

**Burkina Faso
Ministry of Health**

**Survey of the Socio-Economic and Health
Determinants of ARV Treatment
in Burkina Faso**

FINAL REPORT

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Table of contents

	Page
Acronyms and abbreviations	iv
I. Introduction	1
II. General framework of the survey	1
2.1 Overview of the fight against HIV/AIDS in Burkina Faso	1
2.2 Context and justification of the survey	2
III. Objectives of the survey	3
IV. Methodology	3
4.1. Clarification of the terms	3
4.2. Nature of the survey	4
4.3. Conceptual basis of the survey	4
4.4. Survey variables	5
4.5. Sample and sampling	5
4.6. Data collection	6
4.7. Analysis and use of data	7
4.8. Chronogram of the survey	8
V. Ethical issues	9
VI. Limitations of the survey	9
VII. Findings	9
7.1 Findings on the analysis of the TAP design and implementation.....	9
7.1.1 Design and content of the TAP programme	9
7.1.1.1 Programme content.....	10
7.1.1.2 Knowledge of the expected programme outcomes	10
7.1.1.3 Principle of public/civil society partnership	10
7.1.2 Implementation of the TAP programme.....	11
7.1.3 Findings on the implementation of the TAP	11
7.1.3.1 Voluntary testing and counselling.....	12
7.1.3.2 Prevention of mother-to-child transmission.....	12
7.1.3.3 Medical care with ARVs	12
7.1.3.4 Psychosocial and nutritional care services	12
7.1.3.5 Follow up/evaluation.....	13
7.1.3.6 Financial implementation.....	14
7.2 Findings on the socio-economic determinants on adherence to ARV treatment	14
7.2.1 Sources of data	14
7.2.2 Characteristics of the sample of the PLW HAs surveyed	15
7.2.3 Presentation of the findings	17
7.2.3.1 Profile of the facilities in the survery.....	17

7.2.3.2	Adherence according to the data sources	19
7.2.3.3	Adherence according to the care facility.....	20
7.2.3.4	Adherence according to the profile of the care facility public compared with association facility.....	21
7.2.3.5	Adherence and proximity to the care facility.....	22
7.2.3.6	Adherence according to treatment regime	23
7.2.3.7	Adherence according to the duration of the treatment	24
7.2.3.8	Adherence according to age, sex, marital status of the PLWHAs	25
7.2.4	Analysis of the findings	27
7.2.4.1	Adherence according to care facility	27
7.2.4.2	Adherence according to the proximity of the facility to the residence of the PLWHA	27
7.2.4.3	Adherence according to the treatment regime and duration of treatment	27
7.2.4.4	Adherence according to sex, marital status and education.....	27
7.2.4.5	Drug and alcohol consumption.....	28
7.2.4.6	Conviction and acceptance of HIV positive status by the person.....	28
7.2.4.7	Apparent improvement in the health of the person receiving treatment	28
7.2.4.8	Family support for the person receiving treatment.....	28
7.2.4.9	Oversight of the times and days of appointments	29
7.2.4.10	Fear of being diagnosed HIV positive	29
7.2.4.11	Other issues raised.....	29
VIII.	DISCUSSIONS	29
IX.	CONCLUSION	31
X.	RECOMMENDATIONS	31
XI.	BIBLIOGRAPHY	33
XII.	ANNEXES	35

List of tables

- Table 1: Summary of the analysis
- Table 2: Situation of persons undergoing ARV treatment in the TAP sites according to health region
- Table 3: Summary of data collection sources
- Table 4: Breakdown by age group
- Table 5: Breakdown by sex
- Table 6: Breakdown by marital status

- Table 7: Basic data on the survey sites
- Table 8: Adherence team among those interviewed, by facility
- Table 9: Adherence according to the interviews with PLWHAs
- Table 10: Adherence according to the files examined
- Table 11: Adherence according to the public or associative nature of the facility
- Table 12: Adherence depending on the residence of the PLWHA
- Table 13: Breakdown of patients according to the treatment regime indicated during the interview
- Table 14: Adherence according to treatment regime
- Table 16: Adherence according to the facilities and duration of ARV treatment
- Table 17: Summary of findings from an examination of the files of patients receiving ARV treatment
- Table 18: Summary of findings from interviews conducted with patients receiving ARV treatment

List of figures

- Figure 1: Conceptual base of the adherence factors
- Figure 2: Adherence according to statistics compared to the data obtained from individual interviews
- Figure 3: Adherence level according to the source of information

Acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AIDSETI	AIDS Empowerment and Treatment International
AMMIE	Moral Material and Intellectual Support for the Child
ARV	Anti-Retroviral
ASA	African Solidarity Association
AZT	Azidothymidine
CHU	University Teaching Hospital
CHR	Regional Government Hospital
CICDoc	Centre for Information, Counselling and Documentation on HIV/AIDS and Tuberculosis
CMLS/Sante	Ministerial Committee on AIDS Control/Health Sector
CNLS-IST	National AIDS and Sexually Transmissible Disease Control Council
HIV	Human Immune-deficiency Virus
MCSS	Medical Centre with Surgical Staff
MS	Ministry of Health
WHO	World Health Organization
NGO	Non-Governmental Organization
OI	Opportunistic Infection
PADS	Health Support Development Programme
PAMAC	Support Programme for Rural Associations and Communities
PLWHA	Person living with HIV/AIDS
PMTCT/PMTCT+	Preventing Mother-to-Child Transmission, and Family Support
RAP	Regional Multidisciplinary Consultation Panel
SP/CNLS-IST	Permanent Secretariat of the National Aids and Sexually Transmissible Disease Control Council
STD/STI	Sexually Transmissible Disease/Sexually Transmissible Infection
TAP	Treatment Acceleration Programme
TOR	Terms of Reference
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNECA	United Nations Economic Commission for Africa
VCT	Voluntary Counselling and Testing
WFP	World Food Programme

I. INTRODUCTION

1. Burkina Faso is a landlocked country in the Sahel with a population of 13,730,258 (according to the 2006 General Population and Housing Census) and a surface area of 274,000 km². The overall morbidity and mortality rates are still high despite the progress made in the socio-health areas during the last fifteen years. The general mortality rate is 14 per cent while the infant-juvenile mortality rate is 184 per cent. Maternal mortality is 484 per 1,000 live births (EDSB 1998).
2. The Human Development Index was estimated at 0.303 in 2000. The national statistics indicated that in 1998, 46.4 per cent of the population lived below the absolute poverty line, which was estimated at 82,672 FCFA per adult per annum.
3. It is in a context characterized by poverty, low school enrolment and persistently high levels of general morbidity and mortality that HIV/AIDS is raging in Burkina Faso. The HIV prevalence rate among the population in the 15-49 age group was estimated at 4.2 per cent at the end of 2002. Between 2002 and 2003, the figures of reported HIV cases rose from 19,540 to 20,446. Efforts were made with the support of various partners to improve access to ARVs through price reduction and the establishment of initiatives to improve access to ARVs. Thanks to several initiatives and innovations in sensitization and community care developed by NGOs, community structures and associations, including associations of PLWHAs, a decline was observed in the epidemic. The prevalence rate, which was estimated at 7.17 per cent in 2000, dropped to 6.5 per cent in 2001 and to 4.2 per cent in 2003. The present HIV prevalence rate is 2 per cent.

II. GENERAL FRAMEWORK OF THE SURVEY

2.1 Overview of the fight against HIV/AIDS in Burkina Faso

4. The emergence of AIDS in the world since the 1980s has defied all forecasts and health and economic development plans. In sub-Saharan Africa, despite sensitization campaigns, AIDS is still a major public health concern. The segment of the population most affected by the disease remains 20-45 age group. The population, the authorities and the actors are well aware of the demographic, social, economic, health and policy consequences of the disease.
5. In Burkina Faso, HIV prevalence has grown since the discovery of the first AIDS case in 1986 to become an issue of much concern. This is justified by the fact that AIDS is not only a sexually transmissible disease, but also a lethal illness and an epidemic that can spread over a wide geographic area. It has been observed that from 1996 to 2000, the proportion of adults infected increased tenfold, rising from less than 1 per cent to more than 10 per cent, representing more than 660,000 carriers of the virus¹. In 2006, the health services reported 5,144 cases of AIDS, including 1,835 men and 3,309 women, representing 36 per cent and 64 per cent respectively of the cases. The sex ratio is estimated at 0.55. The lethal rate among hospitalized patients is an average of 22 per cent, with a higher rate among those above 15

¹ HIV/AIDS in Burkina Faso, National Committee to fight AIDS, March 2001

years of age. The statistics indicate a downtrend in the prevalence rate in the rural and urban areas. The prevalence rate among detainees is 2.3 per cent. At the end of 2007, the Ministry of Health released the following statistics:

Number of centres or PMTCT sites	413
Number of patient care structures	77
Number of VCT sites	170
Number of health districts providing patient care	53
Number of persons undergoing ARV treatment	17,263

6. Burkina Faso has developed and published guidelines on patient care for PLWHA and mobilized resources to implement its programme. This programme focuses on five main areas: (a) voluntary counselling and testing; (b) care for sexually transmissible infections; (c) PMTCT; and (d) treatment of opportunistic infection and ARV treatment; and (e) psycho-economic and social care services for PLWHAs. While care and treatment have been provided to HIV patients, the care and treatment have been poorly coordinated and the coverage is low. The prescription of ARVs is still limited, although there is a considerable increase in the number of care facilities.

2.2 Context and justification of the survey

7. The ARV Treatment Acceleration Programme (TAP) is the outcome of a partnership between the World Bank, WHO and the United Nations Economic Commission for Africa. The aim is to provide assistance to the countries concerned, namely, Ghana, Burkina Faso and Mozambique, to increase coverage in anti-retroviral treatment through an innovative partnership between the public sector and civil society. This programme took off in 2005 and was supposed to end in September 2007, but was extended to September 2008. The objective of the programme was to improve access by persons living with HIV/AIDS to anti-retroviral drugs in the countries mentioned. The TAP was also aimed to improve care for HIV/AIDS patients through a more comprehensive approach which, in addition to the anti-retroviral therapy will provide services such as voluntary counselling and testing, ARV treatment, treatment of opportunistic infections, prevention of HIV transmission from mother to child with the use of anti-retroviral drugs, and support for persons living with HIV/AIDS.

8. The adherence level for treatment is still not well known. A survey carried out in Ouagadougou and Bobo Dioulasso showed that 58 per cent of patients adhere to their treatment. The socio-economic factors examined in this survey are not linked to adherence to ARV treatment (Aboubacrine SA, Niamba P et al). However, other surveys undertaken have addressed the influence of socio-economic factors on adherence to treatment by PLWAHs^{2 3}

9. Numerous discussions are ongoing on the issue of adherence to anti-retroviral therapy, and a consensus seems to be emerging on the need for self-evaluation (by the patients themselves) of adherence to treatment. It is within this context that the TAP programme

² C. Andreo et al, *Public Health* 2001, Volume 13, no.3 pp 249-262

³ A. Sarna et al: Adherence to anti-retroviral therapy and its determinants among HIV patients in India, *Indian J Med Res* 127, January 2008, pp 28-36.

requested the services of independent consultants to analyze the socio-economic determinants of adherence to ARV treatment in Burkina Faso and in the two other countries concerned.

III. OBJECTIVES OF THE SURVEY

10. The overall objective of the survey is to identify and analyze the health and socio-economic determinants of adherence to ARV treatment in Burkina Faso.

11. More specifically, the study aims:

(a) To identify the determinants associated with the individual, such as age, sex, marital status, alcohol consumption, of adherence to treatment;

(b) To identify the determinants associated with the family or the community that affect adherence by patients to ARV treatment; and

(c) To identify the determinants associated with health services which could affect adherence to ARV treatment.

IV. METHODOLOGY

4.1 Clarification of terms

12. *Socio-economic determinants.* These are acquired or transmitted characteristics attributable to the social and/or economic context of the patients undergoing treatment. As the meaning of these factors can vary from one environment to another, a clear definition of each is essential for any causal analysis.

13. A study of the determinants of adherence to treatment and continuing care cannot be limited only to the attitude of the patient. The conditions of care and treatment as well as the relationship between the service provider and the health system organization, and the distribution of treatment are all factors to be taken into consideration.

14. The discussions on the French term for adherence is still ongoing, but for the purposes of this survey and in keeping with the idea expressed in the terms of reference (TOR), we have opted to use the word “observance” in French (Catherine Tourette-Turgis, et al).

15. *Adherence to ARV treatment.* The issues examined here is not just the taking of drugs but also all the steps involved in monitoring the treatment. The process of caring for PLWHAs should be well explained in order to understand its shortcomings. Adherence is the result of a learning process that depends on the many variables that affect the subjective life of the patient and his objective reality (living conditions, events). Adherence to treatment refers to the ability of a person to take treatment according to prescription. This ability is influenced positively or negatively by cognitive, emotional, social and behavioural co-factors described by Catherine Tourette-Turgis. Adherence is also defined as the ability of the patient to adopt an active approach in order to take ownership of and to become fully in his treatment.

16. This survey examines two principal groups of factors: socio-economic and health factors linked to the individual, and the factors linked to service providers and the social environment.

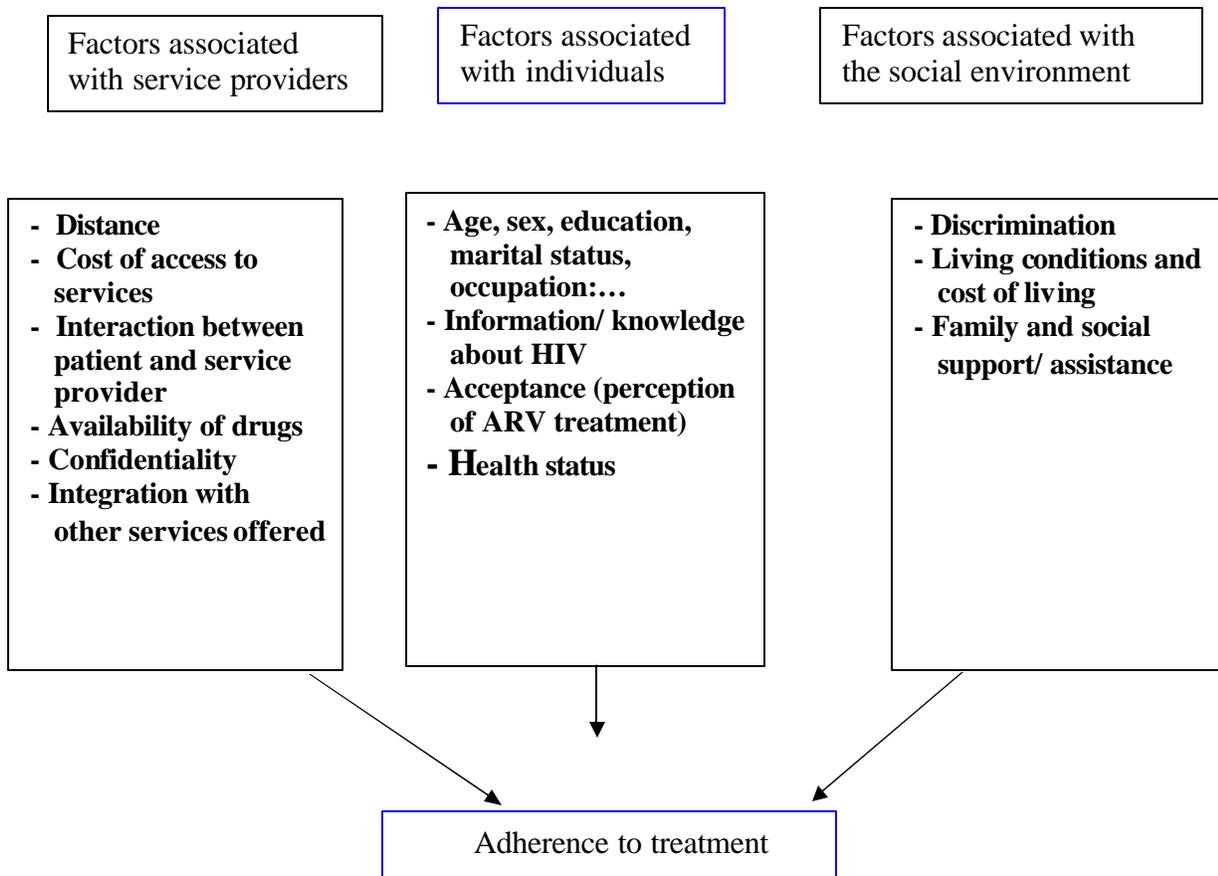
4.2 Nature of the survey

17. Given the objectives outlined by the sponsor, a forward-looking approach would be more appropriate in the search for variables for analyzing the impact of the determinants. The analytic aspect cannot be covered, as a limited period of three weeks has been provided for the collection of data for the survey. However, considering the limited time as well as the approach agreed with the teams from the three countries participating in the process, it was decided that a crosscutting descriptive survey with an exploratory aim should be conducted, despite its shortcomings. The results of this approach will suggest some potential factors which could be further developed through forward-looking surveys.

4.3 Conceptual basis of the survey

18. The potential determinants of adherence to ARV treatment can be grouped into three broad categories as follows:

Figure 1: Conceptual basis of the potential determinants of adherence



4.4 Survey variables

19. Two groups of variables are examined in this survey:

Individual socio-economic variables

Demographic variables (sex, age, marital status...)

Sociological variables (occupation, level of education...)

Economic variables (purchasing power, lifestyle..)

Health variables (medical history, health status..)

Perception by the individual of the clinical and social effects of the treatment: (nuisance, individualization, constraints..);

Variables linked to the care facilities for PWLHAs

Organization and institutional framework for care: cost, monitoring system

Care providers

Type of care proposed (treatment, biological follow-up, treatment of opportunistic infection).

4.5 Sample and sampling

20. With regard to the conceptual basis of the potential factors, the sampling method took into account the potential differences in the organization of service offerings which can affect adherence to treatment. Since all the facilities involved in the prescription of ARVs are guided by the same procedures drawn up by the Ministry of Health for the prescription and monitoring of HIV positive persons, the sampling took into account the public or private/associative nature of the facility. Moreover, geographic coverage (services to patients in urban or rural areas) was also included in the method used for the selection of survey sites. Consequently, in addition to the public or private/associative profile, the sampling included service coverage to the population in urban and rural areas. The prescription of ARVs is at the moment restricted to national and district hospitals.

Selection of facilities/ treatment sites

21. Given the timeframe for the survey, four TAP and non-TAP treatment sites were selected in a logical manner:

- (a) Sites in urban areas as opposed to rural areas;
- (b) Sites run by the public sector as opposed to association/NGO sites;
- (c) Sites accessible at the time of the survey; and
- (d) Acceptance by the officials at the sites to welcome the survey.

22. The survey took place in four care centres for PLWHAs in three health regions of the country: (a) an association centre in Ouagadougou, the capital, (b) an association centre in Ouahigouya, a town in a rural area: and (c) two public centres in Bobo Dioulasso, the second-largest city in the country.

23. It should be noted that following discussions between the consultant and officials of the St. Camille Centre, the CTA in Ouagadougou and the CMA sites of Sector 30 and Pissy in Ouagadougou, it was not possible to include a public site and the only NGO site for data collection as was planned.

Selection of survey targets

24. In each site 40 to 60 files of patients undergoing treatment in 2007 were examined with the use of an established analytical grid; discussions were held with 50 to 60 patients after receiving treatment in the care centres and with the staff working in the centre. The principal characteristics of each survey site were collected through a form that the service providers or the official of the centre filled out.

Determination of adherence

25. Cases of adherence and non-adherence were identified and analyzed in relation to the procedures described in the therapeutic plan prepared by the CNLS/CMLS as well as the various documents prepared by the PAMAC used for the training of service providers. The concept of adherence has two aspects: (a) adhering to treatment; and (b) adhering to the prescribed follow-up plan. Adherence to treatment considers the intake of the recommended molecules as well as the prescribed quantities, compliance with the hours for taking the drugs and the dietary regimes and dietary advice. Adherence to follow-up includes compliance with appointments given and the prescribed biological tests.

26. The patient is considered to comply with the prescription regime if he takes the prescribed molecules and drugs (number and type) in the prescribed dose daily. Compliance with the monitoring plan is effective when the patient turns up regularly for follow-up appointments during treatment as prescribed (say 15 days, 1 month or every 6 months).

27. In this survey, any patient who, according to his statements and information taken from the records that were examined, did not miss any appointments and did not interrupt his intake of ARVs since he started treatment is considered to have adhered to his treatment.

4.6 Data collection

28. Data were collected from 25 April to 31 May 2008 depending on the availability of the service providers, by counsellors working in the care sites including some who were PLWHAs or leaders in community organizations providing care for PLWHAs.

Data collection tools

29. Six types of data collection tools were used (copy annexed):
- (a) A guide for interviewing patients in the care facilities of the survey sites;
 - (b) A guide for focus groups involving men and women (PLWHAs);
 - (c) A guide for interviewing service providers of the care facilities;
 - (d) A document containing information on services provided in the care facilities;
 - (e) A guide for interviewing leaders or key persons within the community; and
 - (f) A guide for interviewing or discussing with the officials of the TAP programme in Burkina Faso.

4.7 Analysis and use of data

30. The data were entered using the EPI-INFO software and analyzed with SPSS 11.5. The analyses were carried out based on univariate frequency and cross tabulation between some variables.

Analytical plan

Table 1: Summary of analytical plan

	Examination of documentation	Interview with service providers	Interview with patients	Interview with leaders
Socio-economic factors	X		X	
Age, sex, profession, occupation, income, membership in PLWHA association	X	X	X	X
Perception of treatment and molecules (duration, continuity, constraint, cost, social stigma);				
Constraints of taking medication and follow-up		X	X	X
Factors associated with the care facilities				
• availability of molecules		X	X	X
• cost of the search for medication			X	X
• organization of the delivery of treatment		X	X	X
• organization and cost of follow-up treatment				
• impact of the data in the organization of services		X	X	

4.8 Chronogram of the survey

Period																			
Preparatory phase of the survey																			
Contact, information to the officials of the TAP on the survey																			
Analysis of the documents, design of the approach and tools, review of the literature																			
Identification and analysis of documents																			
Preparation of the methodology, tools and techniques for data collection																			
Submission of methodology, tools and approaches for comment																			
Collection of assessment by the principal actors of the TAP in Burkina Faso																			
Preparation for data collection, training of data collectors, pre-test tools																			
Collection phase, processing of data and preparation of report																			
Collection of data on the ground																			
Entry and analysis of the data																			
Preparation of the preliminary report																			
Submission of the preliminary report to ECA																			
Restitution and collection, amendment of preliminary report (workshop)																			
Finalization of the amended report by the workshop																			
Submission of the amended report to ECA																			
Workshop at ECA																			
Finalization of the report																			
Submission of the final report to ECA																			

V. ETHICAL ISSUES

31. People are generally sensitive to the issue of HIV/AIDS and STIs and some responded with reservations during interviews for the survey. In view of the need to maintain confidentiality and anonymity, the data collection tools did not reveal any name or identification number in the records. Moreover, there was no pressure to obtain answers, particularly with regard to individual status. The collectors working on the personal data of patients were members of PLWHAs organizations or people working in care facilities to ensure discretion and confidentiality. The patients to be interviewed were informed about the objective of the survey and they had to give their consent before the interview could be conducted in accordance with the form in the annex of the patient interview questionnaire.

VI. LIMITATIONS OF THE SURVEY

32. Given the objective of analyzing the effects of various factors, a longitudinal approach was adopted instead of a crosscutting survey. A crosscutting survey does not establish direct linkages between the variables and adherence. The logical method of sample selection as well as the scope limited the application of the multivariate analysis which would have helped identify possible conflicting factors.

33. The timeframe set for the study did not allow for a representative selection of sites providing care and ARV treatment.

VII. FINDINGS

7.1 Findings on the analysis of the TAP design and implementation

34. The findings in this part come from an examination of reports and other documents on TAP in Burkina Faso and from discussions with the various actors on the ground (service providers), partners, officials of the Ministry of Health, and officials from the National Council to Fight AIDS on the TAP in Burkina Faso.

7.1.1 Design and content of the TAP programme

35. The discussions revealed that the Ministry of Health and the National Council to Fight AIDS (SP/CNLS) took part in the discussions on the content of the TAP from the start. There was unanimity on the need and relevance of measures to increase access to ARVs. There was unanimity also regarding the participation of civil society, particularly community organizations fighting AIDS, considering that the disease could not be fought solely by the officials of the Ministry of Health. The various actors with whom discussions were held underlined the fact that the participation of community organizations in fighting AIDS contributes not only to increased access in treatment, but also to providing support and strengthening the actions to be taken particularly in the communities to combat this pandemic.

7.1.1.1 Programme content

36. The content of the programme was discussed with the stakeholders at the national level. The various points which were seen as difficulties were ironed out by consensus and later on the final content of the programme was accepted by the various officials at the national level. The activities designed to increase access to treatment both in the public structures and in the private sector as well as in the community organizations were planned through the prior identification of the reinforcements to be carried out in each participating structure. An evaluation of needs for the acceleration was carried out in 2005. However, the discussions revealed that the issue of sustainability was not adequately taken into account in this programme which some qualified as “pilot”.

7.1.1.2 Knowledge of expected programme outcomes

37. A stronger public/NGO/associations and civil society participating helped test and speed up the extension of coverage of treatment in twenty medical centres with surgical staff (MCSS) and in the official care structures of associations/NGO/ civil society taking part in the initiative.

38. Access to comprehensive, complete, equitable and affordable care was speeded up for the population through an approach that ensures sustainability and durability.

39. Certain lessons were learned for strengthening the programme thanks to the monitoring and evaluation system of the initiative. The lessons learned, experiences acquired and implementation tools developed were disseminated for use by other communities.

7.1.1.3 Principle of public/civil society and partnership

40. In Burkina Faso, the partnership was between civil society and the private sector. The participation of organizations and programme management in this process was “hotly contested” at the outset, as mentioned by some actors who were interviewed. However, the discussions later ended in a consensus and accepted by all the following parties taking part in the programme:

(a) Institutions of the Ministry of Health;

- (i) Ministerial Committee on AIDS Control (CMLS) Health: technical coordination;
- (ii) Directorate of Health and Family Affairs (DSF): implementation of PMTCT/PMTCT plus; and
- (iii) 21 Health Districts of the TAP spread over the thirteen health regions.

(b) Community Organizations and NGOs: The community organizations participating are from two networks: AIDS Empowerment and Treatment International (AIDSETI) and CICDoc. Six associations out of the 22 in the AIDSETI network are part of TAP: AAS, ALAVI, AMMIE, Espoir-Vie, REV+ and Positive Life. The HIV/AIDS and Tuberculosis Information, Counselling and Documentation Centre (CICDoc) has five associations that are part of TAP: AJPO, AFAFSI, BERGERIE, SOS/SIDA and URBLs. The SAINT CAMILLE NGO, CENTRE MEDICAL SAINT CAMILLE (CMSC), which is a pioneer in AIDS care in Burkina Faso, participates in the TAP programme; and

(c) Financial and technical partnership: UNECA is the coordination and implementation agency, WHO provides technical support and the World Bank is the funding agency.

7.1.2 Implementation of the TAP programme

41. The implementation and coordination of the programme was entrusted to the Health Development Support Programme (PADS) with the participation of all stakeholders and partners. Since the commencement of the programme in 2005, periodic reports have been issued and discussed during six meetings of the TAP held in Accra, Maputo, Nairobi, Addis Ababa and Ouagadougou.

42. The technical support for the service providers was provided by WHO and PAMAC with its publication of care manuals and increasing the number and skill levels of the staff.

43. PAMAC provided support in technical teaching aids by preparing and distributing registers and the manuals on treatment and training the staff on the use of these tools.

44. Adherence to ARV treatment is taken into account in the aids and reminders have been developed to improve adherence to treatment by patients undergoing treatment. The aids were put in place and the staff trained to use them. Teams responsible for monitoring adherence were also put in place, but they are hardly functional in the public sector structures due to lack of logistic resources according to the service providers.

45. In the association and private facilities, in addition to the trained personnel, resources were put in place for community follow-up of patient undergoing treatment. When an issue of non-adherence is observed which requires close follow-up, the patient is put in an adherence centre where he/she can receive medical attention as well as psychosocial support to resolve the issue.

7.1.3 Findings on the implementation of the TAP

46. It is important to point out that credit for the success in fighting HIV/AIDS should not be given solely to the TAP. The TAP only strengthens other ongoing initiatives and programmes to fight AIDS. The results shown below should be interpreted along these lines. Since 2003, Burkina Faso has been developing measures to provide increased care for persons living with HIV/AIDS. The implementation of the TAP reinforced these measures. The

analysis of the results obtained up to 2007 shows that there has been continued increase in coverage indicators in the key areas of the TAP. These activities include the strengthening of the skills of the actors on the ground, support in the form of material resources and technical and teaching equipment and tools for programme monitoring/evaluation.

7.1.3.1 Voluntary testing and counselling

47. On testing and counselling, it should be mentioned that through various combined efforts, 511,658 persons were sensitized, indicating that the rate established within the framework of the TAP was clearly attained, even though this success is not credited entirely to the TAP⁴.

7.1.3.2 Prevention of mother-to-child transmission (PMTCT)

48. The number of PMTCT centres increased by about 40 times from 12 to 413. Moreover, 1,538 mother-child couples were undergoing treatment in December 2007. The report of the TAP monitoring team shows that the objectives of the TAP were clearly attained in the prevention of mother-to-child transmission.

7.1.3.3 Medical care with ARVs

49. The number of medical care structures rose from 69 to 77 in December 2007. The number of persons living with HIV and receiving anti-retroviral treatment rose from 13,388 in the first quarter of 2007 to 17,268 PLWHAs⁵. Regarding coverage, the number of health districts participating in medical care rose from 44 to 53 (96.4 per cent) out of the 63 that exist in the country.

7.1.3.4 Psychosocial and nutritional care services

50. The association networks and the NGO St. Camille have developed measures aimed at providing foodstuffs to HIV positive persons. The reports indicated that more than 9,494 persons have received food assistance during activities to strengthen adherence. These nutritional support activities, the psychosocial care as well as the improvement in adherence have contributed considerably to improving overall care for PLWHAs in the TAP beneficiary structures.

⁴ General Report, SP/CNLS, Dec 2007.

⁵ TAP Report - Burkina, Nairobi Dec 2007

Table 2: Situation of patients undergoing ARV treatment in the TAP sites per health region

Regions	Total PLWHAs undergoing ARV treatment	Number undergoing ARV treatment in TAP sites	TAP percentage
Boucle du Mouhoun(6)	441	258	58.5%
Cascades(2)	211	196	92.9%
Central(21)	10,680	7290	68.30%
East Central(4)	397	390	98.20%
North Central (5)	353	189	53.50%
West Central(4)	563	507	90.10%
South Central(4)	139	82	59%
East(4)	173	137	79.20%
Upper Basin(11)	3,076	1104	35.90%
North (6)	723	683	94.50%
Central Plateau(3)	153	50	32.70%
South West(4)	241	187	77.60%
Sahel(3)	113	90	79.6%
	17,263	11163	64.7%

Source: TAP final report, Burkina Faso July 2008

51. More than 60 per cent of PLWHAs receiving ARV treatment are in the sites participating in the TAP.

7.1.3.5 Follow up/evaluation

52. The coordination team for the implementation of the programme took part in the various coordination meetings. The members of the association structures and NGOs were provided with training on planning, monitoring and evaluation. Various surveys were undertaken within the framework of programme implementation such as that dealing with TAP documentation in Burkina Faso.

53. The implementation of the TAP since 2005 has boosted demand for treatment because of the availability and accessibility of services in the TAP structures. The genuine motivation of the AIDSETI and CICDOC association networks as well as the NGO Saint Camille has contributed in the provision of care for PLWHAs under TAP sites to the enhancement of medical care for PLWHAs as well as the prevention of HIV infection in Burkina Faso.

7.1.3.6 Financial implementation

54. As at December 2007, 85 per cent of the allocated budget had been disbursed as shown in the summary table below prepared by the national TAP coordination body in Burkina Faso.

Disbursements as at 31 December 2007 (FCFA)

Category A	Item B	Initial allocation C	Adjusted allocation D	Cumulative disbursement E	Balance F=D-E	Rate of disbursement G=E/D
1	Works	160 813 662	148 458 116	71 245 524	77 212 592	48%
2	Supply of medication and materials	3 599 161 300	3 322 634 016	3 588 636 121	-266 002 105	108%
3	Consultancy services- training	796 410 160	735 221 144	1 403 277 101	-668 055 957	191%
4	Subsidiary grants	3 959 077 430	3 654 897 418	2 261 434 328	1 393 463 090	62%
5	Operational expenses	210 589 225	194 409 437	164 593 574	29 815 863	85%
6	Contingency	846 185 795	781 172 466	0	781 172 466	0%
Total		9 572 237 572	8 836 792 597	7 489 186 648	1 347 605 949	85%

Annex 1: Shows the details of the financial implementation per health facility and region.

7.2 Findings on the socio-economic determinants on adherence to ARV treatment

7.2.1 Sources of data

Analysis of the interviews with the site service providers in the survey as well as with the HIV positive persons receiving treatment in the sites.

Table 3: Summary of data collection sources

	OASIS (Ouagadougou) Site	AMMIE (Ouahigouya) Site	CNSS (Bobo Dioulasso) Site	CMA Dafra (Bobo Dioulasso) Site	Total
Number of service providers interviewed	2	2	2	2	8
Number of PLWHAs interviewed	33	38	30	29	130
Number of files examined	51	22	60	60	193
Number of summary files from data sites	1	1	1	1	4
Number of focus groups (with 8 to 11 participants per group)	2	2	2	3	9

7.2.2 Characteristics of the sample of the PLWHAs surveyed

55. The following tables show a breakdown of those interviewed in the survey by age group, sex and marital status.

Table 4: Breakdown of the sample by age group

Age group		OASIS (Oagadougou)	CNSS(Bobo Dioulasso)	AMMIE (Ouahigouya)	CMA Dafra (Bobo Dioulasso)	Total
18 to 27 yrs	Total	2	1	3	3	9
	% of total	1.5%	0.8%	2.3%	2.3%	7%
28 to 37 yrs	Total	10	19	12	17	58
	% of total	7.7%	14.6%	9.2%	13.1%	44.6%
38 to 47 yrs	Total	19	9	13	5	46
	% of total	14.6%	6.95%	10.0%	3.8%	35.4%
48 yrs and above	Total	2	1	10	4	17
	% of total	1.6%	0.8%	7.7%	3.1%	13%
Total	Total	33	30	38	29	130
	% of total	25.4%	23.1%	29.2%	22.3%	100%

56. **The minimum age for those in the survey was 18 years and the oldest person was a man 70 years old.** The age groups ranging from 28 to 37 years and from 38 to 47 are the most representative among the sample of PLWHAs in the survey.

Table 5: Breakdown of the sample by sex

Sex	OASIS (Ouagadougou)	CNSS (Bobo Dioulasso)	AMMIE (Ouahigouya)	CMA Dafra (Bobo Dioulasso)	Total	
Male	12	8	12	10	42	32.3%
Female	21	22	26	19	88	67.7%
Overall	33	30	38	29	130	100%
	25.4%	23.1%	29.2%	22.3%	100	

57. In the sample of PLWHAs in the survey, 67.7 per cent are women compared to 32.3 per cent men, with a M/W sex ratio of 0.47.

Table 6: Breakdown by marital status

Marital status	OUSIS (Ougadougou)	CNSS (Bobo Dioulasso)	AMMIE (Ouahigouya)	CMA Dafra (Bobo Dioulasso)	Total	
Married monogamous	5	9	14	15	43	33.1%
Married Polygamous	1	10	4	4	19	14.6%
Co-habiting	6	1	1	0	8	6.2%
Bachelor	4	6	8	4	22	16.9%
Widower/Widow	15	2	10	5	32	24.6%
Divorced	2	1	1	1	5	3.8%
Others	0	1	0	0	1	0.8%
Total	33	30	38	29	130	100
	25.4%	23.1%	29.2%	22.3%		100.0%

58. In the sample of PLWHAs in the survey, the married monogamous are the most representative, accounting for 31.1 per cent, followed by widower/widow with 24.6 per cent, bachelors with 16.9 per cent and the married polygamous with 14.6 per cent.

7.2.3 Presentation of the findings

7.2.3.1 Profile of the facilities in the survey

59. **According to the interviews with the staff in each centre, the service package provided is made up generally as follows:** consultation and care, issue of ARVs at subsidized prices (2,500 FCFA minimum, free of charge in the association sites) medical and biological follow-up, food for those in need).

Table 7: Basic data of the facilities in the survey

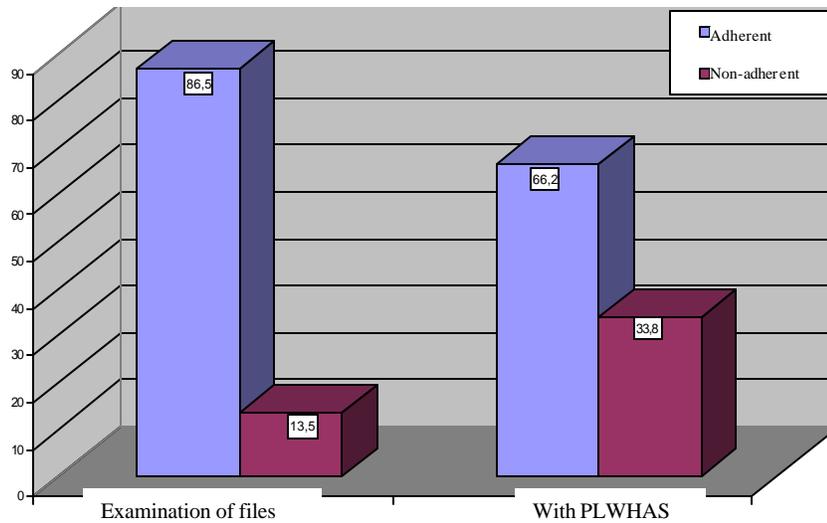
	<i>OASIS (ASS) Ouagadougou Centre</i>	<i>AMMIE (Ouahigouya) Centre</i>	<i>PEC CMA DAFRA Abobo Centre</i>	<i>CNSS (Abobo Dioulasso Centre</i>
Location of the centre	Urban association	Semi-urban association	Urban/ Public	Urban/ Public
Profile of centre	2001	2005	25/10/2005	27/12/2005
Date of commencement of ARV treatment in the site	50	25	150	8
Average number of PLWHAs in the site under treatment				
Number of PLWHAs under treatment				
Before 2005	46	72		0
2005	190	120	06	01
2006	257	135	49	41
2007	108	118	114	44
Average cost of services:				
Transportation	1000	1000	1000	1000
Cost of drugs	1500	1500	1500	1500
Biological tests	5000	5000	5000	5000
Personnel:	63	14	04	04
Doctor	4	1	1	02
Nurse	6	2	3	01
Social worker	33	7		01
Others	20	4		
Personnel according to sex				
male	63	14	04	04
female	18	8	1	02
	45	6	3	02

60. Other than the ASA site which started treatment in 2001, all the sites started ARV treatment in 2005. The OASIS site has a large number of service personnel compared to the other three. The Dafra site in Bobo Dioulasso has no social personnel to monitor activities at the community level.

7.2.3.2 Adherence according to the data sources

61. Figure 3 compares the level of adherence according to the data source (files compared with statements)

Figure 2: Percentage of adherence to ARV treatment (examination of files and individual interviews)



62. The retrospective assessment of the level of adherence on the basis of the statistical data is very inadequate. The information on the registers very often focuses on the keeping of appointments for the provision of medication. It does take into account the possible interruptions in the intake of medication between appointments. The direct interviews with the persons receiving treatment more aptly indicate adherence as well as the interruptions in the intake of medication and the keeping of appointments.

63. A total of 28 patients stated that they had interrupted their ARV treatment, including 12 who said that they had had several interruptions, ranging from 2 to 5 times since they were put under treatment. The duration of these interruptions also varied: 21 patients said that the interruption period ranged from 1 to 74 days. The reasons for these interruptions are varied: oversight, travel, health reason.

7.2.3.3 Adherence according to the care facility

64. According to the definition adopted, adherence takes two aspects into account.

Table 8: Adherence among the patients interviewed according to the facility

Survey facilities	Adherence		Total
	Yes	No	
OASIS (Ouagadougou)	19	14	33
CNSS (Bobo Dioulasso)	23	7	30
AMMIE (Ouahigouya)	31	7	38
CMA Dafra (Bobo Dioulasso)	12	17	29
Overall	85	45	130

65. Table 9 shows the adherence level by facility from the data obtained from individual interviews.

Table 9: Adherence according to interviews with PLWHAs

Name of the site	PLWHAs interviewed	
	Number of persons: 130	
	Adherence (%)	Non-adherence (%)
AMMIE	81.6	18.4
CMA DAFRA	41.4	58.6
CNSS BOBO	80.0	20.0
OASIS	57.6	42.4
Overall	66.2	33.8

66. Using the proportions recorded at the CNSS Bobo as the reference, the proportions are significantly higher at the CMA Bobo (public facility); $p < 0.05$ and at OASIS (private facility); $p < 0.05$.

67. Table 10 shows the level of adherence by facility from the files examined.

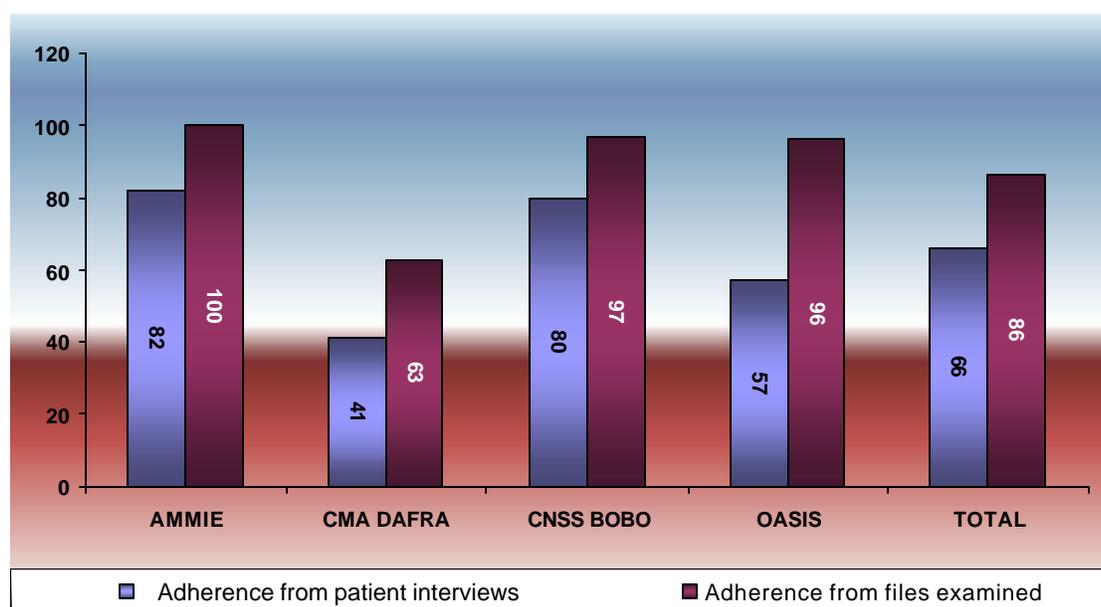
Table 10: Adherence according to the files examined

Name of the facility	Individual files	
	Number of persons: 193	
	Adherence (%)	Non-adherence (%)
AMMIE	100	0
CMA DAFRA	63.3	36.7
CNSS BOBO	96.6	3.4
OASIS	96.1	3.9
Overall	86.5	23.5

68. Using the proportions recorded at the CNSS Bobo as the reference, the percentage of non-adherence is significantly higher at the CMA Dafra in the Bobo Dioulasso region, although this facility has a similar number of personnel as the facility at the CNSS (National Social Security Fund). A significant difference is the absence of social workers, which probably explains the lack of follow-up at home and support for adherence.

69. A comparison of the data from the interviews and the data from the files does not show the influence of the care facility on adherence.

Figure 3: Adherence level according to the source of information



7.2.3.4 Adherence according to the profile of the care facility (public compared with association facility)

70. Table 11 shows the adherence level according to the profile of the service provider.

Table 11: Adherence according to the public or association nature of the facility

		Adherence	Non-adherence	Total
Public sector	Total	36	23	59
	% of total	27.7%	17.7%	45.4
Associations	Total	50	21	71
	% of total	38.5%	16.2%	54.6%
Total	Total	86	44	130
	% of total	66.2%	33.8%	100%

71. The association facilities offer their services for a lower fee or often free of charge. Fees in the public facilities are often decided by the health authorities. The public or

associative nature of the treatment facility does not show a significant difference in the level of adherence by the patients.

7.2.3.5 Adherence and proximity to the care facility

72. Table 12 is based on the examination of the registers and shows the level of adherence depending on the place of residence of the PLWHAs, taking into account those residing in the main administrative areas and those residing outside these areas.

Table 12: Adherence according to the place of residence of the PLWHAs

		Adherence	Non adherence	Total
Residing in the main administrative area of the care facility	Total % of total	154 79.8%	26 13.5%	180 93.2%
Residing outside the main administrative area of the care facility	Total % of total	12 6.2 %	0 0%	12 6.2%
Total	Total % of total	167 86.5%	26 13.5%	193 100%

73. It is important to point out that the distance from the facility does not constitute a factor for non-adherence to treatment. Indeed, all the 12 persons residing outside the main administrative area of the care facility adhered to treatment.

74. On the contrary, the direct discussions with patients undergoing treatment show that distance and financial means could play a crucial role in adherence to care. Two persons out of 22 stated that they failed to turn up for appointment due to distance and their inability to move as a result of neuropathy.

75. The lack of financial means was raised as the reason for non-adherence by 6 out of 22 PLWHAs as follows:

(a) “I was buying the medication and at some point I had no more money” (a 35 year old man said); and

(b) “I failed to turn up for an appointment as I had no money for the biological tests”; (says a 30 year old illiterate woman).

7.2.3.6 Adherence according to treatment regime

Table 13: Breakdown of patients according to their treatment regime

	Two times per day	Three times per day	Four times per day	Total
AZT+3TC+NVP/EFV	44	14	4	62
D4T+3TC+NVP/EFV	39	8	0	47
D4T+3TC+IDV	3	0	1	4
AZT+3TC+IDV	0	0	1	1
Other treatment regimes	3	0	0	3
Total	89	22	6	117

76. The coherence between the number of reported medication taken daily and the type of treatment regime could be linked either to the inability to retain the names of the prescriptions or the lack of control over the number of medications taken daily by the patients.

77. Table 14 shows adherence according to the treatment regime as indicated in the national care manual.⁶

Table 14: Adherence according to the treatment regime

Type of treatment regime	Adherence		Total
	Yes	No	
AZT+3TC+NVP/EFV	66.1%	33.9%	100.0%
D4T+3TC+NVP/EFV	68.1%	31.9%	100.0%
D4T+3TC+IDV	25.0%	75.0%	100.0%
AZT+3TC+IDV		100.0%	100.0%
Other treatment regimes	66.7%	33.3%	100.0%
Overall	65.0%	35.0%	100.0%

78. Out of the 130 patients interviewed, 117 provided complete information on their treatment regime. The variations in the proportion of non-adherents according to the type of treatment are not statistically significant. It is important to note that other aspects linked with services were raised by patients. In addition to distance, the quality of care and the financial means to acquire services also affected:

- The lack of confidentiality: “ the lack of confidentiality obliged me to change facility”, says a man;
- The side effects of the medications was raised by more than 10 patients and it sometimes led to the change in medication;

⁶ Standard and protocol of care for HIV infection in Burkina Faso, SPCNLS-CNLS health: 2003

- Some of the patients interviewed said that the failure to do biological tests on time due to the lack of reagents led to a delay Sometimes in the provision of treatment;
- The cost of medications and laboratory tests were raised in all the focus groups held in Bobo Dioulasso, Ouagadougou and Ouahigouya. Although the charges were revised downwards, it was expressed by both men and women that the charges for care should be further reduced or eliminated altogether;
- The constraints associated with the period of taking medication: “I have a problem taking medication on an empty stomach”; and
- A 32-year-old woman old under treatment for the past 36 months had to stop her treatment ‘because she could not see her doctor to change the treatment regime which was not suitable for her’.

79. An analysis of the possible reasons raised by the service providers themselves for non-adherence to prescriptions shows a slight inconsistency in the argument. Both patients and service providers raised the issue of lack of financial means, the side effects and transport difficulties. The service providers further pointed out that patients did not understand the directions for taking their medication, probably due to illiteracy and the large number of medications to be taken.

7.2.3.7 Adherence according to the duration of treatment

Table15: Adherence according to the facilities and the duration of ARV treatment

Survey facility	Adherence			Non-adherence		
	1 to 36 months	More than 36 months	Total	1 to 36 months	More than 36 months	Total
OASIS (Ouagadougou)	52.6	47.4	100	50.0	50.0	100
CNSS (Bobo Dioulasso)	87.0	13.0	100	66.7	33.3	100
AMMIE (Ouahigouya)	67.7	32.3	100	85.7	14.3	100
CMA Dafra (Bobo Dioulasso)	100.0		100	70.6	29.4	100
Total	74.1	25.9	100	65.9	34.1	100

80. Although at the start of treatment patients had considerable difficulty accepting and to getting used to the pace, we can state on the basis of our findings that the duration of the ARV treatment had no bearing on adherence to treatment.

7.2.3.8 Adherence according to age, sex, marital status of the PLWHAs

81. The following tables show adherence according to a number of individual characteristics, taking into account the data from files and data from individual interviews.

Table 16: Summary of the results from the examination of the files of patients receiving ARV treatment

	Adherence	Non-adherence	Value P
AGE GROUP OF PATIENTS (n=193)			0.351
Inf to 27yrs (N=23)	78.3	21.7	
28 to 37 yrs (N=92)	89.1	10.9	
38 to 47 yrs (N=58)	87.9	12.1	
48 to 57 yrs (N=18)	83.3	16.7	
58yrs and above (N=2)	50.0	50.0	
Total	86.5	13.5	
BREAKDOWN ACCORDING TO SEX			0.116
Male (N=119)	80.0	20.0	
Female (N= 143)	88.8	11.2	
Total	86.5	13.5	
MARITAL STATUS (n=193)			0.534
Married (N=119)	84.0	16.0	
Divorced (N=7)	85.7	14.3	
Bachelor (N=40)	95.0	5.0	
Co-habiting (N=7)	85.7	14.3	
Widow/Widower	85.0	15.0	
Total	86.5	13.5	
NUMBER OF CHILDREN(n=193)			0.222
0 children(N=68)	88.2	11.8	
1 to 3 children (N=92)	84.8	15.2	
4 to 5 children (N=23)	95.7	4.3	
6 children and above	70.0	30.0	
Total	86.5	13.5	
MEMBERSHIP IN A PLWHAs ASSOCIATION			0.482
Yes (N=7)	71.4	28.6	
No (N=18)	88.9	11.1	
Total	71.4	28.6	
ALCOHOL CONSUMPTION (n=193)			0.000
Yes (N=14)	85.7	14.3	
No (N=62)	69.4	30.6	
Total	86.5	13.5	
HIV POSITIVE STATUS OF PARTNER (n=193)			0.357
HIV positive (N = 35)	80.0	20.0	
HIV positive (N – 17)	82.4	17.6	
Total	86.5	13.5	
DURATION OF ARV TREATMENT (n = 193)			0.052
1 to 12 months (N=45)	100.0		
13 to 24 months(N=111)	80.2	19.8	
25 to 36 months(N=26)	88.5	11.5	
37 to 48 months(N=5)	100.0		
49 to 60 months(N=4)	75.0	25.0	
61 months and more (N=1)	100.0		
Total	86.5	13.5	

82. The individual variables in the survey according to the patient care files show that the consumption of alcohol is a factor for non-adherence to ARV treatment in the survey sample.

Table 17: Summary of the results from interviews with patients receiving ARV treatment

	Adherence	Non-adherence	Value P
SEX(n=130) Male(N=42) Female(N=88) Total	54.8 71.6 66.2	45.2 28.4 33.8	0.580
PATIENTS AGE GROUP (n=130) 18 to 27yrs (N=9) 28 to 37yrs (N=58) 37 to 47yrs (N=46) 48 to 57yrs (N=15) 58 and above(N=2) Total	66.7 65.5 69.6 53.3 100.0 66.2	33.3 34.5 30.4 46.7 33.8	0.668
MARITAL STATUS (n=130) Married monogamous (N=43) Married polygamous (N=19) Co-habiting (N=8) Bachelor (N=22) Widower/Widow (N=32) Divorced (N=2) Total	67.4 89.5 75.0 59.1 53.1 60.0 66.2	32.6 10.5 25.0 40.9 46.9 40.0 33.8	0.208
EDUCATION Literate (N = 83) Non-literate (N = 47) Total	62.7 72.3 66.2	37.3 27.7 33.8	0.263
CONSUMPTION OF DRUGS (no.129) Yes(N=3) No(N=126) Total	66.7 65.9 65.9	33.3 34.1 34.1	0.977
ALCOHOL CONSUMPTION Yes (N=46) No (N=81) Total	47.8 76.5 66.1	52.2 23.5 33.9	0.001
DURATION OF ARV TREATMENT 4 to 12 months (N=26) 13 to 24 months(N=41) 25 to 36 months(N=25) 37 to 48 months(N=20) 49 to 60 months(N=9) 61 months and above(N=9) Total	62.5 78.3 57.1 69.6 71.4 64.0 66.2	37.5 21.7 42.9 30.4 28.6 36.0 33.8	0.472
FREQUENCY OF INTAKE OF ARV Once a day(N=35) Twice a day(N=93) Total	62.0 78.4 55.6 66.4	38.0 21.6 44.4 33.6	0.171

83. The individual variables in the survey according to the data from individual interviews show that alcohol consumption is a factor for non-adherence to ARV treatment in our sample.

7.2.4. Analysis of the findings

84. The analysis covers both the quantitative and the qualitative results. The survey sample is not representative of the care facilities currently existing in Burkina Faso. However, the study is more exploratory and has examined some socio-economic and health factors in adherence to ARV treatment.

7.2.4.1 Adherence according to care facility

85. Our survey did not observe any major difference in adherence to treatment based on the care facility. However, this may be partly attributable to the method for the selection of survey facilities. With regard to the support at the community level in association facilities, greater adherence to treatment is expected from the patients.

7.2.4.2 Adherence according to the proximity of the facility to the residence of the PLWHAs

86. Our survey did not show any influence of the distance between the place of residence of the PLWHAs and the location of the care facility on adherence to treatment. However, the qualitative data suggest that distance as well as financial means could affect adherence at the individual level.

7.2.4.3 Adherence according to the treatment regime and duration of treatment

87. Our survey did not show any impact of the treatment regime, duration of the treatment and the pace in intake of medications on adherence to treatment. However, the statements show that the treatment regime is not fully understood by the patients receiving treatment. The interviews showed that the patients encounter greater difficulties during the first months of treatment.

7.2.4.4 Adherence according to sex, marital status and education

88. Our survey did not show any impact of sex, education, marital status, age of the patient on adherence to treatment. However, in the opinion of the service providers, HIV positive women receiving treatment adhere more to their treatment than men. They affirm that lack of understanding and illiteracy are factors for non-adherence. However, this has not been ascertained, as our results point to the contrary. Nonetheless, illiteracy constitutes a problem in understanding instructions for taking medication and the times that they should be taken. However, these difficulties were resolved through family support.

7.2.4.5 Drug and alcohol consumption

89. The fact that only three patients admitted that they take drugs does not bring out the correlation between adherence and individual behaviour. However, the consumption of alcohol was stated by both men and women and the analysis shows that this behaviour is a factor for non-adherence to treatment.

7.2.4.6 Conviction and acceptance of HIV positive status by the person

90. The interviews and focus groups showed that the conviction of an HIV positive person regarding the contribution of treatment to his life plans is a basic factor in adherence to treatment:

- *“A person conscious of his situation will never abandon his treatment”* (Women focus Bobo Dioulasso);
- *“I always recall the times for taking my medications as it is my life, I think a lot about it”* (a 40-year-old woman);
- *“I am often scared, I cant forget, its my life”* (a-37- year- old woman);
- *“I am unable to accept my illness”* (a young woman 26 years old);
- *“I have learnt to read the times with the support of my husband”* (a 29-year-old illiterate woman).

7.2.4.7 Apparent improvement in the health of the person receiving treatment

91. In all the focus groups in the cities as well as in the semi-urban areas, it was reported that *“feeling better after taking the medication might make someone to think that he has been cured”* and has made some patients to stop treatment. These observations have been reported in Rwanda⁷ but the data can neither confirm nor deny it.

7.2.4.8 Family support for the person receiving treatment

92. During the individual interviews and the focus groups, the issue of family support was raised:

- *“The presence of my daughter helps me to overcome the difficulties”*;
- Stigmatization from friends and family and the community, and job loss;

⁷ FHI-USAID – Factors influencing adherence to treatment among PLWHAs, October 2003, Kigali.

- In opinion of some counsellors questioned, religion as a whole and certain religious beliefs in particular suggest that there is the possibility of cure through prayer, making some believers to stop treatment. ***“I have a patient who stopped treatment only to return after a relapse”*** (counsellor, monitoring adherence).

93. However, the lack of family support and understanding sometimes leads to non-adherence to treatment, as this young girl says: ***“I stopped taking treatment following a row with my mother”***.

7.2.4.9 Oversight of the times and days of appointments

94. Two patients cited the case of oversight but this is not sufficient to draw conclusions. The very low number could be associated with the way patients organized themselves. The majority of those interviewed use various means to remember their appointments: memory, watches, alarm clocks, radio sets. For some patients, prayer times serve as reminders to take their medications. Family support prevents oversight, as these stories show.

95. ***“My children and my husband remind me about the times to take my medication”*** (45-year-old woman in a rural area): ***“I ask the time from my school-going children”*** (50-year-old woman): ***“My husband has thought me how to read the time”*** (45-year-old woman):

7.2.4.10 Fear of being diagnosed HIV positive

96. During the individual interviews, three persons raised the fear of being seen receiving treatment. They do not still have the courage to inform their friends and family about their HIV positive status and said they had difficulty pursuing treatment. The patients themselves put it more aptly:

- ***“My medications are well hidden as I do not want them to be discovered”*** (a woman 36 years old).
- A young girl 30 years old wanting to get married to her young boy friend concealed her HIV positive status by stopping treatment, but just to get into a relapse which obliged her to restart treatment (narrated by a counsellor)

7.2.4.11 Other issues raised

Trips, travels

97. Out of the 28 persons who temporarily interrupted their treatment, 4 of them said that they had to travel (for professional reasons, death of a close relative). The interruption in treatment could be related to the fear of being seen as receiving treatment as the patients concerned could take along their medication with them.

- State of health: difficulties to travel to the health facility, difficulties in taking the medication.

98. The main reason raised was due to neuropathy which prevented 6 out of 28 persons from travelling to their care facilities but some found a short term solution by requesting assistance from a relative to take them to the care facility or to ask them to collect their medication on their behalf.

- Financial difficulties in the regular supply of medication and the cost of biological tests

99. The purchasing power of the patients was not analyzed during the survey but nonetheless, the surveys have indicated the weaknesses in their financial resources for the regular purchase of medication and to meet the cost of the biological tests. Despite the limited number of cases in this regard, the patients expressed the difficulties and the reasons for the interruption in treatment. These difficulties were expressed in all the survey facilities even in the association care facilities where costs were subsidized.

- “I was buying my medication but at some point I had no more money” (a-35-year old man says);
- I did not turn up for my medical appointment as I did not possess the means to pay for my biological tests” (a 30 year old young illiterate woman says).

VIII. DISCUSSIONS

100. A first group of factors raised were those associated with the service facilities. In this group, our survey did not notice any significant difference compared to the profile of the service facility. However, the qualitative information obtained from the persons interviewed shows the need to ensure that the cost of medication and laboratory fees and the proximity services do not hinder the utilization of services. In this respect, although the persons interviewed wanted the prices of drugs to be “reduced” or eliminated completely, the study did not explore in depth this factor, which was identified in India (15) and in France (21) as essential for adherence to ARV treatment. Nonetheless, we observed that even in the association facilities in which medication is provided free of charge, there is a considerable degree of non-adherence. The service providers in association facilities said they limited the systematic donation of food for fear of creating dependency on the centre. Moreover, lack-of-means criteria were established for the provision of medication and care free of charge. The systematic donation of food through WFP as analyzed in Benin⁸ was not thoroughly examined in our survey, but the discussions with the service providers, indicated that food is not systematically donated to all PLWHAs receiving treatment.

101. The user-friendly nature of the services provided: the various centres have put in place an attractive set-up so that HIV positive persons can be comfortable in the facilities:

⁸ Phillipe B et al: Impact of integrated nutritional support for patients receiving ARV treatments

reception, enquiries, information and waiting area. These arrangements as proposed by various surveys attract more patients and make them feel better. Our survey did not examine if these various factors have an impact on adherence.

102. The objective of adherence support teams in the various facilities is to improve adherence to treatment. This service seems to be well developed in the OASIS centre where “non-adherent” persons who are detected are sometimes admitted for observation for a given period in order to eliminate the cause for stopping treatment or failing to turn up for fixed appointments. However, our study did not show the impact of these facilities on adherence, the fact that they are relatively new and handle very few cases might explain the lack of impact on the level of adherence. It would be important also to revisit the communication techniques used by the actors facilitating the adherence support exercise, because the communication may still be inadequate in practical terms, as observed in San Francisco and Copenhagen (17).

103. The second group of factors sought in our survey are those associated with individuals. These are factors like age, sex, marital status, occupation, taking of drugs and alcohol, which some identified (15, 16, 19) as factors for adhering to treatment. These factors exist but we did not note any significant difference except for alcohol consumption.

IX. CONCLUSION

104. Adherence to ARV treatment has been a source of concern for the TAP actors in Burkina Faso. Some capacity-building tools for service providers have been developed and used on the ground. Support activities at the community level have been developed by community associations. Nonetheless, our analysis shows that the level of non-adherence is still high in some care facilities, due in part to both the service facility and the individuals themselves. Regarding support for adherence, greater effort should be placed on male patients and alcohol consumption in the care facilities. Pre-treatment counselling should focus on the number and frequency of intake of medications. The national body has designed new treatment regimes that are in the process of being adopted, including the use of triple-combination therapy. Illiteracy especially among women is a constraint but it can be resolved through family and community support.

X. RECOMMENDATIONS

105. Based on the findings of this survey and considering the importance of adherence to the effectiveness of ARV treatment, the following recommendations are made to officials and stakeholders at both the national and the decentralized level at the Ministry of Health as well as to service providers.

106. **To the central and decentralized levels of the Ministry of Health**

- To put in place strategies to sustain and strengthen continuity in TAP interventions through the availability of ARVs;
- To undertake a comprehensive study on adherence to complement this explanatory survey;
- To continue seeking alternatives to reduce the cost of ARVs and laboratory tests.

107. **To the care service providers**

- To reinforce monitoring at the community level of patients receiving treatment in order to detect cases of interruption of treatment;
- To put in place a system for monitoring and analyzing the reasons for interruption of treatment through small action-oriented activities that will redirect the focus towards the need to support patients receiving treatment;
- To reinforce follow-up among patients receiving treatment and drinking alcohol as well as among HIV persons who still lack the courage to inform their family about their status.

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XII. ANNEXES

1. Results of the financial implementation of the TAP in the DS/CHR/OND compared to the amount allocated in the agreement dated 30 June 2007
2. Guidelines on the approach for the implementation of the TAP study in the country
3. Interview questionnaire for persons living with HIV/AIDS
4. Interview questionnaire for service providers in VCT centres
5. Grid for using the statistical data of VCT facilities
6. Interviews guide for leaders and key persons within the community
7. Guide for analyzing the implementation of the TAP in Burkina Faso
8. Terms of reference of the study on the socio-economic and health determinants of adherence to ARV treatment in Burkina Faso

Annex 1: Results of the financial implementation of the TAP in the DS/CHR NGO compared to the sum allocated in the agreement dated 30 June 2007

A	B	C		D	E		F	G =D-F	H = F/D	I
N°	DS, CHR AND NGO	Sum allocated		Amount spent		Cumulative difference	Cumulative rate of implementation Cumulatif	Observations		
		2007	Cumul	S1 2007	Cumul					
	DRS Boucle du Mouhoun /Dédougou									
1	DS DEDOUGOU	16 465 800	36 215 025	9 316 315	26 432 890	9 782 135	72,99%			
2	CHR DEDOUGOU	15 518 650	44 235 215	0	34 901 356	9 333 859	78,90%			
	Sub total n°1	31 984 450	80 450 240	9 316 315	61 334 246	19 115 994	76,24%			
	DRS Cascades / Banfora									
3	DS BANFORA	20 232 500	32 500 295	7 542 190	18 229 985	14 270 310	56,09%			
4	CHR BANFORA	23 585 130	49 495 555	0	8 510 425	40 985 130	17,19%	GAP = medications		
	Sub total n°2	43 817 630	81 995 850	7 542 190	26 740 410	55 255 440	32,61%			
	DRS Centre / Ouagadougou									
5	DS KOSSODO	8 287 510	64 806 326	1 688 175	53 044 033	11 762 293	81,85%			
6	DS PAUL VI	18 255 900	69 631 707	3 504 694	30 078 924	39 552 783	43,20%	Medical technical equipment 2005		
7	DS PISSY	17 786 511	90 235 779	4 966 510	37 451 977	52 783 802	41,50%			
8	DS SECTEUR N°30	22 596 338	61 344 963	9 340 465	47 786 547	13 558 416	77,90%			
	Sub total n°3	66 926 259	286 018 775	19 499 844	168 361 481	117 657 294	58,86%			
	DRS East centra / Tenkodogo									
9	DS KOUPELA	14 910 300	39 274 390	8 766 325	27 143 555	12 130 835	69,11%	Renovation and chair for 2005		
10	DS OUARGAYE	12 552 290	23 596 715	7 473 970	18 387 405	5 209 310	77,92%			
11	DS TENKODOGO	18 670 000	34 071 115	13 504 200	28 678 065	5 393 050	84,17%			
12	CHR TENKODOGO	26 713 125	49 964 250	9 259 250	32 140 375	17 823 875	64,33%			
	Sub total n°4	72 845 715	146 906 470	39 003 745	106 349 400	40 557 070	72,39%			
	DRS Central North / Kaya									
13	DS KAYA	13 333 175	19 554 920	7 601 270	13 693 475	5 861 445	70,03%			
14	CHR KAYA	18 080 777	21 216 577	12 156 465	12 639 565	8 577 012	59,57%	Activities not carried out in 2006		
	sub total n°5	31 413 952	40 771 497	19 757 735	26 333 040	14 438 457	64,59%			
	DRS West central / Koudougou									
15	DS KOUDOUGOU	19 952 380	39 436 845	8 980 545	28 400 450	11 036 395	72,02%			
16	DS NANORO	13 252 840	37 749 195	3 114 756	26 488 265	11 260 930	70,17%			
17	CHR KOUDOUGOU	15 478 300	54 221 400	4 539 274	40 660 323	13 561 077	74,99%			
	Sub total n°6	48 683 520	131 407 440	16 634 575	95 549 038	35 858 402	72,71%			
	DRS Central South/ Manga									
18	DS PÖ	14 209 696	39 258 401	8 171 750	30 990 290	8 268 111	78,94%			
	Sub total n°7	14 209 696	39 258 401	8 171 750	30 990 290	8 268 111	78,94%			
	DRS East/Fada									
19	DS FADA	16 174 525	30 617 840	13 041 925	27 380 040	3 237 800	89,43%			

20	CHR FADA	22 769 187	41 219 357	12 081 362	30 139 982	11 079 375	73,12%	
	Sub total n°8	38 943 712	71 837 197	25 123 287	57 520 022	14 317 175	80,07%	
	DRS Hauts Bassins / Bobo							
21	DS SECTEUR N° 15	16 666 600	69 281 100		19 103 207	50 177 893	27,57%	Equipment 2005 =17 850 000 and overestimation of equipment 2006 =14 368 943
				2 576 450				
22	DS SECTEUR N° 22	10 544 604	22 219 354	4 464 604	6 939 354	15 280 000	31,23%	Automates CD4 and milk + flour
	Sub total n°9	27 211 204	91 500 454	7 041 054	26 042 561	65 457 893	28,46%	
	DRS North / Ouahigouya							
23	DS OUAHIGOUYA	19 650 380	37 338 524	4 846 230	19 365 430	17 973 094	51,86%	
14	CHR OUAHIGOUYA	23 642 950	55 830 325	14 117 306	41 388 263	14 442 062	74,13%	Activities not carried in 2005
	Sub total n°10	43 293 330	93 168 849	18 963 536	60 753 693	32 415 156	65,21%	
	DRS Plateau Central/ Ziniaré							
25	DS BOUSSE	8 416 400	14 251 050	1 394 950	7 130 325	7 120 725	50,03%	
	Sub total n°11	8 416 400	14 251 050	1 394 950	7 130 325	7 120 725	50,03%	
	DRS Sahel / Dori							
26	DS DORI	9 635 800	36 545 175	4 083 875	33 028 066	3 517 109	90,38%	Excess renovation
27	DS DJIBO	13 352 350	40 882 245	3 783 450	31 313 345	9 568 900	76,59%	
28	CHR DORI	11 753 382	30 982 082	6 951 347	23 034 076	7 948 006	74,35%	Activities not carried out in 2005
	Sub total n°12	34 741 532	108 409 502	14 818 672	87 375 487	21 034 015	80,60%	
	DRS Sud Ouest / Gaoua							
29	DS Gaoua	14 990 600	43 026 455		21 103 374	21 923 081	49,05%	Counter 2006 and medical technical equipment 2005
				6 355 875				
30	CHR GAOUA	16 204 600	39 278 600	7 873 100	30 386 600	8 892 000	77,36%	
	Sub total n°13	31 195 200	82 305 055	14 228 975	51 489 974	30 815 081	62,56%	
	ONG/Associations							
31	AIDSETI	399 995 092	1 342 418 957	181 477 740	1 026 997 873	315 421 084	76,50%	
32	CICDOC	399 994 486	1 196 873 258	204 785 242	974 355 072	222 518 186	81,41%	
33	C. M. SAINT CAMILLE	99 810 141	205 133 297	51 322 788	145 007 178	60 126 119	70,69%	
	Sub total n°14	899 799 719	2 744 425 512	437 585 770	2 146 360 123	598 065 389	78,21%	
	TOTAL GENERAL	1 393 482 319	4 012 706 292	639 082 398	2 952 330 090	1 060 376 202	73,57%	
	TOTAL DS	319 936 499	881 837 419	134 518 524	552 169 002	329 668 417	62,62%	
	TOTAL CHR	173 746 101	386 443 361	66 978 104	253 800 965	132 642 396	65,68%	
	TOTAL ONG	899 799 719	2 744 425 512	437 585 770	2 146 360 123	598 065 389	78,21%	

- A: N° order
B: Nominal list of DS/CHR/NGO
C: Sum in the agreement DS/CHR/NGO in 2007
D: Sum in the agreement DS/CHR/ONG in 2005, 2006 and 2007
E: Expenditure (transfers and purchases) at 30 June 2007
F: Expenditure (transfers and purchases) for the years 2005, 2006 and S1 2007
G: Difference between the cumulative agreements 2005, 2006 and 2007 and the cumulative expenditure for the years 2005, 2005 and that of S1 2007
H: Implementation rate of the TAP all along

Annex 2: Approach in the implementation of the study in Burkina Faso

First of all an assessment of the principal actors in the TAP programme was done. During a day's working meeting, the consultant presented the draft of the survey to be carried out in Burkina Faso. These discussions led to the review of the approach in the selection of survey facilities. The performance criteria will be linked more to the establishment of logistic human and technical resources. Consequently, with regard to the place of the selection on the basis of facility performance, it was agreed to consider the profiles of service facilities in the urban areas compared to rural, public versus NGO/ASSOCIATION the selection of one or two facilities in each of the categories identified. The number of facilities will depend on the time set aside for these analyses and particularly the acceptance of the facility to be included in the survey.

To make an analysis in each of the facilities selected, the factors for adherence to treatment according to the variable groups described below, the selection of targets for the survey should take into account their availability and their acceptance and to be part of the survey. It is crucial to make a directory on some files to as to bring together data on several users of the facilities as the time frame for the collection of data does not allow for a large number of patients from the facilities. The overall chronogram defines the survey and summarizes it as follows:

(a) To produce a preliminary report now against 12th May which will be presented and discussed during the two workshops which will bring together the principal stakeholders in order to sound their opinion on the observations and eventual interpretations;

(b) This meeting should take place at the latest 23rd May 2008 so that the report will be produced and sent to ECA;

(c) Present the report during a workshop to be held on the 12th of June 2008 in Addis- Ababa; and

(d) Coordinate the amendments of the workshops and prepare the final reports of the survey up to the 3rd July, 2008 at the latest.

QUESTIONNAIRE ON CARE FOR PEOPLE LIVING WITH HIV/AIDS

Information sheet and prior consent

Sir/madam

The Ministry of Health in collaboration with its partners namely: The United Nations Economic Commission for Africa in collaboration with the World Bank and WHO within the frame work of the Accelerated Treatment Programme on ARV is carrying out a survey on the determinants for adherence to treatment in Burkina Faso, Ghana and Mozambique.

The research team in Burkina Faso seeks your support to identify and analyse the determinants to adherence on ARV treatment. Your valued support will contribute to the identification of the major causes impacting the adherence of patients to treatment through the use of ARV.

Do you agree to take part in the survey? Yes ? No ?

Are you prepared to respond to the questions that we wish to ask you? Yes ? No ?

We are not going to indicate your name but we are asking you if you agree to sign at the bottom of this sheet

Signature

Profile of the respondent

Identification: I _ I _ I _ I _ I

1- Age : Age group :	2- Sex of respondent (tick the appropriate box): Male ? Female ?
---	--

Encircle the appropriate response

<p>3- What is your present marital status</p> <ul style="list-style-type: none"> • 1 = Monogamous Marriage ; • 2= Polygamous Marriage • 3= Co-habiting ; • 4= Bachelor • 5 =Widower/Widow ; • 6= Divorced • 7= Others; • 9 = no reply 	<p>4. What is your religion</p> <ul style="list-style-type: none"> • 1 = animist ; • 2 = Catholic • 3 = Muslim ; • 4 = Protestant • 5 = Others
<p>5 Did you go to school? No ? Yes ?</p>	<p>6. If you are presently going to school or went to school, what is the grade that you reached?</p> <p>2 = primary level 3 = secondary level 4 = higher level 4 = Koranic school 5= Others.....</p>

Information on the usual treatment facility

7. Location of the facility: Ouagadougou ? Bobo Dioulasso ?

9. Profile of the facility:

- Urban ? Semi Urban ?
- TAP facility ? Non TAP facility ?
- Public facility ? Facility religious ? NGO facility/association ?

10. Date of the start of treatment in the facility

11. Pace in the monitoring of treatment by service providers:
Socio-health behaviour

12. Have you ever taken substances like drugs? No ? Yes ?

13. What type of drugs?

- 14. Have you ever taken alcohol? No ? Yes ?
- 15. What quantity?
- 16. How often do you drink alcohol? :
Daily ? ; weekly ? ; monthly ? ; no information ?

Status and treatment

- 17. When did you discover that you were HIV positive?
- 18. Since when are you receiving ARV treatment?
- 19. Which medications do you take?
.....
- 20. At what intervals do you take the medication during the day?
- 21. Have you once stopped taking your daily treatment since you started receiving treatment?
No ? Yes ?
- 22. If so, when?
- 23. How many times?
- 24. What is the duration of the interruptions?
a)
b)
- 25. What were the causes fro the interruption/(s)?
a)
b)
- 26. Have you ever failed to turn for your appointment with your doctor for you follow up? No
? Yes ?
- 27. IF yes when?
- 28. How many times?

29. What was the period during which you failed to turn up for your appointments?
 a)
 b)
30. What were the causes for this interruption/s?
 a)
 b)
31. Have you already changed medication since you have been receiving treatment?
32. At which date did you change?
33. What was the reasons for your change in medication?
34. How do you remind yourself to take your ARV medication?
35. What difficulties have you encountered since you started receiving treatment?

36. How did you overcome these difficulties?.....
37. Did you contract any illness during the last month? Yes ? No ?
 Don't Know ?
37. If yes, how were you treated? :.....

38. Who administered the treatment?
 VTC ? health centre/hospital ?
 self ? a friend ?
 Others: (specify).....
39. What are the most often methods you use as protection from these illnesses ?

CARE QUESTIONNAIRE WITH THE FACILITY SERVICE PROVIDERS

The Ministry of Health in collaboration with its partners namely: The United Nations Economic Commission for Africa in collaboration with the World Bank and WHO within the frame work of the Accelerated Treatment Programme on ARV is carrying out a survey on the determinants for adherence to treatment in Burkina Faso, Ghana and Mozambique.

The research team in Burkina Faso seeks your support to identify and analyse the determinants to adherence on ARV treatment. Your valued support will contribute to the identification of the major causes impacting the adherence of patients to treatment through the use of ARV.

Thank you for your availability and understanding.

Information on facility

Identification:

- Location of the facility : Ouagadougou ? Bobo Dioulasso ?
- Profile of the facility: Urban ? rural ? semi urban ?
- TAP facility ? Non TAP facility ?
- Public facility ? Professional facility ? Facility NGO/association ?
- Date of the start of treatment in the facility :

Profile of the service provider

Sex of the service provider Male ? Female ?

Age:

Professional Category

- Doctor : ?
- Midwife/Nurse : ? Social Workers: ? Others ?

1. Since when did the facility started caring for HIV positive persons?
2. What is the number of persons receiving treatment?
3. What is the average cost of the treatment in the facility (cost, transportation, medication)
4. How many patients do not follow their prescription during treatment/ and or the fixed appointments?

- What do you think are the reasons for not adhering to the prescriptions?

.....
.....
.....

5. In what way and how can the information collected during the period of treatment are used and / or contributed readapting the approach of the programme in order to facilitate adherence to treatment?

- The reorganization for care procedures for groups?
- The follow up procedures targeting per category of patients?

.....
.....
.....

6. What are the principal reasons raised by the users of your facility to explain why they have abandoned or stopped treatment or failure to turn up for appointments?

Sound out the medical reasons associated with the medication and cost,

- The social and economic reasons (analyse the data of the patient that was not seen again/abandoned treatment, place of origin and distance)

.....
.....

7. What are the reasons that explain the adherence to treatment by some of your patients?

Sound out the medical reasons associated with the medication and cost.

The social and economic reasons.

.....
.....
.....

=====

GRID FOR THE DEVELOPMENT OF STATISTICAL DATA OF CDV FACILITIES

The Ministry of Health in collaboration with its partners namely: The United Nations Economic Commission for Africa in collaboration with the World Bank and WHO within the frame work of the Accelerated Treatment Programme on ARV is carrying out a survey on the determinants for adherence to treatment in Burkina Faso, Ghana and Mozambique.

The research team in Burkina Faso seeks your support to identify and analyse the determinants to adherence on ARV treatment. Your valued support will contribute to the identification of the major causes impacting the adherence of patients to treatment through the use of ARV.

Thank you for your availability and understanding.

Information on facility

Identification: I _ I _ I _ I _ I _ I

- Location of the facility : Ouagadougou ? BoboDioulasso ?
- Profile of the centre: urban ? rural ? semi urban ? TAP facility ? non-TAP facility ?
- Public facility ? Religious facility ? facility NGO/association ?
- Date of start of the treatment in the facility :
- Rhythm in the follow up set by services providers:
 - Rhythm in the follow up applicable to patients receiving treatment
 - Number of follow up cases per day and/or per month
 - Average distance of the place of origin of the patient
 - Number of workers:
 - Breakdown according to the sex of the service providers Male ? Female ?
- Category of professionals working in the facilities:
 - Doctor :
 - Midwife/Nurse :
 - Social workers :
 - Others

Information on the files examined

Statistics of the facilities

	Before 2005	2005	2006	2007
Number of old cases receiving treatment				
Number of new cases receiving treatment				
Not seen anymore				
Opted out of treatment(migration, transfer)				
Death,				

Analysis of the individual files

Identification of the files: facility: I _ I _ I n° file: I _ I _ I _ I

1. Age:.....
2. Sex: male ? female ? ;
3. Marital status: married (e): ? divorced ? bachelor ?
4. Place of origin of the patient:
 - Main administrative area of the facility ? ;
 - Immediate environment ? ;
 - Far from the facility (> 50km): ?
 - Distance not specified ?
5. Number of children:
6. Profession/occupation:
 - Unemployed ? ; Worker in the public sector ? ;
 - Worker in the private sector ? ; Businessmen ? Sex worker : ?
7. Membership of PLWAs association
 - Yes ? No ? Not specified ?
8. Past history of the patient:
 - Consumption of alcohol? Yes ? No ? ; Not specified ?

- Notion of drug consumption Yes ? No ? ; Not specified ?

9. HIV status of the partner:

Positive ? ;

Negative ? ;

Not known/Not specified ? ;

10. Medical history /ATCD

10.1 Date put under treatment :

10.2 The treatment regime :

Option n°1: AZT/3TC +EFV/NVP: ?

Option n°2: D4T/3TC+ EFV/NVP: ?

Option n°3a: D4T/3TC+ Indinavir : ?

Option n°3b : AZT/3TC+ Indinavir: ?

Option n°4: Others to be specified: ?

11. Patient adhering to treatment and follow up? Yes ? ; No ? ;

12. Noted interruption of the treatment :

10.3 date,

10.4 The respective durations

10.5 Reasons why :

13. Interruption or lateness in appointments set for medical follow up

	Interruption/lateness in appointment	Duration of interruption	Reasons raised
15 days			
1 month			
3 months			
6 months			
After 6 months			

14. Difficulties/problems narrated by patients during consultations
- (a) ? Reactions to medication : (b) ? Follow up on the diet
 - (c) ? Memory problems
 - (d) Others.....

CARE MANUAL WITH LEADERS OR KEY PERSONS WITHIN THE COMMUNITY

The Ministry of Health in collaboration with its partners namely the United Nations Economic Commission for Africa in collaboration with the World Bank and WHO within the frame work of the Accelerated Treatment Programme on ARV is carrying out a survey on the determinants for adherence to treatment in Burkina Faso, Ghana and Mozambique.

The research team in Burkina Faso seeks your support to identify and analyse the determinants to adherence on ARV treatment. Your valued support will contribute to the identification of the major causes impacting the adherence of patients to treatment through the use of ARV.

Thank you for your availability and understanding.

1. What is the reason why some patients receiving ARV treatment abandon their treatment?

- *Social consequences: Stigmatization divorce, Loss of social standing lack of family or social support, loss of job or social rank, difficulties associated with other needs: food, children distance to the care facility, the cost of the transportation of medication.*

.....

2. **What support does the community or the family provide to the HIV positive person receiving treatment?**

Sound out:

- *Financial support*
 - *Moral support and compassion:*
Organization for the follow up of the treatment, movement, place
-
-

3. **What difficulties do HIV positive persons experience within their family and community?**

Sound out:

- The social difficulties, stigmatization, divorce, loss of social standing
- Family and social intimacy
- To continue working
- The difficulties associated with other needs: food, children
- Distance to the care facility
- Cost of various care needs (transportation, medications, lab tests etc).

ANALYSIS OF THE IMPLEMENTATION OF THE TAP IN BURKINA FASO

The Ministry of Health in collaboration with its partners namely: The United Nations Economic Commission for Africa in collaboration with the World Bank and WHO within the frame work of the Accelerated Treatment Programme on ARV is carrying out a survey on the determinants for adherence to treatment in Burkina Faso, Ghana and Mozambique.

The research team in Burkina Faso seeks your support to identify and analyse the determinants to adherence on ARV treatment. Your valued support will contribute to the identification of the major causes impacting the adherence of patients to treatment through the use of ARV.

Thank you for your availability and understanding.

NB: The discussion themes mentioned below will form the basis for an exchange of views during the workshop planned at the start of the evaluation and also during individual interviews with some of those concerned. In the case of unforeseen difficulties, it is possible that some will comment on the said document in writing.

Targets

- MOH: structure to control AIDS: SG, MCAC, DOH,...
- TAP coordination: national coordinator, MCAC coordinator, TAP/AIDSETI coordinator. President CICDoc: NTP coordinator, Officer responsible for MCAC care, association representation of AIDSETI/NACP-STIs...
- Partnership : WHO, World Bank and UNAIDS

Discussion themes

1. What is your assessment of the content of the TAP in Burkina Faso
 - Preparation
 - The wide target area
 - Follow up/monitoring
 - Implementation
2. What is your assessment of the partnership-public-private as proposed in this programme?
 - * **Criteria** for the selection of partners?
 - * Technical capacity of the partners to play the expected role?
 - * Contribution of the partners in the acceleration of ARV treatment
 - * Technical follow up of cases receiving treatment.
3. What are the results obtained per facility and what is your assessment on each of the facility?
 - the most performing facility? At the bottom of their performance level? Adherence level?
 - Facilities that are not performing at all? Explanation for their poor performance? Level of adherence.
4. What is the general level of treatment of ARV? Existence of dropouts? What is the possible explanation? In what ways and how can information collected during the period of treatment are used and/or have led to the readaptation of the programme in order to facilitate adherence to treatment?
 - reorganization of procedures of care for groups
 - the procedures on follow up for targets per category of patients?
5. What are your expectations on the on-going evaluation as requested by ECA.
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TERMS OF REFERENCE

Social and Economic Determinants of adherence in Burkina Faso

Background

The Treatment Acceleration Program (TAP), a joint partnership between the World Bank, World Health Organization (WHO) and the United Nations Economic Commission for Africa (UNECA), aimed at scaling up Anti-Retroviral Treatment (ART) coverage programs in Ghana, Burkina Faso and Mozambique through innovative public-private partnerships (PPP) has been extended until September 2008.

The relevance of treatment adherence in preventing the spread of drug-resistant strains and in increasing life expectancy among people living with HIV requires designing of strategies that will reduce the number of missed doses in various settings.

Although many studies have been carried out to predict causes of non-adherence, most studies related to social and economic determinants such as substance abuse and depression have often been incomplete and inconclusive, resulting in an urgent need to identify psychosocial determinants of adherence that can be incorporated into interventions to promote optimal adherence.

Despite the challenges of predicting ART adherence, there is a growing agreement that patients' self-assessments of adherence shows significant correlation with viral load tests, whereas estimations by health-care providers often leads to invalid results. ART adherence has therefore become extremely important priority for allocating resources HIV/AIDS resources. It is in that context that the TAP requires the services of an independent consultant to study and analyze various social and economic determinants of adherence in Burkina Faso.

The terms of reference detail the consultant's scope of work.

Scope of Work

Under the overall supervision of the OIC of the African Centre for Gender & Social Development (ACGS) and direct supervision of the Chief of the Human and Social Development Section, the consultant will be required to study and analyze various social and economic determinants of adherence in Burkina Faso including but not limited to:

- Age;
- Gender;
- Occupation;
- Employment status;
- Marital status;
- Income;
- Substance abuse;
- Medical history (chronic illness, depression, other mental disorder);
- Disability;
- Sexual orientation;

- Education;
- Disclosure of HIV status to spouse, partner or/and friends;
- Transactional sex activities;
- Association with PLWA organization;
- Type of adherence support provider;
- Alcohol;
- Incarceration;
- Characteristics of adherence support programs and;
- Nutritional support importance.

The study would consider whether the data that was gathered systematically was used to revise the treatment program. For example, if age had a particular impact on adherence, and that in particular older patients were more adherent than younger patients, were there any implications or revisions in the treatment program that resulted in partnering older with younger patients or training older patients as volunteers to ensure that their experiences would benefit other patients as well.

Performance indicators and Timelines

- (a) De-briefing by 18th March, 2008;
- (b) Data collection by 30th March, 2008;
- (c) Data Analysis by 11th April, 2008;
- (d) First draft submission for review to UNECA by 12th May, 2008;
- (e) Review and discussion of research findings by 30th May, 2008;
- (f) Brief workshop report by 13th June, 2008;
- (g) Final submission of report after incorporation of feedback from reviews and workshop by 3rd July 2008.

Deliverables

- (a) Workshop in Burkina Faso to review findings;
- (b) Workshop report and;
- (c) Evaluation of Social Determinants under TAP, research report

Qualifications

Education

Advanced university degree (Master's or equivalent) in health economics, economic development, social sciences or any related field.

Work Experience

At least 5 years of demonstrated experience in HIV/AIDS research. Knowledge and understanding of theories and concepts related to social science, governance, anthropology and development issues as they apply to HIV/AIDS.

Languages:

Fluency in written and oral English or French and knowledge of a second UN language is an advantage.

Other skills and competencies

Excellent interpersonal skills and respect for diversity. Strong computer skills including the use of software relating to economics and social sciences, presentation programs and Internet research skills are desirable.

Practical working Arrangements

The consultancy will be for a period of 4 months starting from March, 2008 and ending on July, 2008.

The consultant will be expected to travel to Addis Ababa for debriefing and thereafter travel to Burkina Faso for research. The consultant will then travel back to Burkina Faso for the workshop.