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# **FOLLOW-UP TO THE DECLARATION OF COMMITMENT ON HIV/AIDS (UNGASS Report) - Burkina Faso 2005**

*Dec 2005-vp*

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## I. STATUS AT A GLANCE

Burkina Faso committed itself to the fight against the HIV/AIDS epidemic when the first cases were discovered in 1986. Faced with the epidemic's spread, the country implemented a strategic planning process in 1998 so as to define strategies which were more suited to the fight against HIV/AIDS. This process led to the creation of the 2001-2005 National Strategic Framework for action against HIV/AIDS (CSLS), which focussed on strengthening the multi-sector approach. This period saw a greater level of commitment both from the country itself and from international partners. This commitment materialised in an increase in the amount of resources allocated to the fight against HIV/AIDS by development partners and by the government of Burkina Faso. The fruits of such action resulted in greater commitment from players in different sectors, namely, the health sector (private and public), ministries other than health and business, the community sector, including traditional and religious communities, and non-governmental organisations (NGO) and Community-Based Organisations (CBO). Significant progress was also made in areas such as care for the sick by improving access to antiretrovirals as well as by implementing measures targeted at specific groups.

Despite these achievements, the epidemic still remains widespread; it affects all strata of society and all sectors and thus poses an obstacle to the country's development.

Since the Declaration of Commitment, signed during the United Nations special session on HIV/AIDS in June 2001, Burkina Faso has submitted two reports: one in April 2003 and the other in March 2005. This report focuses on progress made between 2003 and 2005. It presents the results recorded by Burkina Faso in the following areas:

- ✓ **Indicators covering national actions and commitments** which concern:
  - expenditure (amount of funds disbursed by the government to fight HIV/AIDS),
  - development of policies and their implementation status,
  - national programmes implemented concerning education, workplace policies, STI management, blood safety, prevention of mother-to-child HIV transmission, antiretroviral combination therapy coverage and services for orphans and vulnerable children.
- ✓ **Knowledge and behaviour indicators**
- ✓ **Impact indicators**
- ✓ **Most-at-risk populations indicators**

### ❖ **Methodology used**

The Permanent secretary of the national council for the fight against AIDS and sexually transmitted infections (SP/CNLS-IST) has put a team of people in place to draft this report. They come from: the SP/CNLS-IST, the support programme for associations and communities (PAMAC), the Ministry for the teaching of core skills and literacy, the Ministry for upper secondary school education and scientific research and the national statistics office (INSD).

The data presented comes from programme and survey follow-up data. As some data was not available for certain indicators, estimates were made on the basis of the information available.

The table below presents an overview of the indicators proposed by UNGASS regarding the HIV/AIDS situation in Burkina Faso. The data concerns either the past 12 months or previous years.

**Table N°1: Indicator overview**

Indicators	Level	Source
<b>NATIONAL RESPONSE</b>		
<b>Expenditures</b>		
<b>GE Indic</b> Amount of national funds disbursed by governments in low- and middle- income countries	<b>US\$ 7,090,476</b>	2005 programme follow-up data
<b>Policy Development and Implementation Status</b>		
<b>GE Indic</b> National Composite Policy Index	<b>77%</b>	2005 programme follow-up data
<b>National Programmes</b>		
<b>GE Indic 3</b> Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year	<b>Primary education:</b> Rural: 0.37% Urban: 4.72% <b>Secondary education:</b> Rural: 1.8% Urban: 3.3%	2005 education sector follow-up data
<b>GE Indic 4</b> Percentage of large enterprises/companies which have HIV/AIDS workplace policies and programmes	Public sector: 80% Private sector: 57.14% <b>As a whole: 70.6%</b>	2005 workplace programme review data
<b>GE Indic 5</b> Percentage of women and men with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled	Men: 10% Women: 4.1% <b>As a whole: 4.8%</b>	2001 IP6 and IP7 surveys undertaken in health care facilities
<b>GE Indic 6</b> Percentage of HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission	<b>4.7%</b>	PMTCT programme 2005 report
<b>GE Indic 7</b> Percentage of women and men with advanced HIV infection receiving antiretroviral combination therapy	<b>24.7%</b>	2005 medical health care programme follow-up data
<b>GE Indic 8</b> Percentage of orphans and vulnerable children whose households received free external support in care for the child	<b>6.5%</b>	2004 Orphans and vulnerable children support programme follow-up data

<b>GE Indic 9</b> Percentage of transfused blood units screened for HIV	<b>100%</b>	2005 medical health care programme follow-up data
<b>KNOWLEDGE AND BEHAVIOUR</b>		
<b>GE Indic 10</b> Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	<b>Rural: 2.4 % Urban: 8.4 % National: 2.89%</b>	2003 Burkina Faso Population and Health based survey (through CRIS)
<b>GE Indic 11</b> Percentage of young women and men who have had sex before the age of 15	<b>Rural: 3.8% Urban: 5.2%</b>	2003 Burkina Faso Population and Health based survey
<b>GE Indic 12</b> Percentage of young women and men aged 15-24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months	<b>Rural: 22.9% Urban: 57.3% As a whole: 42.96%</b>	2003 Burkina Faso Population and Health based survey
<b>GE Indic 13</b> Percentage of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner	<b>Rural: Men 51.7%, Women 31%, national 41.5% Urban: Men 86.2%, Women 66.1% national 72.1%</b>	2003 Burkina Faso Population and Health based survey
<b>GE Indic 14</b> Ratio of current school attendance among orphans to that among non-orphans, aged 10 to 14	<b>Rural: 104.3% Urban: 90.2% As a whole: 98.3%</b>	2003 Burkina Faso Population and Health based survey
<b>IMPACT</b>		
<b>GE Indic 15</b> Percentage of young women and men aged 15-24 who are HIV infected (Target: 25% reduction in most-affected countries by 2005; 25% reduction globally by 2010)	<b>Capital: 2.8% Other urban areas: 2.3% Rural: 0.7%</b>	2004 HIV sentinel surveillance
<b>GE Indic 16</b> Percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy	<b>Under 15 years of age: 88.9% Over 15 years of age: 87.8% All ages: 87.9%</b>	2005 medical health care programme follow-up data
<b>GE Indic 17</b> Percentage of infants born to HIV infected mothers who are infected (Target: 20% reduction by 2005; 50% reduction by 2010); biennial	<b>26%</b>	PMTCT programme 2005 report
<b>MOST-AT-RISK POPULATIONS</b>		
<b>C/LPE Indic 3</b> HIV testing among most-at-risk populations	<b>Sex workers: 9.7%</b>	Testing campaign 2005
<b>C/LPE Indic 4</b> Prevention programmes aimed at most-at-risk populations	<b>Gold diggers: 75% Truck drivers: 69% Military personnel: 84.15% Sex workers: 42.06%</b>	Survey on the sexual behaviour, attitude and habits of gold diggers, military personnel and truck drivers (PROMACO, 2004)
<b>C/LPE Indic 5</b> Knowledge on how to prevent HIV transmission among most-at-risk populations	<b>Gold diggers: 47.9% Truck drivers: 41% Military personnel: 56% Sex workers: 85%</b>	Survey on the sexual behaviour, attitude and habits of gold diggers, military personnel and truck drivers (PROMACO, 2004)

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<b>C/LPE Indic 6</b> Condom use among sex workers	<b>Sex workers: 95.85%</b>	STI/HIV prevalence and sexual behaviour survey among sex workers and their male partners in Ouagadougou, Burkina Faso (AIDS 3 Project, 2004). Please note: 2002 survey
<b>C/LPE Indic 7</b> Condom use among men having sex with other men	<b>Not applicable</b>	-
<b>C/LPE Indic 8</b> Injecting drug users who have adopted behaviours that reduce transmission of HIV	<b>Unavailable</b>	-
<b>C/LPE Indic 9</b> Reduction in HIV prevalence among most-at-risk populations.	<b>Sex workers: 20.9%</b>  <b>Recruits: 0.1%</b>	STI/HIV prevalence and sexual behaviour survey among sex workers and their male partners in Ouagadougou, Burkina Faso (AIDS 3 Project, 2004). Please note: 2002 survey Knowledge, attitude and habits evaluation of new recruits' seronegativity (CMLS défense 2004)

## II. OVERVIEW OF THE HIV/AIDS EPIDEMIC

According to the method used by WHO/UNAIDS based on HIV sentinel site surveillance, HIV prevalence among the adult population of Burkina Faso was estimated at 6.5% at the end of 2001, 4.2% at the end of 2002 and 2.3% at the end of 2004. The UNAIDS 2005 report put the number of people living with HIV at 180,000, of which 79,000 were women and 20,000 children. According to the same report, the estimated number of new HIV cases stands at 25,000, of which approximately 50% concerns the 15-24 age bracket. The number of deaths caused by HIV/AIDS is 17,000, which results in a total number of OVCs of 80,000.

The Population and Health based survey (EDS 2003) results show that mean seroprevalence stood at 1.8% among the general population. Nevertheless, seroprevalence at the national level varies according to location, gender and age. It varies among the general population (15-49 years of age) from 1.3% in rural areas to 3.6% in urban areas. Results according to gender show a fairly similar seroprevalence rate among men and women (1.9% and 1.8% respectively). With regard to the following age brackets: 15-19, 20-24 and 35-39, women are by far the most frequently infected with HIV. However, the prevalence rate is generally higher among men aged 30-34.

The prevalence data taken from surveys and specific studies is given below:

- the screening campaigns organised by PAMAC in the context of World AIDS Day in testing centres revealed a seroprevalence rate of 13.3% in 2003, 7.10% in 2004 and 7.18% at the end of October 2005;
- the testing campaign in schools and universities revealed a seroprevalence rate of 0.8% in universities and 1.3% in schools in 2004;
- the results of the 'VIRUS' project review entitled "national assessment of the HIV and STI situation in rural and urban areas and in the health and education sectors" reported HIV prevalence of 3.4% in the health sector and 2.8% in the education sector in 2003.

Although the prevalence rate is levelling off and even dropping, Burkina Faso is still affected by a widespread epidemic.

### III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

The national response, as of 1998, (strategic planning process) was built on the basis of the 2001-2005 strategic framework, which comprises four strategic areas of intervention, namely:

- the strengthening of measures to prevent the transmission of STIs and HIV;
- the stepping up of epidemic surveillance;
- the improvement of the quality of the overall care given to those infected and affected by the epidemic;
- the broadening of the response and the promotion of national and international partnerships and multi-sectorial coordination.

The 2001-2005 CSLS (Strategic framework for action against AIDS) is in line with the Poverty Reduction Strategy and its objectives reflect those of the Millennium Development Goals and those of NEPAD. The indicators presented in this report are related to the implementation of the said framework.

#### 3.1. National Commitment and Action

##### 3.1.1. Expenditures

**INDICATOR: *Amount of national funds disbursed by governments in low- and middle-income countries***

Overall, there was an increase in national funds allocated to the fight against HIV/AIDS between 2002 and 2004.

Allocated funds in 2004 were 1.7 times higher than those of 2002. The amount spent to soften the impact of HIV/AIDS in 2004 was 7.8 times higher than that spent in 2002. The amount increased 3.1 times in the area of Institutional support and 2.3 times in the area of Coordination and prevention

**Table 2: Amount of national funds allocated to the fight against HIV/AIDS** (in millions of FCFA)

Programme Categories	2002	2004	total % 2002	total % 2004	2004/2002 ratio
	Amount	Amount			
Prevention	672.7	1573.4	27.9	39.0	2.3
Clinical care and HIV/AIDS treatment	1551.7	1409.2	64.4	35.0	0.9
Softening of impact	100.0	780.6	4.1	19.4	7.8
Institutional support/Coordination	85.9	267.1	3.6	6.6	3.1
<b>Total</b>	<b>2410.2</b>	<b>4030.2</b>			<b>1.7</b>

In relation to the distribution of funds among the various areas, the amount of funds allocated to clinical care and HIV/AIDS treatment in 2004 is lower than that allocated in 2002. Clinical care and HIV/AIDS treatment accounted for 64.3% of the total amount of national funds in 2002 compared to 35% in 2004. It should be noted that several foreign projects guaranteed the funding of this area in 2004 and 2005 (the HIPC initiative, ESTHER, MAP, TAP, the ADF support project for the fight against HIV/AIDS, the French Red Cross, the Global Fund, Médecins Sans Frontières, the Health service strengthening project (PRSS) and the Tan Aliz company).

In 2004, 39% of funds were allocated to prevention compared to 27.9% in 2002.

The amount of state funds disbursed for HIV/AIDS was 2,410,185,665 FCFA and 4,670,000,000 FCFA in 2002 and 2003 respectively. This amount was 5,439,470,000 FCFA in 2004 and 3,899,761,528 FCFA according to unconsolidated amounts at the end of 2005.

**Table 3: Amount of national funds allocated to the fight against HIV/AIDS**

Source of funding	Amount spent in millions of FCFA
State budget	310.901528
PAPMLS (IDA credit)	2,888.860
HIPC	600
Solidarity fund	100
<b>Total</b>	<b>3,899.761528</b>

### 3.1.2. Policy development and implementation

#### **INDICATOR: National Composite Policy Index**

This indicator assesses the progress made in the development and implementation of national-level HIV/AIDS policies and strategies.

The national composite policy index score in 2005 in Burkina Faso was: 77%. In comparison to the 2003 score (100%), this indicator has seen a drop. This is probably due to the consideration of new parameters in the indicator calculation method.

### 3.1.3. National Programmes

**INDICATOR GE Indic 3: *Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year***

HIV/AIDS education has been officially introduced both in primary and secondary schools. It is at an experimental stage in primary schools. This experiment has primarily concerned the urban areas of the experiment zones. This explains the indicator score: 0.37% in rural areas and 4.72% in urban areas.

The PPIE - HIV/AIDS and NTIC programmes (Education - HIV/AIDS integrated pilot programme and new information and communication technology) represent a joint effort by the government and the UNDP to fight HIV/AIDS in the education sector on the basis of information and communication technology. It was launched in February 2004 and represents an opportunity to formalise HIV/AIDS education at a basic level of education. In this project, 395 teachers were trained and HIV/AIDS education started in February 2005 on the sites.

The score is also low for secondary schools. This is due to the fact that teaching of this subject is not yet systematic. The score is 3.3% in urban areas and 1.8% in rural areas.

**INDICATOR GE Indic 4: *Percentage of large enterprises/companies which have HIV/AIDS workplace policies and programmes***

In this area, 80% of public sector employers and 57.1% of private sector employers, or 70.6% for both sectors at a national level, have implemented HIV/AIDS workplace policies and programmes.

**INDICATOR GE Indic 5: *Percentage of women and men with sexually transmitted infections attended in health care facilities, who are appropriately diagnosed, treated and counselled* (Available data from 2001)**

The information available for this indicator dates from 2001. The 2001 survey covered a sample of 291 health care centres chosen according to stratified sampling. A total of 358 STI consultations were observed.

The **IP6** prevention indicator corresponds to a complete anamnesis, a full physical examination and a compliant diagnosis-treatment. The **IP7** prevention indicator

corresponds to the advice given to the patient regarding the use of condoms and information given to the patient's partner. The two scores together are 10% for men and 4.1% for women: 4.1% and 4.8% for men and women together.

Data concerning young men and women under 20 years of age and those above 20 is not available. A survey to measure these indicators will be held in 2005 so as to provide more recent data.

**INDICATOR GE Indic 6: *Percentage of HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission (Source: prevention of mother-to-child transmission programme 2004 and 2005 reports)***

The prevention of mother-to-child HIV transmission programme (PMTCT), which began in 2002, has the following strategies:

- the strengthening of manpower in terms of both quantity and quality;
- the inclusion of PMTCT activities in the minimum activities package (PMA) offered by health care facilities;
- the improvement of the quality and availability of care;
- the strengthening of the organisational and managerial capacities of the facilities involved.

Retroviral prophylaxis treatment is based on Névirapine: one 200 mg hard gelatin capsule taken as a single dose by the mother at the start of labour, and 2 mg per kilogram of weight taken in an oral suspension as a single dose by the child, administered within the first 72 hours of life. The mother receives her dose at the last prenatal consultation, so that she can start the treatment. If Névirapine has been taken in the past or in the case of HIV-2 infection, prophylaxis is based on Zidovudine (AZT). For the mother: one 300 mg tablet twice a day as of the 36<sup>th</sup> week of pregnancy and one 300 mg tablet every three hours during delivery. For the newborn: a dose of 4 mg of AZT syrup per kilogram of weight every day for seven days. These two protocols halve the risk of mother-to-child HIV transmission.

Other forms of treatment are offered to pregnant women under the KHESO BORA research project. This concerns triple therapy (AZT-3TC- LPV/r for seven months) or AZT-NVP for one month.

In 2005, the indicator score was at 4.7%. The level of this indicator has improved as it stood at 0.13% in 2002 and 1.76% in 2004

**INDICATOR: GE Indic 7: *Percentage of women and men with advanced HIV infection receiving antiretroviral combination therapy***

The score for this indicator calculated on the basis of new UNAIDS estimates for the number of people living with HIV/AIDS in 2005 stands at 24.7%. Significant efforts were therefore made between 2003 and 2005. Nevertheless, the aim to treat half of those sick by the end of 2005 has not been achieved.

However, there was a large increase in the number of those receiving antiretroviral combination therapy. This figure improved from **675** at the end of 2002 to **6,666** at the end of September 2005.

It is worth noting that this indicator is closely linked to the estimates on the number of sick people used for its calculation and therefore requires a reliable basis for these estimates.

***INDICATOR GE Indic 8: Percentage of orphans and vulnerable children whose households received free external support in care for the child***

In this area, **6.5%** of orphans and vulnerable children living in households received a form of support (schooling, food, medicine, psycho-social, financial, etc.) according to a survey taken in 2004 and published in 2005. Nevertheless, the proportion of orphans and vulnerable children needing support still remains high.

***INDICATOR GE Indic 9: Percentage of transfused blood units screened for HIV***

The indicator score is 100%. This means that all of the transfused blood units are tested for HIV.

**3.2. Knowledge and behaviour**

***INDICATOR GE Indic 10: Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission***

The scores obtained are given below.

**Table 4: Level of knowledge of young women and men aged 15-24 regarding HIV prevention**

Men (N <sup>o</sup> =1,439)			Women (N <sup>o</sup> = 5,052)			Total (N <sup>o</sup> = 6491)		
Rural	Urban	National	Rural	Urban	National	Rural	Urban	National
12.46	47.80	21.4	7.07	35.75	14.74	8.29	38.3	18.07

We note that:

- the level of knowledge among young people is higher in urban areas than rural areas both among men and among women and when both sexes are considered together. This highlights the need for greater decentralisation of actions.
- the knowledge of men regarding HIV/AIDS is better than that of women in both rural and urban areas. This fact clearly raises the issue of access to information by women, who are the most affected by the HIV/AIDS epidemic.

The indicators used to measure the sexual behaviour of young people are given below with their respective scores.

In relation to the level of actual knowledge corresponding to the correct answers to the five questions, 3.64% of young people in urban areas are perfectly knowledgeable about HIV/AIDS compared to 2.14% in rural areas. At a national level this score stands at 2.89%.

**INDICATOR GE Indic 11: *Percentage of young women and men who have had sex before the age of 15***

We note that a significant number of young people under the age of 15 have had sex: 3.8% in rural areas and 5.2% in urban areas. It is clear that communication campaigns aimed at minimising the risk of HIV transmission by changing behaviour are needed for these youngsters from an early age.

**INDICATOR GE Indic 12: *Percentage of young women and men aged 15-24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months***

This indicator's scores are 22.9% in rural areas, 57.3% in urban areas and 42.9% at a national level.

We note that casual sex with non-cohabiting partners is quite frequent among young men and women aged 15-24, especially in urban areas.

**INDICATOR GE Indic 13: *Percentage of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner***

This indicator's scores are 72.1% at a national level in urban areas and 41.5% in rural areas. Breakdown by gender in rural areas reveals 51.7% for men and 31% for women; in urban areas this stands at 86.2% for men and 66.1% for women.

Condom use by young people with non-cohabiting partners remains unsystematic, especially in rural areas where only 41.5% used a condom the last time they had sex.

**INDICATOR GE Indic 14: *Ratio of current school attendance among orphans to that among non-orphans, aged 10 to 14* (there is a bug in CRIS)**

This indicator compares the school attendance of children aged 10-14 orphaned by both parents with that of children from the same age bracket whose parents are both still alive. While this ratio is in favour of non-orphans in urban areas and at a national level, as shown by the indicator score (urban: 90.2%, national: 98.3%), it is in favour of orphans in rural areas: 104.3%. According to the results, more orphans go to school in rural areas than non-orphans. This reflects the numerous efforts made in favour of orphans and other vulnerable children in the fight against HIV/AIDS.

### 3.3. Impact

**INDICATOR GE Indic 15: Percentage of young women and men aged 15-24 who are HIV infected (Target: 25% reduction in most-affected countries by 2005; 25% reduction globally by 2010)**

To calculate the indicator, the estimates regarding the distribution of young people aged 15-24 in the capital, other urban areas and rural areas are 6.9%, 8.7% and 84.4% respectively. (Source: General population and housing census, 1996).

Calculating the indicator reveals the prevalence rates mentioned in the table below.

**Table 5: Prevalence according to age bracket and location**

	Capital	Other urban areas	Rural areas
15-19 years of age	4.25%	1.33%	0.49%
20-24 years of age	1.97%	2.96%	0.92%
15-24 years of age	2.84%	2.30%	0.74%

An in-depth analysis of 2004 HIV sentinel surveillance data according to age bracket and location reveals the following:

- HIV prevalence in the 15-19 age bracket in the capital, Ouagadougou, is four times higher than in other urban areas (4.25% compared to 1.33%). In the same age bracket, prevalence in the other urban areas is higher than in rural areas.
- However, for 20-24 year olds, prevalence in other urban areas (2.96%) is higher than in the capital (1.97%).

**INDICATOR GE Indic 16: Percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy**

According to the data collected in the three health care centres (Saint Camille, Centre Oasis and CMA Pissy), the survival rate of HIV infected adults and children receiving antiretroviral treatment 12 months after the initiation of this treatment is 88.97% for those under 15 years of age, 87.86% for those over 15 years of age and 87.91% for all ages combined. These results fall within the accepted range, namely 80% to 90%.

**INDICATOR GE Indic 17: Percentage of infants born to HIV infected mothers who are infected (Target: 20% reduction by 2005; 50% reduction by 2010)**

This indicator allows the level of mother-to-child HIV transmission to be measured.

The indicator's score is calculated as follows:  $\{T \times (1-e) + (1-T)\} \times v$

**T**= proportion of HIV infected pregnant women receiving antiretroviral treatment. This indicator has a value of 0.05.

**v** = Mother-to-child transmission rate without any form of treatment. The default value is 25.

**e** = effectiveness of treatment provided. The default value is 0.5.

Indicator's score =  $\{0.047 \times (1 - 0.5) + (1 - 0.047)\} \times 0.25 = 0.26 = 26\%$

### **3.4. Most-at-risk populations**

The at-risk populations retained for Burkina Faso are: sex workers, gold diggers, truck drivers, military personnel and prisoners. The indicators for these populations are presented below.

#### **INDICATOR C/LPE Indic 3: *HIV testing among most-at-risk populations.***

The data available for this indicator concerns sex workers (TS). Out of 1080 sex workers tested in 2005 during a screening campaign, 105 sex workers, or 9.7%, tested HIV-positive.

#### **INDICATOR C/LPE Indic 4: *Prevention programmes for most-at-risk populations***

This indicator measures the proportion of at-risk populations having had access to prevention programmes in 2004, namely, 79.85% of gold diggers, 68.99% of truck drivers, 84.15% of military personnel and 42.06% of sex workers in 2005.

#### **INDICATOR C/LPE Indic 5: *Knowledge on how to prevent HIV transmission among most-at-risk populations***

This indicator measures the knowledge of the various at-risk populations on how to prevent the transmission of AIDS. We note that 47.9% of gold diggers, 41.5% of truck drivers, 56% of military personnel and 85% of sex workers who came into contact with the programmes have a good knowledge on how AIDS is transmitted.

#### **INDICATOR C/LPE Indic 6: *Condom use among sex workers***

95.85% of sex workers used a condom with their latest customer.

#### **INDICATOR C/LPE Indic 7: *Condom use among men having sex with other men***

This indicator does not apply to Burkina Faso.

#### **INDICATOR C/LPE Indic 8: *Injecting drug users who have adopted behaviours that reduce transmission of HIV***

Injectable drug consumption does not currently constitute a major transmission route for HIV in Burkina Faso. The main transmission route is through sex.

#### **INDICATOR C/LPE Indic 9: *Reduction in HIV prevalence among most-at-risk populations.***

In 2003, HIV prevalence among most-at-risk populations was 20.8% for sex workers and 0.1% for newly recruited military personnel. Among sex workers, prevalence stood at over 57% in 1994 according to a survey taken in the same year in the sentinel sites of Ouagadougou and Bobo Dioulasso. Another study undertaken in 1998 revealed that bar stool prostitutes were more HIV positive than street prostitutes (56% versus 29%). Prevalence among this population has dropped considerably.

There is no prevalence data available for former military personnel.

## **IV. MAJOR CHALLENGES FACED AND ACTIONS NEEDED TO ACHIEVE THE GOALS/TARGETS**

A medium-term review of the 2001-2005 CSLS was carried out in 2004. It revealed a number of challenges.

### **4.1. MAJOR CHALLENGES**

The major challenges encountered according to strategy are outlined as follows:

#### **4.1.1. The strengthening of STI and HIV prevention and transmission measures**

- the lack of a harmonised national communication strategy in the areas of IEC/BCC and the dissemination of messages among specific target groups;
- the poor implementation of specific programmes targeted at specific groups;

#### **4.1.2. Stepping up of epidemic surveillance**

- the low rate of case reporting due, among other things, to under-use of health facilities by the population
- the lack of epidemic follow-up studies in specific groups.

#### **4.1.3. The improvement of the quality of the overall care given to those infected and affected by the epidemic**

- the low level of decentralisation of medical care, including antiretroviral combination therapy;
- the poor technical capacities of the community bodies involved in care.

#### **4.1.4. The broadening of the response and the promotion of national and international partnerships and multi-sectorial coordination**

- the coordinating structures' poor operating capacity
- the large number of resource management procedures due to the diversity of participants and the vertical nature of projects and programmes
- the fragility of the data collection system.

## **4.2. SOLUTIONS FORESEEN**

The measures considered to overcome these challenges were retained as priority actions in the new 2006-2010 CSLS adopted in July 2005 by the Burkinian government. These measures include:

- Definition of a communication strategy;
- Promotion of targeted actions in favour of vulnerable groups;
- Improvement of the data collection and management system through the systematic notification of AIDS and STI cases;
- Undertaking of epidemiological, behavioural, sectorial and impact studies;
- Improvement of access to antiretroviral combination therapy and other valid forms of treatment;
- Strengthening of the community's commitment to the continuing provision of care to those infected and affected by HIV/AIDS;
  - strengthening of the organisational and institutional capacity of structures involved in the fight against HIV/AIDS and STIs;
  - organisation of the national system which monitors and evaluates measures taken to fight HIV/AIDS and STIs.

## **V. SUPPORT REQUIRED FROM TECHNICAL AND FINANCIAL PARTNERS**

To facilitate coordination between the partners' actions, the following are necessary:

- support of the national priorities by partners,
- support for monitoring-evaluation through significant funding and support of the "Three Ones" approach,

Despite the large amount of money already invested, it appears that significant funds have to be mobilised to enable implementation of the priority actions mentioned.

Support from Technical and Financial Partners to the government to facilitate the mobilisation and management of resources needed for the national response is also very important.

## **VI. MONITORING AND EVALUATION ENVIRONMENT**

Monitoring and evaluation is coordinated by the Department responsible for planning, monitoring and evaluation (DPSE) in SP/CNLS-IST. The Department comprises specialised services and a database management unit. It is the main body in charge of research planning, orientation and coordination. It is the central repository for all information concerning the fight against HIV/AIDS and STIs.

The DPSE and the other SP/CNLS departments have the task of developing and managing the national monitoring-evaluation system in collaboration with the CNLS-IST's decentralised coordination bodies, the Monitoring-evaluation technical group (GTSE) and the other key players. To fulfil its role, the DPSE coordinates national response review mechanisms through, among other things, the drafting of quarterly,

biennial and annual reports for the PNM (multi-sectorial national plan) and the biennial UNGASS report. The DPSE also coordinates preparation of the CNLS-IST's annual sessions and the periodic evaluations of the CSLS involving all national response players.

A monitoring-evaluation manual has been developed to help the Department implement the monitoring-evaluation system. All the sectors involved in the system (including civil society) contributed to its development and the manual was adopted in November 2004. It is an instruction manual for the national monitoring-evaluation system for the implementation of the National Strategic Framework for HIV/AIDS and STIs (CSLS). The manual is a national reference document for monitoring and evaluating activities aimed at fighting HIV/AIDS and STIs and is meant for all those involved in this task. Its purpose is to provide guidelines on the planning, collection, analysis and use of information with a view to harmonisation and in accordance with a common monitoring-evaluation framework.

The monitoring-evaluation manual encompasses a set of process and impact indicators which are in line with the CSLS and the UNGASS objectives and the Millennium Development Goals. It also presents the organisations involved in the implementation of sector-based activities and outlines their roles and responsibilities at the various levels of monitoring-evaluation as well as the data monitoring and collection mechanisms and information analysis/dissemination strategies. A database is currently in development to facilitate data handling and capitalisation.

The manual also has a long section on action-research, skills development and continuous education of the structures involved. It complements the protocol concerning HIV/AIDS Second Generation Surveillance in Burkina Faso and the proposed instrument enables follow-up of the United Nations Declaration of Commitment on HIV/AIDS signed by the Burkina Faso government.

Other documents have been published for use with the manual: a training guide on planning and monitoring-evaluation, a manual for the practical implementation of the decentralisation process and a document outlining the sector-based tools for monitoring and evaluation.

There is still work to be done in the field of monitoring-evaluation in the following areas:

- enhancing monitoring and evaluation decentralisation among implementation organisations;
- setting up of a well-founded and efficient nationwide data collection system;
- strengthening the abilities of those responsible for monitoring and evaluation;
- coordination of studies and research to be undertaken in the area of HIV/AIDS concerning priority areas;

So as to improve the monitoring-evaluation system, support is needed:

- to strengthen the abilities of those responsible for monitoring and evaluation at a central level;

- to share experience with other countries;
- regarding technical assistance.