



# Hope and Life

**Access to ARVs in a community context:**  
Rural-Urban Experiences in Burkina Faso

Report of a study by ACORD, SOS-SIDA and REGIPIV

**Cover picture:** AIDS play during the opening ceremony of the new wing of the Health Centre in zone 19

# HIV/AIDS in ACORD

---

ACORD is an Africa-led international alliance working for social justice and equality. ACORD aims to prevent the further spread and mitigate the impact of HIV/AIDS through community-based research and advocacy and working in alliance and partnership with others.

HASAP – ACORD’s HIV and AIDS Support and Advocacy Programme – exists to support ACORD’s HIV/AIDS work in its programmes. In addition to training and technical support, it facilitates information-sharing and exchanges, both internally and externally, and provides strategic direction and coordination of ACORD’s HIV/AIDS-related research and advocacy work.

This publication is a HASAP initiative and is aimed at documenting and disseminating the lessons from research carried out by ACORD in Burkina Faso to be shared with others, both within and outside ACORD. It is the first in a planned series of research projects exploring similar issues.

Written by Angela Hadjipateras and Angele Diello  
Research carried out by Omer Bouda, Consult Group International (COGI),  
Burkina Faso. [Afric.consult@fasonet.bf](mailto:Afric.consult@fasonet.bf)



# Foreword

---

«Hope and Life» seeks to explore how access to ARVs affects the existence of those living with HIV: their work life; their emotional and physical health; their social relations and their financial situation. It was with this aim in mind that the information in this study was collected.

The study was aimed at deepening our understanding of the impact on individuals of discovering their HIV positive status and to compare their living conditions before and after treatment.

It also explores the extent to which access to ARVs and ARV services have been decentralised to reach people living outside the urban centres in the rural areas.

The first part of the study deals with general aspects of HIV/AIDS in Sub-Saharan Africa, and more specifically Burkina Faso, providing a general overview of the epidemiological situation and the different initiatives developed in response, as well as the socio-economic consequences of the pandemic.

The second part describes the process of data-collection and analysis and in the third and fourth parts, the findings and recommendations are presented accordingly.

The recommendations are aimed at improving the ARV treatment and care-related services provided to PLHAs through greater community involvement, changes in pricing policies, nutritional and dietary support and through better integration of gender and youth issues.

The information generated throws light on the issues relating to HIV infection and ARV access and, as such, constitutes an important contribution to the fight against HIV/AIDS within the Burkina context and beyond.

Dr. Wamarou Traoré  
Head of Health Unit, Permanent  
Secretariat of National Council of  
the Fight against AIDS and STIs



# Table of Contents:

---

<b>HIV/AIDS in ACORD</b>	<b>3</b>
<b>Foreword</b>	<b>5</b>
<b>Acknowledgements</b>	<b>9</b>
<b>List of Acronyms</b>	<b>11</b>
<b>Executive Summary</b>	<b>13</b>
<b>Chapter 1: Context and Rationale</b>	<b>17</b>
Introduction	17
Aims of the Study	19
<b>Chapter 2: Study Methodology</b>	<b>21</b>
The Research Sites and Partners	21
The study sample	22
The research methods	22
The data-collection and analysis tools	23
<b>Chapter 3: The Study Findings</b>	<b>25</b>
Respondent characteristics	25
Discovery of HIV status	27
Experiences of ARV treatment	31
The ARV programme	34
<b>Chapter 4: Recommendations and Conclusion</b>	<b>43</b>
Recommendations	43
Conclusion	44
<b>Annex 1: The main actors in the Delivery of ARVs             countrywide</b>	<b>47</b>
<b>Annex 2: Research Partners</b>	<b>48</b>
<b>Annex 3: Administrative Map of Burkina Faso</b>	<b>50</b>





# Acknowledgements

---

The research was developed and written up by Angela Hadjipateras, HIV/AIDS Research and Advocacy Officer for ACORD.

The research process in Burkina Faso was managed and coordinated by Angele Diello, the HIV/AIDS Officer for ACORD's Programme – Sahel 1 – covering Burkina Faso, Mali, Guinea Conakry and Mauritania.

The research was carried out by Omer Bouda, consultant with the Consult Group International and a research team including a Statistician, Sylvestre Ouedraogo, 10 interviewers, and 4 data-inputers.

Comments on the research design and on the research findings and recommendations were provided by Emmanuel Kaboré of SOS-SIDA, Savadogo Mamadou, the President of REGIPIV and Pascal Ouadraogo, President of ASEP, the Association for Support and Hope, Pô.

Information on the ARV programme in Burkina Faso was provided by Dr. Wamarou Traoré of the Permanent Secretariat of the CNLS, in Burkina Faso.

Comments and feedback on the research design and report were also provided by Sara Théophile, the Coordinator of the ACORD Sahel Programme, Dennis Nduhura, Manager of HASAP and Ellen Bajenja, Programme Support Officer, HASAP (Kampala, Uganda).

The text was translated by Francette Dusserre.

Many thanks are due to Oxfam NOVIB, SIDA and Cordaid who funded the research and the publication of this report.

Above all, the research would not have been possible without the patience and cooperation of the survey respondents in both Pô and Ouagadougou, and the staff and members of the two main partner organisations SOS-SIDA and REGIPIV-BF.



# List of Acronyms

---

AIDS	Acquired Immuno-Deficiency Syndrome
AJPO	Association of Youth for the Promotion of Orphans
ALAVI	Association Laafi La Viiim
ARV/T	Anti-Retro Virals/Therapy
ASEP	The Support and Hope Association, Pô
CBO	Community Based Organisation
CNLS	National Committee for AIDS Control
HASAP	HIV/AIDS Support and Advocacy Programme (ACORD)
HIV	Human Immuno- deficiency Virus
MSF	Médecins Sans Frontière – Doctors without Borders
NGO	Non-Governmental Organisation
OVC	Orphans and Vulnerable Children
PLHA	Person Living with HIV/AIDS
REGIPIV-BF	Network of People Living with HIV/AIDS in Burkina Faso
STI	Sexually Transmitted Infection
Tan Aliz	Tannerie Alizêta
UNAIDS	Joint UN Programme for AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation



# Executive Summary

## Context and aim of the research

Following on from the dramatic fall in prices, anti-retroviral therapy (ART) is no longer restricted to those living in the more affluent countries of the so-called 'developed' world, but is increasingly being accessed by people infected with HIV in other parts of the world, including some of the poorest countries in sub-Saharan Africa.

Grassroots-led pressure on the international community and on governments in the region have led to a number of initiatives, such as the establishment of the Global Fund for HIV/AIDS, Malaria and TB and the '3 by 5' initiative backed by the WHO/UNAIDS, aimed at rapidly scaling up access to treatment to include poor populations previously excluded by the prohibitive cost of drugs. These initiatives have resulted in the intensification of efforts to achieve the national treatment targets established by the WHO in conjunction with national governments.

ACORD is an international, Africa-led alliance working to promote social justice and equality in sub-Saharan Africa. HIV/AIDS is mainstreamed into all ACORD's work and constitutes one of 4 strategic priorities in ACORD's work. In line with its mission of promoting social justice and equality, ACORD decided to undertake research aimed at assessing the extent to which the poorest and most marginalised communities are able to access and benefit from ARVs within sub-Saharan Africa. A further objective of the research was to look into community and intra-household dynamics to gain insights into issues, such as the influence of gender on who gains access to ARVs and the impact of ARVs on HIV/AIDS-related stigma and on relations with community, friends and family.

The research was carried out in collaboration with SOS-SIDA, a well-established organisation providing a wide range of services to PLHAs, including ARVs, VCT, home-based care and support, and REGIPV BF, the National Network of PLHAs in Burkina Faso, which brings together about 50 PLHA associations from around the country. In order to compare and contrast the situation in the urban and rural areas, REGIPV put ACORD in touch with one of its member associations based in a rural area, called ASEP - the Support and Hope Association in Pô.

The research also sought to get the views of service providers and others on the quality and coverage of the ARV programme with a view to identifying strengths and weaknesses and being able to recommend improvements in the service.

In all, 176 beneficiaries in the 2 research sites – Ouagadougou and Pô – were interviewed using a semi-structured face-to-face survey questionnaire. And a further 66 service providers, including health workers, social workers, pharmacists and also members and staff of the two partner organisations were interviewed

## **Key Findings:**

### **Impact of ARVs on individuals**

#### **Situation prior to commencing treatment**

The research sought to get an understanding of how ARV treatment affects the various spheres of the lives of people living with HIV: their professional lives; their physical and emotional health; their social relations; and their financial status. To this end, information was gathered about their situation after discovery of their HIV status, but prior to commencing treatment and also about their situation after treatment commenced.

The survey findings revealed high levels of HIV/AIDS-related stigma. After discovery of their status, many individuals experience rejection and/or isolation. Moreover, around one third said that they had not spoken to anyone about being HIV positive, in all likelihood due to the fear of rejection by family and/or friends. In terms of physical symptoms and impact on professional life, a significant number spoke of experiencing fatigue and some also mentioned increased absences from work. A few also reported a drop in income resulting from a reduction and/or loss of employment.

#### **Situation after starting on ARVs**

Although many reported some initial side-effects of the drugs, including nausea and diarrhoea, the vast majority – 81% of the total - reported great improvements in their overall physical and also mental health. Examples of improved mental health include: increased self-confidence and self-respect and increased optimism and motivation. These improvements in general morale are accounted for, in part by feeling physically stronger and better, but also by the changes in the attitudes of others towards people with HIV. Close to half of the survey respondents (45%) reported that, since taking ARVs, their relations with family members had improved significantly. In

terms of the financial impact, the situation was mixed. Some said they were better off as they had resumed working and had been able to start up their savings again. On the other hand, others (especially those who were paying for treatment) faced increased treatment-related expenditure and were thus worse off financially.

## **Views on the ARV Programme**

### **Efficiency of programme delivery**

Overall, beneficiaries, and in particular, service providers, had a very low opinion of the ARV programme and considered it to be very inefficient. The main criticisms of the programme delivery are: the lack of trained personnel; restrictions on those able to prescribe the drugs; insufficient reliability and regularity of drug supplies; and the variations in the cost of treatment. These programme inadequacies undermine many of the benefits of treatment by causing anxiety and uncertainty among PLHAs and, furthermore, threaten to provoke drug resistance to treatment in the longer term.

### **Access to treatment**

Another key interest of the research was to find out the extent to which access to treatment extends beyond the capital to reach those living in more marginalized and/or rural areas. As expected, the survey confirmed that, in the views of those implementing the programme, the ARV programme is still failing to reach people in large parts of the country outside the capital city. Moreover, even where people living in remote rural areas, like Pô, are able to access ARVs, they are still worse off in terms of access to services, than those living in the capital. So, for example, one person living in Pô reported that he has to travel to the capital every month to be tested and get his drugs. This is not only physically draining, but also imposes major cost burdens on such individuals, both directly and indirectly. Furthermore, whereas all the respondents living in the urban area did not have to pay for treatment, a sizeable minority from Pô were paying for their treatment. The amount paid varied widely from 5,000 to 50,000 CFAs per month.

The research also wanted to examine any gender differences in terms of access. It was found that a majority of those receiving ARVs are women. Moreover, women were also more likely to be receiving free treatment as compared with men. Representatives of the structures providing treatment claim this reflects the women's greater concern with their sexual reproductive health, as a result of which they are more likely to seek out available services.

## ***Key Recommendations***

### ***Improvements in programme delivery:***

- More training for health service personnel
- Improvements in drug supply and distribution systems
- Decentralisation of drug distribution and testing facilities

### ***Pricing policies:***

- Increased access to free treatment for those who need it

### ***Dietary supplements:***

- Dietary supplements to be provided for those on ARVs to ensure adequate diet

### ***Support for PLHA Associations and structures:***

- Increased financial and capacity-building support.

### ***Further research:***

- On reasons why more women than men are on ARVs
- On financial impact of ARVs on individual and household income
- On impact of stigma and discrimination in accessing ARVs and related services



# Chapter 1: Context and Rationale

---

## Introduction

Over two decades since the start of the epidemic, the number of people infected with HIV is at its highest level with over 40 million people living with the virus around the world, 60% of whom (28 million people) live in sub-Saharan Africa. While a cure remains to be found, anti-retroviral therapy (ART) is offering hope and life to the more fortunate minority living in countries where such treatment is available and accessible to all who need it. That is not the case for people living in sub-Saharan Africa where the vast majority have limited or no access to these life-saving drugs and the death toll continues to rise by the day.

The high cost of these drugs constitutes one of the main obstacles to access. However, thanks to the effective campaigning of activists around the world, particularly those led by people living with HIV themselves (PLHAs), global awareness of the issue has spread resulting in a growing sense of moral outrage at the injustice of a system that defends profits at the expense of lives. As a result, changes in patent regulations and the regulations affecting the production of generic medicines have been introduced resulting in a dramatic fall in the prices of ARV drugs from around US\$10,000 per person per year in 2001 to as little as US\$140 per patient per year for some generic combinations (MSF, 2006)

At the same time, the international community has taken further steps to expand access to life-saving treatments to the thousands of people around the world who need them. On World AIDS Day 2003, the World Health Organisation (WHO) and UNAIDS launched the '3 by 5 initiative' aimed at providing access to antiretroviral therapies to 3 million people in developing countries (half of those in need of such treatment) by the end of 2005.

As a result of this initiative, the number of people receiving ARVs in sub-Saharan Africa rose steeply from fewer than 30,000 in 2001 to around half a million people by the end of 2005 – but still well short of the '3 by 5' target. None the less, a renewed commitment – this time aimed at achieving universal access for all by the year 2010, was adopted at the G8 Summit and at the UN World Summit, both at the end of 2005.

With a population of 12.6 million (2004), Burkina Faso is one on the most

densely populated states in Western Africa. It is also one of the poorest countries in the world, ranking 175 out of 177 in the Human Development Index (UNDP Human Development Report, 2005) characterised by.

- Endemic drought, which gives rise to particularly harsh conditions in the rural areas;
- Poor economic conditions: in 2003, 46% of the population was living below the absolute poverty threshold, up from 44% a decade earlier, resulting in mass population displacements from the rural areas to the urban centres and also to neighbouring countries in search of work and better living conditions
- Life expectancy at birth is 42.9 years
- Very low literacy levels are low: just over one in four children (27.1%) complete their primary education.

All these factors create an environment favourable to the spread of HIV/AIDS. The HIV prevalence rate is on the rise and according to the latest estimates (end 2003) currently stands at 4.2%. In all, there are estimated to be around 300,000 people living with HIV, 55% of whom are women.

An initiative to expand access to ARVs was launched in 2001 and ART was introduced in public health facilities in 2003. The National Strategic Framework for HIV/AIDS for 2006-10 includes the provision of ARV drugs and the treatment of opportunistic infections as a key strategic area of intervention. The average annual cost per person is about US\$912 (June 2005), but public subsidies reduce the user charge to US\$120 per year.

The number of people receiving ARV treatment has been steadily rising from 2,000 at the end of 2003 to 5,200 at the end of 2005. However, this number still falls well short of the estimated 45,000 needing treatment. In line with the 'three by five' targets, the government has set the following targets for treatment access over the next few years:

- |                      |   |        |
|----------------------|---|--------|
| • By the end of 2005 | - | 20,000 |
| • By the end of 2006 | - | 30,000 |
| • By the end of 2007 | - | 40,000 |

The delivery of ARVs and related services in Burkina Faso is implemented by numerous different organisations, such as the World Bank, the French Red Cross, the Global Fund, MSF, PPTE, ESTHER, the TAN ALIZ Society for the strengthening of health services and others, each with their own

approach and sources of funding (see Annex 1 for more information about these structures).

For organizations, like ACORD, working with the poorest and most marginalized sectors of the population in sub-Saharan Africa, the increasing emphasis on scaling up access to treatment gives rise to new challenges, as well as opportunities in its work with communities affected by HIV and AIDS.

On the one hand, access to treatment for even the poorest and most marginalized is no longer just a pipe dream, but a goal within reach. But, on the other hand, if people do not have access to an adequate diet or means of livelihood, they may not be in a position to benefit from such drugs. Moreover, if the basic health infrastructure needed to ensure a safe and effective service – such as trained health workers, a secure and sufficient supply of drugs, quality voluntary counselling and testing facilities (VCT), and so on – are not available, there is a danger that people will not only be denied access to the full benefits, but may also suffer harm as a result of drug resistance or other ill effects from improper use of the drugs. The need to develop strategies to address unequal access to treatment based on factors, such as age, gender, social class, religion and geographical location, also presents a major challenge to organizations, like ACORD seeking to promote social justice and equity.

## **Aims of the Study**

The overall aim of the study was to examine the ways in which ARVs are being delivered within urban and rural settings in Burkina and to study the implications at the level of individuals, households and the community.

### ***Specific objectives:***

The specific study objectives were to:

- i. Provide a profile of those in receipt of ARVs
- ii. Identify obstacles that come in the way of ARV access and their differential impact on different groups based on different factors, such as gender, geographical location (urban/rural) and so on.
- iii. Evaluate the potential risks for individuals without access to adequate information and support
- iv. Make recommendations for improvements based on the experiences of patients

- v. Analyse the impact of the ARV programme on other health services
- vi. Identify lessons learned in order to inform the strategies of ACORD and its partners aimed at improving and scaling up access to ARVs

It is hoped that the findings of this research will serve to support the scale-up efforts of Burkina and other countries by highlighting the benefits to individuals, families and communities of providing access to ARVs. And in addition, it is hoped that the research findings and recommendations will lead to improvements, both in the scope and the delivery of ARV scale-up programmes, not only in Burkina Faso, but also in other countries in sub-Saharan Africa and elsewhere.

This country study is the first in a planned series of research studies in a number of countries in sub-Saharan Africa likely to include Rwanda, Mozambique and Tanzania, which will explore similar issues. In this sense, it can be viewed as a 'pilot study' that will guide the approach to the subsequent studies.

## Chapter 2: Study Methodology

### The Research Sites and Partners

The research was undertaken in Ouagadougou and Pô, the capital cities of Kadiogo and Nahouri Provinces, respectively. One of the criteria for the selection of these sites was to compare and contrast services available in the capital and a remote rural area. A further criterion was access to people receiving ARVs through the partners established for the purposes of this study, namely SOS-SIDA and REGIPIV-BF. SOS-SIDA is an organisation providing a range of services for PLHAs, principally in the Ouagadougou area, and REGIPIV –BF, is a network of PLHA associations with members located in many different provinces. ASEP, the Association for Hope of Pô is one of the member associations and provided access to its members for the purposes of the present study (for more information on the partners, see Annex 2).

#### Ouagadougou, Kadiogo Province

Ouagadougou, the political capital of Burkina Faso has an estimated population of 1.42 million and an estimated HIV prevalence rate of 4.2%. It is made up of 4 health districts with a total of approximately 400 staff including doctors, paramedics, administrative and support staff. Each of the health districts has 4 official health centres and various other health facilities. Ouagadougou also has 2 national hospitals and a number of well equipped private health clinics. Private and state-run health structures are also supported by various international partners and by a dynamic, pioneering movement in the area of HIV/AIDS prevention and treatment.

#### Pô, Nahouri Province

Nahouri Province is situated in the South of Burkina, has an estimated population of 157,439 and an estimated HIV prevalence rate of 0.6%. Pô, the provincial capital, is 147 kms from the capital and 20 km from the border with Ghana. There is a high level of internal and international migration in the province, particularly among young people aged 15 to 25 years. Pô health district has 88 staff. The district has a comparable number of health centres to districts of the same population size in Ouagadougou, but, there are shortages in terms of medical equipment and financial resources owing to very limited foreign aid in the area, compared with the capital. However, the various associations promoting decentralisation of services have helped to increase access to services in the province.

## The study sample

As shown in Table 1 below, the sample includes two sets of respondents:-

- a) The direct ARV programme beneficiaries: these included a total of 176 PLHAs from 2 sites, one urban (Kadiogo, Ouagadougou) and the other rural (Nahouri, Pô)
- b) The Service Providers: these included a total of 66 respondents split into two categories: (i) health workers, social workers, and pharmacists; and (ii) members and staff of the 2 partners organisations, REGIPIV and SOS-SIDA and officers in charge of VCT services.-

**Table 1: Breakdown of Study Sample**

Study Sites	Beneficiaries		Service-Providers	
	Planned	Actual	Planned	Actual
Ouagadougou	140	136	50	44
Pô	40	40	25	22
<b>TOTALS</b>	180	<b>176</b>	75	<b>66</b>

## The research methods

The research was carried out over a period of one month in November 2005. Four methods of data-collection were used:-

- a) Documentary review of key ACORD and partner documents and of other relevant reports and documentation.
- b) Questionnaire-based Survey aimed at service providers (mainly quantitative in focus) and service users/ARV recipients
- c) A checklist for assessing the organisational and other capacities of 5 service-provider organisations in the capital and also the rural area.
- d) Direct Observation

## The data-collection and analysis tools

Data collection and analysis was carried out by a research team comprising: a lead consultant, one statistician, 3 data-inputers, one survey supervisor and 5 interviewers.

Questionnaire for Service Providers: A standardised, pre-coded and pre-tested questionnaire was used. The questions covered 3 main areas: a) policies and programmes relating to ARV provision in Burkina Faso b) organisational, technical and material capacities of intervention agencies c) recommendations for improvement

Questionnaire for ARV recipients: the questionnaire covered 3 main areas: facts linked to sero-status of the respondent; issues relating to availability and access to ARVs; and recommendations.

Epi info version 2000 was used for analysis of the quantitative data.

The first draft of the report was distributed to ACORD and the partners and their comments were incorporated into the final draft.





## Chapter 3: The Study Findings

The study findings are organised under the main areas of focus of the research, namely:-

- The respondent characteristics
- Discovery of HIV status
- The impact of HIV on the individual
- Experiences of ARV treatment
- The ARV programme
- Review of service-providers: strengths and weaknesses

### Respondent characteristics

As can be seen in Table 2 below, the majority of the beneficiary respondents were female (70% female versus 30% male). This shows that a higher proportion of women are accessing the services of the HIV/AIDS support structures included in the research study.

In terms of occupation, over one third are housewives (35%), followed by those involved in trade (15%), farmers (11%) and private sector workers (11). Close to one third of those included in the research (29%) have had no schooling at all.

**Table 2: Respondent Socio-demographic Characteristics**

Variables		Number	%
Sex	Male	123	70
	Female	53	30
Age	19-39 years	135	77
	40—49 years	36	20
	50 and over	5	3

<b>Marital status</b>	Divorced	11	6
	Married monogamous	50	28
	Widowed	43	24
	Married polygamous	9	5
	Single	44	25
	Separated	11	6
	Cohabitors	8	5
<b>Ethnicity</b>	Mossi	100	57
	Bamou	1	1
	Boaba	7	4
	Bissa	9	5
	Gourounsi	36	20
	Dioula	12	7
	Other	11	6
<b>Religion</b>	<i>Animist</i>	3	2
	Christian	90	51
	Muslim	81	46
	Other	2	1
<b>Education</b>	<i>Koranic</i>	7	4
	<i>Basic Literacy</i>	1	1
	<i>Primary</i>	61	35
	<i>Secondary</i>	50	28
	<i>Further education</i>	6	3.41
	<i>None</i>	51	29
<b>Occupation</b>	<i>School pupil</i>	5	3
	<i>College student</i>	3	2
	<i>Housewife</i>	62	35
	<i>Trader</i>	26	15
	<i>Farmer</i>	18	11
	<i>Public servant</i>	9	5
	<i>Private sector worker</i>	20	11
	<i>Voluntary workers</i>	6	3.4
	<i>Other</i>	26	15

**Source:** Field Study: November 2005

## Discovery of HIV status

### *Period of time since discovery of HIV status*

Respondents were asked when they first heard they were HIV positive. As can be seen from the table below, the majority have known their HIV status between 1 to 2 years. However, approximately one third have known their status for over 3 years. An analysis by sex, found that there were no significant differences between men and women in this respect.

**Table 3: Time HIV status known**

Less than one year	41 (23%)
1-2 years	111 (63%)
3 years and over	59 (33.5%)

**Table 4: To whom HIV status was first revealed**

	Kadiogo, Ouaga	Nahouri, Pô	Total	
Friend	3	1	4	(8%)
Partner	8	7	15	(29%)
Boyfriend/girlfriend	5	-	5	(10%)
Relative	19	3	22	(43%)
None	11	3	14	(27%)
Others	1	-	1	(2%)
Total	47	14	61	

### **To whom HIV status was confided**

In an effort to explore general attitudes towards HIV among the population in the research sites, the respondents were asked to whom they confided their HIV status after discovering they were positive. Of those who answered the question, a majority (43%) said they confided in a relative. People from the urban area were more likely to tell a relative, while those from the rural area were more likely to tell their partner. Over one in four (27%) did not tell anyone about their. These findings reveal that HIV-related stigma is still very prominent in both the rural and the urban areas.

### **Reactions of others on hearing about their HIV status**

In order to get a better understanding of attitudes towards HIV and the prevalence of HIV/AIDS-related stigma, respondents were asked how others reacted upon hearing of their HIV status. As illustrated by the responses

cited below, people's reactions to PLHAs are mixed, ranging from very supportive to very hostile.

*"With my numerous illnesses, when I announced my status to my parents, they were already expecting it and they were not too shocked. They supported me morally"*  
- young woman from Nahouri

*"As soon as I told my husband about my sero-status, he did not accept it and we separated"*  
- woman from Kadiogo

### ***Impact of HIV on the individual***

Respondents were asked to describe the impact of their HIV status on various aspects of their lives: their employment, their emotional state and their income. As shown in the table below, respondents experienced a range of negative impacts in relation to their employment and income level. On the emotional front, a majority reported no change in how they felt. However, a considerable number did experience stigma and other negative effects. A few also reported some positive consequences in terms of the caring and support received.

**Table 5: Changes in respondents following discovery of HIV status**

<b>Professional</b>	Fatigue	54
	Weakness	22
	No effect	15
	Handicapped by the illness	14
	Unable to work	10
	De-motivated	6
	Absences	2
	Reduced productivity	2
	Loss of job	2
	Stress	2
	Isolation	1
	Rejection	1
	N/A	28
<b>Social/emotional</b>	<b>Negative</b>	
	Disillusionment	3
	Rejection	4
	Anguish	2
	Low morale	4
	Divorce	4
	Isolation	3
	Mistrust	4
	Separation	6
	Stigmatisation	5
	Lack of understanding	2
	Abandonment	2
	Hostility	2
	<b>Positive</b>	
	More attention	1
	Confidence	1
	Understanding	1
	Compassion	19
	<b>Neutral</b>	
	None	53
	N/A	19

Financial	Loss of any income	14
	Increased expenditure	49
	Reduction in income	22
	Poverty	8
	Loss of job	3
	None	30
	ND	31

**Source:** Field Study: November 2005

**The quotations below further illustrate the impact of being HIV positive in these different spheres.**

### ***Professional impact***

In a number of cases, people said they had to change their job after discovering their HIV status.

*"Before, I used to do some cleaning at the hospital and I earned a little money. Now, it's not possible. That's what led me to take up training in dressmaking so as to meet my family's needs"*

*positive woman from Kadiogo*

### ***Social/emotional impact:***

Many respondents spoke of experiences of rejection and social isolation, both by close family members and others in the same social entourage:

*"I've noticed that people approach me and some pity me, but my sister and young mother don't use the same things as me. If they are chatting and I arrive, they stop talking."*

*young positive woman from Kadiogo*

*"Even though I did not tell anyone else except for my wife, the people around me systematically rejected me, including my wife."*

*positive man from Nahouri*

However, over time, attitudes appear to soften:

*"My older sister was very shocked and it seemed like she was the one who was ill because she became so dispirited. But now, she invites me to her home to chat."*

*Positive woman from Kadiogo*

### **Impact on income:**

*"On the financial front, I am gradually learning to get by and managing to earn enough to look after my family".*

*Married man from Nahour*

In some cases, the impact of HIV extended beyond one specific sphere and left people feeling destitute on all fronts:

*"I had grown so thin that everyone would avoid me. I was poor before, but the illness has come to destroy everything I had."* Woman from Nahouri

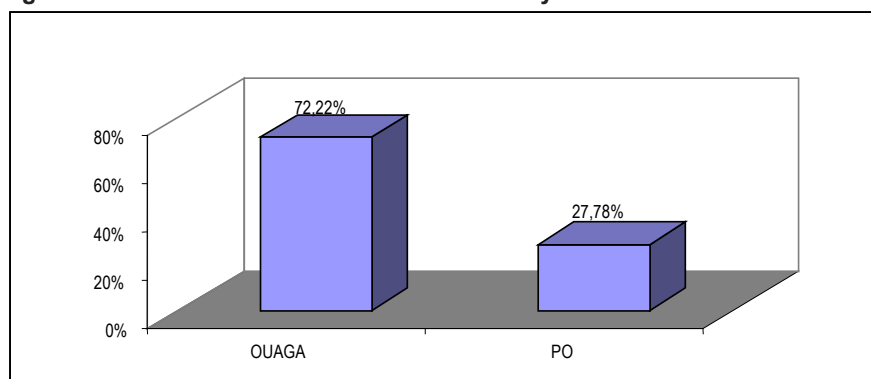
## **Experiences of ARV treatment**

### **Number of people on treatment**

Out of the total 176 beneficiary respondents, a total of 144 (82%) were on ARV treatment. Of these, 104 were from the capital and 40 were from rural area. In all, 32 of the beneficiary population were not in receipt of ARV treatment. All of those not on treatment in the survey were from the urban area, Kadiogo.

As shown in Figure no.1 below, the large majority of the beneficiaries in the sample were from the urban area. This breakdown reflects the heavy concentration of ARVs and ARV-related services in the urban centres.

**Figure no. 1: Breakdown of ARV beneficiaries by zone**



### ***Length of time on treatment***

The survey looked at the length of time respondents have been receiving ARV treatment comparing the rural and urban areas. As shown in Table 6 below, the large majority in both areas have been on treatment for less than one year (69% and 60% in Kadiogo and Nahouri, respectively), which reflects the newness of the ARV programme and the impact of the 3 by 5 initiative, which has intensified efforts at the national level to scale up access to treatment nationwide.

**Table 6: Length of time on treatment**

Zone	Period on treatment	
Ouagadougou	Under 1 year	72 (69%)
	1 to 2 years	25 (24%)
	Over 2 years	7 (6.7%)
	<b>TOTAL</b>	<b>104</b>
Pô	Under 1 year	24 (60%)
	1 to 2 year	11 (27.5%)
	Over 2 years	5 (12.5%)
	<b>TOTAL</b>	<b>40</b>

**Source:** Field surveys, November 2005



### **Impact on Health (physical and mental)**

Over half of the respondents (58%) reported some physical side effects following the onset of treatment. These included: dizziness, vomiting, diarrhoea, migraine, insomnia, and numbness in limbs, nausea, nightmares and others. The beneficial impact on health is most noticeable in those who have been taking ARVs for a year or more.

As shown in the table below, overall 81% of men and women reported improvements in their overall health (both physical and mental). Women were even more likely than men to say that they felt a very significant impact.

**Table 7: Beneficiary views on impact of ARVs on physical and mental health**

	Men		Women		TOTAL	
Big improvement	12	70%	55	83%	67	81%
Moderate improvement	1	6%	6	9%	7	8%
Small improvement	4	23.5%	4	6%	8	10%
No improvement	-		1	1.5%	1	1%

Examples of improvement in general physical and mental health include:-

- ☉ Increased self-confidence
- ☉ More cheerful
- ☉ Increased strength
- ☉ More hope
- ☉ Increased self- respect
- ☉ Increased motivation

As put by one of the service providers interviewed, the main benefit of ARVs is that they have given people hope – the hope to go on living:

*“ARVs have helped those infected to feel better and has given them the hope of life.”*

*Health worker from Kadiogo*

### **Impact on social relations**

Just under half (45%) of the beneficiary respondents reported that since taking ARVs, their relations with family members had improved significantly, compared with 10% who said there had been no change in their relationship. Over 20% reported that relations with their neighbours and other community members had also improved.

Examples given include:

- More moral support;
- More courtesy and respect from friends, family and colleagues
- More tolerance and understanding on the part of others
- More affection
- Less discrimination
- More advice and support.

### ***Financial impact***

In relation to the financial impact, there was no uniform pattern in the experiences reported by beneficiaries. Some felt their situation had improved considerably while others felt they were financially worse off. The reasons cited by those who felt better/worse off, respectively include:

#### ***Better off because of:***

- Being able to resume working
- Fall in cost of prescriptions
- Being able to resume commercial activities
- Being able to start saving again

#### ***Worse off because of:***

- Cost of tests and treatments (for those who pay)
- Cost of travel to laboratories for tests
- Cost of travel to collect drugs
- No income due to loss of employment

### ***Impact on employment***

A total of 5 reported that they had stopped work in the first 3 months after commencing treatment; 9 reported fatigue; 7 reported feeling generally weaker; and 2 reported experiencing stigma and rejection in the workplace.

## **The ARV programme**

This section presents the views of the respondents on the ARV programme in relation to the following key criteria:

- Efficiency
- Access to information
- Access to treatment
- Rural-urban differences
- Cost of ARVs and access to free treatment
- Prescribing treatment

- Supply of medicines
- Assessment of service providers

### **Key components of programme**

The following are the key services that are supposed to be provided under the ARV programme in Burkina Faso:-

- VCT
- Patient identification
- Testing for eligibility for ARV
- Medical prescription
- Treatment of ill patients
- Patient follow up and support for adherence
- Dietary supplements
- Research
- Sale of generic medicines
- Coordination of activities
- Staff training

### **Efficiency of delivery**

Service providers were asked to rank the ARV programme overall in terms of efficiency of delivery. Their responses were as follows:

- 40% said they thought it was inefficient
- 33% said it was moderately efficient
- 11% consider it to be efficient

### **Access to information**

Respondents were asked where they had obtained information about ARVs. The majority had heard of them through associations, like SOS-SIDA. Some also mentioned health centres and others said they heard about them when they had travelled to neighbouring countries, such as the Ivory Coast.

The length of time that they had known about ARVs varies. Just over one third of respondents had heard during the last year. Around one quarter had known about them for 2 years and 15% for over 4 years.

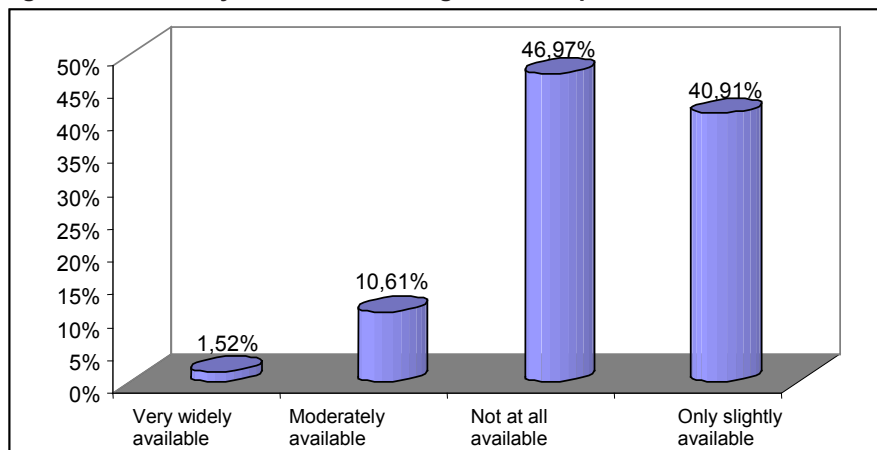
### **Accessibility and availability of treatment**

As shown in Figure 2 below, service providers have a very low opinion of the availability of ARVs nationally. Fewer than 2% expressed the view that ARVs are widely available, while close to half said that they are not at all easy to access.

Key problems relating to access and availability cited by the service-providers include:

- Distance of support structures and lack of transport facilities to access services
- High price of the drugs relative to low incomes of patients
- Drug supplies often run out

**Figure 2: Availability of ARVs according to service providers**



*“One of the weaknesses of the current programme is that ARVs are not available in most of the health districts and very few doctors have been trained to prescribe ARVs”*  
*male ARV beneficiary from Nahouri)*

## Rural/urban differences

Lack of availability of drugs was seen as problem in both the urban and the rural sectors. In terms of the major barriers, the most frequently cited obstacle in the urban area is the prohibitive cost and in the rural area, it is the distances and cost/time involved in accessing medicines and services, as indicated in table 8 below:

**Table 8: Rural/ urban differences in availability of drugs**

	Ouagadougou (urban)	Pô (rural)
Very widely available	2%	-
Moderately available	11%	9%
Only slightly available	27%	68%
Not at all available	59%	23%

Source: Field Study: November 2005

For those living in Pô, the lack of drug availability in the locality poses serious burdens:

*"I have to go to the capital, Ouagadougou, every month, to get my ARVs. That's far from Pô and it's very expensive."*

*Positive man from Nahouri*

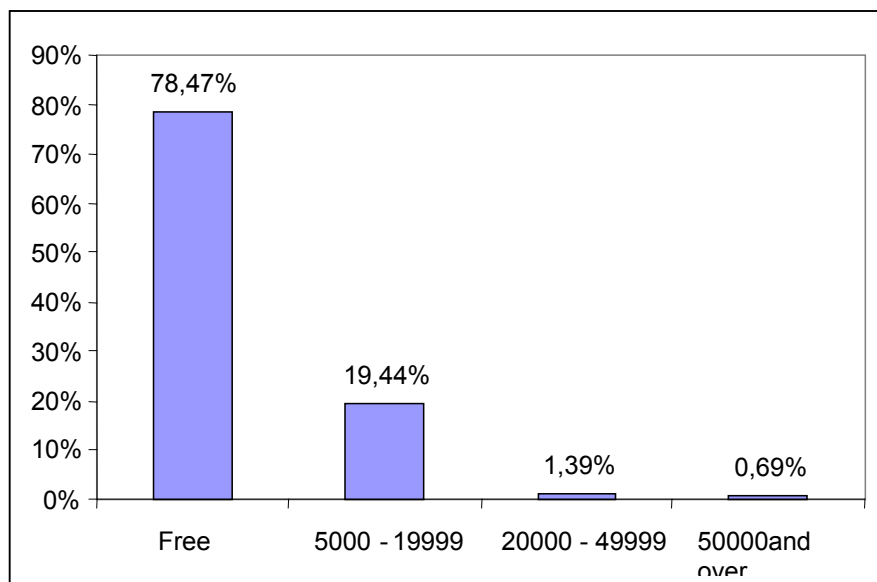
### **Cost of ARVs and access to free treatment**

It should be noted here that Burkina does not provide universal access to free treatment. Some people are able to access the drugs free through organisations, like SOS-SIDA, but others have to pay. There are basically, three main pricing mechanisms applied to ARVs and the cost of the drugs varies depending on the type of drug and the supplier:-

- The cost price: this is often the price charged to the 3 sectors (private, voluntary and state) for training purposes (between 12,000 and 75,000 FCFA per month – US\$22 – US\$139)
- A subsidised price (5000 FCFA per month or around: US\$9) for the triple therapy combination: this price is available for certain structures, such as associations, community-based and faith-based groups
- Free for those on very low income and/or no income linked to associations, national and regional hospitals. They must be identified by a doctor, pharmacist and social services agent or association officer.

As can be seen in Figure 3 below, 78.5% of respondents in the survey were receiving their drugs free of charge, just under 20% were paying between 5 – 20,000 CFAs per month and a small number paid more than that amount.

**Figure 3: Monthly cost of drugs (in CFA)**



*Source: Field Survey, Nov 2005*

Among the survey respondents, proportionately more women than men are in receipt of free ARV treatment. In all, 81% of women on ARVs were getting free ARV treatment. There are various possible explanations, which may account for why more women appear to access free treatment. The most probable is that more women go for tests and find out their status, so they are more likely to access free services. It may also be that men have more access to resources and are, therefore, more likely to be able to pay for the drugs privately.

However, as shown in Table 9 below, men are more likely to access free treatment in the urban areas whilst a higher proportion of men were paying for treatment in the rural area.

**Table 9: Access to Free Treatment: Urban – Rural**

	Urban		Rural	
	Women	Men	Women	Men
Free	76% (56)	83% (10)	59% (10)	23% (3)
Paying	11% (8)	25% (3)	41% (7)	77% (13)

Some people expressed the view that all people should be entitled to free treatment:

*"I've heard that some people pay for their treatment. That's not right. There should be a policy of providing ARVs free to all who need them."*

*Female beneficiary Kadiogo*

According to the survey respondents, the monthly cost of ARVs countrywide ranges from 5,000 to 50,000 CFAs or over (that is approximately £5 - £50). In the specific sites surveyed, the highest monthly price was for ARVs provided by AJPO in the rural area – that is 12,000 CFA (approx, £12). Then, ASEP (5,000 CFAs - £5) and CMA-Pô (5,000 CFAs - £5).

### Who can prescribe the drugs?

One of the main problems highlighted by beneficiaries and service-providers alike was the issue of who is able to prescribe the drugs. In contrast to the situation with other illnesses, including the opportunistic infections linked to HIV/AIDS, which can be prescribed by paramedical staff, in most cases ARVs can only be prescribed by trained doctors belonging to a therapeutic committee or attached to a hospital. The survey found that out of 176 beneficiary respondents, 144 – that is 82% - had obtained their ARVs through a prescription provided by a trained doctor. A number of respondents criticised this situation on the grounds that it restricts access to the drugs:

*"The list of people allowed to prescribe the drugs should be broadened so that all health workers can prescribe them".*

*Woman from Kadiogo, AJPO*

## Lack of regular supply

Despite the critical importance of ensuring regular intake of ARVs in order to avoid developing resistance, many people spoke of irregularities in the supply of drugs. This was of particular concern to service providers:

*"The drugs are not always supplied on time and patients have to wait whilst the drugs should be taken daily. For example, this month we only got sent enough for 80 people, which is well below the number required".*

*A psycho-social counsellor from Kadiogo*

*"The order forms are often not sent out on time from the headquarters despite the fact that the medicines are desperately needed by those who are sick" (health care worker*

*from Kadiogo, SOS-SIDA*

Some respondents expressed their concerns about the supply over the longer term:

*"If the programme comes to an end, what will happen to me since I have no income? How can the continuity of the programme be secured so as to sustain those currently on treatment?"*

*Married woman from Kadiogo, AJPO*

## Review of HIV/AIDS service organisations: strengths and weaknesses

As part of the research, an organisational review of 5 organisations involved in ARV delivery in the 2 sites surveyed was undertaken in order to assess the strengths and weaknesses of these organisations and their capacity to deliver a good service.

The 5 organisations, two of which are based in the capital Ouagadougou and 3 in the rural area, Pô, are: AJPO (Association of Young People for the



Support of Orphans), ASEP (Association for Support and Hope of Pô), CMA Pô, SOS-SIDA and URBLs (Union of Burkinabe Truck drivers in the fight against HIV/AIDS).

Between them, the 5 organisations concerned service a total of 1083 PLHAs. Of these, 261 are receiving ARV treatment.

**Table 10: PLHAs under the care of each organisation**

	Total no. of PLHAs	PLHAs on ARVs	PLHAs without treatment
AJPO	214	18	196
ASEP	46	25	21
CMA PO	44	13	31
SOS-SIDA	637	169	368
URBLs	142	36	55
<b>TOTAL</b>	<b>1083</b>	<b>261</b>	<b>671</b>

*Source: Field Study (November 2005)*

These associations provide a range of services for PLHAs as shown in Table 11 below.

**Table 11: Services provided by AIDS-support organisations in Ouagadougou and Pô**

Urban		Rural		
SOS-SIDA	URBLs	AJPO	ASEP	CMA PO
Psychosocial support	Free generic treatments	Psychosocial support	Food Distribution	Psychosocial support
Support with adherence	Care and treatment of opportunistic infections	Support groups	ARV provision	Medical care
Medical support	Referrals to clinic	Home visits and hospital visits	Provision of treatment for opportunistic infections	
		Medical follow-up	Nursing support	

		Adherence Club	Psychological support	
		Payment of prescriptions		
		Free medical care		

## Key weaknesses/limitations

Staff of these organisations were asked to assess what they saw as their strengths and weaknesses. Their responses are summarised below:-

- Staffing : Staff shortages (AJPO) ; lack of qualified staff (SOS-SIDA, AJPO) ; lack of staff motivation
- Organisational aspects : lack of systems in place (URBLS)
- Material and Equipment : lack of laboratory equipment (REGIPIV) ; shortage of drug supplies (AJPO) ; no office and/or office equipment (ASEP, CMA-Pô)
- Logistical problems : Distance to testing laboratories (ASEP) ; poor condition of motorcycles (AJPO)
- Services provided : Inadequate food support (SOS-SIDA, AJPO; lack of adherence centre (SOS-SIDA) ; insufficient supplies of ARVs and other drugs (CMA-Pô)
- Financial resources : inadequate financial support (SOS-SIDA, REGIPIV, AJPO; URBLS) lack of funders (ASEP, CMA-Pô)

Overall, lack of resources and equipment were perceived by all five organisations to constitute serious constraints on the level and quality of service they are able to provide to positive people in the community. Human capacity and lack of skills and access to training were also seen to have an adverse impact on their services, resulting in the de-motivation of staff and volunteers.

## Risks attached to treatment

The service providers interviewed identified the following main risks resulting from weaknesses in the ARV programme implementation:

- Development of resistance to treatment
- Patient loss of confidence
- Treatment discontinuity leading to death
- Lack of motivation on the part of health workers
- Persistence of sickness and pain

## Summing up

The chief criticisms of the ARV programme and policy mentioned by respondents include:

- Limited availability of ARVs country-wide
- Poor geographic coverage of ARV programme
- Lack of qualified personnel (for making out prescriptions, follow-up, and so on)
- Inadequacy of information linked to treatment
- The treatment eligibility criteria
- High cost of treatment for many patients
- Low incomes of those on treatment
- Does not take account of high illiteracy levels among beneficiaries
- Lack of therapeutic monitoring and follow-up
- Inadequacy of training and/or refresher training for health workers
- The policy is not well adapted to socio-economic context of the country
- Poor policy implementation capacity



## Chapter 4: Recommendations and Conclusion

### Recommendations

The following set of recommendations emanate from the major findings of the research and from specific recommendations made by ARV beneficiaries and/or by those directly involved in service provision.

#### Improvements in programme delivery:

1. More training should be provided for health service personnel
2. The list of people qualified to prescribe ARVs should be broadened
3. The system of drug supply and distribution should be improved to ensure that an adequate supply of drugs reaches all distribution points in a reliable and timely manner.
4. Drug distribution and testing facilities should be decentralised so that people living in rural areas are able to enjoy equal access to the benefits of ARVs.

#### Access to free treatment:

5. Treatment and related services should be available free to all who need them.

#### Nutritional supplements:

6. Services provided should include dietary supplements for those who need them (both men and women).

#### Support for structures of and for PLHAs:

7. PLHA associations, such as ASEP, play a vital role in identifying people in need of treatment and supporting them with essential information and counselling and other services. These associations must be supported and strengthened through increased financial and capacity-building support. In addition, the valuable contribution of the national network of PLHA associations - REGIPIV, in coordinating the work of these associations and ensuring that PLHAs participate actively in the design, planning and implementation of services across the country, must be fully recognized and supported.
8. Increased financial resources and capacity-building support should also be provided to structures, such as SOS-SIDA, in order to improve the scope and quality of ARV-related and other services they provide for PLHAs.

## Further research:

There is a need for further research in order to:

9. Find out more about the reasons why women seem to access services more readily than men and to examine in greater depth the gender dynamics within the household where more than one person is positive.
10. Explore the financial impact of ARVs on individual and household income in order to inform policies aimed at supporting PLHAs.
11. Study the impact of stigma and discrimination, particularly in relation to access to care and treatment take-up.

## Conclusion

In the last few years, the combined efforts of the government of Burkina Faso, the PLHA community and the NGO sector, backed by funding from multilateral and private donors have made a significant contribution to scaling up access to treatment as part of the multi-sectoral response to HIV/AIDS in the country. The number of testing and other facilities established to support the ARV programme has been increasing resulting in a steady increase in the number of people accessing treatment. Those who have succeeded in accessing treatment are not only enjoying significant improvements in their physical health and ability to resume work and normal activities, but also in their mental and emotional health.

Further, the findings indicate that these improvements in people's physical and emotional well being are also contributing to reducing the extent of stigma and discrimination related to HIV and AIDS. This is a very welcome finding that will, in turn, contribute to the prevention efforts in the country as people will more readily go for testing in a climate in which it is possible to talk more openly about HIV and AIDS without fear of social marginalization and exclusion.

The findings also suggest that people with HIV are able to return to work and be more productive in the workplace, so there will also be economic benefits at the level of the national economy in the medium to longer term.

Thus, although the 2005 treatment targets were not reached and we are now well into 2006, it is critically important that efforts on all fronts should be redoubled to continue working towards these targets. Moreover, the Burkina Government, as all governments in sub-Saharan Africa and beyond, must set

new targets aimed at achieving universal access by 2010, as agreed at the last UN Summit.

In addition, every effort must be made to address the serious inequalities in terms of geographical coverage of the ARV programme and to improve the quality of the services provided. In particular, the quality and extent of training for health service personnel and the provision of a regular and timely supply of treatment must be addressed as a matter of topmost priority.

To achieve all of the above, it will be critical to ensure that all the sectors, central and local government, the health services, NGOs, the multi-lateral donor agencies and the pharmaceutical companies, work closely together to support efforts to achieve these targets and make universal access a reality and bring an end to the unnecessary hardship and suffering borne by the weakest and most impoverished sectors of society.

# Annex 1: The main actors in the delivery of ARVs countrywide

In all, around 30 structures are officially involved in delivering ARVs within Burkina Faso. The main actors include:

## **Initiative PPTE**

Provides approx. £500,000 per year and in October 2004 was providing treatment to roughly 527 PLHAs.

## **ESTHER (Collective for a therapeutic hospital solidarity Network)**

Through this initiative, involving a twinning between 4 Burkina hospitals and 4 university hospitals in France, the Burkina state has received around £500,000 for ARV treatment. During 2005, 300 PLHAs, of whom 50 are children, received services. From 2006 onwards, the Global Fund will take over from ESTHER

## **World Bank**

The World Bank has adopted the following two main approaches to ARV scale-up:

- (a) Supporting treatment costs for 450 PLHAs (of whom 50 are children) in 8 health centres country-wide.
- (b) Operational research in two urban and four regional hospitals supporting community-based care for 400 patients.

## **The French Red Cross**

Supports treatment for 296 patients in Ouagadougou.

## **The Global Fund**

An agreement was signed in October 2003 and activities involving medical and community-based support commenced in 2004. By the end of 2005, a total of 2,400 people were receiving treatment supported by the Global Fund.

## **TAN Aliz Society**

This society is supporting treatment services provided by various associations for approximately 417 people.

## **MSF**

MSF is supporting the Medical Centre of Pissy and by the end of 2004, was supporting the treatment of 512 patients.

## **SOS-SIDA**

Providing treatment for patients with funding from the World Bank

## **AAS (African Solidarity Association)**

Provides treatment and community-based support for 121 patients.

Together with some people who are accessing ARVs through various other private sources, there were approximately 2,617 people receiving ARV treatment in Burkina Faso at the end of 2005, including 117 children.



## Annex 2: Research Partners

### ACORD

ACORD is an Africa-led international consortium working to promote social justice and equality. It is currently operating in 17 countries across sub-Saharan Africa. ACORD has been working in the Sahel region for over a quarter of a century. Its interventions have been aimed at supporting communities to adapt to the serious challenges posed by environmental, climatic, economic and political trends in the region; promoting strategic and coordinated grass roots responses to the globalization of markets and the economy.

#### Activities

ACORD activities in the Sahel region are aimed at providing:

- Support for civil society through decentralization and democratization
- Support for sustainable livelihoods
- Increasing awareness of HIV/AIDS
- Support for conflict resolution

One of the key strategies employed by ACORD is working in partnership with others and building alliances between organizations at all levels from the local to the international.

### SOS-SIDA

SOS-SIDA was established by a group of students and unemployed youth who wanted to make a contribution to the battle against HIV/AIDS in their country. The association was formed in the early 1990s when HIV/AIDS was still a taboo subject and no support was available for those infected and/or affected. Small discussion groups were established to promoting awareness of HIV/AIDS, mainly with the support of PLHAs. The Association currently has over 200 members, mostly individuals.

#### Objectives:

- To facilitate access to prevention services
- To promote VCT
- To improve living conditions and quality of life of PLHAs and their families
- To support orphans and other vulnerable children

#### Activities:

- Provision of medical, psychological and socio-economic support for PLHAs
- Promote behaviour change amongst target groups
- Provision of VCT
- Providing support for orphans and vulnerable children

### REGIPIV- Burkina Faso

REGIPIV was established in June 2001 as a network of organizations of PLHAs in Burkina Faso. It has around 50 member organizations countrywide.

It was born out of the will of its members to increase both their intellectual and physical involvement in the design and delivery of care and support services and in order to extend support for community-based care throughout the whole of the country.

**Objectives:**

- To promote access to care, advice and treatment for PLHAs
- To promote the participation of PLHAs in care and education services
- To build the capacity of PLHA associations

**Activities:**

- Leadership training for PLHAs
- Resource mobilization
- Technical support
- Building partnerships and alliances
- Advocacy
- Supervision

**ASEP – (Association for Hope and Support)**

ASEP is a member organization of REGIPIV established on 28 July, 2003. ASEP is based in Pô, the capital of Nahouri. It has around 69 members of whom the majority are PLHAs. ASEP is also supporting 71 orphans and/or vulnerable children of whom 51 are classified as economically vulnerable.

**Objectives**

The overall aim of the association is to improve the care and support provided to its members and to promote the active involvement of positive people in the services directed at them. In particular, ASEP seeks to:

- Develop partnerships to support the implementation of HIV/AIDS policies and programmes in the locality
- To contribute to changing the perceptions about PLHAs so as to promote community ownership of initiatives aimed at supporting PLHAs
- To serve as a channel for disseminating and providing access to care and information for all its members
- To share experiences with others
- To promote and defend the rights of PLHAs
- To promote positive living
- To support the establishment of mutual support groups across the province
- To promote good quality care for PLHAs
- To denounce injustices committed against PLHAs

**Activities**

- Psychological support
- Medical and nursing care
- Paying school fees for orphans
- Support for income-generating activities
- Social and material support for PLHAs (clothing, food)
- Institutional support

Key strategies include IEC (information, education and communication); training; inter-sectoral collaboration; resource mobilization; and evaluation. ASEP is supported by international NGOs in the Netherlands and by the World Bank.

## ANNEX 3: Administrative Map of Burkina Faso





#### KAMPALA OFFICE:

Plot no. 1272 Ggaba Road,  
Block 15,  
Nsambya  
PO BOX 280  
Kampala  
Uganda

Tel: +256 (41) 267 668/266 596

E mail: [hasap@acord.or.ug](mailto:hasap@acord.or.ug)

---

#### LONDON OFFICE

Development House  
56-64 Leonard Street,  
London EC2A 4JX  
United Kingdom

Tel: +44 (207) 065 0850

E mail: [info@acord.org.uk](mailto:info@acord.org.uk)

---

#### NAIROBI OFFICE:

ACK Garden House  
PO Box 61216-00200  
Nairobi  
Kenya

Tel: +254 (20) 2721186/1185

Email: [info@acordnairobi.org](mailto:info@acordnairobi.org)

---

ACORD is a company limited by guarantee  
Company registration no. 1573552

ACORD is a registered charity governed by  
memorandum and articles of association.

UK Registered Chairty Number 283302

---

Copyright ACORD 2004

---

ISSN 1812 1276