vous pensez que le SIDA constitue un problème important?

3.4. Si oui, pourquoi le SIDA constitue-t-il un problème important?

3.5. Que peut-on faire d'autres pour éviter le SIDA? (citer)

3.6. Est-ce que le problème du SIDA est dû aux surtout aux comportements des jeunes hommes ou des jeunes femmes?

3.7. Est-ce que les garçons au village ont changé leurs comportements sexuels depuis la connaissance du SIDA? Si oui, en quoi faisant?
Et les filles? (même question)

3.8. Est-ce que l'utilisation de capotes lors de relations sexuelles est un bon moyen d'éviter le SIDA?

3.9. Est-ce que dans le village les jeunes utilisent ces capotes? Problèmes ou difficultés rencontrées (timidité, honte de demander, difficulté d'utilisation: lesquelles etc.)?

3.10. Est-ce qu'il est facile ou difficile d'avoir (d'acheter?) des capotes? Problèmes ou difficultés rencontrées (pas d'approvisionnement, pas de disponibilité, problème de coûts...)

3.11. Est-ce que des jeunes cherchent les informations sur les problèmes du SIDA, ou bien des Maladies Sexuellement Transmissibles, ou bien de Planning Familial? Est-ce qu'ils les trouvent disponibles? Auprès de qui (personnes? structures)? Ont-ils des difficultés pour les obtenir? Lesquelles?

3.12. Quelle structure ou personne est la mieux adaptée d'après vous pour vous fournir des informations sur le SIDA que vous cherchez?

APPENDIX 4C

VULNERABILITY FACTORS: ORIGINAL FINDINGS

FACTEURS DE VULNERABILITE PERSONNELLE

CONNAISSANCE DES MOYENS DE PREVENTION:

RURAL:

- "Il faut éviter le vagabondage sexuel et rester fidèle à sa femme" (un jeune homme de Banlo)
- "Si tu n'es pas fidèle à ton partenaire, c'est sûr que tu vas avoir le SIDA" (une jeune femme de Banlo)
- "Pour moi, il y a beaucoup de moyens qui peuvent permettre d'éviter le SIDA: il faut éviter d'utiliser les lames déjà utilisées par d'autres personnes, lorsque les ciseaux du coiffeur sont couverts de sang il faut les faire bouillir ou les brûler avant un autre usage, il faut porter les capotes pendant les rapports sexuels" (un jeune homme de Banlo)
- "... Pour moi, ce qu'il vient de dire c'est vrai parce qu'on ne peut pas cesser de faire la cour aux femmes donc il vaut mieux porter les capotes" (un jeune homme de Banlo)
- "En enjambant les urines d'un malade du SIDA on peut avoir le SIDA... et si un porc mange les selles d'un malade du SIDA et que l'on consomme sa viande, on peut avoir le SIDA" (une jeune femme de Banlo)
- "Celui qui utilise la capote, si elle est bonne c'est un bon moyen pour éviter le SIDA." (une jeune femme de Sidimoukar)

URBAIN:

- "Il faut éviter d'exciser plusieurs personnes avec le même matériel, éviter de recevoir du sang non examiné." (une jeune femme de Kampti)
- "(Le préservatif) c'est un bon moyen pour celui qui sait l'utiliser" (une jeune femme de Kampti)
- "C'est un bon moyen, mais il faut aussi un préservatif pour les femmes." (un jeune homme de Kampti)
- "Il faut s'abstenir" (une jeune femme de Gaoua)
- "Pour les accouchements, il faut faire attention et avoir tout son matériel nécessaire (gants, plastiques...) pour couvrir la table." (une jeune femme de Gaoua)

RECHERCHE D'INFORMATIONS DE PREVENTION:

RURAL:

- "C'est quand on a la maladie qu'on cherche des informations" (une jeune fille de Banlo)

URBAIN:

- "Il faut que l'on sensibilise la population sur l'utilisation des condoms. Avant nos parents de la brousse ignoraient le SIDA, mais avec la sensibilisation du PPI, ils se méfient actuellement des filles." (un jeune homme de Kampti)

CHANGEMENTS DE COMPORTEMENTS POSITIFS:

RURAL:

- "Ils (les jeunes hommes) ont changé de comportements parce qu'ils utilisent les capotes maintenant" (un jeune homme de Banlo)
- "Les jeunes filles ont changé leurs comportements, elles sont devenues fidèles..." (une jeune femme de Banlo)
- "Les jeunes hommes portent la capote parce que les filles l'exigent" (une jeune fille de Banlo)

Banlo)

- "Pour éviter le SIDA, moi je resterai fidèle." (un jeune homme de Sidimoukar)
- "J'accuse les garçons et les filles, car les deux se valent et sont frivoles. Certains garçons ne sont pas aussi fidèles et fréquentent plusieurs filles à la fois." (un jeune homme de Sidimoukar)
- "Moi j'accuse les grands aussi car certains ne suivent que les petites filles." (un jeune homme de Sidimoukar)
- "Moi j'ai changé de comportements: je reste fidèle à ma copine." (un jeune homme de Sidimoukar)
- "J'ai remarqué chez les jeunes qui ont reçu des conseils de comportements, que ceux qui "draguaient" à droite et à gauche ont arrêté par crainte de la maladie." (un jeune homme de Sidimoukar)

URBAIN:

- "Certains ont changé, d'autres pas: ceux qui ont changé ont peur et ont un seul partenaire, les autres s'en foutent du SIDA." (une jeune femme de Kampti)
- "Beaucoup ont changé de comportements. Quand nous étions petits, nos aînés disaient que le bon jeune c'est celui qui fait la cour à beaucoup de filles. On disait même qu'un vrai jeune doit contracter la gono. De nos jours ce n'est plus le cas. (un jeune homme de Gaoua)
- "C'est un bon moyen, sauf si c'est mal utilisé." (une jeune femme de Gaoua)

CHANGEMENTS DE COMPORTEMENTS NEGATIFS ET CROYANCES NEGATIVES: RURAL

- "Les jeunes hommes n'ont pas changé, ils ne peuvent même pas changer" (une jeune femme de Banlo)
- "... d'autres garçons n'ont pas changé du tout" (un jeune homme de Sidimoukar)
- "Certaines filles n'ont pas laissé leur infidélité parce qu'elles ne croient pas au SIDA." (une jeune fille de Sidimoukar)
- "Je n'ai pas confiance aux condoms car ce sont les blancs qui les fabriquent et ils peuvent y introduire la maladie qu'on peut contracter en les utilisant." (un jeune homme de Sidimoukar)

URBAIN

- "Actuellement nous n'avons plus confiance à nos copines, on a peur du mot SIDA." (un jeune homme de Kampti)
- "C'est une femme qui a introduit le SIDA dans le monde en couchant avec un singe. Les femmes construisent des chambres noires qui augmentent le SIDA." (une jeune femme de Kampti)
- "C'est dû aux hommes parce qu'il y a des hommes qui viennent de la Côte d'Ivoire atteints du SIDA et qui négocient une fille une fois dans la chambre, et refusent d'utiliser le préservatif." (une jeune femme de Kampti)
- "Une femme ne négocie pas un homme, c'est l'homme qui le fait et si il ne te dit pas qu'il est Sidéen qu'est-ce que tu vas faire?" (une jeune femme de Kampti)
- "Selon moi, c'est tout le monde, car certains ne sont pas sérieux et font le vagabondage sexuel" (un jeune homme de Kampti)
- "Il y a même des papas qui ont des femmes partout et des mamans qui ont des hommes partout: si on sensibilise ceux-ci, nous (les jeunes) nous serons aussi sensibilisés." (un jeune homme de Kampti)
- "Certains garçons disent que si tu ne meurs pas de SIDA, c'est que tu n'es pas beau."

(une jeune fille de Kampti)

- "Je trouve que l'infidélité règne beaucoup ici et j'accuse les filles car aujourd'hui elles sont avec toi et demain ailleurs." (un jeune homme de Kampti)
- "Beaucoup ne l'utilisent pas parce qu'ils trouvent que la fille est sérieuse." (une jeune femme de Kampti)
- "Seuls quelques uns l'utilisent ici." (une jeune femme de Kampti)
- "Elles n'ont pas du tout changé. A l'approche des fêtes, si une fille veut 10 paquets de mèche, elle fait la prostitution." (un jeune homme de Gaoua)
- "C'est surtout les garçons qui sont infidèles." (une jeune femme de Gaoua)
- "Certains hommes et certaines femmes ne veulent pas de capotes." (une jeune femme de Gaoua)
- "Les filles n'aiment pas utiliser la capote. Certaines filles pensent qu'avec la capote il n'y a pas de goût" (une jeune femme de Gaoua)
- "C'est dû aux comportements des filles qui disent qu'avec la capote, elles ne reçoivent pas tout le sperme car c'est le sperme qui met la fille en forme et que la capote fatigue seulement." (une jeune femme de Gaoua)
- "Garçons et filles, les deux sont infidèles" (une jeune femme de Gaoua)
- "C'est les deux sexes, car les hommes ne savent pas s'abstenir et les femmes non plus." (une jeune femme de Gaoua)

MAUVAISES EXPERIENCES:

RURAL:

- "Ce n'est pas tout à fait un bon moyen car il peut se percer, il faut donc s'abstenir" (un jeune homme de Banlo)
- "Il y en a qui utilisent la capote et tombent enceintes, alors pourquoi tu n'attraperas pas le SIDA si tu l'utilises?" (une jeune femme de Sidimoukar)
- "Selon moi ceux qui l'utilisent ne font pas une bonne chose. On voit des gens qui l'utilisent mais malgré cela leurs copines contractent une grossesse. Qu'est-ce qui prouve que le condom empêche le SIDA?" (un jeune homme de Sidimoukar)

URBAIN:

- "Les filles n'ont pas changé, car si un homme vient de l'extérieur avec une 404 et leur donne un rendez-vous puisque c'est l'argent qu'elles veulent, si cet homme est atteint de SIDA, elle sera également atteinte: c'est ce que l'on voit à Kampti." (un jeune homme de Kampti)
- "On a des problèmes pour le mettre car il pète souvent, certains le mettent à l'envers, d'autres disent qu'une fois placé il peut sortir" (un jeune homme de Kampti)
- "Moi j'ai fait beaucoup de démonstrations sur le port du condom pendant les sensibilisations, mais en l'utilisant une fois elle s'est éclatée avec moi." (un jeune homme de Gaoua)
- "J'ai fait une expérience. En mettant de l'eau dans une capote et lorsque j'ai attaché le bout de la capote et que je l'ai déposé sur un miroir, le lendemain j'ai trouvé des gouttelettes d'eau entre la capote et le miroir. Donc elle est perméable." (un jeune homme de Gaoua)
- "En mettant le doigt dans du piment, si on remt ce doigt dans la capote et qu'on la passe devant les yeux, le piment vous pique, donc elle est perméable." (un jeune homme de Gaoua)

FACTEURS DE VULNERABILITE EN RELATION AUX SERVICES ET PROGRAMMES

FAIBLESSE DES SERVICES:

RURAL:

- "La capote constitue le seul remède contre le SIDA, mais il faut attirer l'attention des commerçants sur les conditions de conservation car ils sont parfois exposés au soleil" (un jeune homme de Banlo)
- "Je ne sais pas si c'est bien ou pas parce que je ne l'ai pas utilisé. Je n'ai plus confiance aux condoms car ils sont adaptés aux climats des pays qui les fabriquent et non les nôtres: la température peut les détériorer." (un jeune homme de Sidimoukar)
- "... il faut seulement qu'on évite les ruptures de stock" (un jeune homme de Banlo)

URBAIN:

- "Nous sommes à la frontière et beaucoup de nos frères sont en Côte d'Ivoire, le pays le plus touché de la région, et le car vient chaque vendredi d'Abidjan. Il faut que les gens fassent des test et qu'on aide les malades." (un jeune homme de Kampti)
- "Oui il est utilisé ici, parfois même il y a un manque de préservatifs dans les boutiques parce que les gens l'achètent beaucoup et ça finit." (un jeune homme de Kampti)
- "Il n'a pas de coins pour les MST, c'est uniquement sur le SIDA ici à Kampti." (un jeune homme de Kampti)
- "...Actuellement je suis plus informé sur le SIDA que la gonococcie dont je ne connais même pas toutes les voies de transmission. (un jeune homme de Kampti)

ACCESSIBILITE AUX SERVICES D'INFORMATIONS SUR LE VIH/ SIDA:

RURAL:

- "Le lieu d'informations est loin, ce n'est pas facile: il serait souhaitable qu'on nous envoie quelqu'un qui nous donne ces informations ici" (une jeune femme de Banlo)
- "Il serait intéressant qu'on vienne nous apprendre comment porter la capote" (parce que certains ne savent pas comment l'utiliser) (un jeune homme de Banlo)
- "Les jeunes ne cherchent pas d'informations sur le SIDA et les MST, parce qu'ils ne savent pas à quelle structure s'adresser" (un jeune homme de Sidimoukar)
- "Nous nous informons entre jeunes pour le moment en attendant d'avoir au village des personnes qui sont en mesure de nous informer." (un jeune homme de Sidimoukar)
- "Nous ne connaissons pas d'autres personnes en dehors des agents de santé pour nous offrir des informations sur le SIDA." (un jeune homme de Sidimoukar)
- Il faut que quelqu'un vienne d'ailleurs pour nous informer." (une jeune femme de Sidimoukar)

URBAIN:

- "C'est un problème important parce qu'on veut s'informer mais on ne sait pas où le faire." (une jeune femme de Kampti)
- "Le problème est très sérieux parce que la sensibilisation est moindre, surtout pour nos soeurs." (un jeune homme de Kampti)
- "Il y a des fois des infirmiers qui viennent nous sensibiliser sur le SIDA." (un jeune homme de Kampti)
- "Je ne cherche pas d'informations parce que je ne sais pas à qui les demander." (une jeune femme de Kampti)
- "Les jeunes cherchent des informations sur le SIDA car beaucoup lisent à Kampti le

livret SIDA-STOP” (un jeune homme de Kampti)

- “On a participé à une Conférence organisée par les jeunes où on a abordé le SIDA avec quelqu’un venu de Ouagadougou.” (un jeune homme de Kampti)

- “Si on projette un film vidéo sur le SIDA, les jeunes y affluent” (un jeune homme de Kampti)

- “Il y a une place vers le Marché de Kampti, où on pouvait avoir des informations sur le SIDA, j’y voyais beaucoup de jeunes.” (un jeune homme de Kampti)

- “Je ne suis pas d’accord pour le cas du Docteur car nos parents des villages n’ont pas le courage de s’adresser à un Docteur. Donc il faut des agents de sensibilisation qui parcourent tous les villages. De plus le Docteur n’est pas disponible, il a son travail.” (un jeune homme de Kampti)

- “Il faut quelqu’un de Kampti pour nous sensibiliser parce que tout le monde le connaît” (un jeune homme de Kampti)

- “Avant il y avait un groupe de théâtre chargé de la sensibilisation contre le SIDA donc il faut que ce groupe revive” (un jeune homme de Kampti)

- “Quand elles vont dans les SMI, les jeunes cherchent des informations.” (une jeune femme de Gaoua)- “Les jeunes cherchent des informations entre amies à l’école.” (une jeune femme de Gaoua)

- “Les Docteurs ou les infirmiers, et là on peut croire.” (une jeune femme de Gaoua)

- “Ce sont les infirmiers qui connaissent ça très bien.” (une jeune femme de Gaoua)

ACCESSIBILITE GEOGRAPHIQUE A LA PREVENTION (préservatifs, tests):

RURAL:

- “Il est facile à avoir, dans la ville il y a un boutiquier qui le vend” (un jeune homme de Banlo)

- “Il faut aller à Bouroum-Bouroum pour l’avoir” (une jeune femme de Banlo)

- “Il y en a plein ici au PSP.” (un jeune homme de Sidimoukar)

URBAIN:

- “Ici les gens ne font pas de test pour savoir si ils ont la maladie, il n’existe pas un Centre pour ça” (un jeune homme de Kampti)

- “Si on part dans les boutiques pour l’acheter, certains trouvent qu’on est trop jeune et on est obligé de mentir que c’est pour notre frère.” (un jeune homme de Kampti)

- “Si on va pour l’acheter en boutique, on se gêne car les boutiquiers sont nos parents, et on a des problèmes pour le payer” (un jeune homme de Kampti)

- “Souvent il est facile de l’avoir, souvent il est difficile, quand ça manque le réapprovisionnement se fait lentement car les condoms viennent de Gaoua ou Ouagadougou.” (un jeune homme de Kampti)

- “Certains font le trafic de condoms sur la Côte d’Ivoire parce que là-bas il coûte plus cher. Si on pouvait ouvrir un centre ici, cela pourrait diminuer le problème de ruptures. (un jeune homme de Kampti)

- “Oui, c’est facile d’en avoir, on en trouve dans les boutiques.” (une jeune femme de Gaoua)

ACCESSIBILITE FINANCIERE A LA PREVENTION (ACHAT DU CONDOM):

RURAL:

- "Le prix est abordable..." (un jeune homme de Banlo)
- "Il est cher, le paquet fait 50 fr. et lorsque tu n'as pas d'argent, tu restes toujours exposé" (un jeune homme de Banlo)
- "Mon inquiétude c'est qu'il y des jours où l'on n'est pas en mesure de l'acheter par manque d'argent" (un jeune homme de Banlo)
- "Ce n'est pas un problème de femmes (que d'acheter les condoms) je n'ai aucune idée du prix" (une jeune femme de Banlo)
- "Comme la femme ne porte pas de capotes, je ne connais pas le prix" (une jeune femme de Banlo)
- "... et ce n'est pas cher, environ 15 F CFA l'unité." (un jeune homme de Sidimoukar)
- "C'est disponible pour ceux qui en ont besoin mais c'est cher, 50 F. CFA (le paquet) (une jeune femme de Sidimoukar)

URBAIN:

- "Le jour de la sensibilisation, les jeunes luttent pour l'avoir gratuitement." (un jeune homme de Kampti)
- "Avant on le vendait au détail (10 f/ l'unité) et maintenant on vend plus que le paquet à 50 f. et pour quelqu'un qui n'a pas 50f., c'est dur." (un jeune homme de Kampti)
- "Pour moi on devrait diminuer le prix pour que beaucoup de gens puissent l'avoir, même à 5 f. je suis d'accord" (un jeune homme de Kampti)
- "Si on diminue le prix, ça peut encourager les gens à l'acheter beaucoup, ce n'est pas à ma portée, on peut le faire à 25 f. le paquet" (un jeune homme de Kampti)
- "Il faut diminuer le prix du paquet à 25 au lieu de 50 f." (une jeune femme de Gaoua)
- "En tout cas pour ce fléau qui est en train de ravager le monde, il doit être distribué gratuitement." (un jeune homme de Gaoua)

ACCESSIBILITE FINANCIERE AUX SOINS:

RURAL:

- "Si on n'a pas d'argent, on ne peut pas se soigner dans un service de santé: la pauvreté en elle-même est une maladie" (une jeune femme de Banlo)

FACTEURS SOCIAUX ET ECONOMIQUES

IMPACT MORTEL DE LA MALADIE:

RURAL:

- "C'est un problème important parce qu'il a tué beaucoup de jeunes dans le village: au moins 5 personnes" (un jeune homme de Banlo)
- "Lorsqu'on a le SIDA, on est condamné à mourir" (une jeune femme de Banlo)
- "Tous ceux qui ont eu le SIDA en sont morts" (une jeune femme de Banlo)
- "Le SIDA a tué beaucoup de gens dans le village: femmes comme hommes (une jeune femme de Banlo)
- "C'est un problème parce que j'ai vu des Sidéens ici et si ça continue nous sommes foutus. J'ai connu 5 personnes mortes de SIDA à Sidimoukar." (un jeune homme de Sidimoukar)
- "Il (le SIDA) a tué 3 hommes et 4 femmes" (une jeune femme de Sidimoukar)
- "Le SIDA n'est pas bien parce qu'on ne peut le soigner." (une jeune femme de Sidimoukar)

URBAIN:

- "On trouve ici beaucoup de malades du SIDA, il fait souffrir les gens, il les fait maigrir." (un jeune homme de Kampti)
- "Le SIDA est grave à Gongone (quartier enquêté de Kampti), il y en a beaucoup qui sont morts de SIDA, il y en aura encore parce qu'il y a beaucoup de malades actuellement." (une jeune femme de Kampti)
- "...A Loropéni (un village à quelques kms. de Kampti), il y a une soixante de cas de SIDA." (un jeune homme de Kampti)
- "C'est un problème de santé au niveau du Secteur 3 à Gaoua, parce que ça a fait beaucoup de décès." (une jeune femme de Gaoua)

IMPACT FINANCIER DE LA MALADIE:

RURAL:

- "Tu dépenses ta fortune avant de mourir" (une jeune femme de Banlo)
- "C'est une maladie qui amène aussi la pauvreté parce que quand ces gens sont malades, leurs parents bien portants ne peuvent plus travailler" (un jeune homme de Banlo)

URBAIN:

- "A Cause du SIDA certains bras valides ont disparu alors qu'ils constituaient des éléments importants pour leurs familles et la société." (un jeune homme de Banlo)

IMPACT SUR LA POPULATION:

RURAL:

- "le SIDA diminue le nombre de la population car il tue les jeunes qui sont appelés à faire des enfants" (une jeune femme de Banlo)

IMPACT SUR LE DEVELOPPEMENT:

RURAL:

- "Le SIDA est un problème de santé ici parce que ce sont les jeunes qui sont chargés de développer le village et ce sont eux qui sont les plus frappés par la maladie: alors qui va cultiver les champs? Qui développera le village?" (un jeune homme de Sidimoukar)
- "Ce sont les jeunes qui ont des idées pour le village et ils meurent. Notre village ne se

développera pas.” (un jeune homme de Sidimoukar)

IMPACT SUR LE SOUTIEN FAMILIAL TRADITIONNEL:

RURAL:

- “le SIDA tue beaucoup de jeunes qui sont les travailleurs des vieux” (un jeune homme de Banlo)

URBAIN:

- “C’est dangereux le SIDA car le jeune qui l’a abandonné ses enfants avec leurs mères qui a de la peine à s’occuper de ceux-ci” (un jeune homme de Kampti)

IMPACT DE SOUFFRANCE HUMAINE:

RURAL:

- “Si le SIDA attrape quelqu’un, il souffre beaucoup avant de mourir et la famille souffre aussi parce qu’elle voit leurs parents mourir.” (une jeune femme de Sidimoukar)

URBAIN:

- “C’est un problème important parce que nos frères et soeurs viennent de Côte d’Ivoire et meurent du SIDA sous nos yeux impuissants” (une jeune femme de Kampti)

- “C’est un vrai problème, j’avais des amis qui ne sont plus, quand je pense à cela ça me travaille.” (un jeune homme de Gaoua)

NORMES CULTURELLES ET SEXISME:

RURAL:

- “Aujourd’hui les filles ne sont pas sérieuses, elles peuvent se rendre à Gaoua pour établir leurs pièces d’identité et partir pour la Côte d’Ivoire où elles peuvent avoir le SIDA avant de revenir le transmettre à ceux qui les épousent au village.” (un jeune homme de Banlo)

- “C’est surtout (dû aux comportements des) filles, elles se croient éveillées, n’écoutent pas leurs parents et se rendent en Côte d’Ivoire, comme elles y sont entretenues par des hommes qui ont le SIDA...” (un jeune homme de Banlo)

- “C’est une maladie qui passe de la femme à l’homme.” (un jeune homme de Sidimoukar)

URBAIN:

- “Ce sont surtout les filles car elles ‘servent’ trop, c’est-à-dire qu’elles ne sont pas fidèles.” (un jeune homme de Kampti)

- “Ce sont surtout les filles qui maigrissent et qui vomissent tout le temps.” (un jeune homme de Kampti)

- “La plupart du temps le garçon est fidèle, mais les filles se vendent et propagent le SIDA.” (un jeune homme de Gaoua)

AUTRES NORMES:

RURAL:

- “Certains disent qu’ils ont honte de l’utiliser mais je pense que c’est parce qu’ils ne savent pas l’utiliser...” (un jeune homme de Banlo)

- “Pour moi c’est une maladie des jeunes: ce sont eux qui se promènent et vont en Côte d’Ivoire et donc à eux de s’informer” (un jeune homme de Banlo)

FORCES SOCIALES ET STIGMATISATION:

RURAL:

- "...au village ici les filles se moquent des malades du SIDA donc il faut tout faire pour ne pas l'avoir" (une jeune femme de Banlo)
- "Il ne faut pas manger avec un Sidéen." (une jeune femme de Sidimoukar)
- "Il faut éviter de manger la nourriture qu'un Sidéen a préparé parce qu'il peut mettre ses urines ou ses selles dans le repas." (une jeune femme de Sidimoukar)
- "Personne n'ose remarier une veuve du SIDA." (un jeune homme de Sidimoukar)

URBAIN:

- "Il faut s'éloigner du Sidéen." (une jeune femme de Kampti)

APPENDIX 4D

GENERAL QUESTIONNAIRE AT THE DISTRICT LEVEL

Key Approaches, Purposes, and General Sample Questions for the Local Level
(Vers. 21.04.97)

1. Assessment of the present performance of each system

- 1.1 Auto assessment by each system of its own performance, based on documents and available information, using existing indicators
- 1.2 External review of the above assessment, using the above and other existing external evaluations or reports (only for health and community organization)
- 1.3 Assessment of the existing capacity and the tools used to carry out cost analysis, e.g. cost-effectiveness analysis. If not, existing what is the potential for setting up a costing system?
- 1.4 If cost-effectiveness analysis exists, what are the tools used to carry out sustainability analysis? If not done, what is the potential to set up such a system?
- 1.5 Assessment of the monitoring system for behavioral changes and evaluation of the existing capacity to set up such a system

2. Position Map with the self-analysis of and other organizations roles from different district systems' leaders opinions

(questions based on the findings of new policy decisions relating to an improved HIV/AIDS response at a district level; a sample checklist of specific problems)
(based on M. Reich's "Political Mapping of Health Policy", Jun. 1994)

- 2.1 What has been your role for the past five years in response to the HIV/AIDS in the district ?
- 2.2 What is your present role in response to HIV/AIDS in the district? If positive, what are the main enabling factors?
- 2.3 How do you foresee your role (and strategies) to an improved response to HIV/AIDS in your district for the next 3-5 years? (probe for each system, if necessary)
- 2.4 Do you think you can achieve this, if not what are the main constraints?
- 2.5 What is your organization's position on the proposed decision: support, opposition, or non-mobilized?
- 2.6 How strong is your organization's position on the proposed decision: high, medium, or low?
- 2.7 Which organizations are supporting the proposed decision? (high, medium, and low opposition)
- 2.8 Which major organizations have not taken positions on the proposed decision (non-mobilized)?

3. Stakeholder analysis for an improved response, Policy Network Map, and Transitions Assessment: priorities for organizations or individuals, based on various units of analysis of the sample checklist of specific problems
(Appendix C)

(based on M. Reich's "Political Mapping of Health Policy", Jun. 1994)

STAKEHOLDER ANALYSIS:

- 3.1 What are the main objectives or interests of your of your organization in the proposed policy decision? (Each organization or individuals (units of analysis) within their own system rank themselves (high, medium, low) in relation to their present positions to the HIV/AIDS district response policy)
- 3.2 How important to the organization are those interests in the proposed decision: high, medium, or low priority? (Each organization or individual prioritize by order (1, 2, 3) the three most important questions/ issues of the checklist of its own system: specify which are the main constraining factors, and which main enabling factors would help to overcome the problem(s))
- 3.3 What would the organization be willing to accept at a minimum from the proposed decision?
- 3.4 What are the main interests in the decision of another involved organization? (and Each organization or individuals (units of analysis) rank (high, medium, low) the other systems as a whole)
- 3.5 Each organization or individual prioritize by order the three most important actors (units of analysis) of the checklists of the other systems: specify for each the main enabling and constraining factors

POLICY NETWORK MAP:

- 3.6 Which organizations affect your organization on the proposed decision? How strong is the influence and what are the main forms of influence (finances, information, people)?
- 3.7 Which other organizations does your organization influence on the proposed decision? How strong is the influence? What are the main forms onf influence (finances, information, people)?

TRANSITIONS ASSESSMENT:

- 3.8 What current transitions are occurring in the group or project responsible for implementation of the proposed decision?
- 3.9 What current transitions are occurring in the major organizations likely to be affected by the proposed decision?
- 3.10 What current transitions are occurring the broader political and economic and health (sector reform) environment that could affect the proposed decision?

4. Categorizing the types of organizations running each system

based on "Mintzberg on Management Inside our Strange World of Organizations," 1989)

4.1 External final assessment and classification of the type of organizations running each system (entrepreneurial, machine, diversified, professional, innovative / adhocracy, ideology and missionary, politics and political)

4.2 Consequences in terms of management and organizational set-up

5. Assessment of the community managed response

(specific, for the "Communities Organization System" based on WHO/ TDR "Qualitative research Methods", Resource Paper No. 3, and for 5.4 based on the new approach to community participation assessment Bjaras, Haglund, Rifkin, Health Promotion International 1991)

5.1 Assessment of the communities' roles in response to HIV/AIDS (ref 1.1, 1.2, 1.3)

5.2 Which systems could help you most in the future in improving the response to HIV/AIDS and why?

5.3 What are the three major positive aspects, your community has accomplished to improve the response to HIV/AIDS and what are the three major obstacles?

5.4 Assessment of the degree of present community participation based on the ranking of the following process indicators

- needs assessment
- leadership
- organization
- resource mobilization
- management

5.5 Optional (for countries with an advanced reporting system in place already, i.e. Uganda ...): setting up of a sensitive surveillance system for monitoring the diffusion of new norms of behavior, and attitudes in relation to utilization and quality of HIV/AIDS services in the health but other systems as well, using semi-structured interviews at the village level.

ANNEXE 5A
MATRIX TO DESCRIBE VULNERABLE POPULATIONS
RESULTATS DES TRAVAUX DU GROUPE TECHNIQUE: MATRICE POUR DECRIRE LES POPULATIONS CIBLES

Cibles	Taille	Comportement à risque	Facteurs influençant les risques d'infection	Possibilité que la population s'infecte ou infecte les autres (E,M,I,F)	Importance relative	Intervention présentes	Intervention futures
1. Les jeunes	30 % de la population	Précocité des rapports sexuels non protégés partenaires multiples	Harcelement sexuel Lévirat Migrations l'excision consommation d'euphorisants	Elevée	primaire	Formation des volontaires communautaires jeu radiophonique Magasins radio-diffusés theatres dans les village Distribution de boites à images au FS et aux association Causeries et projection de film	Apprécier l'importance relative des interventions présentes Impliquer de nouveaux partenaires s'informer sur ce qui se fait avec les service agricoles(Ver de guinée VIH/SIDA)
2. Les femmes en âge de procréer	22,8 % de la population	Idem aux comportement des jeunes	Idem aux facteurs des jeunes Accouchement septiques Mariages précoces la polygamie	Elevée primaire	Idem aux intervention pour les jeunes	Idem aux actions futures pour les jeunes	
3. Patients MST							
4. Migrants							
5. Orphelins							
6. Militaires							
7. Routiers							
8. Prisonniers							
9. Personnes ayant le VIH							
10. Prostituéés							

APPENDIX 5B

SYNTHESIS TABLE

TABLEAU DE SYNTHESE (PLANIFICATION ET CONSENSUS) DES 5 OBJECTIFS PRIORITAIRES DE LA REPONSE ELARGIE AU VIH/ SIDA 1998-2000/ 2003: DISTRICT DE GAOUA, BURKINA FASO

Chaque représentant d'une institution ou organisation, devait pour chaque objectif prioritaire, stratégie et intervention définir son apport en terme de:

- 1 - Apport d'expériences
- 2 - Apport de compétences (ressources humaines qualifiées et disponibles)
- 3 - Apport de moyens didactiques
- 4 - Apport de moyens matériels
- 5 - Apport de moyens financiers
- 6 - Mise en oeuvre d'une stratégie ou intervention déjà planifiée.
- 7 - Appui dans la mobilisation des populations

Tableau de synthèse de l'objectif prioritaire 1

OBJECTIF PRIORITAIRE 1	Intervenants (objectifs1)			
La prévention de l'infection VIH dans les groupes cibles est assurée	ONUSIDA 5	GTZ 1,2		
	PROMACO 1,2,3,4, 6	CNLS 2,3,4,6		
Stratégies Objectifs 1	Intervenants (Stratégies Objectifs 1)			
Promouvoir l'adoption de comportement sexuel Sûrs chez les jeunes de moins de 35 et les femmes en âge de procéder	CNLS 4,2		GTZ 1,2,3,6	
Promouvoir les comportements sexuels sûrs au sein des jeunes et des migrants				
Rendre disponibles les préservatifs dans la communauté	GTZ/PPF 6	ECD/FS 6	<u>PROMACO</u> 6	PIB 6
Impliquer les personnes vivant avec le VIH dans les activités IEC et conseils (témoignage)				
Education des jeunes par des jeunes	Croix rouge 1,2,7	PIB 4-6	Coeur vaillants 7	
	<u>Jeunesse sport</u> 7	Scouts 1,7,2		
Education des femmes par des femmes (groupements association)	Scouts 7	ABBEF 1,2,7	<u>APFG</u> 1,2,7	

NB: Les mots ou sigles soulignés désignent le chef de file de la stratégie ou de l'intervention.

Les chiffres au bas ou à côté des mots ou sigles indiquent le domaine dans lequel le partenaire peut s'engager. Par exemple l'ONU/SIDA se propose d'intervenir pour le financement (5) de l'objectif prioritaire 1.

Par contre pour le même objectif prioritaire la GTZ apportera de l'expérience (1) et des compétences (2).

Tableau de synthèse de l'objectif prioritaire 1 (suite et fin)

Interventions sur l'objectif prioritaire 1	Intervenants
	Objectifs
Poursuivre la sensibilisation sur les moyens de protection contre l'infection du VIH/SIDA	<p>Agri 7 Resp. Sect3 7 Commun.,Cath. Mobilisation 7 Scouts 2-7</p> <p>Pénitencier 7 APFG 1 RG 7 Enseig. Sécon. 2</p> <p>PIB 1,3,5,6,2 APASP 7,6 AHPG 7 APFG 6</p> <p>+ rouge Prim. 7 Prefet 7 ECD (Stand Santé) 6 enseig. 2</p> <p><u>CRESA/DRS</u> ATEFO FILPAH</p> <p>Jeu. Sport 1,2 6,7,2 2</p> <p>PROMACO Action social 6 Resp musul. 7 ABBEF 2,7</p>
Informers les populations sur les voies de transmission du VIH dans leur milieu	<p>PIB 2,1,6,5 <u>R.G</u> 4,7+1 GTZ/PPF 3</p> <p>Assoc.pr Epanuis- sement enfance au Poni 7 ECD/PF 1,3,4 APFG 2</p> <p>Scouts 1,7 trpe théat. 7 + rouge 2,1</p>
Encourager la population à faire le test	<p>CHR 2,6 SCOUT 2 APASP 7 Trpe Théat. 2</p> <p>Club Unesco 7 R.G 2 Action sociale 6</p>
Les jeunes et les migrants sont informés sur les voies de transmission du VIH/SIDA en leur milieu	<p>Préfet 7 R.G 4+7-1</p> <p>Jeunesse et sport 7 PIB 3,5,6</p>

Tableau de synthèse de l'objectif prioritaire 2

Objectif prioritaire 2	Intervenant Objectifs (priorité) 2	
La participation multi sectorielle et communautaire est assurée	CNLS 1	GTZ 1,2,4,5,6 Accompagnement du processus de reponse élargie
	ONUSIDA 5	PSD 2
Stratégies sur l'objectif prioritaire 2	Intervenants strategies/objectif 2	
Les ONG et les agents techniques travaillent en collaboration avec la communauté		
Impliquer l'ensemble des secteurs de développement à la lutte contre le SIDA	<u>ECD</u> 6	
Intervention sur l'objectif prioritaire 2	Intervenants	
Améliorer la communication entre les secteurs en vue de la lutte contre le VIH/SIDA	PIB 2-6	
Evaluer le niveau des interventions dans la lutte contre le VIH/SIDA	CRESA/DRS Appui 1-6	PSD 2
Impliquer les responsables politico-administratifs dans l'encadrement des intervenants		
Mettre en place dans le District un organe efficace multisectoriel et communautaire de coordination des interventions de lutte contre le VIH/SIDA		

Tableau de synthèse de l'objectif prioritaire 3

Objectif prioritaire 3	Intervenant Objectifs 3	
Les soins et les conseils en matière de MST/SIDA sont assurés (FS et communauté)	GTZ 1,2,3,6	<u>ECD</u> 2,3
	ONUSIDA 5	CNLS 1;5
Stratégies sur l'objectif prioritaire 3	Interveants	
Responsabiliser la médecine traditionnelle	Préfet 2;7	<u>mairie</u> 4,7
Former le personnel de santé sur la prise en charge des patients MST/SIDA	P I B 5	<u>ECD</u> 2;3
Former les agents d'animation aux techniques de counselling pour la prise en charge	P I B 5	Action sociale 2
Former le personnel de santé en counselling pour la prise en charge	P I B 6	<u>ECD</u> 2;3
Assurer une surveillance chez les enfants nés de mères seropositives	Action Sociale 2	CHR 1,2
Interventions sur objectif prioritaire 3	Intervenants	
Améliorer les compétences des agents de santé sur la prise en charge des MST/SIDA	N E A N T	
Rendre disponible le test VIH		

Tableau de synthèse de l'objectif prioritaire 4

Objectif prioritaire 4	Intervenants objectif 4			
Le SIDA est ressenti comme priorité par les groupes cibles (importance, gravité, comportements à risque)	GTZ 1,2,4	PROMACO 6	CNLS 2,3	
	ONUSIDA 5	ECD/CHR 6		
Stratégies sur objectif prioritaire 4	Intervenants stratégie/objectif			
Informations des personnes ressources sur le VIH				
Mise à jour et diffusion régulières sur l'évolution de la prévalence VIH/SIDA et de ses conséquences	ABBEF 1-7	Mairie 4 7	Scouts 7-1	Préfet 7
renforcement des capacités de l'IEC d'exposer le problème du VIH/SIDA	Trpe théat. 1	APASP 7	<u>Action sociale</u> 2	
Interventions sur objectif 4	Intervenants			
Mettre en place un mécanisme de coordination entre ECD et secteur Privé pour un plaidoyer VIH/SIDA				

Tableau de synthèse de l'objectif prioritaire 5

Objectif prioritaire 5	Intervenants sur objectifs 5			
L'impact socio-économique du SIDA et des MST est réduit dans le District	ONUSIDA 5	CNLS 2	GTZ 1,2,3,6	
Stratégies sur objectif 5	Intervenants			
Développer des stratégies pour favoriser un comportement social qui démystifie le SIDA Promouvoir des activités pour réduire les conséquences socio-économiques du VIH/SIDA Mettre en place une stratégie de suivi et de prise en charge des enfants orphelins du SIDA	NEANT			
Interventions sur objectif prioritaire 5	Intervenants			
Apporter un soutien social aux personnes atteintes, leurs familles	<u>Act. sociale</u> 2	APASP 7	Eglise catholi. 4	ECD (Ajout santé) 6
IEC sur la séropositivité				
IEC MST pour population	<u>PROMACO</u> 1,2,6			
Appuyer les activités génératrices de revenus pour les familles affectées par le VIH				

APPENDIX 5C

EXPLANATORY FACT SHEET OF THE FRAMEWORK FOR THE TOOLS USED FOR THE IMPLEMENTATION OF THE HEALTH REFORM AND HIV AGENDA IN VARIOUS NATIONAL SETTINGS (version of 19.2.99)

Update of: day/ mo./year

1. Tool Category: (select one)

1. to conduct a situation analysis (sectorial, community...)
2. to assess the institutions' and sectors' roles and capacities
3. to assess the existing policies vs. needs and realities
4. to calculate intervention costs
5. to mobilise resources
6. to monitor and evaluate the program

2. Tool Name: Self-explanatory

3. Purpose and Objectives of the Tool: Self-explanatory

4. Level(s) of Application: National, Regional/ Provincial, District/ Local, Communities

5. Description of Methods: Brief type of methodology used

6. Contribution to Programme Planning, Monitoring and Evaluation:

How is the tool contributing to the determination of planning and/ or monitoring and/ or evaluation?
How are results fed back to the informants (individuals, communities, institutions...)?

7. Role in the Determination of Strategies and Interventions:

How is the tool contributing to the determination of strategies and interventions?

8. Advantages: of using this tool

9. Limitations: of using this tool

10. Primary Users: of this tool

11. Preferred or Suggested Technical Background and Training for Users of Tool:

Expertise or technical background preferred to use the tool
Time requested for training the user(s) (if accomplished)

12. Resources Needed to Apply the Tools: Time, human resources, cars, computers ...

13. Used by and Location:

Institutional: Ministry, Agency...
Geographical: Country, District...

14. Original References:

Original document/ report etc. full reference. (number of pages)
Sources for availability (ref. ordering through Agency or Web-site address below)

15. Source of Technical Advice:

Name and e-mail or other contacts for technical purposes

NOTA: The tool may be obtained from the following web address: UNAIDS.ORG/PSR
pointing to "Reform HIV"

16. Tool Summary Description:

1-2 pages max. (Content and others, including Additional References related to the Tool)

APPENDIX 5D
SUMMARY TABLES OF SIX CATEGORIES OF KEY TOOLS FOR THE IMPLEMENTATION OF
THE HEALTH REFORM AND HIV AGENDA IN VARIOUS NATIONAL SETTINGS
(vers. Update 19.2.1999)

CATEGORIES OF TOOLS:	TOOLS REFERENCES:
<p>1. Situation Analysis see attached detailed outline</p>	<p>1.1. Guide to the Strategic Planning Process for a National Response to HIV/ AIDS: Situation Analysis. UNAIDS, Module 1</p> <p>1.2. Guide to the Strategic Planning Process for a National Response to HIV/ AIDS: Strategic Plan Formulation. UNAIDS, Module 3</p> <p>1.3. Strengthening health management in districts and provinces (AIDS technical function), A. Cassels and K. Janowsky (Additional specific situation analysis are documented in Categories 2 to 6 as well)</p>
<p>Reference List of additional tools either existing or in development</p>	<p>“Situation analysis for a district HIV/ AIDS programme” Ties Boerma and Marc Urassa, in HIV prevention and AIDS care in Africa. A district level approach. Japhet Ng’weshemi et al. Ed. Royal Tropical Institute-The Netherlands 1997</p> <p>Rapport Initiative ONUSIDA/ OMS/ GTZ de Riposte Elargie au niveau du District. Etude de Cas du Burkina Faso (District de Gaoua). C. Pervilhac. Mai/ Juin 1997</p> <p>Report on the District Expanded Response Initiative (DRI) UNAIDS/ WHO/ GTZ, Case-Study of Kabarole District, the Republic of Uganda, Vol. 1 Report, Vol. 2 Detailed Documentation of Study Findings and Questionnaires, C. Pervilhac et al., Dec. 1997</p> <p>“Patterns of HIV Spread in the Four Districts” (Participatory Rural Appraisal (PRA) methods), The Zambian HIV/ AIDS District Response Initiative. An Assessment of Four Districts in Zambia. James K. Sulwe. March 1998</p> <p>“Guidelines for conducting a review of a National Tuberculosis Programme” WHO/TB/98.240. WHO. 1998 (AIDS Programme identified as a potential site for field visit)</p> <p>“Young people and HIV/ AIDS: Background discussion paper on the elements of a global strategy” Programme Coordinating Board (UNAIDS/PCB(7)98.3. 21 October 1998) with a detailed list of 7 sets of action (policies, participation, peer and youth groups, parents and policy-makers and media and religious organisations mobilisation, school programmes, youth-friendly health services, orphans and young people living with HIV/ AIDS)</p>

	<p>Rapid Assessment of the Continuum of Care of PLHA and Chronically Ill Patients in Botswana, AIDS/ STD Unit in collaboration with WHO, July 1998, E. Van Praag et al.</p> <p>Tools and Methods for Health System Assessment: Inventory and Review. WHO Div. of Analysis, Research and Assessment. WHO/ ARA/ 98.4. 1998. Phyllida Travis and David Weakliam.</p> <p>Vulnerable Groups, UNAIDS (in development, to be published in 1999)</p> <p>Mainstreaming Gender into National Strategic Plans, UNAIDS (in development, to be published in 1999)</p> <p>Key Questions to issues relating to Human Rights UNAIDS (in development)</p> <p>Rapid Assessment of Community Initiatives at local levels (in development, Best Practice on Community Mobilization to be published in 1999)</p>
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CATEGORIES OF TOOLS:	TOOLS REFERENCES:
<p>2. Institutions' and Sector's Capacity Assessment see attached detailed outline</p>	<p>2.1. Guide to the Strategic Planning Process for a National Response to HIV/ AIDS: Response Analysis. UNAIDS, Module 2 2.2. Rapid Organisational Review (ROR), Burkina Faso, Uganda, 1997, C. Pervilhac 2.3. "Mapping of Institutional Relationships and Decision-Making (Power Relationships Flows) in Public Sector" in Progress Report on Tanzania District Response Initiative Study, Hamisi I. Mahigi and Damas S. Muna, March 1998 2.4. Rapid Assessment of Access to Care and HIV/ AIDS-Related Drugs in Communities and the Health System, Malawi, UNAIDS and WHO, January 1999</p>
<p>Reference List of additional tools either existing or in development</p>	<p>"Coordinated care in different settings" in TB/ HIV A Clinical Manual WHO/TB/96.200, WHO, 1996, pp.119-122</p> <p>"Integration and Sustainability" Gijjs Walraven and Japheth Ng'weshemi, in HIV prevention and AIDS care in Africa. A district level approach. Japheth Ng'weshemi et al. Ed. Royal Tropical Institute-The Netherlands 1997</p> <p>"Human Rights and HIV/ AIDS: Effective Community Responses" International Human Rights Documentation Network, May 1998 (case-studies related to Law Reform, Developing HIV/ AIDS Charters, Advocacy Work, Networking, Education Information-Gathering and Documentation, and Services for People Living with HIV/ AIDS</p> <p>"Organising the integration of voluntary counselling and testing for HIV infection in antenatal care. A practical guide " (with 10 key elements) Richard Baggaley and Eric van Praag, WHO (draft 15/12/98)</p> <p>Guidelines on Human Rights for Parliamentarians, UNAIDS, to be published 1st trim. 1999.</p> <p>"Country Health System Profiles" data bank (at least 55 from AFRO, PAHO, EMRO, EURO, SEARO, WPRO Regions) to be available (at least 55 countries planned for 1999) from WHO/ EIP including national data related to organisation and management, health care finance and expenditure, service delivery, financial resource allocation, and health care reforms</p>

CATEGORIES OF TOOLS:	TOOLS REFERENCES:
<p>3. Assessment of Existing Policies vs. needs and realities see attached detailed outline</p>	<p>3.1. "Decentralisation and Health Systems Change: A Framework for Analysis" Revised Working Document, WHO/SHS/NHP/95.2 3.2. "Health Financing Reform A Framework for Evaluation" Revised Working Document, WHO/SHS/NHP/96.2 3.3. "HIV/ AIDS and Human Rights International Guidelines" United Nations, 1998</p>
<p>Reference List of additional tools either existing or in development</p>	<p>Guidelines on Human Rights for Policy-Makers, to be published in 1st trim. 1999 M. Maluwa. Guidelines on Human Rights for Parliamentarians, to be published in 1st trim. 1999 M. Maluwa. Guidelines on Human Rights for NGOs, to be published in 1st trim. 1999 M. Maluwa. planned for 1999: Key questions and issues relating to Human Rights. M. Maluwa. United Nations and National Response in Countries towards HIV/ AIDS: Qualitative Assessment Guidelines, Nefise Bazoglu, to be published in 1999</p>

CATEGORIES OF TOOLS:	TOOLS REFERENCES:
<p>4. Calculation of intervention costs see attached detailed outline</p>	<p>4.1. "Costs of district AIDS programmes" Ties Boerma and Japheth Ng'weshemi, in HIV prevention and AIDS care in Africa. A district level approach. Japheth Ng'weshemi et al. Ed. Royal Tropical Institute-The Netherlands 1997</p> <p>4.2. Costing Guidelines for HIV/ AIDS Prevention Strategies. A companion volume to Cost Analysis in Primary Health Care. A Training Manual for Programme Managers. World Health Organisation. Lilani Kumarayake, Jane Pepperall, Hilary Goodman, Anne Mills, 1998</p> <p>4.3. "Distribution of Intervention Costs (Proportions)" in "HIV and Health Care Reform in Phayao From Crisis to Opportunity" (Draft Apr. 8. 1998) UNAIDS, PAAC, Health Care Reform Project, HIV/ AIDS, A. Tanbanjong, Piyanat, J.L. Lamboray</p>
<p>Reference List of additional tools either existing or in development</p>	<p>none reported</p>

CATEGORIES OF TOOLS:	TOOLS REFERENCES:
<p>5. Resource mobilisation see attached detailed outline</p>	<p>5.1. "Resource Mobilisation and Allocation" in District Response Initiative on HIV/ AIDS. Ghana Case-Study, J. Annan et al., Nov. 1997</p> <p>5.2. Calculation of Origins of Project Funding. UNAIDS, PAAC, Health Care Reform Project, HIV/ AIDS epidemiological and behavioural monitoring and evaluation in "HIV and Health Care Reform in Phayao From Crisis to Opportunity" (Draft Apr. 8. 1998) A. Tanbanjong, Piyanat, J.L. Lamboray</p>
<p>Reference List of additional tools either existing or in development</p>	<p>Guide to the Strategic Planning Process for a National Response to HIV/ AIDS: Resource Mobilisation. UNAIDS, Module 4, for publication in 1999</p>

CATEGORIES OF TOOLS:	TOOLS REFERENCES:
<p>6. Programme monitoring and evaluation see attached detailed outline</p>	<p>6.1. "Monitoring and evaluation (a district level approach)" Awene Gavyole, Ties Boerma and Dick Schapink, in HIV prevention and AIDS care in Africa. A district level approach. Japhet Ng'weshemi et al. Ed. Royal Tropical Institute-The Netherlands 1997</p> <p>6.2. Using a Simplified Tool: A Monitoring Tool for Assessing, Analysing and Improving the Health Sector Response to HIV/AIDS, in HIV and Health Care Reform: Making Health Care Systems Respond Effectively to HIV and AIDS. A Tool for Local Assessment, Analysis and Action by and for Peripheral Managers and Communities, March 1 1998 Agnès Soucat with inputs of J.L. Lamboray, P. Jongudomsuk, P. Daveloose, R. Msiska, W. Sittitri, A. Tanbanjong. Office of Health Care Reform-AIDS Division and Ministry of Public Health Thailand, UNAIDS</p> <p>6.3. HIV/ AIDS epidemiological and behavioural monitoring and evaluation (Phayao District, Thailand) in "HIV and Health Care Reform in Phayao From Crisis to Opportunity" (draft Apr. 8. 1998), UNAIDS, PAAC, Health Care Reform Project</p> <p>6.4. Protocol for Setting and Monitoring Locally Acceptable Standards of Counselling in relation to HIV Diagnosis, UNAIDS, July 1994 draft, for publication in 1999</p> <p>6.5. Care Programs for People Living with HIV/ AIDS"(chap. 7) in Operational Approaches to the Evaluation of Major Programme Components, by E. Van Praag and D. Tarantola, for publication in 1999</p>
<p>Reference List of additional tools either existing or in development</p>	<p>Relationships of HIV and STD declines in Thailand to behavioural change A synthesis of existing studies. Key Material. UNAIDS Best Practice Collection. UNAIDS/ 98.2.</p> <p>Looking deeper into the HIV epidemic: A questionnaire for tracing sexual networks. Key Materials. Best Practice Collection. UNAIDS/ 98.7.</p>

APPENDIX 5E
Sample of Seven Tools Reviewed

Update of: 11/ 02/1999

1. Tool Category:

Category 1: to conduct a situation analysis (sectorial, community...)

2. Tool Name:

1.1. Guide to the Strategic Planning Process for a National Response to HIV/ AIDS: Situation Analysis. UNAIDS, Module 1

3. Purpose and Objectives of the Tool:

For UNAIDS country programs, donor agencies, NGOs to conduct a situation analysis of HIV/ AIDS at a national or decentralized level

4. Level(s) of Application:

National, Regional/ Provincial, District/ Local

5. Description of Methods:

Document review, field visits with qualitative methods (interviews, group discussion etc.).

6. Contribution to Programme Planning, Monitoring and Evaluation:

Preliminary step of the planning stages comprising next the Response Analysis (Module 2, ref. Cat. 2), followed by the Strategic Plan Formulation (Module 3, ref. Cat. 1). Maximum openness in the dissemination of the report recommended to general population and vulnerable groups and communities: public presentations, simple publications, media releases, posting information on the Internet.

7. Role in the Determination of Strategies and Interventions:

Preliminary stage to the determination of strategies and interventions.

8. Advantages:

Step approach to planning concentrating on the situation analysis only.

9. Limitations:

The situation analysis covers a broad spectrum of areas for enquiries which can overwhelm the team into details, and can at the end make prioritization difficult.

10. Primary Users:

The situation analysis team, followed by the group who analyses the response, and then by the people who formulate the strategic plan, or in a nutshell, ultimately the national or local planners and managers.

11. Preferred or Suggested Technical Background and Training for Users of Tool:

Multi-disciplinary team, e.g. economist, civil servant, community organizer, anthropologist, private sector market specialist, sociologist... and person(s) living with HIV.

2 weeks to 8 months (longer for first situation than subsequent analysis and pending upon depth of analysis).

12. Resources Needed to Apply the Tools:

Time and human resources as per above. Cars depending of data collection needs. Word processing facilities necessary.

13. Used by and Location:

Presently a dozen Ministries in West Africa, and several in the East Africa, Asia, Latin America Regions.

14. Original References:

Guide to the Strategic Planning Process for a National Response to HIV/ AIDS: Situation Analysis. UNAIDS, Module 1. UNAIDS/98.19. 32 pages. Sections: Introduction, Responsibilities, The Situation Analysis Process (a steps approach), Next Steps: towards the response analysis, Bibliography.

15. Source of Technical Advice:

Clément Chan Kam, Department of Country Planning and Programme Development, UNAIDS. E-mail: ?

Pierre M'Pele, Strategic Planning for Gaoua District, Burkina Faso, 1998. E-mail: ?

NOTA: The tool may be obtained from the following web address: UNAIDS.ORG/PSR pointing to "Reform HIV", or available at UNAIDS Information Center, Geneva

16. Tool Summary Description:

Guide to the Strategic Planning Process for a National Response to HIV/ AIDS: Situation Analysis. UNAIDS/98.19, Module 1

The rationale to conduct a complete situation analysis points to the necessity to identify:

- who is vulnerable to HIV/ AIDS and why;
- the most serious obstacles to expanding the response;
- the most promising opportunities for expanding the response.

The overall responsibility in-country to own and carry out the process is described, as well as the ideal composition of the team.

The main phases to conduct the situation analysis's main work are broken down into:

1. Preparatory Work
2. Team Briefing
3. Information Gathering. This key section is well designed and contains the main questions to be asked and answered: guiding principles, main factors determining the spread of HIV and its impact (underlying factors, risk behaviours, epidemiological considerations) and identification of determinants, obstacles, opportunities for priority areas. Topic areas to enquire into are detailed as well: population issues, health issues, social issues, political/ legal/ economic issues, social services, partnerships.
4. Analysis: identified as the most important step in the analysis with the team analysing the response using next the results of this analysis
5. Production of the Report. The section gives a suggested format under the form of Tables which can be used to layout findings (needs, obstacles and opportunities), and a Report Outline
6. Circulation of the Report for Comments and Finalization

Bibliographical References: list of 14 references

M.S., DRS Gaoua, D.S. Gaoua. Plan de Lutte contre le VIH/SIDA et les MST dans le District Sanitaire de Gaoua. (Pierre M'Pele, 1999)

Update of: 11/ 02/1999

1. Tool Category:

Category 1. to conduct a situation analysis (sectorial, community...)

2. Tool Name:

1.2. Guide to the Strategic Planning Process for a National Response to HIV/ AIDS: Response Strategic Plan Formulation. UNAIDS, Module 3

3. Purpose and Objectives of the Tool: for UNAIDS country programs, donor agencies, NGOs to conceive a strategic plan or general framework to implement the response, and detailed strategies necessary to change the current situation, and the successive intermediate steps needed to reach stated objectives.

4. Level(s) of Application:

National, Regional/ Provincial, District/ Local

5. Description of Methods:

Document review, field visits with qualitative methods (interviews, group discussion etc.)

6. Contribution to Programme Planning, Monitoring and Evaluation:

Third step of the planning stages, preceding the Resource mobilization (Module 4, Cat. 5, in development), following the Situation Analysis (Module 1, ref. Cat. 1) and Response Analysis (Module 2, ref. Cat. 2). Dissemination of the final strategic plan to all those who have participated in the process, and to everyone interested in the Response or whose partnership is sought.

7. Role in the Determination of Strategies and Interventions:

End-stage of planning with the determination of strategies and interventions, before the Resource Mobilization (Module 4, Cat. 5, in development).

8. Advantages:

Step approach to planning concentrating on the strategic planning process only. Clarifies what is a strategy, and detailed explanation of all the steps necessary to set objectives in priority areas in order in turn to determine the most effective strategies

9. Limitations:

The Strategic Plan Formulation does not address how to develop targets and indicators, workplans with time tables and budgets to operationalize the strategies, or the very last stage of the planning process (ref. may be necessary to other documents such as Logical Framework Planning exercises, or Objectives-Oriented Project Planning...)

10. Primary Users:

The programme managers who implement activities that seek to diminish the spread of HIV and its impact. Reference to everyone seeking to contribute to the Response.

11. Preferred or Suggested Technical Background and Training for Users of Tool:

Strategic Plan Formulation team: solid Government representation, all key stakeholders, if necessary appropriate expertise, team(s) who conducted the situation and response analyses

12. Resources Needed to Apply the Tools:

Time and human resources as per above. Word processing facilities necessary. Meeting space.

13. Used by and Location:

Presently a dozen Ministries in West Africa, and several in the East Africa, Asia, Latin America Regions.

14. Original References:

Guide to the Strategic Planning Process for a National Response to HIV/ AIDS: Strategic Plan Formulation. UNAIDS, Module 3. UNAIDS/98.21. 28 pages. Sections: Responsibilities, Formulation of a Strategic Plan, Producing a Strategic Plan Document, Next Steps: resource mobilization, operational plans, implementation. Bibliography: 7 references.

15. Source of Technical Advice:

Clément Chan Kam, Department of Country Planning and Programme Development, UNAIDS. E-mail: ?

Pierre M'Pele, Strategic Planning for Gaoua District, Burkina Faso, 1998. E-mail: ?

NOTA: The tool may be obtained from the following web address: UNAIDS.ORG/PSR pointing to "Reform HIV", or available at UNAIDS Information Center, Geneva

16. Tool Summary Description:

Guide to the Strategic Planning Process for a National Response to HIV/ AIDS: Strategic Plan Formulation. UNAIDS/ 98.21, Module 3

The rationale for strategic plan clarifies how the planning process is based on situations which are different according to the population group addressed, and to the changes over time. Strategies are tailored to be flexible enough to adapt to situation changes, based on realistic limited resources, or taking advantage of initiatives developing with built-in resources.

Three possibilities to design the Strategic Plan Formulation, among the multitude existing based on each country administrative structures, are illustrated: national level planning, national priorities with local strategies, and province setting the agenda.

The key section of the Module consists of the Formulation of a Strategic Plan explaining in details the main steps in strategic plan formulation:

1. Re-examine the guiding principles (ref. Policies outlined in the Situation Analysis)
2. Confirm priority areas for a response
3. Set objectives in priority areas
4. Develop strategies to reach objectives in priority areas
5. Develop a strategic framework for the response
6. Examine the strengths and weaknesses of proposed strategies
7. Revise objectives and strategies when necessary
8. Plan flexible management and funding to ensure support for emerging strategies

The steps are illustrated using as an example a "Strategy formulation for one priority area: Reducing HIV transmission among young people." 4 specific objectives and their strategies to achieve those are outlined.

Finally the Module documents how to produce a strategic plan document.

Bibliographical References: list of 7 references

M.S., DRS Gaoua, D.S. Gaoua. Plan de Lutte contre le VIH/SIDA et les MST dans le District Sanitaire de Gaoua. (Pierre M'Pele, 1999)

Update of: 11/ 02/1999

1. Tool Category:

Category 2. Institution's and Sector's Capacity Assessment

2. Tool Name:

2.1. Guide to the Strategic Planning Process for a National Response to HIV/ AIDS: Response Analysis. UNAIDS, Module 2

3. Purpose and Objectives of the Tool: for UNAIDS country programs, donor agencies, NGOs to assess how various Institutions and Sectors are responding to HIV/ AIDS at a national or decentralized level

4. Level(s) of Application:

National, Regional/ Provincial, District/ Local

5. Description of Methods:

Document review, field visits with qualitative methods (interviews, group discussion etc.)

6. Contribution to Programme Planning, Monitoring and Evaluation:

Second step of the planning stages following the Situation Analysis (Module 1, ref. Cat. 1), and followed by the Strategic Plan Formulation (Module 3, ref. Cat. 1). Maximum openness in the dissemination of the report recommended to general population and vulnerable groups and communities: public presentations, simple publications, media releases, posting information on the Internet.

7. Role in the Determination of Strategies and Interventions:

Mid-stage to the determination of strategies and interventions.

8. Advantages:

Step approach to planning concentrating on the response analysis only. Gives good illustrations on how to analyze data to understand better and improve the present response in specific areas.

9. Limitations:

The response analysis is limited to few focus areas only in comparison to the broad spectrum of interventions available for program managers: one on care, one on mitigating the impact, six on prevention, and one on human rights.

10. Primary Users:

The response analysis team supported by a governing (or local) committee, followed by the group who formulates the strategic plan, or in a nutshell, ultimately the national or local planners and managers.

11. Preferred or Suggested Technical Background and Training for Users of Tool:

Multi-disciplinary team, e.g. economist, civil servant, community organizer, anthropologist, private sector market specialist, sociologist... and person(s) living with HIV, preferably same team as the one used for the situation analysis. A one-off exercise of 1 to a few weeks pending upon depth of analysis.

12. Resources Needed to Apply the Tools:

Time and human resources as per above. Cars depending of data collection needs. Word processing facilities necessary.

13. Used by and Location:

Presently a dozen Ministries in West Africa, and several in the East Africa, Asia, Latin America Regions.

14. Original References:

Guide to the Strategic Planning Process for a National Response to HIV/ AIDS: Response Analysis. UNAIDS, Module 2. UNAIDS/98.20. 28 pages. Sections: Responsibilities, Steps for the Response Analysis (from preparatory work to circulating the report for comment and finalize), Next Step towards the strategic plan formulation.
Bibliography: 8 references.

15. Source of Technical Advice:

Clément Chan Kam, Department of Country Planning and Programme Development, UNAIDS.
E-mail: ?
Pierre M'Pele, Strategic Planning for Gaoua District, Burkina Faso, 1998. E-mail: ?

NOTA: The tool may be obtained from the following web address: UNAIDS.ORG/PSR pointing to "Reform HIV", or available at UNAIDS Information Center, Geneva

16. Tool Summary Description:

Guide to the Strategic Planning Process for a National Response to HIV/ AIDS: Response Analysis. UNAIDS/ 98.20, Module 2

Clarification of the difference between a response analysis and a programme review with emphasis in the changing situation, and considering the broader social and economic sectors' contribution.

Identification of the overall responsibility, the response analysis team, and the response analysis governing committee.

Suggested process steps of the response analysis process are outlined:

1. Preparatory work
2. Brief the response analysis team
3. Gather information from documents, interviews and field research
4. Analyse (2 examples: "Expanding the syndromic treatment of STDs in Zimbabwe" and "Reducing HIV transmission among young people")
5. Produce the Report
6. Circulate for comments, finalize

The main questions to be answered (section 3) constitute the main section of the Guide:

- a) What is the situation?
- b) What is being done to respond to HIV?
- c) Is the national response relevant to the current situation?
- d) Is the response working in priority areas?
- e) Why is a response working or not working?

Bibliographical References: list of 14 references

M.S., DRS Gaoua, D.S. Gaoua. Plan de Lutte contre le VIH/SIDA et les MST dans le District Sanitaire de Gaoua. (Pierre M'Pele, 1999)

Update of: 12/02/1999

1. Tool Category:

Category 3: to assess the existing policies vs. needs and realities

2. Tool Name:

3.1. Decentralization and Health Systems Change: A Framework for Analysis

3. Purpose and Objectives of the Tool:

A framework to systematically review the development and implementation of decentralization policies, and to examine concurrent changes in the health system that may, at least in part, be ascribed to decentralization.

4. Level(s) of Application:

National, Regional/ Provincial, District/ Local through “streams of decentralization,” i.e. local governments, different levels and institutions within the Ministry of Health and other relevant Ministries in the context of democratization, social insurance funds, and various provider institutions in the public and private sectors.

5. Description of Methods:

Qualitative and impressionistic rather than quantitative and factual. Rapid rather than exhaustive assessment. Literature review, routine health information system and/ or special existing studies, semi-structured questionnaires of key informants and focus group discussions with various representatives (national, district, sub-district and health units).

6. Contribution to Programme Planning, Monitoring and Evaluation:

The tool can be applied for programme planning, or monitoring, or evaluation:

- for planning: to focus in the “Situation Analysis” (UNAIDS, Guide to the Strategic Planning Process for a National Response to HIV/ AIDS, Module 1) in the political and legal and partnership issues and identify needs, obstacles, and opportunities
- for monitoring: to consider variables to be monitored for prospective study of the effects of decentralization
- for evaluation: for a retrospective analysis to study the effects of decentralization on equity, efficiency and quality

Dissemination recommended as per Strategic Planning Process (UNAIDS) to all those who have participated in the process, and to everyone interested in the Response or whose partnership is sought. 2-3 days Workshop suggested for feedback.

7. Role in the Determination of Strategies and Interventions:

The tool allows to understand the environment in which the strategies and interventions for a response to HIV/ AIDS takes place, and be able too understand better the policy needs, or to take advantage of the opportunities, or to overcome the obstacles.

8. Advantages:

The tool is structured in a “Framework for Analysis” which is a stepwise approach that can be used based on the different stages of decentralization the country has reached: 1) Countries in which decentralization has been in place for some time: analysis of structure and functions, 2) Countries at mid-stage of decentralization: analysis of organsational structures and processes, 3) Countries with mature stage of decentralization: analysis of equity, efficiency, and quality.

9. Limitations:

Long term processes with important contextual enabling or disabling factors over which HIV/AIDS response has little or no control. Difficulty in the case of countries in the mature stage to choose among the 27 facets of the framework which ones to use.

10. Primary Users: the national or local authorities to take action or catalyze some of the processes.

11. Preferred or Suggested Technical Background and Training for Users of Tool:

Policy implementers, Consultants or Academicians or Social Scientists (e.g. Economists, Sociologists...) from University setting

The tool is not planned to be disseminated and replicated through training exercises but national or local policy-makers involved in the use of the tool will definitely learn and benefit from the process as well as feel more committed to the long-term processes.

12. Resources Needed to Apply the Tools

Team of 2 to 4 people. Other resources (time, vehicles ...): unknown

13. Used by and Location:

27 countries in the mid-nineties from Africa, Latin America, Asia and Europe in a global comparative project aiming to establish generalizable links between decentralization and changes in health systems in different countries.

14. Original References:

“Decentralization and Health Systems Change: A Framework for Analysis” Revised Working Document WHO/SHS/NHP/95.2, March 1995 (26 pages)

Sources for availability: ref. Web site or WHO/ SHS

15. Source of Technical Advice:

Name and e-mail or other contacts for technical purposes:

Katja Janovsky, WHO: email:

Andrew Creese, WHO: email

Phyllida Travis, WHO: email

NOTA: The tool may be obtained from the following web address: UNAIDS.ORG/PSR pointing to “Reform HIV”

16. Tool Summary Description:

5 Components of the following Table

Decentralization and Health Systems Change

Framework for Analysis: Overview

(to insert Table p. 3)

Bibliography:

WHO/ARA/CC/97.3. Barbara McPake and Joseph Kutzin. “Methods for Evaluating Effects of Health Reforms” Div. of Analysis, Research and Assessment. Current Concerns ARA Paper number 13

WHO/ARA/CC/97.6. Sara Bennett, Elias Ngalande-Banda, with annotated bibliography by Ole Teglgaard. “Public and Private Roles in Health. A Review and Analysis of Experience in sub-Saharan Africa.” Current Concerns ARA Paper number 6

WHO. Health System Decentralization in Africa: An Overview of Experiences in Eight Countries” (Botswana, Burkina Faso, Ghana, Kenya, Mali, South Africa, Uganda, Zambia)

Background Document Prepared for the Regional Meeting on Decentralization in the Context of Health Sector Reform in Africa, no date.

Update of: 16/02/1999

1. Tool Category:

Category 4. to calculate intervention costs

2. Tool Name:

4.1. Costs of district AIDS programmes

3. Purpose and Objectives of the Tool: To compare the costs and benefits of different interventions and their relative costs in relation to their effectiveness, in order to set priorities based on the resources available

4. Level(s) of Application:

Regional/ Provincial, District/ Local, Communities

5. Description of Methods:

Costs estimation per year of HIV prevention and AIDS care

6. Contribution to Programme Planning, Monitoring and Evaluation:

The tool allows to determine priorities to plan which interventions to prioritize in relation to funding levels, and assess the necessary additional efforts to be made to attract additional funding (ref. category 5 Resource Mobilization). Information can be shared and discussed with the participants of the strategic planning workshop.

7. Role in the Determination of Strategies and Interventions:

The tool allows to prioritize which interventions are the most cost-effective, and give tips on how to reduce costs under limited resources (focus on high transmission areas, including vulnerable populations, STD management services etc.)

8. Advantages:

Comparative costs and benefits with assessment of effectiveness for 8 preventive, 2 both preventive and curative, and 2 curative interventions.

9. Limitations:

Costs estimated for a population of 300,000, including 125,000 adults/ adolescents and an estimated 100,000 sexually active individuals with an HIV prevalence of 5% to 10%: needs to be adapted to the local situation

10. Primary Users:

Program planners and managers at the local level

11. Preferred or Suggested Technical Background and Training for Users of Tool:

Economic or accounting background. No time assessed to train the users in the application of the tool.

12. Resources Needed to Apply the Tools:

No resources estimated.

13. Used by and Location:

Institutional: TANESA Project, Mwanza Region, Tanzania

14. Original References:

“Costs of district AIDS programmes” Ties Boerma and Japheth Ng’weshemi, in HIV prevention and AIDS care in Africa. A district level approach. Japheth Ng’weshemi et al. Ed. Royal Tropical Institute-The Netherlands 1997, pp. 353-370

15. Source of Technical Advice:

Ties Boerma e-mail:

John Bennett e-mail:

NOTA: The tool may be obtained from the following web address: UNAIDS.ORG/PSR pointing to “Reform HIV”

16. Tool Summary Description:

The tool estimates the costs of HIV prevention and AIDS care for:

- 1) Preventive interventions:
 - promotion of safer sexual behaviours: general population
 - promotion of safer sexual behaviours: youth
 - promotion of safer sexual behaviours: high-transmission areas
 - STD control: general population
 - STD control: core groups
 - condom promotion and distribution
 - reduction of HIV transmission through blood transfusions
 - reduction of HIV transmission through injections
- 2) Preventive and curative interventions:
 - AIDS care: training of health workers
 - counseling
- 3) Curative interventions:
 - care for AIDS patients
 - survivor assistance

Comparing interventions for a comprehensive HIV intervention programme covering the whole district with 300,000 people (5-10% HIV prevalence) with STD control, intensive health education, youth activities, condom promotion and distribution, training of health workers, and a safe blood supply, amounts to US\$ 350,000 or US\$ 1.16 per person (\$3.50 per sexually active adult), excluding capital costs or most government or other staff salaries.

An estimated US\$ 200,000-300,000 per year may be needed for basic care of AIDS patients, including a home-based care programme and a fund for survivor assistance, or US\$ 1 per capita per year, or US\$ 3 per adult.

Based on 5 different categories of resources available from very limited (US\$ 25,000) to high (US\$ 300,000), a Table illustrates in a useful manner for program managers the different options available for district AIDS programmes at different funding levels for the example of that district.

Bibliographical References:

WHO. The costs of HIV/ AIDS prevention strategies in developing countries.

WHO/GPA/DIR/93.2. Geneva, 1993.

WHO. Provision of HIV/ AIDS care in resource constrained settings. Geneva. n.d.

The hidden cost of AIDS: the challenge of HIV to development. The Panos Institute. London. 1992

Soderlund N. et al. The costs of HIV prevention strategies in developing countries. Bulletin of the WHO 1993, 71: 595-604.

Update of: 19/ 02/1999

1. Tool Category:

Category 5. to mobilise resources

2. Tool Name:

5.1. "Resource Mobilization and Allocation" in the District Response Initiative on HIV/ AIDS
Ghana Case-Study

3. Purpose and Objectives of the Tool:

To broaden the spectrum of HIV/ AIDS activities from a vertical health sector focused approach towards an integrated multisectoral and development-oriented approach with the following objectives:

- a) Review the policy and organisational environment within participating countries and their districts
- b) Review responses to HIV/ AIDS and relevant social sector experiences
- c) Advice on districts' responses to HIV/ AIDS
- d) Development assessment tools to assist districts and communities to determine options for social and developmental challenges including HIV/ AIDS
- e) Develop a framework that will take districts through a capacity-building process, to ensure greater intersectoral problem identification and problem-solving.

4. Level(s) of Application:

Three-tier nature of the system in Ghana surveyed: National, Regional/ Provincial, District/ Local

5. Description of Methods:

Documents and Reports review, interviews

6. Contribution to Programme Planning, Monitoring and Evaluation:

The main conclusions and recommendations of the Study address planning issues to improve not only resource allocation, but also other important areas such as how to influence policy-making, to strengthen intersectoral collaboration, to address district capacity issues, and to promote opportunities for the District Response Initiative.

Feedback through debriefing sessions with the central administration of the district assemblies and group discussions at area council or community levels. Discussion at the national level, debriefing meeting with the national Multisectoral Taskforce.

7. Role in the Determination of Strategies and Interventions:

The tool gives general orientations to determine strategies useful at the national level (Ministries, Donors/ NGOs), and key Regional and District partners. Identified more attention to be paid to interventions for the promotion of attitude and behaviour changes.

8. Advantages:

Allows to capture quickly and comprehensively the national, regional, and district levels for some of the key issues to expand the response to HIV/ AIDS

9. Limitations:

Tool does not include the interviews schedules. No thorough review of the community needs.

10. Primary Users:

Decision-makers at the different levels of the system

11. Preferred or Suggested Technical Background and Training for Users of Tool:

5 consultants with the following overlapping expertise: public health physician, health economist, development planner, HIV/ AIDS specialist, demographers, home-based care specialist, social anthropologist, health systems analyst, manpower planner

Users: not trained (consultants)

12. Resources Needed to Apply the Tools:

Time, human resources, cars, computers: not specified

13. Used by and Location:

Institutional: Ministry of Health in Ghana and UNAIDS

National and Regional levels, including Wenchi, Adansi West, and Fanteakwa Districts

14. Original References:

“Resource Mobilization and Allocation” in the District Response Initiative on HIV/ AIDS Ghana Case-Study, November 1997 (43 pages)

Sources for availability (ref. ordering through UNAIDS or JSA Consultants Ltd., P.O.Box A408, La-Accra, Ghana, or Web-site address below)

15. Source of Technical Advice:

Joe Annan, e-mail:

NOTA: The tool may be obtained from the following web address: UNAIDS.ORG/PSR pointing to “Reform HIV”

16. Tool Summary Description:

Broad review of the key institutional reform and decentralisation

Findings:

- national policies and strategies
- donor/ NGO findings
- regional level assessment
- mapping of institutional authority and resource allocation

Three District Case-Studies and comparative analysis of district findings

Discussion of the Expanded Response by national, regional and district levels, with additional aspects related to interventions and participation

Conclusions and Recommendations for: resource allocation, policy-making, intersectoral collaboration, district capacity issues, and opportunities to promote the District Response Initiative.

Update of: 18/ 02/1999

1. Tool Category:

Category 6. to monitor and evaluate the program

2. Tool Name:

6.2.Using a Simplified Tool: A Monitoring Tool for Assessing, Analyzing and Improving the Health Sector Response to HIV/ AIDS

3. Purpose and Objectives of the Tool:

The tool aims to assess, analyze, and consequently design and take actions both for management (local level) and reform (local and national) purposes.

4. Level(s) of Application:

Regional/ Provincial, including District/ Local and Communities, with a total of about 500,000 population

5. Description of Methods:

Rapid assessment methods with focus groups, interviews, reviews of local data

6. Contribution to Programme Planning, Monitoring and Evaluation:

The tool is used for planning and monitoring the implementation of the District Response to HIV/ AIDS. Results are fed back to the informants of community organization, associations, and representatives of staff from health center, and district level by including them in the local analysis of data and problems, and the elaboration of actions to solve problems identified, and the synthesis of experiences, and elaboration of recommendations for Reform.

7. Role in the Determination of Strategies and Interventions:

The tool is geared to identify the necessary interventions/ actions that are relevant at different levels: individual and household, community organizations and associations, health system and services, and policy.

8. Advantages:

The tool provides a number of grids and examples of problem-solving frameworks, and indicators for planning and monitoring for key preventive and curative and sustainable interventions which can be adapted to a local situation.

Detailed background information on the Health Care Reform and HIV provided (original ref. pp. 1-34), including two examples from Thailand and Côte d'Ivoire of "packages of interventions" offered at community, sub-district, and district levels.

9. Limitations:

The process of adapting the tool to the local situation may be difficult for local managers if not assisted by a multi-disciplinary skilled team (e.g. economists, policy analysts, community specialists with experience in qualitative methods etc.)

10. Primary Users:

Regional and District health managers

11. Preferred or Suggested Technical Background and Training for Users of Tool:

Program managers (taking into consideration the limitations identified in sect. 9)

Time requested for training the user(s): twice, three days

12. Resources Needed to Apply the Tools:

2 months plus a preliminary step of 1 week or 2 to adapt the tool.

Human resources, cars, computers: no indication

13. Used by and Location:

In Phayao District, Thailand by the Office of Health Care Reform-AIDS Division and Ministry of Public Health Thailand and UNAIDS

14. Original References:

“Using a Simplified Tool: A Monitoring Tool for Assessing, Analyzing and Improving the Health Sector Response to HIV/ AIDS,” in HIV and Health Care Reform: Making Health Care Systems Respond Effectively to HIV and AIDS. A Tool for Local Assessment, Analysis and Action by and for Peripheral Managers and Communities, March 1 1998 Agnès Soucat with inputs of J.L. Lamboray, P. Jongudomsuk, P. Daveloose, R. Msiska, W. Sittitri, A. Tanbanjong. Office of Health Care Reform-AIDS Division and Ministry of Public Health Thailand, UNAIDS (pp. 1-34: background information, pp. 35 to 55: tool)

Sources for availability (ref. ordering through UNAIDS or Web-site address below ...)

15. Source of Technical Advice:

Agnès Soucat, UNAIDS, Thailand, e-mail:

Jean-Louis Lamboray, UNAIDS, Geneva, e-mail:

NOTA: The tool may be obtained from the following web address: UNAIDS.ORG/PSR pointing to “Reform HIV”

16. Tool Summary Description:

- 1) Analysis of Response for community-based monitoring and planning at individual and household level:

Knowledge, skills, attitude and behavioral change by General population and Specific groups, General population and Families of HIV+people, and pregnant women

Problem-Solving Framework for Behavioral Change: Example of IEC for Safe Sexual Behavior

- 2) Analysis of Response for community organizations and associations or interface level:

Life Skills Training and Condom Distribution, Psychological and Social Support, Home-Caring Support, Co-management of health services, Community-Based Problem-Solving and Planning looking at various stages or determinants (equity, autonomy, quality, continuity, utilization, access, availability of resources, target population).

Problem-Solving Framework for Analyzing the Response at the interface level: example of life-skills training and condom distribution

- 3) Analysis of Response for health system and services:

Conceptual Framework for Monitoring the Production of Sustained Health Outcomes

Conceptual Framework for the Production of Sustained Response

Indicators for Planning and Monitoring the Implementation of the Process of Production of Sustained Outcomes to address the HIV Epidemic in the Health Care System. Example of Effectiveness Indicators.

Example of necessary conditions to be fulfilled to ensure final effective coverage with prevention of vertical transmission, monitoring and the three phases of the intervention: screen, treat, care.

Indicators for Planning and Monitoring the Implementation of the Process of Production of Sustained Outcomes to address the HIV Epidemic in the Health Care System. Example of Effectiveness Indicators for Curative Interventions.

Indicators for Planning and Monitoring the Implementation of the Process of Production of Sustained Outcomes to address the HIV Epidemic in the Health Care System: Coverage, Cost, and Funding

4) Analysis of Response for policy:

Policy Monitoring Framework

Problem-Solving Framework for Analysis of Management and Policy Factors affecting Effectiveness, Efficiency, and Financial Viability at Health Center level, Management Factors: Policy Factors

Example of Corrective Management Actions to improve Effective Coverage, Efficiency, and Financial Viability of the Health Sector Response to HIV/ AIDS

Matrix for Monitoring the Cost and Funding Issues on the Policy Response to HIV/ AIDS

Additional information:

- 2 months schedule of the activities, duration and actors to be involved in the Assessment, Analysis and Feedback of the Health Sector Response to HIV/ AIDS.

- Methods of data collection and list of informants, and list of questionnaires to be developed.

Fourteen References on the subject, including:

Lamboray J.L., "Can we develop a common framework for analysis and action?" South East Asian J. Trop. Med. Public Health. Vol. 27, no. 2, Jun. 1996

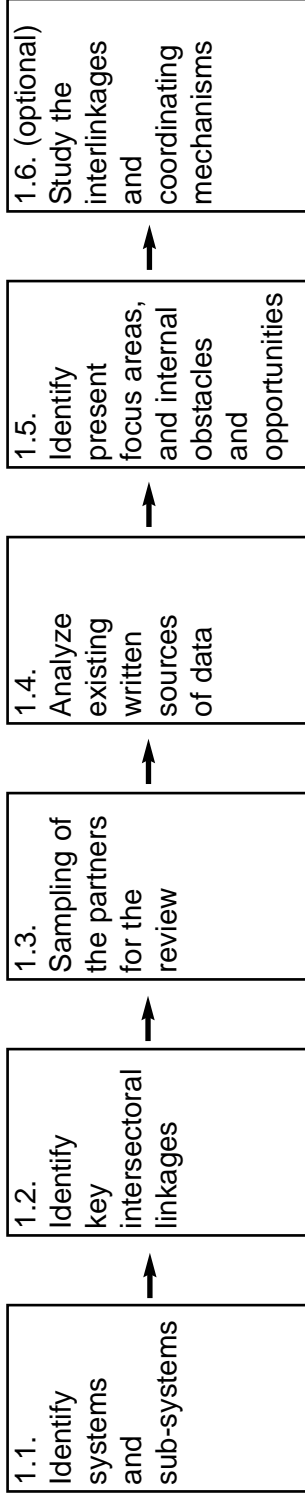
Mills A., "Current Policy Issues in Health Care Reform from an international perspective: the battle between bureaucrats and marketers in Health Care Reform: at the frontier of Research and Policy Decisions"

**RAPID ORGANIZATION REVIEW (ROR)
BUILDING THE ORGANIZATIONAL PLAN**

APPENDIX 5F: A Tool for Partnerships and Consensus Building at the Local Level

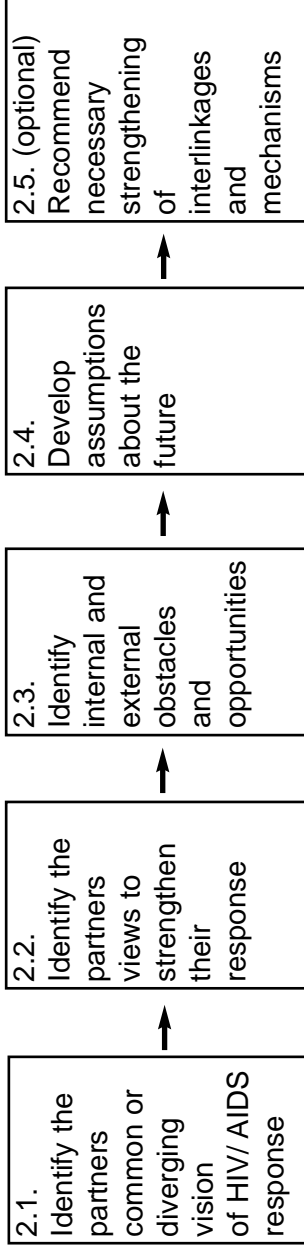
**STEP 1.
SITUATION
ANALYSIS**

Where are we?
(Study)



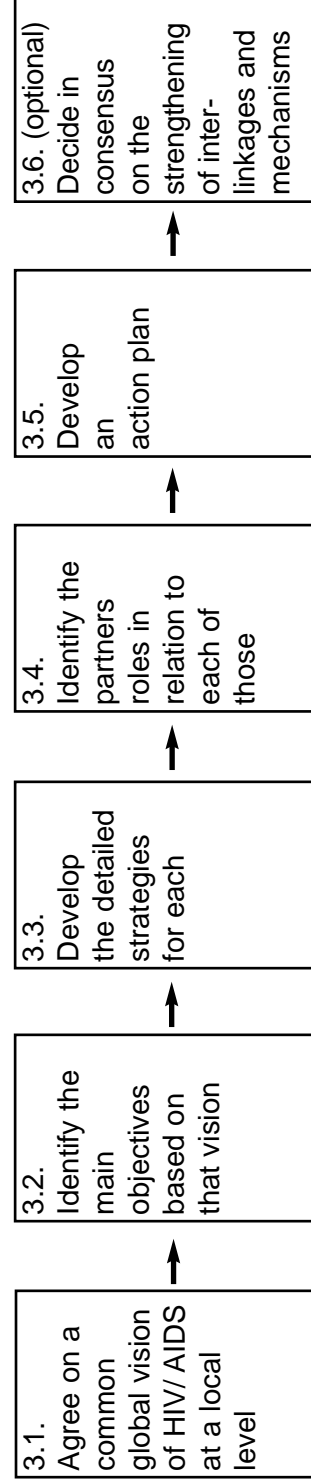
**STEP 2.
STRATEGIES**

Where do we want to be?
(Study)



**STEP 3.
ACTION PLAN**

How do we get there?
(Workshop)



APPENDIX 5G

Introduction Sheet to the Rapid Organizational Review (ROR) tool for the HIV/ AIDS District expanded Response Initiative (DRI)

(\RORDRITOOOL.doc)

Purpose:

The Rapid Organizational Review (ROR) tool to be used during –but not limited to– the planning stages of a program aims to contribute to a situation analysis of the effectiveness and efficiency of organizations functioning at the local level as partners for the HIV/ AIDS District expanded Response Initiative (DRI), and on the long term to improve their inputs and to monitor and evaluate their progresses.

Description:

The Rapid Organizational Review (ROR) tool assists the District or local level managers to review rapidly in one particular aspect --the organizational one-- of the situation analysis some of the key organizations from the public and the private sectors, including communities, which are present or can be future potential partners in HIV/ AIDS activities by:

- first, carrying an inventory,
- second, mapping these organizations into active or not, and for those active (if possible) estimate how much,
- third, appraising their present capacities and limitations,
- finally, defining better their roles in relation to the information collected and the future needs for planning purposes.

Developed by:

Cyril Pervilhac

Users:

- District Health Management Team
- District Project Planning Teams
- District Monitoring and/ or Evaluation Teams

Application:

Ministry of Health-German Technical Cooperation (GTZ) Projects in the UNAIDS-WHO-GTZ collaborative efforts in the planning stage of the DRI:

- Gaoua District, Burkina Faso
- Kabarole District, Uganda

Advantages:

- Rapid Assessment Procedures (RAP) approach with existing qualitative methods
- Focus possible on the public, or private (NGOs), or communities (CBOs), or a mix of those as needed
- Option to understand in more details the intersectoral linkages and multisectoral approaches
- Looking more at why and how much the response (process oriented) is occurring and sustained rather than considering only outputs and outcome
- Collection of data feasible with a team of 2-4 maximum in 5-10 days
- Data analysis feasible in 2-3 weeks maximum
- Use as organizational/ institutional baseline possible
- No particular software or special skills needed
- Method to look at “Partnerships” as one of the “Topic areas for enquiry” (UNAIDS, “Guide to the strategic planning process for a national response to HIV/ AIDS Situation Analysis”, 98.19), with the “Response Analysis” (UNAIDS, 98.20) at the district level

Limitations:

- Difficulties to collect data related to finances at a local level (sensitive)
- Answers are soft data, difficult to verify or cross-check,
- Difficulties to distinguish in the answers between present and future, real activities and planned one
- Users need minimum interest and curiosity in social sciences and the methods used
- Policy analysis not included in this tool (ref. to other tools, e.g. "*PolicyMaker*" by Michael R. Reich, Harvard SPH, or Joe Annan, Ghana DRI Case-Study Report, 1997, JSA Consultants Ltd.), but possible through the district level data collection
- Community participation not included in this tool (ref. to other tool, G. Bjaras et al., 1991), the survey at the community level can combine these data collection as well
- No magic bullet approach or solution, but part of a planning process with emphasis on organizations and institutions, or the local partners

Recommendations for Users:

- Should be familiar with qualitative methods and techniques (group discussion, focus groups, key informants...)
- Adapt the tool and matrices, develop questions and pre-test for first time use in a country, preferably with the expertise of a social scientist (sociologist...)
- Accompany the review team for the first rounds to make sure questions are consistent
- Use if possible a team which collect data as impartially and objectively as possible (i.e. not the DMO, or an influential person), for example a retired instructor or nurse etc.
- Analyze the data immediately following the survey, and if possible on the spot
- Use a brief (2-3 days) planning/ consensus workshop at the local level for feedback and applications of findings
- The ROR exercise can be a useful local preparation or preliminary step to a broader Objectives Oriented Project Planning (ZOPP)

Report Attached:

- Roger Salla et al., "Handout Supplement" of the "District Response Initiative (DRI): Fostering Partnership in HIV/ AIDS Control. Situation Analysis in Burkina Faso." Poster Presentation. 12th World AIDS Conference, Geneva.

Reports and Publications:

- C. Pervilhac, Rapport Initiative ONUSIDA/ OMS/ GTZ de Riposte Elargie au Niveau du District. Etude de Cas du Burkina Faso. 1997. GTZ: Eschborn.
- C. Pervilhac, W. Kipp, and D. Babikwa, Report on the UNAIDS/ WHO/ GTZ Initiative of the expanded District Response Initiative. Case-Study from Uganda. 1997. GTZ. Eschborn.
- C. Pervilhac, "Rapport de Synthèse de l'Atelier sur l'Initiative de la Réponse Elargie au VIH/ SIDA: District de Gaoua, Burkina Faso." GTZ. Eschborn.1998.
- Joe Annan, DRI Tools ?, Accra. 1998.
- C. Pervilhac et al., "Handout Supplement" of the "District Response Initiative (DRI): Missing Link in HIV/ AIDS Control. A Situation Analysis in Uganda. Poster Presentation. 12th World AIDS Conference, Geneva.

Background Publications:

- UNAIDS Best Practice Collection, "Expanding the global response to HIV/ AIDS through focused action" UNAIDS/ 98.1
- Soucat Agnès, "HIV and Health Care Reform: Making Health Care Systems Respond Effectively to HIV and AIDS. A tool for local assessment, analysis and action by and for peripheral managers and communities. Office of Health Care Reform-AIDS Division, Ministry of Public Health Thailand-UNAIDS. March 1, 1998.
- Bjaras G., B. Haglund, S. Rifkin, "A new approach to community participation assessment", Health Promotion International, 6, 3, 1991, pp. 199-206.
- Reich M., "*PolicyMaker*" Political Mapping of Health Policy. A Guide for Managing the Political Dimensions of Health Policy," Harvards SPH, 1994, at web site: //www.polimap.com/pmintro.html

Languages:

English

Instrument:

The three steps of the Rapid Organizational Review (ROR)

ROR guides you through three steps of applied organizational analysis for strengthening and building partnerships at a district/ local level to generate strategies and plans tailored to the local needs and possibilities. The present illustrations are coming from the Case-Study of Gaoua District, Burkina-Faso. (ref. Report Attached)

The three steps correspond to, the normal stages of any planning strategy, and therefore complement those. It is designed to improve the understanding and functions of the various partners, e.g. organizations, with a sequential analysis, and accompanying visualization (illustrations) through three steps:

- Step 1: Situation Analysis
Where are we: who is doing what at the present time?
- Step 2: Strategies
Where do we want to be: who is willing to contribute to what, and how in the future?
- Step 3: Action Plan
How do we get there: what is the consensus and what is the plan?

Each step and their detailed sequences can be illustrated under the form of a path analysis as per attached "**Rapid Organizational Review (ROR): Building the Organizational Plan**" scheme, and summarized with an overview as follow. Each step and their detailed sequences are explained in the last section, **Users' Guide**. (Appendix 6H)

APPENDIX 5H

Users' Guide to the Rapid Organizational Review (ROR) Tool

(\RORUSERSGUIDE.doc)

A full detailed guide of the various steps and sequences of each sub-category follows.

STEP 1: SITUATION ANALYSIS

Where are we: who is doing what at the present time?

Illustration: ***Model of the District and Communities Systems***

1.1. Identify and define the various systems and sub-systems (inputs and processes) in the program cycle (inputs, process, outputs, and outcome), as well as the main strategies existing presently.

Rationale: Inventory taking and categorization. Moving the thinking early on in the planning stages from individual focus to broader groups, e.g. communities and organizations, and visualizing the process. Distinguishing and categorizing 3 key systems at the local level, and their actors (sub-systems): the public sector (including projects contracted with a Ministerial bi-lateral Government agreement), the private sector, and the communities placing the latter at the center of the overall system.

1.2. Identify the key intersectoral linkages, and illustrate the main ones: first, within or between the public sector partners (with health, or between other Departments), second, between the partners of the public and private sectors, third, between the Communities and the partners of either sector. Identify the key intra-sectoral linkages within the Ministry of Health (between Departments or sections).

Rationale: Identification of relationships, and/ or of coordinating mechanisms existing or needed.

1.3. Sampling of the partners for the review: an equal sample of approximate a dozen partners from the public and a dozen from the private, including at the community level, sectors.

Rationale: This sample size allows to have a full picture of the public sector (i.e. to sample all or the large majority of the public sectors which work or can work in HIV/AIDS activities), and sufficient numbers of different types of organizations from the private sector, including at the community level (4 communities). As aggregate data, the reviewers can understand as a whole the activities in the public, in the private sectors, including at the community level.

1.4. Analyze existing written sources of data from the various partners.

1.5. Identify the present focus areas (strategies, interventions) for each partner. Identify internal issues (population, health, social political and legal and economic and social and partnerships in "Situation Analysis" UNAIDS 1998, pp. 15-25), and some of the main factors which are predisposing to the risk and vulnerability of infections (epidemiologic and demographic factors, support services factors, political and cultural factors, social and economic factors) (GPA 1995, p. 25 and UNAIDS, A Guide for Strategic Planning Process, Working Vers. Draft 3, 16 Apr. 1997, p. 5-7) and hence identify as a consequence the opportunities for the present activities.

1.6. Study of the interlinkages and coordinating mechanisms (optional): finally, as an option, in addition to the individual interlinkages, the global coordinating mechanisms between the three systems necessary to strengthen the partnerships, are reviewed.

Rationale: for more mature programs where decentralization is already advanced down to the communities' level (e.g. Uganda)

STEP 2: STRATEGIES

Where do we want to be: who is willing to contribute to what, and how in the future?

Illustration: ***Institutional Landscape of the Partners from the Public and Private Sectors (present situation or organizational baseline)***

2.1. Identify the partners' common or diverging global vision of HIV/ AIDS response at a local level

2.2. Identify how the partners envision to strengthen their response in the focus area(s) they are presently involved in, and how much? The same, in another new area of need?

2.3. Identify internal obstacles or organizational factors of constraints (experiences, competencies, didactic and other materials, financial means, specific present activities, population mobilization...) and external obstacles ("super-structural factors" or background and environmental factors which neither individuals nor governments can change in the short or medium term, ref. UNAIDS A Guide for Strategic Planning Process, Working Vers. Draft 3, 16 Apr. 1997, p. 5-7), and opportunities for the future activities

2.4. Develop assumptions about the future

2.5. Recommend necessary strengthening of interlinkages and mechanisms to facilitate those (optional)

STEP 3: ACTION PLAN

How do we get there: what is the consensus and what is the plan?

Illustrations:

***Institutional Landscape of the Partners from the Public and Private Sectors
(future situation)***

Planning and Consensus Synthesis Matrix by Objectives and Inputs

(temporary version in French, to be translated)

- 3.1. Agree on a common global vision of HIV/ AIDS at a local level
- 3.2. Identify the main objectives based on that vision
- 3.3. Develop the detailed strategies for each
- 3.4. Identify the partners' roles in relation to each of those (ref. Strategies 2.2)
- 3.5. Develop an action plan (priorities and calendar of implementation)
- 3.6. Decide in consensus on the strengthening of interlinkages and mechanisms to facilitate those (optional)

APPENDIX 5I

1 1997 SITUATION ANALYSIS PUBLIC SECTOR:

MOH and Radio/ Communication
Political Structures & Min. Educ.
5 Ministries potential actors

■ PRIVATE SECTOR:

5 partners quite active
2 less active (PROMACO/ SMC & youth Assoc.)
Large untapped sources of private organizations (communities, Churches, NGOs)
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2 1997 SITUATION ANALYSIS:STRATEGIES

■ PREVENTIVE:

The bulk of organizations active intervene in preventive strategies

■ CARE AND SUPPORT:

Only the MOH (public sector),
and one NGO/ Plan International (private sector) active in care and support strategies

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3 1999 STRATEGIC PLANNING

(next 3 overheads)

■ PUBLIC SECTOR:

7 new partners involved
4 in preventive strategies
3 in care and support

■ PRIVATE SECTOR:

8 new partners involved (including Associations)
18* in preventive strategies
16* in care and support strategies
*: some involved in both strategies
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4 2000-2001 PLANNED SCENARIO MONITORING & EVALUATION

■ OLD PARTNERS:

responding with a strong or a medium response given their means

■ NEW PARTNERS:

responding, at least, with a weak response (are at least active)
new balance between preventive and care & support strategies

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