

**HIV/AIDS Alliance and IPC Proposal  
Assessment: Assisting Orphans and  
Vulnerable Children in Burkina Faso**

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by

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## Acronyms

A.PRO.DE.C	Association Professionel de Dépistage et Counseling
ALAVI	Association Laafi Viim
AMMIE	Association Appui Moral, Maerial et Intellectual a L'Enfant
APES/Jeunes	Association Preventative
AVOB	Association des Vueves et des Orphelins de Burkina
CADI	Centre Anonyme de Dépistage et de l'Information
CNLS	Comité National de Lutte Contre le SIDA
CPAM	Comité Paroisse d'Aide aux Malades
CRC	United Nations Convention of the Rights of Children
CRS	Catholic Relief Services
DCOF	Displaced Children and Orphans Fund
DITRAME	Dépistage de la Transmission de la Mère et de L'Enfant
FAARF	Fond d'Appui aux Activités Renumeratrices de Femmes
FUC	Association la Bergerie-Foi, Univers, Compassion
GTZ	German development agency
GNP	Gross National Product
HBC	Home Based Care
HDI	Human Development Index
HPI	Human Poverty Index
IEC	Information Education Communication
IPC/BF	Initiative Privée et Communautaire de Lutte contre le SIDA au Burkina Faso
NGO	Nongovernmental Organization
PLWA	People living with AIDS
REVS+	An association of PLWA
SAS	Services des Actions Sociales
OTRAO	Burkinabé Transporters Union
STD	Sexually Transmitted Diseases
TB	Tuberculosis
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
UNPOP	United Nations Population Program
USD	U.S. Dollars
WHO	World Health Organization



## **Executive Summary**

From July 12 to July 23, 1999, the Displaced Children and Orphans Fund (DCOF) conducted an assessment in Burkina Faso (Burkina) of an HIV/AIDS Alliance proposal titled “Addressing Priorities Related to Orphans and Highly Vulnerable Children Affected by AIDS in Burkina Faso.” The proposal is a three-year capacity-building effort to support activities to mitigate the impacts of HIV/AIDS on orphans and vulnerable children. HIV/AIDS Alliance’s partner in Burkina is the Initiative Privée et Communautaire de Lutte contre le SIDA au Burkina Faso (IPC/BF).

### **HIV/AIDS in Burkina**

Burkina has joined the Ivory Coast and Ghana as the three countries most affected by HIV/AIDS in Western Africa. Unfortunately, there are very few sources of reliable data available to track the evolution of HIV/AIDS in Burkina. Although the official rate of HIV prevalence among the general population (aged 15 to 40) is 7 percent, it is widely acknowledged that a 10 percent rate of HIV prevalence is probably more realistic. According to a report issued by the Ministry of Health in June 1998, there were 12,285 officially diagnosed cases of AIDS. A December update puts the number of cases at 13,518. The ministry report admits, however, that HIV/AIDS cases are severely underestimated and cited a 1994 study claiming 500,000 to 600,000 people live with HIV in Burkina.

Several factors have exacerbated the spread of AIDS in Burkina. The first factor is the country’s long tradition of migration inside and outside its borders. Between 1985 and 1991, 10.1 percent of the population—mostly young men—migrated either from the north and east provinces to those in the south, or to Cote d’Ivoire and Ghana. The second factor is the practice of wife inheritance, especially within the extended families of married, migrant men who have HIV/AIDS and return to Burkina when they fall seriously ill. The third factor is the lack of access to affordable testing and counseling facilities.

There is only one testing and counseling center in Burkina. Other facilities such as private clinics and hospitals are either too expensive or offer no counseling. This lack of access has led to the “invisibility” of HIV/AIDS. The Burkina Government consequently underestimates the impending impact and assigns a low priority (i.e., few resources and little attention) to combating its spread. Burkina also has a very young population—49 percent are under 15 years of age. Among these young people, girls are especially at risk. Girls start having sex much earlier than do boys; in fact, 31 percent of girls aged 15 to 19 are either pregnant or have had a baby. Of particular concern is the practice of older men seeking out younger girls for sex.

## **Impact of HIV/AIDS on Children and Families**

Estimating the numbers of children orphaned by AIDS is as problematic as estimating the numbers of AIDS cases and seroprevalence among the general population. Nevertheless, a World Health Organization (WHO) study estimated there were 200,000 AIDS orphans in 1997. The Ministry of Social Action recently reported 2,000 orphans in the Ouagadougou urban center. “Children on the Brink” estimates that in 1985, roughly 16 percent of children under 15 were orphans and that in 2000, that figure will rise to 20.85 percent.

Despite scant information and anecdotal information of current perceptions of service providers, government and youth interviewed suggest that children and their families in Burkina suffer the same consequences as those in other countries. Problems related to increased family poverty, diminished parental protection and authority, and psychological stress are all major consequences stemming from increased death and illness related to HIV and AIDS. The most widely reported impact of HIV/AIDS on families was the heavy cost of tending to infected family members’ medical needs.

Of particular concern to the well-being of children is the “culture of silence” around HIV/AIDS, combined with the low-priority given to mental health in Burkina. These realities overshadow responses to children’s need for assurance, guidance, and support and reinforce the environment of denial. Without adult support, feelings of guilt, insecurity, and fear are common. Children often manifest these feelings in destructive and unhealthy behavior.

## **Responses to Mitigating the Impact of HIV/AIDS**

Burkina has a strong tradition of mutual support within the extended family network and within communities. Most orphans and widows are absorbed into the extended family. In addition, it is considered common courtesy to visit someone who is sick and offer some type of assistance. There are signs, however, that this tradition is weakening and that spontaneous support from neighbors, friends, and the extended family cannot be sustained in the face of a disease that consumes family resources over a long period of time.

On the other hand, new forms of solidarity are surfacing. It is widely acknowledged that children are best cared for within their extended family network and communities. Community networks have created informal care situations—either through adoption, fostering, or support to children living on their own. Associations and religious groups are the forefront of this new response. In spite of this, there are children who do fall through the gaps; either ending up on the streets, in unsupervised child-headed households or, in the case of girls, falling into a life of prostitution.

There is also a wide consensus that focusing only on orphans or, worse yet, AIDS orphans would worsen stigmatization. Most NGOs, associations, and government workers agree that building on the growing concern within communities for vulnerable children could be an effective entry point for heightening awareness of HIV/AIDS, for bringing issues into the open and thus reducing

stigma.

### **Crisis Response**

Most IPC-supported associations carry out palliative care through home based care (HBC). However, they have neither the financial nor the human resources to respond to all the demands they receive for their services. They are even more hard pressed to respond to the needs of orphans or other children made vulnerable by HIV/AIDS. As a result, they concentrate on reaching the most acute cases.

The attention of most development organizations in Burkina is on catching those who fall through family and community safety nets after those nets have failed. Such crisis mode thinking concentrates on satisfying immediate material needs that require significant and on-going sources of financial assistance. Burkina is already a poor country with a limited capacity to respond to the needs of vulnerable children and families. Thus, the prevailing mood is one of helplessness and disempowerment. Burkinabé are focused on what they cannot do, rather than on building on what people in the wider community are already doing.

### **Mitigating HIV/AIDS Impact By Strengthening Family Economic Resources**

The well-being of children in families affected by HIV/AIDS and of orphans absorbed into extended families depends on the economic means of the household. In order to support such endeavors effectively, however, one must first distinguish between activities designed to strengthen household resources in anticipation of crises, and those aimed at providing relief assistance to households in extreme situations. These two activities must also be differentiated from income-generating projects that aim to create a source of funds for the activities of an association.

## Recommendations

IPC/BF, HIV/AIDS Alliance, and the associations they support must seek to develop a strategy whose fundamental approach seeks to strengthen family and community safety nets. This strategy must also seek to take proactive steps to address situations while they are still relatively manageable.

To do so, IPC/BF and HIV/AIDS Alliance should revise their original proposal to elaborate more specifically on how they will build the capacity of selected IPC-supported associations to integrate community mobilization within their current activities. The proposal should place special emphasis on the following:

- Training associations to engage in interactive community participation and act as catalysts and facilitators of community responses to the needs of families and children affected by HIV/AIDS, as opposed to carrying out new activities on behalf of communities.
- Training association members to conduct a participatory, child-focused assessment on HIV/AIDS impact on children, their families, and their communities—including young people from the onset of the project planning process.
- Expanding the definition of care and support to look at the family as a whole, considering children's psychosocial needs well before the death of the parent.
- Identifying local resources that can assist associations in acquiring participatory techniques and tools that are appropriate for both adults and youth.
- Maximizing resources, and seeking collaboration with other development organizations.

IPC and HIV/AIDS Alliance should also organize an opportunity for reflection on the issues surrounding the impact of HIV/AIDS and on developing a systematic response to them. Key people from associations and NGOs, government officials, and extension workers should be invited to participate.

Given that Burkina's people are especially vulnerable to poverty, attention must be given to strengthening the economic resources of families. To this end, IPC and HIV/AIDS Alliance should ensure that the following provisions are made:

- Build the capacity of associations engaging in community mobilization to address the need to create a sustainable source of funds for relief assistance; and
- Collaborate with Fond d'Appui aux Activités Renumeratrices de Femmes (FAARF), United Nations Development Program (UNDP), and Catholic Relief Services (CRS) on developing a savings mobilization and/or microcredit scheme (implemented by FAARF or CRS) that would overlap with the community mobilization activities of IPC-supported associations.

## **Introduction**

### **Purpose of Assistance**

From July 12 to July 23, 1999, two Displaced Children and Orphans Fund (DCOF) consultants conducted an assessment in Burkina Faso of an unsolicited proposal submitted to DCOF by the International HIV/AIDS Alliance. The proposal is titled “Addressing Priorities Related to Orphans and Highly Vulnerable Children Affected by AIDS in Burkina Faso.” The proposal aims to “address the needs of orphans and vulnerable children who have one or both parents living with HIV/AIDS through the establishment of new strategies, tools, activities and means of assessing results.” The proposal is for a three-year capacity-building effort to integrate the above priorities into existing NGO projects supported by the Alliance’s partner in Burkina, the Initiative Privée et Communautaire de Lutte contre le SIDA au Burkina Faso (IPC/BF).

The consultants focused on two aspects for the assessment:

1. Gaining a broad understanding of the contextual issues in Burkina surrounding orphans, vulnerable children, and HIV/AIDS; and
2. Reviewing the technical aspects of the proposal with IPC and with the associations IPC supports.

### **Methodology**

The consultants interviewed four associations involved in care and support activities (La Bergerie, Association Laafi Viim [ALAVI], Comité Paroisse d’Aide aux Malades [CPAM], and REVS+) and two associations engaged in IEC prevention activities (APES/Jeunes APES/Jeunes [Association Preventative] and CEPROFET). These associations are supported by IPC, HIV/AIDS Alliance’s partner in Burkina Faso. Four of these associations are located in Ouagadougou, one in Bobo-Dioulasso, and one in Kaya. The team contacted additional NGOs, government departments and committees, and resource persons to gain a broad perspective of the Burkina context for HIV/AIDS and the response so far to its impact.<sup>1</sup> Interviews took place in Bobo-Dioulasso, the second major city in Burkina and the epicenter of the HIV/AIDS epidemic, Ouagadougou, and Kaya, a rural site approximately 125 km from Ouagadougou.

In Bobo-Dioulasso, the consultants had two focus group discussions: one with three children orphaned by HIV/AIDS who are now the head of their households, and one with a group of Muslims and their Imam (mosque’s prayer leader).

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<sup>1</sup> See Appendixes for a full contact list, an itinerary, and discussion topics.

## Context of HIV/AIDS in Burkina Faso

### Geographic and Demographic Profile<sup>2</sup>

Burkina is a land-locked country located in West Africa and bordered by Mali and Niger to the North and Benin, Togo, Ghana, and Cote d'Ivoire to the South. The 1996 census reported a total population of 10,469,747. If the population continues to grow at its present rate, this number should rise to approximately 12,000,000 in the year 2000. Whether mortality from HIV/AIDS is taken into account in this estimation is unknown.

Ouagadougou, the capital city, is the largest urban center followed by Bobo-Dioulasso. Other major cities with a population over 25,000 include Koudougou, Banfora, Ouahigouya, Tenkodogo, Pouyatenga, Dédougou, Kaya, and Fada N'Gourma.

Burkina Faso's population is young (49 percent are under 15 years old) with a majority of women (51.1 percent in 1991). Nearly 90 percent of the population makes a living farming small family plots to produce subsistence products (sorghum, millet, and corn). Cotton is the major cash crop, but peanuts, sesame, shea nut kernels, and sugar cane are also exported, albeit in small amounts. Cattle breeding is also an important source of income.

**Table 1: Socioeconomic Data for Burkina Faso**

Socioeconomic Data	Number	Source & Date
Total population (in thousands)	11,087	UNPOP, 1997
Population living in urban areas	16%	UNPOP, 1996
Population under 15 years (as of 1991)	49%	Jeune Afrique Atlases, Burkina Faso 1998
Annual population growth	2.6%	UNPOP, 1980-95
Child mortality-deaths < age 5 per 1,000	184.3	U.S. Bureau of Census, June 1996
Maternal mortality rate per 100,000 births	566	Jeune Afrique Atlases, Burkina Faso 1998
Life expectancy	46	UNPOP, 1996
Per capita GNP (\$)	230	World Bank, 1995
People living under poverty level	44.5%	World Report on Poverty, UNDP 1998
Human Poverty Index Value (HPI)	58.2	
Human Development Index (HDI)	0.219	
Adult literacy rate	M30%, F9%	UNESCO, 1995
School attendance (children attending school in 1997-8)	40	UNICEF, 1999

Source: *Country Brief, Burkina Faso, HIV/AIDS Alliance*

<sup>2</sup> Source for information in this section is the "Jeune Afrique Atlases—Burkina Faso", 3<sup>rd</sup> edition, 1998.

## **Children in Burkina**

**Economic contributors:** Beginning at a young age, many children in Burkina provide either direct or indirect economic support to their family. This is particularly true in rural settings, where children act as needed labor for agricultural work. Other children or youth work in the informal sector as domestic workers, street hawkers, and daily laborers. UNICEF estimates that 60.7 percent of youth between the ages of 10 and 14 work in Burkina.

**Low school and literacy rates:** Despite a national law requiring all children to attend primary school, only 40 percent attended school in 1997-8. Girls are less likely than boys to attend school; 33.4 percent of girls attended primary school and 36.31 percent of girls attended secondary school (UNICEF 1999). Recognized obstacles include high schooling fees and related costs that average 15,000 to 20,000 CFA (roughly 22 to 24) per student per year. Weak demand for schooling is also a factor, since many parents commonly believe that school does not adequately prepare their children for the future.

**Health status:** In the most recent National Demographic and Health Study, approximately one in three children under the age of five suffers from chronic malnutrition. Poor nutrition is related to low levels of food security (over 1.7 million Burkinabés are reported to suffer from chronic food shortages, 2.7 million from periodic food shortages), poverty, and poor knowledge of basic nutrition.

**Children participation issues:** Many Burkinabé see young children as needing constant protection, control, and supervision. With the exception of older adolescents and young adults, there is little tradition of encouraging children to be active decision-makers and participants in family and community affairs. As one association member explained “a child in the Burkina context is like an empty glass which needs to be filled (by adults) and can only receive. Even in respect to adolescents, the glass is only half full. It is difficult for a Burkinabé to see children as contributors.” Hence, children’s participation in family affairs and access to information is very limited. In general, children are not informed about family affairs nor are they part of family decisions.

**Gender issues:** In Burkina, girl children are often discriminated against. Girls have less access to school than boys, have a higher illiteracy rate, are responsible for heavy household work at an earlier age, and are married young. According to the UNICEF’s situational analysis of Burkinabé women and children for 1999, 31 percent of female adolescents ages 15 to 19 are either pregnant for the first time or have had a baby. Forced marriages are not uncommon and contribute to this high rate of early pregnancies. In Kaya, the Emmanuelle Order of nuns provides refuge to 47 girls who have run away from forced marriages.

## **Tradition of Migration**

A very significant aspect of Burkina Faso's demographic character is the traditional mobility of its population. Many Burkinabé, primarily young men aged 15 to 24 from rural areas, see migration, usually to Cote d'Ivoire, as a major way out of poverty. Between 1985 and 1991, 10.1 percent of the population migrated either within the country or for other countries. Up to 18 percent of Burkinabé live outside the country, a fact which makes Burkina the major source of emigration in West Africa. Remittances from the savings of these Burkinabé workers amounted to 10 percent of the total national revenue in the 1980's. Internal migration is also a notable dimension of Burkina's mobile population. The dense population of the Central Plateau has exhausted the land and has forced people to migrate to other regions where there are major farming developments. The most popular destinations within Burkina are Ouagadougou, Bobo-Dioulasso, Koudougou, and Banfora, in that order. Together, these urban areas absorb 80 percent of the rural exodus.

## **AIDS Epidemic in Burkina Faso**

Burkina reported its first AIDS case in 1986. Since then, Burkina has joined Cote d'Ivoire and Ghana as the three countries most affected by HIV/AIDS in Western Africa. According to a Ministry of Health report from June 1998, 12,285 individuals were officially diagnosed with AIDS. A December update from the National Committee for the Fight against AIDS (CNLS) puts the number of cases at 13,518. However, the ministry report also admits that HIV/AIDS cases are severely underestimated due to limited testing and cited a 1994 study that claimed between 500,00 and 600,000 people were living with HIV in Burkina at the time. Although the official rate of HIV prevalence among the general population (ages 15 to 40) is 7 percent, it is widely acknowledged that 10 percent is probably more realistic. Seroprevalence among blood donors is around 10 percent.

Sentinel surveillance sites target pregnant women, people treated for STDs, and prostitutes. In 1996, 10 percent of pregnant women tested in Ouagadougou during pre-natal visits were HIV positive. According to statistics gathered by UNAIDS, 9.7 percent of pregnant women in Bobo-Dioulasso are HIV positive. Other reports reviewed by the team indicate the percentage is presently 12 percent.

Studies also estimate that between 25 and 50 percent of Burkinabés who suffer from STDs subsequently test positive for HIV, including 24 to 30 percent of Burkinabés diagnosed with tuberculosis. A doctor from the Bobo-Dioulasso hospital, which has approximately 2,000 patients per year, reported that between 30 and 50 percent of the hospital's patients suffer from AIDS-related illnesses.

## Geographic Areas Most Affected

According to available data, Bobo-Dioulasso is the most heavily affected city in Burkina; followed by Ouagadougou, Ouahigouya, Tenkodogo, and Gaoua.<sup>3</sup> Bobo-Dioulasso is an important crossroads for commerce and migration between Burkina, Mali, Ghana, and Cote d'Ivoire. It is also a major destination for people leaving the hostile climate of the North and East in search of agricultural employment or other opportunities.

Like many other countries in Africa that are heavily affected by HIV/AIDS, the epidemic was first concentrated in major urban areas. What is striking in Burkina is the swiftness with which rural areas threaten to overtake urban ones in terms of being infected and affected by HIV/AIDS. To explain this reality, one only has to look to Burkina's ancient tradition of migration—both internal, from the north and east portions of the country to the south and west, and external—to neighboring coastal countries, in particular Cote d'Ivoire. For example, Gaoua, Ouahigouya, and Tenkodogo are all secondary cities in rural areas close to the borders of coastal neighbors.

It is a tradition for young men to go seek their fortune in Cote d'Ivoire, and when they go they usually cannot afford to bring their spouse with them or are single. They come back when they are ready to bring their spouse back with them, want to get married, or are very ill and come back to their village to be cared for and die. In the first case, there are many that are HIV-positive but seemingly in good health; so they go off with their wives. When these migrant men begin experiencing AIDS-related illness; they usually come back to their home villages with their wives and children. If the man's wife is still young, she is often re-married when he dies; if not by the brother, then someone else in the village. This strong tradition of wife inheritance<sup>4</sup> further exacerbates the spread of AIDS in rural areas when the wife is also infected.

## Population Groups Heavily Affected

In 1994, the National Institute of Statistics embarked on a survey in Burkina to provide a snapshot of seroprevalence among the following population groups:

### Demographics of Poni—A rural province

Borders	Ghana and Cote d'Ivoire 40km from Ouagadougou
200,000	inhabitants with 18,000 people living in the chief city of Gaoua
601	villages with an average of 150 inhabitants each
52%	of the population are women
7%	of the population emigrates to Ghana or Cote d'Ivoire

### HIV/AIDS in 1998

6%	of blood donors are HIV+
27%	of people treated for STDs are HIV+
15.8%	of pregnant women in Gaoua are

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<sup>3</sup> The statistics in the accompanying text box were taken from the draft HIV/AIDS Health District Plan for Gaoua, January 1999.

<sup>4</sup> A deceased man's brother is often expected to marry his brother's wife so she and the children stay in the extended family.

**Table 2: Burkinabé Seroprevalence**

Population group	Seroprevalence
Of 1,295 pregnant women <sup>5</sup> ...	8% are HIV+
426 prostitutes...	58.2% are HIV+
236 truck drivers...	18.6% are HIV+

Source: *Demographic Survey of Burkina—National Statistics Institute, 1994-1995*

Many Burkinabé organizations feel it is not useful to classify who is at risk in terms of population groups that are easily stereotyped (for example, prostitutes and truck drivers). Labeling who is at risk allows the general population to point fingers and continue talking about “those people over there” rather than taking responsibility for their own risky behavior. The more compelling factors are those that describe who, in a broad context, is vulnerable to contracting HIV.

The above list suggests that vulnerability extends beyond the risk groups typically associated with HIV/AIDS. In the above context, young girls (45 percent of the Burkinabé female population) are in the most precarious position. This is related to three key factors:

**Vulnerability Factors**

- To be young, sexually active, and sleeping with multiple partners.
- To be a migrant, working in areas with a high HIV-prevalence rate.
- To be in an economically and socially disadvantaged position.
- To be a woman who has little formal education or economic power, has little decision-making authority, and is dependent on her male partner.
- To be duty-bound to submit to certain traditions like excision, circumcision, and early forced marriage.

- Girls begin having sexual relations (premarital and within marriage) much earlier than boys do. One-third of all girls between the ages of 15 and 19 have had a child or are pregnant.
- It is not uncommon for poor adolescent girls to engage in sex for money or gifts. There is a tradition of older men seeking out younger girls, attracting the impressionable by virtue of their resources.
- Within marriage, women have little control or ownership over their own reproductive health.

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<sup>5</sup> Pregnant women are not usually considered a stereotypical “risk group.” In Bobo-Dioulasso, however, awareness of the HIV status of pregnant women is very high—despite the lack of access to testing centers and low rates of pre-natal visits to health centers. This is due to the DITRAME research project, “Dépistage de la transmission de la mère et de l’enfant” or “Testing for HIV/AIDS transmission from mother to child.” The project was later re-named “Prevention of HIV/AIDS transmission from mother to child”. To many Burkinabé, DITRAME was a controversial project. The mothers were given AZT to reduce (and test) the rate of transmission, but as soon as the study ran its course, the project was through with them. In their eyes, they were used for research purposes, burdened with the knowledge that they were HIV-positive and then abandoned.

Although no study has been conducted to track infection rates among younger women, numerous service providers interviewed during the assessment shared their concern with the team. Several leading doctors interviewed at the Bobo-Dioulasso hospital stated that they had observed an increase in the number of young women frequenting the hospital for HIV/AIDS-related illnesses. ALAVI, an association focusing on care and support for people living with AIDS (PLWA), also stated that young women represent a large percentage of their current caseload. Most alarming, however, are the following figures from the Centre Anonyme de Epistage et le l'Infomation (CADI) in Bobo-Dioulasso:

- As of April 1999, 1,323 people have been tested at the center. Of these, 55 percent were men and 45 percent are women. Of the 1,323, a total of 200 (or 15 percent) tested positive for HIV; Of these 200, (135 or 68 percent) are female.
- These 135 HIV-positive females are split roughly into two equal groups: widows and young, unmarried girls.

### Estimates of Orphaned Children

There is no single source of definitive information regarding the number of children who are orphaned by HIV/AIDS. However, a 1997 WHO study estimated 200,000 AIDS orphans are in Burkina.

**Table 3: Estimates of Orphans in Burkina Faso from “Children on the Brink”<sup>6</sup>**

Year	Maternal/double <sup>7</sup> orphans-all causes	% of maternal/double orphans from AIDS	Total orphans - all causes	Total orphans as % of children < age 15
1990	201,211	23.50%	574,899	13.38%
1995	323,161	46.50%	807,903	16.25%
2000	526,698	67.70%	1,170,440	20.85%
2005	774,910	79.10%	1,549,820	25.22%
2010	1,014,873	85.50%	1,845,224	28.10%

Source: “Children on the Brink,” 1997, which uses figures taken from U.S. Bureau of Census and developed by S. Hunter, 1997 using Census Bureau estimates, African censuses, and research studies.

### Socioeconomic Impact

Service providers interviewed by the team report a growing sense of concern over the impact of HIV/AIDS. The Ministry of Social Action reported 2,000 orphans in the Ouagadougou urban center. Although cause of parents’ death was not documented, the government representative

<sup>6</sup>USAID commissioned this study, which looks at the AIDS epidemic in 23 countries. It focuses particular attention of HIV/AIDS impact on families and vulnerable children and on orphaning rates.

<sup>7</sup> Maternal orphans: children who have lost their mothers; double orphans: children who have lost both their parents.

stated that many of these children are the legacy of AIDS. At a mental health center, one psychologist reported that of the 82 family therapy cases he followed, 40 stemmed from the impact that HIV/AIDS had on a family unit. A street children project coordinator reported that although they do not document children per se, there appears to have been an increase in the number of children on the street and he projected that one cause is a direct result of HIV/AIDS. The overwhelming majority of interviewees expressed this vague sense of uneasiness.

## Children and Adolescents

Scant information is available on the situation of orphans in Burkina, let alone on the particular situation faced by infected and affected children. Despite this, anecdotal information and current perceptions of service providers, and government and youth interviewed suggest that children in Burkina suffer the same consequences as infected and affected children in other countries. Problems related to increased family poverty, diminished parental protection/authority, and increased psychological stress play a major role in curtailing children's access to their basic rights as guaranteed in the Convention on the Rights of the Child.<sup>8</sup> A brief discussion of the impacts of HIV and AIDS on children before and after the death of one or both parents follows.

**Issues related to survival rights:** Families where one or both parents are sick are often unable to provide children with minimum standards of care. As the illness progresses, families typically use scarce family resources to pay for expensive medical care. This is often exacerbated by the loss of family income when the sick drop out of the labor force. The slow and progressive nature of the illness can quickly deplete a family's limited resources, often causing even well-to-do families to slide into complete destitution. With the onset of poverty, a child's health often deteriorates. On a more basic level, parents living with HIV/AIDS are often unable to provide family members with a daily meal. Although the extent and severity of this problem is not documented, many associations that the team visited reported cases that require on-going emergency food relief. Others report children being forced to beg for food—either from neighbors or on the street.

**Survival Rights cover the child's rights to life and basic needs required for existence. These include an adequate living standard, shelter, food and access to medical services.**

In addition to an increased risk of malnutrition, children are more prone to common childhood illnesses. This is related to a lack of basic hygiene and parental care, and an increased exposure to a number of opportunistic illnesses. UNICEF/Burkina's situation analysis reported a rise in child TB cases and pointed to increased levels of HIV as the culprit. When children fall sick, medical care is inadequate due to limited access to care and high costs.

In some cases, an orphaned child's right to shelter is also at risk. As is seen in many other

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<sup>8</sup>Burkina ratified the United Nations Convention of the Rights of Children (CRC) on July 23, 1990.

HIV/AIDS affected countries, several associations reported cases of “property grabbing.”<sup>9</sup> Although the national laws have strict rules on inheritance, children and widows are often unaware of their rights or are unable to pay the legal fees required to protect them. In addition, many respondents felt that the justice system is highly bureaucratic and weak, particularly in the enforcement of decisions regarding children.

**Issues related to development rights:** A child needs an opportunity to play, explore, and learn in a supportive environment in order to grow into a healthy, happy, and productive citizen.

HIV/AIDS can hinder this natural development. As children watch their family fall into a prolonged crisis, all sense of normalcy can disappear. Children often become withdrawn and despondent. For children privileged enough to attend school, the economic burdens of caring for the sick and psychological distressed often means dropping out. For non-school goers, informal educational opportunities are often sacrificed for similar reasons. This is particularly true for girls, who often assume the responsibilities of caring for the sick.

**Development Rights cover what children need to grow and develop fully as human beings. These include the right to education, play and leisure, cultural activities, access to information and freedom of conscience and religion.**

Of particular concern is the “culture of silence” around HIV/AIDS in Burkina. Added to it is the low priority most service providers give to the importance of mental health. This combination overshadows responses to children’s needs for assurance, guidance, and support and reinforces the environment of denial. In other countries heavily affected by HIV/AIDS, child welfare experts agree that children affected by HIV/AIDS suffer high levels of stress and distress before and after their parents die. Without adult support, feelings of guilt, insecurity, and fear are common. Children often manifest these feelings in destructive and unhealthy behavior.

**Out of twenty-nine adolescent girls attending sewing training at the Center SAS,<sup>10</sup> over half dropped out before completing the program. Reasons reported included the following:**

- 1) **Suicide attempt (one case),**
- 2) **Out of wedlock pregnancies (six cases),**
- 3) **Caring for a sick parent (one case),**
- 4) **“Laziness/Disinterest” (three cases),**
- 5) **Theft (one case),**
- 6) **Earn income to support younger siblings (one case), and**
- 7) **Death (one case).**

**All seven reasons cited here indicate the importance of providing not only learning opportunities, but also some form of psychosocial support.**

**Protection Rights cover safeguarded children against harm, such as all forms of abuse, neglect, and torture. These rights include special care for vulnerable children and protection**

**Issues related to protection rights:** Children affected or

<sup>9</sup> When family members confiscate the deceased’s goods/property despite a child or widows’ legal right to their inheritance.

<sup>10</sup> Services des Actions Sociales or Social Action Services is a voluntary social service center in Bobo-Dioulasso that provides psychosocial support to people infected and affected by HIV/AIDS.

orphaned by HIV/AIDS are generally more vulnerable to being exploited, neglected, and abused. With no, or reduced, parental supervision or protection and increased poverty, children are often exposed to a number of harmful situations. This includes working as street hawkers, domestic workers, or petty criminals to earn needed income. Adolescent girls are particularly at risk to informal prostitution in exchange for gifts or money. This can lead to unwanted pregnancies, social rejection, and the increased probability of contracting HIV/AIDS.

In addition, once a child is orphaned, it is not clear that a child's "best interest" is always respected by the extended family. As one mental health expert stated, "In Burkina, we are often fooled by the traditional ideal of the family. While it is true that most orphans will be taken care of by extended family, it is not guaranteed that orphans will grow up in a supportive and loving environment. In many cases, these children assume the status of a second-class family member, and are used as domestic or farm labor."

Issues related to Participation Rights: Within the traditional Burkina context, children have very little opportunity to participate in family decisions. Children orphaned by AIDS have little say in what happens to them after one or both parents die. It is not uncommon for girls to be married off, with or without their consent, or for boys to be sent to a distant relative to work.

**Participation Rights emphasize the important role that children can and should play in their communities and nations. They include the freedom to express opinions, to have a say in matters affecting their own lives, to join associations and to assemble peacefully.**

## Families and Communities

During the team's interviews in Burkina, the most widely reported impact of HIV/AIDS on families was the heavy cost of caring for the infected family members' medical needs. Many families end up spending so much money on treatment that they neglect other needs, such as food. The worst cases are when the person with AIDS (usually the husband) is also the primary breadwinner. As this family member becomes ill more frequently and for longer periods of time, other adults in the household have to either withdraw from their jobs or from other income earning activities.

**One respondent told of his older brother who migrated to Cote d'Ivoire but came back with his wife and four children when he was already in the advanced stages of AIDS. The brother died, and his wife remarried within the extended family—the four children stayed also.**  
**Another man described how his cousin married a man and then migrated with him to Cote d'Ivoire. They came back with their two children when the husband became seriously ill. He died and she followed shortly thereafter. He doesn't know what happened to the children. He would help support them if he knew where they were.**

When the ill family member is in the later stages of AIDS, there is little time available for the caregiver to look for work or to start some kind of activity to bring money into the household. In such circumstances, an extended family member may move in with the family to help out; sometimes remaining to become a permanent member of the household.

## Response to Mitigating the Impact of HIV/AIDS

### An Orphan's Experience

Like children in many African countries, orphaned children in Burkina are traditionally considered the responsibility of the extended family on the paternal side. In the past, fulfilling this duty was rarely questioned. However, it is becoming common now for the husband's family to come and take the deceased's possessions, but not his dependents—especially in urban areas. Children are the most vulnerable in these situations. This new insecurity is commonly attributed to increasing national poverty levels, the emergence of the nuclear family in city settings, and the consequent loosening of extended family ties.

**In Burkina, a child is considered an orphan if one or both parents have died.**

It is encouraging that new forms of solidarity are surfacing to assist children who are not cared for by their families. Community networks have created informal care situations, either through adoption, fostering, or community-based support to children living on their own. Associations and religious groups are at the forefront of this new response. At least three community-based organizations visited reported cases of adoption and community care provided to children abandoned by their families. Many organizations are attempting to establish sponsorship programs to provide some economic support to substitute families.

Despite strong community solidarity, it is important to recognize that a small number of children still fall through the gaps. Many children not absorbed into the community end up on the streets; other children end up in unsupervised child-headed households. Girls often fall into lives of prostitution.

Many children living on their own maintain some contact with family members.<sup>11</sup> In Burkina, family and community safety nets exist, and friends, extended families, and neighbors do respond to children in such situations. And, at least for these children, these safety nets do provide some level of support so siblings can stay together. This is important since international experience shows that—after the death of parents—being separated from their brothers and sisters is the most traumatic experience for orphans.

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<sup>11</sup> The three children interviewed may not be representative of the child-headed household population in Burkina. The interviews did not include girls and all these children were receiving some assistance from the Center SAS.

#### Case Study: Oussen, a 22-year-old boy

My problems started in 1993 when I was 16 years old. My father died, and my mother followed him a few months later. My mother's brother came around to look in on us from time to time and help us. But, I still had to drop out of school for a year to do whatever odd jobs I could find to support my twin sister and three younger brothers (14, 13, and 10). Our main concern was getting enough to eat. After a while I was able to get enough money to go to night school. My father had a good job with the Transporters Union (SOTRAO), so we all had plans for school. But when my parents died only my youngest brother and I got a chance to continue. After a year, in 1994, my father's brother came and took my youngest brother with him to Ouagadougou. But that uncle died too and another uncle went and took my brother from Ouagadougou out to a village in Sourou province. I think about him a lot because he was closest to our mother and felt her death more than the rest of us and he doesn't have us anymore. I haven't seen him since he left.

I found out about Centre SAS in 1994, and was able to get a scholarship to continue regular daytime school. But in 1996, I took the BEPC (high school graduation exam) and failed. The Centre wanted me to continue studies and try again, but it didn't seem worth it to me. So I went to the Cote d'Ivoire to work and eventually was able to get my driver's license. I came back to Burkina in May 1999 when my twin sister got married and came to Cote d'Ivoire herself. My brothers—now 19 and 16—are street traders<sup>12</sup> and walk around Bobo-Dioulasso selling merchandise.

I've only been back in Bobo for a few months, and I'm trying to get a job. I hope that my driver's license will help. I'd also really like to find out what happened with my youngest brother and bring him back to Bobo to be with us.

## Families and Communities

Most people interviewed felt that Burkina's extraordinarily strong tradition of family and community solidarity meant that families responded by caring for the infected person themselves and absorbing widows and orphans into the extended family network.

Traditionally, orphaned children in Burkina are considered the responsibility of the extended family on the paternal side. This is especially true in rural areas. Urban dwellers (the majority of interviewees) feel that, in the village, family solidarity is alive and well. In addition, for many Burkinabé, paying visits to someone who is ill is common courtesy, not a special effort. When the assessment team pressed for descriptions of activities of a youth association, the members emphasized the material aspect of their programs (i.e., donations and scholarships). When asked if they did not do things on the social level, they replied, "but visiting someone and providing

Several respondents interviewed by the team challenged the conventional wisdom about Burkinabé family solidarity and questioned its effectiveness in caring for both widows and orphans. As one interviewee stated, "unlike before, an orphan's future is no longer secure." Similarly, a doctor at the hospital in Bobo-Dioulasso said, "I just don't buy this family solidarity business anymore—maybe in the rural areas, but not in the cities. Everyone [in Bobo] is just looking out for them self." At one youth association gathering, one young woman quarreled with one of her peers after he made a comment that the family unit was taking care of its own. She told him his views of things were too idealized.

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<sup>12</sup> Commonly referred to as "le commerce ambulante," a walking business.

moral support isn't really doing something, it's just what you do. It's not considered a special activity."

One religion-based association working in a rural area of Burkina reported that some families are not responding at all to the infected person or to his or her children—because of fear. The association recounted a case where they went to visit a household where there was a woman suffering from AIDS whose spouse had already died. They found the family had completely neglected her. They immediately started a top-to-bottom clean up of the house—even washing the clothes of the patient. The family watched closely and asked the visitors if they weren't afraid of getting infected by handling her clothes. This provided the opportunity to explain about HIV transmission and how to care for someone who was suffering from the disease. They eventually joined in the effort and continue to care for the woman.

In Bobo-Dioulasso, the team asked to meet with a group of Muslims after their evening prayers. An IPC-supported association had previously been in contact with the Imam to discuss raising awareness about HIV/AIDS and ended up discussing the groups' concerns about how to respond to the number of orphans, widows, and sick people they found themselves trying to help.

Since the Imam is responsible for preparing bodies for burial, he is acutely aware of the increase in the number of deaths. Many people also ask him for help paying for the funeral shroud. In addition, every morning sick people are left on the Mosque steps, and it has gotten so that the Imam has had to make a place in a spare room across the street for the sick because there is nowhere else to bring them. He rattled off a list of donations (sacks of rice, money, shelter, or food) that either he or his followers have provided to people who are sick, to widows, or to those who couldn't pay for the burial shrouds. He spoke of several cases of aunts, uncles, or neighbors bringing children to him that they could no longer care for. Usually, such children's parents had died. Although overwhelmed, this group has made a

**The Imam described one case where a widow brought a group of siblings to him. The children's mother had died and the father was in prison. The oldest was a girl of fifteen and the widow couldn't afford to take care of them, but was afraid of what would happen if she didn't do something. They are currently staying with the Imam and his family until he finds another solution. When the team asked how many cases of orphans needing support they had run across, the Imam shook his head and said, "they are too numerous to count, we've lost track". The Imam said they would continue doing whatever they could. "But," he said, "we can't continue this alone."**

commitment to actively seek support from others to increase their capacity and resources. Equally important, they are setting an example of tolerance and compassion in the community. For example, the Imam shares some meals with PLWA to show his followers the importance of providing the sick with a sense of belonging and dignity.

## NGOs, Associations, and Government Social Services

There is agreement among almost everyone interviewed that focusing only on orphans or, worse yet, AIDS orphans would not be effective and would worsen stigmatization. Most organizations also agreed that building on the growing concerns within communities for vulnerable children could be an effective entry point for heightening awareness of HIV/AIDS, bringing issues into the open, and reducing stigma.

It is widely acknowledged in society generally and among development actors specifically, that children are best cared for within their extended family networks and communities (“family first”), not orphanages. Burkina does not condone placing orphaned children in residential care centers. Placement in a center is regarded as a last resort reserved for children who are considered lost causes or stigmatized by bad luck (typically children living with HIV or children surviving the death of a mother during childbirth).

### IPC-Supported Associations

Burkina has a strong tradition of grassroots work and community action. With the onslaught of the HIV/AIDS epidemic, these community-based structures are becoming actively involved in supporting families and communities affected by HIV/AIDS. In 1998, IPC supported 18 associations that ranged from small, informal community groups to organized, local NGOs. Each association is engaged in a variety of activities around HIV/AIDS work. IPC acts as a clearing house and provides the associations and organizations with information, technical assistance, and skills training.

In general, associations supported by IPC work in two primary areas:

- 1) **“Prise-en charge,” or, home-based care projects:** These projects typically take the form of home/hospital visits, with some clinic work. During visits, members provide medical care, distribute free medication, and provide moral and spiritual advice. Other “relief-type” assistance (clothing, soap, and food) is provided on a sporadic basis, depending on availability. Currently IPC supports eight such associations who assist over 800 families.
- 2) **Prevention:** These activities include traditional IEC campaigns and most recently, a new emphasis on behavior change strategies. IPC is currently supporting 10 associations targeting 500 beneficiaries. IPC has introduced more appropriate adult-learning techniques in its prevention work. This is commonly referred to as the Participatory Prevention or the “Parcours” (Stepping Stones) program.

Associations supported by IPC have growing concerns about the children in the HIV/AIDS affected households. Their concerns arise from their relationships with the families for whom they provide home-based care. The patient in these households is usually in acute need or in the advanced stages of AIDS. Making a visit to a household where the patient and the children have not eaten for more than a day (sometimes several) happens more often than they would care to admit. At these times, moral support and friendly words are not enough.

Members have reached out to other organizations and benefactors for food donations and have collaborated with parent and teacher associations to negotiate reduced-cost or free schooling for orphans. However, these responses address emergency needs for what amounts to relief assistance. While this relief is needed, it is still a stopgap measure. The numbers of such cases are increasing, not just because of the evolution of the epidemic, but because communities in which associations operate learn what they are doing, and many feel they have no other safety net to catch them. Association members the team spoke with expressed frustration at not having enough resources, enough people, or enough time to get ahead of the needs they saw. They felt the needs of families and children (especially orphans) affected by HIV/AIDS demanded a systematic and proactive response.

#### Other Associations and NGOs

Other associations and NGOs with whom the team met are also grappling with developing a response to the impacts of HIV/AIDS. The Widows and Orphans Association (AVOB) has been active in Burkina a long time. They have traditionally been involved in protecting widows' and orphans' legal and economic interests. The association has established nursery schools and initiated training activities for girls (i.e., sewing and knitting). As a result of HIV/AIDS, AVOB members have added IEC for HIV/AIDS prevention and home-based care visits to AIDS patients to their list of activities. It is interesting to note how AVOB's traditional activities have evolved as a result of HIV/AIDS. For example, the girls who attend the sewing and knitting classes provide information to AVOB members on who is sick in their communities so the widows can go visit the family and assess the situation. Nursery schools now provide a haven during the day for children whose families are dealing with HIV/AIDS. Activities at the school keep children busy and engaged so they do not dwell on their fears and become withdrawn. AVOB widows have rallied around orphans who do not have extended family members nearby; they either take these children into their own homes, or they put the word out to find the nearest relatives.

**During a national youth conference, the team met with several youth representatives to discuss what young people are currently doing in HIV/AIDS prevention and care work. Youths questioned listed several examples, ranging from formal IEC activities to informal efforts. In one case, association members mobilized to assist a friend living with HIV/AIDS and his family. When the young infected man fell sick, he was unable to tend to his family's fields. His fellow association members worked together and harvested his fields. This provided the family with crucial support at a time when the family needed it most.**

In Bobo, health professionals have demonstrated incredible initiative and personal commitment to creating an effective service system to respond to the full range of medical and social needs associated with HIV/AIDS. Prompted by the negative consequences of the Dépistage de la transmission de la mère et de l'enfant (DITRAME) study, concerned doctors, nurses, and other social service professional began meeting to discuss issues surrounding HIV/AIDS in their community. This resulted in creating links among key structures: The Centre Anonyme de Dépistage et de l'Information (CADI), which performs HIV/AIDS testing, counseling and information center; the Center Services des Actions Sociales (SAS) or social services; the Bobo-Dioulasso hospital (hospitalization, lab facilities), A.PRO.DE.C (training in counseling skills), REVS+, an association of PLWA (moral support and palliative care via HBC) and a satellite Health Center (base for palliative care teams). Their investment and persistence in improving response to HIV/AIDS merits credit. The effort to create CADI alone—the sole testing and counseling facility in Burkina—took 52 meetings.

### Government Policy and Social Services

**Social services:** The Child Protection Department of the Ministry of Social Action has a street child's drop-in center and a transit center for children that social workers are trying to place with distant family members or foster families. This department has attempted to document the number of orphan cases, but has not done so routinely for geographic areas where HIV/AIDS may have had an effect on increasing numbers of children orphaned. The department is also advocating to strengthen the judicial system to protect the legal rights of children. The department was instrumental in organizing a workshop to discuss children in vulnerable circumstances in collaboration with UNICEF (see below).

**Efforts to decentralize and coordinate responses:** The National Committee for AIDS has mobilized local government officials in health district areas to develop district HIV/AIDS plans in five districts (three current, two planned). The plans aim to create a multi-sectoral effort. The initiative is supported by WHO, the German development agency (GTZ), and UNAIDS. The first plan took several months to complete, but the plan is not yet operational. The National Committee also strives to play an advocacy role to raise visibility for issues related to HIV/AIDS and to stimulate a national debate so that effective policies, informed by public opinion can be developed.

**Government policy on orphans:** There is an existing family code that states a deceased adult's possessions should be divided between the spouse (one fourth of the inheritance) and children (three fourths of the inheritance). Traditional rules prevail at community level, however, and property grabbing is becoming more common.

Although there is no official national government policy for orphans, informal guidelines appear to define current government response. Most significant is Burkina's rejection of orphanages as the response to the growing numbers of orphans.

In addition, a national level workshop held in Ouagadougou (hosted by the Child Protection Department in the Ministry of Social Action with UNICEF support) in October 1996, set out the following guidelines:

- The Ministry of Social Welfare will ensure that project interventions respect a “no-discrimination” policy between children orphaned by HIV/AIDS and other vulnerable children.
- The HIV status of children and the cause of their parent’s death are strictly confidential.
- Placement of orphans in families is preferred to placement in orphanages.
- Orphans and their host families will have access to free medical consultations and treatment as well as reduced fees for hospitalization and medical analysis.

The workshop proposed that orphans be allowed access to free schooling and an allowance to cover materials. Participants also stressed the need to develop opportunities for professional training and employment and to create mechanisms to provide food, morale, and legal support.

**Government leadership on HIV/AIDS issues:** Despite some positive progress in responding to the national HIV/AIDS epidemic, the government has been largely silent on HIV/AIDS issues. There is only one testing and counseling center in all of Burkina. It was the result of long and hard battles fought by A.PRO.DEC and others. Its survival is not at all sure. There are private clinics, but they are expensive and do not provide counseling. Hospitals are much the same. Access to testing—let alone counseling—is inadequate, and people are reluctant to find out their status when they know that their options for support (both medical and psychosocial) are limited at best.

This national silence exacerbates the challenge of making HIV/AIDS a visible danger. It contributes to the crisis mode that AIDS service providers are forced to operate in and cannot seem to break out of. They are responding to people who most often do not know they have HIV, but come to them when they are desperate for help. Not being aware of one’s HIV status enables a person to deny the symptoms until they develop into a crisis. Health and economic planning to mitigate these consequences becomes an exceedingly difficult proposition.

## Issues and Concepts Surrounding Impact Mitigation

### Visibility of HIV/AIDS

Scant access to testing and counseling makes it difficult for Burkinabés to determine their status. Even though the disease is becoming more personalized among the general population, there is still a strong sense of fear and shame surrounding the disease. In addition, most people know that access to counseling and other social services, health care, and the like are problematic at best. So the most commonly held attitude is “why find out what your status is when there are literally no support services to lean on? Ignorance seems better.”

The visibility issue has ramifications throughout society, especially when development actors and communities think about mitigating the consequences of the disease. The best time to prepare oneself and other family members is while the HIV-positive person is relatively healthy. When healthy, families are in a better position to plan for their children’s futures and to participate in income and savings activities. However, response usually doesn’t come until there is an emergency and by then it is all the more difficult to plan. Likewise, those individuals helping are hard pressed to respond to the acute needs of the infected person and his or her family, let alone anticipate what will happen. The invisibility of HIV/AIDS in Burkina has fostered personal denial, which reinforces a crisis mentality. Within this context, the special needs of children living in a family affected by HIV/AIDS are forgotten or overlooked.

### Child-Focused Activities in Care and Support

The current assistance environment in Burkina can be best described as relief assistance for orphans in the form of material support. This includes providing children who have lost one or both parents with food assistance, school fees, and clothing. Psychosocial support pre-death of a parent is extremely limited. Although many associations describe their support as family focused, in practice, little attention is dedicated to children, especially if they are not yet orphans. As one mental health expert explained, “In the area of counseling, we are not taking the

**Since the adoption of the CRC in 1989, more and more NGOs are engaging in child-focused work. Definitions range from traditional responses, which include NGOs strategies to help children by directly supporting their parents, to more progressive interpretations, which target children and youth directly. For the purpose of this report, “Child-focused” incorporates a more modern definition. Rooted in a rights-based approach, child-focused activities integrate concepts of the convention, including a child’s right to survival, development, protection, and participation. Key to this is the belief that young people are active participants in their development, and should be provided an opportunity to express their ideas, be informed, and participate in decisions regarding their lives. This definition does not exclude parents’ roles as protectors and guardians, but rather extends traditional support to families to include specific actions with children and youth. This way, children are not considered in isolation.**

needs of children into account. This is problematic—although the family does not address the issues surrounding the illness, others outside the family do. This has serious consequences on the child.”<sup>13</sup>

The lack of concrete programming in this area is symptomatic of poor national awareness regarding the importance of psychosocial support to affected children and very limited experience in community mental health. Community-based organizations do provide some informal support to PLWA, but they have not yet tailored their approach to children. Currently, there is no real vision on the part of the government, IPC, and other actors to develop a community-based psychosocial program for children. Furthermore, in an extremely poor country like Burkina, the present challenge will be “how to integrate the psychosocial component in such an economically fragile environment.”<sup>14</sup>

**During the visit, only one IPC-supported association, ALAVI, had deliberately focused on psychosocial support for children affected by HIV/AIDS. In May 1999, with the support of Solensi France<sup>15</sup>, ALAVI initiated a small program providing opportunities for play, information sessions, and informal counseling or support for approximately 20 children and young people on a drop-in basis. With the support of volunteer center staff, children are given a chance to discuss HIV/AIDS and their personal concerns in a non-threatening, low-key environment.**

**In addition, ALAVI offers counseling to parents on how to prepare for their children’s future. This is mutually beneficial for the adult and the child. In one case example, a father, with the support of association members, negotiated the conditions of care of his children with his family. He was also able to inform his older children of his condition. Before his death, he told association members that he could leave this world more comfortably knowing that his children's futures were prepared.**

### **Crisis Response to Versus Mitigation of HIV/AIDS Impacts**

Most associations that the team interviewed said that the demand for their services far outweighs their current financial resources and number of volunteers. As a result, they are focusing attention on those patients with the most acute care needs. Once the patient dies, and especially if the children in the household have now lost both parents, attention turns to taking care of the orphans. In these cases, the needs of children are also acute. This experience leads to a relief mentality where associations have literally no option but to limit their responses to ad hoc activities to meet crisis needs for food, shelter, and clothing. This mentality also prevails among the NGO and government community when designing program responses to the consequences of HIV/AIDS. In other words, the attention of most development actors in Burkina is on catching those who fall through family and community safety nets after those nets have failed.

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<sup>13</sup> Dr. Sanou Zezouma, Medicin Chef, Bobo.

<sup>14</sup> Desire Yameogo, Psychologist, Action Nord Sud.

<sup>15</sup> A French NGO specializing in assisting HIV/AIDS infected and affected children.

Crisis-mode thinking focuses on satisfying immediate material needs (food, medicine) that require significant and on-going sources of financial assistance. Since such means are woefully inadequate and Burkina is already a very poor country, the prevailing mood is one of feeling overwhelmed and helpless, and the focus is placed on what one cannot do rather than building on what people in the wider community are doing already. An environment of disempowerment prevails. As one key resource person stated: “One of our major problems is that we are too focused on what we can’t do. But, if we organize and begin to stress what we can do, we can accomplish a lot. There is so much we can do, even without money.”<sup>16</sup>

It is documented that children’s needs begin well before the death of a parent. Yet reacting in a crisis mode has prevented a comprehensive understanding of the scope of HIV/AIDS impact on children. This in turn makes it difficult to develop systematic response strategies that deal with the constellation of issues that increase vulnerability of children. It has also led to overemphasizing orphans at the expense of children affected by HIV/AIDS who are equally vulnerable.

This perspective and focus on crisis serves to concentrate resources and energy on relief assistance. Everyone’s attention is consumed by responding to crises so that little energy remains to consider whether it might be possible to address situations while they are still relatively manageable, by strengthening the capacity of the extended family and community social safety nets. Although the actions taken within these safety nets will not in themselves be sufficient, they can reduce the numbers of vulnerable children and families to levels that associations, NGOs, and government services can manage.

### **Examining Community Mobilization in the Burkina Context**

During most interviews, the team asked for a definition of community mobilization—as the respondent understood it. In most cases, the reply was along the lines of “helping the wider community analyze its problems and develop solutions that they can undertake themselves.” In other cases, respondents felt that since associations were made up of members of a community, that mobilizing associations amounted to community mobilization. Yet every association, NGO, and government organization the team interviewed expressed feelings of being overwhelmed by the crisis needs of the wider community. Several people, after debating among themselves what the answer could be, said, “we need to go back to what has always sustained us—we have to rebuild our tradition of community solidarity and of watching out for each other.”

At a different meeting, association members discussed the “Six S Movement” in Burkina. This movement was started as a response to rapid decertification in Northern Burkina. It adapted traditional means of building community solidarity to mobilize grassroots activities to stop the

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<sup>16</sup> Dr. Sanou Zezouma, Chief of Medicine, Bobo.

desert from encroaching on agricultural land.<sup>17</sup> The association members felt that if they could learn how to use participative techniques to mobilize their communities around concerns for vulnerable children and their families, they could improve the situation.

International experience in countries heavily affected by HIV/AIDS indicates that the health, economic, social, and emotional impacts of HIV/AIDS are too extensive for any organization or body concerned with development to address them unilaterally. This is especially true when HIV/AIDS occurs in the context of an already poor country with a limited capacity to respond to the needs of vulnerable children and families. To be effective on a sufficient scale, responses must mobilize the commitments and resources of many different participants. This includes families, neighbors, associations, NGOs, the private sector, religious networks, international organizations, bilateral development bodies, and government ministries. Strong coordination is also crucial to maximizing existing resources.

However, the actions taken by the aforementioned entities must not be formulated or implemented in a vacuum. Families and communities make the most important responses to the impacts of HIV/AIDS. Not only are they on the front line of the impacts of HIV/AIDS, they are the front line of response to the health and welfare problems caused by the epidemic. They are the key stakeholders. The fundamental strategy needs to be strengthening the capacities of families and communities to provide a safety net for the majority of orphans and vulnerable children.

Community mobilization goes beyond mobilizing associations. Associations must become the mobilizers of the community within which they live and work and move beyond the current crisis response mode. It is the team's feeling that communities are not only concerned about the impacts of HIV/AIDS, but, in many cases, are also prepared to take leadership, demonstrate ownership, and devise ways of sustaining the activities they initiate. Community ownership and management of these responses to the consequences of HIV/AIDS are the key features of success. Many associations can effectively act as catalysts to achieve this ownership using participatory processes. They can maximize their efforts by being facilitators, not managers; by being capacity builders, not direct-service deliverers.

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<sup>17</sup> The results of this movement were so impressive that its founder, Dr. Ouedraogo, won the Hunger Award for his efforts.

## **Strengthening the Activities of IPC-Supported Associations**

### **Existing Care and Support Activities**

The majority of IPC-supported associations' activities revolve around delivering home-based care services. They are dedicated to providing a quality service and place a high value on acquiring skills and materials that allow them to maintain their standards. Many members are health professionals in their own right. IPC has been instrumental in supporting them in delivering quality care by organizing training workshops and mobilizing local resource people to provide periodic technical assistance. IPC has also pioneered an effort to disseminate information about low-cost, generic drugs for palliative care. To a large extent, they have replaced the expensive prescriptions given out by doctors who were not aware of the generic options. This information has been crucial to families and health care professionals confronted with seriously ill people who were depleting their household resources buying expensive drugs.

One major dilemma facing associations involved in palliative care is attaining access to the relatively low-cost, generic drugs that are indispensable to service delivery. On the one hand, having a modest amount of drugs to offer families in acute need has provided associations with credibility in the community. On the other hand, there has not been a way to make this service sustainable and it may always require some type of subsidy. Many members in the associations are not comfortable with asking families to pay for the drugs. The long-term challenge is to create a system that results in sustainable access to such drugs, but that does not undermine the association's credibility or detract from their mission. It is possible that continued financing of drugs would detract from attention to finding long-term solutions.

For example, Burkina subscribes to the Bamako Initiative concept of decentralizing health delivery systems. Part of the Bamako Initiative approach includes creating community-managed pharmacies that stock inexpensive drugs most needed by the pharmacy clients. The HCK project in Bobo-Dioulasso is involved in such an endeavor. In addition, they are in the process of creating health insurance schemes where clients set aside money as prepayment toward future medicines and health needs. Fond d'Appui aux Activités Renumératrices de Femmes (FAARF), a UNDP-supported microfinance institution, also has savings schemes for health needs in place. Even if these two projects are not focused on the same groups as the IPC-supported associations, they could still be sources of local skills for designing new approaches that could provide long-term solutions for access to basic drugs.

### **Community Mobilization**

In their proposal to the Displaced Children and Orphans Fund, IPC and its partner, the HIV/AIDS Alliance, have chosen a strategic approach that takes incremental steps to mobilize the associations they support. The basic idea is to move toward community mobilization in a

steady and measured way. IPC's overall role is to provide systematic technical assistance over three years to build the community mobilization capacity of the care and support associations with whom IPC already has an established working relationship. HIV/AIDS Alliance proposes to reinforce IPC's capacity for activities that IPC and Alliance staff carry out jointly in Burkina (technical assistance), and to reinforce support provided by Alliance staff from their London offices (technical support).

The first step envisioned is that IPC would build associations' capacities to integrate activities that respond to the needs of orphans and children affected by HIV/AIDS. The second step is to mobilize community response to the needs of orphans and children affected by HIV/AIDS. The third step is to initiate participative activities with children to enhance HIV/AIDS prevention and reduce stigmatization toward all children affected by HIV/AIDS.

The team believes, however, that the primary vehicle through which associations can effectively integrate activities that respond to the needs of orphans and children is community mobilization. For communities to be truly mobilized, people within them must feel they "own" the problems identified and that it is their responsibility to take action. Community ownership will not result when the process of identifying needs and the process of identifying possible actions are detached from each other or from the community. It is the process of identification and claiming ownership that mobilizes a response. And as one association declares firmly—"it does more harm than good to try and care for the PLWA on behalf of the family, in effect, replacing the family."

This same spirit must prevail in responding to the needs of orphans and vulnerable children and mitigating the impacts of HIV/AIDS on them. Activities to mobilize community responses to orphans and vulnerable children should be integrated into present activities. But communities, not associations, should carry out the activities that they identify as priorities. They should start with activities that are urgent but within their means to address (e.g., identifying and monitoring vulnerable families and children, organizing visits to families to help with household chores, and ensuring that children are not isolated and withdrawn). Associations could identify local resources to provide additional skills (e.g., psychosocial support for children, or training from IPC to provide to the communities. As far as meeting material needs, which require a source of financial assistance (food, medicine, and school fees), IPC could identify local capacity to provide training in resource mobilization and fundraising.

There are other associations already moving toward mobilizing community responses to children and families affected by HIV/AIDS. For example, reaching out to a parent and teachers association to discuss taking care of orphans' school fees or approaching a church organization to provide emergency food. IPC can reinforce this trend by building association capacity to use techniques that will mobilize responses within their wider communities. In the area of responding to the needs of vulnerable children and their families, the associations should see themselves as catalysts and facilitators of community responses instead of seeing themselves as individuals carrying out activities on their behalf. Capacity building should also focus on facilitating an

analysis of HIV/AIDS impact on children and their families with communities before formulating response strategies. Associations should initiate a process that facilitates the following responses:

- Recognition on the part of community members that they are already dealing with the needs of orphans and vulnerable children in informal ways and that they can be more effective if they work together (“we need to support each other to deal with this”);
- A sense of responsibility and ownership that comes with this recognition is the starting point for identifying what responses are possible (“this is happening to us so it’s up to us to do something about it”);
- Identification of internal community resources and knowledge, individual skills and talents (“who can, or is already doing what, what resources do we have, what else can we do”);
- Identification of priority needs (“what we’re really concerned about is...”);
- Community members planning and managing activities using their internal resources; and
- Increasing capacity of community members to continue carrying out their chosen activities, to access external resources once internal means are exhausted, and to sustain their efforts over the long term.

Emphasis should be placed on strengthening capacity to elicit interactive community participation around preoccupations relating to children and families affected by HIV/AIDS. The community is a partner in gathering information on needs, analyzing problems and causes, deciding what actions are needed and feasible, taking responsibility for them, mobilizing available resources, and deciding how those resources are channeled and managed.

Focusing on building participative development skills could also be a way for associations to expand their membership base. For example, in REVS+, there are 21 active association members. Many more would like to join the ranks of the active membership but REVS+ does not want anyone conducting home visits without the appropriate training. One way to expand the possibilities for involvement is to add a “branch” or sub-committee of people who would focus on mobilizing a community response concerned with orphans and vulnerable children.

Although this is a new technical area for IPC and the Alliance, it is not an unfamiliar philosophy. To assist IPC, local resources skilled in participatory training and tools appropriate for both adults and youth are available; for example: Mwaganza, (Pape Sene and Djingri Ouaba); Save the Children/UK, (Boureima Ouedraogo); Aide Enfance Canada (Julian Mann); CPAM, (Justin Rouamba); and APES Jeunes, (Denis Ouedraogo).

IPC-supported associations who are dedicated to providing direct palliative care to PLWA, and focus heavily on providing HBC may not feel they are in a position to integrate community mobilization activities into their current portfolio. In these cases, community mobilization may take the form of simply identifying and mapping community resources and referring their clients to them. In any event, each association considering community mobilization should carefully

consider whether this is within their purview. Some may decide that their comparative advantage as an association is to specialize in HBC and leave community mobilization up to other organizations.

### **Addressing Psychosocial Needs**

IPC should identify local resources to help associations expand their current activities of care and support to include a stronger, culturally appropriate psychosocial component that specifically targets children (as ALAVI has, for example). Efforts should aim to mainstream children, not isolate them. Local resources could assist IPC to develop a comprehensive training program on psychosocial support for children. Training topics could include an introduction to the psychosocial needs of children affected by HIV/AIDS; age-appropriate, culturally-specific counseling skills; family mediation skills; and identification of relevant community resources (recreation facilities, school and association activities, non-formal training, etc.).

### **HIV/AIDS Impact Mitigation Strategies**

IPC could provide valuable leadership by bringing together people who are struggling to respond to the impact of HIV/AIDS on children and their families to discuss strategies. A recurring theme among those whom the team interviewed was “we are all in a period of reflection about this issue [vulnerable children]. We can’t yet decide how to respond.” Organizing a one- or two-day workshop with selected people to analyze their reflections and come up with initial conclusions is a first step to building a consensus on how to move forward. Such a meeting should not be seen as creating a national policy, but as building a shared vision and creating momentum among those struggling to formulate a response to mitigate the impacts of HIV/AIDS. Whether such meetings would continue or be the start of a theme group should be entirely up to the individuals at the workshop.

The following are key points for such a debate:

- What does community-mobilization and child-focused activities mean? What is care and support for children?
- How can youth be more involved in current HIV/AIDS work?
- Should the role of associations be to integrate delivery of children-focused services with those of HBC, or to mobilize or tap into other associations, NGOs, or community groups that provide those services? Or should they simply refer those service needs to other organizations?
- How can association coverage be expanded to match the scope of the HIV/AIDS impact, and at the same time maintain quality and innovative programming for impact mitigation?

- How can principles of assistance be established that guide and inform a broad spectrum of development actors. These principles should include guidelines on how and when to provide material and non-material support to children and families affected by HIV/AIDS.

Suggested organizations and people to include in this discussion follow: REVS+ (Helene Badini or Martine Somda); Bergerie (Wendtoin Ouedraogo &/or Jean-Marie Tapsoba); C.P.A.M. (Justin Rouamba); A.PRO.DE.C (Dr. Zézouma); Action Nord Sud (Dr. Désiree Yameogo); SP/CNLS (Dr. Paul Thomas &/or Mme Tall); ONU/SIDA (Dr. Kourouma); MWAGANZA (Pape Sene &/or Djingri Ouoba); PNUD (Marc Saba); AEC (Kinda Téné, Julian Mann); SCF/UK (Boureima Ouegraogo); HCK Projet (Dr. Traoré &/or Dr. Casal-Gamelsy); Affaires Sociales/Protection Enfance (Mme Marie Coulibaly); and Director of Youth Associations, Ministry of Youth and Sports (Vincent de Paul Belemsigri).

### **Creating Collaborative Relationships with Other Organizations**

Because no one organization can possibly attempt to respond to all the needs of an HIV/AIDS-affected community, an emphasis on maximizing resources and seeking collaboration and participation at all levels of response development is necessary.

Coverage of mitigation activities for affected people, families, children, and communities is inadequate. Activities among various actors in the fight against AIDS are not coordinated to attain better coverage, although there are beginnings of such collaborations. There is recognition that AIDS is not just a health problem and that a multi-sectoral response is crucial.

Efforts need to be taken beyond a philosophical attitude to an operational strategy. IPC-supported associations could be catalysts for such partnerships by mobilizing communities and helping them tap into resources around them. Training in resource mobilization could include this aspect. The aforementioned workshop could also result in strategic partnerships.

### **Strengthening Economic Resources of Affected Families**

The well-being and quality of care afforded to orphans and ill family members rely largely on the capacity of households to maintain or stabilize their livelihoods. Income generation through self-employment is an important activity by which poorer households amass resources. It is not a new coping mechanism. This is a long-standing strategy used to respond to crises and times of economic stress, whatever the cause.

Income generation came up several times in discussions and interviews, usually in the guise of creating income-generating projects for widows and orphans. In order to support such endeavors effectively, one must first distinguish between activities designed to strengthen household

resources in anticipation of crises, and those designed to provide relief assistance to households in extreme situations. These two activities must also be differentiated from income-generating projects that aim to create a source of funds for the activities of an association.

In the first case, strengthening family resources in anticipation of crises, microfinance programs are one of the few interventions that have shown potential for increasing poor households' incomes in a cost-effective manner. Access to credit and savings mitigates HIV/AIDS by the following means:

- Maintaining or increasing small but steady income flows to poor households,
- Providing opportunities to acquire secure savings that are easy to liquidate quickly and retain their value,
- Reducing vulnerability to loss by increasing coping mechanisms, and
- Enabling affected households to avoid irreversible coping strategies that would destroy future income earning and productive capacity.

For the second case, providing relief assistance to households in extreme situations, material relief and moral support furnished by friends and neighbors appear to be more viable alternatives. Formal community mobilization programs can strengthen these informal safety nets. However, it is important to keep in mind that the impact of such relief assistance for households is not sustainable in and of itself. The safety net sustains a household economy only as long as material relief continues or until the household is out of danger. Over the long run, the household must continue to function on its own resources, thus freeing resources for others who find themselves in dire need.

For the third and final category, creating a source of funds for an association's activities, carefully chosen and planned fundraising activities appear to be effective. The methods used can range from simple cash or in-kind donations scraped together within the community, to sophisticated, formal events like raffles, to creating foundations. Communities organize these activities so as not to interfere with individual livelihoods. The most successful fundraising is based on skills and resources that already exist within the community.

The kind of pressure experienced by households affected by AIDS can often overwhelm modest, traditional fundraising efforts. Consequently, many groups are encouraged to initiate externally funded community-run microenterprises (referred to as income-generating projects) to finance their activities.

It is not clear whether this approach should be a standard and long-term solution to the problem of fundraising. Communal businesses are notoriously risky endeavors that have enormous difficulties generating significant profits, and they frequently require more management skills than a community can offer. The time and effort necessary to achieve the desired profits can sometimes distract members from carrying out the very tasks the profits are supposed to finance.



## Major Findings

The following elements in the Burkina context create an environment that is conducive to creating strategies for mitigating the negative consequences of HIV/AIDS towards children and their families:

- It is acknowledged at all levels that children are best cared for within their extended family network and communities (“family first”), as opposed to orphanages.
- There is a consensus among development actors that focusing only on orphans or, worse yet, AIDS orphans, is not effective and will worsen stigmatization. However, building on the growing concern within communities for vulnerable children could be an effective way to broach the subject of HIV/AIDS.
- There is a strong tradition of mutual support within communities and families.
- Families and informal groups of concerned community members are mobilizing their limited resources as best they can to respond to emergency needs of families and children affected by HIV/AIDS. Some of these informal groups have evolved into associations.
- Eight of the associations supported by IPC and interviewed by the team are delivering home-based care services to families in acute need. Some of the associations are already providing ad hoc support to orphans and other vulnerable children.
- These eight associations are already reaching out to mobilize responses to orphans and vulnerable children within the wider community. There is a general awareness of the need for a more organized and systematic response—a genuine need emanating from communities and articulated to associations, NGOs, and government organizations—versus one imposed from external donors.
- The team consulted with association members who are extremely committed and have considerable skills and talents.
- There is a tradition of donor support to grassroots associations, made up of community leaders. There is also a large number of youth associations; some are involved in HIV/AIDS prevention (IEC) campaigns.
- IPC is also committed to building local association capacity, identifying and collaborating with local resource people and institutions, learning and trying innovative participative strategies, documenting experiences and processes, and sharing among partners.

- Savings and loan associations or credit unions and microfinance institutions provide fairly good coverage throughout Burkina. Two organizations—FAARF (UNDP) and the HCK Project (French government)—are working to create and expand access to health insurance schemes based on savings mobilization.
- There are several local resources that can provide training and guidance in acquiring participative techniques for community/social mobilization.

Following are some potentially problematic elements:

- Visibility of HIV/AIDS is problematic. Access to testing—let alone counseling—is shockingly inadequate, and people are reluctant to find out their status when they know that their options for support (both medical and psychosocial) are limited at best.
- NGOs, government organizations, communities, and families are so far responding to the impact of HIV/AIDS in a crisis mode. This has meant that attention to children is limited to ad hoc responses to crisis needs for food, shelter, clothing and school attendance when one (and especially after both) their parent (s) die.
- Although there is a felt need for strategies to respond to children and families affected by AIDS, associations, NGOs, resource people, and government structures have not had an opportunity to come together and analyze their experiences so that they can create strategies and move beyond a crisis mode.
- The focus on crisis response has led to gaps in acquiring a comprehensive understanding of the scope of the impact of HIV/AIDS on children—making it difficult to develop systematic response strategies that deal with the constellation of issues that increase vulnerability of children. It has also led to over-emphasizing orphans and under-emphasizing children affected by HIV/AIDS who are also vulnerable. There is also a lack of awareness among association members, government, and IPC of the importance of providing psychosocial support to children affected by HIV/AIDS. Few concrete programs have been initiated to assist children in this domain.
- Girls are especially vulnerable to becoming infected by HIV/AIDS and to suffering the consequences of the disease. They become the primary caregivers of children when adults are ill, or care for the person who is sick especially when it is the mother. They experience economic pressure to trade sex for money to support the family.
- In general, “child-focus” is defined as providing direct assistance to children, but not involving them as active participants in project development and implementation. With the exception of youth associations, few organizations have considered including children and youth in their future efforts.

- Coverage of mitigation activities for affected people, families, children, communities is inadequate and activities among various actors in the “fight against AIDS” are not coordinated so that they could attain better coverage.

## Recommendations

### For IPC and HIV/AIDS Alliance

- Develop a revised proposal that proposes to reinforce associations that are already moving toward mobilizing community responses to children and families affected by HIV/AIDS. The proposal should emphasize the following:
  - Building the capacity of associations to elicit interactive community participation and to facilitate community responses to the needs of families and children affected by HIV/AIDS, as opposed to carrying out new activities on behalf of communities.
  - Training association members how to conduct a participatory, child-focused assessment on HIV/AIDS impact on children, their families, and their communities. This should include young people from the onset of the project planning process. Participatory action plans developed directly with community members, young and old, should build on this basic understanding.
  - Moving beyond a crisis mode to one of anticipating the negative impact of HIV/AIDS and trying to mitigate them.
  - Expanding the definition of care and support to include non-medical aspects and looking at the family as a whole, considering children's psychosocial needs well before the death of the parent.
  - Maximizing resources and seeking collaboration and participation with all levels of development actors.
  - Identifying local resources that can assist associations in acquiring participatory techniques and tools appropriate for both adults and youth.
- IPC and the associations should seriously consider which associations will embark on community mobilization. Some associations may prefer to specialize in home-based care activities; acting as referral points to, and seeking to create partnerships with, other organizations engaged in mobilizing community responses to children affected by HIV/AIDS.
- Increase the amount of funding requested to include two additional IPC staff who would focus on managing and implementing the proposal's activities.
- In collaboration with NGOs specializing in youth participation (e.g., Save the Children UK/Canada), IPC can begin to integrate a youth component into their standard needs assessment

training, or develop new training materials to help members adopt more child-focused programming approach.

- Organize a one- or two-day workshop for key people to discuss the issues surrounding developing systematic responses to the impact of HIV/AIDS (costs for this could be included in the proposal submitted to DCOF).
- Collaborate with FAARF, UNDP, and CRS on developing a savings mobilization scheme or microcredit scheme (implemented by FAARF and/or CRS), or both, that would overlap with the community mobilization activities of IPC-supported associations. Estimated costs for developing such a program should be included in the proposal.

### **For Displaced Children and Orphans Fund**

- Support a proposal from IPC and HIV/AIDS Alliance that emphasizes developing the skills and capacity of associations to mobilize community responses to the needs of orphans and vulnerable children.
- Carefully examine whether DCOF funds should be used to stock IPC-supported associations with drugs for palliative care. Given all the challenges inherent in HBC programs, a longer-term solution to sustainable access for such drugs will probably not be a priority as long as funding is provided.
- Additional funding should be included for technical assistance to support and further develop the FAARF, UNDP, and CRS savings mobilization/micro-credit schemes.
- If the IPC and HIV/AIDS Alliance is funded, DCOF should provide additional technical assistance during the proposal's implementation phase. Suggested technical areas are participatory techniques appropriate for youth and adults, providing psychosocial support to children affected by HIV/AIDS, and resource mobilization.

## **Scope of Work**

### **A. Overview**

Two Displaced Children and Orphans Fund (DCOF) consultants, Jill Donahue and Brigette De Lay, will evaluate an unsolicited proposal submitted by the International HIV/AIDS Alliance for work in Burkina Faso. The consultants will travel to Burkina Faso from July 12 to July 22, 1999. The team will assess the relative merits of the work proposed, put the problem of HIV-AIDS orphans in context by describing the efforts currently underway to mitigate the problem, and discuss future plans including microfinance issues. With that report, Lloyd Feinberg, manager of the DCOF, will decide what further actions may be necessary.

### **B. DCOF**

The Displaced Children and Orphans Fund is a special fund within USAID (funded by Congress) that serves vulnerable groups of children. These groups include street children, children orphaned by HIV-AIDS, and children affected by war. Lloyd Feinberg of USAID's Office of Health and Nutrition in Washington is charged with management of the funds. He is responsible for identifying and assessing program opportunities, allocating and monitoring funds, and reporting on the funds uses.

### **C. The International HIV/AIDS Alliance**

The proposal submitted by the International Alliance on HIV/AIDS, "Addressing Priorities Related to Orphans And Highly Vulnerable Children Affected by AIDS in Burkina Faso," aims to "address the needs of orphans and highly vulnerable children who have one or both parents living with HIV/AIDS" through the establishment of "new strategies, tools, activities and means of assessing results." The proposal is for a three-year capacity-building effort to integrate the preceding priorities into existing, NGO projects supported by the Alliance's in-country partner organization, Initiative Privee et Communautaire de Lutte Contre le Sida au Burkina Faso (IPC). The proposal requests \$381,481 of DCOF funding.

There are two sets of questions the proposal elicited. The first set of questions are concerned with general information regarding the problems of HIV-AIDS orphans in Burkina. Because DCOF has not worked in Burkina before, it is interested in contextual questions that allow it to make comparisons with similar programs. Answers to contextual questions also explain the issue in terms of Burkina's own cultural context. Not all these questions are answerable, but it is important to see what data is available and subjectively, what IPC views as the issues. The second set of questions are concerned with the specifics of the technical proposal.

### **Regarding the nature, extent, and scale of problems in Burkina Faso:**

1. When did the epidemic start in Burkina Faso?
2. What geographic areas are the most seriously affected?
3. Where do families and communities seem to be having the greatest difficulties caring for orphans?
4. How do those areas relate to the ones where Burkinabe NGOs are working or will be working?
5. Do estimates and projections in “Children on the Brink” seem a reasonable reflection of the scale and evolution of orphaning in Burkina Faso, or are other estimates more accurate?
6. What kind of long-term strategy is needed to mitigate the impacts of HIV/AIDS in Burkina Faso, and how would the proposed activities fit into it?
7. Do orphans and other vulnerable children experience any particular material needs? Are they able to attend school?
8. What is the general experience of orphans in Burkina?
9. What is the government policy towards orphans? Do orphans and other vulnerable children have any particular problems regarding inheritance?
10. Is stigmatization greater or more problematic in Burkina Faso than in other countries?

### **The Alliance Program to Mobilize and Build the Capacities of Families and Communities to Meet the Needs of Orphans and Vulnerable Children**

#### **Please describe the Alliance/IPC relationship:**

- C What are the relative strengths and weaknesses of IPC as a service delivery NGO?
- C How is the Project Approval Committee working?
  - Discuss the introduction of the participatory approach now being used by IPC (especially regarding the December meeting of NGO field workers.)
  - What kinds of interventions are most requested?
- C DCOF is also interested in the development of locally-contracted technical resource. How was that concept introduced and how effective is it?

#### **Regarding the technical proposal:**

1. Does the Alliance see any ways that broadening the focus of Burkinabe NGOs to include orphans and other vulnerable children might increase the effectiveness of their prevention efforts?
2. Concerning the phasing in process...The first year will be devoted to building NGO capacity: Is there any way to work on community mobilization skills earlier?
3. At what stage would community members be trained in community mobilization skills?
4. Concerning the proposed funding level:
  - c What costs are covered under mobilization costs?
  - c What are the plans for documentation and dissemination

- c Is the funding sufficient for the proposed capacity-building effort?
5. There is funding for both prevention and care efforts; What types of programs are envisioned?
  6. Concerning indicators, How were they developed? (For instance, “number or %” often appears as baseline indicators. These figures should always be expressed as a percent.) Do the proposed indicators get at the aimed outcome? Is there a clear indication of data needs in relation to proposed indicators? If there is not a clear understanding, how will one be reached?
  7. What are the current reporting requirements? Is there a way that DCOF-funded initiatives can fit into the existing schedule mindful that these funds must be accounted for separately?
  8. What are IPC’s thoughts on sustainability? How will goals in that area be addressed?

**Regarding microfinance:**

DCOF-funded HIV-AIDS orphans programs have a microfinance component as a goal. While this has been discussed in general terms with the Alliance, and they in turn with IPC, the consensus is that it is important to keep the current work funded while the issue of microfinance is explored. Please discuss IPC’s (and the Alliance’s) view on the subject. In addition, please provide context about the current microfinance environment. Who are the current players? What are their strategies? What are their experiences with HIV-AIDS clients? Are there any possibilities for arranging geographic overlap and collaboration between community mobilization efforts and effective microfinance programs?

**D. Methodology**

Upon completion of travel, a draft report will be prepared and submitted to USAID DCOF/Washington.

## Contacts and Itinerary

Date	Location	Persons	Activity
July 10, 1999	Ouagadougou	Jill Donahue (JD), DCOF technical advisor	Arrival in Burkina
		Kevin Orr (KO), HIV/AIDS Alliance Technical Advisor to IPC; JD	Discuss logistical arrangements, initial discussions on assessment
July 11	Ouagadougou	Brigette DeLay (BD), DCOF consultant	Arrival in Burkina
		KO; BD; JD	Schedule organization; preparatory discussions
July 12	IPC office	Marie Rose Sawadogo, Executive Director of IPC (MRS); KO; BD; JD	Introduction to IPC staff; briefing on SOW; recommendations for meetings; distribution of key documents.
		M. Zerbo, member of REVS+; MRS; KO; BD; JD	Briefing of REVS+ activities, discussion of members' observations regarding vulnerable children
		BD; JD	Review of documents; scheduling appointments
July 13	IPC office	KO; BD; JD	History of IPC; background on IPC supported assns.
	Hotel	BD; JD	Review documents; make appointments
July 14	Ouagadougou	BD; JD	Visits to offices for appts; doc rev
	IPC office	MRS; KO; BD; JD	Discussion on expectation of IPC and Alliance; feedback from DCOF;
	Widows and Orphans Ass. (AVOB)	Mme. Dominique Kaboré, née Lucie Traoré, Founder; BD; JD	Overview of assn. activities as they relate to orphans and vulnerable children; discussion of how HIV/AIDS has affected assn.'s work.
July 15	Ministry of Social Action	Mme. Rosalie Traoré, Head of Family Services Dept; BD; JD	Discussion on gov't social workers experience with families affected by HIV/AIDS
		Mme. Marie Coulibaly, Head of Child Protection Dept; BD; JD	Discussion on gov't policies regarding orphans and vulnerable children; dept. activities; recent workshop on orphans
	Population Council	Mr. Inoussa Kaboré, Director; Mme Lydia Saloucou, Horizon study sociologist; BD; JD	Discussion of Horizon study on IPC supported associations of HIV+ members

	Kamboinsin	<p>Denis Ouedraogo, president of Youth Prevention Association (APES Jeunes) and IPC resource person; Vincent de Paul Belemsigri, Director of Youth Assns, Ministry of Youth and Sports; BD; JD and various leaders of Burkina youth assns</p>	<p>Evening informal discussion on youth perspective on HIV/AIDS in both prevention and mitigation efforts; description of various youth assn. activities; potential for increased youth involvement; brainstorm on possible activities; debate on the state of Burkina families and community solidarity. Leaders of youth assns had gathered in Kamboinsin for a national discussion of coordinating govt. responses to needs of assns.</p>
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Date	Location	Persons	Activity
July 16	SCF/UK	Boureima Ouedraogo, project coordinator for child protection activities; BD; JD	Explanation of SCF/UK's approach to mobilizing communities around vulnerable children issues in collaboration with GTZ microcredit project.
	Family Health and HIV/AIDS Prevention Regional project (SFPS)	Youssouf Ouedraogo, Burkina Faso Technical Advisor and IPC board member; JD	Evolution of HIV/AIDS; government policies; response of NGOs and donor community; personal experiences on the affects of HIV/AIDS.
	Bergerie compound in Ouagadougou	Wendtoin Ouedraogo, president; Angel Sawadogo, nurse/member; Jean-Marie Tapsoba, nurse/member; Racimata Ouedraogo, midwife/member; BD;JD	Description of assn. activities; discussion of issues surrounding orphans and vulnerable children; support from IPC; discussion of community mobilization and potential strategies
	Hotel	Dr. Desireé Yameogo, Clinical psychologist; BD	Discussion of activities relating to psychosocial needs of children in HIV/AIDS affected families; information on local resources and other activities in the area
	IPC office	Mr. Romvald Sawadogo, president of CEPROFET; JD	Community based organization (association) that assists village based groups in their grass roots activities; discussion of HIV/AIDS prevention care and support activities
	UNDP	Mr. Marc Saba, advisor to FAARF (Fonds d'Appui aux Activités Renumetrices des Femmes or Assistance to Women's IGAs); JD	Description of FAARF as an MFI; explanation of health insurance scheme and coverage of services; discussion of potential for IPC/FAARF and UNDP collaboration.
July 17	HOTEL	BD; JD	Review documents; consultant discussions on various meetings; observations so far; planning meeting
July 18	Ouagadougou	BD; JD	Travel to Bobo-Dioulasso

	REVS+	Mme Martine Somda, president; H��l��ne Badini, treasurer; Hien Basilesa, member; Korotimi Sawadogo, member; Somosome Sogbele, Asst. Sect'y; Mamadou Sawadogo, Sec. Gen'l.; JD	History of and discussion on REVS+ activities; description of what constitutes care and support for them; exchange of views on community mobilization and responding to orphan and vulnerable children's needs.
	Centre SAS	Mme Rose Marie Meda, Director of Solidarity for Social Action Center; BD	Discussion of center's activities; exchange of views on community mobilization and responding to orphan and vulnerable children's needs

<b>Date</b>	<b>Location</b>	<b>Persons</b>	<b>Activity</b>
July 19	Centre SAS	Dr. Anselme Sanou, psychologist; Mlle Assumpta Meda; JD; BD	Further information on Centre SAS; explanation of extension services
		Harouna, Ousseni, Bagayan, orphans who are head of their households; BD	Focus group discussion on child protection issues
		Harouna; Ousseni Bagayan; BD; JD	Individual interviews for profiles
	CADI (Anonymous HIV/AIDS testing and information Center)	Mme Madina Traoré, Director of Center; JD	Evolution of center and of HIV/AIDS in Bobo-Dioulasso; issues of access to testing and counseling; trends observed since 1996; issues of orphans. Widows and families affected by HIV/AIDS
	Bobo-Dioulasso hospital	Dr. Adrian Sawadogo, “AIDS doctor”; BD; JD	Discussion of HIV/AIDS from a govt. hospital and medical professional perspective; health delivery systems, professional “burn-out”.
	Hotel Auberge	Khalifa, IPC in charge of Care and Support projects; Denis Ouedraogo, APES Jeunes; Georges Badolo and Moussa Kafando, Pres and Xpres of the Youth Assn. Federation in Bobo; JD; BD	Information on Bobo youth federation activities; discussion on involvement of youth and children from a cultural perspective; community mobilization and HIV/AIDS mitigation activities-how to anticipate needs rather than respond to crises.

	Bobo-Dioulasso Mosque	Cheik Mouhamed Tiemogoba Dienepo, Imam; the Imam's advisors, followers and wives; Mamadou Sawadogo, PLWA and REVS+ member; BD; JD	Description of Imam's and members of the Islamic community's response to families and children affected by HIV/AIDS; discussion of community mobilization; description of DCOF activities in other parts of Africa.
July 20	Community Health Center	Dr. Zézouma, psychologist and president of A.PRO.DEC; BD	Description of A.PRO.DEC; discussion of community mobilization and atmosphere of dis-empowerment regarding HIV/AIDS
	HCK Project- (Bamako Initiative)	Dr. Etienne Traoré, Director of HCK project; Dr. Robert Casal-Gamelsy, French technical assistant to project; JD	Explanation of efforts to de-centralize health system delivery; discussion of community mobilization; potential collaboration between IPC's assns and HCK's efforts to create health insurance schemes.
	Bobo-Dioulasso	BD; JD	Travel to Ouagadougou
	Ouagadougou UNICEF	Dr. Flavia, UNICEF; BD	Discussion of UNICEF activities around child protection
	MWAGANZA	Djingri Ouoba, SED project mgr; JD	Discussion of MWANGAZA as a potential local resource for training in participatory techniques for community mobilization
	ONU/SIDA (UNAIDS)	Dr. Kékoura Kourouma, Regional Technical advisor; JD	Review of UNAIDS activities; discussion on community mobilization, need for scaling up and coordination/collaboration among NGO, CBO, and govt. ministries.

<b>Date</b>	<b>Location</b>	<b>Persons</b>	<b>Activity</b>
July 21	SP/CNLS (Nat'l Committee for fight against HIV/AIDS)	Dr. Paul Thomas Sanou & Mme. Madina Tall, head of care and support activities; BD; JD	Discussion on the gov't response to HIV/AIDS; community mobilization and responding to orphans and vulnerable children.
	Kaya/CPAM (Comité Paroisse d'Aide aux Malades)	Justin Rouamba, coordinator; Pascal Sawadogo, president; 5 catechists/HBC volunteers; 3 girl members of youth groups conducting IEC activities on HIV/AIDS; BD; JD	Catholic parish response to visiting the sick transformed into care and support for AIDS patients; discussion with volunteers and members of a youth group; community mobilization and support for orphans and vulnerable children.
July 22	ALAVI	Amadou Kaboré, president/founder ALAVI; BD	Description of care and support activities, heavy focus on vulnerable children and orphans in addition to support for HIV/AIDS patients
	IPC Office	MRS; BD; JD	Discussion on community mobilization approach, strategy of parallel MFI partnership
	HOTEL	Beth Mbaka, HIV/AIDS Alliance; MRS; BD; JD	Tele-conference debriefing to discuss major findings and recommendations
	CRS	Amy Davis, Microfinance Project Mgr; BD; JD	Discussion of CRS credit activities; explore potential for collaboration with IPC community mobilization.
July 23	Ouagadougou	JD; BD	Depart Ouagadougou
July 24	Kampala	JD	Arrive Kampala

## IPC-Supported Association Profiles

<b>REV+ in Bobo-Dioulasso</b>	
<b>Brief History</b>	Created as an outgrowth of a collaborated effort by health professional in the Bobo region to respond to the multiple problems of HIV/AIDS in the community. Officially recognized in 1997.
<b>Membership Profile</b>	21 active association members. 30% of members are infected, 70% affected. 63% women. 67% social or health professionals. No paid staff members.
<b>Objectives</b>	<ul style="list-style-type: none"> <li>a) Fight against stigma, humiliation, discrimination and social rejection of people living with HIV/AIDS</li> <li>b) To provide moral support to its members</li> <li>c) To improve PLWA quality of life</li> </ul>
<b>Main Activities</b>	<ul style="list-style-type: none"> <li>a) <u>Home-based Care</u>: including medical, psychosocial and spiritual support. Members contact the sick via home visits, hospital visits, a telephone hotline and during pre/post test counseling. When needed, REV+ also plays an active role in referring its clients to other services.</li> <li>b) <u>Prevention</u>: Through community discussion, films and mass media, conduct prevention information campaigns. Beneficiaries include over 800 school students, 50 opinion leaders, 1000 community members and 50 women.</li> <li>c) <u>Advocacy</u>: Actively involved in efforts to improve hospital care of the sick</li> </ul>
<b>Present / planned assistance to children</b>	Informal care support offered to children, but no systematic response. Proposed actions include providing school support, food assistance and medical care.
<b>Funding Sources/ Technical and Material Support</b>	Multiple sources of support, including local NGOs, international NGOs, UN agencies and bilateral donors. IPC is the only organization that has provided long-term funding to support daily care activities.
<b>Other Comments</b>	REV+ has gained national recognition for its efforts in anti-stigma work and its courageous approach to confronting stereotypes head on. Through personal testimonies, members have sought to demystify the illness and create more national visibility around HIV/AIDS.
<b>Association la Bergerie-Foi, Univers, Compassion (FUC) in Ouagadougou</b>	
<b>Brief History</b>	Modeled after a protestant program in France, La Bergerie was created as part of a church movement in 1994 to assist those in need. In 1996, a branch of the Bergerie, F.U.C, became independent and focused on assisting families infected and affected by HIV/AIDS.
<b>Membership Profile</b>	9 active members; 11 non-active members. 90% health professionals. 25% women. All volunteers.
<b>Objectives</b>	<ul style="list-style-type: none"> <li>a) To care for persons affected and infected with HIV/AIDS</li> <li>b) To train health professional, develop training material and participate in IEC activities</li> <li>c) To assist members address their own needs via simple activities</li> <li>d) Provide literacy training</li> </ul>
<b>Main Activities</b>	<ul style="list-style-type: none"> <li>a) <u>Home-based Care</u>: including medical, psychosocial, economic and spiritual support. Members contact the sick via home visits and at the Bergerie center. Members also provide free medicines, help beneficiaries to plan income-generating activities, and provide relief assistance. The Bergerie also conducts a support group for PLHIVA.</li> <li>b) <u>Prevention</u>: Through community discussion, trainings, peer educators and mass media, conduct prevention information campaigns. Beneficiaries include over 100 teachers, 710 religious leaders, 350 church members.</li> <li>c) <u>Advocacy</u>: Advocated with IPC to provide free medication to beneficiaries.</li> </ul>
<b>Present / planned Assistance for Children</b>	Currently supporting 82 orphans (representing 27 families) and 45 affected children. Assistance includes free medical care, food assistance and other relief type assistance. Are interested in provide schooling fees for needy children. Currently exploring sponsorship possibilities.

<b>Funding Sources/ Technical and Material Support</b>	Multiple sources of support, including local NGOs, international NGOs, UN agencies and the church. Membership dues also provide some financial resources.
<b>Other Comments</b>	Financial problems have created some disruption in services and affected the organization's credibility in the community.
<b>Association Appui Moral, Material et Intellectuel a L'Enfant (AMMIE) in Ouahigouya</b>	
<b>Brief History</b>	Created in the early 90s to respond to health and educational problems of children, AMMIE incorporated HIV/AIDS prevention work in 1992 and care work in 1996. From the beginning, "AIDS was regarded by AMMIE as a problem that touches the family as a whole."
<b>Membership Profile</b>	40 active members, 20 community assistants, and 60 volunteers. 80% membership are health professionals, 15% teachers. 50% women. 8 paid staff members.
<b>Objectives</b>	a) Child survival b) Child protection c) Facilitate the development of the child in a family and social setting
<b>Main Activities</b>	a) <u>Home-based Care</u> : Provide home visits to 82 people, provide medical care, transportation to health appointments and support for testing. Also provide psychosocial and economic support. Relief assistance provided. b) <u>Prevention</u> : Through community discussions. Target women, community members and students.
<b>Present / planned Assistance for Children</b>	Provide free medical and schooling support to children.
<b>Funding Sources/ Technical and Material Support</b>	Multiple sources of support, including local NGOs, international NGOs, UN agencies and the church. Membership dues also provide some financial resources. IPC provided the association training in care services.
<b>Other Comments</b>	Team did not visit this association.
<b>Comité Parissoise Aide aux Malades (C.P.A.M.) in Kaya</b>	
<b>Brief History</b>	Created as part of the CARITAS movement dedicates to assist the most vulnerable. In 1994, integrated the current HIV/AIDS component. Began with prevention activities and then branched out into care and support.
<b>Membership Profile</b>	Volunteers include church representatives and concerned congregation members. CPAM also works closely with key resource people.
<b>Objectives</b>	ü To assist those who are ill (from all causes) and other marginalized populations ü Motto-"Do unto others as you would have them do unto you."
<b>Main Activities</b>	a) <u>Basic Care</u> : Provide care and support through a network of volunteers. Members contact the sick via home visits. Volunteers offer medical, psychosocial, economic and spiritual support. Members also provide free medicines, emergency food aid (through a communal food bank, church donations) and other types of relief assistance. b) <u>Prevention</u> : Organize community discussion, work in schools and within the religious community.
<b>Present or planned Assistance for Children/ Youth</b>	Currently monitoring 9 orphan/widow cases. Assistance includes free medical care, food assistance and other relief type assistance. Ideas for future actions include: Help parents take into account the needs of children within the family; establishing a permanent food bank; providing better medical assistance to children; campaigning against forced marriages; creating opportunities for youth to express themselves/be more involved; focusing and identifying new strategies which stress self-reliance over charity.
<b>Funding Sources/ Technical and Material Support</b>	Multiple sources of support, including the church and local NGOs. IPC trained members in care and support activities.

