Burkina Faso: A Community-Driven Approach to HIV/AIDS

Burkina Faso has the second highest HIV/AIDS infection rates in West Africa, with an overall HIV prevalence rate of around 7.2 percent. A large number of development agencies are active in the fight against HIV/AIDS. An innovative community driven scheme to the epidemic was piloted under a recently completed Bank project and is now being replicated under a follow up HIV/AIDS Disaster Response Project. This brief describes the design of this pilot scheme both in terms of process and content; presents preliminary results; and identifies key lessons and future challenges.

Poni Province was selected for three key reasons. First, it is characterized by heavy external migration, which places it at higher risk, as young men earn their livelihood in the coffee and cocoa plantations of neighboring Cote d'Ivoire and return infected, placing a heavy burden on their families and running the risk of infecting their partners. Second, the Gaoua district had a good foundation of bottom up, participatory process of addressing the epidemic, which was spearheaded by UNAIDS and supported by other donors in the late 1990s. Third, there was strong leadership and staunch commitment at the provincial level.

Project design

The pilot scheme had two objectives: (i) to test the capacity of communities to prepare, implement and monitor their own micro-projects and to manage funds put at their disposal; and (ii) to determine the feasibility of getting financial resources quickly to a large number of stakeholders.

While the pilot used the same broadly participatory, bottom-up process of involving all segments of society, it adopted a “learn by doing” approach and differed in a number of important ways from the earlier phase: (a) broader in scope, aiming to reach the entire province of 200,000 inhabitants; (b) greater reliance on local actors for the provision of training and technical support; (c) shift in emphasis towards getting the money out rather than on a formal strategic planning process; and (d) reliance on working directly with community representatives rather than through local associations.
The major milestones in designing and implementing the pilot scheme can be summarized as follows. First, a massive social mobilization campaign was undertaken to inform and engage local political, administrative and community leaders. This process involved focus group discussions, community meetings, and radio spots. A provincial AIDS technical team with multi-sectoral representation was established to coordinate activities and approve micro-projects. It also created departmental (10), village (close to 600), and sectoral (20) committees to facilitate the preparation, approval and execution of micro-projects.

Second, training manuals were elaborated, and roughly 2000 trainers were trained at all levels throughout the province. Trainers represented all segments of society. Most trainers were recruited locally which is expected to enhance ownership and improve follow up. All village representatives benefited from basic training (i.e., What is AIDS? How can it be prevented? How to prepare sub-projects?).

Third, all village committees undertook a simple analysis of their situation, prepared micro-projects based on a standardized format, and opened up local bank accounts. While the pilot was intended to support both preventive activities and support and treatment of the affected, in practice local authorities decided to give priority in this initial phase to activities which communities were most familiar with and which could be carried out quickly. Finally, an external firm was recruited to document what works, what needs to be scaled up, and how it should be done.

Results

The September 2001 external evaluation found that it is "feasible to mount a major initiative, on a large scale, in a relatively short time, and at a reasonable cost". In nine months, the pilot scheme funded close to 600 micro-projects worth US$175,000, covering close to 95 percent of all villages. The pilot demonstrated the capacity and commitment of provincial and local authorities to mount an initiative of major scale, and to move away from boutique approaches.

The "learn by doing" approach worked out generally well. The tight time-line created an environment of innovation and flexibility. Community representatives adapted as needs evolved and circumstances changed. The limited timeframe, however, created some artificial constraints, which did not always allow sufficient time to plan and to build consensus.

While the initial goal of the pilot scheme was to fund micro-projects of all stakeholders in practice the major focus was on the community and line ministry micro-projects. Lack of clarity with regard to the roles and responsibilities of grassroots associations and NGOs, and how they would collaborate with communities impeded the execution of these micro-projects. As a result, the process of approval and disbursement of funds for
these micro-projects encountered delays. This experience highlights the importance of clarifying from the outset the comparative advantages of all players in mounting community driven approaches to HIV/AIDS.

The results in terms of setting up flexible and efficient mechanisms for channeling funds to multiple stakeholders were extremely encouraging. The direct transfer of funds from the IDA Project Management Unit to village bank accounts gave greater autonomy in use of resources to local committees and held them accountable for results. However, the large number of transactions (i.e. to over 550 village accounts) taxed the fragile banking system and resulted in occasional disbursement delays.

**Key lessons**

A number of key lessons are emerging as ingredients of success:

- Strong political commitment and leadership at central and local levels are critical.
- Community involvement in planning and oversight enhances ownership.
- Autonomy and flexibility in use of resources improves motivation and accountability.

**Social mobilization**

Massive social mobilization has been one of the key accomplishments. As authorities consider scaling up these activities, a number of key lessons need to be considered: (i) allow sufficient time to adapt activities to the pace of life, to ensure that community representatives take ownership of the process; (ii) take into account the social and cultural characteristics (e.g. religious factors, traditional languages, role of women) of each community; (iii) promote the use of local radio which proved to be a powerful tool for reaching illiterate people; and (iv) expand the involvement of civil society, with a particular attention to women, who are disproportionately affected by the epidemic, as well as people living with HIV/AIDS, who have a potentially pivotal role to play in advocacy and in project design and execution.

**Training**

The pilot scheme highlighted the importance of training in improving knowledge and raising awareness. Participatory diagnostic techniques, which have a long-standing tradition in Burkina Faso, were instrumental in improving the community’s understanding of the HIV/AIDS situation, and in increasing ownership. For example, a Methodology for Mapping High Transmission Areas allowed participants to identify areas in their communities where the largest numbers of sexual encounters occur, and to propose interventions without stigmatizing specific groups. The pilot relied on using local training experts, which is expected to improve the acceptability of messages and to enhance chances of success. The pilot also demonstrated the importance of the quality of training and its adaptation to local culture (e.g. match materials to audience, translate materials into local languages, ensure trainers are fluent in local languages). Trainers were selected to take into account local ethnic and linguistic diversity with most speaking at least two languages.

**Micro-projects**

The major accomplishment to date is the fact that close to 600 micro-projects were prepared, approved, and funded. The breakdown of the allocation of resources, by stakeholder, was as follows: (i) communities: 63 percent; (ii) line ministries: 27 percent, and (iii) NGOs/associations: 10 percent. The bulk of these micro-projects were for preventive activities, with a focus on Information, Education and Communication (IEC) and peer education.

The experience to date has demonstrated that the decentralized manner in which this process occurred generated positive results in terms of ownership, which augurs well for the future. Communities have the motivation and capacity to take charge by analyzing their problems, proposing solutions, carrying out their activities and managing the funds put at their disposal. Nevertheless, capacities are fragile and communities have multiple demands on their time. Hence, it is important to: (i) promote the use of simple, standardized procedures for accessing the funds, (ii) specify the rules of the games clearly; (iii) agree from the outset on deliverables; and (iv) establish criteria of eligibility for all stakeholders and revise, as needed, to respond to changing needs.

In addition to improving the process, it will also be important to reassess the content of the micro-projects. First, communities need to ensure that HIV/AIDS interventions are well integrated at the community level, and do not displace other key activities. One of the problems cited during the pilot scheme is that HIV/AIDS activities have displaced family planning (FP)
activities at the community level. As the goals (e.g., altering behavior) and means (e.g., condom promotion) of HIV/AIDS and FP programs are broadly similar there is no need why one should displace the other. It is critical that these programs work together both at the national and local levels to reap the positive potential synergies of coordinated action. A related point deals with the need to ensure that community activities are better coordinated with those of health districts, to ensure that a continuum of interventions are put in place. For example, while communities focus on raising awareness and increasing demand for services (e.g., STI management; VTC, treatment of opportunistic infections), health districts need to ensure that the services provided are timely and of high quality.

Second, one of the challenges will be to assist communities to shift the focus from educational activities to care, treatment and support of those affected by the epidemic. Key priorities include developing simple models for home-based care, support of local orphans, and provision of counseling and psychosocial services. This will not be easy as most people living with the disease in Burkina Faso continue to live in fear of stigmatization and discrimination. Local associations have a clear comparative advantage in these areas, as they know their constituents best and can attend to their needs in a discrete and sensitive manner.

Third, the scheme has emphasized the importance of a simple system for monitoring and evaluation of micro-projects that is adapted to the capacities of various stakeholders (e.g., communities, associations/NGOs, and line ministries).

**Flow of funds**

The overriding lesson in terms of flow of funds is the importance of getting the money directly to the beneficiaries. While it might be tempting to channel funds to communities through different layers of government, it is more efficient to make payments directly into village bank accounts. This process gained credibility and inspired the confidence of the local population. It should be noted that the process of reaching 550 villages and some 50 organizations/ministries was not trouble-free. The project management team adopted a hands-on approach in resolving these problems as they arose. The main problems stemmed from the lack of local bank accounts in each village and/or the limited capacities to absorb considerable amounts of money in a relatively short time span. The transaction costs also taxed the limited capacities of village administrators. The specific lessons to take into account for the scale-up phase can be summarized as follows: (i) ensure that the operational manual stipulates clearly the procedures for accessing funds and accounting for their use; (ii) simplify reporting requirements; and (iii) explore ways of reducing delays in disbursements.

**Future challenges**

The main challenge at this stage is to design a strategy for scaling up the successful aspects of this pilot scheme to other provinces of the country. In many ways, Poni Province is a unique place. This implies that one has to use caution in thinking about the replicability and sustainability of this innovative scheme. On the one hand, it has been argued that this scheme benefited from a positive enabling environment: (i) high levels of awareness resulting from an earlier strategic planning process; (ii) strong social capital at the village level, with a tightly-knit extended family structure; and (iii) strong political leadership, with the Governor demonstrating a high level of personal commitment in the fight against HIV/AIDS. On the other hand, it has been argued that if such an initiative can work in Poni it can work in other places. In this regard, two points are worthwhile highlighting. First, most provinces have a much smaller number of villages than Poni (i.e., under 550), which implies that in principle it should be relatively simple to channel resources to other regions. Second, the population of Poni Province is characterized as relatively independent, which implies that it may be even easier to mobilize communities in other regions.

To conclude, the main challenge in scaling up is the need to adapt community driven approaches to the local socio-cultural environment. This has to be done on a case-by-case basis. A second important lesson is the need to allow more time to build ownership of the process. Finally, it is important to overcome problems of stigmatization. In the words of one official “if people living with HIV/AIDS could be accepted in society, that would already be a great victory.”

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